



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

Quality Improvement Health Equity Committee Voting Items Policies & Procedures August 8, 2025

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

Policy Procedures Summary of Changes

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)
Behavioral Health	BH-001	Behavioral Health Services	Alameda Alliance shall provide the following Behavioral Health Services when they are provided or ordered by a licensed health care professional acting within the scope of his or her license.	Added language: Section G.8. Alameda Alliance will arrange coverage and facilitate scheduling appointments or arranging the admission for out-of-network services for medically necessary treatment of mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards.	X		
Behavioral Health	BH-005	Care Coordination- Behavioral Health	Alameda Alliance for Health (the Alliance) Primary Care Providers (PCPs) are required to provide behavioral health and/or substance abuse services, including diagnosis and treatment, within their scope of practice.	Added language: Section J. 4.J.The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.	X		
Behavioral Health	BH-008	Behavioral Health Services (GroupCare/IHSS)	Alameda Alliance will cover medically necessary behavioral health services for GroupCare members.	New Policy to split from Medi-Cal due to different regulations.		X	
Quality Improvement/CLS	001	Cultural and Linguistic Services (CLS) Program Description	Describes elements of the Alliance Cultural and Linguistic Services including objectives, activities, roles, work plan and organization chart.	Alignment with DSNP requirements. Minor grammar and formatting updates. Added DSNP as an acronym.	X		
Quality Improvement/CLS	002	Community Engagement	Describes role, function and policies for the Alliance Community Advisory Committee (CAC).	Alignment with DSNP requirements. Minor grammar and formatting updates. Updated designated CAC Coordinator. Added Center for Medicare and Medicaid Services (CMS) as a reference. Added DSNP as an acronym.	X		

Policy Procedures Summary of Changes

Quality Improvement/CLS	003	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities	Describes how the Alliance ensures interpreter and translation services for Alliance members who require language assistance services.	Alignment with DSNP requirements. Updated to comply with APL 25-006, including ability of member's representative to request alternative formats, updating name of multi-lingual "Taglines" to "Notice of Availability," and adding our process for including language access language in small notices. Minor grammar, wording, and formatting updates.	X		
Quality Improvement/CLS	008	Member Assessment of Cultural and Linguistic needs	Describes how the Alliance monitors the language needs of members and ensures these members have access to language assistance services.	Alignment with DSNP and Health Equity requirements. Minor grammar and formatting updates. Added Center for Medicare and Medicaid Services (CMS) as a reference. Expanded and updated language for Notice of Availability. Updated and added Definition/Acronyms section.	X		
Quality Improvement/CLS	009	CLS Program - Contracted Providers	Describes how the Alliance ensures its providers are informed of their responsibilities and provide language assistance services to members.	Alignment with DSNP requirements. Minor grammar and formatting updates. Expanded and updated Quality Improvement Department's role around member and provider language capacity. Updated and added Definition/Acronyms section.	X		
Quality Improvement/CLS	010	CLS Program - Staff Training and Assessment	Describes how the Alliance ensures staff receives cultural sensitivity training and are assessed for bilingual capacity.	Alignment with DSNP requirements. Minor grammar and formatting updates. Added Center for Medicare and Medicaid Services (CMS) as a reference. Updated and added Definition/Acronyms section.	X		
Quality Improvement/CLS	011	CLS Program - Compliance Monitoring	Describes how the Alliance ensures quality language assistance services through monitoring of staff, providers and language services vendors.	Alignment with DSNP requirements. Minor grammar and formatting updates. Updated and added Definition/Acronyms section.	X		
Quality Improvement	QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)	Describes site review process by which Alliance conducts, scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines.	Added DSNP Modified HCQC to QIHEC Clarified that monitoring of missed appointments are applicable to all providers	x		

Policy Procedures Summary of Changes

Quality Improvement	QI-107	Appointment Access and Availability Standards	Describes how the Alliance implements and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care from all applicable provider types.	DSNP-42 CFR 422.112-Access to Care/Medicare Manage Care Mauual 1) Updates Appointment Wait Time (D-SNP)- Urgent/emergency services without PA (immediate), Non-Urgent (PCP)- 7 business days of request, Routine/Preventive Care-30 business days of request 2) Definition of Routine or Preventive Care 3) Monitoring Missed Appointment- updates policy to include all provider within our network 4)APL 25-008- Updated P&P to ensure Member receive hospice care services within 24 hours of request	X		
Quality Improvement	QI-108	Access to Behavioral Health Services	Describes how the Alliance implements and maintain procedures to ensures the Alliance complies with the access and availability standards set by DMHC and DHCS.	DSNP-42 CFR 422.112-Access to Care/Medicare Manage Care Mauual	x		
Quality Improvement	QI-116	Provider Appointment Availability Survey (PAAS)	Describes the PAAS survey process designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members.	DSNP-42 CFR 422.112-Access to Care/Medicare Manage Care Mauual 1) Updates Appointment Wait Time (D-SNP)- Urgent/emergency without PA (immediate), Non-Urgent (PCP)- 7 business days of request, Routine/Preventive Care- 30 business days of request	x		
Quality Improvement	QI-124	Initial Health Appointment (IHA) and Initial Preventive physical Exam (IPPE)	Requirement on completing IHA within 120 days and IPPE within 12 months. Policy provides guidance on the elemens that need to be completed, monitoring, timeline and exlusions.	Included language for Initial Preventive Physical Exam (IPPE) and Annual Wellness Exam (AWE), which is required for the DSNIP program.	X		
Health Education	HED-001	Health Education Program	Descibes Alliance Health Education Program Elements	Updated to align with D-SNP policy guide to include the addition of STARS measures to inform the Alliance Health Education Program.	x		
Health Education	HED-002	Health Edcation Materials	Describes process for creating and approving health education and member informing materials.	Updated to include the D-SNP population.	x		
Health Education	HED-006	SABIRT Services	Describes alcohol and drug screening, assessment, brief interventions and referral to treatment benefit.	Updated to include the D-SNP population.	x		
Health Education	HED-007	Tobacco Cessation	Describes Alliance policy on tracking tobacco use and implementing cessation services.	Updated to include the D-SNP population.	x		
Health Education	HED-009	Diabetes Prevention Program	Describes how the Alliance offers the Diabetes Prevention Program to eligible members.	Updated to add the Medicare Diabetes Prevention Program as a covered D-SNP benefit.	x		
Health Education	HED-010	Doula Services	Describes how the Alliance offers the Doula Benefit to eligible members.	Updated to include the D-SNP population.	x		

Policy Procedures Summary of Changes

Population Health	PH-001	Population Health Management Program	Describes the elements of the Alliance's Population Health Management Program in alignment with the DHCS PHM Policy Guide. Refers to Alliance policies and procedures that detail Alliance population health management elements and programs.	Annual review and updated to include the D-SNP population and NCQA Health Equity Accrediation standards for reducing disparities.	x		
Population Health	PH-002	Basic Population Health Management	Describes Alliance Population Health Management supports including provision of BPHM services by PCPs, role of Alliance ECM, LTC and Care Management staff, Wellness and Prevention activities and refers to related P&Ps and services.	Annual review and updated include the D-SNP population and align language to the PHM policy guide.	x		
Population Health	PH-003	Risk Stratification and Segmentation	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Updated to include the D-SNP population, replace PHM Service with "Medi-Cal Connect," and indicate that the Alliance will use the DHCS RSS tiers once available.	x		
Population Health	PH-005	Population Assessment	Describes how the Alliance understands and assesses its member population and subpopulations by demographics, health, utilization, SDOH and other characteristics in compliance with DHCS PHM Policy Guide and NCQA PHM requirements.	Annual review and updated to include the D-SNP population and NCQA Health Equity Accrediation standards for health equity data collection.	x		
Grievance and Appeals	GA-D-001	Integrated Grievances	New Policy for DSNP grievances. The policy covers procedure for handling of expedited, standard, dismissed and withdrawn grievances. It also included the IRE review process.	New Policy		X	
Grievance and Appeals	GA-D-002	Integrated Reconsiderations and Redeterminations (Level I Appeals)	New Policy for DSNP Level I Appeals. The policy covers procedure for handling of expedited, standard, dismissed and withdrawn appeals. It also includes IRE review process and SFH and further appeal rights.	New Policy		X	
Grievance and Appeals	GA-D-003	D-SNP Complaint Tracking Module (CTM)	New policy for complaints received through the CTM module in HPMS. The policy covers the process for handling urgent, immediate and standard CTMs.	New Policy		X	
CS	CS-002	Community Supports – Housing Transition Navigation Services	This policy outlines the process in which Alameda Alliance for Health processes the Housing Transition Navigation Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	x		

Policy Procedures Summary of Changes

CS	CS-003	Community Supports – Housing Deposits	This policy outlines the process in which Alameda Alliance for Health processes the Housing Deposits Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-004	Community Supports – Housing Tenancy and Sustaning Services	This policy outlines the process in which Alameda Alliance for Health processes the Housing Tenancy and Sustaning Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-007	Community Supports – Medically Tailored Meals/Medically Supportive Food	This policy outlines the process in which Alameda Alliance for Health processes the Medically Tailored Meals/Medically Supportive Food Community Support.	Changed Name to Align with the DHCS renaming, Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-008	Community Supports – Respite Services	This policy outlines the process in which Alameda Alliance for Health processes the Respite Services Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-009	Community Supports – Personal Care and Homemaker Services	This policy outlines the process in which Alameda Alliance for Health processes the Personal Care and Homemaker Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-010	Community Supports – Environmental Accessibility Adaptations (Home Modifications)	This policy outlines the process in which Alameda Alliance for Health processes the Environmental Accessibility Adaptations (Home Modifications) Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-011	Community Supports – Assisted Living Facility Transitions	This policy outlines the process in which Alameda Alliance for Health processes the Assisted Living Facility Community Support.	Changed name to align with the DHCS renaming, Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CS	CS-012	Community Supports – Community or Home Transition Services	This policy outlines the process in which Alameda Alliance for Health processes the Community or Home Transition Services (formerly known as “Community Transition Services/Nursing Facility Transition to a Home”) Community Support.	Added D-SNP, Updated format, Updated policy to align with new DHCS policy guide, Added closed loop referral process	X		
CMDM	UM 16	Transportation Guidelines	Structure of Plan's Transportation Benefit	Addition of DSNP language, update that subcontractor inform liaison about critical incidents.	X		
CMDM	CM-009	Enhanced Care Management Program Infrastructure	AAH leverages existing relationships and communications with our provider network to facilitate care planning, care coordination, and care transition coordination as stated in DHCS ECM Program guide.	Updated to include language for closed loop referral processes	X		

Policy Procedures Summary of Changes

CMDM	CM-011	Enhanced Care Management - Care Management & Transitions of Care	Outreach and engagement are ensured and ECM services are prioritized accordingly by ECM providers. ECM members are thoroughly assessed.	Updated to include language for closed loop referral processes	X		
CMDM	CM-18	Enhanced Care Management - Member Notification	AAH is responsible for the development, implementation and distribution of requirements for ECM services and related activities to contracted entities, including member identification and notification.	Updated to include language for closed loop referral processes	X		
CMDM	CM-041	Enhanced Care Management - Outreach/Member Engagement	AAH is responsible for engaging ECM eligible members, using state determined CMS approved criteria.	Updated to include language for closed loop referral processes	X		
CMDM	CM-001	Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment	Identify, screen, enroll and assess for CCM.	Move auditing language to CM-006	x		
CMDM	CM-002	Complex Case Management Plan Development and Management	Care plan requirements for CCM cases	Move auditing language to CM-006	x		
CMDM	CM-003	Complex Case Management Plan Evaluation and Closure	Criteria to close out CCM care plan and close case	Move auditing language to CM-006	x		
CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Move auditing language to CM-006	x		
CMDM	CM-006	Internal Audit and Monitoring	Monitoring and auditing of all CM cases and HRA cases	Add auditing language for all CM positions to CM-006	x		
CMDM	CM-008	SPD HRA - Survey and Interventions	Structure of Health Risk Assessment (HRA) and Procedure for Seniors and Persons with Disabilities (SPD)	Move auditing language to CM-006	x		
CMDM	CM-034	Transitional Care Services	Structure of Plan's Transitional Care Services program	Move auditing language to CM-006	x		
CMDM	CM-D-001	CICM - Program Infrastructure	CICM program overview, including goals, member engagement and additional requirements for specific CICM populations			X	
CMDM	CM-D-002	CICM - Member Identification & Grouping	Identifying members eligible for CICM populations of focus			X	
CMDM	CM-D-003	CICM - Care Management	Care management for CICM members, including member outreach, engagement, assessment, and care plan development			X	
CMDM	CM-D-004	CICM - Staffing	CICM team including roles, functions and credentials (if appropriate)			X	
CMDM	CM-D-005	CICM - Member Notification	CICM notification to members and providers and how to change lead care manager			X	

Policy Procedures Summary of Changes

CMDM	CM-D-007	CICM - IT Data Sharing	Sharing of data, including assessments and care plans, care transition notifications/alerts, community referrals, etc.			X	
CMDM	CM-D-009	CICM: Adults at Risk for Long-Term Care Institutionalization	Identification and management of members who are eligible for CICM population of focus: At risk for LTC institutionalization			X	
CMDM	CM-D-103	DSNP Individualized Care Plan Components	Care plan components are made of HRA, communication between the interdisciplinary care team and various data sources			X	
CMDM	CM-D-105	DSNP Individualized Care Plan Documentation, Maintenance, Updates and Notifications	Documentation, maintenance, updates and notifications related to the care plan			X	
CMDM	CM-D-106	Developmental Disabilities	Supporting the member population of developmentally disabled and collaboration with RCEB			X	
UM	UM 000	DSNP UM 000 Out of Area/ Out of Network Utilization Management Review Policy RGR	Process for ensuring access to medically necessary care for D-SNP enrollees seeking or receiving services from out-of-area (OOA) or out-of-network (OON) providers, in compliance with CMS and DHCS regulations.	New Policy		X	
UM	UM 000	DSNP UM 000 Prior Authorization/ Concurrent Review/ Organization Determination Audit Process Policy RGR	Process for ensuring compliance with Regulations for PA, CCR and org determination process. Addresses Standard Auditing process	New Policy		X	
UM	UM 000	DSNP UM 000 Readmissions Review Policy RGR	Process to review all Reasmissions within 30 days. Policy describes process to evaluate reasmissions, medical necessity and potentially preventable readmissions	New Policy		X	
UM	UM 000	DSNP UM 000 Review of Hospital Logs Policy RGR (New Name ADT File Review)	Process for reviewing admissions, discharges and transfers file review to ensure we are aligned with the regulations on how to collect, review and analyze the ADT feeds.	New Policy		X	
UM	UM 001	UM 001 Utilization Management Process	Overarching UM Policy discussing the UM services and functions including reporting and heirarchy for UM decision Making.	Addition of NCD/ LCD to the Heirarchy, Alignment with the 42 CFR guidances	X		
UM	UM 004	DSNP UM 004 Over/ Under Utilization	Policy describes approach to identify, monitor and address patterns of healthcare over and under utilization for all 3 LOB.	Updated policy to reflect DSNP elements of STARS, readmission specific to 30 days, CMS regulations. Updated definitions sections. Aligned with updated BH policies	X		

Policy Procedures Summary of Changes

UM	UM 005	DSNP UM 005 Second Opinions	Policy describes process for members to have access to 2nd opinions from qualified healthcare professionals within the Alliance Network.	Update the TAT for notification to the member and provider to align DSNP and MCAL LOBs	X		
UM	UM 007	DSNP UM 007 New and or Experimental Technology Review Process	New and/or Experimental Technology Review Process to review new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.	New Policy created to cover specific guidances related to the DSNP utilization of new and experimental Technologies		X	
UM	UM 007	MediCal/ IHSS UM 007 New and or Experimental Technology Review Process	New and/or Experimental Technology Review Process to review new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.	Minor formatting updates, Annual Review	X		X
UM	UM 011	DSNP UM 011 Coordination of Care- Hospice and Terminal Illness	Policy outlining process for all terminally ill members and potential hospice coordination	Updates added to align with DSNP regulatory requirements including the provision for services under FFS, clarification on the conference opportunity and LCD/ NCD determination utilizations. Alignment with APL 25-008 Hospice services	X		
UM	UM 014	DSNP UM 014 COC Identifying Abuse	Policy highlighting the PCP's role and responsibility to report potential cases of abuse.	DSNP Updates including HRA required questions, CFR 42 definitions and reporting timeframes. Updates to the definitions and references sections	X		
UM	UM 023	DSNP UM 023 Communicable Disease Reporting and Services	Policy outlining the process for Community Health Care Providers/ PCPs to work in alignment with the Local Health Department to report any infectious diseases/ outbreaks.	Significant formatting changes from original MCAL/ IHSS Policy removing duplication, older phone numbers and Tuberculosis specific guidance that was outdated. Updated UM Hierarchy reviews when appropriate. Included CMS regulation.	X		
UM	UM 029	DSNP UM 029 Sensitive Services	This policy outlines the process and procedure for Sensitive Services including Family Planning, Sterilization, Sexually Transmitted Diseases (STD), HIV Testing and Counseling and Abortion in compliance with the Informed Consent, Minor Consent Services and freedom of choice regulations	Significant formatting changes from original MCAL/ IHSS Policy removing duplication, Included D-SNP and CMS regulation.	X		

Policy Procedures Summary of Changes

UM	UM 036	DSNP UM 036 Continuity of Care	ating provider (NPP) of any type at the member	Updated policy to include DSNP regulations pertaining to the member's ability to received continuity of care services upon transition into the Alliance. Correct FY age from 25 to 26 in the policy.	X		
UM	UM 045	DSNP UM 045 Communication Services	Describes process to ensure timely access to UM staff regarding UM process in accordance with DHCS and CMS.	Update purpose statement, include CMS regulations and DSNP relevant process. Details regarding methods for receipt of information and requests from members and providers including contact phone numbers and relevant citations and references.	X		
UM	UM 046	DSNP UM 046 Use of Board Certified Consultants	establish guidelines for the effective utilization of board-certified physicians in a healthcare setting. To ensure that utilization management decisions are informed by appropriate clinical expertise, particularly in complex or specialized cases, by incorporating board-certified consultants into the UM decision-making process.	Minor updates to align with D-SNP regulation and highlight that Board-Certified reviewers may also be used in appeals.	X		
UM	UM 047	DSNP UM 047 UM Subcommittee	(UM) Sub-Committee of the Quality Improvement Health Equity Committee (QIHEC) is a forum for the Alliance to evaluate current activities, processes, and metrics internal to the Inpatient and Outpatient UM department. The Sub-Committee also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes	Updates to include the DSNP requirements for the UM Subcommittee specific to the differences between the MCAL/ IHSS UM Subcommittee and the DSNP LOB	X		
UM	UM 048	DSNP UM 048 Triage and Screening Services	Describes process for triage and screening services in accordance with DHCS and CMS.	Update policy to include CMS requirements, and minor edits to include contact information, references and appropriate citations.	X		
UM	UM 049	DSNP UM 049 UM Utilization Management Satisfaction Survey	Describes process for conducting and reporting results of UM Satisfaction Survey in compliance with DHCS and CMS.	Update policy to include CMS requirements, DSNP references, and survey analysis methodology along with minor edits.	X		
UM	UM 050	UM 050 Tracking and Monitoring of services Prior Authorized	establishes procedures for the systematic tracking and monitoring of healthcare services subject to prior authorization (PA) requirements. It ensures compliance with CMS and Medicaid services regulations for PA and safeguards against improper utilization.	Minor formatting updates,added DSNP References including LCD and NCDs			

Policy Procedures Summary of Changes

UM	UM 052	DSNP UM 052 Discharge Planning to Lower Level of Care	Describes process for review and oversight of discharge planning, administrative days, and care coordination and lower level of care placement.	Update policy to include CMS requirements, DSNP references, and minor edits of both content and grammar.	X		
UM	UM 055	DSNP UM 055 Palliative Care			X		
UM	UM 063	DSNP UM 063 Gender Affirming Surgery and Services			X		
QI	QI-104	Potential Quality of Care Issues	Describes the evaluation, monitoring and appropriate action to address all PQIs	Closure of PQI from date of receipt to be changed to 150 days. Change of responsible parties to be inclusive of any QI Medical Director for the review of PQIs, ie, "QI Medical Director" changed to "Medical Director." Removal of "QI Supervisor" title due to changes in the PQI team structure.	X		



POLICY AND PROCEDURE

Policy Number	BH-001
Policy Name	Behavioral Health Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	MCAL, IHSS
Effective Date	03/21/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	4/19/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

- A. Alameda Alliance shall provide the following Behavioral Health Services when they are provided or ordered by a licensed health care professional acting within the scope of his or her license:
1. Individual/group Mental Health evaluation and treatment (psychotherapy);
 2. Psychological testing when clinically indicated to evaluate a Mental Health condition;
 3. Outpatient services for the purposes of monitoring drug therapy;
 4. Psychiatric consultation for medication management;
 5. Outpatient laboratory, supplies and supplements;
 6. Alcohol Misuse Screening and Counseling (AMSC) for Members who misuse alcohol, in accordance with Alameda Alliance Policy UM-013 Coordination of Care-Substance Abuse
 7. Family therapy (composed of two (2) or more family members) for adult Members with a Mental Health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
 - a. Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.
- B. Alameda Alliance collaborates with Alameda County Behavioral Health (ACBH) and contracted mental health providers to gather and share member's mental health treatment information for the purposes of care coordination. PHI is shared securely to ensure member information is protected and viewed only by authorized staff and treating providers for the purpose of care coordination.
- C. Alameda Alliance refers members to the ACBH ODS program for SUD treatment.

Alameda Alliance ensures that member privacy and data security for SUD treatment is maintained according to State and Federal guidelines including 42-CFR. Member authorization to release information allowing treatment history, active treatment, and health information to be exchanged in obtained as required by law.

- D. For Members under the age of twenty-one (21), Alameda Alliance shall provide Medically Necessary non-specialty Mental Health services listed in Section II A of this Policy, regardless of the severity of the impairment.
- E. For Members under the age of twenty-one (21), Alameda Alliance shall provide Medically Necessary Behavioral Health Treatment (BHT) services
 - 1. BHT services are evidenced-based and include but are not limited to Applied Behavioral Analysis (ABA).
 - 2. If diagnosis is complete or there is prior BHT treatment history, the member is triaged by the Alliance ABA Analyst who is a Board-Certified Behavioral Analyst.
 - 3. If the member seeking BHT services does not have a treatment history and has not been evaluated and diagnosed, a referral is made for evaluation with a pediatrician or psychologist to determine the need for the Comprehensive Diagnostic Evaluation and ABA services.
 - 4. The parent or guardian is instructed to submit a copy of the available information from the treating provider that must show that the member exhibits the presence of excessive and/or deficits of behaviors that significantly interfere with home and community activities.
 - 5. The Alliance BCBA reviews the available information and confirms that the member is medically stable and without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.
 - 6. The Alliance BCBA conducts a thorough assessment of the Member's history and may request additional documentation from the parent or guardian to determine specific treatment needs and the number of hours needed for the initial Functional Behavioral Assessment (FBA). This initial assessment completed by the Alliance BCBA may include one or more of the following:
 - a. Additional evaluations or diagnostic report.
 - b. Release of Information form.
 - c. Individual Education Plan (IEP) report for the member.
 - d. Reports from therapists providing any other services.
 - e. Previous assessments/treatment plans if applicable.
 - f. Previous behavior plan if applicable.
 - 7. The Alliance BCBA reviews the information provided by the parent or guardian, diagnostic and assessment information and follows MCG guidelines and the Board of Behavioral Analysis guidelines to refer the member to a Qualified Autism Service Provider for a Functional Behavioral Assessment (FBA) if a current FBA is not already completed.
 - 8. The Alliance BCBA reviews the FBA and provides authorization for 6 months of BHT services utilizing MCG guidelines and the Board of Behavioral Analysis

guidelines.

9. The Alliance Behavioral Health Care Managers (Clinicians) and staff assist the Alliance BCBA in responding to member needs throughout the course of BHT treatment and the BCBA reviews subsequent treatment reports submitted by the Qualified Autism Service Provider at 6-month intervals and provides subsequent authorizations for continuing BHT services.
- F. Alameda Alliance shall *not* impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by Alameda Alliance, in accordance with the parity in Mental Health and substance use disorder requirements in Title 42, Code of Federal Regulations (CFR), Part 438, Subpart K.
- G. For Group Care Members Alameda Alliance does not require prior authorization for emergency MH/SUD inpatient admissions but does require prior authorization for residential services, intensive outpatient services, psychological testing, electroconvulsive therapy and transcranial magnetic stimulation.
 1. Alameda Alliance will cover behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services without prior authorization.
 2. Alameda Alliance will require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system only if the plan's prior authorization requirements comply with Section 1374.721.
 3. If there is a disagreement between Alameda Alliance and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan will assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to Section 1374.72 at a level of care consistent with utilization review criteria pursuant to Section 1374.721
 4. Alameda Alliance will not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with Section 1374.721.
 5. If contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, Alameda Alliance will either authorize post stabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider within 30 minutes of the time the provider makes the initial telephone call requesting authorization for post stabilization care.
 6. To the extent permissible under federal law, the plan will not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one post stabilization telephone call to the number provided in advance by the plan.
 7. Alameda Alliance will not require the representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the post stabilization telephone call to the plan to be a physician or surgeon.
 - 7.8. Alameda Alliance will arrange coverage and facilitate scheduling appointments or arranging the admission for out-of-network services for medically necessary treatment of mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of

Formatted: Font: Times New Roman, 12 pt

these services, to the maximum extent possible, within geographic and timely access standards.

- H. Alameda Alliance shall use tools mutually agreed upon with Alameda County Behavioral Health (ACBH), administered by Alameda Health System (AHS) to assess the Member's disorder, level of impairment, and needed care.
- I. Through a network of licensed Mental Health care Providers, Alameda Alliance shall provide Behavioral Health Services to Members with Mild to Moderate impairment of behavioral, cognitive, and emotional functioning resulting from a mental condition in the current Diagnostic and Statistical Manual (except relational problems), individual/group Mental Health evaluation and treatment (psychotherapy), testing when clinically indicated to evaluate a Mental Health condition, and outpatient services for the purpose of monitoring drug therapy; and psychiatric consultation for medication management.
- J. Alameda Alliance and its contracted Primary Care Providers (PCPs) shall provide AMSC for Members identified as at-risk of alcohol misuse in accordance with Alameda Alliance Policy.
- K. Alameda Alliance and its contracted PCPs shall be responsible for screening and providing Mental Health services within the scope of their practice.
- L. Alameda Alliance shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with Alameda Alliance Policies: Tracking and Reporting Disclosures of Protected Health Information (PHI), Protected Health Information Disclosures Required by Law, Use and Disclosure for Treatment, Payment, and Health Care Operations. (CMP-005 Minimum Necessary Use & Disclosures)
- M. Alameda Alliance shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with Alameda Alliance Policies: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, Member Authorization for the Use and Disclosure of Protected Health Information.
- N. Alameda Alliance shall maintain and monitor an appropriate provider network and ensure timely access to Behavioral Health Services as set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and Alameda Alliance Policy: QI 108 Access and Availability Standards.
- O. If Behavioral Health Services that are the responsibility of Alameda Alliance are unavailable to the Member within the network, Alameda Alliance shall arrange for the provision of Behavioral Health Services outside the network in a timely manner, and in accordance with Alameda Alliance Policy: UM-057 Authorization Request.

- P. Alameda Alliance shall not require a referral from a PCP or Prior Authorization for an initial Mental Health assessment performed by a network Mental Health Provider. In addition, Behavioral Health Services do not require Prior Authorization except for Psychological Testing and Behavioral Health Treatment (BHT) Services, in accordance with Alameda Alliance Policies and APL 22-005 (No Wrong Door for MHS) Prior Authorization requirements shall be in compliance with the requirements for parity in Mental Health and substance use disorder benefits in Title 42 CFR section 438.910(d).
- Q. Alameda Alliance shall provide a direct telephone call center for emergencies during non-business hours for Members to access and for Providers to coordinate care or to access the nearest emergency room during a crisis.
1. Alameda Alliance shall ensure:
 - a. Timely access to screening of Members for Mild to Moderate Behavioral Health Services using the age appropriate DHCS approved Screening Tool;
 - b. Appropriate staffing levels of the call center; and
 - c. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to Alameda Alliance Policy: Cultural and Linguistic Services.
 2. Alameda Alliance shall ensure its call center staff have relevant knowledge to:
 - a. Provide information regarding Covered Services;
 - b. Identify the location, qualifications, and availability of Providers within the Alameda Alliance Behavioral Health Provider network;
 - c. Inform Members of their rights and responsibilities, in accordance with Alameda Alliance Policy: Member Rights and Responsibilities;
 - d. Communicate the procedure for Member Complaints, Grievances, and Appeals, in accordance with Alameda Alliance Policies, Member Grievance and Appeal Process;
 - e. Communicate the procedure for Provider Complaints and disputes, Appeals and Grievances in accordance with Alameda Alliance Policies, Alameda Alliance Provider Complaint and Appeal Process;
 - f. Access oral interpretation services and written materials in Threshold Languages for Members;
 - g. Provide information on other community services or resources available to Members; and
 - h. Educate the Member regarding the procedure and department at Alameda Alliance to contact if the Member would like to change their Health Network or has questions about Health Network options.
- R. Alameda Alliance shall identify and refer an eligible Member to ACBH for the provision of Medi-Cal Specialty Mental Health Services.
- S. Alameda Alliance shall identify and refer an eligible Member to the County Drug-Medi-Cal Organized Delivery System (DMC-ODS) for the provision of Drug Medi-Cal services.

- T. Alameda Alliance will develop an annual outreach and education plan for Medi-Cal members and primary care providers to increase awareness of the non-specialty mental health services (NSMHS) available to Alliance members which is posted on the Alliance website. The outreach and education conducted for Members will meet cultural and linguistic appropriateness standards, incorporate best practices in stigma reduction, and provide multiple points of contact for Members to access NSMHS. The outreach and education plan will be reviewed annually with the Quality Improvement Health Equity Committee (QIHEC).

The Alliance collaborates with Alameda County Behavioral Health and relevant community organizations including tribal liaisons, with the focus on ensuring that members understand how they can “receive timely mental health services without delay regardless of the delivery system where they seek care and that members are able to maintain treatment relationships with trusted providers without interruption.”

The outreach and education plan includes content specifically created for both members and PCPs and it is informed by, but not limited, to the following:

- 1) The MCP’s stakeholders, including the community advisory committee (CAC) established by the MCP and Quality Improvement and Health Equity Committee (QIHEC) which includes tribal liaisons.
- 2) Most recently approved DHCS Population Needs Assessment as defined by the Population Health Management (PHM) Policy Guide, or the most recently approved National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) Population Assessment.
- 3) A utilization assessment of provided NSMHS that is, at a minimum, stratified and analyzed by race, ethnicity, language, age, sexual orientation, gender identity, and disability.
- 4) Regularly scheduled Operational and No Wrong Door Meetings with ACBH are utilized to collaborate with the County Mental Health Plan (ACBH) to coordinate outreach and education efforts for Members to improve access to mental and behavioral health services.
- 5) Quarterly No Wrong Door Meetings, Joint Operational Meetings and monthly Coordination of Care meetings with ACBH address timely access to services and facilitate and support uninterrupted treatment relationships between members and providers in both the Alliance provider network and the ACBH network of services.
- 6) Collaboration with ACBH leadership and the ACBH Mental Health Services Act implementation team is ongoing to ensure alignment and awareness of programs and services developed and available through the Mental Health Services Act funding.

U. Alameda Alliance's Behavioral Health Department performs the care management and utilization management functions requiring behavioral health expertise and experience. The Alliance integrates behavioral health into its UM, CM and QI program descriptions, work plans and annual evaluations to ensure parity and enable the Alliance's efforts to provide integrated whole person healthcare services.

V. Grievances are reviewed monthly by Behavioral Health Leadership for monitoring, and the identification of trends and areas for improvement. Process improvements may be implemented by the Behavioral Health Department or in other Alameda Alliance departments (e.g., contracting). The process improvements are monitored for effectiveness in improving member experiences.

W. Alameda Alliance's Behavioral Health Department provides Care Management and Utilization Management for Mental Health and Autism Services. The Behavioral Health Department is overseen by the Senior Director of Behavioral Health and the Senior Medical Director. The Senior Medical Director is an Emergency Medicine Physician and the Senior Director of Behavioral Health is a licensed psychologist. Together, they are responsible for Behavioral Health Care Management and Utilization Management processes and level of care determinations. The Behavioral Health Department is staffed by licensed Mental Health clinicians including LCSWs, LMFTs, BCBAs, RNs and Behavioral Health navigators.

Formatted: Indent: Left: 0.86", No bullets or numbering

PROCEDURE

A. PCP and Behavioral Health Services

1. For alcohol misuse, a PCP shall:
 - a. Administer the DHCS-approved screening tool for identifying alcohol misuse in accordance with DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care.
 - b. Provide behavioral counseling intervention on identified issue(s); and
 - c. Refer to ACBH for additional assessment and counseling when indicated.
2. For Mental Health, a PCP shall:
 - a. Screen and provide Mental Health services within the scope of their practice; and
 - b. Refer the Member for further Mental Health services through Alameda Alliance's and / or ACBH's Mental Health Provider Network.

B. Accessing Alameda Alliance Behavioral Health Services

3. A Member may access Behavioral Health Services through the Alameda Alliance Member Services Phone Line.
4. A Member may be referred to the Alameda Alliance Member Services Phone Line from the following:
 - a. Alameda County Mental Health Plan (ACBH) ACCESS Line;
 - b. Self-referral;
 - c. Authorized Representative or caregiver.
 - d. PCP;
 - e. Specialty Care Provider;
 - f. Behavioral Health specialist;
 - g. Long-Term Support Services (LTSS) Provider;
 - h. Community-based agency;
 - i. Case manager, Disease Management staff, or discharge planner; and
 - j. Other Providers of a Member's health care team.

C. Alameda Alliance Member Services Phone Line

5. Call Center requirements shall include:
 - a. Complying with telephone access standards in accordance with Alameda Alliance Policies: Access and Availability Standards; and Member Services Clinical Referral and Triage Process (MBR – 062)
 - b. Utilizing linguistic interpreter services, or the California Relay Service for Members, as necessary to ensure effective communication;
 - c. Verifying the caller's Medi-Cal eligibility and Health Network assignment;
 - i. If the caller is a Alameda Alliance Medi-Cal Member assigned to Kaiser Foundation Health Plan (Kaiser), Alameda Alliance shall refer and provide the caller the Kaiser phone line to access services.
 - ii. If the caller is not a Medi-Cal beneficiary and not in crisis, call center staff shall refer the caller to Alameda County Social Services or provide enrollment information and suggest a community resource for treatment of their described symptoms.
 - d. Determining if the caller is seeking help for a Mental Health concern;
 - e. Screening for crisis and determining if the call is routine, urgent or emergent. If determined urgent or emergent, call center staff shall immediately complete safety screening;
 - f. If a caller's needs are indicated as requiring Emergent or Urgent Services including when a caller who potentially presents as a danger to self or others, call center staff shall transfer the caller to the Alliance BH Care Management Team and/or County's Crisis Response services without delay to prevent further deterioration of the caller's condition;
 - g. Call center staff must link Emergent calls to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than two (2) hours after determining the call is emergent;
 - h. Call center staff must transfer urgent calls for services to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no

- case more than within twenty-four (24) hours after making the determination that the call is urgent;
- i. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to the Alliance Behavioral Health Care Management Team (Clinician) and:
 - j. If the Caller is determined to be a Medi-Cal beneficiary assigned to Alameda Alliance with a Mental Health need, the call center staff shall conduct a brief telephone clinical screening tool approved by DHCS to verify appropriate level of services and transfer/refer members meeting the threshold criteria for Specialty Mental Health Services to the ACBH Access Team to initiate appropriate mental health services.
 - k. The member services staff will use the DHCS approved screening tool to determine the need for a referral to Alameda County Behavioral Health of moderate to severe services. Member services will transfer/refer members to the ACBH Access Team to initiate appropriate mental health services.
6. As a result of the brief telephone clinical screening using the DHCS approved Screening Tool:
- a. If it is determined the Member meets Mild to Moderate need for Behavioral Health Services, the call center staff will provide the Member with referrals to appropriate Behavioral Health Services. The call center staff will ensure the Member is directed to Providers that are within the Alameda Alliance Behavioral Health Network, are currently accepting Alameda Alliance Medi-Cal Members, can provide appropriate cultural and linguistic services, and can offer a first appointment within the standards pursuant to Alameda Alliance Policy: Access and Availability Standards.
 - b. If determined the Member does *not* meet Mild to Moderate need for Behavioral Health Services and rather does meet for Serious Mental Illness (SMI), the call center staff will warm transfer the member to the Alliance BH Care Manager who will complete the DHCS clinical assessment and transition of care form and subsequently transfer the member to ACBH ACCESS where the Member will establish appropriate services consistent with APL 22-005 No Wrong Door for MHS.
 - i. Based on screening, member will be referred to ACBH if member has:
 - a. An included diagnosis for services with ACBH
 - b. A significant impairment in an important area of life functioning or a reasonable probability of deterioration in an important area of life functioning
 - ii. Member can also initiate services by self-referring to an Alliance contracted provider. The Alliance contracted provider to complete the initial screening during the first initial assessment appointment. If based on the screening, member meets criteria for Specialty Mental Health Services, current provider to notify Alliance BH department to refer the member to ACBH for services utilizing the DHCS approved Transition of Care Tool.
 - iii. Transfer/refer members to ACBH Access Team:
 - a. If during clinical review or during the course of treatment the

behavioral health provider determines that member meets criteria for Specialty Mental Health Services through the Mental Health Plan, BH Case Manager will coordinate with member and current behavioral health provider to transition member to the ACBH for services. BH Case Manager will ensure successful linkage to ACBH for services consistent with “closed loop” referral requirements.

- c. If further assessment and treatment for alcohol and/or substance use is determined, the call center staff shall warm transfer the Member to ACBH for Drug Medi- Cal services.
- 7. Alameda Alliance shall ensure the following steps are completed during the Member call:
 - a. Member’s eligibility status and Health Network assignment shall be verified each time the Member contacts the Alameda Alliance Member Services Phone Line;
 - b. A safety screening and an age-appropriate Screening Tool approved by DHCS will be completed, the outcome/results of the screening, and if applicable, any resources/Provider referrals that were provided; and
 - c. Warm transfer to the Alliance BH Care Management Team for further clinical assessment based on the Safety Screening and protocols for identification of urgent and emergent access to care.

D. Care Coordination

- 8. Alameda Alliance shall coordinate Mental Health care for Members enrolled in the Enhanced Care Management (ECM) and Community Supports (CS) in accordance with Alameda Alliance policies for ECM and CS.
 - a. Alameda Alliance shall ensure compliance with all applicable State and federal requirements related to ECM and all CSS requirements determined by DHCS.
 - b. Alameda Alliance shall ensure Members are receiving appropriate and coordinated services.
- 9. Alameda Alliance shall ensure care coordination with ACBH is addressed in interagency Alameda Alliance/ACBH Collaboration Meetings to ensure:
 - a. Provision of all Medically Necessary Covered Services; and
 - b. Identification and referral of eligible Members to LTSS based on Member’s Plan of Care.
 - c. When Alameda Alliance is determined to be responsible for covered Behavioral Health Services, Alameda Alliance shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the Memorandum of Understanding with the ACBH.
 - d. Transition of care is provided for Members transitioning to or from Alameda Alliance or ACBH Mental Health services in compliance with APL 22-005 (No

Wrong Door for MHS) requirements. ACBH clinical consultation, including consultation on medications, shall be provided to Alameda Alliance's PCPs who are treating Members with mental illness;

10. Coordination of care for Inpatient Mental Health treatment:

- a. ACBH requires that inpatient hospital Providers notify a Member's PCP within twenty-four (24) hours of admission and discharge from an inpatient Mental Health treatment to arrange for appropriate follow-up services.
- b. To facilitate transition of care for Members transiting to or from ACBH Mental Health services, Alameda Alliance's PCPs and the outpatient Behavioral Health Providers treating Members with mental illness shall receive clinical consultation, including consultation on medication from ACBH.
- c. Alameda Alliance and contracted Health Network PCPs and the outpatient Behavioral Health Provider shall review and update the care plan of the Member as clinically indicated.

11. Services provided Simultaneously by Alliance and ACBH

- a. ACBH and Alameda Alliance will coordinate provision of prescribing psychiatrists and psychiatric NPs who are serving Alameda Alliance members; and
- b. Ensure non-duplicated specialty Mental Health services provided through ACBH, including psychiatric medication management, can be provided simultaneously with Mental Health services provided by Alameda Alliance network providers when clinically appropriate.

12. Emergency Services

- a. Alameda Alliance shall provide emergency room facility and related services (other than Specialty Mental Health Services), home health agency services as described in Title 22 of the California Code of Regulations (CCR) section 51337, Non-Emergency Medical Transportation as defined in Alameda Alliance Policy: Transportation: Emergency, Non- Emergency, and Non-Medical, and Covered Services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical examination required upon admission;
- b. Alameda Alliance shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's Mental Health or medical condition; and
- c. As the County Mental Health Plan, ACBH provides emergency assessment of the Member's Mental Health condition through their Crisis Services Team and designated Emergency Departments throughout Alameda County.

13. Information Exchange

- a. Alameda Alliance shall ensure timely sharing of information and roles and responsibilities for sharing Protected Health Information (PHI) for the purposes of medical and Behavioral Health care coordination pursuant to Title 9, CCR, section 1810.370(a)(3), and in compliance with Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal privacy laws.
14. Members receive Specialty Mental Health Services, as well as alcohol and/or substance use disorder treatment while receiving services from a Specialty Mental Health Provider; and
15. Members are receiving services from ACBH and/or Drug Medi-Cal program.

DEFINITIONS

Term	Definition
Appeal	A review by Alameda Alliance of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both Mental Health and substance use disorder services, as covered by Alameda Alliance.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.

Alameda Alliance Member Services Phone Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call to obtain referrals for all Alameda Alliance Covered Outpatient Mental Health Services. Telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

Term	Definition
Child with Serious Emotional Disturbance (SED)	Pursuant to Section 1912(c) of the Public Health Service Act and Section 5600.3 of the Welfare and Institutions Code, children with a serious emotional disturbance are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the Alameda Alliance program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under Alameda Alliance's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the Alameda Alliance Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.

Drug Medi-Cal Treatment Program (Drug Medi-Cal)	Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Generally accepted standards of mental health and substance use disorder care	Generally accepted standards of mental health and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73 . Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Term	Definition
Emergent Services	For purposes of this policy, shall be indicated when the caller has a psychiatric condition that meets criteria for acute psychiatric hospitalization and cannot be treated at a lower Level of Care. These criteria include the caller being a danger to self or others.
Grievance	An oral or written expression of dissatisfaction, about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Enhanced Care Management Program (ECM)	This program is required by DHCS to replace the prior Health Homes Program and is designed to provide targeted services and resources for members who meet ECM criteria in order to provide additional support and Care Management services for members with complex needs.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable Alameda Alliance policies.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
Member	A Medi-Cal eligible beneficiary as determined by the County of Alameda Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the Alameda Alliance program.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Plan of Care	An individual written Plan of Care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or other institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Alameda Alliance or Business Associates and relates to: 1. The past, present, or future physical or Mental Health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Behavioral Health provider, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Rehabilitation services, which include Mental Health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services. Specialty Mental Health Services may also include: 1. Psychiatric inpatient hospital services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; and 5. Early Periodic Screening, Detection, and Treatment (EPSDT) Specialty Mental Health Services
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely Mental Health intervention that shall be appropriate to the severity for the condition.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews including:
Behavioral Health,
Case and Disease Management,
Grievance and Appeals,
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning
UM-005 Second Opinions
UM-014 Identifying Abuse
UM-015 Emergency Services and Post Stabilization Services
UM-016 Transportation Guidelines
UM-036 Continuity of Care
UM-045 Communication Services

UM-048 Triage and Screening Services
UM-057 Authorization Requests
UM-058 Continuity of Care for Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Transitioning into Medi-Cal Managed Care
CM-001 CCM Identification Screening Enrollment and Assessment
CM-002 CCM Plan Development and Management
CM-004 Care Coordination
CM-011 ECM Care Management and Transitions of Care
MBR-062 Member Services Clinical Referral and Triage Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 3/21/2023

Revisions: 6/12/2024, **12/18/2024**

Red = substantive updates

REFERENCES

- Alameda Alliance Contract with Department of Health Care Services (DHCS)
- Memorandum of Understanding with ACBH
- Alameda Alliance Policy: Member Rights and Responsibilities
- Alameda Alliance Policy: Cultural and Linguistic Services
- Alameda Alliance Policy: Appeal Process
- Alameda Alliance Policy: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
- Alameda Alliance Policy: Authorization for Psychological Testing for Mental Health Conditions
- Alameda Alliance Policy: Access and Availability Standards
- Alameda Alliance Policy: Alameda Alliance Provider Complaint
- Alameda Alliance Policy: Member Grievance
- Alameda Alliance Policy: Tracking and Reporting Disclosures of Protected Health Information (PHI)
- Alameda Alliance Policy: Protected Health Information (PHI) Disclosures Required by Law
- Alameda Alliance Policy: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations
- Alameda Alliance Policy: Member Authorization for the Use and Disclosure of Protected

Health Information

- DHCS All Plan Letter (APL) 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
 - DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
 - DHCS APL 21-002 Implementation of SB 855, MH/SUD Coverage
 - DHCS APL 22-005 No Wrong Door for Mental Health Services
 - DHCS APL 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders.
 - DHCS APL 22-007 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
 - Medi-Cal Provider Manual – Part 2: Psychological Services
 - Title 9, California Code of Regulations, §§1810.370(a)(3), 1830.205 and 1830.210
 - Title 22, California Code of Regulations, §51337
 - AA. Welfare and Institutions Code, §§14132.03 and 14189 BB. Title 42, Code of Federal Regulations, Part 438, Subpart K CC. Title 42 Code of Federal Regulations §438.910(d)
-

MONITORING

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

a.

collaboration

collaboration



POLICY AND PROCEDURE

Policy Number	BH-005
Policy Name	Care Coordination – Behavioral Health
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Senior Director, Behavioral Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/15/2024~~ TBD
Administrative Oversight Committee Approval Date	~~12/18/2024~~ TBD

POLICY STATEMENT

- A. Alameda Alliance for Health (the Alliance) Primary Care Providers (PCPs) are required to provide behavioral health and/or substance abuse services, including diagnosis and treatment, within their scope of practice.
- B. PCPs are required to provide mental health (MH) and substance use disorder (SUD) screening for their assigned members.
 - 1. If the PCP cannot perform the mental health/SUD assessment, they are required to refer the member to an appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, whether to the Alliance’s Behavioral Health department, or to the Alameda County Behavioral Health services.
 - 2. Members with positive screening results may be further assessed by the PCP or by referral to the appropriate mental health/SUD delivery system.
- C. PCPs treating Members with behavioral health SUD needs beyond the PCP’s scope of practice, in terms of diagnosis or treatment, must refer the member to the appropriate Mental Health/SUD Provider.
 - 1. Medi-Cal – The Alliance’s Behavioral Health department which will in turn coordinate with the Alameda County Behavioral Health (ACBH)
 - 2. All other Lines of Business – The Alliance’s Behavioral Health department.
- D. At any time, members can choose to seek and obtain an outpatient mental health/SUD assessment from a licensed mental health provider within the AAH network without prior authorization.
- E. AAH furnishes all services defined as appropriate and medically necessary under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health/SUD conditions, discovered by a screening service, regardless of whether those services are covered in the California Medi-Cal plan.
- F. Behavioral Health/SUD services need not be curative or restorative to ameliorate a behavioral health condition, consistent with federal guidance from Centers for Medicare and Medicaid Services (CMS.)
- G. Behavioral/SUD Health services that sustain, support, improve or make more tolerable a behavioral health/SUD condition are considered to ameliorate the condition, and are thus medically necessary. They are also covered as Early and Periodic Screening, Diagnostic and Treatment, (EPSDT) services.
- H. For members who are 21 years of age or older, services are considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- I. AAH arranges for the provision of Non-Specialty Mental Health Services (NSMHS) and SUD services for all Medi-Cal members, including the following populations:
 - 1. Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM);

2. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;
3. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in absence of a mental health disorder, are subject to psychotherapy, and
4. Members of any age with potential mental health disorders not yet diagnosed.

4.J. The Alliance will arrange coverage for out-of-network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.

Formatted: Indent: Hanging: 0.01"

J.K. AAH covers up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.

K.L. AAH arranges for the provision of medically necessary SMHS for members who meet access criteria for SMHS as described in the Behavioral Health Information Notice (BHIN) 21-073

L.M. AAH arranges for the provision of the following non-specialty mental health services (NSMHS):

1. Mental health evaluation and treatment, including individual, group and family psychotherapy;
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for purposes of monitoring drug therapy;
4. Psychiatric consultation;
5. Outpatient laboratory, drugs, supplies, and supplements.

M.N. Services are defined as "medically necessary" or a "medical necessity" in accordance with the California Welfare and Institutions Code (W&I) sections 14059.5 and 14184.402, for individuals under 21, a service is "medically necessary" or a "medical necessity" when the service meets the standards set forth in Section 1396d(c)(5) of Title 42 of the United States Code (U.S.C.) This includes NSMHS and SUD services and are covered by AAH as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

AAH covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. This includes facility and professional services and facility charges claimed by emergency departments, all professional physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member

N.O. AAH arranges for the provision of Medications for Addiction Treatment (MAT) provided in primary care, inpatient hospitals, emergency departments, and other contracted medical settings.

O.P. AAH arranges for the provision of emergency services necessary to stabilize the member for behavioral health/SUD and/or medical condition

P.Q. AAH provides non-business hour, (including 24 hour/7 days per week) psychiatric emergency services coordinated through the Behavioral Health department. See policy MBR-062 Member Services Clinical Referral and Triage Process, and policy BH-001 Behavioral Health Services.

Q.R. The AAH Nurse Advice Line uses protocols to ensure that members who call the Advice Line displaying symptoms of psychiatric emergencies or requesting psychiatric emergency services are directed to appropriate care. This may include referring to a mental health evaluation team and/or law enforcement with authority to write a hold for psychiatric care. For the provision of behavioral health and SUD services for people over the age of 21 years old all medically necessary determinations for covered specialty mental health services and substance use disorder services provided by AAH shall be made in accordance with W&I Section 14184.4, and is considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain. (W&I Sec.14059.5)

R.S. AAH covers clinically appropriate NSMHS/SUD even when services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether the member meets criteria for NSMHS or that SMHS access or SUD criteria are met.

S.T. AAH covers clinically appropriate NSMHS/SUD services whether or not services are included in an individual treatment plan; whether or not the member has a co-occurring mental health

condition and substance use disorder (SUD); and whether or not NSMHS and SMHS services are provided concurrently, (if those services are coordinated and not duplicated

~~T.U.~~ AAH does not deny or disallow reimbursement for NSMHS/SUD services provided during the assessment process if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS or SUD.

~~U.V.~~ Clinically appropriate and covered NSMHS delivered by providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan.

~~V.W.~~ AAH is responsible to:

1. provide Comprehensive Medical Case Management Services for members with NSMHS or SHMH needs, including coordination of care to ensure the provision of all medically necessary services, whether those services are delivered in the Alliance network or out of network.
2. cover and pay for medically necessary Medi-Cal covered physical health care services for a member receiving NSMHS and SMHS, whether those services are delivered within or outside of the Alliance's provider network.
3. appropriately manage a member's mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health/SUD services, within and outside of the AAH provider network; and to
4. coordinate care with the ACBH service system.

~~W.X.~~ Drug Medi-Cal (DMC) services are delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services through ACBH. These clinically appropriate and covered services are covered whether or not the member has a co-occurring mental health condition.

~~X.Y.~~ Any concurrent NSMHS and SMHS/SUD for adults, as well as children under 21 years of age, are coordinated between AAH and ACBH to ensure member choice. AAH arranges for the coordination with ACBH to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider, and vice versa.

~~Y.Z.~~ Members with established therapeutic relationships with an AAH provider may continue receiving NSMHS from the AAH provider (billed to the AAH), even if the member simultaneously receives SMHS/SUD from an ACBH or AAH provider (billed to AAH), (as long as the services are coordinated between the delivery systems and are non-duplicative.)

~~Z.AA.~~ Alliance member informing materials (such as the Member Handbook,) clearly state that referral and prior authorization are not required for a member to seek an initial mental health assessment from an AAH network mental health providers and notifies members of applicable policies.

~~AA.BB.~~ The Alliance ensures that its provider network is adequate to provide a full range of covered NSMHS to its pediatric and adult members, consistent with APL 21-006.

~~BB.CC.~~ Members referred for behavioral health treatment remain enrolled in the Alliance and the assigned PCP remains responsible for all necessary physical health care.

~~CC.DD.~~ The Alliance maintains a process of communication amongst the member's assigned PCP and mental health providers.

~~DD.EE.~~ The Alliance's case management team ensures internal communication and communication with the Alliance's contracted entities between all levels of care.

~~EE.FF.~~ The Alliance retains full responsibility for assuring continuity of care.

Assessment, Screening and Referrals

The Alliance has a process for assessing, screening, and referring members for behavioral health services. AAH does not require prior authorization for an initial mental health assessment. AAH is obligated to cover the cost of an initial mental health assessment completed by an out of network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and access requirements.

Confidentiality

The Alliance provides reasonable protection of member's confidentiality that does not cause undue delay or disruption in care.

Medi-Cal Behavioral Health Care Coordination

- A. Alameda Alliance for Health is obligated to cover and pay for mental health assessments for members with potential mental health disorders conducted by licensed mental health professionals as specified in the Medi-Cal Provider Manual.
1. This is in addition to the requirement that PCPs offer mental health services within their scope of practice.
 2. The Alliance covers outpatient mental health services and coordinates care for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool, transition of care tool, and sets of tools agreed upon by both the Alliance and its MHP), resulting from a mental health disorder, as defined in the current DSM.
 3. AAH arranges for the provision of the following non-specialty mental health services (NSMHS):
 - i Mental health evaluation and treatment, including individual, group and family psychotherapy;
 - ii Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
 - iii Outpatient services for purposes of monitoring drug therapy;
 - iv Psychiatric consultation;
 - v Outpatient laboratory, drugs, supplies, and supplements.
 4. Conditions that the DSM identifies as relational problems (e.g., couples counseling, family counseling for relational problems) are not covered as part of the new benefit by the Alliance or the MHP.
 5. All services must be provided in a culturally and linguistically appropriate manner.
- B. The Alliance provides Alliance Medi-Cal members with outpatient mental health services as described in DHCS MMCD All Plan Letter 13-021, DHCS MMCD All Plan Letter 13-023, and all other members with both outpatient and inpatient behavioral health services.
- C. The Alliance maintains a Memorandum of Understanding (MOU) with Alameda County Behavioral Health Care Services (ACBHCS) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of behavioral health/SUD and medical services for Medi-Cal members enrolled in the Alliance. The MOU includes a process for resolving disputes between AAH and ACBHCS that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services (SMHS) and prescription drugs, while the dispute is being resolved. The dispute resolution process and liaison function will address issues related to behavioral health services for Alliance members. The MOU will include the following provisions:
1. ACBHCS will provide and be responsible for specialty mental health/SUD services as described in DHCS MMCD Policy Letter 00-001REV to Medi-Cal beneficiaries enrolled in the Alliance and Exhibit A, Attachment III, Section 5.6.
 2. ACBHCS will provide emergency specialty mental services during regular business hours, which meet the criteria outlined in State regulations, Title 9, Section 1830.205 and 1830.210
 3. Specify the entity responsible for establishing contracts detailing payment mechanisms with providers
 4. Require coordinated case management and concurrent review by both the Alliance and ACBHCS for any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders).
 5. Specify procedures to ensure timely and complete exchange of information between the Alliance and ACBHCS for the purpose of medical and behavioral health care coordination. This procedure ensures the member's medical record is complete and that the Alliance can meet its care coordination obligations.
 6. Specify the financial responsibility for the service.

Group Care Requirements for Behavioral Health

- A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.
- B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "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:
- a. In accordance with the generally accepted standards of mental health and substance use disorder care.
 - b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
 - c. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

- C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
- D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a mental health or substance use disorder when services are not available in network within geographic and timely access standards to ensure the delivery of these services, to the maximum extent possible, within geographic and timely access standards. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
- E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program. F. In accordance with CA Health and Safety Code §1374.721:
 - a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
 - b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
 - c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
 - d. The Alliance and its delegates will conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90 percent. AAH complies with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

PROCEDURE

Identification/Diagnosis

- A. PCPs are responsible for identifying Members with behavioral health conditions requiring professional treatment. Identification of these members can occur during routine physical exams through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.
- B. PCPs are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.
- C. Members presenting with complex or mixed psychiatric symptomatology that make the diagnosis uncertain must be referred to a behavioral health practitioner for assessment and diagnosis.
- D. The Alliance ensures timely evaluation, screening, and diagnosis of members with ASD.
- E. The Alliance has methods in place to ensure communication between and among member's mental health providers and medical providers. These methods help ensure appropriate evaluation, screening, diagnosis, and treatment for SED, SMI, and autism conditions.
- F. Alliance members with both mental and medical conditions are screened, identified, and referred in a timely manner.
- G. The Alliance has set standards to uphold timely evaluation, screening, and diagnosis of members. Specifically:
 - 1. Patients with ASD
 - 2. Members diagnosed with co-existing medical and mental health conditions.
- H. The effectiveness of screening enrollees with co-existing conditions is monitored at least annually for members receiving mental health services. This monitoring includes review of timely access to treatment and any follow-up being done.

Treatment

- A. PCPs are responsible for treating Members with behavioral health conditions within their scope of practice. Treatment includes the provision of appropriate psychotropic medications, as indicated. Typical behavioral health conditions within the scope of practice of PCPs include:
 - 1. Depression - uncomplicated depression responsive to first line anti-depressant medication.
 - 2. Anxiety - uncomplicated generalized anxiety requiring the short-term use of anxiolytics.
 - 3. Adjustment Reaction – grief reaction, anxiety, or other symptoms as a result of negative life occurrence. The PCP is responsible for medication management, if necessary.
 - 4. Attention Deficit Hyperactive Disorder (ADHD-) – this disorder is evaluated by the PCP; however formal diagnosis and medication management of the disease may or may not be within the PCP's scope of practice.

B. The following conditions, when combined with significant impairment, are generally beyond the PCP's scope of practice and require a referral to a behavioral health practitioner for evaluation and diagnosis:

1. Schizophrenia;
2. Schizoaffective Disorder;
3. Bipolar Disorder;
4. AD-D - formal diagnosis and/or medical management;
5. Depression with psychotic or anxiety features, or unresponsive to typical antidepressant medication;
6. Obsessive Compulsive Disorder;
7. Severe anxiety;
8. Any Member with symptoms suggestive of mental illness that cannot be definitively diagnosed by the PCP;
9. Pervasive Development Disorder or Autism;
10. Anorexia Nervosa (Behavioral component);
11. Bulimia Nervosa (Behavioral component); and
12. Any Member not responding as expected to prescribed psychotropic medications.

C. To ensure that high quality, effective care, vital clinical and demographic patient information will be provided by the PCP to the Behavioral Health Practitioner.

The Behavioral Health Practitioner is expected to provide written communication to the PCP periodically throughout the visits and when there are changes in the level of care. In addition, behavioral health providers should communicate with PCPs or other treating physicians any time that such communication is deemed clinically appropriate, examples are but are not limited to:

1. Concerns for the patient's physician safety or the safety of others interacting with the patient.
2. Indication that the patient may be abusing prescription medication or illegal drugs.
3. Presentation of symptoms that may be medical in origin.
4. Indication of adverse reaction(s) to medication.

D. Referrals.

1. PCPs and/or specialists, with the assistance of the Alliance, are responsible for referring Members to the appropriate Mental Health Provider for treatment.
2. Medi-Cal Members referred to the Alliance's Behavioral Health department who will then coordinate with County Mental Health Plan (ACBHCS) for assessment, diagnosis and treatment as needed. PCPs may also call the Alliance's Behavioral Health department or the Alameda County Behavioral Health (ACBHCS) for advice or consultation regarding Member behavioral health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.
3. Providers and PCPs can also receive assistance in making referrals for behavioral health care through the Alliance by contacting Member Services.
4. Members may also self-refer to behavioral health practitioners for treatment. The Alliance Member Services can assist Members desiring to self-refer and/or with accessing behavioral health services as needed.
5. When members are referred to the Alliance's Complex Case Management (CCM) program, the Alliance's case management staff performs a General Assessment. During the assessment, the assigned case manager evaluates the member's mental health status, including review of psychosocial factors, cognitive functions, and depression. Referrals are made to behavioral health clinicians for case management members that meet specified criteria.

Care Coordination

A. The Utilization Management/Medical Services Department is responsible for managing the coordination of care for members receiving ongoing services with a behavioral health practitioner. Coordination activities include:

1. Facilitating clinician-to-clinician conversations between the PCP and the behavioral health practitioner, as necessary;
2. Maintaining liaison with the East Bay Regional Medical Center to:
 - a. Assist members with developmental disabilities to understand and access services.
 - b. Act as a central point of contact for questions, access and care concerns, and problem resolution as required by Welfare and Institutions Code 14182.9(c)(10).
3. Facilitating transfer of medical records between a treating Alliance physician and the behavioral health practitioner as necessary; and
4. Other Care Coordination/Utilization Management services as needed to assure all appropriate services (home health, laboratory or other diagnostic testing, specialty referral, etc.) are available for the Member.

B. PCPs are responsible for direct coordination of the clinical care of the member in concert with the behavioral health practitioner through phone calls, transfer of medical records, and other specialty referrals as indicated.

- C. The Alliance has processes in place to ensure appropriate communication and exchange of information between the plan's clinical case management staff and its contracted entities including delegates, IPA/medical groups, and facilitates. as it relates to behavioral health services and treatment for its members.
- D. The Alliance clinical case management staff ensures there's coordination in care between the medical and mental health providers to improve the Member's diagnosis, treatment, and referral of mental health conditions in the medical setting.
- E. The Alliance Utilization Management/Health Care Services Department is responsible for informing the PCP (assuming release of information consented to by the Member) upon learning that a Member has directly accessed an out of- network behavioral health practitioner without going through the PCP or the Alliance.
- F. Care Coordination is also available for consultation regarding complex cases, members with co-existing medical conditions and mental disorders, and/or to assist with coordinating care with behavioral health practitioners, including county practitioners.
- G. The Alliance's case management team ensures internal communication and communication with the Alliance's contracted entities between all levels of care.
 - 1. Levels of care include but are not limited to inpatient care, partial hospitalization, outpatient care, day and residential treatment.
 - 2. Interdisciplinary rounds that include Behavioral Health are conducted by The Alliance Case Management staff and The Alliance Inpatient Utilization Management staff.
- H. The Alliance upholds a coordination of care process that includes communication amongst providers between levels of care. This process and its accompanying standards are disseminated amongst the plan's providers.

Eating Disorders

- A. AAH is responsible for all medically necessary physical health components of eating disorder treatment, and for providing or arranging medically necessary non-specialty mental health services (Non-Specialty Mental Health Services,) and specialty mental health services (SMHS) to its members.
- B. AAH and ACBH will provide services necessary to correct or ameliorate eating disorders for members of all ages, including members under age 21.
- C. Regarding members with eating disorders, AAH provides inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.
 - 1. AAH will also provide or arrange for NSMHS for members requiring these services.
- D. AAH will cover and pay for emergency room professional services.
- E. As additionally noted above, AAH will provide care coordination for medically necessary care for members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a member.
- F. AAH will coordinate with Alameda County of Behavioral Health (ACBH) to provide, arrange, and pay for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
 - 1. For partial hospitalization and residential eating disorder programs, AAH will coordinate with the ACBH to ensure coverage for medically necessary physical health components.
 - 2. AAH and ACBH mutually agree to arrangements to cover the cost of medically necessary services provided in partial hospitalization and residential eating disorder programs. This includes agreement on the services, unit costs, and total costs associated with an episode or case of eating disorder treatment.

Medications

- A. AAH covers outpatient laboratory tests, drugs, supplies and supplements prescribed by the mental health providers in the AAH network, PCPs, and non-network physicians prescribing for members, including physician administered drugs administered by a health care professional in the clinic, physician's office or outpatient setting through the medical benefit, to assess and treat mental health conditions.
- B. The Alliance is responsible for informing network pharmacies of the coverage status of medications and provides instructions on which entity to bill for specific psychotropic medications.
- C. Alliance and non-network (prescribing for members,) physicians are responsible for writing prescriptions for needed medications, and providing any additional information required by the Alliance or Medi-Cal Rx to obtain a particular medication.

- D. The Alliance covers Substance Use Disorder (SUD) services including medications for addiction treatment, (also known as Medication-Assisted Treatment, or MAT) when delivered in Primary Care Offices, Emergency Departments, inpatient hospitals, and other contracted medical settings.

Dispute Resolution

- A. Regardless of the MOU status, AAH and ACBHCS must complete the plan level dispute resolution process within 15 business days of identifying the dispute.
- B. Within three business days of receipt of a Request for Resolution from AAH or ACBHCS, DHCS will forward a copy of the Request for Resolution to the Director of AAH or ACBHCS via secure email.
- 1 AAH will respond and provide relevant documents to the requesting party within 3 business days.
 - 2 If ACBHCS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by AAH. Conversely, if AAH fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBHCS.
- C. Within three business days after failure to resolve the dispute during that timeframe,
1. AAH or ACBHCS must submit a written Request for Resolution to DHCS
 2. Request for Resolution will be signed by AAH CEO or CEO's designee.
 3. Request for Resolution must include:
 - a. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the member by either AAH or the ACBHCS and the expected rate of payment for each type of service;
 - b. A history of the attempts to resolve the issue(s) with the ACBHCS;
 - c. Justification for AAH's desired remedy; and
 - d. Any additional documentation that AAH deems relevant to resolve the disputed issue(s), if applicable.
 - e. The Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov.
- D. Within 20 business days from the third business day after the Notification date, DHCS will communicate the final decision via secure email to the AAH's CEO (or the CEO's designee, if the designee submitted the Request for Resolution) and the ACBHCS's Director (or the Director's designee, if the designee submitted the Request for Resolution).
- E. Any such action required from the DHCS of either AAH or ACBHCS must be taken no later than the next business day following the date of the decision.
- F. The Alliance may submit a request for resolution to DHCS, in accordance with the rules governing resolution of disputes in Title 9, CCR, Section 1850.505, when a dispute with ACBHCS about Alliance contractual obligations cannot be satisfactorily resolved for the Alliance's Medi-Cal members.
- G. AAH is contractually responsible for the provision of case management and care coordination and continuity of care for all medically necessary services a member needs, including those services that are the subject of a dispute between AAH and ACBHCS.
- H. This includes assurance that new members going through transition of care with acute, serious, or chronic mental health conditions receiving services from a non-participating to participating provider are kept safe throughout the transition.
- I. Any dispute between the Alliance and ACBHCS shall not delay case management and care coordination, as well as coverage of medically necessary specialty mental health services, physical health services, or related prescription drugs and laboratory, radiological or radioisotope services to Alliance members.
- J. During resolution of the dispute, AAH will be responsible for working with ACBHCS to ensure that there is no duplication of SMHS, for which ACBHCS will provide case management.

Expedited Dispute Resolution Process

- A. AAH may seek to enter into an expedited dispute resolution process if a member has not received a disputed service(s) and AAH and/or ACBHCS determine that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.
1. AAH and ACBHCS will have one business day after identification of an expedited dispute to attempt to resolve the dispute at the plan level.
 2. Within one business day after a failure to resolve the dispute in that timeframe, both plans will separately submit a Request for Resolution to DHCS, as set out above, including an affirmation of the stated jeopardy to the member.
 3. If ACBHCS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by AAH. Conversely, if AAH

fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBHCS.

Financial Liability

If DHCS’ decision includes a finding that the unsuccessful party is financially liable to the other party for services, AAH or ACBHCS is required to comply with the requirements in Title 9, California Code of Regulations (CCR), section 1850.530.

Confidentiality

- A. The Alliance maintains Business Associates Agreements (BAA) with its contracted provider network. Provisions in these agreements ensure the Alliance’s members medical information is kept confidential as medical information is shared as part of the care coordination process.
- B. The Alliance’s Member Services department maintains an information release form for authorization to release mental health records/information.

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

AB 88 Mental Illness (HSC) 1374.72 – Health Plans that provide hospital, medical or surgical coverage must cover the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbance in a child. The law lists nine (9) mental illnesses to be covered:

- 1. anorexia and bulimia
- 2. bipolar disorder,
- 3. major depression,
- 4. obsessive compulsive disorder,
- 5. panic disorder,
- 6. pervasive developmental disorder or autism,
- 7. schizoaffective disorder,
- 8. schizophrenia

Behavioral Health Provider – the Alliance network of behavioral health care providers.

Behavioral Health Services includes the range of assessment, referral, treatment and follow up services for mental health and substance abuse disorders.

Crisis Intervention is sudden short-term medically necessary treatment required to restore a member in crisis to the pre-crisis level of functioning. The member suffers a sudden mental condition which interferes with the member’s daily activities from which the member is incapable of recovering without assistance.

Mental Health Services may be provided on an inpatient and outpatient basis and include treatable mental disorders such as severe mental illness and stress related conditions.

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directors - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

Provider Services
Utilization Management
Case Management
Behavioral Health
Member Services

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENT

BH-001 Behavioral Health Services
BH-002 Behavioral Health Services
CM-001 CCM Identification Screening Enrollment and Assessment
CM-004 Care Coordination of Services
MBR-062 Member Services Clinical Referral and Triage Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 4/1/2011, 6/1/2011, 9/7/2012, 3/5/2013, 7/12/2013, 12/26/2013, 12/30/2013, 4/7/2014, 4/13/2015. 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023, [12/18/2024](#)

Changed from UM-012 to BH-005 on 3/19/2024

Blue = material updates

REFERENCES

- DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11.Provision 6. A and B; 12. Provision 3 and Attachment 21
- MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
- MMCD All Plan Letter 13-021 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
- MMCD All Plan Letter 13-023 Continuity of Care for Medi-Cal Beneficiaries who transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
- MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage
- NCQA QI 9 Standard Continuity and Coordination Between Medical Care and Behavioral HealthCare
- DHCS All Plan Letter 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders
- DHCS All Plan Letter 22-005 No Wrong Door for Mental Health Services
- DHCS All Plan Letter 22-006 Medi-Cal Managed Care Health Plan Responsibilities for NSMHS
- Medicaid Mental Health Parity Final Rule (CMS-2333-F)
- Behavioral Health Information Notice (BHIN) 21-073
- California W&I Code sections 14059.5 and 14184.402
- United States Code (USC) Section 1396d(r)(5) of Title 42
- CCR Section 53855 of Title 22

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 Compliance Committee annually.



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

POLICY AND PROCEDURE

Policy Number	BH-008
Policy Name	Behavioral Health Services (Group Care/IHSS)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	Group Care
Effective Date	
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

- A. **Benefit Scope:** Alameda Alliance shall cover medically necessary Behavioral Health Services when they are provided or ordered by health care professional acting within the scope of his or her training and licensure. Through a network of licensed Mental Health care Providers and facilities, Alameda Alliance shall provide Behavioral Health Services to Members resulting from a mental condition in the current edition of the Diagnostic and Statistical Manual.

The behavioral health benefit includes a non-exhaustive list services to ensure member's behavioral health needs are met. Alameda Alliance manages the behavioral health benefits for all levels of care. Behavioral healthcare is screening, assessment and treatment for substance and mental health disorders. Screenings include but are not limited to:

- Behavioral Health and Wellness Screenings for members aged 8-18 years old
- Perinatal and post-partum mental health
- Substance use
- Depression,

- Cognitive health.

"Mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

B. **Medical Necessity:** "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.

C. **Utilization Review:** No prior authorization is required for outpatient visits with contracted behavioral health providers. Prior authorization is required for all non-emergency inpatient admissions, residential, partial hospitalization, intensive outpatient, BHT/ABA, neuro/psychological testing, electroconvulsive therapy (ECT) and transcranial magnetic stimulation. All non-emergent care with out of network providers requires a prior authorization.

MH/SUD treatment services that do not require prior authorization will not be auto-authorized. BH UM staff will follow procedures to notify the referring provider that no prior auth is required.

Licensed clinical staff apply utilization review criteria to determine medical necessity.

Clinical Area	Non-Profit Professional Association Criteria for Medical Necessity Determination
Behavioral Health, ages 0-5 yrs	Early Childhood Service Intensity Indicator (ESCI)
Behavioral Health, ages 6-17 yrs	Child and Adolescent Level of Care/Service Intensity Utilization

	System (CALOCUS)
Behavioral Health, ages 18+ yrs	America Association of Community Psychiatrists (LOCUS)
Substance Use All Ages	American Society for Addiction Medicine (ASAM)
Transgender Care	World Professional Association for Transgender Health (WPATH).
TMS/ECT	American Psychiatric Association
Psychological/Neuropsychological Testing	American Psychological Association

When conducting utilization review using ASAM, LOCUS, CALOCUS-CASII, and/or ECSII, and there is ambiguity on a dimension of an assessment regarding the correct score in dimensions AAH will apply the higher score per , CCR Title 28 Section 1300.74.721(i). Additionally, Alameda Alliance will authorize the next higher level of care when a level of care is not available.

Alameda Alliance will ensure that Group Care members and providers will have access to the nonprofit criteria and trainings at no cost. through the Alliance Web site.

Alameda Alliance shall *not* impose quantitative or non-quantitative treatment limitations more stringently on covered Behavioral Health Services than are imposed on medical/surgical services covered by Alameda Alliance, in accordance with the parity in Mental Health and substance use disorder requirements in Title 42 Code of Federal Regulations (CFR), §§ 439.900-438.930.

- D. **Emergency Services:** For Group Care Members Alameda Alliance does not require prior authorization for emergency MH/SUD inpatient admissions but does require prior authorization for residential services, partial hospitalization, intensive outpatient services, psychological testing, electroconvulsive therapy, and transcranial magnetic stimulation.
1. Alameda Alliance will cover behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services without prior authorization.
 2. Alameda Alliance will require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system only if the plan's prior authorization requirements comply with California Code, HSC § 1374.721.
 3. If there is a disagreement between Alameda Alliance and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan will

assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to with California Code, HS C§ 1374.721 at a level of care consistent with utilization review criteria pursuant to Section with California Code, HSC § 1374.721

4. Alameda Alliance will not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with California Code, HSC § 1374.721.
 5. If contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, Alameda Alliance will either authorize post stabilization care or inform the provider it will arrange for the prompt transfer of the enrollee's care to another provider within 30 minutes of the time the provider makes the initial telephone call requesting authorization for post stabilization care.
 6. To the extent permissible under federal law, the plan will not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one post stabilization telephone call to the number provided in advance by the plan.
 7. Alameda Alliance will not require the representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the post stabilization telephone call to the plan to be a physician or surgeon.
- E. **Primary Care:** Alameda Alliance and its contracted Primary Care Providers (PCPs) shall provide screening and referrals for Members identified as at-risk of substance misuse in accordance with Alameda Alliance Policy. PCPs may also provide substance use treatment within the scope of their practice. Alameda Alliance and its contracted PCPs shall be responsible for screening and providing Mental Health services within the scope of their practice.
- F. **Confidentiality:** Alameda Alliance shall maintain the privacy of Member's Protected Health Information (PHI), in accordance with all federal and state laws when using or disclosing PHI for treatment, payment, and health care operation, including applying minimum necessary standards, when applicable, in accordance with Alameda Alliance Policies: Tracking and Reporting Disclosures of Protected Health Information (PHI), Protected Health Information Disclosures Required by Law, Use and Disclosure for Treatment, Payment, and Health Care Operations. (CMP-005 Minimum Necessary Use & Disclosures)

Alameda Alliance shall obtain written authorization from the Member prior to the use or Disclosure of PHI for purposes other than treatment, payment, and health care operations, in accordance with Alameda Alliance Policies: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations, Member Authorization for the Use and Disclosure of Protected Health Information.

- G. **Network Adequacy:** Alameda Alliance shall maintain and monitor an appropriate provider network and ensure timely access to Behavioral Health Services as set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and Alameda Alliance Policy: QI-108 Access to Behavioral Health Services.
- H. **Out of Network Services:** If Alliance network behavioral health services are unavailable to the Member within timely and geographic access standards, Alameda Alliance shall arrange for the provision of Behavioral Health Services outside the network.

Alliance staff will arrange out of network coverage for medically necessary services.

Within 5 days the plan must provide written notice to the enrollee, the enrollee's authorized representative (if any) and the requesting provider (if any) of the plan's obligation to arrange and pay for out-of-network services because the plan does not have an in-network provider available within the required timeframe or geographic area. The enrollee shall also be notified of their right to only be responsible for paying their usual in-network cost sharing amount for these services, pursuant to Rule 1300.74.72(c)(6).

The Alliance will schedule the appointment or arrange for the admission with the out-of-network providers for the enrollee within the following timeframes:

- a. No more than 10 business days after the initial request for non-urgent MH/SUD services:
- b. Within 15 business days of a request for a specialist physician MH/SUD services
- c. Within 48 hours of the initial request for urgent MH/SUD services if no prior authorization is required
- d. Within 96 hours of the initial request for urgent MH/SUD services if prior authorization is required
- e. Within 24 hours of the scheduling of the out-of-network appointment or admission accepted by the enrollee, the plan must provide the enrollee, the enrollee's authorized representative, or the enrollee's provider with information regarding the appointment or admission.
- f. If the plan is unable to arrange for covered services as set forth above the enrollee or the enrollee's representative may arrange for care from any appropriately licensed provider, so long as the appointment or admission occurs no more than 90 days after the initial request for services.
- g. If out-of-network coverage is obtained as described in (f) above, the plan shall reimburse the provider for the entire course of medically necessary services unless there is an in-network timely and geographically accessible provider available to deliver MH/SUD services, transfer to the new provider would not

harm the enrollee and transfer is within the standard of care for the enrollee's MH/SUD condition. Before the health plan may transition the enrollee to an in-network provider, the health plan shall provide the enrollee, the enrollee's representative (if any), and the provider(s) treating the enrollee with at least 90 calendar days' notice. The notice shall inform the enrollee of the name and contact information of the in-network provider to which the plan intends to transition the enrollee and information about how the enrollee may file a complaint with the plan if the enrollee, the

enrollee's representative, or enrollee's provider believes transitioning the enrollee to an in-network provider will harm the enrollee or is not within the standard of care

- I. **Nurse Advice Line:** The AAH Nurse Advice Line uses protocols to ensure that members who call the Advice Line displaying symptoms of psychiatric emergencies or requesting psychiatric emergency services are directed to appropriate care. Callers with behavioral health concerns will be directed to the Behavioral Health department for review and outreach.
- J. **After-hours behavioral care:** Alameda Alliance shall provide a direct telephone call center for emergencies during non-business hours for Members to access and for Providers to coordinate care or to access the nearest emergency room during a crisis. Alameda Alliance shall ensure:
 - a. Appropriate staffing levels of the call center; and
 - b. Recruitment of staff who speak the Threshold Languages and provide, at no cost to the Member, access to interpreter services pursuant to Alameda Alliance Policy: Cultural and Linguistic Services.

K. Behavioral Health Department:

Behavioral Health Department Alameda Alliance's Behavioral Health Department provides Care Management and Utilization Management for Mental Health and Autism Services. The Alliance integrates behavioral health into the Alliance's Utilization Management, Case Management and Quality Improvement program descriptions, work plans and annual evaluations to ensure parity and enable the Alliance's efforts to provide integrated whole person healthcare services.

The Behavioral Health Department is overseen by the Senior Director of Behavioral Health and the Senior Medical Director. The Senior Medical Director is an Emergency Medicine Physician, and the Senior Director of Behavioral Health is a licensed psychologist. Together, they are responsible for Behavioral Health Care Management and Utilization Management processes and level of care determinations. The Behavioral Health Department is staffed by licensed Mental Health clinicians including LCSWs, LMFTs, BCBAs, and RNs. Non-licensed staff include Behavioral Health navigators.

PROCEDURE

A. PCP and Behavioral Health Services

1. For mental health and substance use disorders, the PCP shall:
 - a. Screen for behavioral health issues and provide services within the scope of their practice; and
 - b. Refer the Member for further Mental Health or Substance Use services through Alameda Alliance's

B. Accessing Alameda Alliance Behavioral Health Services

1. A Member may access Behavioral Health Services through the Alameda Alliance Member Services Phone Line.
2. A Member may be referred to the Alameda Alliance Member Services by a provider, provider group or may self-refer.

C. Alameda Alliance Member Services Phone Line

1. Call Center requirements shall include:
 - a. Complying with telephone access standards in accordance with Alameda Alliance Policy: QI-107 Appointment Access and Availability Standards: & MBR-062 MS Referrals and Triage
 - b. Utilizing linguistic interpreter services, or the California Relay Service for Members, as necessary to ensure effective communication.
 - c. Determining if the caller is seeking help for a Mental Health or substance use concern;
 - d. Screening for crisis and determining if the call is routine, urgent or emergent. If determined urgent or emergent, call center staff shall immediately complete safety screening;
 - e. If a caller's needs are indicated as requiring Emergent or Urgent Services including when a caller who potentially presents as a danger to self or others, call center staff shall transfer the caller to the Alliance BH Care Management Team and/or County's Crisis Response services without delay to prevent

- further deterioration of the caller's condition;
- f. Call center staff must link Emergent calls to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than two (2) hours after determining the call is emergent;
 - g. Call center staff must transfer urgent calls for services to the Alliance Behavioral Health Care Management Team (Clinician) immediately, but in no case more than within twenty-four (24) hours after making the determination that the call is urgent;
 - h. Call center staff must obtain confirmation and document that any caller assessed as requiring Emergent or Urgent Services has been appropriately connected to the Alliance Behavioral Health Care Management Team (Clinician).and:
2. Alameda Alliance shall ensure the following steps are completed during the Member call:
- a. Member's eligibility status shall be verified each time the Member contacts the Alameda Alliance Member Services Phone Line;
 - b. Warm transfer to the Alliance BH Care Management Team for further clinical assessment based on the Safety Screening and protocols for identification of urgent and emergent access to care.

D. Care Coordination

1. The behavioral health staff are responsible for care coordination for members at all levels of care. This includes discharge planning for members to ensure that members have follow-up care when being discharged from higher levels of care. For members needing assistance with medical care, housing, food, transportation and related social needs, the behavioral health staff will refer to the medical case management team via TruCare. The behavioral health and medical care managers will work together to jointly coordinate care for members with both medical, behavioral and social service needs. See BH-005 for further care coordination guidance.

DEFINITIONS

Term	Definition
Authorized Representative	A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Behavioral Health Services	Services which encompass both Mental Health and substance use disorder services.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder and related disorders. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Alameda Alliance Member Services Phone Line	Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call to obtain referrals for all Alameda Alliance Covered Services. Telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either: 1. Have authority to approve Covered Services; 2. Can transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or 3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

Term	Definition
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the Alameda Alliance program.
Department of Managed Health Care (DMHC)	The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. The release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Emergency/Emergent Services and Care	“Psychiatric emergency medical condition” means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: (A) An immediate danger to himself or herself or to others. (B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to mental disorder. California Code, Health and Safety Code - HSC § 1317.1
Generally accepted standards of mental health and substance use disorder care	Generally accepted standards of mental health and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Term	Definition
Grievance	An oral or written expression of dissatisfaction, about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable Alameda Alliance policies.

Term	Definition
Medically Necessary or Medical Necessity	L. “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: M. (i) In accordance with the generally accepted standards of mental health and substance use disorder care. N. (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration. O. (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.
Primary Care Provider (PCP)	For purposes of this policy, a Primary Care Provider may be a Primary Care Practitioner, or another institution or facility responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Alameda Alliance or Business Associates and relates to: 1. The past, present, or future physical or Mental Health or condition of a Member. 2. The provision of health care to a member; or 3. Past, present, or future Payment for the provision of health care to a member.

Term	Definition

Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Behavioral Health provider, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Urgent Services	For purposes of this policy, shall be indicated with a situation experienced by a caller that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Callers in need of Urgent Services shall receive timely Mental Health intervention that shall be appropriate to the severity for the condition.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews including:
Behavioral Health,
Case and Disease Management,
Grievance and Appeals,
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning
UM-005 Second Opinions
UM-014 CoC-Identifying Abuse
UM-015 Emergency Services and Post Stabilization Services
UM-016 Transportation Guidelines
UM-025 Guidelines for Obstetrical Services
UM-036 Continuity of Care
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Service Requests
UM-058 Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care
CM-001 CCM Identification Screening Enrollment and Assessment
CM-002 Complex Case Management Plan Development and Management
CM-004 Care Coordination of Services
CM-011 Enhanced Care Management – Care Management & Transitions of Care
MBR-062 Referrals and Triage

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy XXXXX

REFERENCES

- American Academy of Child and Adolescent Psychiatry (AACAP)
 - American Association of Community Psychiatry (ACAP)
 - American Psychiatric Association
 - American Psychological Association
 - American Society of Addiction Medicine (ASAM)
 - Section 1368.017 Behavioral Health and Wellness Screenings
 - 42 CFR, §§ 438.900-438.930
 - California Code, Health & Saf. Code, § 1374.721.
 - World Professional Association for Transgender Health (WPATH)
-

MONITORING

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



Cultural and Linguistic Program Description

2025

02/14/2025 Quality Improvement Health Equity Committee Approval: DATE

Alameda Alliance for Health Cultural and Linguistic Services Program Description 2025

Overview

The Alameda Alliance for Health (Alliance) is committed to delivering culturally and linguistically appropriate services (CLAS), to all eligible Medi-Cal, [D-SNP](#) and Group Care members. The Alliance's Cultural and Linguistic Services Program complies with 22 CCR sections 51202.5 and 51309.5(a), 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04 (c)(2)(G)(v) - (c)(4), 42 CFR section 438.206(c)(2), Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. The Alliance CLS Program aligns with the National Standards for Cultural and Linguistically Appropriate Health Services (CLAS) created by the U.S. Department of Health & Human Services ([CLAS Standards - Think Cultural Health \(hhs.gov\)](#)).

The goal of the Cultural and Linguistic Services (CLS) Program is to ensure that all members receive equitable access to high quality health care services, including behavioral health services, that are culturally and linguistically appropriate. This includes ensuring culturally appropriate services and access for members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer its members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Identify, inform, and assist limited English proficiency (LEP) members in accessing quality interpretation services.
- Ensure that Alliance health care providers follow the Alliance CLS Program.
- Integrate community input and population assessments into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

Cultural and Linguistic Services Workplan

A workplan is developed to outline program goals and activities. This workplan is incorporated into the overarching Quality Improvement (QI) Department's Workplan and is reviewed and approved annually by the Quality Improvement and Health Equity Committee (QIHEC), which is a subcommittee of the Alliance Board of Governors. Please see the *Alliance Quality Improvement Workplan* for details.

Formatted: Font: Bold

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

Formatted: Normal, No bullets or numbering

Formatted: Font: Italic

Culturally and Linguistically Appropriate Services (CLAS) Goals

Formatted: Font: Bold

Formatted: Font: Bold

There is also regular evaluation of the program performance to improve the delivery of Culturally and Linguistically Appropriate Services (CLAS) and reduce health care inequities among Alliance members. The Alliance Cultural and Linguistic Services Manager monitors performance on goals quarterly, reviews and solicits input on outcomes with the Alliance Cultural and Linguistic Services (CLS) Subcommittee. The CLS Subcommittee reports to the Alliance QIHEC.

Measurable CLAS improvement goals include:

<u>Priority</u>	<u>Opportunity</u>	<u>Action Taken</u>	<u>Rationale for Action Decision</u>	<u>Intervention</u>	<u>Plan to Measure Effectiveness</u>
<u>1</u>	<u>Expand Outreach to Underserved Language Groups</u>	<u>Yes</u>	<u>These groups (Arabic, Farsi, Korean, Russian, Hindi, Khmer and Mien) meet NCQA threshold criteria but are currently underrepresented in outreach materials.</u>	<u>Create member facing outreach and education on access to interpreter services in additional languages and distribute through providers.</u>	<u>Track changes in engagement metrics and interpreter services utilization among speakers of these languages. Maintain or increase rate of utilization.</u>
<u>2</u>	<u>Increase Specificity in Language Data Collection</u>	<u>Yes</u>	<u>Over 8,543 members are grouped under "Other Chinese and Unknown," preventing tailored services.</u>	<u>Use interpreter services provision data to identify language needs for the "Other Chinese and Unknown groups." Share with key leaders at internal and external committees.</u>	<u>Use improved specificity of language data to improve program alignment with language preferences.</u>
<u>3</u>	<u>Reinforce Member Awareness</u>	<u>Yes</u>	<u>Despite high satisfaction, continuous reinforcement is needed to maintain awareness, especially among newer or LEP members.</u>	<u>Launch multilingual education campaign reinforcing interpreter service rights.</u>	<u>Evaluate awareness via CAHPS and Timely Access survey questions and increased interpreter service utilization.</u>

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer its members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic program through cultural competency training.

- ~~Identify, inform, and assist limited English proficiency (LEP) members in accessing quality interpretation services.~~
- ~~Ensure that Alliance health care providers follow the Alliance CLS Program.~~
- ~~Integrate community input and population assessments into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.~~
- ~~Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.~~

The **Organizational Chart** in Appendix B displays reporting relationships for the Alliance organization and identifies key staff with overall responsibility for the operation of the CLS Program.

Cultural and Linguistic Services Leadership

The **Quality Improvement Department** is responsible for developing, implementing, and evaluating the Alliance’s Cultural and Linguistic Services Program in coordination with other Alliance departments including Provider Services, Human Resources, Analytics and Performance, Member Services, Communications and Outreach, Quality Assurance, Vendor Management and Compliance.

Population Health and Equity is a part of the Alliance’s Quality Improvement Department. The Manager of Cultural and Linguistic Services, under the direction of the Director of Population Health and Equity, and in collaboration with the aforementioned departments, develops the CLS Program work plan and integrates information and resources on cultural competency into the Alliance’s programs and services. The Manager of Cultural and Linguistic Services also facilitates the Cultural and Linguistic Services Subcommittee (CLSS).

The **Director of Population Health and Equity** who oversees the Manager of Cultural and Linguistic Services has a Master’s in Public Health with a concentration in Community Health Education and over 30 years’ experience leading culturally and linguistically appropriate services. The staff include individuals who have bilingual capacity and experience in medical interpretation, program development in diverse Medi-Cal populations, and working with people with disabilities.

The **Chief Health Equity Officer** partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees.

The Manager of Cultural and Linguistic Services and the Communications and Outreach Senior Manager are responsible for supporting the **Alliance Community Advisory Committee (CAC)** (see below for description) in accordance with Title 22, CCR, Section 53876 (c). The Health Education Coordinator’s responsibilities include providing administrative support to the CAC.

Other Departmental Roles Related to the Provision of Cultural and Linguistic Services

The **Behavioral Health (BH) Department** oversees services provided for members with Mental Health Disease and Autism Spectrum Disorder. In April of 2023, Alameda Alliance has de-delegated responsibility of these services and is now responsible for the Program work plan. The BH team integrates information and resources on cultural competency into the Alliance’s programs. It is also responsible for behavioral health utilization and case management activities including triage and referral and

participation on the multi-disciplinary case management teams. The team is led by the Senior Director of Behavioral Health (Licensed Psychologist) and Senior Medical Director (MD).

The **Communications and Outreach Department** is responsible for ensuring that marketing practices for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. In addition, they take into consideration results from member surveys and assessments, community feedback and other CLS monitoring activities when producing member materials. The department is also responsible for quality translations of member written materials and communications and assists all departments in sending the appropriate non-discrimination and language assistance service notices to members.

Compliance is responsible for conducting audits of the Alliance CLS Program, monitoring delegated CLS responsibilities, and ensuring that all state and federal regulations are followed.

Health Education, also a part of Quality Improvement, staff ensure that members have access to qualified interpreters when participating in health education programs and make health education materials available to members and providers that meet the literacy, cultural, linguistic, clinical, and regulatory standards.

The **Human Resources (HR) Department** is responsible for bilingual assessment of new staff who will use their bilingual skills with members. They maintain a listing of Alliance bilingual staff and ensure quality monitoring of bilingual staff is not monitored through the Member Services quality assurance program. HR also ensures Alliance staff complete Diversity, Equity, and Inclusion (DEI) trainings, including participation in the cultural sensitivity training, annually.

The **Member Services Department** assesses member cultural and linguistic needs at each contact by identifying and verifying language preferences, reported ethnicity and preference for use of interpreter services. Members are informed that they can access no cost oral interpretation in their preferred language and written materials translated into Alliance threshold languages or provided in alternative formats. Member Services also monitors call quality of Member Services Representatives' ability to follow cultural and linguistic protocols.

The **Provider Services Department** is responsible for ensuring that the Alliance provider network composition continuously meets members' cultural and linguistic needs. Provider Services also trains providers on the Alliance Cultural and Linguistic program requirements. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and providers update language capacity with the Alliance regularly.

The **Quality Assurance Department** supports the CLS program through monitoring and reporting of grievances related to CLS services.

Quality Improvement Specialists conduct member and provider surveys, and Quality Nurses conduct medical record and facility site reviews that monitor CLS requirement implementation at the provider office level and issue corrective action plans as needed.

Vendor Management supports compliance oversight of language services vendors and implements corrective action plans as needed.

Cultural and Linguistic Services Committee

The Alliance **Cultural and Linguistic Services Subcommittee (CLSS)** role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSS reports to the Quality Improvement Health Equity Committee which is a standing committee of the Alliance Board of Governors.

The **Community Advisory Committee (CAC)** purpose is to provide a link between the Alliance and the community. The CAC advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. It offers the opportunity for our culturally diverse community to provide input into identifying and prioritizing opportunities for improvement. The CAC is supported by the Manager of Cultural and Linguistic Services and the Senior Manager of Communications and Outreach and their respective departments.

The committee's responsibilities include:

- a. Identify and advocate for preventive care practices to be used by the Alliance.
- b. Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
- c. Advise on Alliance member and provider-targeted services, programs, and trainings.
- d. Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
- e. Review findings from the Population Needs Assessment (PNA) and discuss improvement opportunities on Health Equity and Social Drivers of Health and provide input on selecting targeted health education, cultural and linguistic, and Quality Improvement (QI) strategies.
- f. Provide input and advice, including, but not limited to, the following:
 - i. Culturally appropriate service or program design
 - ii. Priorities for health education and outreach program
 - iii. Member satisfaction survey results
 - iv. Findings of the PNA
 - v. Plan marketing materials and campaigns
 - vi. Communication of needs for network development and assessment
 - vii. Community resources and information
 - viii. Population Health Management
 - ix. Quality
 - x. Health Delivery Systems Reforms to improve health outcomes
 - xi. Carved Out Services
 - xii. Coordination of Care
 - xiii. Health Equity
 - xiv. Accessibility of services
 - xv. Development of the provider manual and clarification of new and revised policies and procedures in the manual
 - xvi. Development of the covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.

The Alliance CAC is comprised of over 51% members or their caregivers/parents. The Alliance actively recruits CAC members who reflect the cultural diversity of the Alliance membership. At minimum, the CAC includes individuals representing the racial, ethnic and linguistic groups that comprise at

least 5% of the population.

The CAC enables the Alliance to maintain community partnerships with consumers, community advocates and traditional and safety net providers regarding CLAS, ensuring diverse perspectives and inclusive decision-making.

Standards and Performance Requirements

The Alliance's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. The Alliance has systems and processes to:

- Provide all members – including those with mental health and autism spectrum disorder - access to no cost language assistance services at all points of contact, 24 hours a day, 7 days a week. Educate members and providers about the availability of language services and how to access them.
- Assess and track linguistic capability of interpreters, bilingual employees, and contracted staff in medical and non-medical settings. Implement a system to provide adequate training regarding the Alliance language assistance programs to all employees and contracted staff that have routine contact with LEP Members or Potential Members.
- Conduct a Population Needs Assessment (PNA) according to the [Department of Health Care Services \(DHCS\)](#) and [Centers for Medicare and Medicaid Services \(CMS\)](#) timeline to:
 - Identify member health needs and health disparities.
 - Evaluate health education, CLS, and quality improvement (QI) activities and available resources to address identified concerns.
 - Implement targeted strategies for health education, CLS, and QI programs and services.
 - Inform Alliance cultural and linguistic services program priorities.
- Provide annual Diversity, Equity and Inclusion Training that covers sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings for staff, providers, and clinical and non-clinical contracted staff. The training will cover the Alliance Cultural and Linguistic Program, language and literacy, gender affirming care, as well as working with identified diverse cultural groups within the Alliance service areas.
- Monitor and evaluate the Cultural and Linguistic Services Program and the performance of individuals providing linguistics services. The Alliance tracks and addresses any identified gaps in the Alliance's ability to address members' cultural and linguistic needs.

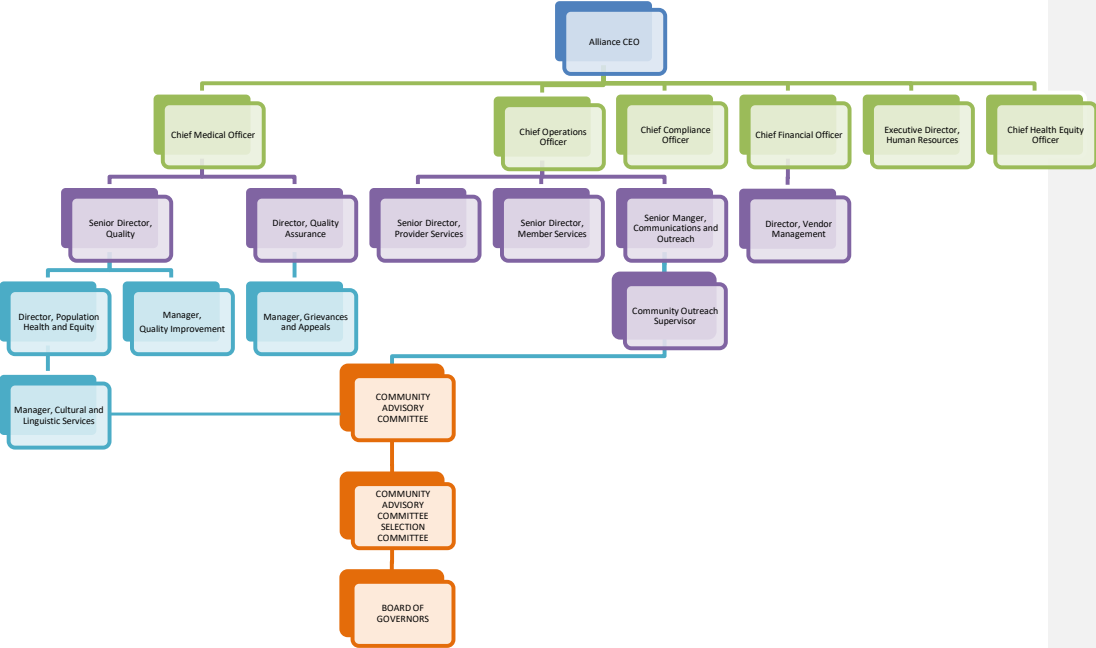
The program meets the standards detailed in the following Alliance Policies and Procedures:

- CLS-001: Cultural and Linguistic Services Program Description
- CLS-002: Cultural and Linguistic Services Program - Member Advisory Committee
- CLS-003: Cultural and Linguistic Services Program – Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
- CLS-008: Cultural and Linguistic Services Program - Member Assessment of Cultural and

Linguistic Needs

- CLS-009: Cultural and Linguistic Services Program – Contracted Providers
- CLS-010: Cultural and Linguistic Services Program - Staff Training and Assessment
- CLS-011: Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services
APPENDIX B





POLICY AND PROCEDURE

Policy Number	CLS-002
Policy Name	Community Engagement
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	4/1/1999
Subcommittee	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>2/14/2025</u> TBD
Administrative Oversight Committee Approval Date	<u>TBD</u> 4/16/2025

POLICY STATEMENT

The Alameda Alliance for Health and Alameda Alliance Wellness (D-SNP) (the Alliance) community engagement strategy ensures that members and families are partners in the delivery of covered services. The Alliance community engagement efforts encourage Alliance members and families to participate in the public policy of the health plan and the development of programs that ensure health care access and dignity for its diverse members. The structure, functions, accountability, and scope of community engagement shall be in accordance with applicable regulations and contracts.

The Alliance community engagement strategy follows applicable laws and Department of Healthcare Services mandates including Title 22 California Code of Regulations section 53876 (c), Title 28, California Code of Regulations, Section 1300.69, and the 2024 DHCS Single Plan Contract Exhibit A. Centers for Medicare and Medicaid Services (CMS)

PROCEDURE

1. The Alliance community engagement strategy includes the following elements:
 - 1.1. Maintaining an organizational leadership commitment to engaging members and families in the delivery of care through adequate funding of resources to promote community engagement activities and support the dissemination of community engagement results.
 - 1.2. Quality and health equity initiatives routinely engage members and families through focus groups, listening sessions, surveys and/or interviews. The findings,

recommendations, and results are incorporated into policies and decision-making and inform interventions.

- 1.3. As the Alliance creates new initiatives or process updates, project leaders consider whether member and family feedback will be needed, what would be the best format, and how to incorporate the feedback into updated policies and decision-making.
- 1.4. Members who participate in the process will be informed of the impact of their feedback through community meetings or other forms of communication.
- 1.5. The Alliance maintains documentation of member feedback and results in order to ensure accountability for incorporating ~~member~~members and family input into policies and decision-making.
- 1.6. Member engagement and input is incorporated into the Quality Improvement and Health Equity Program Evaluation to measure and monitor the impact of the input. (*QI-101 Quality Improvement Program*)
- 1.7. The Alliance conducts member surveys and incorporates the results in quality improvement and health equity activities. (*QI-117 Member Satisfaction Survey*)
- 1.8. The Alliance has a Community Advisory Committee (CAC) that meets regularly to provide diverse ~~member~~members and family input into Alliance policies, procedures, and programs. The findings and recommendations inform Alliance activities and interventions.
- 1.9. The CAC is comprised primarily of Alliance members, as part of the Alliance's implementation and maintenance of member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.
- 1.10. The Alliance partners with community-based organizations to cultivate member and family engagement.
- 1.11. The CAC's input is actively utilized in policies and decision-making.
2. Community Advisory Committee Membership
 - 2.1. The Alliance convenes a selection committee tasked with selecting the members of the CAC. The CAC Selection Committee reports to the Alliance Board of Governors (~~BOG~~). The Alliance makes a good faith effort to ensure that the Alliance CAC Selection Committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC.
 - 2.1.1. Alliance BOG representatives including Safety Net Providers, Federally Qualified Health Centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, Indian Health Service (IHS) Facilities, and home and community-based Providers.
 - 2.1.2. Persons and community-based organizations who represent the diversity of Alameda County.
 - 2.2. ~~The Committee membership reflects the general Medi-Cal and D-SNP member population in Alameda County, for members enrolled in the Alameda Alliance for Wellness D-SNP, a dedicated Community Advisory Committee has been established.~~

~~This stand-alone committee is designed to represent the interests and needs of the D-SNP member population in Alameda County. The membership of this committee reflects the general demographics and characteristics of the Medi-Cal and D-SNP members in the county.~~ Including the following or their representatives:

2.2.1. Representatives from any Indian Health Service providers

2.2.2. Adolescents and/or parents and/or caregivers of children, including foster youth.

2.2.2.2.3. D-SNP members

2.3. The make-up of the CAC is adjusted as the community changes to ensure the community is represented and engaged and makes a good faith effort to include representatives from diverse and ~~hard-to-reach~~hard-to-reach populations, with a specific emphasis on:

2.3.1. Populations who experience health disparities

2.3.2. Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

2.3.3. Persons with chronic conditions

2.3.4. Limited English Proficient (LEP) Members

2.4. The CAC is comprised of the following members:

2.4.1. At least 51% of the CAC are Alliance enrollees (and/or the parents/caregivers of Alliance enrollees who are minors or dependents).

2.4.2. At least one CAC member shall be a provider

2.4.3. The CAC may also include community advocates for hard-to-reach member populations.

2.5. At least one CAC member serves on the Alliance Board of Governors.

2.6. Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, the Alliance will make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy, including holding a CAC Selection Committee meeting, where Selection Committee members will vote and select new members.

2.7. One member of the CAC or another Alliance member designated by the CAC will be appointed to serve as the Alliance's representative to DHCS' Statewide Community Advisory Committee.

2.8. All members complete a Confidentiality and Conflict of Interest Agreement pertaining to maintaining confidentiality of information utilized or maintained by the Alliance and the CAC member's responsibility to declare any actual or potential conflict of interest and withdraw from participation where there might be a conflict.

3. CAC Coordinator

3.1. The Alliance designates the ~~Health Education Coordinator~~Cultural and Linguistic Services Specialist as the CAC Coordinator and maintains a detailed job description detailing the CAC Coordinator's responsibility to manage the operations of the CAC

in compliance with all the statutory, rule, and contract requirements including but not limited to:

- 3.1.1. Scheduling meetings and creating agendas with the input of CAC members.
- 3.1.2. Maintaining committee membership, including outreach, recruitment, and onboarding of new members that is adequate to carry out the duties of the CAC.
- 3.1.3. Actively facilitating communications and connections between the CAC and Alliance leadership, including ensuring CAC members are informed of Alliance decisions relevant to the work of the CAC.
- 3.1.4. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings.
- 3.1.5. Ensuring compliance with all CAC reporting and public posting requirements.
- 3.1.6. The CAC coordinator is an employee of the Alliance and not a member of the CAC or member enrolled with the Alliance.

4. CAC Terms of Service and Attendance:

- 4.1. The term of service for each CAC member is two (2) years.
- 4.2. Committee members may serve more than one term, at the discretion of the CAC Selection Committee.
- 4.3. A member may be dismissed from the committee if he or she fails to attend two (2) meetings of the committee within one (1) year without an excused or approved absence.
- 4.4. Members must notify the Alliance of expected absences.
- 4.5. Members can request a leave of absence if needed for up to one (1) year for health or personal reasons.
- 4.6. Plan members receive compensation or a stipend for each meeting attended to cover time and participation, including participation in the CAC, the Alliance Board of Governors and participation in the DHCS' Statewide Community Advisory Committee. Stipends for in-person meetings cover transportation costs for members. Members may also request and receive reimbursement for childcare.
- 4.7. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.

5. CAC Meetings:

- 5.1. Regularly scheduled CAC meetings are open to the public, and meetings are posted on the Alliance website in a centralized location 30 calendar days prior to the meeting, and no later than 72 hours prior to the meeting.
- 5.2. The Alliance provides a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting

accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.

5.3. The Alliance CAC drafts written minutes of each of its meetings and the associated discussions. All minutes are posted on the Alliance website and submitted to DHCS no later than 45 calendar days after each meeting. The Alliance retains the minutes for no less than 10 years and provides them to DHCS upon request.

5.4. The CAC Chair and Vice Chair are the Alliance's CEO's designees. The CEO does not vote at CAC meetings.

~~5.5. A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the CAC to vote on any matter.~~

6. Alliance CAC Support

6.1. The Alliance will provide the following to the CAC:

6.1.1. Educate CAC members to ensure they can effectively participate in CAC meetings.

6.1.2. Support to address barriers to participation of CAC members, including childcare, transportation, flexible meeting times and formats so the highest CAC member participation is possible, convenient location, and format.

6.1.3. Sufficient resources, within budgetary limitations, to support CAC activities, member outreach, retention, and support, as well as consumer listening sessions, focus groups, and/or surveys.

6.1.4. The Alliance will provide a feedback loop to inform CAC members how their input has been incorporated into relevant policies and procedures.

6.2. The Alliance Chief Health Equity Officer participates as a non-voting member of the CAC and supports the work of the CAC through consultation and reports as needed.

7. Duties of the CAC

7.1. Participate in establishing the public policy of the plan as described in Title 28, California Code of Regulations 1300.69(b).

7.2. Provide input into annual reviews and updates to relevant policies and procedures; and in particular, and particularly those affecting quality improvement and health equity.

7.2.1. CAC feedback is incorporated into the Cultural and Linguistic Services Program, the Population Health Management Strategy and the Quality Improvement and Health Equity Program.

7.3. Identify and advocate for preventive care practices to be utilized by the Alliance.

7.4. Provide input into developing and updating cultural and linguistic policy and procedure decisions including those related to quality improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. This may include advising on necessary Member or Provider targeted services, programs, and trainings.

7.5. Provide and make recommendations regarding cultural appropriateness of

communications, partnerships, and services.

7.6. Review Population Needs Assessment (PNA) findings and discuss opportunities with an emphasis on Health Equity and Social Drivers of Health, and providing input in the selection of health education, cultural and linguistic and quality improvement strategies.

7.7. Provide input and advice, including, but not limited to, the following:

7.7.1. Culturally appropriate service or program design

7.7.2. The Alliance's diversity, equity, and inclusion strategy

7.7.3. Priorities for health education and outreach programs

7.7.4. Member satisfaction survey results

7.7.5. Findings of the PNA

7.7.6. Plan marketing materials and campaigns

7.7.7. Communication of needs for Network development and assessment

7.7.8. Community resources and information

7.7.9. Population health management and health equity

7.7.10. Quality Improvement, including:

7.7.10.1. Member satisfaction survey results pertinent to timely access standards

7.7.10.2. Quality improvement activities and interactions

7.7.11. Health Delivery Systems Reforms to improve health outcomes

7.7.12. Carved Out Services

7.7.13. Coordination of Care

7.7.14. Health Equity

7.7.15. Accessibility of Services

7.7.16. Development of the covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.

8. Annual CAC Demographic Report

8.1. The Alliance will submit an annual demographic report regarding the CAC on April 1st of each year using the DHCS CAC Annual Demographic Report template with descriptions of the following.

8.1.1. The demographic composition of CAC membership

8.1.2. How Alliance defines the demographics and diversity of its Members and Potential Members within Alliance's Service Area

8.1.3. The data sources relied upon by the Alliance to validate that its CAC membership aligns with the Alliance's Member demographics

8.1.4. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area

8.1.5. Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Alliance's Service Area.

- 8.1.6. A description of the CAC’s ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Alliance’s initiatives and/or policies.

9. Reporting structure for the CAC

- 9.1. The CAC’s activities and feedback are reported to the Cultural and Linguistic Services Subcommittee, and other subcommittees as requested, which report to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.

DEFINITIONS / ACRONYMS

CEO: Chief Executive Officer

CHEO: Chief Health Equity Officer

BOG: Board of Governors

CAC: Community Advisory Committee

DHCS: Department of Health Care Services

D-SNP: [Dual Eligible Special Needs Plan](#)

Health Disparity: Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental ~~disadvantaged~~[disadvantages](#), which are often driven by the social conditions in which individuals live, learn, work, and play.

Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity: The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity: A systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

FQHCs: Federally Qualified Health Centers

IHS: Indian Health Services

PNA: Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

All

REVISION HISTORY

4/1/1999, 1/1/08, 9/1/09, 2/26/10, 3/11/10, 2/5/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, 12/19/2023, 03/19/2024, [4/16/2025](#), [TBD](#)

Blue = substantive updates

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
QI-101 Quality Improvement Program
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment III, 5.2.11
MMCD Policy Letter 99-01
Title 28, California Code of Regulations, Section 1300.69
Title 22, California Code of Regulations, Section 53876 (c)
[CMS Centers for Medicare and Medicaid Services](#)

MONITORING

This policy will be reviewed annually to ensure effectiveness.

Updates on CAC activities and feedback are reported to the Cultural and Linguistic Services Subcommittee, which reports to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.



POLICY AND PROCEDURE

Policy Number	CLS-003
Policy Name	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, ~~D-SNP~~
Effective Date	7/01/1998
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

POLICY STATEMENT

Alameda Alliance for Health ~~and Alameda Alliance Wellness~~ offers language assistance services to monolingual, non-English-speaking or limited English proficiency (LEP) members and potential members and effective communication for members with disabilities at no charge. The Alliance has processes in place to effectively identify LEP member language assistance needs at all points of contact, to inform Alliance members and members with disabilities of available language assistance services, including interpretation, telephone language services, translation, and alternate formats, or legally compliant electronic options, to facilitate member's access to language services and effective communication and ensure the timeliness and quality of the services. The Alliance also has processes in place to abide by its regulatory and contractual standards related to providing language services to its members. Regulatory standards that inform the Language Assistance Services at the Alliance are listed in the "Reference section" below.

PROCEDURE

1. **Member Identification.** The Alliance identifies members who need interpreter services through the following methods:
 - 1.1. Uploading enrollment data each month (or more frequently if available) into our data and contact management systems. Data includes member ethnicity and preferred language.
 - 1.1.1. Alliance staff can view language preferences and ethnicity in our data contact management systems.
 - 1.1.2. The Alliance network of providers and behavioral health providers can view the language preferences of members in the provider portal.
 - 1.1.3. Automated voice systems respond to member phone calls to the Alliance in identified threshold languages and connect the member with bilingual/[multilingual](#) Alliance staff if available or staff will contact our interpreter vendor for assistance.
 - 1.2. Alliance staff updates member preferred language information in contact management systems as new preferences are communicated.
 - 1.3. Providers document member's preferred language in the member's medical record.
 - 1.4. The Alliance maintains a list of non-English languages likely to be encountered. This membership report is updated monthly by the Health Care Analytics Department and reviewed quarterly by the Cultural and Linguistic Services Subcommittee.
2. **Interpreter Access.** Interpreter services are offered at no cost to Alliance members at all points of contact including medical, behavioral health and non-medical care, including, but not limited to telephone, advice and urgent care transactions, outpatient encounters with providers, Member Services, new member orientations, and appointment scheduling. Interpretation services are available 24-hours a day, 7 days a week, so member's timely access to care will not be delayed due to any lack of interpreter services. The Alliance assures timely delivery of no cost interpretation services in the following ways:
 - 2.1. Oral Interpreters, sign language interpreters or bilingual providers are provided in all languages spoken by members and potential Members, not limited to threshold or concentration languages.
 - 2.2. Members who call or visit the Alliance during Alliance business hours, Monday – Friday, 8 am – 5 pm, except for holidays, seeking assistance in a non-English language:
 - 2.2.1. Member calls are routed by Alliance threshold languages to a bilingual/[multilingual](#) staff member or a staff-person who will use the Alliance interpreter vendors to speak with the member in their language.
 - 2.2.2. Members who visit the Alliance offices will be assessed by the reception staff using the "Point to Your Language" poster. A staff-person who speaks the member's language will be called, or a staff person will call the Alliance interpreter vendor for language assistance.
 - 2.3. Members can access no cost interpreter services for routine and urgent health care appointments, when accessing emergency services or after hours.
 - 2.3.1. Language needs may be met through Alliance providers, i.e. providers with

- qualified bilingual/[multilingual](#) staff, hospital, or clinic interpreter services.
- 2.3.2. If an Alliance provider cannot meet the language need of a member, or for after- hours interpreter services, the provider can call the Alliance interpreter service vendor directly to receive telephonic interpreter services.
- 2.3.3. Some providers have capacity to offer video remote interpreting services (VRI). These services must comply with federal quality standards.
- 2.3.4. Members can call Member Services and receive interpreter services.
- 3. The Alliance coordinates interpreter services at the time of appointment scheduling. Members needing interpreter services for a future health care appointment:
 - 3.1. May call Alliance Member Services to request assistance with arranging for an interpreter for their future appointment.
 - 3.1.1. If the request is at least 5 business days advanced notice, the Alliance Member Services contacts the provider and asks them to submit an *Interpreter Services Request Form* to the Alliance to request an interpreter or use Alliance's 24/7 telephonic interpreter services. In-person requests must meet current guidelines.
 - 3.1.2. If less than 5 business days-notice, Alliance Member Services staff contacts provider and provides education on accessing telephonic interpretation through Alliance interpreter services vendor, or as last resort, reschedules the appointment.
 - 3.2. May call the provider to request an interpreter for their appointment. Providers will offer interpreter services to members with non-English language preferences. These services may be provided by:
 - 3.2.1. A qualified bilingual staff or interpreter at the health care provider office
 - 3.2.2. The Alliance 24/7 telephonic interpreter service
 - 3.2.3. Providers can fax a request to the Alliance to schedule in-person or prescheduled telephonic/video interpreters.
 - 3.3. In-person interpreters are available for American Sign Language (ASL), complex, highly sensitive visits, or other circumstances upon approval by Alliance.
 - 3.4. When interpreter requests for in-person interpretation are made with less than 5 business days' notice, the provider or member may be asked to use a telephonic interpreter for the appointment (except for ASL interpreters) or reschedule only if no in-person interpreter can be arranged.
 - 3.5. ASL interpreter requests cannot be arranged with a telephonic interpreter. When an ASL interpreter cannot be arranged in advance or offered through video remote interpreting, providers may use the California Relay Service (CRS) to contact deaf or hard of hearing members by phone, if other services are not available in the office.
- 4. Alliance staff document refusal of interpreter services or member's language preferences in the Alliance data management systems and Alliance health care providers document in the member's medical record.

5. The Alliance assures timely delivery of language assistance services through performance monitoring of interpreter services coordination, provision of telephone and video interpreting (where available) and scheduling in-person interpreter services for future appointments. See *CLS-011 Compliance Monitoring of C & L Program* for details.
6. The Alliance ensures that individuals who provide language interpretation services for Alliance members are qualified.
 - 6.1. Qualified interpreters:
 - 6.1.1. Has demonstrated proficiency in speaking and understanding both spoken ~~Are~~ ~~proficient in~~ English and at least one other relevant interpreted spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages);
 - 6.1.2. Can Be able to interpret effectively, accurately, and impartially to and from such language and English (or between two non-English languages for relay interpretation), both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment and emotional level of original orate statement, terminology, and phraseology.
 - 6.1.3. Adhere to Comply with the generally accepted interpreter ethical principles, protocols including client confidentiality.
 - 6.2. These standards are included in the vendor contracting language.
 - 6.3. See *CLS-010 CLS Staff Training* for additional details on Alliance bilingual staff assessment.
 - 6.4. See *CLS-009 CLS Program - Contracted Providers* for details on documenting qualifications of bilingual providers.
 - 6.5. See *CLS-011 CLS Program Compliance Monitoring* for details on how the Alliance monitors interpreter quality.
7. **Remote Interpreting Technology.** Remote audio interpreting services offered by the Alliance provide real-time audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses, clear, audible transmission of voices and adequate training to users of the technology so they can easily use the remote interpreting services.
8. **Translation.** The Alliance provides members written informing materials in the Alliance threshold languages based on the Member's language of preference.
 - 8.1. LEP members that speak the identified threshold or concentration standard languages have full and immediate translation of written informing materials as defined in 42 CFR sections 438.10(d)(3), 438.404, and 438.408; W&I Code 14029.91; 22 CCR sections 53876 and 53884 10. The threshold or concentration languages are identified by DHCS within the Alliance's Service Area, and by the Alliance through membership

assessments. See *CLS-008 Member Assessment* for more details.

8.2. Translations are produced by qualified translators who:

- 8.2.1. Adhere to generally accepted translator ethics principles, including client confidentiality
- 8.2.2. Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation

8.3. Can translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology

8.4. Member Informing materials, also known as vital documents, include but are not limited to:

- 8.4.1. Member Handbook (Evidence of Coverage)
- 8.4.2. Provider Directory
- 8.4.3. new member welcome packets
- 8.4.4. marketing information
- 8.4.5. member rights information
- 8.4.6. form letters and individual notices including notice of action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and other letters containing important information regarding eligibility and participation criteria
- 8.4.7. applications, consent forms,
- 8.4.8. notices advising LEP members of the availability of at no cost language assistance, and
- 8.4.9. documents that require a response by the member
- 8.4.10. and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL [21-00425-005](#)

8.5. Non-threshold language translations of informing materials are available upon request. The Alliance will provide the translation in 21 days or less from the date of request. If a vital document is not standardized, but contains member's specific information, a written notice of the availability of interpretation services is included with the documents.

8.6. Alliance departments initiates member communication work with the Communications and Outreach Department and our translation vendor to create quality translations and refer to the Alliance data systems or the Health Care Analytics Department to identify members' language and alternate format preferences.

- 8.6.1. All translated materials will abide by the English version approved by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) or the qualified plan Health Educator (for health education materials only).

[8.6.2.](#) The Alliance Communications and Outreach Department maintains files with an English version of all translated member informing and health education documents an attestation as to the accuracy of the translation. The Alliance translation vendor also provides attestations for translated member communications with member-specific language. Policy and procedure *C&O-001 Community Relations and Outreach Activities* describes the plan's translation process.

~~8.6.2~~[8.6.3.](#) When Members request to receive translated written information in either traditional or simplified Chinese characters, the Alliance provides information in

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

the Member's preferred characters. Otherwise, the Alliance has a process to translate written information in Traditional Chinese characters.

8.7. Member Services staff are also available to assist non-English speaking members in understanding information in Alliance documents. Bilingual/multilingual staff will read relevant documents to the member, staff will use our interpreter service to interpret the document, or staff will request a translation of the document for the member.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

9. **Community Services Program Referrals.** The Alliance maintains referral lists of culturally and linguistically appropriate community services programs. Members are informed of available programs through contact with the Member Services, and Health Care Services Departments, the Alliance website (alamedaallianc.org) and member newsletters. Providers are informed of available programs at least annually through provider visits and through the Alliance provider website.

10. **Effective Communication with ~~Individuals~~ Members with Disabilities.** The Alliance takes steps to ensure effective communication with members with disabilities, including persons with impaired sensory, manual, or speaking skills. This includes Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including ASL interpreters, and information in alternative formats including Braille, audio format, large print (no less than 20 point Ariel font), and accessible electronic format, such as data CD, as well as requests for other auxiliary aids and services that may be appropriate.

10.1. The Alliance provides telecommunication access for deaf or hard of hearing members ~~→ (TDD)~~ through TTY/California Relay System (CRS) numbers listed on member communications, in the Member Handbook (Evidence of Coverage) and newsletters. All member facing staff are trained on the use of CRS.

10.2. The Alliance provides members with alternative formats of Alliance written materials and auxiliary aids and services upon request. Auxiliary aids are also available to Alliance members' authorized representatives or someone with whom it is appropriate for the Alliance to communicate, including a family member, friend, or associate involved in the member's healthcare.

10.3. Alternative format requests may include Braille, audio format, large print (no less than 20-point Ariel font), and other electronic formats, such as a data CD.

10.3.1. Members contact Alliance Member Services to request alternative formats of member materials. See P&P C&O-001 Community Relations and Outreach Activities for details. Requests are sent to the Alliance Communications and Outreach Department and the requested format is distributed to the member.

~~10.3.2.~~ The Alliance collects and stores the alternative format request in main data systems for use when sending member communications and to share with DHCS. Included is the following information:

10.3.2.

•• Beneficiary Client Index Number

Formatted: Indent: Left: 0.6", Hanging: 0.5", Right: 0", Line spacing: single, Tab stops: Not at 1.1" + 1.1"

Formatted: Font: Not Italic

Formatted: Indent: Left: 0.6", Hanging: 0.5", Right: 0", Space Before: 0 pt, Line spacing: single, Tab stops: Not at 1.1" + 1.1"

Formatted: Font: 12 pt

- Name
- Date of request
- Requested alternative format

10.3.3. Members, Authorized Representatives (AOR), or someone with whom it is appropriate for the Alliance to communicate can request auxiliary aids and services by calling Member Services. Member Services will connect the individual to Alliance Case Management who will offer health navigation support to receive the needed auxiliary aids and services needed. See Alliance policy UM-045 Communications Services for more information.

Formatted: Space Before: 0 pt, Bulleted + Level: 1 + Aligned at: 1.35" + Indent at: 1.6", Tab stops: Not at 1.1"

Formatted: Indent: Left: 0.6", Tab stops: Not at 0.88"

Formatted: Font: Not Italic

11. Quality of Interpreter Services for Members with Disabilities. When providing interpreting services to members with disabilities, the interpreter must meet the qualifications described previously in this document. Qualified interpreters may include ASL interpreters, oral transliterators, or cued language transliterators. Any interpreter for members with disabilities provided through VRI must have high quality images with display able to accommodate the interpreter's and participating individual's face, arms, hands and fingers, and meet VRI requirements described previously in this document.

11.1. As with other language interpreters, the Alliance does not require members with disabilities to bring their own interpreter and does not rely on adult or minor children to accompany an individual except as listed below.

12. Informing Members. The Alliance informs members, including members with disabilities, and providers of the availability of language services at no cost, including interpreters for LEP members, ASL interpreters, written translation, availability of alternative formats, auxiliary aids and services, and access for the deaf or hard of hearing through multiple methods.

12.1. The Alliance does not rely on the use of the member's family, friends, or unqualified staff as interpreters.

12.1.1. Providers are educated on the risks of using unqualified interpreters.

12.1.2. Adult or minor children should not interpret except in cases of emergency where there is imminent threat to the safety and welfare of the person, or the public, and a qualified interpreter is not available or the LEP member specifically requests that an accompanying adult interprets, the adult agrees to assist and relying on that adult is appropriate under the circumstances.

12.1.3. Providers must inform members of their right to qualified interpreter services and document the refusal in the patient's medical record.

12.2. Members are informed of their right to language services at no cost, alternative formats and auxiliary aids in the New Member Welcome packet, the Member Handbook, the Alliance member website, member newsletters, non-discrimination notice and language assistance ~~taglines~~ [Notice of Availability \(previously "taglines"\)](#) sent out

- ___ with member informing communications and when
 - ___ communicating with Alliance
 - ___ staff.
- 12.3. Providers are informed of how to access the plan's language services at no cost and are educated on how to use interpreter services, alternative formats, and auxiliary aids and services through the New Provider Orientation, provider site visits, Alliance provider website and the Provider Manual.

13. Nondiscrimination Notice.

- 13.1. The Alliance posts a nondiscrimination notice that informs members, potential ~~enrollees~~ members and the public about nondiscrimination, protected characteristics, and accessibility requirements and the Alliance's compliance with those requirements. The Notice of Non-Discrimination includes the seven (7) required elements as contained in the sample nondiscrimination notice.
- 13.2. The notice ~~is posted in at least 12-point font size and~~ is included in the Member Handbook, member information and all other information notices targeted to members, potential ~~enrollees~~ members, and the public. (Except those that are small-sized, see below).
- 13.3. This notice is included as well in outreach, education, and marketing materials as well as notices that require a response or that pertain to the member's rights and benefits.
- 13.4. The notice is also posted in at least 20-point sans serif font in conspicuous physical locations where the Alliance interacts with the public, as well as on the Alliance website in an easily found location.
- ~~13.4.~~ The Alliance does not replace printed nondiscrimination notices or Notice of Availability by the use of quick response codes (QR codes).
- ~~13.5.~~ The nondiscrimination notice includes all legally required elements as well as information on how to file discrimination grievances with DHCS Office of Civil Rights (OCR), and with the plan, as is described in the DHCS nondiscrimination notice template.
- ~~13.5.~~ 13.6. The Alliance uses an abbreviated nondiscrimination statement for small-sized information notices (i.e., postcards, pamphlets, newsletters, brochures, and flyers that are printed and/or distributed on paper or folded in a way that is smaller than 8.5 X 11 inches). The abbreviated nondiscrimination statement is accompanied by the full set of language taglines in 18 non-English languages.

14. Discrimination Grievances

- 14.1. The Alliance has a grievance process in place with the capacity to capture grievances in the language spoken by the member.
- 14.2. Upon enrollment, Alliance Members are informed of the Plan's grievance and

Formatted: Right: 0.23"

appeals process and are offered forms for filing grievance and appeals. These forms are available in the Alliance threshold languages and are available upon request.

- 14.3. Additionally, the Alliance ensures all members can participate in its grievance system by providing assistance to LEP Members or with a visual or other communicative impairment.
- 14.4. The Alliance has a designated discrimination grievance coordinator responsible for ensuring compliance with both federal and state nondiscrimination requirements, including compliance with Section 1557 of the Patient Protection and Affordable Care Act (ACA).

15. Language Assistance ~~Taglines~~**Notice of Availability.** The Alliance ensures members are aware of language assistance availability through use of ~~Taglines~~**the Notice of Availability.**

- 15.1. The Alliance ~~provides~~~~posts~~ ~~taglines~~~~the Notice of Availability~~ in at least 12-point ~~sans serif~~ font

~~in English and at least the top~~
~~California~~~~the top 18 non-English~~ languages.

- 15.2. Current languages in the ~~taglines~~**Notice of Availability** include the top ~~185~~ non-English

~~languages spoken~~
~~by LEP individuals in California, as identified by HHS OCR in~~
~~2016, Arabic,~~
~~Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese,~~
~~Korean, Punjabi,~~
~~Russian, Spanish, Tagalog, Thai, and Vietnamese as well as~~
~~Laotian, Ukrainian~~
~~and Mien which are used in Medi-Cal Fee for Service (FFS).~~

- 15.3. The **Notice of Availability**~~taglines~~ informs ~~members~~, potential members, and the public of

~~the availability~~
~~of no-cost language assistance services including assistance in non-~~
~~English~~
~~languages and the provision of free auxiliary aids and services for people~~
~~with~~
~~disabilities.~~

- 15.3.1. ~~Taglines~~**The Notice of Availability is provided upon request,**~~are included~~~~posted~~
in the Member Handbook/**EOC and other electronic and written communications,**
posted in clear and prominent physical locations where the Alliance interacts with
the public in at least 20-point sans serif font, on the Alliance website, conspicuous
~~locations~~**and in all member information and other informational** notices.

16. Access for Persons with Disabilities. The Alliance ensures access for persons with disabilities in compliance with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405.

- 16.1. Offering qualified interpreters when oral interpretation is a reasonable step to

Formatted: Right: 0.42", Tab stops: 0.81", Left + Not at 0.75"

Formatted: Right: 0.42", Tab stops: 0.81", Left

provide meaningful access.

- 16.2. Using qualified translators for written translation.
- 16.3. Offering free, accurate, timely and confidential language services (Sections 3-5)
- 16.4. Ensuring access for individuals with disabilities, including accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces and accessible drinking water. Accessibility is monitored through the Alliance's physical accessibility review surveys. See Policy and Procedure *QI-105 Facility Site Reviews (FSRs)*, *Medical Record Reviews (MRRs)* and *Physical Accessibility Review Survey (PARS)* for details.
- 16.5. Providing auxiliary aids and services to individuals with disabilities.
- 16.6. Making reasonable changes to policies, practices, and procedures to provide equal access for members with disabilities. Policies and procedures are reviewed annually by all internal departments to ensure there are no barriers for members to access care.
- 16.7. Members with disabilities and their Authorized Representatives (AOR) can request care coordination from Alliance Case Management. See UM-002 Coordination of Care and CM-029 Developmental Disabilities.

Formatted: Tab stops: Not at 0.88"

Formatted: Indent: Left: 0.65", No bullets or numbering

DEFINITIONS / ACRONYMS

ACA: Affordable Care Act

Alternative Format: Formats such as Braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate.

Formatted: Indent: Left: 0.1"

ASL: American Sign Language

Auxiliary Aids: Devices used by persons with disabilities for communication, such as Telephone Typewriters (TTY) or Telecommunication Devices for the Deaf (TDD).

CLS: Cultural and Linguistic Services

CRS: California Relay Services

Cued language transliterators: Individuals who represent or spell by using a small number of handshapes.

Formatted: Font: 11 pt

Formatted: Right: 0.32"

~~**Alternative Format:** Formats such as Braille, audio format, large print (no less than 20 point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate.~~

~~**Auxiliary Aids:** Devices used by persons with disabilities for communication, such as Telephone Typewriters (TTY) or Telecommunication Devices for the Deaf (TDD).~~

Formatted: Font: 11 pt

~~**D-SNP:** Dual Eligible Special Needs Plan~~ **OCR:** Office of Civil Rights

Formatted: Font: Bold

FFS: Fee for Service

Formatted: Font: 11 pt

Interpreter: An interpreter is a person who renders a message spoken in one language into one or more languages.

Formatted: Font: 12 pt

~~**CRS** California Relay Services~~

~~**Cued language transliterators** Individuals who represent or spell by using a small number of~~

Formatted: Indent: Left: 0.1", Right: 0"

~~handshapes.~~

Interpretation services include: (1) availability of trained bilingual/multilingual plan and provider staff (2) hiring staff interpreters (3) contracting with an outside interpreter service for qualified interpreters (4) arranging for the services of voluntary, qualified community interpreters (5) contracting for telephone, videoconferencing, or other telecommunication supported interpretation services.

Formatted: Font: 12 pt

~~**Interpreter**—An interpreter is a person who renders a message spoken in one language into one or more languages.~~

Formatted: Font: Bold

LEP:—Limited English Proficient

OCR: Office of Civil Rights

Oral transliterators:—Individuals who represent or spell in characters of another alphabet.

TDD:—Telecommunications Devices for Deaf

Translation – Translation is the replacement of written text from one language into another.

TTY:— (Teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

COMPLIANCE COMMITTEE REVISION HISTORY

7/1/1998, 11/1/04, 1/1/08, 9/29/09, 2/26/10, 3/13/12, 4/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, 03/19/2024, 4/16/2025, TBD

RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	CLS Program Compliance Monitoring
CM-029	Developmental Disabilities
C&O-001	Community Relations and Outreach Activities

Page 11 of 12

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

QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Survey (PARS)
UM-002	Coordination of Care
UM-045	Communications Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Americans with Disabilities Act of 1990
 CFR, Part 42 Sections 438.10(d), 439.10, 438.404 and 438.408
 DHCS All Plan Letter 25-005
 DHCS All Plan Letter 22-002
 DHCS Exhibit A, contract Attachments 9, Sections 13 and 14
 Government Code Sections 11135 and 7405
 2024 DHCS Exhibit A Attachment III Section 5.2.10 Access Rights
 Patient Protection and Affordable Care Act, Section 1557
 Title VI, Civil Rights Act of 1964
 Title 22, CCR, Sections 51202.5 and 51309.5(a), 53853(c), 53876, and 53884
 Title 28, CCR sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4)
 Rehabilitation Act of 1973, Sections 504 and 508
 SB 223 Health Care Language Assistance Services
 SB 1423 Oral Interpretation Services
 W&I Code 14029.91
[Centers for Medicare and Medicaid Services \(CMS\)](#)

MONITORING

This policy will be reviewed annually to ensure effectiveness.



POLICY AND PROCEDURE

Policy Number	CLS-008
Policy Name	Member Assessment of Cultural and Linguistic Needs
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	4/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>2/14/2025 TBD</u>
Administrative Oversight Committee Approval Date	<u>4/16/2025 TBD</u>

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness (D-SNP) complies with all contractual and regulatory requirements pertaining to the assessment of enrollees to offer its members culturally and linguistically appropriate services. Results of the assessments are used to determine threshold languages and translation of member informing materials for members. The Alliance's cultural and linguistic assessments comply with Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3); ~~and~~ the Department of Health Care Services (DHCS) APL 17-006, Title 42, Code of Federal Regulations, and Centers for Medicare and Medicaid Services (CMS);

PROCEDURE

1. The Alliance collects reported ethnicity and preferred language information from the Department of Health Care Services (DHCS) (Medi-Cal), the Centers for Medicare and Medicaid Services (CMS), and employer eligibility files (Group Care). In addition, Alliance staff documents ~~reported~~reported on member ethnicity, preferred language, use of interpreters and member requested changes to ethnicity or preferred language in the Alliance information systems. Quarterly reports are reviewed by Alliance staff at the Cultural and Linguistic Services Subcommittee meetings.
2. The Alliance assesses members' language needs and demographic profile for Medi-Cal, D-SNP and Group Care lines of business at least annually. At minimum the following information is provided as part of this member assessment:

- 2.1. Total members by race/ethnicity, preferred language, age, sex and SPD aid code
 - 2.2. Total members as percent of membership
 - 2.3. Comparison of prior year(s) to current year by percent change.
3. The Alliance implements a Population Assessment of Medi-Cal, D-SNP and Group Care members annually (See *PH-005 Population Assessment* for details on purpose, content, implementation, and reporting requirements of the Population
 4. The Alliance translates, using a qualified translator, member informing materials into languages that meet the following criteria:
 - 4.1. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
 - 4.2. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).
 - 4.3. The Alliance distributes written notice, a Notice of Availability, in English and up to 15 languages. The Notice informs members that the Alliance provides free language assistance services and how to obtain the services.
 - 4.3.1. The up to 15 languages include DHCS defined in APL 25-001 and languages spoken by 1% of individuals or by 200 individuals, whichever is less, who are served by the organization.
 - 4.3.2. See CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities for policies and procedures regarding distribution of the Notice of Availability.
 - 4.3.4.4. All Alliance departments communicating with members are responsible for ensuring their staff translate or interpret all member informing materials. The Alliance's Communications and Outreach Department has the responsibility of providing translations using qualified translators of those materials as needed. See *CLS-003 Language Assistance Services* and *C&O-001 Community Relations and Outreach Activities* for policies and procedures regarding document translation.
 5. Alliance Cultural and Linguistic Services and Communications and Outreach work together to ensure that members receive regular notices with regards to availability of free Language Assistance Services (LAS) for members. Messages include the following content:
 - 5.1. Information on availability of LAS in all threshold languages for each line of business.
 - 5.2. Information on how to request LAS
 - 5.3. No-cost nature of LAS
 - 5.4. Encouragement of members to use professional interpreters and not use family, friends, or non-qualified interpreters
 - 5.5. Not to use children as interpreters except in an emergency
 6. The Alliance informs LEP members of language services at no cost through the following strategies (For more details on these notices and strategies for informing members about language services, see *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities*.):

- 6.1. Member ID card letter
 - 6.2. Alliance provider and member websites
 - 6.3. Plan member newsletter
 - 6.4. Plan letters connecting members to plan services including Health Education and Case Management
 - 6.5. Notice of non-discrimination, language assistance and effective communication for individuals with disabilities and taglines offering free language assistance services
7. The Alliance maintains a list of non-English languages likely to be encountered among the Plan's members. This information is also documented in the enrollee assessments. Member demographics are also a part of the plan's annual Diversity Equity and Inclusion (DEI) Training. All employees are required to complete a yearly DEI Training, and the training is made available to the plan's provider network on the plan's website. See Alliance policy *HR-027 DEI Training Program* for more details.

DEFINITIONS / ACRONYMS

[DEI: Diversity, Equity, and Inclusion](#)

DHCS: Department of Healthcare Services

[D-SNP: Dual Eligible Special Needs Plan](#)

LAS: Language Assistance Services

LEP: Limited English Proficiency

Member Informing Materials: Informing materials/documents provide essential information to members regarding access to and usage of plan services. Examples include member handbooks, newsletters, provider directory, notices of action and form letters.

PNA: Population Needs Assessment. The PNA is an assessment of the demographics, health status, health care access and health disparities of the Alliance member population.

[DEI: Diversity, Equity, and Inclusion](#)

AFFECTED DEPARTMENTS/PARTIES

Case Management
Communications and Outreach
Health Care Analytics
Health Care Services
Operations

REVISION HISTORY

Replaced MED-CLS-006 Language Identification 11/20/2008

Updates: 4/13/2025, 3/24/2016, 5/25/2021, 7/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, 3/19/2024, 4/16/2025, [TBD](#)

RELATED POLICIES AND PROCEDURES

HED-003 Population Needs Assessment (GNA)
CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-010 Cultural and Linguistic Services Program_ Staff Training
CLS-011 CLS Program Compliance Monitoring
C&O-001 Community Relations and Outreach Activities
HR-027 DEI Training Program

REFERENCES

Title 22, CCR, Section 53858(e)(6)
Title 28, CCR, Section 1300.68(b)(3)
Health and Safety Code section 1367.04(b)
DHCS Contract Exhibit A, Attachment 9
DHCS All Plan Letter 17-011 Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
DHCS All Plan Letter 19-011 Population Needs Assessment (PNA)
DHCS All Plan Letter 23-025

MONITORING

This policy will be reviewed annually to ensure effectiveness and it meets regulatory and contractual standards. Monitoring activities are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services*.



POLICY AND PROCEDURE

Policy Number	CLS-009
Policy Name	Cultural and Linguistic Services (CLS) Program – Contracted Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>2/14/2025TBD</u>
Administrative Oversight Committee Approval Date	<u>4/16/2025TBD</u>

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness (Alliance) is committed to meeting the cultural and linguistic needs of our members. We contract with a diverse network of providers and ensure that our contracted health care providers, behavioral health providers, subcontractors, and downstream subcontractors are compliant with all standards related to the Alliance's Cultural and Linguistic Services Program.

All Alliance contracted providers, subcontractors, and downstream subcontractors must offer qualified interpretation services to Alliance Members at all points of contact for covered benefits. These standards are outlined in the following policies and procedures: *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities, CLS-008 Enrollee Assessment of Cultural and Linguistic Needs, CLS-010 Staff Training.*

The Alliance's contracted provider network will deliver adequate access and availability of bilingual providers and office staff in its contracted network. The Alliance retains financial responsibility for these services unless delegated financial responsibility has been documented in a written contract.

The Alliance ensures that all delegated provider networks, subcontractors, and downstream subcontractors provide a Cultural and Linguistic Services Program to Alliance Members and mechanisms are in place to fulfill their responsibilities, including administrative capacity, technical expertise, budgetary resources for language assistance and culturally responsive services. The Alliance reviews and identifies problematic areas and effective action is taken to improve care.

PROCEDURE

1. The Alliance engages with local providers of primary care, specialty, behavioral health, care management, and enhanced care management (ECM) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment and retention of providers who can meet the cultural, language, age, and disability needs and preferences of our members.
2. Alliance contracts with healthcare providers and vendors, including subcontractors and downstream contractors, state the responsibility to comply with the Alliance Cultural and Linguistic Services program, which includes compliance with state and federal language and communication assistance requirements.
3. The Alliance ensures compliance of providers, subcontractors, and downstream contractors with the requirements for access to interpreter services for all limited English proficiency (LEP) Members by:
 - 3.1. Informing providers of the ways in which they can improve patient access to quality health care through culturally appropriate and linguistic services such as the Alliance's Interpreter Services:
 - 3.1.1. The Provider Manual, available on the Alliance provider website, describes provider responsibilities to provide culturally and linguistically appropriate services. The manual includes the Alliance Interpreter Services Guide that describes how to request interpreter services at no cost to providers or member.
 - 3.1.2. The Alliance distributes to providers a *Point to Your Language* sign as well for use in the office when interacting with LEP members to identify the need for interpretation and language requested.
 - 3.1.3. Providers are reminded about the Alliance interpreter services and the importance of professional interpreter services on the Alliance provider website, provider quarterly packets, provider visits, provider training curriculum and regularly distributed health education resource guides.
 - 3.1.4. Providers are required to participate in a Diversity, Equity, and Inclusion (DEI) Training when first contracted and yearly thereafter, which includes information on Health Equity, Diversity, Equity, Inclusion and Belonging (DEIB), and complying with the Alliance Cultural and Linguistic Services Program, assisting

LEP members, accessing interpreter services and best practices for working with interpreters. See *CLS-010 Staff Cultural and Linguistic Training* for details.

3.2. Informing providers of the language needs of Alliance members:

3.2.1. The Alliance includes the language needs of Alliance members assigned to clinics or provider offices on the member rosters and in the Alliance Provider Portal.

3.2.2. If providers need members' preferred language information, requests can be made through Provider Services or through the Alliance Provider Portal.

3.2.3. Population level information about Alliance member language and cultural needs are shared through the required annual Cultural Sensitivity Training.

3.3. Monitoring provider performance through facility site reviews, the re-credentialing process, review/response to member grievances, and quarterly tracking of in-person and telephonic service requests:

3.3.1. The Quality Improvement Department, through Facility Site Reviews, monitors provider performance for culturally appropriate and linguistic services (See *CLS-011 Compliance Monitoring of the Cultural and Linguistic Services Program*).

3.3.2. The Cultural and Linguistic Services Subcommittee monitors grievances regarding provider language capacity and reviews in-person and telephonic service requests. Reports are forwarded to the Quality Improvement Health Equity Committee (QIHEC).

3.3.3. Use of corrective action plans and retraining when indicated.

4. The Provider Services and Quality Improvement Departments collect information on the bilingual capacity of the provider network. All updates are entered into the Alliance provider database.

4.1. During initial credentialing, provider language capacity is documented.

4.2. Providers are asked to provide the Alliance quarterly updates to the languages available at their offices.

4.3. The Quality Improvement Department monitors the adequacy of availability of bilingual providers through quarterly reports to the Cultural and Linguistic Subcommittee and forwarded to QIHEC for review. Provider Services and the Quality Improvement Departments work together to address any issues that arise.

4.4. Providers are asked to maintain documentation of proficiency for all bilingual staff.

4.5. At a minimum the Quality Improvement Department analyzes the capacity of its network to meet:

4.5.1. The language needs of individuals

4.5.2. To meet the needs of members for culturally appropriate care

5. Based on findings of analysis described in 4.5 above the Quality Improvement Department develops a plan to address gaps identified as a result of the analysis if applicable

4.4.5.1. The Quality Improvement Department will address gaps based on the plan if applicable.

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

5.1.6.1. All languages spoken at the office are listed below the provider listing, whether the provider is a Primary Care Provider or specialist.

5.2.6.2. Member Services staff use this information to assist members in selecting an appropriate provider.

6.7. In the event that a Network provider, subcontractor or downstream subcontractor has religious or ethical objections to perform or otherwise support the provision of covered services, the Alliance will arrange for, coordinate, and ensure the member receives services in a timely manner through a provider with no moral objections.

6.1.7.1. Members are notified in the member handbook of the right to access services from another provider.

6.2.7.2. Members can call the Member Services Department for assistance in identifying another provider or behavioral health provider. When appropriate, Member Services staff will refer the member to the Case Management Department or Behavioral health Department for care coordination support.

DEFINITIONS / ACRONYMS

ECM: Enhanced Care Management

D-SNP: [Dual Eligible Special Needs Plan](#)

Limited English Proficient (LEP): A person that is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social services agencies and providers.

QIHEC – Quality Improvement Health Equity Committee

AFFECTED DEPARTMENTS/PARTIES

Alliance Provider Network

Member Services

Provider Services

Quality Improvement

Vendor Management

REVISION HISTORY

2/13/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, 03/19/2024, 4/16/2025, [TBD](#)

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-008 Enrollee Assessment of Cultural and Linguistic Needs
CLS-010 Cultural and Linguistic Services Program - Staff Training
CLS-011-Compliance Monitoring of Cultural and Linguistic Services Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

CA Health and Safety Code section 1367.04(f)
Title 28, CCR 1300.67.04

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services*.



POLICY AND PROCEDURE

Policy Number	CLS-010
Policy Name	Cultural and Linguistic Services Program: Staff Training and Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, ~~D-SNP~~
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

POLICY STATEMENT

Alameda Alliance for Health [and Alameda Alliance Wellness](#) D-SNP (Alliance) ensures that all staff, network providers, and subcontractors are compliant with the Cultural and Linguistic Services Program through cultural competency/humility, sensitivity, health equity and diversity training. The purpose of the training is to promote access and delivery of services in a culturally competent manner to all members and potential members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56.

Additionally, bilingual staff that is hired to work with Alliance's limited English proficiency (LEP) members receive bilingual proficiency assessments. Bilingual members' proficiency is regularly monitored and any areas of concern addressed.

PROCEDURE

1. The Alliance creates and updates on an annual basis a Cultural Sensitivity Training that includes the following:
 - 1.1. Knowledge of the Alliance's policies and procedures related to language assistance.

- 1.2. Instruction on working effectively with members and interpreters through all means of communication.
- 1.3. Understanding the cultural diversity of the Alliance's member population and sensitivity to cultural difference relevant to delivery of health care interpretation services.
- 1.4. How structural and institutional racism and health inequities impact members, staff, network providers, subcontractors, and downstream subcontractors.
- 1.5. Information about the identified cultural groups in its service area including but not limited to members with:
 - 1.5.1. Limited English proficiency
 - 1.5.2. Refugee and immigrant status
 - 1.5.3. Diverse cultural and ethnic backgrounds
 - 1.5.4. Seniors and persons with disabilities
 - 1.5.5. Gender, gender identity and sexual orientation
- 1.6. Information about the health inequities and identified cultural groups in Alameda County including, but not limited to the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with providers and the health care structure; traditional home remedies that can impact treatment; and health literacy needs.
2. All Alliance staff are required to participate in the Cultural Sensitivity Training within the first 90 days of employment and annually thereafter. See Alliance policy *HR-027: DEI Training Program* for more details on implementation.
3. The Alliance ensures network providers and allied health personnel receive pertinent information regarding the Alliance Population Needs Assessment (PNA) findings using a communication method to ensure the information can be accessed and understood. See Alliance policy *PH-005 Population Assessment* for details.
4. The Alliance's network providers, subcontractors, and downstream subcontractors, including behavioral health providers, must also provide cultural competency/humility, sensitivity, health equity and diversity training to staff at key points of contact with members.
 - 4.1. Providers are informed of the training requirements through new provider orientations, provider quarterly packets, provider manual and provider office visits. They have access to the Alliance Cultural Sensitivity Training on the Alliance provider website.
 - 4.2. Additional training and resources on providing cultural and linguistic services are posted on the Alliance provider website and promoted through regular provider visits.
5. The Human Resources Department requires that bilingual or multilingual employees are assessed on their linguistic proficiency prior to performing duties that use multilingual skills. See Alliance policy *HR-020 Assessing Language Skills – New Hires, Promotions & Annual Testing* for more details.
 - 5.1. An employee linguistic proficiency assessment includes assessing:

- 5.1.1. Proficiency in English and the relevant interpreted language
- 5.1.2. Knowledge of healthcare terminology and concepts relevant to health care delivery systems in both languages
- 5.1.3. Understanding of the ethical principles, protocols and guidance on roles and intervention as promulgated by the California Healthcare Interpreters Association (CHIA)
- 5.2. Human Resources ensures that designated multilingual staff are assessed by a qualified outside vendor.
 - 5.2.1. Assessments are pass/fail. Staff who fail their departmental test for a certain non-English language will not be permitted to serve members in that language until they pass the assessment.
 - 5.2.2. Human Resources will maintain a list of current multilingual employees including the language(s), testing date and clinical or non-clinical capacity.
 - 5.2.3. Human Resources, or their designee, reviews the quality of multilingual staff communication with members through yearly reassessment.
- 5.3. Bilingual staff sign an attestation to confirm understanding of CHIA standards,
- 5.4. Member Services reviews cultural and linguistic skills in their monthly quality monitoring of member services calls.
- 5.5. Supervisors provide feedback to the employee about their performance including areas for improvement. Retraining or reassessment takes place as deemed necessary.

DEFINITIONS / ACRONYMS

CHIA: California Healthcare Interpreters Association

D-SNP: Dual Eligible Special Needs Plan

LEP: Limited English Proficiency - A person that is unable to speak, read, write or understand

— the English language at a level that permits him/her to interact effectively with health
 — and social services agencies and providers.

~~**CHIA:** California Healthcare Interpreters Association~~

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
 Alliance Provider Network

REVISION HISTORY

2/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021,
 11/23/2021, 3/17/2022, 3/21/2023, 03/19/2024, 4/16/2025, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-011 Monitoring of Cultural and Linguistic Services
HR-020 Assessing Language Skills – New Hires, Promotions & Annual Testing
HR-027-DEI Training Program
PH-005 Population Assessment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Section 13
Title 28 §1300.67.04(c)(2) Language Assistance Program
U.S. Code of Federal Regulations, Title 42, CFR Section 440.262
DHCS All Plan Letter 23-025
[Centers for Medicare and Medicaid Services \(CMS\)](#)

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Monitoring of Cultural and Linguistic Services*.



POLICY AND PROCEDURE

Policy Number	CS-011
Policy Name	Community Supports – <u>Assisted Living Facility Transitions</u> ~~Nursing Facility Transition/Diversion to Assisted Living Facilities~~
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ <u>Long Term Services and Supports</u>
Line(s) of Business	~~D-SNP~~ , MCAL
Effective Date	9/18/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ <u>TBD</u>
Administrative Oversight Committee Approval Date	~~9/18/2024~~ <u>TBD</u>

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Assisted Living Facility Community Support.

Formatted: Font: 12 pt

Assisted Living Facility Transitions (formerly known as “Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities”) is designed to assist individuals with living in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent nursing facility admissions for Members living in the community. This Community Support is intended for Members with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility.

For the purposes of this service definition, the term assisted living facility (ALF)

includes a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF). This service includes two components, as follows:

- Time-limited transition services and expenses to enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF. The transitional period will vary in length and services provided based on a Member's unique circumstances. Allowable expenses are those necessary to enable a person to establish ALF residence (except room and board), including, but not limited to:
 - i. Assessing the Member's housing needs and presenting options.
 - ii. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the ALF, so the Member can be safely and stably housed.
 - iii. Assisting in securing an ALF residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
 - iv. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
 - v. Communicating with facility administration and coordinating the move.
 - f. Establishing procedures and contacts to retain housing at the ALF.
- Ongoing assisted living services are provided to Members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, as long as the Member can maintain residency in the ALF. These services include:
 - i. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
 - ii. Meal preparation
 - iii. Transportation d. Medication administration and oversight e. Companion services
 - iv. Therapeutic social and recreational programming provided in a home-like environment
 - v. 24-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security
 - vi. Care coordination services to screen for eligibility and support enrollment of Members in Enhanced Care Management (ECM) and other Community Supports

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.5" + Indent at: 1.75"

- ~~1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.~~
- ~~1.2 AAH works with community resources to ensure access to and delivery of CS services.~~
- ~~1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Nursing Facility Transition/Diversion to Assisted Living Facilities for their CS clients.~~
 - ~~1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.~~
- ~~1.4 Nursing Facility Transition/Diversion to Assisted Living Facilities services assist individuals to live in the community and/or avoid institutionalization when possible.~~
 - ~~1.4.1 The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long term placement in a nursing facility when they meet eligibility requirements.~~
- ~~1.5 As indicated in P&P CLS 009, *Cultural and Linguistic Services (CLS) Program—Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.~~
 - ~~1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.~~
 - ~~1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~
 - ~~1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~
 - ~~1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.~~

PROCEDURE

- ~~2.1 The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.~~

~~2.2 This Community Support is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) or Adult Residential Facilities (ARF) and includes wrap around services such as assistance w/ ADLs and IADLs as needed, companion services, medical oversight, and therapeutic social recreational programming provided in a home-like environment. It includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:~~

~~2.2.1 Assessing the Member's housing needs and presenting options.~~

~~2.2.2 Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.~~

~~2.2.3 Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).~~

~~2.2.4 Communicating with facility administration and coordinating the move.~~

~~2.2.5 Establishing procedures and contacts to retain facility housing.~~

~~2.2.6 Coordinating with the Alliance to ensure that the needs of Members who need enhanced services to be safely and stably housing in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.~~

~~2.3 Member Identification~~

~~2.3.1 Referrals Based CS~~

~~2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~

~~2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929 (TTY) during normal business hours or the AAH Nurse Advice Line at 1-~~

888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

~~2.4 Request for Nursing Facility Diversion/Transition to Assisted Living Facilities~~

~~2.4.1 Once AAH verifies a member's health plan eligibility:~~

~~2.4.1.1 Request is reviewed:~~

~~2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request:~~

~~2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request:~~

~~2.4.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits:~~

~~2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented:~~

~~2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources:~~

~~2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow):~~

~~2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services:~~

~~2.5 Continuity of Care~~

~~2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member:~~

~~2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.5.2.1 AAH offers the CS service which the member received through their prior MCP:~~

Formatted: Right: 0.44"

Formatted: Tab stops: 1.68", Left + 1.68", Left + Not at 0.63" + 2"

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 1", Tab stops: 1.68", Left + 1.68", Left + Not at 0.63" + 1.5"

Formatted

Formatted: Tab stops: 1.68", Left + 1.68", Left + 5.94", Left + 6.19", Left

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 1"

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

I. Eligibility

a) Members residing in a nursing facility who:

1. Have resided 60+ days in a nursing facility and
2. Are willing to live in an assisted living setting as an alternative to a nursing facility; and
3. Are able to reside safely in an ALF.

b) Members residing in the Community who:

1. Are interested in remaining in the community; and
2. Are willing and able to reside safely in an ALF; and
3. Meet the minimum criteria to receive nursing facility LOC services, and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.

Members residing in the community” includes Members living in a private residence or public subsidized housing and Members already residing in an ALF who are at risk of institutionalization.

Members who are receiving facility level health care services on an acute or postacute care basis (such as hospitalization or a short-term skilled nursing facility stay) may be eligible for this Community Support, provided they otherwise meet the eligibility criteria.

II. Referrals

a. Referrals to the Assisted Living Facility Community support can be received from:

- i. The member themselves
- ii. A members representative
- iii. A Members Provider
- iv. Other internal departments at the Alliance
- v. Through Analytic data ran by the Alliance

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

c. Members may call AAH Member Services at 1-877-932-2738 or 1-800-

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.5"

Formatted: Font: 12 pt, Bold

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

735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1- 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

Formatted: Font: Bold

III. Review

Formatted: Font: 12 pt, Bold

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

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

1. Documentation that the member has resided in a nursing facility for 60+ days or meet the criteria for a nursing facility admission
2. Documentation that the member is willing and able to safely reside in the assisted living facility
3. Documentation of waiver submission

Formatted: Normal, No bullets or numbering

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

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

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

Formatted: Normal, No bullets or numbering

IV. Closed Loop Referral

Formatted: Font: 12 pt, Bold

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

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

Formatted: Indent: Left: 2.75", No bullets or numbering

2.5.3

Formatted: Font: 12 pt

2.6V. Data Sharing

Formatted: No bullets or numbering

2.6.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

Formatted: Font: 12 pt, Bold

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

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

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS

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

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

~~2.6.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.6.4c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.6.5d) AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.~~

~~2.7 Eligibility~~

~~2.7.1 For Nursing Facility Transition:~~

~~1.1 The Member has resided 60+ days in a nursing facility;~~

~~2.1 The Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and~~

~~3.1 The Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.~~

~~2.7.2 For Nursing Facility Diversion:~~

~~1.1 The Member is interested in remaining in the community;~~

~~2.1 The Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and~~

~~3.1 The Member must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.~~

~~2.8 Payment~~

~~2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.~~

~~2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.8.3 AAH will adhere to standard claims processing turn around times for claims, invoices or encounter data that will be reimbursed on a fee for service basis as follows:~~

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

~~2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.8.42.1.2 _____ PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.9~~**VI. Restrictions and Limitations**

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

~~1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service,~~

~~2) beneficiaries are not required to use the Community Supports and~~

~~3) the Community Supports is authorized and identified in the AAH managed care plan contracts.~~

~~b) Room and board expenses are not included in this service. Members may receive assistance with room and board from other sources at the same time as receiving this service.~~

~~c) The ALW is not considered a state-level enrollment pathway for the purpose of enrolling these operators as Medi-Cal Providers offering Community Supports. The ALW is a distinct program authorized under the 1915(c) Waiver and is available to Medi-Cal managed care Members, with restrictions as a Medi-Cal FFS benefit, and is carved out of the Medi-Cal managed care program authority.~~

~~2.9.1~~

~~2.9.2 Individuals are directly responsible for paying their own living expenses.~~

~~2.9.3c) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.~~

~~2.10~~**VII. Discontinuing Services**

~~2.10.1a) Discontinuing of CS services will be based on:~~

~~2.10.1.1• _____Goals met/improved health status~~

~~2.10.1.2• _____Termination of coverage~~

~~2.10.1.3• _____No longer meets criteria~~

~~2.10.1.4• _____Member/caregiver declines services~~

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 1"

Formatted: Font: Bold

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

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

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

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

Formatted: Font: Bold

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

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

Formatted: Font: 12 pt

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

~~2.10.1.5~~ –Death of member

~~2.10.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.~~

~~2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

2.11.VIII. Licensing / Allowable Providers

~~2.11.1a~~ AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Assisted Living Facility Transitions~~Nursing Facility Transition/Diversion to Assisted Living Facilities.~~

~~2.11.2b~~ AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

- ~~2.11.2.1~~ Case management agencies
- ~~2.11.2.2~~ Home Health agencies
- ~~2.11.2.3~~ ARF/RCFE Operators
- ~~1915c~~ Home & Community Based Alternatives (HCBA)s/ALW providers

~~2.11.3c~~ AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

~~2.11.4d~~ CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

~~2.11.5e~~ AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.11.6f~~ AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

Formatted: Font: Bold

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

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

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 1.68" + Indent at: 1.93"

Formatted: Font: 11 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 1.68" + Indent at: 1.93"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 3 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

DEFINITIONS / ACRONYMS

CS Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

New Policy: 9/18/2024
Revisions: 05/03/2025

REFERENCES

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

MONITORING

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

Formatted: Font: Bold



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

POLICY AND PROCEDURE

Policy Number	QI-105
Policy Name	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
Department Name	Quality Improvement Division
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, and DSNP
Original Effective Date	01/01/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	7/5/2024
Administrative Oversight Committee Approval Date	9/18/2024

POLICY STATEMENT

1. This policy outlines Alameda Alliance for Health's ("the Alliance") and Alameda Alliance for Wellness (D-SNP) site review process, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), and the process by which Alliance conducts, scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines.
2. The Alliance Chief Medical Officer is responsible for oversight of site review policies in accordance with regulatory requirements. All Alliance contracted and subcontracted Primary Care Provider (PCP) sites must be compliant with applicable local, state, and federal standards related to FSRs. The California Department of Health Care Services (DHCS) only accepts site reviews that are conducted and completed by a Certified Master Trainer (CMT) and/or a Certified Site Reviewer (CSR).
3. The Alliance conducts site review processes to ensure access for people with disabilities in accordance with the protections of the Americans with Disabilities Act of 1990 (42 U.S.C. § 1211 et seq.), Section 504 and 508 of the Rehabilitation Act (29 U.S.C. § 794), 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), SB 223, SB 1423, APL 17-006, and Title 28, Code of Federal Regulations (CFR), section 35.151.
4. The Alliance complies with the DHCS requirement (Contract, All Plan Letter [APL], and Policy Letter [PL]) that the PCPs undergo an initial and subsequent full scope FSR, MRR, and PARS, in order to participate in Medi-Cal managed care, regardless of a PCP site's other accreditations and certifications. Alliance must ensure that:

- a) Each PCP site has passed an initial FSR and, as applicable, correct all deficiencies in order to close their Corrective Action Plan (CAP) prior to adding the provider(s) to the Alliance network and assigning members to the provider(s).
 - b) Each PCP site completes an initial MRR after the PCP is assigned members, and, as applicable, submits all appropriate documentation to address all deficiencies to close their CAP.
 - c) Each PCP site completes a periodic subsequent site review at least every three (3) years after the initial FSR, consisting of an FSR, MRR, and PARS. The purpose of these subsequent FSRs and MRRs is to evaluate the continuing capacity of the site in supporting the delivery of quality health care services.
 - d) The most current DHCS FSR and MRR tools and standards are being utilized when conducting site reviews.
 - e) All PCP sites are held to the same standards.
 - f) The site review status of each contracted PCP site is properly documented and monitored.
 - g) For shared providers, Managed Care Plans (MCP) will collaborate locally to determine how they will notify each other of site review statuses and results.
5. The Alliance must issue a Certificate of Completion to providers that successfully complete both the FSR and MRR and close all CAPs.
- a) This certificate is dated based on the most recent FSR, is valid for up to three (3) years, and affirms that the site has been deemed a DHCS Certified Provider Site.
 - b) The Alliance must develop a process for issuing the Certificate of Completion and coordinate with the county collaborative in the issuance and revocation of certificates for shared provider sites.
 - c) If a site's certification is revoked as a result of noncompliance with applicable requirements, the site is no longer deemed a DHCS Certified Provider Site and will not be allowed assignment of members as a PCP until the PCP site has successfully completed the FSR/MRR and closed all CAPs.
 - d) The Certificate of Completion does not replace the information from the site review results and outcomes that are shared based on agreed upon processes and methodology.
6. The Alliance must notify its providers in advance for scheduled site reviews. However, inspection of an Alliance's provider facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program.
7. The Alliance collaborates with other MCPs in geographic areas where shared providers are identified in accordance with DHCS requirements. The Alliance may choose to delegate site review responsibilities to another MCP and accept a collaborating MCP's site review findings. The Alliance retains ultimate responsibility for the assigned sites and oversight of site review completion, results, any necessary CAP, and monitoring of assigned PCP sites per county collaboration.

8. The Alliance requires that Urgent care facilities undergo an initial and subsequent periodic full scope FSR, using the Alliance tool, to participate in Medi-Cal managed care. All urgent care facilities must pass an initial FSR, as part of the credentialing process and a subsequent FSR every three (3) years thereafter, beginning no later than three years after the initial FSR. The purpose of these subsequent FSRs is to evaluate the continuing capacity of the site in supporting the delivery of quality health care services.
 9. Physical Accessibility Review Surveys (PARS) (FSR Attachment C, D and E) will be conducted for all PCP sites, Specialist sites, Ancillary Services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPDs).
 10. Delegation of the FSR and MRR processes require a mutually agreed upon contract language in which delegated functions are identified. The Alliance shall oversee and monitor all delegated activities. Through monitoring, the Alliance ensures that the delegated FSR and/or MRR functions are properly carried out. Delegation oversight activities are described in the Alliance policy QI-111 Delegation Management and Oversight.
 11. The Alliance will submit aggregated site review data to DHCS every six (6) months as required by APL 22-017.
 12. The Alliance ensures that relevant provider-specific information is shared interdepartmentally.
 13. The Alliance complies with the Department of Managed Health Care's (DMHC) requirements referenced in Title 28, CCR, Section, 1300.67.1(c) related to medical records for its Medi-Cal and Group Care lines of business.
 14. The Alliance ensures its ~~physicians-providers~~ have a process in place to follow up on missed or canceled appointments. The Alliance monitors missed, canceled, and rescheduled appointments through periodic full-scope, focused, and interim monitoring FSR/MRR evaluations.
 15. During public health emergencies, the Alliance shall:
 - a) Follow local, state, and federal guidelines and requirements to respond to concerns resulting from public health emergencies, such as a pandemic
 - b) Follow emergency Executive Orders or APLs that may temporarily change existing FSR policies
 - c) Develop standardized protocols for conducting alternatives to in-person site reviews (i.e. video "walk-through", interviews, return demonstration, collection of documentation, desktop review)
 16. The Alliance is responsible for ensuring that subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. —These requirements are communicated to subcontractors and network providers.
-
-

PROCEDURE

1 Initial Site Review and Medical Record Review

- 1.1 An initial site review consists of an initial FSR, an initial MRR, and PARS.
 - 1.1.1 The initial FSR and the initial MRR might not occur on the same date.
 - 1.1.2 The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations.
- 1.2 The Alliance must not add PCPs to the network or assign members to providers until the PCP sites receive a passing FSR score and completes all CAPs.
- 1.3 An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score. In situations of provider credentialing or recredentialing, a site survey does not need to be repeated if the site to which the provider is being added has a current passing site review survey score from a prior Alliance-conducted assessment, or from a local MCP with which the Alliance collaborates.
- 1.4 A DHCS Site Identification Number (“DHCS Site ID”) is a unique identifier and must be assigned by the Alliance to each PCP site reviewed.
 - 1.4.1 In the event of an ownership change at an established PCP site, a new DHCS Site ID will be assigned. The new DHCS Site ID may be existing Site ID but with a modifier to represent a change of ownership at the site.
 - 1.4.2 Local county MPCs collaborate to manage and assign the DHCS Site ID numbers specific to the county.
- 1.5 Once a PCP site passes the initial FSR and completes all CAPs, if applicable, the Alliance may add the site’s PCP(s) to the network and can begin assigning members to the PCPs at that site.
- 1.6 An MRR survey is performed at the time of the FSR if Medi-Cal patient records are available; otherwise, the Alliance must complete the initial MRR of the new PCP site within 90 calendar days of the date that Alliance first assigns members.
 - 1.6.1 The Alliance may defer this initial MRR for an additional 90 calendar days only if the new PCP(s) does not have enough assigned members to complete the MRR on the required minimum number of medical records. See Shared Medical Records Practice below for details regarding the required minimum number of medical records.
 - 1.6.2 If, after 180 days following member assignment, the PCP still has fewer than the required number of patient records, the Alliance must complete the MRR on the total number of medical records it has available, and adjust scoring accordingly to the number of medical records reviewed.
- 1.7 The Alliance may choose to conduct the MRR portion of the site review on-site or virtually. The virtual process must comply with all applicable Health Insurance Portability and Accountability Act (HIPAA) standards at all times.

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

- 2.1 A new PCP site is added to the Alliance network.
- 2.2 A newly contracted provider joins/assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 3.2 Mobile clinics are self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic services, and may also serve to deliver equipment to locations that operate temporary clinics.
- 3.3 In general, supplemental facilities that provide primary care services may serve as an extension of a PCP site, a community-based clinic, a Federally Qualified Health Center county facility, or a stand-alone clinic with members assigned.
- 3.4 The Alliance must conduct an initial site review and subsequent site reviews of supplemental facilities at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
- 3.5 The Alliance must establish a process to complete the oversight of supplemental facilities and collaborate with MCPs within the county.
- 3.6 Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.
 - 3.6.1 For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, the Alliance must conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017.
 - 3.6.2 For street medicine providers serving as an assigned PCP, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, the Alliance must conduct a condensed FSR and MRR of the street medicine provider to ensure member safety.

4 Requirements for Subsequent Site Reviews

- 4.1 The Alliance is required to conduct subsequent site reviews, consisting of an FSR, MRR, and PARS, at least every three (3) years.
- 4.2 The subsequent site visit would be conducted no later than three (3) years after the initial FSR, and at least every three (3) years thereafter.
- 4.3 The Alliance may conduct site reviews more frequently when determined necessary based on monitoring, evaluation, or CAP follow-up issues.

5 Scoring Requirements

- 5.1 The Alliance must base FSR and MRR scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel.
- 5.2 If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method.
- 5.3 The Alliance must not alter the scored criteria or assigned weights in any way.
- 5.4 The FSR tool is composed of both critical and non-critical elements.
 - 5.4.1 Critical elements (CE) are indicated by bold and underlined text. CEs have the largest potential for adverse effects on patient health or safety and therefore have a scored weight of two (2) points.

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

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

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

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

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

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

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

6 Shared Medical Records Practice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Failing Scores

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

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

- 7.3 When a PCP site receives a failing score on an FSR or MRR, the Alliance must notify the PCP site of the score, all cited deficiencies, and all CAP requirements.
- 7.4 The Alliance may choose to remove any PCP site with a failing FSR or MRR score from the network.
- 7.4.1 If the Alliance allows a PCP site with a failing FSR or MRR score to remain in the network, the Alliance must require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy.
- 7.5 The Alliance must not assign new members to network PCP sites that receive a failing score on an FSR or MRR until the Alliance has verified that the PCP site has corrected the deficiencies and the CAP is closed.
- 7.6 Based upon mutual agreement between the Alliance and the provider site, additional training and technical assistance may be available when a PCP site fails an initial FSR prior to contracting with the Alliance.
- 7.6.1 Pre-contracted providers who do not pass the initial FSR may use the first attempt as a learning and technical assistance opportunity.
- 7.6.2 If the provider fails the site review after the second attempt, the provider will need to reapply to the Alliance after six (6) months from the date of the second attempt.
- 7.7 PCP sites that receive a failing score on either the FSR or MRR for two (2) consecutive site reviews must receive a minimum passing score, i.e. Exempted Pass or Conditional Pass on the next FSR and MRR (including PCPs with open CAPs in place) to remain in the Alliance provider network.
- 7.8 If the PCP site fails on its third consecutive attempt, despite the Alliance's ongoing monitoring and assistance, the PCP site will not have an opportunity to complete a CAP, and must be removed from the Alliance's provider network.
- 7.8.1 Impacted members must be reassigned to other network providers, as appropriate and as contractually required.
- 7.8.2 If a PCP site is removed from one MCP network due to three consecutive failing scores, all other MCPs must also remove the PCP site from their networks.

8 Corrective Action Plan

- 8.1 A CAP is required for all cited deficiencies for PCP sites that have an FSR and/or MRR conditional pass or non-passing score.
- 8.2 The Alliance may require a CAP for other findings identified during the survey that require correction, regardless of the score.
- 8.3 There is no rescoring of the FSR or MRR as deficiencies are corrected or addressed, and points are still deducted even if deficiencies are corrected at the time of the audit.
- 8.4 CAPs are also required when there are CE, pharmacy, and infection control deficiencies found during any site review activity, including but not limited to, focused reviews, monitoring activities, or other reviews done by the Alliance or DHCS.
- 8.5 The Alliance must not assign new members to providers who fail to correct site review deficiencies within the established CAP timelines.

- 8.6 For providers that fail to comply with their CAP, the Alliance must verify that the PCP site has corrected the deficiencies and the CAP is closed before assigning new members.
- 8.7 Ultimately, the Alliance must remove any provider from the network that does not come into compliance with review criteria and CAP requirements with the established timelines.
- 8.7.1 Alliance must expeditiously reassign that provider's members to other network providers. Information regarding provider terminations is described in Alliance policy PRV-005 Provider Terminations.
- 8.8 The Alliance must follow the established timeline below for CAP notification and completion:

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

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

8.9 The Alliance is responsible for providing the site with the CAP requirements, including the CAP template and appropriate documentation as listed below:

- 8.9.1 The specific deficiency;
- 8.9.2 Corrective actions needed;
- 8.9.3 CAP due dates;
- 8.9.4 Instructions for CAP submission; and
- 8.9.5 The Alliance contact information

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

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

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

8.13 Closed CAP documentation must include:

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

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

9 Monitoring

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

9.2 Monitoring methods may include, but not limited to:

- 9.2.1 Site reviews;
- 9.2.2 Follow-up verification of corrective action implementation;
- 9.2.3 Interim Monitoring (IM) Attestation form;
- 9.2.4 Information gathered through internal quality management systems such as grievance data, Potential Quality Issue (PQI) referrals, Healthcare Effectiveness Data and Information Set (HEDIS®) data, and focused review, when necessary;
- 9.2.5 Provider and program-specific reports from external sources of information (e.g. public health).

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

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

10 Focused Review

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

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

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

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

10.5 At the reviewer's discretion, a CAP may be given during a focused review.

- 10.5.1 All deficiencies identified in a focused review requiring a CAP must require the completion and verification of corrective actions according to CAP timelines established in this policy.

11 County Collaboration

- 11.1 The Alliance must collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination, consolidation, and data sharing of site reviews for mutually contracted PCPs.
 - 11.1.1 This may include reviewing medical records of a member belonging to another MCP, including the viewing, collection, storage and transmission of PHI.
- 11.2 All MCPs within a county have equal responsibility and accountability for participation in the site review collaborative processes.
- 11.3 The MCPs must submit an initial written description and periodic update reports as requested and instructed by DHCS describing the county collaboration processes, which must include, but are not limited to, the following:
 - 11.3.1 Names and titles of each MCP's participating personnel.
 - 11.3.2 A work plan that includes goals, objectives, activities, and timelines.
 - 11.3.3 Scheduled meeting dates, times, and locations.
 - 11.3.4 Meeting processes and outcomes.
 - 11.3.5 Communication and information-sharing processes.
 - 11.3.6 Roles and responsibilities of each MCP.
 - 11.3.7 Delegated activities and use of delegated or sub-delegated entities.
 - 11.3.8 Memorandum of Agreement (MOA) requirements established for collaborating MCPs.
- 11.4 The Alliance and MCPs must establish policies and procedures to define local collaborative methodology for the following:
 - 11.4.1 Identification of shared providers.
 - 11.4.2 Confidentiality, disclosure, and release of shared provider review information and site review results.
 - 11.4.3 Site review processes.
 - 11.4.4 Issuance of Certificate of Completion.
 - 11.4.5 Oversight and monitoring of review processes.
 - 11.4.6 Site review personnel and training processes.
 - 11.4.7 Collection and storage of site review results, including PHI.
- 11.5 To avoid duplication of efforts and disruption to PCPs practicing at the same site, the Alliance may include a non-contracted PCP(s) in the site review, at the agreement of the collaborating MCPs.
 - 11.5.1 At the discretion of the collaborating MCPs, site review scores and outcomes may be shared and accepted.
 - 11.5.2 In the event site review scores are not accepted by other MCPs, a site review must be performed.
- 11.6 In instances where contracted PCP sites are located in a bordering county, the MCPs may share site activity information such as scores, CAP completion, and/or noncompliance, with bordering county MCPs to avoid duplicative site reviews.
- 11.7 Formal agreements must be in place in order to disclose PHI, such as the review of medical records of a member belonging to another MCP.
- 11.8 The MOA for MCP collaboration includes the following procedures, but are not limited to:
 - 11.8.1.1 The Alliance agrees to accept other MCP's surveys of PCP sites if completed using approved DHCS survey tools and performed by DHCS CSR or CMT.

- 11.8.1.2 If a PCP site receives a failing score from one MCP, Alliance must consider the PCP site as having a failing score. MCPs will notify other MCPs within three (3) business days of any shared facility failing below 80% via fax or electronic form.
- 11.8.1.3 Notification of the other MCP(s) within 3 business days if PCP sites are non-compliant with CAP timeline.
- 11.8.1.4 MCPs must not assign new members to providers with failing scores and/or providers who do not correct site review deficiencies within the established CAP timelines. MCPs must verify that the PCP site has corrected the deficiencies and the CAP is closed. MCPs must remove any providers from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCPs must appropriately reassign that provider's MCP members to other network providers.

12 Site Reviewer Personnel

- 12.1 The Alliance must designate a minimum of one (1) physician, nurse practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) to be certified by DHCS as the Alliance's CMT.
- 12.2 The CMT has the overall responsibility for the training, supervision, and certification of site reviewers, as well as the monitoring of site reviews and evaluating of site reviewers for accuracy.
- 12.3 A designated CMT/CSR is responsible for and must sign the FSR and MRR tools. Only physicians, NPs, PAs, or RNs are eligible to become CSRs.
- 12.4 A variety of personnel can also be part of the site review team, including pharmacists, dietitians, coordinators, and others to provide assistance and clarification.
- 12.5 An RN is the minimal level of site reviewer acceptable for independently performing site reviews. RN reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures. An RN can only delegate site review tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the site review tasks that the RN would delegate.
- 12.6 The Alliance maintains written policies and procedures that clearly define the duties and responsibilities of all site review personnel.
- 12.7 The Alliance must demonstrate that site review activities established for its reviewers comply with the site reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the site reviewers' level of education and training.

13 Site Review Training and Certification

- 13.1 Physicians, NPs, PAs, and/or RNs that are designated by the Alliance to be CMTs or CSRs must meet the certification and recertification requirements outlined in the respective table below to be certified as a CMT or CSR.
- 13.2 CMT candidates must apply for certification directly to DHCS using Attachment A of APL 22-017, Application for DHCS Site Review Master Trainer Certification.
 - 13.2.1 Applications must be submitted to the Alliance's assigned Nurse Evaluator. Upon certification and recertification, CMTs will receive a certificate signed by DHCS.

- 13.2.2 CMTs must be recertified every three (3) years.
- 13.2.3 CMT certification is transferable across participating MCPs.
- 13.2.4 The Alliance may confirm certification status by contacting DHCS.
- 13.3 The Alliance is responsible for ensuring that all site reviewers are appropriately trained, evaluated, certified, and monitored.
- 13.4 The Alliance may collaborate with the other MCPs to determine local systems for training and certifying site reviewers.
 - 13.4.1 Training must include DHCS seminars, MCP classes, individual or small group training sessions provided by a CMT, and self-study learning programs.
- 13.5 The Alliance can only certify physicians, NPs, PAs, or RNs as CSRs.
 - 13.5.1 Upon certification, CSRs will receive written verification of certification by the Alliance
 - 13.5.2 CSRs must be recertified every three (3) years.
 - 13.5.3 CSR certification is transferrable across participating MCPs.
 - 13.5.4 The Alliance may confirm certification status by contacting DHCS.

14 Inter-rater Review Process

- 14.1 Candidates for CMT and CSR certifications must complete an inter-rater review (IRR) process as part of both the initial certification and recertification processes.
 - 14.1.1 The inter-rater for CMT candidates is a DHCS Nurse Evaluator. The IRR process requires the CMT candidate to concurrently complete and score a site review with the DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.
 - 14.1.2 The inter-rater for CSR candidates is the Alliance's CMT. The IRR process requires the CSR candidate to participate with the Alliance's CMT to concurrently complete and score a site review utilizing the DHCS FSR and MRR tools and standards.
 - 14.1.3 The CMT or CSR candidate must achieve the required inter-rater score as described in the tables below in order to be certified.
- 14.2 If the CMT or CSR candidate does not meet the appropriate inter-rater score variance, they may repeat the process one (1) time.
 - 14.2.1 The appropriate inter-rater (DHCS Nurse Evaluator or Alliance's CMT) and the candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second IRR.
 - 14.2.2 CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second IRR must wait six (6) months to reapply for certification.
- 14.3 The Alliance must develop policies and procedures for certification, ongoing supervision and monitoring of site review personnel to ensure reliability of site review findings and data submitted to DHCS.
- 14.4 The Alliance must maintain certification records including, but not limited to, site review training activities and supporting documentations to support the certification requirements.

Initial Certification Requirements	CMT	CSR

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

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

15 Data Submission Procedures

- 15.1 The Alliance is required to submit site review data to DHCS every six (6) months (July 31 for the period January – June, and January 31 for the period July – December) in an approved format uploaded to a designated DHCS secure site.
- 15.2 The Alliance is permitted to submit data more frequently than every six (6) months.
- 15.3 For preoperational and expansion site reviews, the Alliance must submit site review data to DHCS at least six (6) weeks prior to site operation.
- 15.4 DHCS will make available the database containing all necessary tables and data input forms for the mandatory bi-annual submission of site review data.
 - 15.4.1 DHCS will reject site review data submitted in non-conforming formats.
- 15.5 The Alliance is required to collect PHI as part of the MRR process, and must include the PHI in the bi-annual data submission to DHCS.

16 DHCS-Conducted Site Reviews

- 16.1 DHCS conducts separate site reviews to validate the Alliance's FSR and MRR processes.
- 16.2 Prior to a new MCP's operation, or an MCP expansion to a new county, DHCS conducts initial FSRs followed by initial MRRs of randomly chosen PCP sites in the MCP's network upon MCP beginning operations and assignment of members, as outlined in DHCS APL 22-017.
- 16.3 DHCS also conducts subsequent site reviews on PCP sites within the Alliance's networks.
- 16.4 DHCS will notify the Alliance of critical findings in writing via email within 10 business days following the date of the FSR and/or MRR and provide a written report summarizing all of DHCS' review findings within 30 calendar days following the date of the FSR and/or MRR.
- 16.5 Within 30 calendar days from the date of the Alliance's receipt of the DHCS-conducted site review report, the Alliance must provide a CAP to DHCS responding to all cited deficiencies documented in the report. The Alliance's CAP response must include:
 - 16.5.1 The identified deficiency (ies).
 - 16.5.2 A description of action(s) taken to correct the deficiency (ies).
- 16.6 If a deficiency is determined to require long-term corrective action, the Alliance's CAP response must include indication that the Alliance has:
 - 16.6.1 Initiated remedial action(s).
 - 16.6.2 Developed a plan to achieve an acceptable level of compliance.

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

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

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

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

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

17 Physical Accessibility Review Survey

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

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

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

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

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

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

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

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

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

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

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

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

18 Reviewing medical records and medical records systems

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

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

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

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

18.2.2 Notes of therapies reflect an awareness of current therapies

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

18.2.4 Drug allergies and idiosyncratic medical problems are noted

18.2.5 Pathology, laboratory, and other reports are recorded

18.2.6 The health professional responsible for each entry is identifiable

18.2.7 Any necessary consultation and progress notes are evidenced as indicated

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

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

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

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

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

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

19 All Plan Letter and Policy Letter updates

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

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

19.3 If the Alliance determines that no changes to its P&Ps are necessary, the Alliance must

19.3.1 Submit an email confirmation to its MCOD contract manager within 90 days of the release of the DHCS's APLs or PLs stating that the Alliance's P&Ps have been reviewed and no changes are necessary.

19.3.2 The email confirmation must include the title of the APL or PL as well as the applicable APL or PL release date in the subject line.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

1/1/08, 10/09, 2/26/10, 4/01/11, 5/01/11, 9/18/12, 11/6/14, 4/13/15, 5/3/18, 3/21/19, 5/21/20, 3/18/21, 03/22/2022, 03/21/2023, 6/20/2023, 9/18/2024, [5/15/2025](#)

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	QI-107
Policy Name	Appointment Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSD-SNP, MCAL, IHSS, DSNP
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

Formatted: Font color: Red

Formatted: Font color: Red

POLICY STATEMENT

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

Formatted: Font color: Auto

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

The Alliance ensures ongoing oversight and monitoring of its provider network through the Access and Availability (A&A) Committee. Quality Improvement (QI) staff will engage in any of the following actions with providers failing to meet the access and availability standards set within this policy:

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

PROCEDURE

A. Appointment Access Standards

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

Life-Threatening Emergency:

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

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

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

Non-Life-Threatening Emergency

- Within six (6) hours of the request

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

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

Formatted: Font color: Background 1

Formatted: Font: Bold

Formatted: Font: Bold

¹ Prior authorization

Formatted: Indent: Left: 0", Space After: 5.35 pt

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

B. LTSS Timely Access Network Standards

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

LTSS TIMELY ACCESS NETWORK STANDARDS

Provider Type:	Standard:
Skill Nursing Facility	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 5 business days of request
Community Based Adult Services (CBAS)	
Initial	Within 5 business days acknowledge receipt of request from CBAS center
F2F Eligibility Assessment	Completed within 30 days
IPC by CBAS Center	Within 90 days
Reassessment	6 months
<u>Hospice</u>	
<u>Hospice Care Services</u>	<u>Within 24 hours of request</u>

Formatted Table

Formatted: Centered

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

C. Shortening or Extending Appointment Timeframes

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

D. Telephone Access Standards – For the Plan

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

E. Telephone Access Standards – For the Provider Office

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

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

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

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

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

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

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

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

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

G. Missed Appointments

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

Commented [TM1]: @Fiel, Melissa @Stott, Michelle We will need to add DSNP to this contract

Commented [MS2R1]: @Tran, Loc

Commented [MF3R1]: @Thomsen, Michelle does not need to be D-SNP specific, includes all providers

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

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

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

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

H. Emergency Services

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

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

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

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

- a) assessment of encounter data,

- b) special studies,
- c) claims data,
- d) grievances and appeals,
- e) Potential Quality Issues (PQIs)
- f) medical record audits, and
- g) medical oversight of the Quality Improvement Health Equity Committee (QIHEC).

I. Follow-up of Emergency Room or Urgent Care Visits

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

J. Open Access to OB/GYN Services

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

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

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

K. Access to Sensitive Services for Adults

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

L. Access to Sensitive Services for Minors

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

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

- a) Sensitive services may include, but are not limited to, the following:
 - i. Treatment for sexual assault, including rape.
 - ii. Pregnancy related services.

- iii. Family planning services.
- iv. Sexually transmitted disease diagnosis and/or treatment.
- v. HIV testing and counseling.
- vi. Abortion services
- b) Members are bound by the rules or procedures required for the specific services they are accessing.
- c) Members are informed of their rights to access sensitive services through the Member Handbook

MONITORING

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

DEFINITIONS / ACRONYMS

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

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

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

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

Preventive care – Health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the

following health care services required by sections 1345(b)(5), 1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

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

REFERENCES

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

MONITORING

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

|



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

POLICY AND PROCEDURE

Policy Number	QI-105
Policy Name	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
Department Name	Quality Improvement Division
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, and DSNP
Original Effective Date	01/01/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	7/5/2024
Administrative Oversight Committee Approval Date	9/18/2024

POLICY STATEMENT

1. This policy outlines Alameda Alliance for Health's ("the Alliance") and Alameda Alliance for Wellness (D-SNP) site review process, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), and the process by which Alliance conducts, scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines.
2. The Alliance Chief Medical Officer is responsible for oversight of site review policies in accordance with regulatory requirements. All Alliance contracted and subcontracted Primary Care Provider (PCP) sites must be compliant with applicable local, state, and federal standards related to FSRs. The California Department of Health Care Services (DHCS) only accepts site reviews that are conducted and completed by a Certified Master Trainer (CMT) and/or a Certified Site Reviewer (CSR).
3. The Alliance conducts site review processes to ensure access for people with disabilities in accordance with the protections of the Americans with Disabilities Act of 1990 (42 U.S.C. § 1211 et seq.), Section 504 and 508 of the Rehabilitation Act (29 U.S.C. § 794), 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), SB 223, SB 1423, APL 17-006, and Title 28, Code of Federal Regulations (CFR), section 35.151.
4. The Alliance complies with the DHCS requirement (Contract, All Plan Letter [APL], and Policy Letter [PL]) that the PCPs undergo an initial and subsequent full scope FSR, MRR, and PARS, in order to participate in Medi-Cal managed care, regardless of a PCP site's other accreditations and certifications. Alliance must ensure that:

- a) Each PCP site has passed an initial FSR and, as applicable, correct all deficiencies in order to close their Corrective Action Plan (CAP) prior to adding the provider(s) to the Alliance network and assigning members to the provider(s).
 - b) Each PCP site completes an initial MRR after the PCP is assigned members, and, as applicable, submits all appropriate documentation to address all deficiencies to close their CAP.
 - c) Each PCP site completes a periodic subsequent site review at least every three (3) years after the initial FSR, consisting of an FSR, MRR, and PARS. The purpose of these subsequent FSRs and MRRs is to evaluate the continuing capacity of the site in supporting the delivery of quality health care services.
 - d) The most current DHCS FSR and MRR tools and standards are being utilized when conducting site reviews.
 - e) All PCP sites are held to the same standards.
 - f) The site review status of each contracted PCP site is properly documented and monitored.
 - g) For shared providers, Managed Care Plans (MCP) will collaborate locally to determine how they will notify each other of site review statuses and results.
5. The Alliance must issue a Certificate of Completion to providers that successfully complete both the FSR and MRR and close all CAPs.
- a) This certificate is dated based on the most recent FSR, is valid for up to three (3) years, and affirms that the site has been deemed a DHCS Certified Provider Site.
 - b) The Alliance must develop a process for issuing the Certificate of Completion and coordinate with the county collaborative in the issuance and revocation of certificates for shared provider sites.
 - c) If a site's certification is revoked as a result of noncompliance with applicable requirements, the site is no longer deemed a DHCS Certified Provider Site and will not be allowed assignment of members as a PCP until the PCP site has successfully completed the FSR/MRR and closed all CAPs.
 - d) The Certificate of Completion does not replace the information from the site review results and outcomes that are shared based on agreed upon processes and methodology.
6. The Alliance must notify its providers in advance for scheduled site reviews. However, inspection of an Alliance's provider facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program.
7. The Alliance collaborates with other MCPs in geographic areas where shared providers are identified in accordance with DHCS requirements. The Alliance may choose to delegate site review responsibilities to another MCP and accept a collaborating MCP's site review findings. The Alliance retains ultimate responsibility for the assigned sites and oversight of site review completion, results, any necessary CAP, and monitoring of assigned PCP sites per county collaboration.

8. The Alliance requires that Urgent care facilities undergo an initial and subsequent periodic full scope FSR, using the Alliance tool, to participate in Medi-Cal managed care. All urgent care facilities must pass an initial FSR, as part of the credentialing process and a subsequent FSR every three (3) years thereafter, beginning no later than three years after the initial FSR. The purpose of these subsequent FSRs is to evaluate the continuing capacity of the site in supporting the delivery of quality health care services.
 9. Physical Accessibility Review Surveys (PARS) (FSR Attachment C, D and E) will be conducted for all PCP sites, Specialist sites, Ancillary Services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPDs).
 10. Delegation of the FSR and MRR processes require a mutually agreed upon contract language in which delegated functions are identified. The Alliance shall oversee and monitor all delegated activities. Through monitoring, the Alliance ensures that the delegated FSR and/or MRR functions are properly carried out. Delegation oversight activities are described in the Alliance policy QI-111 Delegation Management and Oversight.
 11. The Alliance will submit aggregated site review data to DHCS every six (6) months as required by APL 22-017.
 12. The Alliance ensures that relevant provider-specific information is shared interdepartmentally.
 13. The Alliance complies with the Department of Managed Health Care's (DMHC) requirements referenced in Title 28, CCR, Section, 1300.67.1(c) related to medical records for its Medi-Cal and Group Care lines of business.
 14. The Alliance ensures its ~~physicians-providers~~ have a process in place to follow up on missed or canceled appointments. The Alliance monitors missed, canceled, and rescheduled appointments through periodic full-scope, focused, and interim monitoring FSR/MRR evaluations.
 15. During public health emergencies, the Alliance shall:
 - a) Follow local, state, and federal guidelines and requirements to respond to concerns resulting from public health emergencies, such as a pandemic
 - b) Follow emergency Executive Orders or APLs that may temporarily change existing FSR policies
 - c) Develop standardized protocols for conducting alternatives to in-person site reviews (i.e. video "walk-through", interviews, return demonstration, collection of documentation, desktop review)
 16. The Alliance is responsible for ensuring that subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. —These requirements are communicated to subcontractors and network providers.
-
-

PROCEDURE

1 Initial Site Review and Medical Record Review

- 1.1 An initial site review consists of an initial FSR, an initial MRR, and PARS.
 - 1.1.1 The initial FSR and the initial MRR might not occur on the same date.
 - 1.1.2 The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations.
- 1.2 The Alliance must not add PCPs to the network or assign members to providers until the PCP sites receive a passing FSR score and completes all CAPs.
- 1.3 An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score. In situations of provider credentialing or recredentialing, a site survey does not need to be repeated if the site to which the provider is being added has a current passing site review survey score from a prior Alliance-conducted assessment, or from a local MCP with which the Alliance collaborates.
- 1.4 A DHCS Site Identification Number (“DHCS Site ID”) is a unique identifier and must be assigned by the Alliance to each PCP site reviewed.
 - 1.4.1 In the event of an ownership change at an established PCP site, a new DHCS Site ID will be assigned. The new DHCS Site ID may be existing Site ID but with a modifier to represent a change of ownership at the site.
 - 1.4.2 Local county MPCs collaborate to manage and assign the DHCS Site ID numbers specific to the county.
- 1.5 Once a PCP site passes the initial FSR and completes all CAPs, if applicable, the Alliance may add the site’s PCP(s) to the network and can begin assigning members to the PCPs at that site.
- 1.6 An MRR survey is performed at the time of the FSR if Medi-Cal patient records are available; otherwise, the Alliance must complete the initial MRR of the new PCP site within 90 calendar days of the date that Alliance first assigns members.
 - 1.6.1 The Alliance may defer this initial MRR for an additional 90 calendar days only if the new PCP(s) does not have enough assigned members to complete the MRR on the required minimum number of medical records. See Shared Medical Records Practice below for details regarding the required minimum number of medical records.
 - 1.6.2 If, after 180 days following member assignment, the PCP still has fewer than the required number of patient records, the Alliance must complete the MRR on the total number of medical records it has available, and adjust scoring accordingly to the number of medical records reviewed.
- 1.7 The Alliance may choose to conduct the MRR portion of the site review on-site or virtually. The virtual process must comply with all applicable Health Insurance Portability and Accountability Act (HIPAA) standards at all times.

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

- 2.1 A new PCP site is added to the Alliance network.
- 2.2 A newly contracted provider joins/assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 3.2 Mobile clinics are self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic services, and may also serve to deliver equipment to locations that operate temporary clinics.
- 3.3 In general, supplemental facilities that provide primary care services may serve as an extension of a PCP site, a community-based clinic, a Federally Qualified Health Center county facility, or a stand-alone clinic with members assigned.
- 3.4 The Alliance must conduct an initial site review and subsequent site reviews of supplemental facilities at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
- 3.5 The Alliance must establish a process to complete the oversight of supplemental facilities and collaborate with MCPs within the county.
- 3.6 Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.
 - 3.6.1 For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, the Alliance must conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017.
 - 3.6.2 For street medicine providers serving as an assigned PCP, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, the Alliance must conduct a condensed FSR and MRR of the street medicine provider to ensure member safety.

4 Requirements for Subsequent Site Reviews

- 4.1 The Alliance is required to conduct subsequent site reviews, consisting of an FSR, MRR, and PARS, at least every three (3) years.
- 4.2 The subsequent site visit would be conducted no later than three (3) years after the initial FSR, and at least every three (3) years thereafter.
- 4.3 The Alliance may conduct site reviews more frequently when determined necessary based on monitoring, evaluation, or CAP follow-up issues.

5 Scoring Requirements

- 5.1 The Alliance must base FSR and MRR scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel.
- 5.2 If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method.
- 5.3 The Alliance must not alter the scored criteria or assigned weights in any way.
- 5.4 The FSR tool is composed of both critical and non-critical elements.
 - 5.4.1 Critical elements (CE) are indicated by bold and underlined text. CEs have the largest potential for adverse effects on patient health or safety and therefore have a scored weight of two (2) points.

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

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

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

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

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

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

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

6 Shared Medical Records Practice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Failing Scores

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

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

- 7.3 When a PCP site receives a failing score on an FSR or MRR, the Alliance must notify the PCP site of the score, all cited deficiencies, and all CAP requirements.
- 7.4 The Alliance may choose to remove any PCP site with a failing FSR or MRR score from the network.
- 7.4.1 If the Alliance allows a PCP site with a failing FSR or MRR score to remain in the network, the Alliance must require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy.
- 7.5 The Alliance must not assign new members to network PCP sites that receive a failing score on an FSR or MRR until the Alliance has verified that the PCP site has corrected the deficiencies and the CAP is closed.
- 7.6 Based upon mutual agreement between the Alliance and the provider site, additional training and technical assistance may be available when a PCP site fails an initial FSR prior to contracting with the Alliance.
- 7.6.1 Pre-contracted providers who do not pass the initial FSR may use the first attempt as a learning and technical assistance opportunity.
- 7.6.2 If the provider fails the site review after the second attempt, the provider will need to reapply to the Alliance after six (6) months from the date of the second attempt.
- 7.7 PCP sites that receive a failing score on either the FSR or MRR for two (2) consecutive site reviews must receive a minimum passing score, i.e. Exempted Pass or Conditional Pass on the next FSR and MRR (including PCPs with open CAPs in place) to remain in the Alliance provider network.
- 7.8 If the PCP site fails on its third consecutive attempt, despite the Alliance's ongoing monitoring and assistance, the PCP site will not have an opportunity to complete a CAP, and must be removed from the Alliance's provider network.
- 7.8.1 Impacted members must be reassigned to other network providers, as appropriate and as contractually required.
- 7.8.2 If a PCP site is removed from one MCP network due to three consecutive failing scores, all other MCPs must also remove the PCP site from their networks.

8 Corrective Action Plan

- 8.1 A CAP is required for all cited deficiencies for PCP sites that have an FSR and/or MRR conditional pass or non-passing score.
- 8.2 The Alliance may require a CAP for other findings identified during the survey that require correction, regardless of the score.
- 8.3 There is no rescoring of the FSR or MRR as deficiencies are corrected or addressed, and points are still deducted even if deficiencies are corrected at the time of the audit.
- 8.4 CAPs are also required when there are CE, pharmacy, and infection control deficiencies found during any site review activity, including but not limited to, focused reviews, monitoring activities, or other reviews done by the Alliance or DHCS.
- 8.5 The Alliance must not assign new members to providers who fail to correct site review deficiencies within the established CAP timelines.

- 8.6 For providers that fail to comply with their CAP, the Alliance must verify that the PCP site has corrected the deficiencies and the CAP is closed before assigning new members.
- 8.7 Ultimately, the Alliance must remove any provider from the network that does not come into compliance with review criteria and CAP requirements with the established timelines.
- 8.7.1 Alliance must expeditiously reassign that provider's members to other network providers. Information regarding provider terminations is described in Alliance policy PRV-005 Provider Terminations.
- 8.8 The Alliance must follow the established timeline below for CAP notification and completion:

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

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

8.9 The Alliance is responsible for providing the site with the CAP requirements, including the CAP template and appropriate documentation as listed below:

- 8.9.1 The specific deficiency;
- 8.9.2 Corrective actions needed;
- 8.9.3 CAP due dates;
- 8.9.4 Instructions for CAP submission; and
- 8.9.5 The Alliance contact information

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

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

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

8.13 Closed CAP documentation must include:

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

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

9 Monitoring

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

9.2 Monitoring methods may include, but not limited to:

- 9.2.1 Site reviews;
- 9.2.2 Follow-up verification of corrective action implementation;
- 9.2.3 Interim Monitoring (IM) Attestation form;
- 9.2.4 Information gathered through internal quality management systems such as grievance data, Potential Quality Issue (PQI) referrals, Healthcare Effectiveness Data and Information Set (HEDIS®) data, and focused review, when necessary;
- 9.2.5 Provider and program-specific reports from external sources of information (e.g. public health).

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

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

10 Focused Review

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

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

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

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

10.5 At the reviewer's discretion, a CAP may be given during a focused review.

- 10.5.1 All deficiencies identified in a focused review requiring a CAP must require the completion and verification of corrective actions according to CAP timelines established in this policy.

11 County Collaboration

- 11.1 The Alliance must collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination, consolidation, and data sharing of site reviews for mutually contracted PCPs.
 - 11.1.1 This may include reviewing medical records of a member belonging to another MCP, including the viewing, collection, storage and transmission of PHI.
- 11.2 All MCPs within a county have equal responsibility and accountability for participation in the site review collaborative processes.
- 11.3 The MCPs must submit an initial written description and periodic update reports as requested and instructed by DHCS describing the county collaboration processes, which must include, but are not limited to, the following:
 - 11.3.1 Names and titles of each MCP's participating personnel.
 - 11.3.2 A work plan that includes goals, objectives, activities, and timelines.
 - 11.3.3 Scheduled meeting dates, times, and locations.
 - 11.3.4 Meeting processes and outcomes.
 - 11.3.5 Communication and information-sharing processes.
 - 11.3.6 Roles and responsibilities of each MCP.
 - 11.3.7 Delegated activities and use of delegated or sub-delegated entities.
 - 11.3.8 Memorandum of Agreement (MOA) requirements established for collaborating MCPs.
- 11.4 The Alliance and MCPs must establish policies and procedures to define local collaborative methodology for the following:
 - 11.4.1 Identification of shared providers.
 - 11.4.2 Confidentiality, disclosure, and release of shared provider review information and site review results.
 - 11.4.3 Site review processes.
 - 11.4.4 Issuance of Certificate of Completion.
 - 11.4.5 Oversight and monitoring of review processes.
 - 11.4.6 Site review personnel and training processes.
 - 11.4.7 Collection and storage of site review results, including PHI.
- 11.5 To avoid duplication of efforts and disruption to PCPs practicing at the same site, the Alliance may include a non-contracted PCP(s) in the site review, at the agreement of the collaborating MCPs.
 - 11.5.1 At the discretion of the collaborating MCPs, site review scores and outcomes may be shared and accepted.
 - 11.5.2 In the event site review scores are not accepted by other MCPs, a site review must be performed.
- 11.6 In instances where contracted PCP sites are located in a bordering county, the MCPs may share site activity information such as scores, CAP completion, and/or noncompliance, with bordering county MCPs to avoid duplicative site reviews.
- 11.7 Formal agreements must be in place in order to disclose PHI, such as the review of medical records of a member belonging to another MCP.
- 11.8 The MOA for MCP collaboration includes the following procedures, but are not limited to:
 - 11.8.1.1 The Alliance agrees to accept other MCP's surveys of PCP sites if completed using approved DHCS survey tools and performed by DHCS CSR or CMT.

- 11.8.1.2 If a PCP site receives a failing score from one MCP, Alliance must consider the PCP site as having a failing score. MCPs will notify other MCPs within three (3) business days of any shared facility failing below 80% via fax or electronic form.
- 11.8.1.3 Notification of the other MCP(s) within 3 business days if PCP sites are non-compliant with CAP timeline.
- 11.8.1.4 MCPs must not assign new members to providers with failing scores and/or providers who do not correct site review deficiencies within the established CAP timelines. MCPs must verify that the PCP site has corrected the deficiencies and the CAP is closed. MCPs must remove any providers from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCPs must appropriately reassign that provider's MCP members to other network providers.

12 Site Reviewer Personnel

- 12.1 The Alliance must designate a minimum of one (1) physician, nurse practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) to be certified by DHCS as the Alliance's CMT.
- 12.2 The CMT has the overall responsibility for the training, supervision, and certification of site reviewers, as well as the monitoring of site reviews and evaluating of site reviewers for accuracy.
- 12.3 A designated CMT/CSR is responsible for and must sign the FSR and MRR tools. Only physicians, NPs, PAs, or RNs are eligible to become CSRs.
- 12.4 A variety of personnel can also be part of the site review team, including pharmacists, dietitians, coordinators, and others to provide assistance and clarification.
- 12.5 An RN is the minimal level of site reviewer acceptable for independently performing site reviews. RN reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures. An RN can only delegate site review tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the site review tasks that the RN would delegate.
- 12.6 The Alliance maintains written policies and procedures that clearly define the duties and responsibilities of all site review personnel.
- 12.7 The Alliance must demonstrate that site review activities established for its reviewers comply with the site reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the site reviewers' level of education and training.

13 Site Review Training and Certification

- 13.1 Physicians, NPs, PAs, and/or RNs that are designated by the Alliance to be CMTs or CSRs must meet the certification and recertification requirements outlined in the respective table below to be certified as a CMT or CSR.
- 13.2 CMT candidates must apply for certification directly to DHCS using Attachment A of APL 22-017, Application for DHCS Site Review Master Trainer Certification.
 - 13.2.1 Applications must be submitted to the Alliance's assigned Nurse Evaluator. Upon certification and recertification, CMTs will receive a certificate signed by DHCS.

- 13.2.2 CMTs must be recertified every three (3) years.
- 13.2.3 CMT certification is transferable across participating MCPs.
- 13.2.4 The Alliance may confirm certification status by contacting DHCS.
- 13.3 The Alliance is responsible for ensuring that all site reviewers are appropriately trained, evaluated, certified, and monitored.
- 13.4 The Alliance may collaborate with the other MCPs to determine local systems for training and certifying site reviewers.
 - 13.4.1 Training must include DHCS seminars, MCP classes, individual or small group training sessions provided by a CMT, and self-study learning programs.
- 13.5 The Alliance can only certify physicians, NPs, PAs, or RNs as CSRs.
 - 13.5.1 Upon certification, CSRs will receive written verification of certification by the Alliance
 - 13.5.2 CSRs must be recertified every three (3) years.
 - 13.5.3 CSR certification is transferrable across participating MCPs.
 - 13.5.4 The Alliance may confirm certification status by contacting DHCS.

14 Inter-rater Review Process

- 14.1 Candidates for CMT and CSR certifications must complete an inter-rater review (IRR) process as part of both the initial certification and recertification processes.
 - 14.1.1 The inter-rater for CMT candidates is a DHCS Nurse Evaluator. The IRR process requires the CMT candidate to concurrently complete and score a site review with the DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.
 - 14.1.2 The inter-rater for CSR candidates is the Alliance's CMT. The IRR process requires the CSR candidate to participate with the Alliance's CMT to concurrently complete and score a site review utilizing the DHCS FSR and MRR tools and standards.
 - 14.1.3 The CMT or CSR candidate must achieve the required inter-rater score as described in the tables below in order to be certified.
- 14.2 If the CMT or CSR candidate does not meet the appropriate inter-rater score variance, they may repeat the process one (1) time.
 - 14.2.1 The appropriate inter-rater (DHCS Nurse Evaluator or Alliance's CMT) and the candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second IRR.
 - 14.2.2 CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second IRR must wait six (6) months to reapply for certification.
- 14.3 The Alliance must develop policies and procedures for certification, ongoing supervision and monitoring of site review personnel to ensure reliability of site review findings and data submitted to DHCS.
- 14.4 The Alliance must maintain certification records including, but not limited to, site review training activities and supporting documentations to support the certification requirements.

Initial Certification Requirements	CMT	CSR

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

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

15 Data Submission Procedures

- 15.1 The Alliance is required to submit site review data to DHCS every six (6) months (July 31 for the period January – June, and January 31 for the period July – December) in an approved format uploaded to a designated DHCS secure site.
- 15.2 The Alliance is permitted to submit data more frequently than every six (6) months.
- 15.3 For preoperational and expansion site reviews, the Alliance must submit site review data to DHCS at least six (6) weeks prior to site operation.
- 15.4 DHCS will make available the database containing all necessary tables and data input forms for the mandatory bi-annual submission of site review data.
 - 15.4.1 DHCS will reject site review data submitted in non-conforming formats.
- 15.5 The Alliance is required to collect PHI as part of the MRR process, and must include the PHI in the bi-annual data submission to DHCS.

16 DHCS-Conducted Site Reviews

- 16.1 DHCS conducts separate site reviews to validate the Alliance's FSR and MRR processes.
- 16.2 Prior to a new MCP's operation, or an MCP expansion to a new county, DHCS conducts initial FSRs followed by initial MRRs of randomly chosen PCP sites in the MCP's network upon MCP beginning operations and assignment of members, as outlined in DHCS APL 22-017.
- 16.3 DHCS also conducts subsequent site reviews on PCP sites within the Alliance's networks.
- 16.4 DHCS will notify the Alliance of critical findings in writing via email within 10 business days following the date of the FSR and/or MRR and provide a written report summarizing all of DHCS' review findings within 30 calendar days following the date of the FSR and/or MRR.
- 16.5 Within 30 calendar days from the date of the Alliance's receipt of the DHCS-conducted site review report, the Alliance must provide a CAP to DHCS responding to all cited deficiencies documented in the report. The Alliance's CAP response must include:
 - 16.5.1 The identified deficiency (ies).
 - 16.5.2 A description of action(s) taken to correct the deficiency (ies).
- 16.6 If a deficiency is determined to require long-term corrective action, the Alliance's CAP response must include indication that the Alliance has:
 - 16.6.1 Initiated remedial action(s).
 - 16.6.2 Developed a plan to achieve an acceptable level of compliance.

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

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

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

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

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

17 Physical Accessibility Review Survey

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

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

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

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

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

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

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

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

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

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

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

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

18 Reviewing medical records and medical records systems

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

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

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

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

18.2.2 Notes of therapies reflect an awareness of current therapies

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

18.2.4 Drug allergies and idiosyncratic medical problems are noted

18.2.5 Pathology, laboratory, and other reports are recorded

18.2.6 The health professional responsible for each entry is identifiable

18.2.7 Any necessary consultation and progress notes are evidenced as indicated

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

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

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

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

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

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

19 All Plan Letter and Policy Letter updates

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

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

19.3 If the Alliance determines that no changes to its P&Ps are necessary, the Alliance must

19.3.1 Submit an email confirmation to its MCOD contract manager within 90 days of the release of the DHCS's APLs or PLs stating that the Alliance's P&Ps have been reviewed and no changes are necessary.

19.3.2 The email confirmation must include the title of the APL or PL as well as the applicable APL or PL release date in the subject line.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

1/1/08, 10/09, 2/26/10, 4/01/11, 5/01/11, 9/18/12, 11/6/14, 4/13/15, 5/3/18, 3/21/19, 5/21/20, 3/18/21, 03/22/2022, 03/21/2023, 6/20/2023, 9/18/2024, [5/15/2025](#)

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	QI-108
Policy Name	Access to Behavioral Health Services
Department Name	Quality Improvement Division
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS <u>and D-SNP</u>
Effective Date	3/31/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	7/5/2024
Administrative Oversight Committee Approval Date	9/18/2024

POLICY STATEMENT

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

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

PROCEDURE

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

A. Behavioral Health Access Standards:

I. Life-Threatening Emergency

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

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

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

II. Non-Life-Threatening Emergency

Within six (6) hours of the request

III. Urgent Behavioral Health (BH) Care by Non-Physician Mental Health (NPMH) Provider

Within forty-eight (48) hours of the request

Requiring Prior Authorization, within ninety-six (96) hours of the request

IV. Non-Urgent BH Care by NPMH Provider

Within ten (10) business days of the request

V. After-Hours Access

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

VI. After-Hours Emergency Instructions

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

VII. Telephone Triage and Screening

Twenty-four (24) hours a day, seven (7) days a week, for triage or screening services by telephone.

The telephone triage or screening services are provided in a timely manner appropriate for the member's condition, with a wait time that does not exceed thirty (30) minutes.

Unlicensed staff persons handling member calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of the member so that the member can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.

B. Member Information Distribution

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

Commented [TM1]: @Fiel, Melissa @Stott, Michelle @Fu, Samson Chiu is this included in the EOC?

C. Monitoring of Behavioral Health Access Standards

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

Commented [TM2]: @Stott, Michelle @Fiel, Melissa we need to set this up for DSNP

Commented [MS3R2]: @Tran, Lou

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

DEFINITIONS / ACRONYMS

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

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

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

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

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

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

MONITORING

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

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

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

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE TEMPLATE

Policy Number	QI-116
Policy Name	Provider Appointment Availability Survey (PAAS)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of
Line(s) of Business	~~D-SNPMC~~ AL, IHSS ~~MCAL, IHSS~~
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

Commented [BN1]: @Thomsen, Michelle I know the other day you mentioned that Kisha would be sharing policies on Health Equity maybe we should review again once we get those, to ensure no further changes are needed.

Commented [TM2R1]: I don't think this one was included in those she shared

POLICY STATEMENT

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

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

PROCEDURE

A. Provider Appointment Availability Survey (PAAS) Methodology

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

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

Commented [TM3]: @Tran, Loc we did not make updates here as this is specific to MCAL - I will review and see if we need a net new policy for D-SNP

e. Ancillary Service Providers

- i. Routine appointments (within 15 business days of request)

f. Appointments Wait Time for D-SNP

i. Urgently needed services or emergency that does not require PA (Immediately)

ii. Non-Urgent primary care appointments (7 business days of request)

iii. Routine or preventive care (30 business days of request)

B. PAAS Analysis and Report

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

DEFINITIONS / ACRONYMS

Patterns of Non-Compliance means any of the following:

QI-116 Provider Appointment Availability Survey

- (A) For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers and 80% for NPMH provider follow-up appointments, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific net had a non-urgent or urgent appointment available within the time-elapsd standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the “Rate of Compliance Urgent Care Appointment (All Provider Survey Types)” field and the “Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)” field in the Summary of Rate of Compliance Tab of the Results Report Form.
- (B) The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of noncompliance that is reasonably related:
- i. Each instance is a violation of the same standard set forth in subsection (c) of this Rule;
 - ii. Each instance involves the same network;
 - a. Each instance involves the same provider group, or subcontracted plan;
 - b. Each instance involves the same provider type;
 - c. Each instance involves the same network provider;
 - d. Each instance occurs in the same region. For purposes of the subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county;
 - e. The number of enrollees in health plan’s network and the total number of instances identified as part of a pattern;
 - f. Whether each instance occurred within the same twelve-month period; or
 - g. Whether each instance involves the same category of health care services.

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

MONITORING

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

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program
QI-104 Potential Quality Issues (PQIs)
QI-105 FSRs MRRs and PARS
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

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

Red = Substantive Changes

REFERENCES

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

MONITORING

~~Any findings and recommendations are reported quarterly to the A&A Committee and to the QIHEC. The Committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care. This information includes, but is not limited to, results from member and provider surveys,~~

QI-116 Provider Appointment Availability Survey

member grievances and appeals, and triage and screening services data. The Committees may recommend CAPs be issued by QI staff and Provider Services. Compliance also reviews the PAAS report on an annual basis. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.



POLICY AND PROCEDURE

Policy Number	QI-124
Policy Name	Initial Health Appointment (IHA) <u>and Initial Preventive Physical Exam (IPPE)</u>
Department Name	Healthcare Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	MCAL, <u>D-SNP</u>
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/14/2025
Administrative Oversight Committee Approval Date	4/16/2025

POLICY STATEMENT

An Initial Health Appointment (IHA) is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her Primary Care Physician (PCP). The IHA is part of Alameda Alliance for Health and D-SNP's Population Needs Assessment to ensure that we determine and address the health needs of our members by providing access to preventive health care, timely screenings, and referrals. The Alliance is required by the California Department of Health Care Services (DHCS), the Centers for Medicare and Medicaid to ensure that new members receive an Initial Health Appointment (IHA) within 120 days of becoming an Alliance member. For members enrolled in D-SNP an Initial Preventive Physical Exam (IPPE) "Welcome to Medicare Exam" is offered to members within the 12-months of Medicare Enrollment. The Alliance also provides enrollees the opportunity to complete the Annual Wellness Exam (AWE) yearly.

PROCEDURE

IHA Assessment Components

The IHA, IPPE, and AWE consists of a history, physical and mental health exam, an identification of risks per PCP assessment, appropriate age dependent preventive screens or services and health education, and the diagnosis and plan for treatment of any disease. If the

medical records contain this information with the previous 12 months, the member does not require an IHA.

1. Comprehensive Physical and Mental Health Exam – the exam is conducted to assess and diagnose both acute and chronic conditions.
 - a. History of Present Illness
 - b. Past Medical History
 - i. Prior major illness and injuries
 - ii. Current medications
 - iii. Allergies
 - c. Social History
 - i. Marital status and living arrangement
 - ii. Current employment
 - iii. Occupational history
 - iv. Use of alcohol, drugs and tobacco
 - v. Level of education
 - vi. Sexual history
 - vii. Any other relevant social factors
2. Identification of Risks – the Alliance adheres to the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, IPPE, and AWE. The Alliance ensures that these services are initiated as soon as possible but no later than 60 days.
 - a. This may include items including family history contributing to member disease, lifestyle that contributes to disease, and / or primary medical disease (i.e. DM) that may contribute to worsening secondary disease (CKD / ESRD).
3. Preventive Services
 - a. Asymptomatic Health Adults
 - i. The Alliance adheres to the Grade “A” and “B” recommendations of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF). Alliance providers must document the status of current recommended services.
 - b. Members Under 21 Years of Age
 - i. The Alliance provides preventive services for all members less than 21 years of age as specified by the most recent American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines and periodicity schedule. Alliance providers must document the status of current age-specific assessments and recommended services.
 - c. The Alliance provides perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG).
4. Health Education
5. Diagnoses and Plan of Care
 - a. Alliance providers create a plan of care that includes all follow-up activities.

Administration of the IHA, IPPE, and AWE

The following practitioners may administer the IHA, IPPE, and AWE:

1. Any PCP, as long as the PCP of record ensures that the documentation of the ~~IHA exam~~ is maintained in the member's primary medical record, completed in an accurate and comprehensive manner, and available during subsequent preventive health visits.
2. Alliance perinatal care providers may administer the IHA, IPPE, and AWE through the initial prenatal visit(s). They must document that the prenatal visit(s) met the ~~IHA~~ content and timeline requirements.
3. PCPs who may administer the IHA, IPPE, and AWE include California licensed physicians qualified to serve as general practitioners. Or specific Alliance physicians who are board certified or board eligible in the following medical specialties: Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice.
4. Non-Physician Mid-Level Practitioners such as nurse practitioners, certified nurse midwives, physician assistants, clinical nurse specialists and PCPs in training.
5. The IHA, IPPE, and AWE may be performed in the following settings:
 - a. Medical settings should be designated as general practice, pediatrics, obstetrics, gynecology, and internal medicine in alignment with the definition of PCs.

Timelines for Provision of the IHA, IPPE, and AWE

An IHA must be scheduled and completed by PCPs as follows:

1. IHA will be conducted with all members within 120 days of initial enrollment or PCP assignment, unless excepted as noted in "Excluded Members" below; or documented within the past 12 months prior to member's enrollment, and the PCP determines that the Member's medical record contains complete and current information consistent with the Alliance assessment. For the IPPE, the exam is offered once within 12 months of initial Medicare enrollment. The AWE is offered annually.
2. For members under the age of 18 months, the IHA will be completed within 120 calendar days following the date of enrollment or within the periodicity timeline established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.
3. If a member requests, or the Alliance initiates a change in PCP assignment within the first 120 days of enrollment, and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members.
4. The Alliance ensures that subcontracted provider organizations selected or assigned to a member receive timely notification of a member's effective date of enrollment to allow scheduling and completion of the IHA within the required timeframe.

5. The effective date of enrollment is defined as:
 - a. The first of the month following notification from DHCS that the member is eligible to be an Alliance member, the member is not on “hold” status, and capitation will be paid.
 - b. For infants born to Alliance members, the effective date of enrollment is the date of birth. The Alliance covers the infant under the mother’s enrollment from date of birth through the last day of the following month.
 - c. In cases of retroactive enrollment, the effective date will be the date the Alliance receives notification of the member’s enrollment.

Excluded Members:

Individual members may be excluded from the IHA requirement under the following circumstances, and only if documented in the medical record:

1. All elements of the IHA were completed within the 12 months prior to enrollment, and the member’s primary care services provider determines the requirements for documentation of the IHA are met.
2. New members who are not continuously enrolled with the Alliance for 120 days.
3. Members, including emancipated minors, or a member’s parent(s) or guardian(s), who refuses an IHA. In this case, a statement signed by the member must be documented in the member’s medical record. If the member or the party legally responsible for the member refuses to sign a refusal statement, the verbal refusal of services will be noted in the medical record.
4. The member missed a scheduled PCP appointment and **TWO** additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation must include at least the following:
 - a. One attempt to contact member by phone.
 - b. One attempt to contact member by letter or postcard sent to the address in the Alliance’s records.
 - c. The Alliance’s good faith effort to update the member’s contact information.
 - d. Attempts to perform the IHA at subsequent member office visit(s).

Provider Communication

1. The Alliance incorporates IHA requirements in the new provider orientation, the Provider Manual, fax blasts, regular primary care visits (by provider representative), during Facility Site Reviews, and provider meetings/webinars.

Informing Members

1. The Alliance informs members about the IHA through the Evidence of Coverage, including: welcome letters, videos on our website, and member outreach.
2. Member information on the IHA includes:
 - a. The availability of the IHA for all members
 - b. Instructions on how to arrange for an IHA appointment within the appropriate timelines.
 - c. The importance of keeping the IHA and other appointments.

d. ~~Member rights, including providing the members with the results of the IHA.~~

Formatted: Normal, No bullets or numbering

3. The Alliance makes reasonable attempts (a minimum of two outreach recommended) to contact members to schedule IHA.

Compliance with IHA:

1. Monthly, the Alliance pulls claims and encounters with specific visit codes to monitor the percentage of newly and reassigned assigned members who had a visit within 120 days of being assigned.
2. An Alliance Facility Site Review (FSR) Nurse routinely reviews and validates medical records for compliance with IHA standards as part of the triennial FSR process. The FSR Nurse ensures that 30% of medical records selected for review are for members eligible for an IHA (e.g., those with an effective date within the review period who have been a member for 120 days or longer). Records are determined to be compliant if all of the following criteria are met:
 - a. The member had a PCP visit within the first 120 days of enrollment or documented within the 12 months prior to Alliance enrollment, ~~and~~
 - b. During the encounter and subsequent encounters, the IHA elements listed above were completed.
 - c. If IHA was not completed, FSR Nurse will review documentation of the attempts made to contact members.
 - d. Failure to complete IHA or provide evidence of outreach attempts can result in a Corrective Action Plan (CAP).
3. Quarterly results and reports are reviewed. Opportunities for improvement are discussed and aggregated results are annually shared with the Quality Improvement Health Equity Committee (QIHEC).
4. The Alliance shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. The Alliance ensures that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow-up.
5. In the absence of risk factors and the need for immediate follow-up, core preventive services for the IHA for adults should be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services
6. In the absence of risk factors and the need for immediate follow-up, core preventive services for the IHA for the pediatric population should be offered in the frequency required by the American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines
7. For newly pregnant women, Alliance will refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c).
8. Alliance will report to the immunization registry(ies) established in the service area as part of the Statewide Immunization Information System, following the Member's IHA and all other health care visits which result in an immunization.

Monitoring:

1. The Quality Improvement (QI) Department will conduct a chart review audit of at least thirty members who have been with the plan for 120 days and have had at least one provider visit. This will be done at a minimum annually. The purpose of these reviews will be to determine if all components of the IHA have been completed, and whether the completion followed the policy guidelines. Providers who fail to complete all elements of the IHA are notified and offered education on meeting the IHA requirements. If there are noted trends by a provider in failure to meet all of the IHA requirements may result in the issuance of a Corrective Action Plan (CAP).
2. The Quality Improvement (QI) Department with track and monitor completion of IPPE and AWE and communicate with providers as necessary.

Data Sharing

1. The Alliance shares IHA data with providers, subcontractors, and other sub-plan entities to facilitate care coordination for their members.

DEFINITIONS / ACRONYMS

American Academy of Pediatrics (AAP)
Facility Site Review (FSR)
Initial Health Appointment (IHA)
Primary Care Physician (PCP)
U.S. Preventive Services Task Force (USPSTF)
Initial Preventive Physical Exam (IPPE)
Annual Wellness Exam (AWE)
Chronic Kidney Disease (CKD)
End Stage Renal Disease (ESRD)

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

12/17/2015, 8/29/2016, 1/04/2017, 4/12/2018, 11/15/2018, 1/16/2020, 11/19/2020, 3/21/2023, 3/19/2024, 4/16/2025

REFERENCES

Title 42, Section 438.208, [410.152, 422.101](#)

APL 22-030 Initial Health Appointment

Alameda Alliance Provider Manual

[Alameda Alliance ~~for Health~~ Wellness D-SNP Model of Care](#)

[Medicare Managed Care Manual Chapter 4](#)

MONITORING

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



POLICY AND PROCEDURE

Policy Number	HED-001
Policy Name	Health Education Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	All (MCAL, IHSS, DSNP)
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD2/14/2025
Administrative Oversight Committee Approval Date	TBD4/16/2025

POLICY STATEMENT

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

PROCEDURE

~~1.~~ The Director of Population Health and Equity (PHE) provides operational oversight and leadership for Alameda Alliance for Health's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health, Cultural and Linguistic Services and member Health Education. In addition, the PHE Director will support health equity

Formatted: Font: Not Bold

initiatives for Stars, by aligning these efforts with broader organizational goals. This position reports to the Senior Director of Quality Improvement and works closely with the Chief of Health Equity. ~~The Equity.~~ The Population Health and Equity Director at the Alliance provides administrative oversight of the Health Education Program. It is a full-time position held by a health educator with a master's degree in public health or community health, with a specialization in health

1. education. The Population Health and Equity Director is a member of the Health Care Services Department and specifically is a part of the Quality Improvement team to ensure coordination and integration.
2. The Alliance provides evidence-based health education programs to all members.
 - 2.1. The Health Education Program aligns health education interventions for addressing health categories and topics within Population Health Management.
 - 2.2. The Alliance uses Population Needs Assessment (PNA) findings, HEDIS results, Star measure performance, and other internal and external data sources, to inform its program priorities, target populations, levels of intervention, and the development of the annual work plan, including program goals and objectives.
 - 2.3. Health Education updates its program goals, objectives, activities, and resource needs annually.
3. The Alliance ensures the organized delivery of health education programs using education strategies and methods appropriate for members and effective in achieving behavioral change. This is accomplished through:
 - 3.1.1. Review of relevant literature, evidence-based interventions, and best practices
 - 3.1.2. Offering accredited programs
 - 3.1.3. Evaluating health education programs
4. The Alliance may offer non-monetary incentives for participating in incentive programs, focus groups and member surveys as authorized by W&I Code section 144.07.1 pursuant to APL 16-005.
5. Alliance health education programs and services are also reviewed through regular audits to ensure they meet the cultural and linguistic needs of members and follow health literacy standards, including sixth-grade or lower reading level. Translation services and alternative formats are available for health education materials for all members upon request at no charge to the member.
6. Alliance health education programs and services are provided at no charge to members and are delivered by the plan directly or through agreements with organizations

Formatted: Space Before: 12 pt, After: 12 pt, Outline numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

~~imbedded~~imbedded within member communities noted for expertise in delivering health education programs. The Alliance maintains listings of the no cost community health education program referrals available to members and promotes health education opportunities through our website and member newsletter.

7. The Alliance health education program covers the following program interventions:
 - 7.1. **Appropriate Use of Managed Health Care Services** including preventive and primary health care services, obstetrical care, health education services and appropriate use of complementary and alternative care.
 - 7.2. **Risk Reduction and Healthy Lifestyles** including, but not limited to programs for tobacco use and cessation; alcohol and drug use; injury prevention, nutrition and physical activity.
 - 7.2.1. Member confidentiality regarding family planning, gender identity, sexual orientation, and alcohol and substance use is protected.
 - 7.2.2. The Centers for Disease Control's Diabetes Prevention Program (DPP) for members who meet the CDC criteria for participation. See *HED-009 Diabetes Prevention Program* for details.
 - 7.3. **Self-Care and Management of Health Conditions** including but not limited to pregnancy, asthma, diabetes, and hypertension.
 - 7.4. **Breastfeeding promotion, education, and counseling** services to pregnant and lactating members.
 - 7.4.1. Prenatal and postpartum mailings to all identified Alliance moms with information on the benefits of breastfeeding, doula services, and referral to Women Infants and Children (WIC).
 - 7.4.2. Eligible members are referred to WIC.
 - 7.4.3. Coordination with community agencies and referrals to ensure that postpartum women receive breastfeeding counseling and support after delivery.
 - 7.4.4. International Board-Certified Breastfeeding Consultants (IBCLC) are available to Alliance members by phone or for in-person visits.
8. Members may access the Alliance Health Education programs upon self-referral or provider referral. The Alliance conducts outreach to maximize members' participation in programs. Health Education staff connects members with services and programs through the following activities:

- 8.1. Explaining the effective use of health care services and availability of health education programs in the Member Handbook (Evidence of Coverage).
 - 8.2. Placement of health education articles in member newsletter distributed two (2) times a year.
 - 8.3. Maintaining a library of health education handouts covering health topics listed in Alliance program interventions above, topics that align to the Population Health Management Strategy, and topics specific to the needs of our members. Handouts are available on-line and are mailed out to members upon request. Members and providers can mail or fax in the Wellness Request form, complete the form in the online provider portal, access the online Live Healthy Library at <https://alamedaalliance.org/live-healthy/live-healthy-library/>, or call Health Education to make a request. Distribution of health education materials is documented in Alliance data systems as a member's Health Education Case when not accessed online.
 - 8.4. Maintaining contracts and relationships with community organizations that provide classes, support groups and self-management programs to Alliance members at no cost.
 - 8.5. Responding to member inquiries to the Health Education Program with information on health education program offerings, facilitate referrals and document referral and class/program completion in Alliance data systems as a Health Education Case.
 - 8.5.1. All referrals are documented, and class completion is documented for programs paid for by the Alliance.
 - 8.5.2. Health Education Cases are closed after 4 months of non-activity.
 - 8.6. Sending targeted mailings to members with specific health conditions. Mailings include health education materials, condition self-management tools and information on self-management programs and classes that are no cost to members.
9. The Alliance ensures that members receive point of services education as a part of preventive and primary health care visits. Supports for providers include:
- 9.1. On-line health education materials in threshold languages culturally appropriate health education resources and referrals that can be shared with members.
 - 9.2. A provider health education listing of health referrals available to Alliance members.
 - 9.3. *Provider Wellness Request Form* available for download or through the Alliance Provider Portal to request Alliance health education programs and materials for members.
 - 9.4. Provider communication, training, and education regarding delivery of health education services through provider quarterly packets and Alliance website resources.
10. The Alliance ensures the availability of Community Health Workers (CHWs) for members to assist members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and

connecting individuals and families with community-based resources. See Alliance Policy *PH-004 Community Health Worker Services* for details.

11. The Alliance educates providers so that health education takes place at medical and non-medical key points of service contacts as part of prevention and primary health care visits. The Alliance also offers provider education and training on the PNA findings, techniques to improve provider/patient interaction, educational and staff resources, plan-specific resources and referrals and health education requirements and monitoring. Provider training regarding health education occurs through the following methods:
 - 11.1. Making available to the provider a resource directory of health education, self-management supports, community programs and ancillary services free to members. This list is available on the provider pages of the Alliance website (<https://alamedaalliance.org/providers/>).
 - 11.2. Information on accessing health education resources is included in the New Provider Orientation and Provider Manual.
 - 11.3. Alliance website Provider section Patient Health and Wellness Education. Providers are informed of how to access website resources during their orientation and in the Provider Manual.
 - 11.4. Informational handouts and community-based or governmental training opportunities are shared at Provider Services during periodic office visits, website postings, and/or distributed by email or fax blast.
12. The health education program conducts appropriate levels of evaluation to ensure effectiveness and monitors performance of providers that are contracted to deliver health education programs.
 - 12.1. The health education program conducts formative, process, impact, and outcome evaluations as appropriate to ensure effectiveness and monitors the performance of providers that are contracted to deliver health education programs. Opportunities for improvement will be identified and appropriate activities implemented. The Health Education Program will be reviewed annually to ensure appropriate allocation of resources based on assessment and evaluation findings and other plan data. Health education accomplishes program evaluation through:
 - 12.2. Utilization of a case management database and automated quarterly reports to track and monitor member requests for materials and participation in health education activities. Utilization is tracked by threshold language to ensure accessibility for Limited English Proficient (LEP) members.
 - 12.3. Reviewing Alliance program satisfaction surveys and/or collection of survey information from contracting providers.

- 12.4. Monitoring of providers contracted to deliver health education services through site visits, an audit tool, and materials review. Issues of concern are addressed, and support is provided as needed to meet Alliance standards.
- 12.5. Collecting and analysis of data to identify ~~change~~changes in behavior, confidence, health status or cost depending on the specific program objectives and available data.

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

Communications and Outreach
Member Services
Provider Services
Case and Disease Management

RELATED POLICIES AND PROCEDURES

HED-002 Health Education Materials
HED-009 Diabetes Prevention Program
[HCSP-001 Community Health Workers](#)~~[PH-004 Community Health Worker Services](#)~~

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Baby Steps Standard Work
HED Diabetes Prevention Program Standard Work
HED Hospital ED Asthma Referral Standard Work
HED Lactation Support Standard Work
HED Materials Standard Work

HED-001 Health Education Program_

HED Member Request Standard Work
HED Programs Monitoring and Evaluation Standard Work
[HED Weight Watchers Standard Work](#)

REVISION HISTORY

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

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	HED-002
Policy Name	Health Education Materials
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD2/14/2025</u>
Administrative Oversight Committee Approval Date	<u>TBD4/16/2025</u>

POLICY STATEMENT

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

PROCEDURE

1. The Health Education Department uses the guide *Document A. Definitions and Requirements*, to determine which written documents are considered health education or member information materials. All Alliance collateral is reviewed by the Communications and Outreach Department. The Compliance Department reviews and submits member information documents to the Department of Health Care Services (DHCS) for approval prior to use.
2. Health education materials will be approved by a qualified health educator employed by the Alliance. The qualified health educator reviews all health education materials (plan-generated, adapted, purchased, or obtained free-of-charge) using the DHCS Readability and Suitability Checklist for Written Health Education Materials.

- 1.1.2.1. Newly acquired materials will be reviewed when they are procured and before distributed to members, providers, and staff.
- 1.2.2.2. Materials can be reviewed for readability standards and approved without completing the Readability and Suitability Checklist if they were produced by the following sources and no significant changes were made:
 - 1.2.1.2.2.1. State-approved companies listed in ‘Approved Companies for Written Health Education Materials’ letter,
 - 1.2.2.2.2.2. City, county, state, and federal government agencies, and
 - 1.2.3.2.2.3. Non-profit agencies or community-based organizations when there is documentation on file that shows the material meets readability and suitability guidelines.
- 1.3.2.3. Materials are reviewed at least every five years or any time there are changes to health guidelines that affect the accuracy of the content.
- 1.4.2.4. Materials are updated as needed. Review may occur when there is a change in best practices or a regulatory board (i.e., DMHC, DHCS or CMS) mandates a change in health practices.
- 1.5.2.5. The Alliance maintains a signed and approved Readability and Suitability Checklist, including justification if needed, with the material and makes it available upon request to DHCS and other auditing agencies.

- 2.3. The Alliance uses the Simple Measure of Gobbledygook (SMOG) Readability Formula, the Flesh-Kinkaid readability tool, or a comparable language assessment tool for readability analysis.
 - 2.1.3.1. The formula is applied to the English version of all health education materials.
 - 2.2.3.2. Materials meet a readability score of sixth grade reading level or less and are at least 12-point font.
 - 2.3.3.3. A copy of the readability score calculation is kept with the completed Readability and Suitability Checklist.
 - 2.4.3.4. The evaluation of readability and suitability may exclude State-mandated legal language and MCP or vendor legal disclaimers; proper nouns; defined words; phone numbers; and website addresses. Medical terminology, technical words and/or multi-syllable words that must be included in health education material and cannot be substituted for simpler words are counted once.
- 3.4. As a part of the Readability and Suitability Checklist, the qualified health educator evaluates health education materials for other readability factors such as content accuracy, use of plain language and key messages, literacy level, layout, visuals, and cultural appropriateness.

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

3.1.4.1. Field-testing is optional for the following:

3.1.1.4.1.1. Brief updates on preventing colds and availability of seasonal flu vaccine

3.1.2.4.1.2. Newsletters

3.1.3.4.1.3. Materials developed by local county/city health departments, California state governmental organizations or the US federal government

3.1.4.4.1.4. Materials developed by a non-profit agency or community-based organization

3.1.5.4.1.5. Materials field-tested by a vendor when the qualified health educator has determined that the field-testing was conducted appropriately and with participants that represent a population similar to the targeted Alliance members

3.1.6.4.1.6. Materials that are from the DHCS list of approved vendors

3.1.7.4.1.7. Materials field-tested by another Medi-Cal Managed Care Plan

3.1.8.4.1.8. Material similar to another that was previously field-tested

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

3.3.4.3. The field-testing may include:

3.3.1.4.3.1. Review by the Community Advisory Committee

3.3.2.4.3.2. Key informant interviews with members, community informants, or internally qualified reviewers

3.3.3.4.3.3. Focus groups with targeted members

3.3.4.4.3.4. Written member or community informant surveys

4.5. Member health education materials containing clinical information are reviewed by the most appropriate clinical staff.

4.1.5.1. Medical accuracy is verified by the plan's nursing/pharmacy staff and/or Medical Directors. Clinical staff signs an attestation once clinical accuracy is confirmed. Attestations documented via email are acceptable.

4.2.5.2. Accuracy of content related to plan procedures, policies and applicable regulations is reviewed by plan staff whose responsibilities focus on the subject matter.

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

6.7. Members, family members or providers can request plan-produced educational materials in alternative formats, including Braille, accessible PDFs, large print, CD, audio, or online access by calling the Member Services Department or making a request online through the Alliance Member Portal. Alliance staff then contacts the

Communications and Outreach Department who fills the request within 21 business days.

~~6.1.7.1.~~ Vendor-produced materials are provided in alternate formats whenever possible, or materials of similar content are provided in alternate formats. When required, the Readability and Suitability Checklist is used to assess and approve written health education materials before conversion to an alternative format.

~~6.2.7.2.~~ Members can make a standing request for an alternate format for member communications.

~~6.3.7.3.~~ If providing an alternative format causes undue hardship, the Alliance will provide the information in another reasonable format, such as by phone or in-person from the plan health educator or other qualified staff (i.e., Nurse Case Manager).

~~7.8.~~ Plan-generated informing documents and health education materials are translated into threshold languages. Upon member request, any Alliance department can request translation of member documents into non-threshold languages by submitting a request to the Communications and Outreach Department. Documents are translated according to Policy and Procedures *C&O-001 Community Relations and Outreach Activities* and *CLS-003 Language Assistance Services*.

~~8.9.~~ The Health Education department will train and advise any Alliance department as needed regarding the readability and suitability of member documents and requirements regarding literacy level, plain language, translation, and alternative format for vision and hearing-impaired options or other disability accommodations.

~~9.10.~~ Health education information that can be downloaded for use by members on the Alliance website is assessed and approved using the Readability and Suitability Checklist and field-tested if required. Alliance Health Education website text and linked external websites are regularly reviewed for readability and cultural appropriateness.

~~10.11.~~ Alliance newsletters principally contain health education messages that are developed using readability and suitability guidelines.

DEFINITIONS/ACRONYMS

CMS – Centers for Medicare & Medicaid Services

DHCS – Department of Health Care Services

DMHC – California Department of Managed Health Care

Field-testing - A process through which member materials are reviewed by the target audience either through in-person review, key informant interviews, focus groups or surveys.

Health education materials – Designed to help members modify personal health behaviors, achieve, and maintain healthy lifestyles, and promote positive health outcomes by including

information on health conditions, self-care, and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, and healthy living.

MCP – Managed Care Plan

Member information materials – Provide members with essential information about access to and usage of Plan services. Evidence of Coverage, booklets, enrollment and disenrollment information, member rights and grievance information, new member welcome packets, provider directories, flyers promoting a health education class, and appointment reminders are examples of informing materials.

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

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

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

SMOG - Simple Measure of Gobbledygook Readability Formula

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

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

C&O-001 Community Relations and Outreach Activities

HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Materials Standard Work

REVISION HISTORY

11/21/06, 1/1/2008, 12/2009, 2/26/2010, 3/28/11, 9/30/11, 3/25/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 03/19/2024, 4/16/2025, [TBD](#)

REFERENCES

CA Health and Safety Code section 1367.04(b)

DHCS Contract, Exhibit A, Attachment 9, 10, 13

DHCS All Plan Letter 18-016 Readability and Suitability of Written Health Education

DHCS APL 18-016 Materials and Attachments:

- Document A. Definitions and Requirements
- Document B. Readability
- Suitability Checklist for Written Health Education Materials)
- DHCS Approved Companies for Written Health Education Materials

MONITORING

This policy will be reviewed annually to ensure effectiveness.



POLICY AND PROCEDURE

Policy Number	HED-006
Policy Name	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL & <u>D-SNP</u>
Effective Date	6/16/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD2/14/2025</u>
Administrative Oversight Committee Approval Date	<u>TBD4/16/2025</u>

POLICY STATEMENT

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

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

This policy details the coverage of SABIRT services for the Alliance’s Medi-Cal and D-SNP members and the procedures for SABIRT services. SABIRT services are provided by the member’s primary care provider (PCP) to identify, reduce, and prevent problematic substance use. The Alliance does not require prior authorization for

SABIRT services and referral to substance use disorder (SUD) evaluation or treatment. See *BH-005 Care Coordination – Behavioral Health* for details.

PROCEDURE

1. General requirements:

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

2. Screening Services

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

3. Brief Assessment

- 3.1. When the screening is positive, Alliance providers use validated assessment tools to determine if unhealthy alcohol use or SUD is present. Validated assessment tools

Commented [MB1]: Does this align with no wrong door or our current process for getting members services?

Commented [LA2R1]: @Doudney, Mary Good question, I'm not sure the connection. Should we connect with Dr. Currie?

Commented [MB3R1]: I don't think this is no wrong door. This is the screening APL. Let's add Dr. C. @Currie, Pete

Commented [CP4R1]: Agreed. Drop any reference to No Wrong Door here.

may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

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

4. Brief Interventions and Referral to Treatment

- 4.1. For patients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Brief interventions will include the following:
 - 4.1.1. Providing feedback to the patient regarding screening and assessment results;
 - 4.1.2. Discussing negative consequences that have occurred and the overall severity of the problem;
 - 4.1.3. Supporting the patient in making behavioral changes; and
 - 4.1.4. Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.
- 4.2. If brief assessment demonstrates probable AUD or SUD, providers will offer appropriate referrals to Alameda County Behavioral Health (ACBH) or outpatient heroin detoxification providers available through Medi-Cal fee-for-service program for additional evaluation and treatment, including medications for addiction treatment.
 - 4.2.1. Providers refer directly to ACBH or to the Alliance Behavioral Health Department for screening and referral to AUD or SUD treatment services.
 - 4.2.2. Alliance case management team may also offer appropriate referrals to members for AUD or SUD treatment services.
 - 4.2.3. SUD referrals and subsequent treatment do not require prior authorization.
- 4.3. The Alliance assists members in locating available treatment services sites, including pursuit of placement outside the area if no slots are available in county. If a medically necessary appointment is unavailable in a timely fashion, the Alliance Utilization Department will approve out-of-network services.
- 4.4. The Alliance covers and ensures the provision of primary care and other services unrelated to alcohol and SUD treatment and coordinates services between Primary Care Providers and treatment programs. Alliance providers are informed in the Provider Manual of their responsibility for appropriate care coordination, including care coordination for behavioral health care.
- 4.5. Providers will make good faith efforts to confirm whether members receive referred treatment and document when, where, and any next steps following treatment. If no treatment was received, providers will follow up with the member to understand barriers and make any needed changes to the referrals. When needed, the provider will facilitate a warm hand off to treatment.

5. Documentation Requirements

- 5.1. Member medical records must include the following:
 - 5.1.1. The service provided (e.g., screen and brief intervention);
 - 5.1.2. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);

- 5.1.3. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and
- 5.1.4. If and where a referral to an AUD or SUD program was made.
- 5.2. The Alliance Quality Improvement Department will ensure provider compliance with SABIRT requirements through the Medical Record Review process (see QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)).
- 5.3. When members transfer from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.
- 5.4. The Alliance will inform members of SABIRT services through the Alliance Member Handbook.

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

Claims/Operations
Compliance
Health Care Services

Provider Services

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
BH-005 Care Coordination – Behavioral Health

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

6/16/2016, 5/25/2017, 1/04/2018, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 6/28/2022, 3/21/2023, 03/19/2024, 4/16/2025, [TBD](#)

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	HED-007
Policy Name	Tobacco Cessation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL & D-SNP
Effective Date	6/16/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

Formatted: Line spacing: Multiple 1.08 li

Formatted: Line spacing: Multiple 1.08 li

POLICY STATEMENT

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

Commented [MT1]: ~~is this part of our benefit under Medicare?~~

Commented [NB2R1]: ~~per the CMS website: Smoking Cessation Counseling Coverage~~

PROCEDURE

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

1. The Alliance requires its providers to conduct initial and annual ~~assessment~~assessments of tobacco use for each adolescent and adult member to identify all members (of any age) who use tobacco products and note use in the member's medical record. The Alliance requires providers to document the following to track all tobacco use.
 - 1.1. Providers must complete the Individual Health Appointment (IHA) which includes review of the social history of the member which includes tobacco use (See Alliance policy and procedure *QI-124 IHA*).
 - 1.2. Providers must annually assess tobacco use status for every member.

- 1.3. Providers must ask tobacco users about their current tobacco use at every visit.
 - 1.4. Provider Services informs primary care providers of the requirements regarding assessment of tobacco use during the New Provider Orientation and yearly thereafter in provider office visits.
 - 1.5. Tobacco user identification will be reviewed during their routine facility site review to confirm compliance. (Reference: QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS).
2. Medi-Cal and D-SNP will provide coverage of prescription and Over-The-Counter (OTC) smoking/tobacco cessation covered outpatient drugs as recommended in “Treating Tobacco Use and Dependence: 2008 Update” published by the U.S. Public Health Service in May 2008 or any subsequent modification of such guideline.
- 2.1. Although the Patient Protection and Affordable Care Act (ACA) Section 4107 authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant persons, the U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons. Providers refer to the tobacco cessation guidelines by the American College of Obstetricians and Gynecologists (ACOG) before prescribing tobacco cessation medications during pregnancy.
3. Prescription and OTC smoking/tobacco cessation products are covered via the Medi-Cal Rx Contract Drugs List (CDL), <https://medi-calrx.dhcs.ca.gov/home/cdl/>.
- 3.1. Quantity limits and other restrictions for the medications are also available in the CDL.
 - 3.2. Providers will need to ensure they can submit prior authorization (PAs) for any drug that will require authorization from Medi-Cal Rx. Here are the different ways that providers can register or submit a PA:
 - 3.2.1. **Medi-Cal Rx Secure Portal:** The prior authorization (PA) system information and forms are available on the Medi-Cal Rx website at www.medi-calrx.dhcs.ca.gov. Providers can check the status of requests on Medi-Cal Rx Provider Portal or by phone by calling the Medi-Cal Rx Call Center Line toll-free at **1.800.977.2273**. Please refer to www.medi-calrx.dhcs.ca.gov.
 - 3.2.2. **CoverMyMeds:** Providers can create an account and log in to submit a PA on the CoverMyMeds website at www.covermymeds.com. If you currently use CoverMyMeds, you can continue to utilize this platform to submit a PA. A link to CoverMyMeds can also be found in the Medi-Cal Rx Secure Portal. ***Please prioritize this submission process to minimize delays.**
 - 3.2.3. **NCPDP P4:** To view the Prior Authorization Request Only (P4) Payer Sheet Template, please visit medi-calrx.dhcs.ca.gov/provider/forms.
 - 3.2.4. **By Fax:** PA requests and attachments can be faxed to **1.800.869.4325**.

- 3.2.5. **By mail:** PA requests and attachments can be mailed to: Medi-Cal Rx Customer Service Center; Attn: PA Request; P.O. Box 730; Sacramento, CA 95741-0730.
- 3.3. The Alliance covers reimbursement for pharmacist professional services for furnishing nicotine replacement as required by Welfare and Institutions Code Section 14132.968 (W&I 14132.968) in a community-based outpatient pharmacy setting.
- 3.4. The Alliance covers processing and payment of all pharmacists' professional services for furnishing nicotine replacement as allowed by W&I 14132.968 that are billed on medical and institutional claims.
4. The Alliance provides individual, group, and telephone counseling for members of any age who use tobacco products and who wish to quit smoking.
- 4.1. Providers receive codes they can use for reimbursement in their New Provider Orientation and regularly thereafter. The Alliance covers four counseling sessions of at least 10 minutes in duration and covered at least two separate quit attempts per year without prior authorization.
- 4.2. The Alliance encourages providers to use the "5 A's" model (see <https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html>) or other validated behavior change models when counseling patients.
- 4.3. The Alliance ensures that providers refer members to Kick It California (<https://www.kickitca.org/>) or the Asian Smokers' Quitline (<https://www.asiansmokersquitline.org/>).
- 4.4. Providers may refer members or members can self-refer to Alliance sponsored tobacco cessation group classes or telephone counseling through Kick It California or the Asian Smokers' Quitline.
- 4.4.1. The Alliance maintains a list of available tobacco cessation services and collaborates with the local county tobacco control program.
- 4.4.2. Members and providers connect with the programs through the Alliance Wellness Request Form, by calling Alliance Health Programs, or through referral from their provider or Alliance Case Management staff.
- 4.4.3. The Alliance refers members directly to Kick It California.
- 4.5. All individual, group and telephone counseling options are free to Alliance members.
5. The Alliance provides services for pregnant tobacco users. At a minimum, providers:
- 5.1. Ask all pregnant persons if they use tobacco or are exposed to tobacco smoke and advise them to stop using tobacco.
- 5.2. Offer all pregnant smokers during pregnancy at least one face-to-face counseling session per quit attempt. The counseling services will be covered for 60 days after delivery plus any additional days up to the end of the month.
- 5.3. Refer pregnant persons to a tobacco cessation quit line.
- 5.4. Refer to the American College of Obstetrics and Gynecology (ACOG) Guidelines before considering offering tobacco cessation medication during pregnancy.
6. The Alliance PCPs provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

Commented [NB3]: NB added links to these sites

- 6.1. The Alliance covers medically necessary tobacco cessation services, both counseling and medications for children up to age 21 in compliance with Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.
- 6.2. Services will be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.
7. The Alliance informs and educates clinicians on to effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant persons and where to find on-line courses.
 - 7.1. The Provider Services Department conducts provider training on tobacco cessation services. (Reference: PR-001 – New Provider Orientation)
 - 7.2. As required in our Department of Health Care Services (DHCS) contracts, provider training includes:
 - 7.2.1. Any new requirements for comprehensive tobacco cessation member services including Policy Letter 16-014, or superseding APL or Contract Amendment;
 - 7.2.2. The overview of the "Treating Tobacco Use and Dependence: 2008 Update;"
 - 7.2.3. How to use and adopt the "5 A's" for treating tobacco use and dependence in the provider's clinic practice;
 - 7.2.4. Requirements for pregnant tobacco users;
 - 7.2.5. Requirements regarding preventing tobacco use in children and adolescents, and
 - 7.2.6. Available online courses in tobacco cessation.
 - 7.3. Provider training links are available on the AAH website. Tobacco related training opportunities are shared with providers as available.
8. The Alliance will ensure that our primary care practices institute a tobacco user identification system per USPSTF recommendations. Reports on tobacco use are used to coordinate members' tobacco cessation interventions.
 - 8.1. The Alliance annually reviews a report on Alliance tobacco users that combines Nicotine Replacement Therapy (NRT) claims, health risk assessment results, case management data and ICD-10 codes for nicotine dependence.
 - 8.2. Summary reports are reviewed annually at the Internal Quality Improvement Committee, ~~and reported to the Health Care Quality Committee.~~
9. Tracking Treatment Utilization of Tobacco Users
 - 9.1. The Alliance maintains a system to track utilization of tobacco cessation interventions. Utilization is tracked through NRT pharmacy claims, aggregate reports from Kick It California, Alliance smoking cessation class referrals, and CAHPS survey results.
 - 9.2. Summary reports are ~~reviewed-reported~~ at least annually at the Alameda Alliance for Health's (AAH)'s Internal Quality Improvement Committee, ~~and reported to the Quality Improvement Health Equity Committee.~~

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

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

Compliance
Pharmacy
Provider Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Tobacco Strategy Standard Work

REVISION HISTORY

6/16/2016, 5/25/2017, 1/4/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 03/19/2024, 4/16/2025, [TBD](#)

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	HED-009
Policy Name	Diabetes Prevention Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, <u>D-SNP</u>
Effective Date	5/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD2/14/2025</u>
Administrative Oversight Committee Meeting	<u>TBD4/16/2025</u>

POLICY STATEMENT

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

PROCEDURE

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

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

- 1.1. Emphasizes self-monitoring, self-efficacy, and problem solving,

Commented [NB1]: [@Thompson, Michelle](#) [@Williams, Mollie](#)
NB added in the MDPP from CMS Medicare for Diabetes Prevention.

Commented [TM2R1]: [@Ayala, Linda](#) [@Duran, Gil](#) please review DSNP language [@Friel, Melissa](#)

Commented [GD3R1]: Updates completed. [@Ayala, Linda](#) can you review next?

Commented [LA4R1]: [@Duran, Gil](#) my review is completed - more formatting changes than anything.

Commented [LA5R1]: Not sure my changes were tracked - but they did not alter the content.

Commented [GD6R1]: Thanks you, yes. Made few minor adjustments.

Commented [GD7R1]: Resolving.

- 1.2. Provides for coach feedback,
- 1.3. Includes participant materials to support program goals, and
- 1.4. Requires participant weigh-ins to track and achieve program goals.

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

3. Benefit eligibility period

3.1. Members must meet the most current CDC DPRP participant eligibility requirements to qualify for the DPP benefit.

~~Members must meet the most current CDC DPRP participant eligibility requirements to qualify for the DPP benefit.~~

3.2. A D-SNP member is eligible for MDPP services offered during the core services period as defined in CFR Title 42 § 410.79.

~~3.2 A D-SNP member is eligible for MDPP services offered during the core services period as defined in CFR Title 42 § 410.79.~~

4. The Alliance covers a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. Months one (1) through 12, known as the core services period, consist of weekly core sessions in the first six (6) months followed by monthly core maintenance sessions in the next six (6) months. Thereafter, the Alliance will provide 12 months of ongoing maintenance sessions to qualified members to promote continuous healthy behaviors.

4.

- 4.1. A member will qualify for the ongoing maintenance sessions if:
 - 4.1.1. The member achieves and/or maintains minimum weight loss of five percent for the first core session, and
 - 4.1.2. The member meets the attendance requirement, as outlined in the Medi-Cal Provider Manual.
- 4.2. The Alliance accepts the below modalities for the required weigh-ins:
 - 4.2.1. In-person weigh-in at a DPP session or DPP provider location;
 - 4.2.2. A remote weigh-in at the member's home using scales with digital or Bluetooth communications capability; or
 - 4.2.3. Self-reported weigh-ins with or without confirmatory documentation.

5. The Alliance will may cover the following delivery methods:

~~5.1.1. for~~ For DPP sessions as deemed clinically appropriate:

- ~~5.1.1.1. In-Person,~~
- ~~5.1.1.2. Distance Learning,~~
- ~~5.1.1.3. Online, or~~

5.1.4. Combination – Combination refers to any combination of in-person, distance learning, or online delivery methods.

5.2. The Alliance will cover the following delivery For methods for MDPP sessions:

- ~~5.2.1. In-person, or~~
- ~~5.2.1. Distance learning (live)~~

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

Formatted

Formatted: Normal

Formatted: Normal, No bullets or numbering

Formatted: Outline numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted: Space After: 0 pt

Formatted

Commented [GD8]: MDPP does not allow asynchronous sessions ("online")

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

5.2.2.

5.4.

6. Duration of the benefit:

—The [DPP](#) benefit will be offered as often as necessary, but the member's medical record must indicate that the member's medical condition or circumstance warrants repeat or additional participation in the [DPP](#) benefit.

6.—

6.1. The Alliance will use the below circumstances when identifying members who warrant repeat or additional participation:

~~6.1.6.1.1.~~ Member switched enrollment from one MCP to a different MCP,

~~6.2.6.1.2.~~ Member transitioned from Fee-for-Service Medi-Cal into an MCP,

~~6.3.6.1.3.~~ Member moved to a different county,

~~6.3.1.~~ Member experienced a lapse in Medi-Cal enrollment, and

6.1.4.

6.4. Member has, or had, medical conditions that hinder DPP session attendance.

6.1.5.

6.2. [The MDPP benefit may last up to one year and include 22 sessions. The full set of MDPP services is available only once per lifetime for each MDPP beneficiary.](#)

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

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

9. The Alliance will maintain documentation of appropriate codes for all DPP/[MDPP](#) services.

DEFINITIONS / ACRONYMS

CDC – Centers for Disease Control and Prevention

[CMS](#) – Center for Medicare and Medicaid Services

[DPP](#) – **Diabetes Prevention Program** - an evidence-based lifestyle change program, taught by peer coaches, designed to prevent, or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes.

[MDPP](#) – **Medicare Diabetes Prevention Program**

DPRP - Diabetes Prevention Recognition Program

Peer Coach - a physician, non-physician practitioner, or an unlicensed person who is trained to deliver the required curriculum content and who possesses the skills, knowledge, and qualities specified in the most current CDC DPRP guidelines.

In-Person Delivery - For in-person delivery, members are physically present in a classroom or classroom-like setting with a peer coach.

Distance Learning Delivery - Distance learning occurs when peer coaches deliver sessions via remote classroom or telehealth. The peer coach is present in one location while participants call in or participate by videoconference from another location.

Formatted: Space After: 0 pt

Formatted: Indent: Left: 0.85", Space After: 0 pt, No bullets or numbering

Formatted

Commented [GD9]: Set of core MDPP services is available only once per lifetime for each MDPP beneficiary (codified at § 410)

Formatted: Left, Indent: Left: 0.5", Don't add space between paragraphs of the same style

Formatted: Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.55"

Formatted

Formatted

Formatted: Space After: 0 pt, Don't add space between paragraphs of the same style

Formatted: Space Before: 0 pt

Formatted: Font: Bold

Formatted: Font: Bold

Online Delivery - Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication. Members can log into DPP sessions via a computer, laptop, tablet, mobile phone, or other device from any location, such as the member's home, without a practitioner or coach present. In addition, members must interact with peer coaches at various times and by various communication methods, including but not limited to online classes, emails, phone calls, or texts.

AFFECTED DEPARTMENTS/PARTIES

Member Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Diabetes Prevention Program (DPP) Standard Work

REVISION HISTORY

5/16/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 3/19/2024, 4/16/2025, [TBD](#)

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	HED-010
Policy Name	Doula Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal, <u>D-SNP</u>
Effective Date	12/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>5/17/2024TBD</u>
Administrative Oversight Committee Approval Date	<u>6/12/2024TBD</u>

Formatted: Line spacing: Multiple 1.08 li

Formatted: Line spacing: Multiple 1.08 li

POLICY STATEMENT

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

PROCEDURE

1. Recommendations for Doula Services

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

- 1.2.2. Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
- 1.2.3. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
- 1.2.4. Up to two extended three-hour postpartum visits after the end of a pregnancy
- 1.3. The initial recommendation can be provided through the following methods:
 - 1.3.1. Written recommendation in Member's record.
 - 1.3.2. Standing recommendation for doula services by a physician group, or other group by a licensed Provider.
 - 1.3.2.1. The standing recommendation issued by DHCS on November 1, 2023, fulfills this requirement until the time it is rescinded or modified.
 - 1.3.3. Standard form signed by a physician or other licensed practitioner that a member can provide to the doula, such as the DHCS Medi-Cal Doula Services Recommendation form.
 - 1.3.4. The Alliance may develop a recommendation form that best meets the needs for the Alliance and Alliance providers.
- 1.4. Additional visits:
 - 1.4.1. A second recommendation is required for additional visits during the postpartum period.
 - 1.4.2. A recommendation for additional visits during the postpartum period **CANNOT** be established by standing order.
 - 1.4.3. The additional recommendation authorizes nine or fewer additional postpartum visits.

2. Role of Doula

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

3. Doula Qualifications

- 3.1. All doulas must (a) be at least 18 years old, (b) provide proof of an adult and infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association, and (c) they attest they have completed basic Health Insurance Portability and Accountability Act training.
- 3.2. Doulas must obtain training for their services through their choice of two pathways:
 - 3.2.1. Training Pathway:
 - 3.2.1.1. Certificate of completion for a minimum of 16 hours of training which includes the following topics:
 - 3.2.1.1.1. Lactation support
 - 3.2.1.1.2. Childbirth education
 - 3.2.1.1.3. Foundations on anatomy of pregnancy and childbirth

- 3.2.1.1.4. Nonmedical comfort measures, prenatal support, and labor support techniques
- 3.2.1.1.5. Developing a community resource list
- 3.2.1.2. Attest that they have provided support at a minimum of three births
- 3.2.2. Experience Pathway: **All requirements** listed below need to be met for this option:
 - 3.2.2.1. Attest that they have provided services in the capacity of a doula in either a paid or volunteer capacity for at least five years. The five years of experience in the capacity as a doula must have occurred within the last seven years.
 - 3.2.2.2. Three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization.
 - 3.2.2.2.1. Letters must be written within the last seven years.
 - 3.2.2.2.2. One letter must be from either a licensed Provider, a community-based organization, or an enrolled doula.
- 3.3. Continuing Education: Doulas complete three hours of continuing education in maternal, perinatal, and/or infant care every three years, maintaining evidence of completed training to be made available to the Alliance upon request.
- 3.4. Doulas are required to enroll as Medi-Cal providers consistent with APL 22-013 or any superseding APLs.
- 3.5. The Alliance will ensure required documentation by doulas for each visit within the member's medical record and be available for encounter data reporting. This documentation includes dates, time and duration of services provided to members. Documentation must also reflect information on the service provided and the length of time spent with the member that day.
- 3.6. "Enrolled doula" means a doula enrolled either through DHCS or through the Alliance.
 - 3.6.1. Network Providers, including those who will operate as Providers of doula services, are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APLs, if there is a state-level enrollment pathway for them to do so.

4. Member Eligibility and Access

- 4.1. A member is eligible for Doula Services if they meet **ALL** the following criteria:
 - 4.1.1. They are currently enrolled as an Alliance member.
 - 4.1.1.1. Doulas must verify the Member's Alliance enrollment for the month of service.
 - 4.1.1.2. Doulas must contact the Alliance to verify eligibility.
 - 4.1.2. They receive a recommendation for doula services from licensed practitioner of the healing arts and would benefit from Doula Services or they request Doula Services.
 - 4.1.3. They are either (a) Pregnant or (b) Pregnant within the past year.
 - 4.1.4. They can only receive Doula Services when provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.
- 4.2. The Alliance as part of their network composition will ensure and monitor for sufficient doula services.

- 4.3. The Alliance will help doulas reduce any identified barriers to accessing hospitals/birthing centers when accompanying members for delivery regardless of outcome. If an Alliance member desires to have a doula during labor and delivery, the Alliance works with our in-network hospitals and birthing centers to allow the doula, in addition to the support person(s), to be present.
- 4.3.1. Alliance doulas may call Provider Services Call Center to request assistance with in-network hospital and birthing center access.
- 4.3.2. Members may call the Alliance Member Services Department for assistance with doula access.

5. Service and Billing Parameters

- 5.1. The Alliance provides doula services for prenatal, perinatal, and postpartum members.
- 5.2. Doula visits are limited to one per day, per member.
- 5.3. Services can be provided virtually or in-person with various locations including, but not limited to homes, office visits, hospitals or alternative birth centers.
- 5.4. A doula can bill for a prenatal or postpartum visit on the day of labor/delivery, stillbirth, abortion, or miscarriage support.
- 5.5. Extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation.
- 5.6. The extended visits are limited to two visits per pregnancy per individual on separate days and are billed in 15-minute increments, up to three hours.
- 5.7. Doulas will work with the Member's Primary Care Provider (if information is available) or with the Alliance for coordination of care for any services available through Medi-Cal by referring the member to an Alliance provider to render the service. These services include but not limited to:
 - 5.7.1. Behavioral health services
 - 5.7.2. Belly binding after cesarean section by clinical personnel
 - 5.7.3. Clinical case coordination
 - 5.7.4. Health care services related to pregnancy, birth, and the postpartum period
 - 5.7.5. Childbirth education group classes
 - 5.7.6. Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)
 - 5.7.7. Hypnotherapy (non-specialty mental health service)
 - 5.7.8. Lactation consulting, group classes, and supplies
 - 5.7.9. Nutrition services (assessment, counseling, and development of care plan)
 - 5.7.10. Transportation
 - 5.7.11. Medically appropriate Community Supports services

~~5.7.11-5.8.~~ **Gender Override: Medi-Cal and D-SNP members of all gender identities may receive doula services so long as they are medically necessary and meet all other requirements for Medi-Cal and D-SNP coverage. Doulas should ensure that the appropriate billing code (CPT or HCPCS code) is listed on the claim in conjunction with an appropriate ICD-10 diagnosis code to ensure the claim does not deny**

~~5.8-5.9.~~ Doula services **DO NOT** include diagnosis of medical conditions, provision of medical advice or any type of clinical assessment, exam, or procedure. However, claims should include a diagnosis code provided by the referring provider.

~~5.9-5.10.~~ Services that **ARE NOT** covered under Medi-Cal or as doula services include: ~~5.9.1-5.10.1.~~ Belly binding (traditional/ceremonial)

Formatted: Font: Bold

Formatted

Commented [MT1]: [Ayala, Linda](#) [Duran, Gil](#) [Fid](#)
Linda and Gil please review for D-SNP language

Commented [LA2R1]: [Thomson, Michelle](#) [Bell, Nomi](#)
Great addition, but I'm wondering where the requirement comes from? In addition, would it be 5.8, rather than a bullet under services doulas may refer members to?

Commented [BN3R1]: [Ayala, Linda](#) [Thomson, Michelle](#)
https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/0075B242-F893-41DB-A418-4129A274E46C/doula.pdf?access_token=6UyVkRRfByXTZEWh8j8QaYyIPyP5ULO . <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.130>

Commented [DG4R1]: Confirmed this was also implemented in our claims process.

- [5.9.2.5.10.2.](#) Birthing ceremonies (sealing, closing the bones etc.)
- [5.9.3.5.10.3.](#) Group classes on babywearing
- [5.9.4.5.10.4.](#) Massage (maternal or infant)
- [5.9.5.5.10.5.](#) Photography
- [5.9.6.5.10.6.](#) Placenta encapsulation
- [5.9.7.5.10.7.](#) Shopping
- [5.9.8.5.10.8.](#) Vaginal steams
- [5.9.9.5.10.9.](#) Yoga
- [5.10.5.11.](#) Doulas **ARE NOT** prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).
- [5.10.1.5.11.1.](#) The visit must be face-to-face, and the assistive or supportive service must be incidental to doula services provided during the prenatal or postpartum visit.
- [5.10.2.5.11.2.](#) The Member cannot be billed for the assistive or supportive service.
- [5.11.5.12.](#) Doulas ARE NOT prohibited from teaching classes available at no cost to Members to whom they provide doula services.
- [5.12.5.13.](#) Doula Documentation:
 - [5.12.1.5.13.1.](#) Doulas must document the dates, time, and duration of services provided to Members.
 - [5.12.2.5.13.2.](#) Documentation must also reflect information on the service provided and the length of time spent with the Member that day. For example, documentation might state, “Discussed childbirth education with the Member and discussed and developed a birth plan for one hour.”
 - [5.12.3.5.13.3.](#) Documentation should be integrated into the Member’s medical record and available for encounter data reporting.
 - [5.12.4.5.13.4.](#) The doula’s National Provider Identifier (NPI) number should be included in the documentation.
 - [5.12.5.5.13.5.](#) Documentation must be accessible to the Alliance and DHCS upon request.

6. Reimbursement for Doula Services

- 6.1. The Alliance Claims Department makes payments in compliance with the clean claims requirements and timeframes outlined in the DHCS MCP Contract and Timely Payments under DHCS All Plan Letters. These requirements apply to both the Alliance and our Network Providers and Subcontractors. (See Alliance Policy *CLM-010 Family Planning and Sensitive Services*).
- 6.2. MCPs must reimburse doulas in accordance with their Network Provider contract.
- 6.3. If a member chooses to see an out-of-network provider for abortion services, the reimbursement rate will not be lower, nor is required to be higher, than the Medi-Cal Fee-For-Service rate, unless the out-of-network provider and the Alliance mutually agree to a different reimbursement rate.
- 6.4. The Alliance is prohibited from establishing unreasonable or arbitrary barriers for accessing doula services.
- 6.5. Claims for doula services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

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

7. Population Health Management

- 7.1. In addition to recommending providers identifying a member's need for Doula services, the Alliance uses data driven approaches to determine and understand priority populations eligible for Doula services.
 - 7.1.1. The Alliance uses available data sources and the Alliance risk tiering strategy to help identify members who meet the eligibility criteria for Doula services.
 - 7.1.2. Priority populations are selected based on the unique needs of the Alliance membership, identified health disparities, and the DHCS Clinical Quality Strategy priorities.
 - 7.1.3. The Alliance collaborates with community partners and providers to ensure priority populations connect to doula services.
 - 7.1.4. The Alliance may also receive referrals from licensed practitioners for Doula benefits.

8. MCP Oversight

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

- services. Out-of-Network care will be coordinated as ~~is defined~~defined by Alliance policy *UM-002 Coordination of Care*.
- 8.7. The Alliance will monitor utilization of services and requirements and comply with all reporting and oversight requirements stipulated by DHCS.
- 8.7.1. Utilization monitoring will include, at the minimum, an annual review of claims and encounters for Doula services and grievances and appeals related to Doula services.
- 8.7.2. Based on monitoring of Doula services, the Alliance will ensure sufficient provider networks for Doula services.
- 8.7.3. The Alliance is responsible for ensuring Alliance Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.
- 8.7.3.1. These requirements are communicated by the Alliance to all applicable Subcontractors and Network Providers.

DEFINITIONS / ACRONYMS

The Alliance: Alameda Alliance for Health

DHCS: Department of Health Care Services

Licensed Practitioner: For the purposes of the doula benefit, a licensed practitioner includes physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Doula: Birth workers who provide health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth and abortion. Doulas are not licensed or clinical providers, and they do not require supervision.

Formatted: Font: Bold

Doula services: Doula services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period.

Formatted: Font: Bold

Evidence-based: A process whereby decisions are made, and actions or activities are understood using the best evidence available with the goal of removing subjective opinion, unfounded beliefs or bias from decisions and actions. Evidence can include practitioner experience and expertise as well as feedback from other practitioners and beneficiaries.

Formatted: Font: Bold

Full-spectrum doula care: Prenatal and postpartum doula care, presence during labor and delivery and doula support for miscarriage, stillbirth and abortion. Doula care includes physical, emotional and other non-medical care.

Formatted: Font: Bold

Postpartum period: Doulas may provide services for up to 12 months from the end of pregnancy. Beneficiaries are eligible to receive full-scope Medi-Cal coverage for at least 12 months after pregnancy.

Formatted: Font: Bold

MCP: Managed Care Plan

Network: Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom the Alliance enters into a Network Provider Agreement.

OON: Out-of-Network

Recommending Provider: The Licensed Practitioner who recommends a member for Doula services, and ensures the member meets medical necessity for Doula services.

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alliance Population Health Strategy

REVISION HISTORY

New Policy: 12/19/2023
Revised: 6/12/2024, [TBD](#)

REFERENCES

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

MONITORING

This policy will be reviewed annually to ensure effectiveness.



POLICY AND PROCEDURE

Policy Number	PH-001
Policy Name	Population Health Management (PHM) Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D- ~~SNP~~
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

POLICY STATEMENT

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

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

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

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

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

1. Population Health Management Strategy

2. Population Needs Assessment
3. Gathering member information and understanding risk
4. Providing supports and services

4. For Medi-Cal and Group Care lines of business, The Alliance follows the NCQA Health Equity Accreditation standards for reducing disparities through regular stratification and analysis of key performance indicators.

PROCEDURE

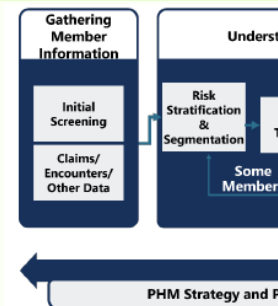
1. The Alliance maintains full NCQA Health Plan Accreditation which includes the PHM standards.
 - 1.1. The Alliance will obtain NCQA Health Equity Accreditation for Medi-Cal by Jan 1, 2026.
2. The Alliance PHM Program includes the following components:
 - 2.1. PHM Strategy and Population Needs Assessment (PNA)
 - 2.1.1. The Alliance develops an annual NCQA population assessment and PHM Strategy.
 - 2.1.2. The PNA requirement is met through meaningful participation in Alameda County's and the City of Berkeley's Community Health Assessment/Community Health Improvement Plan (CHA/CHIP), which are conducted on a three-year cycle. The Alliance submits an annual PNA and PHM Strategy deliverable to DHCS in October. (See *PH-005 Population Assessment*)
 - 2.2. Gathering member information through screenings and assessments
 - 2.2.1. The Alliance conducts necessary screening and assessments to gain timely information on the health and social needs of all members, in accordance with applicable state and federal laws and regulations. The Alliance also follows and NCQA PHM standards for Medi-Cal and Group Care. For implementation and monitoring details, see *QI-124 IHA Policy* and *CM-020 Health Information Form/Member Evaluation Tool (HIF/MET)*.
 - 2.2.2. The Alliance contracts with providers to conduct assessments and integrate the results with care and care management processes.
 - 2.2.3. The following populations are assessed:
 - 2.2.3.1. Those with long-term services and supports (LTSS) needs (See *CM-008 SPD HRA - Survey and Interventions*)
 - 2.2.3.2. Those entering Complex Case Management (CCM) (See *CM-001 CCM Identification Screening Enrollment and Assessment*)
 - 2.2.3.3. Those entering Enhanced Care Management (ECM) (See *CM-011 Enhanced Care Management - Care Management & Transitions of Care*).
 - 2.2.3.4. Children with Special Health Care Needs (CSHCN) (*UM-002 Coordination of Care*)
 - 2.2.3.5. Pregnant individuals (See *UM-025 Guidelines for Obstetrical Services*)
 - 2.2.3.6. Seniors and persons with disabilities who meet the definition of "high risk." (See *CM-008 SPD HRA - Survey and Interventions*)
 - 2.2.3.7. Members who are identified as high risk

Commented [GD1]: Could add #5 here: Use population data to improve services and reduce disparities.

Commented [GD2R1]: @Jew, Jessica @Ayala, Linda

Commented [JJ3R1]: This particular section is referring to the DHCS PHM framework graphic so we wouldn't add that here.

Commented [DG4R1]: Reduction of disparities can be implied from SDOH/equity mention.



Commented [JJ5R1]:

Commented [LA6R1]: I've added NCQA Health Equity Standards to the intro, that might cover this.

Formatted: No bullets or numbering, Tab stops: 0", Left + Not at 1.84"

Commented [LA7]: @Thomson, Michelle @Thorne, G Should we restrict to Medi-Cal and Group care for now? Add this intro? Will this be in PH 001, PH-005 assessment, or a new evaluation P&P?

Commented [NB8]: @Thomson, Michelle Will they be seeking NCQA Accreditation for D-SNP BH by Jan 26? If not, this will need to be revised.

Commented [LA9R8]: @Bell, Nore I specified for Medi-Cal, this is required for DHCS.

Commented [10R8]: Thank you, Linda

Commented [NB11]: @Thomson, Michelle same here on the NCQA part.

Commented [LA12R11]: Clarified.

- 2.2.3.7.1. Prior to the DHCS ~~PHM Service~~ Medi-Cal Connect launch, the Alliance will use their own Risk Stratification and Segmentation (RSS) strategy.
- 2.2.3.7.2. After the statewide RSS and risk tiers are available through the ~~PHM Service~~ Medi-Cal Connect, the Alliance will at minimum assess members who are identified as high-risk ~~through the PHM Service~~.
- 2.2.3.8. In addition, CSHCN and those with LTSS needs receive an annual reassessment.
- 2.2.4. The Alliance or contracted PCP follows up on any positive assessment results.
- 2.3. The Alliance leverages a broad set of data sources to support PHM Program information gathering and inform Risk Stratification and Segmentation (RSS) as described in Understanding risk (See *PH-003 Risk Stratification and Segmentation (RSS) Process*).
- 2.4. The Alliance provides members three types of services and supports:
- 2.4.1. Care management programs including:
- 2.4.1.1. ECM (See *CM-011 Enhanced Care Management*)
- 2.4.1.2. CCM (See *CM-001 CCM Identification Screening Enrollment and Assessment*)
- 2.4.2. Basic Population Health Management (BPHM) (See *PH-002 Basic Population Health Management (BPHM)*) which includes the following services:
- 2.4.2.1. Access to primary care
- 2.4.2.2. Care Coordination, navigation and referrals across health and social services
- 2.4.2.3. ~~sharing and exchange of member information and medical records by providers and MCP~~ Information sharing between providers and the Alliance to facilitate care
- 2.4.2.4. ~~2.4.2.3.~~ 2.4.2.4. Services provided by Community Health Workers (CHWs)
- 2.4.2.5. ~~2.4.2.4.~~ 2.4.2.5. Wellness and prevention programs
- 2.4.2.6. ~~2.4.2.5.~~ 2.4.2.6. Chronic disease programs
- 2.4.2.7. ~~2.4.2.6.~~ 2.4.2.7. Programs focused on improving maternal health outcomes
- 2.4.2.8. ~~2.4.2.7.~~ 2.4.2.8. Case management services for children under EPSDT
- 2.4.3. Transitional Care Services (TCS) (See *CM-034 Transitional Care Services*)
3. The Alliance uses Quality Measures and Key Performance Indicators (KPIs) to assess the overall implementation, operations, and effectiveness of all PHM programs and understand the impact on quality and equity.
- 3.1. Areas that are monitored include, but are not limited to BPHM, ECM, CCM, and TCS.
- 3.2. Quality Measures are reviewed annually based on DHCS guidance.
- 3.3. KPIs are developed based on DHCS guidance and monitored monthly with quarterly submissions to DHCS.
4. ~~The Alliance takes action to reduce health care disparities through the following activities.~~
4. ~~The following NCQA Health Equity Accreditation identified HEDIS measures are stratified by race/ethnicity and reviewed annually to determine if health care disparities exist for each HEDIS measure, stratified by race/ethnicity: Colorectal Cancer Screening (COL).~~

Commented [GD13]: Okay to replace with Medi-Cal Connect?

Commented [LA14R13]: Yes, done **4.

Commented [GD15]: ~~What info~~ info sharing with who? What information?

Commented [JJ16R15]: This list comes from a sentence in the policy guide defining BPHM. It's further explained in the policy guide under "information sharing and referral support infrastructure" as sharing member information and medical records by providers and MCPs

Commented [LA17R15]: I clarified - is this still accurate?

Commented [JJ18R15]: I feel like copy-pasting is generally our approach over paraphrasing: "sharing and exchange of member information and medical records by providers and MCPs"

Commented [LA19R15]: Done

Formatted

Formatted

- Controlling High Blood Pressure (CBP).
- Hemoglobin A1c Control for Patients with Diabetes (HBD).
- Prenatal and Postpartum Care (PPC).
- Child and Adolescent Well Care Visits (WCV).

4.2. At least annually, race/ethnicity, language, gender identity and/or sexual orientation data are reviewed to determine if health care disparities exist among:

4.2.1. Two or more valid measures of clinical performance, by race/ethnicity.

4.2.2. One or more valid measures of clinical performance, such as HEDIS, by preferred language.

4.2.3. One or more measures of clinical performance, such as HEDIS, by gender identity and/or sexual orientation (when data becomes available).

4.2.4. One or more valid measures of individual experience, such as CAHPS, by race/ethnicity or preferred language.

4.3. KPIs are developed based on DHCS guidance and monitored monthly with quarterly submissions to DHCS. The Alliance identifies and prioritizes opportunities to reduce health care inequities and annually selects at least one intervention to address an inequity. This intervention is then evaluated for effectiveness.

4.2.

Commented [GD20]: What if these change? Make broader?

Commented [JJ21R20]: All the NCQA requirements could change every year. I think it used to be more general "meet NCQA standards" but seems like now the approach might be to be more specific?

Commented [LA22R20]: I made this a bit more general.

Commented [JJ23R20]: I thought NCQA Health Equity Accreditation was only Medi-Cal for now?

Formatted

Formatted: Normal, No bullets or numbering

DEFINITIONS / ACRONYMS

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

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

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

CSHCN – Children with Special Health Care Needs

CCM – Complex Case Management

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

DHCS – California Department of Health Care Services

D-SNP – Dual Eligible Special Needs Population

Formatted: Font: Not Bold

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

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

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

KPI – Key Performance Indicators

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

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

MCP – Managed Care Plan

NCQA – National Committee for Quality Assurance

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

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

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

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

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

RSS – Risk Stratification and Segmentation

TCS – Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 9/19/2023

3/19/2024, 4/16/2025, [TBD](#)

REFERENCES

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

PH-001 Population Health Management (PHM) Program

MONITORING

This Policy will be reviewed annually.



POLICY AND PROCEDURE

Policy Number	PH-002
Policy Name	Basic Population Health Management (BPHM)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>2/14/2025</u> <u>TBD</u>
Administrative Oversight Committee Approval Date	<u>TBD</u> <u>4/16/2025</u>

POLICY STATEMENT

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

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

PROCEDURE

1. The Alliance ensures its members receive BPHM services.
 - 1.1. For members who are successfully engaged in primary care, the Alliance requires Primary Care Providers (PCPs) to be responsible for select care coordination and

health education functions. For members who do not engage with a PCP, the Alliance assumes responsibility for provision of BPHM.

- 1.2. For members enrolled in Enhanced Care Management (ECM), the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.
 - 1.3. For members who receive skilled nursing facility or other long term care services, BPHM services are provided by the facility physician or the member's assigned PCP. When additional care coordination is needed, Alliance Long Term Care team provides BPHM services.
2. The Alliance ensures that all members have access to and are utilizing primary care by:
 - 2.1. Identifying members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity, and developing strategies to address utilization patterns.
 - 2.2. Ensuring members have appropriate, ongoing, and timely ~~sources~~ sources of primary care to meet the ~~member's~~ members' needs.
 - 2.3. Ensuring members are engaged with their assigned PCPs. For members who have been assigned a PCP but have not yet engaged with the PCP (e.g., assigned but not seen or lost to follow-up), the Alliance in coordination with PCP partners outreaches to the member.
 - 2.3.1. Sharing outreach reports with delegates and PCPs on assigned members requiring outreach and education on the importance of outreach to engage members in care.
 - 2.3.2. Sharing reports with PCPs on which members are ~~due~~ due for an Initial Health Appointment.
 - 2.3.3. Monitoring HEDIS measures related to preventive health visits and screenings and addressing identified gaps.
 - 2.4. As needed, conducting member outreach to ensure connection with their PCP and BPHM services.
 - 2.5. Assisting members in making appointments, arranging transportation, and providing education on the importance of primary care or have not been seen within the last 12 months, particularly members less than 21 years of age.
 3. The Alliance ensures child and youth members under 21 years of age receive EPSDT (Medi-Cal for Kids & Teens) services through their participation in BPHM, CCM, or ECM.
 - 3.1. Monitor utilization of preventive health visits and developmental screenings, including relevant HEDIS measures.
 - 3.2. Collaborate with community agencies and pediatric providers to address gaps in utilization through education, gap in care reports, and member incentives.
 - 3.3. Contact members through live calls and IVR who have gaps in care with reminders, education and assistance in scheduling needed visits.
 - 3.4. Track use of CHWs and BPHM care coordination efforts to ensure follow up and care coordination needs identified from screenings are delivered.
 - 3.5. Establish MOUs with First 5 programs and providers, WIC providers and every Local Education Agency (LEA) in Alameda County for school-based services to strengthen provision of EPSDT (Medi-Cal for Teens & Kids).

4. Alliance members may receive Care Coordination services and navigation and referrals across health and social services as needed. These services are described in Alliance Policy *UM-002 Coordination of Care*.
5. Alliance members are eligible for CHW services as described in Alliance policy ~~PH-004~~*HCSP-001 Community Health Worker (CHW) Services*.
6. The Alliance offers comprehensive wellness and prevention programs that meet NCQA PHM standards, including the provision of evidence-based self-management tools, and align with the DHCS Comprehensive Quality Strategy's Clinical Focus Areas and Bold Goals. The Alliance offers all members wellness and prevention programs, in collaboration with Local Government Agencies (LGAs) as appropriate. The Alliance:
 - 6.1. Identifies specific, proactive wellness initiatives and programs that address member needs.
 - 6.2. Addresses the NCQA required areas:
 - 6.2.1. Healthy weight maintenance
 - 6.2.2. Smoking and tobacco use cessation
 - 6.2.3. Encouraging physical activity
 - 6.2.4. Healthy eating
 - 6.2.5. Managing stress
 - 6.2.6. Avoiding at-risk drinking
 - 6.2.7. Identifying depressive symptoms
 - 6.3. Offers evidence-based disease management programs that comply with PHM NCQA standards including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, identify members for engagement, and seek to close care gaps for members participating in these programs. the interventions with a focus on improving equity and reducing health disparities. Disease Management Programs are described in the Alliance policy *CM-005 Disease Management Programs*.
 - 6.4. Implements evidence-based initiatives to improve access to preventative health visits, developmental screenings, and services for members less than 21 years of age.
 - 6.5. Implements evidence-based initiatives to improve pregnancy outcomes for women, including through 12 months postpartum.
 - 6.6. Implements evidence-based initiatives to ensure adults have access to preventive care, as described in the DHCS contract and in compliance with all applicable state and federal laws.
 - 6.7. Monitors the provision of wellness and preventive services by PCPs as part of our Site Review process. See Alliance policy *QI-105 Facility Site Review (FSRs)*, *Medical Record Review (MRRs)*, and *Physical Accessibility Review Surveys (PARS)*.
 - 6.8. Develops health education materials, in a manner that meets Members' health education and cultural and linguistic needs. Health Education materials development is described in Alliance policy *HED-002 Health Education Materials*.
 - 6.9. Implements evidence-based initiatives that are aimed at helping Members set and achieve wellness goals.
 - 6.10. Submits wellness and prevention programs to DHCS for review and approval in a form and method prescribed by DHCS.

Commented [GD1]: ~~PH-004~~*HCSP-001* - Added language from PHM Policy Guide.

7. The Alliance continues to meet all requirements for pregnant individuals, including covering the provision of all medically necessary services for pregnant women, administering a comprehensive risk assessment tool comparable to the ACOG and CPSP standards, and providing appropriate follow-ups. Services for pregnant individuals are described in the Alliance Policy *UM-025 Guidelines for Obstetrical Services*.
8. The Alliance ensures members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom the Alliance has or will have an executed MOU.
9. The Alliance provides the following services for members under 21:
 - 9.1. An Initial Health Appointment (IHA) within 120 calendar days of enrollment or within the AAP Bright Futures periodicity timeline for children ages 18 months and younger, whichever is sooner. (See *QI-124 IHA Policy*)
 - 9.2. Preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
 - 9.3. Ensures that all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they ~~could~~can be Medicaid covered services. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
 - 9.4. Coordinates health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services (See *UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)*).
10. All BPHM services promote health equity and align with the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the U.S. Department of Health and Human Services that focus on the delivery of services in a culturally appropriate manner. The Alliance supports CLAS standards through its Cultural and Linguistic Services program (See *CLS-001 Cultural and Linguistic Services Program*).
11. The Alliance ensures non-duplication of BPHM services through documentation of participation in the Alliance Clinical Information System and reports that monitor member participation in BPHM services.
12. The Alliance does not delegate wellness and prevention programs to subcontractors or downstream subcontractors. However, the Alliance works with our delegated entities to ensure provision of wellness and prevention services, including services for members under 21, through:
 - 12.1. Sharing provider resources for wellness and prevention and clinical practice guidelines for preventive services.

- 12.1.1. Listings for Alliance wellness programs and wellness and prevention education handouts, care books and links are accessible on the Provider and Live Healthy pages of the Alliance website, www.alamedaalliance.org.
- 12.1.2. Resources are also shared in periodic provider webinars and at minimum yearly in the Provider Quarterly Packets.
- 12.1.3. Updates to the United State Preventive Services Task Force A and B recommendations and Bright Futures guidelines are updated as available up to quarterly through the Provider Quarterly Packets and on the Alliance website.
- 12.2. Monitoring provision of services through Population Health Management key performance indicators (KPIs) and program participation reports.
 - 12.2.1. The Alliance monitors all DHCS required Population Health Management KPIs monthly.
 - 12.2.2. The Alliance maintains reports of member participation in programs such as prenatal and parenting classes, breastfeeding support, referrals to smoking cessation and other wellness referrals and activities. See *HED-001 Health Education Program* for additional details.
- 12.3. Sharing education and HEDIS performance data with delegated entities.
 - 12.3.1. The Alliance offers provider educational webinars on key HEDIS measures, including those relevant to members 21 and under. Webinars explain required services (such as dental care, developmental and cervical cancer screenings), best practices for successful performance on HEDIS measures, and Alliance wellness and prevention programs and resources.
 - 12.3.2. The Alliance also shares monthly HEDIS measure gap in care reports with all delegated entities.
 - 12.3.3. The Alliance also meets with delegates to share their HEDIS performance and offer quality improvement support to improve performance on HEDIS measures related to population health management and the quality bold goals, including measures relevant to members 21 and under. This information is communicated through articles in the Alliance provider newsletter.

DEFINITIONS / ACRONYMS

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

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

CLAS – Culturally and Linguistically Appropriate Services

DHCS - California Department of Health Care Services

D-SNP – Dual Eligible Special Needs Plan

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

Formatted: Font: Italic

Formatted: Font: Bold

services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

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

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

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

IVR – Interactive Voice Response

KPI – Key Performance Indicator

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

MCP – Managed Care Plan

MOU – Memorandum of Understanding

NCQA – National Committee for Quality Assurance

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

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

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

AFFECTED DEPARTMENTS/PARTIES

Case Management
Member Services
Provider Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

PH-002 Basic Population Health Management (BPHM)

CLS-001 Cultural and Linguistic Services Program
CM-005 Disease Management Programs
CMP-019 Delegation Oversight
[HCSP-001 Community Health Worker \(CHW\) Services](#)
HED-002 Health Education Materials
[PH-004 Community Health Worker \(CHW\) Services](#)
QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical
Accessibility Review Surveys (PARS)
QI-124 Initial Health Appointment
QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for
Teens & Kids) Services
UM-002 Coordination of Care
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis
and Treatment (EPSDT) (Medi-Cal for Teens and Kids)
UM-025 Guidelines for Obstetrical Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy: 9/19/2023
3/19/2024, 4/16/2025, [TBD](#)

REFERENCES

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

MONITORING

This Policy will be reviewed annually.



POLICY AND PROCEDURE

Policy Number	PH-003
Policy Name	Risk Stratification & Segmentation (RSS) Process
Department Name	Health Care Services Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement and Health Equity Committee
Subcommittee Approval Date	<u>8/16/2024TBD</u>
Administrative Oversight Committee Approval Date	<u>9/18/2024TBD</u>

POLICY STATEMENT

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

PH-003 Risk Stratification & Segmentation (RSS) Process

Page 1 of 8

Commented [GD1]: Global change to Medi-Cal Connect?

Commented [LA2R1]: Yes, completed.

Commented [GD3]: @Thomsen, Michelle - do you know if DHCS will include D-SNP in the Medi-Cal Connect RSS? Will they have the same risk tiers?

Commented [GD4R3]: @Ayala, Linda

Commented [MT5R3]: From what I have read it will apply to both.

Commented [DG6R3]: Yes, confirmed in the DSNP policy guide.

the Alliance to assess the needs and characteristics of all members and including at least 3 of the 7 NCQA data sources, and integrate data sources as defined in the 2023 MCP Contract.

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

PROCEDURE

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

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

Commented [GD7]: @Thomsen, Michelle @Ayala, Linda
Alison submitted a request for the DSNP RSS criteria. It is slightly different from the MCAL/IHSS one.

Is this appropriate to note here?

Commented [DG8R7]: Exact criteria for RSS not really explained, but since DSNP may or may not be similar I just added MC and IHSS here. We can further expand later?

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

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

Data Source	Resourced From	RSS Incorporation
Laboratory test results (NCQA PHM 2 Element 3: Laboratory Results)	1. Laboratory test results are collected from AAH's contracted laboratory providers. Data is stored in the AAH databases and utilized by AAH's NCQA certified HEDIS vendor, Cotiviti.	Laboratory test results are included in the calculation of HEDIS outcomes. HEDIS outcomes are evaluated to provide direction in gaps in care and reduction of health disparities/biases. Data to be included in the RSS methodology when the DHCS PHM ServiceMedi-Cal Connect is available.
Social services reports (e.g., CalFresh, WIC, CalWORKs, In Home Services and Supports (IHSS))		Data to be included in the RSS methodology when the DHCS PHM ServiceMedi-Cal Connect is available.
MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Mediations for Opioid Use Disorder), and other SUD; and other non-specialty mental health services information		Data to be included in the RSS methodology when the DHCS PHM ServiceMedi-Cal Connect is available.
Justice-involved data		Data to be included in the RSS methodology when the DHCS PHM ServiceMedi-Cal Connect is available.
Disability status		Data to be included in the RSS methodology when the DHCS PHM ServiceMedi-Cal Connect is available.
For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings		Data to be included in the RSS methodology when the DHCS PHM ServiceMedi-Cal Connect is available.

3. AAH Analytics team runs the RSS algorithm monthly to reflect new information received, including newly enrolled members, and update member risk tiers as necessary.
 - 3.1. AAH also identifies any significant change in health status or member's level of care and occurrence of events or new information that may change a member's needs through internal review activities, provider referrals and member self-referrals including referrals to CCM, ECM, Transitional Care Services (TCS), and Community Supports (CS).
 - 3.2. Any necessary changes in RSS risk tier will be incorporated into the next monthly run.
 - 3.3. The monthly member level risk tier information is stored in the AAH databases for reporting, viewing, and historical purposes.
4. AAH uses risk tiers to:
 - 4.1. Identify members who require assessment. The Alliance assesses members upon enrollment and upon receipt of new information that the Alliance determines as potentially changing a member's level of risk and need.
 - 4.2. Connect all members, including those with rising risk, to an appropriate level of service, including but not limited to, care management programs, basic PHM, wellness and prevention services, and Transitional Care Services (TCS).
 - 4.2.1. Case Management staff use the monthly RSS report to assist in identifying higher risk members.
 - 4.2.2. Key delegates receive monthly RSS reports to assist in identifying higher risk members.
 - 4.2.3. The RSS report assists in identifying high risk members who will receive High Risk TCS.
 - 4.2.4. The RSS report also aids in identifying members for participation in the Alliance Disease Management programs.
 - 4.3. Monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of members who require additional assessments who complete them as well as the connection of members to the programs and services they are eligible for.
5. On a monthly basis, AAH transmits a list of assigned members and their RSS risk tier via Secure File Transfer Protocol (SFTP) to each delegated provider as requested. This file is used to identify the appropriate level of care for the member.
6. The RSS methodology, key performance indicators and outputs will be continually evaluated to determine accuracy and effectiveness of the overall RSS model with the goal of addressing biases, reducing health disparities and improving outcomes.
 - 6.1. Alliance clinical staff participate in the creation and review of the RSS methodology.
 - 6.2. Reports and dashboards are developed to assist with monitoring and reviewing how the RSS methodology is performing overall and identification of any biases that may exacerbate health disparities.
 - 6.2.1. The Alliance maintains a Risk Stratification and Segmentation Dashboard to monitor our RSS methodology and review our member assignment to tiers based on race/ethnicity and language.
 - 6.2.2. The Alliance maintains a HEDIS dashboard that reviews for disparities

based on race/ethnicity, language, gender and age.

6.3. Identified biases will be addressed by adjustment of the methodology as needed. This might include adding additional data sources, in particular data related to social determinants of health, or lowering the weight of identified problematic data sources.

7. After the DHCS [PHM ServiceMedi-Cal Connect](#) RSS and risk tiering functionalities are available, the Alliance will:
 - 7.1. Utilize the [PHM ServiceMedi-Cal Connect](#) RSS outputs and tiers to support statewide standardization and comparisons. The [PHM ServiceMedi-Cal Connect](#) will place each individual into a risk tier (i.e., high, medium-rising, or low).
 - 7.2. Identify and assess member-level risks and needs and, as needed, connect members to services. The risk tiering will set a standard to identify members who require further assessment and connection to appropriate services.
 - 7.3. Inform and enable member screening and assessment activities, including pre-populating screening and assessment tools.
 - 7.4. Support member engagement and education activities.
 - 7.5. Utilize local data sources or real-time data that could supplement identification of additional members for further assessments and services.
 - 7.6. Not manually “override” a risk tier given by the [PHM ServiceMedi-Cal Connect](#) on a member, as these risk tiers will be used to ensure equity and accountability across the state.
 - 7.7. Work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment process.
 - 7.8. Utilize the [PHM ServiceMedi-Cal Connect](#) risk tiers as a starting point for assessment, but not a requirement for or barrier to services.
 - 7.9. Adhere to the data-sharing requirements as defined by the California Health & Human Services Agency Data Exchange Framework.
8. The IHSS line of business will continue to utilize the AAH RSS methodology when the DHCS [PHM ServiceMedi-Cal Connect](#) is implemented for the Medi-Cal population.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
ACG	Adjusted Clinical Groups
CCM	Complex Case Management
CS	Community Supports
DHCS	Department of Health Care Services
D-SNP	Dual Eligible Special Needs Population
ECM	Enhanced Care Management
ED	Emergency Department
HCS	Health Care Services department
IHSS	In Home Support Services line of business

NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PHM	Population Health Management
PHM Service	Medi-Cal Connect Statewide technology service designed to support PHM
	Program functions
RSS	Risk Stratification and Segmentation
RUB	Resource Utilization Band
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
TCS	Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Analytics
Health Care Services

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

PH-001 Population Health Management (PHM) Program

REVISION HISTORY

New Policy 9/19/2023
Updates: **9/18/2024**

Red = substantive updates, [TBD](#)

REFERENCES

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

MONITORING

This policy will be reviewed annually.

PH-003 Risk Stratification & Segmentation (RSS) Process
Page 8 of 8



POLICY AND PROCEDURE

Policy Number	PH-005
Policy Name	Population Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, ~~D-SNP~~
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/44/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/46/2025~~ TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) ~~and Alameda Alliance for Wellness (D-SNP)~~ assesses the needs of its member populations to identify population level health and social needs of the Alliance local communities and members and to identify health disparities.

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

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

and needs, including social drivers of health, of its member population and relevant subpopulations.

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

PROCEDURE

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

- 1.3.1. Aligns with DHCS' Bold Goals (as described in DHCS' Comprehensive Quality Strategy).
- 1.3.2. Supports a relevant LHD project that is currently being implemented or about to ~~be launched~~[launch](#).
- 1.3.3. Has a start date prior to January 2024.
- 1.3.4. Is achievable in 1-2 years.
- 1.4. The Alliance participates in stakeholder engagement.
 - 1.4.1. Attend key CHA/CHIP meetings and/or serve on committees or subcommittees as requested by LHJs.
 - 1.4.2. Engage the Alliance Community Advisory Committee.
 - 1.4.2.1. Regularly report on involvement in and findings from CHAs/CHIPs.
 - 1.4.2.2. Obtain input/advice on how to use findings to influence MCP strategies and workstreams related to Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
 - 1.4.2.3. Over time, work with LHJs to use the CAC as a resource for stakeholder participation in LHJ CHA/CHIPs.
- 2. The Alliance will complete a PHM Strategy Deliverable as required by DHCS [to report on meaningful participation in CHA/CHIPs](#).
- 3. The PNA is shared publicly and with the Alliance Community Advisory Committee, providers, and staff.
 - 3.1. When an LHJ publishes its CHA/CHIP, it will be published on the Alliance website with a brief paragraph on meaningful participation in the process.
 - 3.2. PNA findings are shared with providers, fully delegated subcontractors, downstream fully delegated subcontractors, through presentations at the Quality Improvement Health Equity Committee meeting and provider communications distributed through quarterly provider visits and posted on the Alliance website.
 - 3.3. PNA findings and action plans are shared via presentations at internal subcommittees and meetings with relevant Alliance departments for use in planning and guiding culturally and linguistically relevant programs and member communication.
- 4. Based on participation in the CHA/CHIP processes, the Alliance annually reviews and updates the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:
 - 4.1. Targeted health education materials for members
 - 4.2. Member-facing outreach materials for any identified gaps in services and resources, including but not limited to, Non-Specialty Mental Health Services

- 4.3. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs
- 4.4. Wellness and prevention programs

5. The Alliance develops an annual NCQA population assessment and uses the findings from both the population assessment and the PNA to develop the Alliance NCQA Population Health Management Strategy.

~~The NCQA Population Health Management Strategy includes the analysis of at least one valid measures of clinical performance, such as HEDIS, or other clinical performance measure by preferred language~~

~~The measure is stratified using individual level data or through the Alliance information systems to identify individuals captured in the measure numerator and denominator.~~

~~The measure is stratified by the individual's self-identified preferred language~~

4.5. The NCQA Population Health Management Strategy includes the analysis of at least on valid measure of individual experience, such as CHAPS, by race/ethnicity or preferred language

4.6.5.1. The NCQA population assessment assesses the characteristics and needs including social drivers of health, of its member population, NCQA-required subpopulations, and special populations.

4.7.5.2. The NCQA population assessment collects race and ethnicity data using multiple sources such as enrollment and eligibility data and data collected during the health risk assessment (HRA). If the Alliance doesn't collect data on at least 80% of the population, data is estimated by indirect methods and validated. This data is used to assess and evaluates characteristics such as:

4.7.1.5.2.1. Member demographics such as age, gender, racial and ethnic characteristics

4.7.2.5.2.2. Cultural data such as primary language

4.7.3.5.2.3. Health status, behaviors, and utilization trends

4.7.4.5.2.4. Health disparities

4.7.5.5.2.5. Social determinants (drivers) of health (SDOH)

4.7.6.5.2.6. Member experience

4.7.7.5.2.7. Gaps in services

4.8.5.3. The Alliance uses reliable data sources to identify member health needs and health disparities. Data sources may include Alliance data, including data from subcontractors and downstream subcontractors such as:

4.8.1.5.3.1. Member demographic data

4.8.2.5.3.2. The most recently available member CAHPS survey results

4.8.3.5.3.3. HEDIS results

4.8.4.5.3.4. Medical and behavioral claims or encounters

- 4.8.5.5.3.5. Pharmacy claims
- 4.8.6.5.3.6. Laboratory results when available
- 4.8.7.5.3.7. Alliance program enrollment and participation data
- 4.8.8.5.3.8. Risk data
- 5.3.9. Advanced data sources as available

5.4. The Alliance electronic data system receives, stores, and retrieves individual level data on race, ethnicity, language, and gender identity and sexual orientation when available.

- 5.4.1. ~~The Alliance reports this~~ The race/ethnicity data is rolled up into the data to the Office of Management and Budget (OMB) categories. ~~;~~
- The Alliance reports the HedisEDIS race, ethnicity, and diversity of membership measure if applicable.

4.8.9.5.4.2.

- ~~The NCQA population assessment includes the analysis of at least one valid measure of clinical performance, such as HEDIS, or other clinical performance measure by preferred language~~
- ~~The measure is stratified using individual level data or through the Alliance information systems to identify individuals captured in the measure numerator and denominator.~~
- ~~The measure is stratified by the individual's self-identified preferred language~~
- ~~The NCQA population assessment includes the analysis of at least one valid measure of individual experience, such as CAHPS, by race/ethnicity or preferred language~~

Formatted: Indent: Left: 0.85", No bullets or numbering

Formatted

Formatted

DEFINITIONS/ACRONYMS

CAC – Community Advisory Committee

CAHPS – Consumer Assessment of Healthcare Providers and Systems is a survey asking health plan consumers about their health care experience. The tool is a product of the Agency for Healthcare Research and Quality.

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

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

DHCS – Department of Health Care Services

ECM – Enhanced Care Management

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

LHJ – Local Health Jurisdiction

MCP – Managed Care Plan

NCQA – National Committee for Quality Assurance

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

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

PNA – Population Needs Assessment means a multi-year process during which a Contractor will identify and respond to the needs of its Members and the communities it serves by meaningfully participating in the community health assessment (CHA) of Local Health Departments (LHDs) in the service area(s) where Contractor operates. The findings of the PNA/CHA collaboration will inform the Contractor’s annual PHM Strategy.

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

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Community Stakeholders
Provider Network

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

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

REFERENCES

DHCS All Plan Letter 23-021 Population Needs Assessment ~~an~~ [and](#) Population Health Management Strategy

DHCS CalAIM: Population Health Management (PHM) Policy Guide

DHCS 2024 Contract

[42 CFR sections 438.206\(c\)\(2\), 438.330\(b\)\(4\), and 438.242\(b\)\(2\)](#)

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

Formatted: Font: 12 pt

MONITORING

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



POLICY AND PROCEDURE

Policy Number	G&A-D-001
Policy Name	Integrated Grievances
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	D-SNP
Effective Date	01/01/2026
Committee Name	QIHEC
Committee Approval Date	
Compliance Committee Approval Date	

POLICY STATEMENT

Alameda Alliance for Health (“the Alliance”) will maintain meaningful procedures for the timely resolution of grievances between enrollees and the Alliance or any of its delegated entities. The Alliance will provide all enrollees with written grievance procedures upon initial enrollment, involuntary disenrollment, annually, and upon request. The Alliance will notify enrollees about any changes to its grievance procedures 30 days in advance of the effective date of the change. The Alliance will notify providers and subcontractors at the time they enter into contract of its Integrated Appeals and Grievance System including, at minimum, information on Integrated Appeals, Integrated Grievances, State Hearings, and Independent Medical review (IMR) Procedures and timeframes, as applicable.

The grievance process is only available to enrollees, their representatives, or their providers on their behalf. Decisions made under the grievance process are not subject to appeal.

PROCEDURE

1. The Alliance maintains records of all Integrated Appeals and Integrated Appeals and are available upon request to CMS.
2. Integrated Appeals and Grievances procedures apply to all benefits under D-SNP including optional supplemental benefits. For benefits that are carved out the Alliance will provide Members reasonable assistance completing forms and taking other procedural steps to assist Members with appeals and grievances.
3. Procedures for Handling a Grievance are as follows:

- a. Enrollees can file Grievances at any time in writing or verbally.
- b. The Alliance must:
 - i. Complete the investigation as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days of receipt of the request, or within 24 hours for expedited grievances.
 - ii. Provide reasonable opportunity, in person and in writing, to present any information or evidence and testimony and make legal and factual arguments concerning the grievance.
 - iii. Provide reasonable assistance in completing forms and taking other procedural steps related to grievances.
 - iv. Take prompt, appropriate action, including a full investigation if necessary.
 - v. Provide a response to all grievances raised in the written request.
 - vi. Have procedures for tracking and maintaining records about the receipt and disposition of grievances.
 - vii. Be able to log or capture enrollees' grievances in a centralized location that is readily accessible. The record of each grievance will contain, at a minimum:
 - 1. A general description of the reason for the grievance.
 - 2. Documentation of all telephone calls, correspondence, and case notes related to the grievance.
 - 3. The date of receipt.
 - 4. The date of each review or, if applicable, review meeting.
 - 5. Resolution at each level of the grievance, if applicable.
 - 6. Date of resolution at each level, if applicable.
 - 7. Name of the enrollee for whom the integrated integrated grievance was filed.
 - 8. Date the enrollee was notified of the resolution.
 - viii. Ensure that individuals making decisions on grievances must take into account all comments, documents, records, and other information submitted but the enrollee or their representative without regard to whether such information was submitted or considered in the initial determination. Individuals making decisions on integrated grievances must be individuals who:
 - 1. Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and
 - ix. If deciding any of the following, have the appropriate clinical expertise in treating the enrollee's condition or disease:
 - 1. A grievance regarding denial of expedited resolution of an appeal.
 - 2. A grievance that involves clinical issues.
 - x. Expedite the grievance if:
 - 1. It is related to a decision not to grant an enrollee's request to expedite an initial determination or appeal, and (for Part D Only) the enrollee has not yet obtained the drug, or
 - 2. Part C Only: it involves an MA Plan's decision to extend a timeframe related to an organization determination or appeal.

- xi. Verbal grievances are processed the same as in writing; however, if a verbal grievance can be resolved during the same call by the customer service representative, the plan will document details of the resolution and proceed to log and report the call as a grievance.

		○

c. Received Requirements for Grievances

- i. The Alliance accepts grievances 24 hours a day, 7 days a week (including holidays) via various channels. Grievances are deemed “received” on the date and time:
- The Alliance initially stamps a document received by regular mail (i.e., U.S. Postal Service);
 - A delivery service that has the ability to track when a shipment is delivered (e.g., US Postal Service, UPS, FedEx, or DHL) delivers the document to the Alliance;
 - A faxed document is successfully transmitted to the Alliance, as indicated on the fax transmission report;
 - A verbal request is made by telephone with a customer service representative and/or any enrollee facing departments in the Alliance;
 - A message is left on the Alliance’s voicemail system after normal business hours; or
 - A request is received through the Alliance’s website / member portal.
- ii. For standard grievances, the processing timeframe begins when the Alliance, any department in the Alliance, or a delegated entity receives a grievance.
- iii. For expedited grievances, the processing timeframe begins when the Grievance and Appeals department receives the grievance.
- iv. The Alliance Grievance and Appeals material will clearly state where grievances should be sent to ensure that the complaint is received at the correct location and provides the Alliance the greatest amount of time to process the grievance.

d. Notification Requirements for Grievances

- i. For standard grievances the Alliance will send a written acknowledgement of the grievance that is dated and postmarked within five (5) calendar days of receipt.
- ii. For expedited grievances the Alliance will send written combination acknowledgment and resolution notification within three (3) calendar days of verbal notification.
- iii. For grievances made in **writing**, the response must:
- Be in writing,
 - Address all issues raised in the grievance; and
 - Be written in a manner that is understandable to the enrollee.

- iv. For grievances received **verbally**, the response may be verbal or in writing, unless specifically requested in writing or the grievance is related to quality of care, coverage disputes, or disputed health care service involving medical necessity or experimental or investigational treatment; or the grievance is not resolved by the next business day, regardless of the type of grievance or how it is filed.
- v. For **Standard** grievances, notification must be delivered no later than 30 days from receipt.
- vi. For **Expedited** grievances, notification must be delivered no later than 24 hours from receipt. The Alliance will provide a verbal notification of the resolution and deliver written confirmation of the resolution within 3 calendar days of the verbal notification.
- vii. If the grievance is submitted by the enrollee's representative, the Alliance will provide notice to both the representative and enrollee.

4. Quality of Care Grievances

Quality of care grievances may be received and acted upon by the Alliance, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), or both. For any grievance submitted to the BFCC-QIO, the Alliance will cooperate with the BFCC-QIO in resolving the grievance, including directing providers to respond to BFCC-QIO requests for information, within 14 days. The Alliance will provide any records and requested information as quickly as possible and within 14 days.

- a. Procedures for Handling a Quality-of-Care Grievance
 - i. Quality-of-care grievances submitted to the Alliance may be made verbally or in writing and can be submitted at any time.
 - ii. The Alliance will investigate and respond to the quality-of-care grievance in writing within 30 days of receipt, or as expeditiously as the enrollee's health condition requires.
 - iii. The written notice will:
 - Include a description of the enrollee's right to file a written complaint with the BFCC-QIO and contact information for the BFCC-QIO; and
 - Be written in a manner that is understandable to the enrollee.
 - iv. If the grievance is submitted by the enrollee's representative, the Alliance will provide notice to both the representative and enrollee.
 - v. For quality-of-care grievances submitted to the BFCC-QIO, the Alliance will cooperate with the BFCC-QIO and comply with requirements at 42 CFR Part 476 regarding timely submission of requested information to the BFCC-QIO if an enrollee files a grievance with the BFCC-QIO and the Alliance.

5. Procedures for Handling Withdrawn Grievances

- a. An enrollee may submit a written withdrawal request for a grievance any time before the resolution is mailed by the Alliance.
- b. The Alliance will accept verbal withdrawals for both written and verbal grievances received from an enrollee.
- c. The Alliance will clearly document in the system that the enrollee does not want to proceed with the grievance procedures.

- d. The Alliance will send a written confirmation of the withdrawal to the enrollee within 3 calendar days of receiving the withdrawal request.
- e. If the enrollee submits a quality-of-care grievance verbally or in writing, but later decides to withdraw the grievance, the Alliance will still investigate the quality-of-care grievance; however, the Alliance will not notify the enrollee of the outcome of the grievance since the enrollee decided not to pursue the grievance.

DEFINITIONS / ACRONYMS

- **Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO):** Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.
- **Dismissal:** Dismissal includes a decision not to review a request for an integrated grievance, or integrated appeal because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination.
- **Grievance:** Means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of D-SNP Contractor's or providers' operations, activities, or behavior, regardless of whether remedial action is requested.
- **Integrated Grievance:** A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a "Grievance," the statements and guidance apply equally to integrated grievances for applicable integrated plans.
- **Enrollee:** An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan.
- **Quality of Care Grievance:** A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.
- **Representative:** Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 defines "representative" as an individual either

appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, unless otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

- **Withdrawal:** A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Member Services Department
- Compliance Department
- Departments that have direct contact with enrollees

RELATED POLICIES AND PROCEDURES

- G&A-008 State Fair Hearing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- SOP – Representatives (G&A)
- SOP – Plan Communication to an Enrollee
- SOP – Classification between Grievances, Inquiries, Coverage Requests, and Appeals
- SOP – Handling of Integrated Grievances
- SOP – Handling of Quality-of-Care Grievances
- SOP – Handling Withdrawn Grievances
- SOP – QA Process

REVISION HISTORY

REFERENCES

- 42 CFR §422.629-634, 438.210, 438.400, and 438.402
- CY2025-EAE-SMAC
- Health and Safety Code (H&S) Section 1368(A)(4)(a)
- 28 California Code of Regulations (CCR) section 1300.68(d)(1)
- 42 CFR section 422.562(a)(5)
- Addendum to the Parts C&D Enrollee Grievances, Organizations/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans

MONITORING

1. Internal Reporting

The Alliance maintains a process for evaluating complaints, assessing trends, implementing actions to correct identified problems, having mechanisms to communicate actions and results to the appropriate employees and contracted providers, and having provisions for evaluation of any corrective action plan and measurements of performance.

Grievance and Appeals are reported to the following bodies:

- Monthly Board of Governors
- Quarterly Member Advisory Committee (Public Policy Body)
- Quarterly Health Care Quality Committee
- Quarterly Internal Quality Improvement Committee
- Quarterly Access and Availability Committee
- Quarterly Utilization Management Committee
- Quarterly Cultural and Linguistic Committee

2. Internal Auditing

Auditing is conducted on a quarterly basis by the Compliance Department:

- a. An universe is requested the month after the end of the quarter;
- b. Compliance conducts a 30 file review audit;
- c. Audit Findings are sent to the Manager of Grievance and Appeals for response if required;
- d. Responses on the findings are sent to Compliance 30 days after the request;
- e. The audit findings are also reported during the quarterly Compliance Committee.

3. Regulatory Reporting

The grievance system tracks and monitors all grievances received by the Alliance, and our Delegated Entities with authority to receive and respond to grievances.

Monitoring is done on all grievances received and resolved, and the number of grievances pending over 30 calendar days.

Grievances are indicated by the total number of grievances received, pending and resolved at all levels of grievance review and to describe the issue or issues raised in grievances as:

- Coverage disputes;
- Disputes involving medical necessity,
- Complaints about the quality of care and,
- Complaints about access to care (including complaints about the waiting time for appointments), and
- Complaints about the quality of service, and
- Other issues.

4. Reference SOP – QA Process for monitoring and oversight of the integrated grievance process.5. The policy and procedure will be reviewed annually.



POLICY AND PROCEDURE

Policy Number	G&A-D-002
Policy Name	Integrated Reconsiderations and Redeterminations (Level 1 Appeals)
Department Name	Grievance and Appeals
Department Officer	Chief Medical Officer
Policy Owner	Director, Quality Assurance
Line(s) of Business	D-SNP
Effective Date	01/01/2026
Committee Name	QIHEC
Committee Approval Date	
Compliance Committee Approval Date	

POLICY STATEMENT

A party (as described below) to an adverse initial determination has the right to a reconsideration (Part C) or redetermination (Part D) by the Alliance or delegate of the Alliance. A reconsideration or redetermination consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the Alliance. A party also has the right to, Independent Medical Review, State Fair Hearing, State Administrative Action and State Court for Medicaid benefits. For Medicare benefits a party has a right to review by the Independent Medical Entity, Administrative Law Judge, Medicare Appeals Council, and Federal Court.

PROCEDURE

- 1. Who May Request a Level 1 Appeal**
 - a. Part C

Type of Request	Who May Request An Appeal
Standard or Expedited Reconsideration for a service, item, Part B drug or Medicaid drug (including previously approved services, items, Part B drugs or Medicaid drugs)	• An enrollee (42 CFR § 422.629(l)(1)(i)); • An enrollee's representative (42 CFR § 422.629(l)(1)(ii)); • A provider who is providing treatment to the enrollee may, upon providing notice to the enrollee, request a standard or expedited pre-service integrated reconsideration on behalf of an enrollee.* (42 CFR § 422.629(l)(3)) • Note: If the provider requests that the enrollee continue to receive the previously approved service, item, Part B drug or Medicaid drug while the appeal is pending,
Standard or Expedited Payment Reconsideration	• An enrollee (42 CFR § 422.629(l)(1)(i)); • An enrollee's representative (42 CFR § 422.629(l)(1)(ii)); • The legal representative of a deceased enrollee's estate (42 CFR § 422.629(l)(1)(ii)); or • Non-contract provider (i.e. an assignee of the enrollee, that is, a physician or other provider who has furnished or intends to furnish a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service. See Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 50.1.1 for more detail on waiving the right to payment). A provider may file a standard integrated reconsideration on behalf of the enrollee but may not file an expedited integrated reconsideration related to a payment request on behalf of the enrollee (42 CFR § 422.629(l) and 422.633(e)(1)(ii)); • Any other provider or entity (other than the Alliance) determined to have an appealable interest in the proceeding (42 CFR § 422.629(l)(4)(ii)).

*If the enrollee's records indicate that he or she has not previously visited the requesting physician, the Alliance will undertake reasonable efforts to confirm that the enrollee has received appropriate notification of the appeal.

- b. If an individual is acting as a representative of the enrollee, the OMB-approved Form CMS-1696, Appointment of Representative (AOR), or another form that meets state and Medicare requirements, is acceptable. As noted in Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 20.2.a, for a case involving only a Medicaid-covered benefit, the Alliance may accept a written authorization from an enrollee that complies with state Medicaid requirements.
- c. If the provider requests that the benefits continue while the integrated appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the

provider must obtain the written consent of the enrollee to request the integrated appeal on behalf of the enrollee.

- i. If the provider does not provide the enrollee's written consent to continue benefits at the time that the request is made but the appeal is otherwise valid, the Alliance will begin processing the appeal.
- ii. The consent must state that the enrollee has given the provider permission to request that the service, item, Part B drug or Medicaid drug continue while the appeal is pending. However, the Alliance will not provide continuation of benefits unless it receives the enrollee's written consent (delivered either via the provider or directly from the enrollee or their authorized representative requesting continuation of benefits).
- iii. Such a request must be received within 10 calendar days after the Alliance sends the notice of the integrated reconsideration⁴² CFR § 422.632(c)

d. Part D

Type of Request	Who May Request An Appeal
Standard or Expedited Redetermination	• An enrollee; • An enrollee's representative; • An enrollee's prescribing physician or other prescriber* acting on behalf of the enrollee**; • Staff of a physician's office acting on a physician's behalf (e.g., request is on the office's letterhead)
Standard Payment Redetermination	• For direct member reimbursement, only an enrollee or an enrollee's representative (which may be the prescribing physician or other prescriber) may appeal an adverse reimbursement decision under Part D.

* Pursuant to § 423.560, "other prescriber" means a health care professional other than a physician who is authorized under State law or other applicable law to write prescriptions. It is the Part D plan sponsor's responsibility to identify the types of health care professionals that have prescribing authority in the states in which the Part D plan sponsor operates.

**If the enrollee's records indicate that he or she has not previously visited the requesting physician or prescriber, the Alliance sponsor should undertake reasonable efforts to confirm that the enrollee has received appropriate notification of the appeal.

2. Requirements for Provider Claim Appeals (Part C only)

- a. A non-contracted provider, on their own behalf, may request a reconsideration for a denied claim only if the non-contracted provider completes a Waiver of Liability (WOL) statement, which provides that the non-contracted provider will not bill the enrollee regardless of the outcome of the appeal.
- b. The WOL must be filed with the appeal, and the appeal will need to include other supporting documentation (e.g., copy of remittance advice / notice and clinical records). Non-contracted providers who have executed a WOL are not required to complete the representative form because the provider is not representing the enrollee; therefore, does not need a written representative form. The appeal correspondence regarding the non-contracted provider's appeal will be delivered to the non-contracted provider and not the enrollee. If the WOL isn't filed with the appeal, the Alliance will make a reasonable effort to obtain the WOL. The Alliance will not review the appeal until the WOL is obtained. The appeal will be processed when the WOL is received by the Alliance. If the

Alliance does not receive the WOL by the end of the processing timeframe the Alliance will issue a dismissal notice.

- c. Non-contracted providers that request organization determinations for services furnished to an enrollee, may submit a reconsideration for those services and will be reviewed in accordance with the administrative appeal process.
- d. Non-contracted providers who are the enrollee's assignee, and who has submitted the WOL, will be afforded full administrative appeals rights for the following examples:
 - i. Diagnosis code / DRG payment denials
 - ii. Downcoding
 - iii. Bundling issues and disputed rate of payment
 - iv. Level of care or rate of payment denials
- e. If the Alliance partially pays for coverage, a non-contracted provider is a party to the organization determination may request reconsideration under the Medicare administrative appeals process; a non-contracted provider does not need to receive zero payment to request a reconsideration or to otherwise access the appeals process.

3. Level 1 Appeals Requests

- a. Guidelines for Accepting Level 1 Appeal Requests

A party may request a level 1 appeal by filing a written request with the Alliance. The Alliance will accept verbal requests for expedited appeals and may accept verbal requests for standard appeals.

Method for Filing Request	Standard	Expedited
Written	Must Accept	Must Accept
Verbal	Must Accept	Must Accept Note: If a verbal request to expedite a level 1 appeal is denied by the Alliance, the Alliance cannot require the party to re-file the request in writing. Instead, the Alliance must automatically transfer the request to the standard process.

Verbal requests are summarized and repeated back to the caller. Acknowledgement letters are sent to the enrollee to confirm the facts and basis of the appeal and that the reconsideration request is properly and accurately noted and addressed by the Alliance. The notice advises the enrollee to immediately contact the Alliance if the acknowledgement letter does not correctly capture the enrollee's request.

The Alliance will accept web/internet-based requests and protect individual health information received via web/internet for Part C and Part D.

For both standard and expedited level 1 appeal requests, the following guidelines apply:

- Must be filed within 60 calendar days from the date of the notice of the initial determination. For requests received after 60-day filing timeframe, the appeal may be subject to a good cause exception.
- Request should include: Name of the enrollee, information identifying which denial is being appealed, and contact information for the appellant. Unless the request is from a representative, for which proof of appointment is required, the Alliance will not require additional information in a request.
- The appellant is not required to use any specific language to indicate they are requesting an appeal (e.g., “I am requesting an appeal”). The appellant may say, for example, “I do not agree with your decision” or “Please review this decision”. Requests for appeals should not be classified as requests for a reopening.
- For verbal requests, the Alliance will repeat the summarized verbal request back to the caller and/or send an acknowledgement letter to enrollee to confirm the facts and basis of the appeal to ensure the request is properly and accurately noted and addressed by the Alliance. Notice should advise the enrollee to immediately contact the Alliance if the acknowledgement letter does not correctly capture the enrollee’s request.
- For standard requests, the processing timeframe begins when the Alliance, any department in the Alliance, or a delegated entity (including those not responsible for processing the request) receives a request. If an appeal request is received in the incorrect department, the Alliance will have policies for prompt transfer of the call or document(s) to the Grievance and Appeals department to process the appeal.
- For expedited requests, the processing timeframe begins when the Grievance and Appeals Department receives the request.

b. How to Process Requests for Expedited Level 1 Appeals

Who May Request an Expedited Level 1 Appeal	Alliance Requirements
• An enrollee • An enrollee’s representative • Part C – A physician (regardless of whether affiliated with the Alliance) • Part D – Prescribing physician or other prescriber acting on behalf of the enrollee	• Establish an efficient and convenient means for individuals to submit verbal or written requests; • Establish procedures for accepting and processing verbal and written requests for an expedited decision; • Develop a process for receiving the request, including designating an office and/or department to receive both verbal or written requests and a telephone and fax number to facilitate receipt of the requests; • Document all verbal requests in writing and maintain in the case file; • Decide whether to expedite the request: ○ If a physician (Part C)/prescribing physician or other prescriber (Part D) makes a request or supports an enrollee’s request for an expedited appeal and indicates that applying the standard timeframe could seriously jeopardize the

	life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words), the Alliance must process as expedited.

Requests for an expedited level 1 appeal must be received within 65* days of the date of the notice unless there is good cause (see Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance §50.3).

Part C Only: If an enrollee misses the deadline to file for immediate Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) review of an inpatient hospital discharge or SNF, HHA, or CORF termination decision, then the enrollee may request an expedited reconsideration with the Alliance. When the Grievances and Appeals Department (G&A) identifies a misdirected requests that should go to the BFCC-QIO (see §422.622(b) and 422.626(a)(1)) G&A will contact the member and inform them of the BFCC-QIO contact information.

The Alliance will automatically expedite all valid requests for reconsideration of inpatient hospital discharges and SNF, HHA, or CORF termination decisions. The request will be processed under rules at §422.590(d) and guidance described below.

If a request for review of an inpatient hospital discharge or SNF, HHA, or CORF termination decision received by the Alliance is within the BFCC-QIO filing timeframe, the Alliance will inform the enrollee they must contact the BFCC-QIO to request reconsideration.

Part D Only: The Alliance may choose to expedite a redetermination request from an enrollee without requiring the enrollee's prescribing physician or other prescriber to submit a new statement indicating that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. However, if the Alliance chooses to do so, it should, at a minimum, ensure the enrollee has not obtained the drug in dispute.

Action Following Acceptance of a Request for Expedited Level 1 Appeal

The Alliance will adhere to the following:

Part C

Reconsideration Decision	Processing Requirements for Expedited Reconsiderations
Favorable	• Ensure the person or persons conducting the reconsideration were not involved in the organization determination.* • As expeditiously as the enrollee's health condition requires, but no later than: ○ 72 hours after the request, the Alliance will: ▪ Make the decision; and

	▪ Give notice to the enrollee (and the physician involved, as appropriate); and ▪ Authorize or provide the service. • Notification must be provided within the 72-hour timeframe. • The Alliance will notify the enrollee verbally or in writing. If the Alliance initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 2 calendar days of the verbal notification. • Verbal or written notification of the decision must explain conditions of the approval including (but not limited to): ○ The duration of the approval; and ○ Limitations associated with the approval. • If the enrollee agrees, the Alliance will send the notice by fax or e-mail.
Partially Favorable or Adverse	▪ Ensure the person or persons conducting the reconsideration were not involved in the organization determination.* ▪ As expeditiously as the enrollee's health condition requires, but no later than 72 hours after the request, the Alliance will: ○ Make the decision; and ○ Forward the case file to the Independent Review Entity (IRE) within 24 hours of its affirmation for Level II Appeal process. (see Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance §50.12 for guidance on forwarding case files to the IRE).

*Where the issue is the denial of coverage based on a lack of medical necessity the integrated reconsideration must be made by a physician or other appropriate health care professional with expertise in the enrollee's condition or disease and knowledge of Medicare and Medicaid coverage criteria, before the applicable integrated plan issues the integrated reconsideration determination. (As in the Part C & D Guidance, the physician need not be of the same specialty or subspecialty as a treating physician.)

If the Alliance needs information from a non-contract provider, the Alliance will request the necessary information from the non-contract provider within 24 hours of the initial request for an expedited reconsideration. Regardless of whether the Alliance needs information from non-contract providers, the Alliance is responsible for meeting the timeframe and notice requirements for expedited reconsiderations.

The Alliance will have sufficient and appropriate contract terms to get information and records from contract providers as necessary for expedited (and standard) reconsiderations.

Part D

Level 1 Appeal Decision	Processing Requirements for Expedited Redeterminations
All Decisions (Favorable or Adverse, including requests that involve an exception)	▪ Ensure the person or persons conducting the redetermination were not involved in the coverage determination.*

	▪ The Alliance will make the decision and deliver written notice. to the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of its decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the redetermination request (the Alliance will not extend the timeframe by dispensing a temporary supply of the medication). ▪ If the Alliance initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 2 calendar days of the verbal notification. ▪ If the Alliance fails to provide the enrollee or prescribing physician or other prescriber, as appropriate, with the decision for the expedited redetermination within the timeframes described above, they must forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe (see Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance).

*When the issue is a denial of coverage based on a lack of medical necessity, the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician need not be of the same specialty or subspecialty as the treating physician.

If the Alliance needs medical information, the Alliance will request the necessary information within 24 hours of the initial request for an expedited level 1 appeal. Regardless of whether the Alliance needs information, the Alliance is responsible for meeting the timeframe and notice requirements for expedited level 1 appeals.

Action Following Denial of a Request for an Expedited Level 1 Appeal

Following denial of a request for an expedited level 1 appeal, the Alliance will:

- Transfer the request to the standard level 1 appeal process (the timeframe begins the day the the Alliance receives the request for expedited reconsideration);
- Give the enrollee prompt verbal notice of the denial including the enrollee's rights; and
- Deliver a written notice of the enrollee's rights within 2 calendar days of the verbal notice of the denial to expedite the request.

Notice of the denial of a request for an expedited level 1 appeal will:

- Explain that the Alliance will automatically transfer and process the request using the required timeframe for standard requests;
- Inform the enrollee of the right to file an expedited grievance if he or she disagrees with the Alliance's decision not to expedite the level 1 appeal (the Alliance will use the Notice of Right to an Expedited Grievance for Part C and Notice of Right to an Expedited Grievance for Part D to notify enrollees about their expedited grievance rights.).
- Inform the enrollee of the right to resubmit a request for an expedited level 1 appeal with a physician, prescribing physician, or other prescriber's support, including that if

the enrollee gets the physician/prescriber support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically; and

- Provide instructions about the expedited grievance process and its timeframes.

Change of Review Priority

After a request is initiated as a standard or expedited review, a provider may contact the Alliance to change the review priority (standard or expedited).

If the provider indicates that the enrollee's health requires an expedited decision, the Alliance will begin the applicable expedited review period at the time they receive the physician's request to expedite the decision.

c. Good Cause Exception for Late Filing

The Alliance may accept a request for a standard or expedited level 1 appeal after the 65-day* timeframe if a filing party shows good cause. A request to file a level 1 appeal after the timeframe must be in writing and state why the request for a level 1 appeal was not filed on time.

If an untimely appeal request does not include an explanation as to why the request wasn't filed timely, the Alliance may make an attempt to obtain information supporting good cause for the late filing. The Alliance will consider the circumstance that kept the party from making the request on time and whether any organizational actions might have misled the party. The Alliance policies governing good cause justification when the request for a level 1 appeal is outside the 65-day* timeframe should not be discriminatory and should provide for equal and fair treatment of enrollees.

Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

- The party did not receive the notice for the adverse initial determination, or they received it late;
- The party was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the party's immediate family;
- An accident (e.g., a natural or man-made disaster) caused important records to be destroyed;
- Documentation was difficult to locate within the time limits;
- The party had incorrect or incomplete information concerning the level 1 appeal process;
- The party lacked capacity to understand the timeframe for filing a level 1 appeal; or
- The party sent the request to an incorrect address, in good faith, within the time limit and the request did not reach the Alliance until after the time period had expired.
- The delay is a result of the additional time required to produce enrollee documents in an accessible format (for example, large print or Braille). The delay is the result of an individual having sought and received help from an auxiliary resource (such as a State

Health Insurance Assistance Program (SHIP) or senior center), on account of his or her disability, in order to be able to file the appeal.

If the Alliance obtains information establishing good cause, the adjudication timeframe (i.e., the timeframe in which the Alliance must make its decision on the level 1 appeal) begins on the date the Alliance receives that information.

If the Alliance denies a party's request for a good cause extension for late filing, the request for reconsideration is dismissed.

4. Withdrawal of a Level 1 Appeal Request

A level 1 appeal may be withdrawn at any time before the decision is issued by filing a request with the Alliance. The request to withdraw must be filed by the party who requested the level 1 appeal. If a request to withdraw is filed with the Alliance, the Alliance will dismiss the level 1 appeal request. The request to withdraw may be written or verbal. For verbal withdrawal requests, the Alliance will clearly document in our system the date and the reason why the party chose not to proceed with the appeal. A notice of dismissal will be issued to all parties to the appeal and will include:

- The reason for the dismissal.
- The right to request that the Alliance vacate the dismissal action.
- The rights to request review of the dismissal by the independent entity.

Part C Only: If the withdrawal request from the party that requested a reconsideration is received after the Alliance has forwarded the case file to the IRE, the Alliance will forward the withdrawal request to the IRE for processing.

5. Actions the Appealing Party Can Take During a Level 1 Appeal

a. Opportunity to Submit Evidence

The Alliance will provide the parties to the appeal a reasonable opportunity to present evidence related to the appeal, in person or in writing (e.g. by telephone, fax, or hand-delivered to the Alliance's physical location). A party is not required to submit additional evidence, but each party may exercise this right if they choose. The Alliance will take all of the evidence into account when making the decision.

In the case of an expedited level 1 appeal, the opportunity to present evidence is limited by the short timeframe for making a decision, therefore, the Alliance will inform the parties of the conditions for submitting the evidence.

b. Enrollee Request for Case File Content

Enrollees and their representative may request a copy of the contents of the case file at any point during the appeals process free of charge. Upon an enrollee's request, the Alliance must:

- Provide the enrollee with a copy of the contents of the case file, including, but not limited to, a copy of supporting medical records and other pertinent information used to support the decision. Where an enrollee has an alternate format preference, the case file contents must be provided in that format.
- Make every reasonable effort to accommodate an enrollee's request for case file material (e.g., allowing the enrollee or authorized representative to obtain the material

at an Alliance location or mailing the material to any address specified by the enrollee or authorized representative).

- Abide by all applicable federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or other health information. (See 45 CFR 164 Subpart E regarding the privacy of individually identifiable health information.)

6. Who Must Conduct a Level 1 Appeal

The Alliance must designate someone other than the person involved in any previous level of review or decision-making nor a subordinate of any such individual; and If the applicable integrated plan is deciding an integrated appeal of a denial that is based on lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), is a physician or other appropriate health care professional who has the appropriate clinical expertise, including any state-specific definition of “clinical expertise”, in treating the enrollee's condition or disease, and knowledge of Medicare and Medicaid coverage criteria, before the Alliance issues the integrated reconsideration decision. This does not require the physician to always have the same specialty training as the treating physician.

Part C Only: The physician performing the reconsideration must apply the prudent layperson standard (as described in 42 CFR §422.113(b)(1)(i)) in cases involving emergency and urgently needed services.

7. Conducting a Level 1 Appeal

a. Processing Timeframes

Parts C & D Level 1 Appeal Adjudication Timeframes

Type	Part C	Part C with Extension	Part D
Standard Request for Item, Service, or Part D Drug	30 days	44 days	7 days*
Standard Part B Drug	7 days	N/A**	N/A
Expedited Reconsideration or Redetermination	72 hours	17 days**	72 hours*
Payment	30 days	44 days	14 days

*Note: Part D redetermination exception requests cannot be tolled for receipt of the prescribing physician's supporting statement.

** Part B drug timeframes cannot be extended.

The Alliance will authorize or provide the service or benefit as expeditiously as the enrollee's health condition requires, but no later than the timeframes listed above (based on when the request was received).

If the Alliance cannot obtain all relevant documentation, it must issue the decision no later than the applicable timeframes outlined above.

b. Effect of Failure to Meet the Timeframe for Level 1 Appeals

If the Alliance fails to provide the enrollee with a level 1 appeal decision within the timeframes specified for both standard and expedited appeals, this failure constitutes an adverse decision. In this case, the Alliance must forward the complete case file to the IRE (see §50.12.1 regarding forwarding adverse level 1 appeals to the IRE). The Alliance's failure to provide notice of the level 1 appeal decision within the required timeframe constitutes an adverse decision, but the Alliance is not required to send the adverse decision notice to the enrollee.

If the Alliance fails to provide the enrollee a level 1 integrated appeal decision the timeframes specified (in 42 CFR § 422.633(f)), the Alliance will send a notice to the enrollee which explains:

- The next level of both the Medicaid and Medicare appeals process,
- The steps the enrollee needs to take to make the next level appeal under each program. This includes that, for Medicare appeals, the enrollee will not need to take any action because the Alliance will auto forward the case to the IRE, and for Medicaid cases the enrollee may choose to file for a state fair hearing or, if applicable, a Medicaid external medical review (see 42 CFR § 438.402(c)(1)(i)(B)),
- Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
- For Medicaid-covered benefits, explain that the enrollee can have the benefits continue while the appeal is pending, if applicable, and how the enrollee should make such a request (see 42 CFR §§ 422.633(f)(4)(ii)(B) and 438.420(c)).
- The contents of the notice must comply with the requirements in 42 CFR § 422.633(f)(4), including providing relevant information on the next level of appeal rights for both Medicare and Medicaid.
 - If the case involves a Medicare-covered benefit the notice must include that the Alliance has forwarded the case to the IRE;
 - If it is a Medicaid-covered benefit the notice must include information on the steps the enrollee must take to continue the Medicaid-benefit appeal with a State fair hearing;
 - For cases involving a benefit that may be covered by both Medicare and Medicaid, the case should be forwarded to the IRE and the enrollee should also be informed of Medicaid appeal rights. The Alliance will identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medicaid or potentially both.

8. Service or Benefit Received Prior to Notice of Decision

During the processing of an appeal of a denied coverage request, if the Alliance or a Part D sponsor learns (by any means, including by receipt of a claim or reimbursement request) that the enrollee received the item/service/drug that is the subject of the appeal, the Alliance or Part D sponsor must finish adjudicating the appeal request and issue a substantive decision consistent with the applicable requirements of 42 CFR Part 422, Subpart M or Part 423, Subpart M.

If applicable, the Alliance or Part D sponsor must separately process and issue a decision on any related claim or reimbursement request.

Medicare Parts C and D regulations do not permit the Alliance or Part D sponsor to dismiss an otherwise valid, timely appeal request of an adverse coverage decision solely because an enrollee is concurrently receiving or has already received the item/service/drug that is the subject of the appeal. The Alliance or Part D sponsors may only dismiss appeal requests for the reasons listed at 42 CFR §§ 422.582(f) and 423.582(e) (see section 50.9 of this manual for more details).

9. Dismissal of a Level 1 Appeal Request

The Alliance will dismiss a level 1 appeal request under any of the following circumstances: The individual or entity making the request is not a proper party to the appeal under the applicable regulation. This includes the following situations: If an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed (and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf), the Alliance is obligated to make attempts to secure the missing documentation (see Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance §20.2.1).

- If a non-contracted provider requests a reconsideration of a denied claim (i.e., postservice appeal) but fails to provide a waiver of liability statement indicating that it will not bill the enrollee regardless of the outcome of the appeal, the Alliance will make attempts to secure the missing documentation prior to dismissing the request.
- When the Alliance determines the party failed to make a valid request for an appeal that substantially complies with the applicable regulation for making a valid request for a level 1 appeal.
- When the enrollee dies while the appeal is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the level 1 appeal. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
- When the individual or entity that requested the reconsideration submits a timely written request to withdraw their request for a level 1 appeal.

In evaluating whether to dismiss an integrated reconsideration, in cases involving only a Medicaid-covered benefit where an individual requests an integrated reconsideration on behalf of an enrollee applicable integrated plans must comply with both state (Medicaid) and Medicare requirements.

When the dismissal is the result of a timely withdrawal request, the Alliance is required to mail or otherwise transmit a dismissal notice in accordance with the notice requirements in Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance section 50.9.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. The dismissal notice will explain that the withdrawal request is the reason for dismissal. For reporting purposes, this scenario is categorized as a withdrawal in reporting to CMS.

The guidance in section Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance 50.9 does not alter reporting requirements. Withdrawn requests and dismissals should continue to be reported separately in their distinct categories, per existing reporting requirements.

NOTE: The above list of circumstances under which the Alliance must dismiss a request for a level 1 appeal is exhaustive. The Alliance may not deem a request invalid or dismiss a request for a level 1 appeal for any reason not explicitly included in 42 CFR §§ 422.582(f) and 423.582(e), as applicable.

a. Dismissal Notice

If the Alliance dismisses a level 1 appeal request, the Alliance must mail or otherwise transmit a written notice of the dismissal to the parties at their last known address by the conclusion of the applicable adjudication timeframe.

The dismissal notice will state all of the following:

- The reason for the dismissal;
- The right to request that the Alliance vacate the dismissal action;
- The right to request IRE review of the dismissal; and
- Information on the member's Medicaid rights, if the case involves Medicaid benefits.

Consistent with the timeframe for requesting a timely appeal, a request for review of a dismissal must be filed with the IRE within 65* calendar days from the date of the Alliance's dismissal notice.

The Alliance will use, and modify as necessary, the model Notice of Dismissal of Appeal Request when notifying an enrollee of a dismissal.

Part C only: The rule requiring that a Part C case be automatically sent to the IRE if the Alliance upholds a denial on the merits of the request does not apply in the case of a dismissal of a request for a level 1 appeal (reconsideration) because the MA organization is not making a substantive decision on the merits of the request. If the Alliance dismisses a level 1 appeal request, the enrollee or other party has the right to request IRE review of the Alliance's dismissal; the Alliance will forward the case file for a dismissal to the IRE when a proper party to the appeal requests IRE review of the dismissal under § 422.590(i). The enrollee also has the right to request that the Alliance vacate the dismissal.

b. Dismissal Binding Unless Modified, Reversed or Vacated

The Alliance's decision regarding its dismissal of a level 1 appeal request is binding unless the enrollee or other party requests review by the Independent Review Entity or the dismissal action is vacated by the Alliance. The Alliance may vacate its own dismissal within 6 months of the date of the dismissal if good cause is established.

Upon receipt of a request to review the Alliance's dismissal of a level 1 appeal request, the IRE will contact the appropriate plan to obtain the case file. The Alliance will assemble and forward the case file to the IRE (place in the mail or otherwise transmit the case file). The case file should be forwarded within 24 hours of receiving the IRE's case file request. The Alliance will refer to the IRE website or the IRE Reconsideration Process Manual for information on case file content, organization, and the most appropriate method of transmitting the case file.

If the IRE determines that the Alliance's dismissal of the level 1 appeal request was in error, the IRE vacates the dismissal and remands the case to the Alliance for reconsideration or redetermination (level 1 appeal). The level 1 appeal must be conducted by the Alliance consistent with applicable adjudication timeframes in § 50.7.1. The adjudication timeframe begins when the Alliance receives the IRE's remand order vacating the Alliance's dismissal. The IRE's decision regarding the Alliance's dismissal of a level 1 appeal request is binding and not subject to further review.

Requests to Vacate Dismissal of a Level 1 Appeal Request

The Alliance may vacate its own dismissal if good cause is established within 6 months of the date of the notice of the dismissal. The Alliance may find good cause to vacate a dismissal if, for example, the Alliance determines the dismissal was issued in error because there was good cause for late filing of an appeal request. If a party submits a request to vacate a dismissal of a level 1 appeal request and the request contains sufficient evidence or other documentation that supports a finding of good cause for vacating, the Alliance makes a favorable good cause determination. Once the Alliance makes a favorable good cause determination, it vacates its prior dismissal action, and performs a redetermination or reconsideration consistent with Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance section 50.7, including applicable adjudication timeframes. Where a finding for good cause is made, the Alliance should document the reason for that finding in the case file.

If the Alliance does not find good cause to vacate the dismissal (and the dismissal has not been appealed or overturned on appeal), the dismissal remains in effect. The Alliance issues a letter (not a dismissal notice) explaining that good cause has not been established and the dismissal cannot be vacated. The Alliance should explain in clear language why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

10. Notification Requirements for Level 1 Appeal Decisions

a. Part C Notification Requirements

In accordance with the requirements in 42 CFR § 422.633(f)(4) and CA APL 21-011, this notice must:

- Be written in plain language and available in a language and format that is accessible to the enrollee.
 - Translating the notice, providing it in a large font format, or including a multi-language insert are examples of providing the notice in a format that may make it accessible to an enrollee.
 - The Alliance will comply with Medicaid and Medicare reading level requirements.
- Explain the resolution of and basis for the integrated reconsideration.
- Include the date it was completed.
- For integrated reconsiderations that are not resolved wholly in favor of the enrollee, the notice must also:
 - Explain the next level of both the Medicaid and Medicare appeals process;
 - Explain the steps the enrollee needs to take to make the next level appeal under each program including that:

- If the case involves a Medicare-covered benefit the notice must include that the applicable integrated plan has forwarded the case to the IRE;
- If it is a Medicaid-covered benefit the notice must include information on the steps the enrollee must take to continue the Medicaid-benefit appeal with a State fair hearing;
- For cases involving a benefit that may be covered by both Medicare and Medicaid (an overlap service), the case should be forwarded to the IRE and the enrollee should also be informed of Medicaid appeal rights. The applicable integrated plan should identify, where appropriate, whether the benefit(s) at issue are covered by Medicare or Medicaid.
- Provide information on how the enrollee can obtain assistance in pursuing the next level of appeal under each program, and,
- For Medicaid-covered benefits, explain that the enrollee can have the benefits continue while the appeal is pending, if applicable, and how the enrollee should make such a request.

Favorable Decisions

For favorable decisions, the Alliance will:

- Notify the requesting party and the enrollee in writing of its favorable determination.
- If the enrollee's representative filed the appeal, the Alliance will provide notice to both the representative and enrollee.
- Ensure written notification for appeals for service requests explain the conditions of the approval which include (but are not limited to):
 - The duration of the approval; and
 - Limitations associated with the approval.

Partially Favorable, Adverse, or Untimely Decisions

For partially favorable, adverse, or untimely decisions, the Alliance will send a copy of the complete case file with a written explanation of the Alliance's decision to the IRE within the applicable timeframe. The Alliance is not required to notify beneficiaries upon forwarding cases to the Part C IRE. Enrollees will receive notification from the IRE. The Alliance will inform parties when a case has been forwarded to the IRE may use the model Notice of Appeal Status.

b. Part D Notification Requirements

Favorable Decisions

For favorable decisions, the Alliance will:

- Notify the enrollee in writing in a readable and understandable form, in accordance with the regulatory requirements at §423.590(h). If the enrollee's representative filed the appeal, the Alliance will send written notice to both the representative and enrollee.
- If an enrollee's prescribing physician or other prescriber files a request on behalf of an enrollee, the Alliance will provide notice to the prescriber and written notice to the enrollee.

- Written notices must explain the conditions of the approval. The conditions of approval may include (but are not limited to):
 - The duration of the approval;
 - Limitations associated with the approval; and/or
 - Any coverage rules applicable to subsequent refills.

Adverse Decisions

If the request is denied, in whole or in part, the Alliance will:

- Notify the enrollee in writing. The Alliance will use the model Notice of Redetermination language, or it may develop its own notice. If the enrollee's representative filed the appeal, the Alliance will send a written notice to both the representative and enrollee.
- If an enrollee's prescribing physician or other prescriber files a request on behalf of an enrollee, the Alliance will provide notice to the prescriber and written notice to the enrollee.
- If the Alliance provides verbal notification to a physician or other prescriber, the Alliance will not send a written follow-up.
- In accordance with the regulatory requirements at §423.590(g), the notice must use approved notice language in a readable and understandable form, and will:
 - State the specific reason for denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;
 - Contain the enrollee's Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI), plan sponsor name, plan identification number, contract identification number, and formulary identification number;
 - Provide a description of any applicable Medicare coverage rule or any other applicable plan policy upon which the denial was based, including any specific formulary criteria that must be satisfied for approval. If the drug could be approved under the exception rules, the notice must explicitly state the need for a supporting statement and clearly identify the type of information that should be submitted when seeking a formulary or tiering exception; and
 - Inform the enrollee of his or her right to a reconsideration (level 2 appeal).

Untimely Decisions

If the Alliance fails to provide notice of a decision within the required timeframe, the Alliance will notify the enrollee that the decision was not made timely and is being forwarded to the IRE for review. The notice will:

- Advise the enrollee of his/her right to submit additional evidence that may be pertinent to the enrollee's case, if the enrollee chooses;
- Direct the enrollee to submit such evidence to the independent review entity; and
- Include information on how to contact the independent review entity.

11. Procedure for Handling Misclassified Appeals

If the Alliance misclassifies an appeal as a grievance and later discovers the error, the Alliance must immediately forward the request to the appropriate division for processing and notify the enrollee in writing that the request was misclassified and will be handled through the appeals

process. The timeframe for processing the appeal begins on the date the appeal is received by the Alliance, as opposed to the date the Alliance discovers its error. The Alliance will audit their own appeals and grievance for the presence of errors and institute appropriate quality improvement projects as needed.

12. Timeframes and Responsibilities for Forwarding Case Files to the Independent Review Entity

a. Forwarding Case Files – the Alliance’s Responsibilities

If the Alliance’s appeal decision affirms the adverse initial determination (in whole or in part) or a Part D plan sponsor does not provide notice of its standard or expedited redetermination within the required timeframe or an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file from the Alliance, the Alliance must:

- Make reasonable and diligent efforts to gather and forward all pertinent documentation, including medical records.
- Submit a written explanation with the complete case file the IRE contracted by CMS within the forwarding timeframes.
- Submit the case file by mail or overnight delivery service, fax, or the IRE web portal for Part C or for Part D.

The Alliance should contact the IRE for additional information on electronic submission of case files.

Note: When the Alliance makes a fully favorable determination in less than 24 hours after the end of the applicable adjudication timeframe, the Alliance should consider effectuating and promptly notifying the enrollee of the favorable decision (within the 24-hour period that the case must be forwarded to the IRE) in lieu of forwarding the case to the IRE. See Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance §50.7.2 for additional information regarding untimely decisions made in less than 24 hours after the adjudication timeframe.

For cases forwarded to the IRE, the Alliance will make reasonable and diligent efforts to gather and forward all pertinent information to the IRE.

Forwarding Case Files – Timeframes

Part C Timeframes

Case Type for Adverse and Untimely Decisions	Forward no later than
Expedited	24 hours of the decision (or no later than expiration of applicable extension)
Standard Items and Services	30 calendar days of receipt of request (or no later than expiration of extension)
Standard Part B Drug	7 calendar days of receipt of the request (no extension permitted)

Standard Payment	60 calendar days of receipt of request

Part D Timeframes

Case Type for Decisions	Forward no later than
Expedited	24 hours of receipt of IRE's request for case files
Standard	48 hours of receipt of IRE's request for case files
Untimely	24 hours of the expiration of the adjudication timeframe

b. Preparing the Case File for the Independent Review Entity

The following will be included in the case file forwarded to the IRE:

What to Include in A Case File When Forwarding to the IRE	Part C	Part D
Reconsideration Background Data Form (not required if submitting via IRE web portal)	X	X
Case Narrative	X	N/A
Copy of the Initial Determination Request and Notice	X	X
Copy of the Level 1 Appeal Request and Notice	X	X
Copy of information used to make the plan internal Level 1 decision, including supporting documentation such as medical records, or evidence submitted by the enrollee, provider, and/or prescriber.	X	X
Expedited information regarding the Coverage Determination and Redetermination	N/A	X
Representation documentation for representative appeals	X	X
If file is not submitted via IRE web portal for Part C or for Part D, a complete copy of the relevant Evidence of Coverage on a universal digital storage device (e.g. USB flash drive)	X	X
The name and credentials of the prescribing physician or other prescriber and contact numbers for street address, telephone, fax, and e-mail.	N/A	X
Copy of the relevant plan formulary (on a universal digital storage device if not submitted via IRE web portal), including descriptions of any utilization management requirements	N/A	X
Exceptions process/criteria for determining medical necessity	N/A	X
Any internal plan medical reviews that were obtained during redetermination review	N/A	X
Description of medical documentation missing from the case file based on the failure of the prescribing physician or other prescriber to submit additional medical documentation requested by the plan.	N/A	X
Dismissal Case File Data Form	X	N/A

c. Including Evidence of Coverage and Formulary in Case Files

The Alliance will include complete copies of the relevant Evidence of Coverage (EOC) and their CMS approved formulary (Part D plans, if applicable) with any case files sent to the IRE

for review. ALJs at the Office of Medicare Hearings & Appeals (OMHA) and the Medicare Appeals Council (Council) have indicated that these documents are needed in their entirety in order to properly adjudicate appeals. The Alliance will ensure that each case file sent to the IRE includes complete versions of the EOC and/or formulary relevant to an enrollee's specific case. Failure to include this information could result in an unfavorable appeals decision and/or, in the case of Part D, CMS declining to refer an ALJ or attorney adjudicator decision to the Council for review. The Alliance will submit case files with the EOC and and/or formulary using the IRE web portal for Part C or for Part D. The Alliance will not mail or fax paper copies of the complete EOC and/or formulary to the IRE. The Alliance will submit via the web portal.

13. Continuing Benefits While An Integrated Reconsideration Is Pending

This section applies to cases where an enrollee, or an enrollee's representative or provider, is appealing an Alliance's decision to reduce, terminate, or suspend a previously authorized Medicare Part C or Medicaid-covered service or item, in accordance with 42 CFR § 422.632.

The enrollee or an enrollee's representative or provider, may request that the enrollee continue to receive the previously authorized service, item, Part B drug or Medicaid drug at the previously authorized level while the integrated reconsideration is pending if:

- The request for continuation and the integrated reconsideration are both filed timely:
 - For the service, item, Part B drug or Medicaid drug to continue, the enrollee must make the continuation request by the later of the following: within 10 calendar days after the Alliance sends the notice of its integrated organization determination or the intended effective date of the integrated organization determination.
 - Enrollees must file integrated reconsiderations within 65 calendar days from the date of the notice of the initial determination. For requests received after the 65-day filing timeframe, the Alliance will review the request for a good cause exception.
- The service or item was ordered by an authorized provider,
- The integrated appeal involves the termination, suspension or reduction of previously authorized services, items, Part B drugs or Medicaid drugs, and
- The period covering the initial authorization has not yet expired.

If the request to continue the service, item, Part B drug or Medicaid drug meets the above requirements, the Alliance will continue to provide the service, item, Part B drug or Medicaid drug at the previously authorized level until:

- The enrollee withdraws the request for the integrated reconsideration.
- The Alliance issues an integrated reconsideration determination that is unfavorable to the enrollee.
- For Medicaid-covered services and items only:
 - The enrollee fails to file a request for a State fair hearing and continuation of benefits, within 10 calendar days after the Alliance sends the notice of the integrated reconsideration.
 - The enrollee withdraws the appeal or request for a State fair hearing; or
 - A State fair hearing office issues a hearing decision adverse to the enrollee.

If the Alliance or the State fair hearing entity issues a decision that is adverse to the enrollee, the applicable integrated plan or State agency may not pursue recovery for costs of services furnished by the applicable integrated plan while the integrated reconsideration was pending if the services were furnished solely under the requirements of 42 CFR § 422.632.

If, after the integrated reconsideration decision is final, an enrollee requests that Medicaid services continue until a State fair hearing decision is made, state rules on recovery of costs, in accordance with the requirements of 42 CFR § 438.420(d), apply for costs incurred for items and services provided to the enrollee after the date that the integrated reconsideration decision was made.

14. Level 3 through 5 Review

If a Level II Appeal Review by the IRE is not in favor of the Member, the Member or Provider has a right to subsequent Levels of Appeals based on the disputed amount, an Administrative Law Judge Hearing (Level III Appeal), Medicare Appeals Council (MAC) (Level 4 Appeal) Federal Court (Level 5) for Medicare related services.

At the third, fourth, and fifth levels of review, the request must be filed within 60 calendar days of receipt of a decision or dismissal from the IRE, ALJ/attorney adjudicator, or the Council, respectively. (Unless there is evidence to the contrary, the date of receipt of a decision or dismissal is presumed to be 5 calendar days after the date of decision or dismissal). Extension of filing deadline may be granted for good cause. The request for good cause extension must be in writing (except for requests for Part D expedited hearings, for which the extension may be made verbally or in writing) and state the reason the request was late or Medicaid benefits.

If a Level II appeal review by the State Fair Hearing (Level II) is not in favor of the Member, the Member has a right to subsequent Levels of Appeal to State Administrative Action (Level 3) and State Court (Level 4).

DEFINITIONS / ACRONYMS

- **Integrated Appeal:** The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits. Integrated appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in §422.561 or the procedures required for appeals in accordance with §§438.400 through 438.424 of this chapter. Such procedures include integrated reconsiderations. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to an “Appeal,” the statements and guidance apply equally to integrated appeals for applicable integrated plans.
- **Dismissal:** Dismissal includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination.

Subject to the guidance in this Addendum wherever the Part C & D Guidance refers to a “Dismissal,” the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.

- **Effectuation:** Authorization or provision of a benefit that the Alliance has approved, payment of a claim or compliance with a complete or partial reversal of the Alliance’s original adverse determination.
- **Enrollee:** An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
- **Independent Review Entity (IRE):** An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the Alliance. Under Part C, an IRE can review plan dismissals.
- **Parties:**
 - Part C Only: The parties to an organization determination for purposes of an appeal include:
 - The enrollee (including his or her representative);
 - An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
 - The legal representative of a deceased enrollee’s estate; or
 - Any other provider or entity (other than the The Alliance) determined to have an appealable interest in proceeding.
 - Part D Only: The parties to a coverage determination include the enrollee and the enrollee's representative, if applicable. In some cases, as described in this section, the enrollee's prescribing physician or other prescriber is also a party. However, an enrollee's prescribing physician or other prescriber does not have all of the rights and responsibilities of the enrollee with respect to party status, unless the physician or other prescriber is the enrollee's representative.
- **Integrated Reconsideration:** A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under § 422.580 and appeal under § 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§ 422.629 and 422.632 through 422.634. Integrated reconsiderations do not include redeterminations related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a “Reconsideration,” the statements and guidance apply equally to integrated reconsiderations for applicable integrated plans.
- **Redetermination:** First level in the Part D appeal process in which the Alliance sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.
- **Reopening:** A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
- **Representative:** Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 defines “representative” as an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in

dealing with any of the levels of the appeals process. For both Part C & Part D, unless otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

- **Withdrawal:** A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

AFFECTED DEPARTMENTS/PARTIES

- Grievance and Appeals Department
- Member Services Department

RELATED POLICIES AND PROCEDURES

- G&A-006 Independent Medial Review (IMR)
- G&A-008 State Fair Hearing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- SOP – Representatives
- SOP – Reconsiderations and Redeterminations (Level 1 Appeals)
- SOP – Reconsiderations by the Independent Review Entity (Level 2 Appeal)
- SOP – Key Aspects of Administrative Law Judge (ALJ)/Attorney Adjudicator, Council, and Judicial Review
- SOP – Reopening and Revising Determinations and Decisions
- SOP – Effectuation
- SOP – QA Process

REVISION HISTORY

REFERENCES

- 42 CFR §422.629-634
- 42 CFR §423.420 -560
- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance §20-20.2a and 50-50.9.1
- DHCS APL 21-011
- Health and Safety Code section 1368(a)(4)(A)
- 28 California Code of Regulations section 1300.68(d)(1)
-

MONITORING

- Reference SOP – QA Process for monitoring and oversight of the integrated reconsideration process.
 - Monthly monitoring of overturn rates, turn around timeframes, volume of appeal service types.
- The policy and procedure will be reviewed annually.

POLICY AND PROCEDURE TEMPLATE

Policy Number	G&A-D-003
Policy Name	D-SNP Complaint Tracking Module (CTM)
Department Name	Grievance and Appeals
Department Officer	Chief Operating Officer
Policy Owner	TBD
Line(s) of Business	D-SNP
Effective Date	01/01/2026
Administrative Oversight Committee Approval Date	XX/XX/2025

POLICY STATEMENT

This policy outlines the procedures for managing and tracking complaints filed against Alameda Alliance for Health (Alliance) by a beneficiary or an individual acting on the beneficiary's behalf directly to the Centers for Medicare and Medicaid Services (CMS) via 1-800-MEDICARE. This is to ensure that all complaints received by CMS and forwarded to the Alliance via the Complaint Tracking Module (CTM) within the Health Plan Management System (HPMS) are accessed, investigated, and resolved within the timeframes and guidelines set by CMS, ensuring compliance with all CMS/HPMS regulations, including the CTM Plan Standard Operating Procedure (SOP).

The plan will prioritize timely access to CTM complaints, thorough investigations, and timely resolution in accordance with CMS standards.

This policy applies to all departments, personnel, and contracted entities involved in the operations of the D-SNP plan.

PROCEDURE

1.0 Policy

- 1.1 The G&A Department is responsible for managing the CTM process defined in this policy.
- 1.2 This policy does not apply to grievances and appeals filed through the Alliance's regular grievance and appeal process.
 - 1.2.1 The requirements for resolution of complaints received through the CTM do not override requirements related to the handling of appeals and grievances set forth in 42 CFR 422 subpart M and 423 subpart M.
 - 1.2.2 Please consult the Alliance's grievance and appeal policies for grievances and appeals not received through the CTM.
- 1.3 D-SNP Members are encouraged to first contact the Alliance to file their complaint (i.e. grievance) directly with the Alliance.
- 1.4 The Alliance ensures CTM complaints are acted upon, as defined in this policy, as expeditiously as possible.
- 1.5 The Alliance posts a link to the online Medicare complaint form, as required by 42 CFR 422.2265(b)(8) and 423.2265(b)(8), at the following link:
<https://www.medicare.gov/my/medicare-complaint>

2.0 Obtaining CTM Access

- 2.1 Access to the CTM is limited to the Alliance staff who are authorized to (1) access the Health Plan Management System (HPMS) and (2) the Complaints Tracking Module.
- 2.2 Access requests to the Alliance and the CTM must be submitted to the Compliance Department. The Compliance Department maintains a policy and procedure on granting access to HPMS.
- 2.3 The Compliance-Department will review requests for access. The G&A leadership may be consulted on whether access to the CTM will be granted.
 - 2.3.1 If approved, the Compliance Department will submit a request for an already authorized and registered HPMS user to the HPMS Access email address.
 - 2.3.2 The Compliance Department will notify the requesting user once access is granted by CMS.
- 3.0 Resolution Timeframes: CTM Complaints
 - 3.1 Immediate Need Complaints will be resolved within two (2) calendar days of the assignment date in the CTM Module. Urgent Complaints will be resolved within seven (7) calendar days of the assignment date in the CTM Module.
 - 3.2 All other complaints will be resolved within 30 calendar days of the assignment date in the CTM Module.
 - 3.3 The Alliance G&A department will attempt to contact the individual who filed the complaint within seven (7) calendar days of the assignment date.
 - 3.4 Calculation of days is as defined in the CTM Standard Operating Procedure (SOP), which is based on the day, hour, and minute the complaint is assigned.
 - 3.5 The resolution timelines are calculated mathematically, i.e., “2 calendar days” would be calculated as follows: Complaint received on 8/22 at 8:00 AM must be resolved by 8/24 at 11:59 PM to be in compliance (24 less 22 = 2 days). Assignment dates are reset when a complaint is re-opened, when the Issue Level is upgraded, the CMS Lead flag is set or removed (the Plan Request must be accepted for the date to reset), and when the contract is changed. The assignment date is not changed when a Plan Request to have a complaint designated as a CMS Lead is denied.
- 4.0 General Complaint Handling: Receiving a CTM Complaint
 - 4.1 When a CTM complaint is received, an automated notice is sent from HPMS to all users assigned to the CTM module.
 - 4.2 The G&A Supervisors or their designees access the HPMS twice daily to check for new complaints submitted via the CTM module.
 - 4.3 The G&A Supervisors, or their designees, are responsible for reviewing newly received CTM complaints within 24 hours of receipt, including holidays and weekends.
 - 4.3.1 Planned time off. It is the responsibility of either (or both) individuals to ensure coverage for pre-planned time off.
 - 4.3.2 Unplanned time off. It would be the responsibility of one individual to engage the manager of the absent staff to ensure coverage. In the event both the primary and secondary individuals are out, the G&A Manager is responsible of ensuring CTMs are handled during this period.
 - 4.4 The G&A Supervisors or their designees, will review the CTM complaint at intake, regardless of level type (e.g. Immediate Need, Urgent, or other) to verify the contract number and Issue Level are correct.
- 5.0 General Complaint Handling: Investigating/Categorizing a CTM Complaint
 - 5.1 The G&A Supervisors will engage the Alliance G&A team to assist with investigation of the complaint(s) within the CTM complaint.
 - 5.2 The G&A team will contact the individual who filed the complaint to verify the details of the CTM complaint.

- 5.3 Any complaint related to clinical care or urgent matters (e.g., access to critical services) is treated with priority and escalated as needed to ensure expedited investigation and resolution.
 - 5.4 The G&A team will engage other Alliance staff and teams as necessary to resolve the CTM complaint. Investigations begin promptly, with departments gathering all necessary information to ensure a thorough review.
 - 5.4.1 Complaints that involve potential unauthorized disclosure of PHI or other privacy-related concerns must be referred to the Privacy Department immediately due to the potential 24-hour review and reporting requirements.
 - 5.4.2 Complaints flagged as potentially involving fraud, privacy violations, or system vulnerabilities will also be reviewed by the Compliance, Privacy, and IT departments as appropriate.
 - 5.5 Once resolution has been obtained, the G&A team will provide the resolution detail to the G&A Quality Assurance Team for review.
- 6.0 Complaint Resolution Documentation: Resolving a CTM Complaint
- 6.1 The G&A team will upload the resolution of the complaint in the CTM Module, following the documentation requirements and examples provided in the CTM SOP.
 - 6.2 The G&A Supervisor will review any CTM at the next regularly scheduled call between the Alliance and the CMS Account Manager.
- 7.0 Tracking and Performance
- 7.1 All steps taken to address each complaint, from receipt to closure, will be logged in the CTM.
 - 7.2 G&A Department will document the issue, investigation process, resolution, and any communications with CMS or the complainant in accordance with the CMS CTM SOP.
 - 7.3 G&A Department will upload any supporting documents, such as medical records or provider responses, to ensure a complete record.
 - ~~7.4~~ The G&A Department will monitor CTM complaint trends over time to identify potential deviations from past performance. Monthly CTM reporting will be used to also monitor Stars performance. This includes but is not limited to an increase in the frequency of CTM complaints received year-over-year.
 - ~~7.5~~7.4 Potential deviations from past performance may warrant ad hoc action by the Director of Medicare with the Alliance staff to identify the root cause(s) of performance deviation(s).
 - ~~7.6~~7.5 Investigation and resolution may be communicated to the CMS Account Manager proactively.

The Alliance will promptly work to resolve each CTM complaint in a timely manner as they are presented. Before closing out the CTM Complaint, The Alliance will conduct confirmation that the plan is in agreement with all sections of the CTM, such as Contract Assignment, Issue Level, Category/Sub category assignment, or Lead/Ownership of the CTM. If after careful review and consideration the Alliance disagrees with any of the sections of the CTM, the G&A Department will submit a Plan Request using the CTM SOP as guidance.

8.0 Internal Escalation Process:

- 8.1 Any complaints that cannot be resolved within the designated timeframe, or that involve significant operational issues, will be escalated internally to senior G&A leadership and the Compliance department.
- 8.2 If guidance from CMS is needed, staff will consult with the Chief Compliance Officer for instructions on elevating the complaint to CMS for further review.

DEFINITIONS / ACRONYMS

Complaint: Any expression of dissatisfaction from a Medicare enrollee or their representative regarding the D-SNP plan or its services that is entered into the CMS CTM system.

CMS: Centers for Medicare & Medicaid Services, the federal agency overseeing the administration of Medicare, Medicaid, and other health programs.

CTM: Complaint Tracking Module, the system within HPMS used by CMS and Medicare plans to track and resolve complaints.

D-SNP: Dual Eligible Special Needs Plan, a type of Medicare Advantage Plan for individuals who are eligible for both Medicare and Medicaid.

G&A: Grievance and Appeals.

HPMS: Health Plan Management System, a CMS system used by Medicare plans for reporting and operational tasks.

AFFECTED DEPARTMENTS/PARTIES

The G&A Department is responsible for managing complaints received through the CTM as defined in this policy.

RELATED POLICIES AND PROCEDURES

CMS Memo January 6, 2025 Updated Complaint Tracking Module Standard Operating Procedures

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HPMS Access Policy add policy # once approved in AOC

REVISION HISTORY

07/28/2025

REFERENCES

CMS Medicare Managed Care Manual, Chapter 13 – Complaint Tracking Module (CTM).

42 CFR § 422.564 – Grievance Procedures for Medicare Advantage Organizations.

MONITORING

Daily Monitoring of CTM:

- The Grievance and Appeals department will monitor the CTM in HPMS twice daily to ensure prompt access to new complaints and timely resolution.
- An audit log will be maintained to track which staff access the CTM and the actions taken to resolve each complaint.

Internal Compliance Audits:

- The Compliance Department may conduct audits of complaints processed through the CTM to ensure compliance with CMS requirements.
- Any deviations from CMS timelines or resolution processes must be documented, and corrective action plans must be developed to address deficiencies.

Reporting to CMS:

- The Alliance will comply with any CMS reporting requirements related to CTM activities, including periodic reports on complaint resolution and trending if requested.
-
-



POLICY AND PROCEDURE

Policy Number	CS-002
Policy Name	Community Supports – Housing Transition Navigation Services
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, <u>Long-Term Services and Supports</u> ~~Social Determinants of Health~~
Line(s) of Business	<u>D-SNP</u> , MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD</u> ~~8/21/2024~~
Compliance Committee Approval Date	<u>TBD</u> ~~9/18/2024~~

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Housing Transition Navigation Services Community Support.

Housing Transition Navigation Services assist individuals who are homeless or at risk of homelessness with finding, applying for, and obtaining housing. These services do not constitute room and board or rental payments.

Housing Transition Navigation Services may include:

- Conducting a housing assessment that identifies the member's preferences and barriers related to successful tenancy, and identifies the member's preferences, strengths and barriers.
- Developing a housing support plan.
- Assistance searching for housing.
- Assistance with completing housing applications and securing documentation.
- Benefits advocacy, including support with the SSI application process.
- Identifying and securing available resources to assist with attaining housing, such as Housing Deposits, Transitional Rent, HUD Housing Choice Voucher, and other state

CSM-0024 Community Supports – Housing Transition Navigation Services

- and local assistance programs.
- Fair Housing/anti-discrimination education and reasonable accommodation request assistance.
- Landlord education, advocacy, and engagement.
- Ensuring the living environment is safe and ready for move-in.
- Assistance in, arranging for, and supporting the details of the move.
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- Assistance with transportation to housing options prior to transition and on move in day.
- Assistance with securing environmental modifications to install necessary accommodations for accessibility.

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Highlight

Formatted: Font: 12 pt

Housing Transition Navigation Services will be based on individualized assessments documented in the member's housing support plan. Individuals may only access the services necessary to meet their specific needs.

Formatted: Normal, Indent: Left: 0"

Housing Transition Navigation Services apply best practices for clients experiencing homelessness and/or complex health conditions, including Housing First, Harm Reduction, Motivational Interviewing, Progressive Engagement, and Trauma-Informed Care.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Tab stops: 1.84", Left

Housing Transition Navigation Services will not cover:

- Ongoing rental payments.
- Room and board.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Tab stops: 1.84", Left

Formatted: Font: 12 pt

- 1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.
- 1.2 AAH works with community resources to ensure access to and delivery of CS services.
- 1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Housing Transition and Navigation Services for their CS clients experiencing homelessness and housing instability.
 - 1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.
- 1.4 As indicated in P&P CLS-009, Cultural and Linguistic Services (CLS) Program—Contracted Providers, AAH collaborates with providers to provide non-discriminatory and equitable services.
 - 1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.
 - 1.4.2 The Provider Services Department ensures compliance of

CSM-0024 Community Supports – Housing Transition Navigation Services

providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

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

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

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

I. Eligibility

- Individuals who meet the **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2.
- Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Transition Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan.

II. Referrals

- Referrals to the Housing Transition Navigation Services Community Support can be received from:
 - Alameda County Health or contracted provider
- For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.
- Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

- When the Alliance receives a request for Housing Transition Navigation Services, they will review the documentation submitted by the provider. This will include the following:

CSM-0024 Community Supports – Housing Transition Navigation Services

Formatted: List Paragraph, Left, Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Not Bold, Font color: Text 1

Formatted: Font: 12 pt, Font color: Text 1

Formatted: Font: 12 pt, Bold, Font color: Text 1

Formatted: Font: 12 pt, Font color: Text 1

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: 12 pt, Not Bold, Font color: Text 1

Formatted: Font color: Text 1

Formatted: Right: 0.19", Line spacing: Multiple 1.06 li

Formatted: Font: 12 pt, Not Bold

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Font color: Text 1

Formatted: Font: 12 pt, Not Bold

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

- Request for Housing Transition Navigation Services by the contracted provider
 - Attestation for coordinated entry enrollment or social and clinical risk factor requirement.
 - Meet DHCS eligibility criteria
 - Individualized housing support plan
- b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

IV. Close Loop Referral

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

Formatted: Font: Not Bold

Formatted: Right: 0.19", Line spacing: Multiple 1.06 li

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

V. Data Sharing

- a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.
- b) AAH and CS Provider accesses available data exchange platform(s) when possible.
- c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.
- d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Not Bold

Formatted: Right: 0.19", Line spacing: Multiple 1.06 li

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Right: 0.19", Line spacing: Multiple 1.06 li

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

VI. Restrictions and Limitations

- a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.
- b) Housing Transition Navigation Services must be identified as reasonable and necessary in the housing support plan.
- c) Individuals must have a housing support plan.
- d) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- e) A member cannot receive both Housing Tenancy Sustaining Services and Housing Transition Navigation Services at the same time.

Formatted: Font: 12 pt, Highlight

Formatted: Highlight

VII. Discontinuing of Services

a) Discontinuing of CS services will be based on:

- Housing goals met/member secured housing
- Unable to maintain contact with member
- Termination of coverage
- No longer meets criteria
- Member declines services
- Death of member

VIII. Licensing / Allowable Providers

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

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

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

2.1 AAH provides Housing Transition Navigation services through their CS network of providers, with a goal of assisting members with housing transition and navigation services. Services include:

2.1.1 Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.

2.1.2 Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

2.1.3 Searching for housing and presenting options.

Formatted: Font: 11 pt, Not Bold

Formatted: Right: 0.19", Line spacing: Multiple 1.06 li

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Font color: Text 1

Formatted: Font color: Text 1

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 11 pt, Not Bold

Formatted: Normal

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Right: 0.19", Line spacing: Multiple 1.06 li, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Not Bold

Formatted: Right: 0.19", Space Before: 6 pt, Line spacing: Multiple 1.06 li

- ~~2.1.4 Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).~~
- ~~2.1.5 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.~~
- ~~2.1.6 Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.~~
- ~~2.1.7 If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.~~
- ~~2.1.8 Assisting with requests for reasonable accommodation, if necessary.~~
- ~~2.1.9 Landlord education and engagement.~~
- ~~2.1.10 Ensuring that the living environment is safe and ready for move-in.~~
- ~~2.1.11 Communicating and advocating on behalf of the client with landlords.~~
- ~~2.1.12 Assisting in arranging for and supporting the details of the move.~~
- ~~2.1.13 Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.~~
- ~~2.1.14 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.~~
- ~~2.1.15 Identifying, coordinating, securing or funding environmental modifications to install necessary accommodations for accessibility.~~
- ~~2.2 Housing Transition Navigation Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.~~
- ~~2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.~~
- ~~2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, AAH will work closely~~

with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. AAH and its contracted CS Providers will coordinate access to housing resources (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) through county behavioral health when appropriate.

2.5 Services do not include the provision of room and board or payment of rental costs. AAH will coordinate with local entities to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2.6 Member Identification.

AAH identifies eligible members through the following mechanisms:

2.6.1 Report Based CS

2.6.1.0 Monthly, the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.

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

2.7 Notification of Eligibility

2.7.1 Members are notified of Housing eligibility via written communication.

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

2.8 Referral Based CS

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

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

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

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

~~2.9 Request for Housing Transition Navigation Services~~

~~2.9.1 AAH verifies a member's health plan eligibility.~~

~~2.9.1.1 Request is reviewed~~

~~2.9.1.2 Approval/Denial determination is made per UM Policy, 057 process~~

~~2.9.1.3 Member and provider are notified in accordance with UM Policy, 057, Authorization Service Request.~~

~~2.9.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.9.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.9.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.9.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.~~

~~2.9.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.9.4.1.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

~~2.10 Continuity of Care~~

~~2.10.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.10.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.10.2.1 AAH offers the CS service which the member received~~

through their prior MCP.

~~2.10.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.~~

~~2.10.3 AAH will automatically authorize the CS service when the above conditions are met.~~

~~2.11 Data Sharing~~

~~2.11.1 AAH establishes and maintains a data sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.~~

~~2.11.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.11.3 AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.11.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.11.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.~~

~~2.12 Eligibility~~

~~2.12.1 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or~~

~~2.12.2 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility,~~

substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

~~2.12.3 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:~~

~~2.12.3.1 In W&I Code section 141271 as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.~~

~~2.12.3.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:~~

~~2.12.3.2.1 A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:~~

~~2.12.3.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and~~

~~2.12.3.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or~~

~~2.12.3.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or~~

~~2.12.3.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of~~

household has been homeless; or

~~2.12.4 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:~~

~~2.12.4.1 (1) An individual or family who:~~

~~2.12.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;~~

~~2.12.4.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and~~

~~2.12.4.1.3 Meets one of the following conditions:~~

~~2.12.4.1.3.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;~~

~~2.12.4.1.3.2 Is living in the home of another because of economic hardship;~~

~~2.12.4.1.3.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;~~

~~2.12.4.1.3.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;~~

~~2.12.4.1.3.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;~~

~~2.12.4.1.3.6 Is exiting a publicly funded institution, or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or~~

~~2.12.4.1.3.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved consolidated plan;~~

~~2.12.4.1.4 (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3));~~

section 637(11) of the Head Start Act (42 U.S.C. 9832(11)); section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)); section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)); section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)); or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.12.4.1.5 (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.12.5 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.12.5.1 Have one or more serious chronic conditions;

2.12.5.2 Have a Serious Mental Illness;

2.12.5.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.12.5.4 Have a Serious Emotional Disturbance (children and adolescents);

2.12.5.5 Are receiving Enhanced Care Management; or

2.12.5.6 Are a Transition Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking; or

2.12.6 Individuals who meet the State’s No Place Like Home definition of “at risk of chronic homelessness”, which includes persons exiting institutions that were homeless prior to entering the institution and Transition age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.13 Payment

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

2.13.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-

service basis as follows:

~~2.13.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.13.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.13.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.13.3 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.14 Restrictions and Limitations~~

~~2.14.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:~~

- ~~1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service;~~
- ~~2) beneficiaries are not required to use the Community Supports and~~
- ~~3) the Community Supports are authorized and identified in the AAH plan contracts.~~

~~2.14.2 Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary. AAH will ensure that individuals are not receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.~~

~~2.15 Discontinuing Services~~

~~2.15.1 Discontinuing of CS services will be based on:~~

~~2.15.1.1 Goals met/obtain permanent housing~~

~~2.15.1.2 Termination of coverage~~

~~2.15.1.3 Unable to establish or maintain contact with member~~

~~2.15.1.4 No longer meets criteria~~

~~2.15.1.5 Member/caregiver declines services~~

~~2.15.1.6 Death of member~~

~~2.15.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.~~

~~2.15.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

2.16—Licensing / Allowable Providers

2.16.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.16.2 Clients who meet the eligibility requirements for Housing Transition/Navigation services will also be assessed for Community Supports Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports ~~None~~
AC Health	Alameda County Health
AAH	Alameda Alliance for Health

Formatted: Body Text

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

CLS-009 CLS Program – Contracted Providers

CSM-0024 Community Supports – Housing Transition Navigation Services

CRE-018 Assessment of Community Supports Organizational Providers

UM-051 Timeliness of UM Decision Making and Notification

UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Housing Transition Navigation Services Community Supports Standard Operating Procedures
Referral Process Flow

REVISION HISTORY

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

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	CS-003
Policy Name	Community Supports – Housing Deposits
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, <u>Long-Term Services and Supports</u> <u>Social Determinants of Health</u>
Line(s) of Business	<u>D-SNP</u> , MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD8/21/2024</u>
Administrative Oversight Committee Approval Date	<u>TBD9/18/2024</u>

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Housing Deposits Community Support.

Formatted: Left

Housing Deposits assist individuals who are homeless or at risk of homelessness with identifying, coordinating, securing, or funding one-time services and modifications necessary to establish a basic household. Housing Deposit services do not constitute room and board or ongoing rental payments.

Formatted: Space Before: 12 pt, After: 12 pt

Housing Deposits may include:

- Security deposits required for rental housing.
- Set-up fees/deposits for utilities and arrears.
- First month of utility payments, including gas, electric, water, and phone services.
- Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality standards, or other habitability standards, as applicable, where those costs are not the responsibility of the landlord under applicable law.
- Application fees to cover the cost of the lease application.

Formatted: Highlight

Formatted: Highlight

- Medically necessary goods like air conditioners, hospital beds, Hoyer lifts, or adaptive aids, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal.

Formatted: Space Before: 12 pt, After: 12 pt

Housing Deposit services will be based on individualized assessments documented in the member's housing support plan. Individuals may only access the services necessary to meet their specific needs.

Housing Deposit services apply best practices for clients experiencing homelessness and/or complex health conditions, including Housing First, Harm Reduction, Motivational Interviewing, Progressive Engagement, and Trauma-Informed Care.

Housing Deposit services **will not** cover:

- Ongoing rent payments.
- Room and board.
- First month's and last month's rent.
- Security deposit that exceeds an amount of one month's rent (or two month's rent for small landlords renting to non-service members).

Formatted: Highlight

Formatted: Font: Not Bold

- 1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options through the Community Supports CS program beginning January 1, 2022.
- 1.1 AAH works with community resources to ensure access to and delivery of CS services.
- 1.2 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Housing Deposits Services for their CS clients experiencing homelessness and housing instability.
 - 1.2.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.
- 1.3 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program—Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.
 - 1.3.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.
 - 1.3.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.
 - 1.3.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.
 - 1.3.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper

and online, and is used to appropriately match patients with providers speaking the same language.

~~1.4 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.~~

PROCEDURE

I. Eligibility

- Individuals who meet **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2
- Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Deposits.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan.

II. Referrals

- a) Referrals to the Housing Deposits Community Support can be received from:
 - Alameda County Health or contracted provider
- b) For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.
- c) Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1- 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

- a) When the Alliance receives a request for Housing Deposits, they will review the documentation submitted by the provider. This will include the following:
 - Request for Housing Deposits by the contracted provider
 - Attestation for coordinated entry enrollment or social and clinical risk factor requirement.
 - Meet DHCS eligibility criteria
 - Individualized housing support plan
- b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: List Paragraph, Left, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: (Default) Times New Roman

Formatted: Font: Bold

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Line spacing: Multiple 1.15 li

Formatted: Font: Bold

Formatted: Font: (Default) Times New Roman

Formatted: Indent: Left: 0.5", Space Before: 12 pt, After: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

IV. Close Loop Referral

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

V. Data Sharing

- a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.
- b) AAH and CS Provider accesses available data exchange platform(s) when possible.
- c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.
- d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions and Limitations

- a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.
- b) Once per demonstration period: Housing Deposits are available once per demonstration period with a \$5,000 cap, with a potential second occurrence if documentation justifies why providing Housing Deposits would be more successful on the second attempt.
- c) Housing Deposit services must be identified as reasonable and necessary in the housing support plan and are only available when the individual is unable to meet such expense.
- d) Individuals must have a housing support plan.
- e) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

VII. Discontinuing Services

- a) Discontinuing of CS services will be based on:
- The member meets the demonstration financial maximum of \$5,000
 - Termination of coverage
 - No longer meets criteria
 - Member declines services
 - Death of member

VIII. Licensing / Allowable Providers

- a) AAH CS Providers must have experience and expertise with providing these unique services.
- b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

Formatted: Font: 12 pt

Formatted: Highlight

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Highlight

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

Formatted: List Paragraph, Space Before: 12 pt, After: 12 pt, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

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

~~2.1 AAH Housing Deposits assist with identifying, coordinating,~~

~~securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:~~

~~2.1.1 Security deposits required to obtain a lease on an apartment or home.~~

~~2.1.1 Set-up fees and/or deposits for utilities or service access and utility arrearages.~~

~~2.1.1 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.~~

~~2.1.1 First month and last month's rent as required by landlord for occupancy.~~

~~2.1.1 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.~~

~~2.1.1 Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve an individual's health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.~~

~~2.1 Housing Deposit services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.~~

~~2.1 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.~~

~~Housing Deposit Services will not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.~~

~~2.2 Member Identification~~

~~2.2.1 Report Based CS~~

~~2.2.1.1 Monthly, the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.~~

~~2.2.1.1 The Population Report is provided to the Community Supports (CS) department monthly for further processing.~~

~~2.2.1.1 Notification of Eligibility~~

Members are notified of Housing eligibility via written communication.

If not address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all process in the system of record.

~~2.3 Referrals Based CS~~

~~2.3.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.3.1 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver, or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility then connect the Member to a CS Provider for the provision of services.~~

~~2.3.1.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.3.1 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

~~2.1 Request for Housing Deposit Services~~

~~2.1.1 Once AAH verifies a member's health plan eligibility.~~

~~2.1.1.1 Request is reviewed~~

~~2.1.1.1 Approval/Denial determination is made per UM Policy, UM-057 process~~

~~2.1.1.1 Member and provider are notified in accordance with UM Policy, UM-057, Authorization Service Request.~~

~~2.1.1 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.1.1 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.1.1 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.1.1.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.~~

~~2.1.1.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.1.1 If the member is not enrolled in ECM, a referral would be made to~~

the AAH Care Management Department for identification of alternative services.

~~2.1 Continuity of Care~~

~~2.1.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.1.1 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.1.1.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.1.1.1 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.~~

~~2.1.1 AAH will automatically authorize the CS service when the above conditions are met.~~

~~2.1 Data Sharing~~

~~2.1.1 AAH establishes and maintains a data sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.~~

~~2.1.1 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.1.1 AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.1.1 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.1.1 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS's guidelines.~~

~~2.1 Eligibility~~

~~2.7.1 Any AAH member who received Housing Transition/Navigation Services CS in Alameda County.~~

~~2.7.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or~~

serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.7.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.7.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.7.4.1 In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.7.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR

— 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.7.4.2.1 A ‘homeless individual with a disability,’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.7.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.7.4.2.1.2 Has been homeless and living as described in paragraph (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a

safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.7.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph of this definition, before entering that facility; or

2.7.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.7.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.7.5.1 (1) An individual or family who:

2.7.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.7.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.7.5.1.2.1 Meets one of the following conditions:

2.7.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.7.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.7.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.7.5.1.2.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.7.5.1.2.1.5 Lives in a single room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.7.5.1.2.1.6 Is exiting a publicly funded institution, or system of care (such as a health care facility, a mental health facility,

foster care or other youth facility, or correction program or institution); or

2.7.5.1.2.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.7.5.2 (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.7.5.3 (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.7.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.7.6.1 Have one or more serious chronic conditions;

2.7.6.1 Have a Serious Mental Illness;

2.7.6.1 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.7.6.1 Have a Serious Emotional Disturbance (children and adolescents);

2.7.6.1 Are receiving Enhanced Care Management; or

2.7.6.1 Are a Transition Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or Individuals who meet the State's No Place Like Home definition of “at risk of chronic homelessness”, which includes persons exiting institutions that were homeless prior to entering the institution and Transition age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.8 Payment

2.8.1 AAH receives payment from DHCS and disperses funds in a timely manner to CS Providers through collection and submission of data by the CS Provider, and through the contractual agreement made between AAH and the CS Provider.

2.8.1 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a

fee-for-service basis as follows:

~~2.8.1.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.8.1.1 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.8.1.1 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.8.1 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.8 Restrictions and Limitations~~

~~2.8.1 Community Supports (CS) are alternative services to covered benefits under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered by AAH if:~~

~~2.8.1.1 The State determines they are medically appropriate and a cost-effective substitutes or settings for the State plan service;~~

~~2.8.1.1 Beneficiaries are not required to use the in lieu of service; and~~

~~2.8.1.1 The in lieu of service is authorized and identified in the AAH plan contracts.~~

~~2.8.1 Housing Deposits will be available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services.~~

~~2.8.1 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.~~

~~2.8.1 Individuals will also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.~~

~~2.8.1 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.~~

~~2.8 Discontinuing Services~~

~~2.8.1 Discontinuing of CS services will be based on:~~

~~2.8.1.1 Meeting the lifetime maximum financial limitation~~

~~2.8.1.1 Goals met/completion of housing deposit~~

~~2.8.1.1 No longer meets criteria~~

~~2.8.1.1 Member/caregiver declines services~~

~~2.8.1.1 Death of member~~

~~2.8.1 CS provider will submit weekly reports identifying AAH members who have completed the CS service.~~

~~2.8.1 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

~~2.8 Licensing and Allowable Providers~~

~~2.8.1 Providers must have experience and expertise with providing these~~

unique services in a culturally and linguistically appropriate manner.

~~2.8.1 The entity that is coordinating an individual's Housing Transition Navigation Services, or AAH's case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.~~

~~2.8.1 AAH will ensure CS Providers have demonstrated or verifiable experience and expertise with providing these unique services.~~

~~2.8.1 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.~~

~~2.8.1 AAH plan network providers that have a state level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.~~

DEFINITIONS / ACRONYMS

CS	Community Supports
~~AC Health~~ <u>HCSA</u>	~~Alameda County Health~~ <u>Agency</u> ~~Health Care Services~~
AAH	Alameda Alliance for Health

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Housing Deposits Community Supports Standard Operating Procedures~~Referral Process Flow~~

REVISION HISTORY

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

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	CS-004
Policy Name	Community Supports – Housing Tenancy and Sustaining Services
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, <u>Long-Term Services and Supports</u> ~~Social Determinants of Health~~
Line(s) of Business	<u>D-SNP</u> , MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD</u> 8/21/2024
Administrative Oversight Committee Approval Date	<u>TBD</u> 9/18/2024

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Housing Tenancy and Sustaining Services Community Support.

Housing Tenancy and Sustaining Services assist individuals who are homeless or at risk of homelessness with maintaining safe and stable tenancy once housing is secured. These services do not constitute room and board or rental payments.

Housing Tenancy and Sustaining Services may include:

- Early identification and intervention for behaviors jeopardizing housing.
- Tenant and landlord rights/responsibilities education.
- Fair Housing/anti-discrimination education and reasonable accommodation request assistance.
- Coaching on landlord/property manager and/or neighbor relationships with a goal of fostering successful tenancy.
- Coordination with landlords and case managers (including ECM Provider or non-Medi-Cal housing supportive services providers) to address issues that can impact housing stability.

CSM-00243 Community Supports – Housing Tenancy and Sustaining Services

Formatted: Space Before: 12 pt, After: 12 pt, Line spacing: Multiple 1.06 li

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Space Before: 0 pt, Line spacing: Multiple 1.15 li

Formatted: Highlight

Formatted: Font: (Default) Times New Roman, Highlight

Formatted: Font: (Default) Times New Roman

Formatted: Highlight

Formatted: Font: (Default) Times New Roman

Formatted: Space Before: 0 pt, Line spacing: Multiple 1.15 li

Formatted: Font: (Default) Times New Roman

Formatted: Highlight

Formatted: Font: (Default) Times New Roman

- Assistance with dispute resolution and eviction prevention.
- Advocacy and linkage with community resources to prevent eviction.
- Benefits advocacy, including support with the SSI application process and housing recertification support.
- Lease compliance assistance and support with household management activities.
- Health and safety visits.
- Early intervention services identified in crisis plan when housing is jeopardized.
- Independent living and life skills training.

Housing Tenancy and Sustaining Services will be based on individualized assessments documented in the member's housing support plan. Individuals may only access the services necessary to meet their specific needs.

Housing Tenancy and Sustaining Services apply best practices for clients experiencing homelessness and/or complex health conditions, including Housing First, Harm Reduction, Motivational Interviewing, Progressive Engagement, and Trauma-Informed Care.

Housing Tenancy and Sustaining Services **will not cover:**

- Ongoing rental payments.
- Room and board.

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

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

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS—Housing Tenancy and Sustaining Services for their CS clients experiencing homelessness and housing instability.

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

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

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

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Space Before: 0 pt, Line spacing: Multiple 1.15 li

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

Formatted: No underline, Font color: Text 1

Formatted: Space Before: 12 pt, After: 12 pt

Formatted: Font color: Text 1

Formatted: No underline, Font color: Text 1

Formatted: Font color: Text 1

Formatted: Font: Bold

age and disability needs of our members.

~~1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~

~~1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~

~~1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.~~

~~1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.~~

PROCEDURE

I. Eligibility

- Individuals who meet the **Social Risk Factor** requirements (the U.S. Housing and Urban Development (HUD) definition of homeless or at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations) and **Clinical Risk Factor** requirements as outlined in the DHCS Community Supports Policy Guide Volume 2.
- Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for Housing Tenancy and Sustaining Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system.

Eligibility documentation will be based on clinical assessments, homelessness status verification, and an individualized housing plan.

II. Referrals

- a) Referrals to the Housing Tenancy and Sustaining Services Community Support can be received from:
 - Alameda County Health or contracted provider.
- b) For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.
- c) Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

- a) When the Alliance receives a request for Housing Tenancy and Sustaining Services, they will review the documentation submitted by the provider. This will include the following:

CSM-00243 Community Supports – Housing Tenancy and Sustaining Services

Formatted: Left, Line spacing: single

Formatted: List Paragraph, Left, Space Before: 0 pt, Line spacing: single, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Font color: Text 1

Formatted: Font: 12 pt, Bold

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

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt, No underline, Font color: Text 1, Not Highlight

Formatted: Font: 12 pt, No underline, Font color: Text 1, Not Highlight

Formatted: Font color: Text 1

Formatted: Font: 12 pt, Font color: Text 1, Not Highlight

Formatted: Font color: Text 1

Formatted: Font: 11 pt, Not Bold

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, No underline, Font color: Text 1

Formatted: Font: 12 pt, No underline, Font color: Text 1

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

Formatted: No underline, Font color: Text 1

Formatted: Font: 12 pt, No underline, Font color: Text 1

Formatted: No underline, Font color: Text 1

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

Formatted: Font: 12 pt, No underline, Font color: Text 1

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

Formatted: No underline, Font color: Text 1

Formatted: Font: 12 pt, No underline, Font color: Text 1

Formatted: Font: Not Bold, Underline, Font color: Custom Color(209,52,56))

Formatted: List Paragraph, Indent: Left: 0.5"

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Not Bold, Font color: Text 1

Formatted: Font: Not Bold, Font color: Text 1

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

Formatted: Font color: Text 1

- Request for Housing Tenancy and Sustaining Services by the contracted provider
 - Attestation for coordinated entry enrollment or social and clinical risk factor requirement.
 - Meet DHCS eligibility criteria
 - Individualized housing support plan
- b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Close Loop Referral

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

V. Data Sharing

- a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.
- b) AAH and CS Provider accesses available data exchange platform(s) when possible.
- c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.
- d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

VI. Restrictions and Limitations

- a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.
- b) Housing Tenancy and Sustaining Services must be identified as reasonable and necessary in the housing support plan.
- c) Individuals must have a housing support plan.
- d) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- e) A member cannot receive both Housing Tenancy Sustaining services and Housing Transition Navigation Services at the same time.

VII. Discontinuing Services

- a) Discontinuing of CS services will be based on:
- Housing goals met

CSM-00243 Community Supports – Housing Tenancy and Sustaining Services

Formatted: Font: Not Bold, Font color: Text 1
Formatted: Font: Not Bold, Font color: Text 1
Formatted: Font color: Text 1
Formatted: Space Before: 0 pt, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"
Formatted: Font: 12 pt, Not Bold, Font color: Text 1
Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"
Formatted: Font color: Text 1
Formatted: Font: 12 pt, Not Bold, Font color: Text 1
Formatted: Font color: Text 1
Formatted: Font: 12 pt, Not Bold, Font color: Text 1
Formatted: Font color: Text 1
Formatted: Font: Not Bold, Font color: Text 1
Formatted: Font color: Text 1
Formatted: Font: Not Bold, Font color: Text 1
Formatted: Font color: Text 1
Formatted: Font: Not Bold, Font color: Text 1
Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 12 pt, No underline, Font color: Text 1
Formatted
Formatted: Font color: Text 1
Formatted
Formatted: Font: 12 pt, Not Bold, Font color: Text 1
Formatted: Font: 12 pt, Not Bold, Font color: Text 1
Formatted: Font: 12 pt, Not Bold, Font color: Text 1
Formatted: Font color: Text 1
Formatted: List Paragraph, Indent: Left: 0.5"
Formatted
Formatted: Font: 12 pt, Not Bold
Formatted
Formatted: Font: 12 pt, Not Bold
Formatted: Font: 12 pt, Not Bold
Formatted: Font: 12 pt, Not Bold
Formatted: Font: 12 pt, Not Bold
Formatted: Font: 12 pt, Highlight
Formatted: Highlight
Formatted: List Paragraph, Indent: Left: 0.5"
Formatted
Formatted: Font: 12 pt, Not Bold
Formatted

- Unable to maintain contact with member
- Termination of coverage
- No longer meets criteria
- Member declines services
- Death of member

Formatted: Not Highlight

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

VIII. Licensing / Allowable Providers

- AAH CS Providers must have experience and expertise with providing these unique services.
- AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.
- AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recertification and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Not Bold

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

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt, Not Bold

Formatted: Font: Not Bold

2.1 AAH provides tenancy and sustaining services through their CS network of providers, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

- 2.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
- 2.1.2 Education and training on the role rights and responsibilities of the tenant and landlord.
- 2.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
- 2.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
- 2.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
- 2.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
- 2.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI

~~application process. Such service can be subcontracted out to retain needed specialized skillset.~~

~~2.1.8 Assistance with the annual housing recertification process.~~

~~2.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.~~

~~2.1.10 Continuing assistance with lease compliance, including ongoing support with activities related to household management.~~

~~2.1.11 Health and safety visits, including unit habitability inspections.~~

~~2.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move in).~~

~~2.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.~~

~~2.2 Housing Tenancy and Sustaining Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.~~

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

~~2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed to maintain successful tenancy.~~

~~2.5 Housing Tenancy and Sustaining Services do not include the provision of room and board or payment of rental costs. Please see housing deposits CS.~~

~~2.6 Member Identification~~

~~2.6.1 Report Based CS~~

~~2.6.1.1 Monthly, the Analytics department runs a Population Report, using data from all members using the specific Housing criteria to identify members.~~

~~2.6.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.~~

~~2.6.1.2.1 Notification of Eligibility~~

~~2.6.1.2.1.1 Member are notified of Housing eligibility via written communication.~~

~~2.6.1.2.1.2 If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member.~~

Documenting all progress in the system of record.

~~2.6.2 Referral Based CS~~

~~2.6.3 Assignment to CS Providers will be determined using factors, including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.6.4 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.~~

~~2.6.4.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.6.5 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

~~2.7 Request for Housing Tenancy and Sustaining Services~~

~~2.7.1 AAH verifies a member's health plan eligibility~~

~~2.7.1.1 Request is reviewed~~

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

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

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

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

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

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

~~2.7.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the~~

usual referral process (refer to attached Community Supports Referral Process Flow).

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

~~2.8 Continuity of Care~~

~~2.8.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.8.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.8.2.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.8.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.~~

~~2.8.3 AAH will automatically authorize the CS service when the above conditions are met.~~

~~2.9 Data Sharing~~

~~2.9.1 AAH establishes and maintains a data sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.~~

~~2.9.2 AAH CS Clinical Staff and Analytics Staff support CS Provider(s) with additional data on member's health histories as needed. If additional information is requested, an ad-hoc report will be created and sent to the provider.~~

~~2.9.3 AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.9.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.9.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.~~

~~2.10 Payment~~

~~2.10.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.10.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~

~~2.10.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.10.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.10.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.10.3 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.11 Eligibility~~

~~2.11.1 Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services.~~

~~2.11.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or~~

~~2.11.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or~~

~~2.11.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:~~

2.11.4.1 — In W&I Code section 14127I as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residencee.

2.11.4.2 — By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.11.4.2.1 A “homeless individual with a disability,” as defined in section 401(9) of the McKinney Vento Homeless Assistance Act (42 U.S.C. 11260(9)), who:

2.11.4.2.1.1 — Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.11.4.2.1.2 — Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.11.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.11.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.11.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.11.5.1 — (1) An individual or family who:

- 2.11.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;
- 2.11.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
- 2.11.5.1.2.1 — Meets one of the following conditions:
 - 2.11.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - 2.11.5.1.2.1.2 Is living in the home of another because of economic hardship;
 - 2.11.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
- 2.11.5.1.3 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- 2.11.5.1.4 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- 2.11.5.1.5 Is exiting a publicly funded institution, or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- 2.11.5.1.6 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved consolidated plan;
- 2.11.5.2 — (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- 2.11.5.3 — (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the

McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)); and the parent(s) or guardian(s) of that child or youth if living with her or him; or

~~2.11.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:~~

~~2.11.6.1 Have one or more serious chronic conditions;~~

~~2.11.6.2 Have a Serious Mental Illness;~~

~~2.11.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder~~

~~2.11.6.4 Have a Serious Emotional Disturbance (children and adolescents);~~

~~2.11.6.5 Are receiving Enhanced Care Management; or~~

~~2.11.6.6 Are a Transition Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or~~

~~2.11.7 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.~~

~~2.12 Restrictions / Limitations~~

~~2.12.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the Community Supports, and 3) the Community Supports are authorized and identified in the AAH plan contracts.~~

~~2.12.2 Housing Tenancy and Sustaining Services will be available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if~~

CSM-00243 Community Supports – Housing Tenancy and Sustaining Services

individual has previously received services. Service duration can be as long as necessary.

~~2.12.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer term housing without such assistance.~~

~~2.12.4 Many individuals will have also received Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.~~

~~2.12.5 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.~~

~~2.13 Discontinuing Services~~

~~2.13.1 Discontinuing of CS services will be based on:~~

~~2.13.1.1 Goals met/completion of housing support plan~~

~~2.13.1.2 Termination of coverage~~

~~2.13.1.3 Unable to maintain contact with member~~

~~2.13.1.4 No longer meets criteria~~

~~2.13.1.5 Member/caregiver declines services~~

~~2.13.1.6 Death of member~~

~~2.13.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.~~

~~2.13.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

~~2.14 Licensing / Allowable Providers~~

~~2.14.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.~~

~~2.14.2 If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. AAH will coordinate with county homelessness entities to provide these services.~~

~~2.14.3 Clients who meet the eligibility requirements for Housing and Tenancy Support Services will also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care~~

management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports
<u>AC Health</u>	<u>Alameda County Health</u> — <u>Health Care Services Agency</u>
<u>AAH</u>	<u>Alameda Alliance for Health</u>

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Housing Tenancy and Sustaining Services Community Supports Standard Operating Procedures
Referral Process Flow

REVISION HISTORY

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

REFERENCES

<https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx>
CSM-00243 Community Supports – Housing Tenancy and Sustaining Services

MONITORING

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

| ~~CSM-00243~~ Community Supports – Housing Tenancy and Sustaining Services

| _____ Page 15 of 15



POLICY AND PROCEDURE

Policy Number	CS-007
Policy Name	Community Supports – Medically ~~Tailored Meals/Medically Supportive Food~~ <u>Tailored Meals/Medically Supportive Food</u>
Department Name	Community Supports ~~Division~~
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ <u>Long Term Services and Supports</u>
Line(s) of Business	~~DSNP~~ , MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ <u>TBD</u>
Administrative Oversight Committee Approval Date	~~9/18/2024~~ <u>TBD</u>

POLICY STATEMENT

- ~~1.1 This policy outlines the process in which Alameda Alliance for Health processes the Medically Tailored Meals/Medically Supportive Food Community Support. Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.~~
- ~~1.2 AAH works with community resources to ensure access to and delivery of CS services.~~
- ~~1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Medically Supportive Food/Meals/Medically Tailored Meals to their CS clients.~~
- ~~1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.~~
- ~~1.4 As indicated in P&P CLS-009, Cultural and Linguistic Services (CLS) Program—Contracted Providers, AAH collaborates with providers to provide non-~~

CM-025CS-007 Community Supports – ~~Medically Tailored Meals/Medically Supportive Food~~ Medically Tailored Meals/Medically Supportive Food

~~discriminatory and equitable services.~~

- ~~1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.~~
- ~~1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~
- ~~1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~
- ~~1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.~~

Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition sensitive, leading to improved health outcomes and reduced unnecessary costs.

MTMs and Medically Tailored Groceries (MTGs), Medically Supportive Food (MSF) are covered by this service, defined as follows:

a. **MTMs:** Meals that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

b. **MTG:** Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions.

c. **MSF:** Preselected foods that follow the federal Dietary Guidelines for Americans and meet recommendations for the nutrition sensitive health conditions of the recipients to whom they are prescribed.

Nutrition Education: Health coaching, counseling, classes, behavioral supports, and tools, including equipment and materials, that are based on a Member's health conditions and needs. Nutrition education is part of this service alongside the MTM/MSF services offered. Nutrition education provided as a standalone service is not sufficient to be considered delivery of this Community Support.

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

PROCEDURE

I. Eligibility

Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic

Formatted: Font: 12 pt, Bold

Formatted: Font: Not Bold

kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

II. Referrals

a. Referrals to the Medically Tailored Meals/Medically Supportive Food Community support can be received from:

- i. The member themselves**
- ii. A members representative**
- iii. A Members Provider**
- iv. Other internal departments at the Alliance**
- v. Through Analytic data ran by the Alliance**

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

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

2.1 AAH Medically Supportive Food/Meals/Medically Tailored Meals may include:

- 2.1.1 Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.**
- 2.1.2 Medically Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.**
- 2.1.3 Medically Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition related health outcomes.**
- 2.1.4 Medically supportive food and nutrition services, including medically tailored groceries and healthy food vouchers, and food pharmacies.**
- 2.1.5 Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.**

2.2 Member Identification

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

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Right: 0.51", Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1", Tab stops: 1.14", Left + 1.14", Left + Not at 1.68" + 1.68"

~~2.2.1 Report Based CS~~

~~2.2.1.1 AAH Analytics produces a monthly Population Report, using medical and pharmacy data for all members and includes the specific Medically Supportive Food/Meals/Medically Tailored Meals criteria to identify members.~~

~~2.2.1.2 The Population Report is provided to the AAH CS team for further processing.~~

~~2.2.1.1 Notification of Eligibility~~

~~2.2.1.2.1 Members are notified of Medically Supportive Food/Meals/Medically Tailored Meals eligibility via telephonic communication.~~

~~2.2.2 Referrals Based CS~~

~~2.2.3 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.2.4 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.~~

~~2.2.4.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.2.5 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

III. Review

a) When the Alliance receives a request for Medically Tailored Meals/Medically Supportive Food, they will review the documentation submitted by the provider. This will include the following:

1. Request from the Medically Tailored Meals/Medically Supportive Food provider
2. Clinical that supports the diagnosis and the need, dated within 30 days of the request
3. Lab values to support the diagnosis and the need, dated within 6 months of the request
4. Documentation of other food resources that the member has been referred to

b) Once the information is reviewed, a decision will be made within the turnaround

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

Formatted: Font: Bold

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

Formatted: Font: 12 pt

time standard and processes listed in the UM 057 policy.

- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) A CM or ECM referral may be made if the member is not already enrolled, and additional needs are identified.
- e) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

Formatted: Font: 12 pt

IV. Closed Loop Referral

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

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Normal, No bullets or numbering

2.3 Request for Medically Supportive Food/Meals/Medically Tailored Meals Services

Formatted: Font: Bold

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

2.3.1 AAH verifies a member's health plan eligibility.

2.3.1.1 Request is reviewed

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

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

2.3.2 Urgent request for Medically Supportive Food/Meals/Medically Tailored Meals services will follow the standard AAH timeline in accordance with UM 051, Timeliness of UM Decision Making and Notification.

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

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

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

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

2.3.5.1.1 In terms of coordinating CS referrals with the ECM Provider for

~~members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.3.5.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

2.4 Continuity of Care

~~2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the plan's Evidence of Coverage and Disclosure forms, and upon request, the Alliance also sends a copy of the policy to the member.~~

~~2.4.2 Upon the request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.4.2.1 AAH offers the CS service which the member had received through their prior MCP.~~

~~2.4.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.~~

~~2.4.3 AAH will automatically authorize the CS service when the above conditions are met.~~

2.5V. Data Sharing

~~2.5.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.~~

~~2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.5.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.5.4c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services (DHCS) guidelines.~~

~~2.5.5d) AAH Collects, analyzes, and reports financial measures, health status, and~~

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

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

Formatted: Font: 12 pt

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

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

2.6 Eligibility

~~2.6.1 Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.~~

~~2.6.2 Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or~~

~~2.6.3 Individuals with extensive care coordination needs.~~

2.7 VI. Restrictions / Limitations

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

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

2) beneficiaries are not required to use the Community Supports and

~~2.7.1~~ 3) the Community Supports are authorized and identified in the Medi-Cal managed care plan contracts.

b) ~~Service covers up to two (2) meals and/or meal packages per day using a combination of MTMs and MSF interventions. Up to two (2) medically tailored meals per day and/or medically supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.~~

~~2.7.1.1 c) MTM/MSF can be authorized for up to 12 weeks and may be reauthorized thereafter if medically necessary.~~

~~2.7.1.2 d) Meals that are eligible for or reimbursed by alternate programs are not eligible.~~

~~2.7.1.3 e) Meals are not covered to respond solely to food insecurities.~~

~~2.7.2 Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using AAH funding.~~

2.8 Payment

~~2.8.1 AAH will receive and disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 1.5", No bullets or numbering

Formatted: Indent: Left: 1.5"

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

Formatted: Font: 12 pt

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

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 5 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

~~2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~

~~2.8.3.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.8.3.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.8.3.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.9~~**VII. Discontinuing Services**

~~2.9.1a) Discontinuing of CS services will be based on:~~

~~2.9.1.1• Goals met/completion of meal program with no extension needed~~

~~2.9.1.2• Termination of coverage~~

~~2.9.1.3• Unable to establish or maintain contact with member~~

~~2.9.1.4• No longer meets criteria~~

~~2.9.1.5• Member/caregiver declines services~~

~~2.9.1.6• Death of member~~

~~2.9.2 CS provider will notify AAH CS team if member terminates program early.~~

~~2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System at authorization expiration.~~

~~2.10~~**VIII. Licensing / Allowable Providers**

~~2.10.1a) CS Medically Tailored Meals/Medically Supportive Foods Providers must have experience and expertise with providing these unique services.~~

~~2.10.2b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.~~

~~2.10.3c) AAH plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-00422-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH managed care plans will credential the providers as required by DHCS.~~

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

Formatted: Bulleted + Level: 1 + Aligned at: 1.25" + Indent at: 1.5"

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

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

Formatted: Font color: Black

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

Formatted: Font color: Black

DEFINITIONS / ACRONYMS

CM-025CS-007 Community Supports – Medically Tailored Meals/Medically Supportive Food-Medically Supportive Food/Meals/Medically Tailored Meals

CS Community Supports
HCSA Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024, 9/18/2024, 05/03/2025

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	CS-008
Policy Name	Community Supports – Respite Services
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ Long Term Services and Supports
Line(s) of Business	D-SNP, MCAL
Effective Date	6/12/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/21/2024TBD
Administrative Oversight Committee Approval Date	9/18/2024TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Respite Services Community Support.

Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite Services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

Formatted: Indent: Left: 1.14"

3. Services that attend to the Member's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

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

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

~~1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Respite Services for their CS clients.~~

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

~~1.4 Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.~~

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

~~1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.~~

~~1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~

~~1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~

~~1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.~~

Formatted: Indent: Left: 1.14", No bullets or numbering

Formatted: Right: 0.51", Tab stops: 0.75", Left + Not at 1.14" + 1.14"

Formatted: Right: 0.51", Tab stops: 0.75", Left + Not at 1.14" + 1.14"

Formatted: Tab stops: 0.75", Left + Not at 1.14" + 1.14"

Formatted: Right: 0.51", Tab stops: 0.75", Left + Not at 1.14" + 1.14"

PROCEDURE

2.1 Respite Services can include any of the following:

- ~~2.1.1 Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.~~
- ~~2.1.2 Services provided by the day/overnight on a short term basis because of the absence of or need for relief for those persons normally providing the care to individuals.~~
- ~~2.1.3 Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.~~

~~Home Respite Services are provided to the Member in his or her own home or another location being used as the home.~~

~~Facility Respite Services are provided in an approved out of home location.~~

~~Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.~~

I. Eligibility

Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include:

- Children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver
- Foster care program beneficiaries
- Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program
- Members with Complex Care Needs

II. Referrals

a. Referrals to the Respite Services Community support can be received from:

- i. The member themselves
- ii. A members representative
- iii. A Members Provider
- iv. Other internal departments at the Alliance
- v. Through Analytic data ran by the Alliance

Formatted: Font: Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: 12 pt, Bold

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

- b. For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.
- c. Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1- 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

Formatted: Normal, Indent: Left: 0"

~~2.2 Member Identification~~

~~2.2.1 Referrals Based CS~~

- ~~2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~
- ~~2.2.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~
- ~~2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~
- ~~2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

~~2.3 Request for Respite Services~~

- ~~2.3.1 Once AAH verifies a member's health plan eligibility:~~
 - ~~2.3.1.1 Request is reviewed.~~
 - ~~2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.~~
 - ~~2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.~~
- ~~2.3.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.3.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.~~

~~2.3.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.3.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

2.4 Continuity of Care

~~2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.4.2.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.4.3 AAH will automatically authorize the CS service when the above conditions are met.~~

III. Review

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

1. A Request for Respite Services authorization form
2. Clinical information supports the need for respite services which includes:

Formatted: Font: 12 pt, Bold

- i. Documentation that the individual is dependent on others for ADLs, due to a medical condition
- ii. Documentation that the assistance needed is age appropriate
- iii. Documentation that the relief is to avoid institutional placement
- iv. Hours requested
- v. Name of the caregiver

- b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) A CM or ECM referral may be made if the member is not already enrolled, and additional needs are identified.
- e) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

Formatted: Font: 12 pt

IV. Closed Loop Referral

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

Formatted: Font: 12 pt, Bold

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

Formatted: Normal, No bullets or numbering

Formatted: Normal, Indent: Left: 2.63", No bullets or numbering

Formatted: Font: 12 pt, Bold

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

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

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

2.5.V. Data Sharing

2.5.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

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

2.5.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4c) AAH tracks and reports CS required quality measures as outlined in the

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

Department of Health Care Services' (DHCS) guidelines.

~~2.5.5d)~~ AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

~~2.6 Eligibility~~

~~2.6.1 Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.~~

~~2.6.2 Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.~~

~~2.7 Payment~~

~~2.7.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.7.2 AAH will adhere to standard claims processing turn around times for claims, invoices or encounter data that will be reimbursed on a fee for service basis as follows:~~

~~2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.7.3 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.8 VI. Restrictions and Limitations~~

~~2.8.1a)~~ Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

~~2.8.2b)~~ In the home setting, Respite Services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of

Formatted: Font: 12 pt, Bold

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

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

care. The service limit is up to 336 hours per calendar year and is inclusive of all in-home and in-facility services.

2.8.3c) Exceptions to the 336 hour per calendar year limit can be made, with AAH authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves the Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

2.8.4d) This service is only to avoid placements for which AAH would be responsible.

2.8.5e) Respite services cannot be provided virtually, or via telehealth.

2.8.6f) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9VII. Discontinuing Services

2.9.1a) Discontinuing of CS services will be based on:

- 2.9.1.1• Goals met/improved health status
- 2.9.1.2• Termination of coverage
- 2.9.1.3• No longer meets criteria
- 2.9.1.4• Member/caregiver declines services
- 2.9.1.5• Death of member

~~2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.~~

~~2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

2.10VIII. Licensing / Allowable Providers

2.10.1a) AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Respite Care.

2.10.2b) AAH CS Providers must have experience and expertise with providing these unique services.

2.10.3c) AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.3.1d) CS Providers must be approved by AAH to ensure adequate experience and

Formatted: Font: Bold

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

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

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

Formatted: Font: Bold

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

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

appropriate quality of care standards are maintained.

~~2.10.4e)~~ AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.10.5f)~~ AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See [Credentialing/Recredentialing and Screening/Enrollment APL 22-013](#)) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

New Policy: 6/12/2024

Revisions: 9/18/2024, ~~05/03/2025~~

Red = Substantive Updates

REFERENCES

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

MONITORING

~~CM-035~~CS-008 Community Supports – Respite Services

Page 9 of 10

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



POLICY AND PROCEDURE

Policy Number	CS-009
Policy Name	Community Supports – Personal Care and Homemaker Services
Department Name	Community Supports ~~Division~~
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ Long Term Services and Supports
Line(s) of Business	~~D-SNP~~ , MCAL
Effective Date	9/18/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ TBD
Administrative Oversight Committee Approval Date	~~9/18/2024~~ TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Personal Care and Homemaker Community Support.

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

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

~~1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Personal Care and Homemaker Services for their CS clients.~~

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

1.1 Personal Care Services and Homemaker Services (PCHS) can be provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding.

Formatted: Indent: Left: 0.25", No bullets or numbering

Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services as similarly provided by the In-Home Supportive Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

PCHS aid individuals who could otherwise not remain in their homes.

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

The Personal Care and Homemaker Services Community Support can be utilized:

- During the IHSS application process, including during any waiting period after a referral has been made. PCHS may be authorized prior to, and up until, IHSS services are in place.
- In addition to any approved county IHSS hours when additional support is required, including when IHSS benefits are exhausted.
- For Members who are ineligible for IHSS, PCHS can be put in place to help prevent a short-term stay in a skilled nursing facility (not to exceed 60 days). In order to receive short term PCHS, Members are not required to apply for IHSS, but the authorization request should include information about the need for short term stay in a skilled nursing facility in the absence of PCHS being available.

Formatted: Indent: Left: 0.44", No bullets or numbering

Formatted: Font: 12 pt

Formatted: Font: 12 pt

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

Formatted: Font: 12 pt

1.4 Personal Care Services and Homemaker Services are provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

1.5 This CS includes services provided through the In Home Support Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

1.6 Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

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

1.7.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can

~~meet the cultural, language, age and disability needs of our members.~~

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

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

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

PROCEDURE

I. Eligibility

- a) Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- b) Individuals with functional deficits and no other adequate support system; or
- c) Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: <http://www.cdss.ca.gov/In-Home-Supportive-Services>.

II. Referrals

- a. Referrals to the Personal Care and Homemaker Services Community support can be received from:
 - i. The member themselves
 - ii. A members representative
 - iii. A Members Provider
 - iv. Other internal departments at the Alliance
 - v. Through Analytic data ran by the Alliance
- b. For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.
- c. Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1- 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

III. Review

Formatted: Font: Bold

Formatted: Font: Not Bold

Formatted: Hyperlink, Font: 11 pt, Not Bold

Formatted: Font: Not Bold

Field Code Changed

Formatted: Font: Bold

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

Formatted: Font: Bold

- a) When the Alliance receives a request for personal Care or Homemaker Services, they will review the documentation submitted by the provider. This will include the following:
1. Request from the Personal Care and Homemaker Service provider
 2. IHSS Status (initial assessment or reassessment)
 3. Current IHSS hours being provided
 4. Completed assessment including:
 - i. Hours being requested
 - ii. Documentation of a change in condition (if applicable)
 - iii. Documentation of not being eligible for IHSS (if applicable)
- b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) A CM or ECM referral may be made if the member is not already enrolled, and additional needs are identified.
- e) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

Formatted: Font: 12 pt

IV. Closed Loop Referral

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

Formatted: Font: Bold

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

Formatted: Normal, No bullets or numbering

Formatted: Font: Not Bold

Formatted: Indent: Left: 0.94", No bullets or numbering

Formatted: Normal, No bullets or numbering

2.1 The Personal Care and Homemaker Services Community Support can be utilized:

- 2.1.1 Above and beyond any approved county IHSS hours, when additional hours are required and if IHSS benefits are exhausted; and
- 2.1.2 As authorized during any IHSS waiting period (Member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.
- 2.1.3 For Members not eligible to receive IHSS, to help avoid a short term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through IHSS should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.

~~2.2 Member Identification~~

~~2.2.1 Referrals Based CS~~

~~2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.2.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~

~~2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

~~2.3 Request for Personal Care and Homemaker Services~~

~~2.3.1 Once AAH verifies a member's health plan eligibility:~~

~~2.3.1.1 Request is reviewed.~~

~~2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.~~

~~2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.~~

~~2.3.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.3.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to~~

~~identify alternative resources.~~

~~2.3.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.3.4.1.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

~~2.4 Continuity of Care~~

~~2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.4.2.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.4.3 AAH will automatically authorize the CS service when the above conditions are met.~~

~~2.5V. Data Sharing~~

~~2.5.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.~~

~~2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.5.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.5.4c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.5.5d) AAH Collects, analyzes, and reports financial measures, health~~

Formatted: Font: Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.17" + Indent at: 1.42"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.17" + Indent at: 1.42"

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

~~2.6 Eligibility~~

- ~~2.6.1 Individuals at risk for hospitalization, or institutionalization in a nursing facility; or~~
- ~~2.6.2 Individuals with functional deficits and no other adequate support system; or~~
- ~~2.6.3 Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: <http://www.cdss.ca.gov/In-Home-Supportive-Services>.~~

~~2.7 Payment~~

- ~~2.7.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~
- ~~2.7.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~
 - ~~2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~
 - ~~2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~
 - ~~2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~
- ~~2.7.3 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.8 VI. Restrictions and Limitations~~

- ~~a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:~~
 - ~~1. ~~1)~~ the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service,~~
 - ~~2. ~~2)~~ beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.~~
 - ~~2.8.2b) This service cannot be utilized in lieu of referring to the In-Home Supportive Services (IHSS) program. Member must be referred to the IHSS program when they meet referral criteria.~~
 - ~~2.8.3c) If a Member receiving Personal Care and Homemaker services has~~

Formatted: Font: Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.92" + Indent at: 2.17"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.42" + Indent at: 1.67"

any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period

~~2.8.4d)~~ AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

~~2.9~~**VII. Discontinuing Services**

~~2.9.1a)~~ Discontinuing of CS services will be based on:

- ~~2.9.1.1~~● Goals met/improved health status
- ~~2.9.1.2~~● Termination of coverage
- ~~2.9.1.3~~● No longer meets criteria
- ~~2.9.1.4~~● Member/caregiver declines services
- ~~2.9.1.5~~● Death of member

~~2.9.2~~ CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

~~2.9.3~~ AAH will perform case closure and CS service disenrollment in the Clinical Information System.

~~2.10~~**VIII. Licensing / Allowable Providers**

~~2.10.1a)~~ AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Personal Care and Homemaker Services.

~~2.10.2b)~~ AAH CS Providers must have experience and expertise with providing these unique services.

~~2.10.3c)~~ AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

~~2.10.3.1d)~~ CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

~~2.10.4e)~~ AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be

Formatted: Font: Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.42" + Indent at: 1.67"

Formatted: Bulleted + Level: 1 + Aligned at: 1.75" + Indent at: 2"

Formatted: Font: Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.42" + Indent at: 1.67"

network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2-10.5f)~~

AAH

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

Formatted: Font color: Black

Formatted: Font color: Black

DEFINITIONS / ACRONYMS

CS Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

New Policy: 9/18/2024

Revisions: 05/03/2025

Formatted: Font: Bold

REFERENCES

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

MONITORING

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

~~CM-036~~CS-009 Community Supports – Personal Care and Homemaker Services



POLICY AND PROCEDURE

Policy Number	CS-010
Policy Name	Community Supports – Environmental Accessibility Adaptations (Home Modifications)
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ Long Term Services and Supports
Line(s) of Business	~~D-SNP~~ MCAL
Effective Date	9/18/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ TBD
Administrative Oversight Committee Approval Date	~~9/18//2024~~ TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Environmental Accessibility Adaptations (Home Modifications) Community Support.

Formatted: Normal, Justified, Indent: Left: 0"

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Examples of environmental accessibility adaption include:

- Ramps and grab bars to assist Members in accessing the home that are not covered under the members Durable medical Equipment (DME) benefit
- Doorway widening for Members who require a wheelchair
- Stair lifts
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower)

Formatted: Font: 12 pt

- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed)

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

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

Formatted: Font: Not Bold

Formatted: Left

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

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Personal Care and Homemaker Services for their CS clients.

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

1.4 Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home without which the Member would require institutionalization.

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

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

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

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

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

PROCEDURE

2.1 Examples of environmental accessibility adaptations include:

2.1.1 Ramps and grab bars to assist Members in accessing the home;

2.1.2 Doorway widening for Members who require a wheelchair;

2.1.3 Stair lifts;

2.1.4 Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in

shower);

~~2.1.5 Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and~~

~~2.1.6 Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).~~

~~The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).~~

I. Eligibility

a) Individuals at risk for institutionalization in a nursing facility

Formatted: Font: 12 pt, Bold

Formatted: Font: Not Bold

II. Referrals

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

i. The member themselves

ii. A members representative

iii. A Members Provider

iv. Other internal departments at the Alliance

v. Through Analytic data ran by the Alliance

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

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

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Bold

III. Review

a) When the Alliance receives a request for Environmental Accessibility Adaptations (Home Modifications), they will review the documentation submitted by the provider. This will include the following:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the MCP determines it is appropriate to approve without an evaluation.

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

- a. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;
- b. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and
- c. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
3. That a home visit has been conducted to determine the suitability of any requested equipment or service.
4. That the item being requested is not covered under the Member's DME benefit.

- b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.
- c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.
- d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Closed Loop Referral

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

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

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

Formatted: Font: 12 pt, Bold

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

~~2.2 When authorizing environmental accessibility adaptations as a CS, AAH must receive and document the follow:~~

- ~~2.2.1 The participants current primary care physician or other health professional's order specifying:
 - ~~2.2.1.1 the requested equipment or service~~
 - ~~2.2.1.2 documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate~~
 - ~~2.2.1.3 Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the member describing how and why the equipment or service meets the needs of the member will still be necessary.~~~~
- ~~2.2.2 A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service (unless the Alliance determines it is appropriate to approve without an evaluation):
 - ~~2.2.2.1 This evaluation and report should come from an entity with no connection to the provider of the requested equipment or services~~
 - ~~2.2.2.2 The evaluation and report should contain the following (at a minimum):
 - ~~2.2.2.2.1 An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;~~
 - ~~2.2.2.2.2 An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and~~
 - ~~2.2.2.2.3 A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.~~~~~~
- ~~2.2.3 If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and~~
- ~~2.2.4 That a home visit has been conducted to determine the suitability of any requested equipment or service.~~
- ~~2.2.5 The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a~~

longer time frame.

~~2.3 Member Identification~~

~~2.3.1 Referrals Based CS~~

~~2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~

~~2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

~~2.4 Request for Environmental Accessibility Adaptations (Home Modifications)~~

~~2.4.1 Once AAH verifies a member's health plan eligibility:~~

~~2.4.1.1 Request is reviewed.~~

~~2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.~~

~~2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.~~

~~2.4.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.~~

~~2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached~~

~~Community Supports Referral Process Flow):~~

~~2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

Formatted

~~2.5 Continuity of Care~~

~~2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.5.2.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.5.3 AAH will automatically authorize the CS service when the above conditions are met.~~

Formatted: Indent: Left: 2.31", No bullets or numbering

2.6V. Data Sharing

Formatted: Font: Bold

~~2.6.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.~~

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

~~2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.6.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.~~

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

~~2.6.4c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.6.5d) AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.~~

2.7 Eligibility

~~2.7.1 Individuals at risk for institutionalization in a nursing facility.~~

~~2.8 Payment~~

~~2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.~~

~~2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~

~~2.8.3.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.8.3.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.8.3.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.9~~VI. Restrictions and Limitations

~~2.9.1a)~~ Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

~~2.9.2b)~~ AAH will not use the Environmental Accessibility Adaptations (Home Modifications) CS if another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

~~2.9.3c)~~ EAAs must be conducted in accordance with applicable State and local building codes.

~~2.9.4d)~~ EAAs are payable up to a total lifetime maximum of \$7,500. The only exceptions to the \$7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so ~~significantly~~~~significantly~~ those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

~~2.9.5e)~~ EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

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

2.9.6f) Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

2.9.7g) Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), AAH will provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

2.9.8h) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10VII. Discontinuing Services

2.10.1a) Discontinuing of CS services will be based on:

- 2.10.1.1• Goals met/improved health status
- 2.10.1.2• Termination of coverage
- 2.10.1.3• No longer meets criteria
- 2.10.1.4• Member/caregiver declines services
- 2.10.1.5• Death of member

2.10.2 ~~CS Providers will submit monthly reports identifying AAH members who have completed the CS service.~~

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

2.11VIII. Licensing / Allowable Providers

2.11.1b) AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for EEAs.

2.11.2c) AAH CS Providers must have experience and expertise with providing these unique services.

2.11.3d) AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.31" + Indent at: 1.56"

Formatted: Bulleted + Level: 1 + Aligned at: 1.81" + Indent at: 2.06"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.31" + Indent at: 1.56"

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.31" + Indent at: 1.56"

~~2.11.3.1e)~~ CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

~~2.11.4f)~~ All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License except for a PERS installation, which may be performed in accordance with the system's installation requirements.

~~2.11.5g)~~ AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.11.6h)~~ AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program ([See Credentialing/Recredentialing and Screening/Enrollment APL 22-013](#)) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

~~CM-037~~CS-010 Community Supports – Environmental Accessibility Adaptations (Home Modifications) Page 10 of 11

New Policy: 9/18/2024

Revisions: 05/03/2025

Formatted: Font: Bold

REFERENCES

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

MONITORING

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



POLICY AND PROCEDURE

Policy Number	CS-011
Policy Name	Community Supports – <u>Assisted Living Facility Transitions</u> ~~Nursing Facility Transition/Diversion to Assisted Living Facilities~~
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ <u>Long Term Services and Supports</u>
Line(s) of Business	~~D-SNP~~ , MCAL
Effective Date	9/18/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ <u>TBD</u>
Administrative Oversight Committee Approval Date	~~9/18/2024~~ <u>TBD</u>

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Assisted Living Facility Community Support.

Formatted: Font: 12 pt

Assisted Living Facility Transitions (formerly known as “Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities”) is designed to assist individuals with living in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent nursing facility admissions for Members living in the community. This Community Support is intended for Members with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility.

For the purposes of this service definition, the term assisted living facility (ALF)

includes a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF). This service includes two components, as follows:

- Time-limited transition services and expenses to enable a person to establish a residence in an ALF. Transition services end once the Member establishes residency in the ALF. The transitional period will vary in length and services provided based on a Member's unique circumstances. Allowable expenses are those necessary to enable a person to establish ALF residence (except room and board), including, but not limited to:
 - i. Assessing the Member's housing needs and presenting options.
 - ii. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the ALF, so the Member can be safely and stably housed.
 - iii. Assisting in securing an ALF residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
 - iv. Moving expenses to support a Member's transition, such as movers/moving supplies and necessary private/personal articles to establish an ALF residence.
 - v. Communicating with facility administration and coordinating the move.
 - f. Establishing procedures and contacts to retain housing at the ALF.
- Ongoing assisted living services are provided to Members on an ongoing basis after they transition into the ALF. Members can receive these services indefinitely, as long as the Member can maintain residency in the ALF. These services include:
 - i. Assistance with Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs)
 - ii. Meal preparation
 - iii. Transportation d. Medication administration and oversight e. Companion services
 - iv. Therapeutic social and recreational programming provided in a home-like environment
 - v. 24-hour direct care staff onsite at the ALF to meet unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security
 - vi. Care coordination services to screen for eligibility and support enrollment of Members in Enhanced Care Management (ECM) and other Community Supports

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.5" + Indent at: 1.75"

- ~~1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.~~
- ~~1.2 AAH works with community resources to ensure access to and delivery of CS services.~~
- ~~1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Nursing Facility Transition/Diversion to Assisted Living Facilities for their CS clients.~~
- ~~1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.~~
- ~~1.4 Nursing Facility Transition/Diversion to Assisted Living Facilities services assist individuals to live in the community and/or avoid institutionalization when possible.~~
- ~~1.4.1 The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long term placement in a nursing facility when they meet eligibility requirements.~~
- ~~1.5 As indicated in P&P CLS 009, *Cultural and Linguistic Services (CLS) Program—Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.~~
- ~~1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.~~
- ~~1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~
- ~~1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~
- ~~1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.~~

PROCEDURE

- ~~2.1 The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.~~

~~2.2 This Community Support is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) or Adult Residential Facilities (ARF) and includes wrap around services such as assistance w/ ADLs and IADLs as needed, companion services, medical oversight, and therapeutic social recreational programming provided in a home-like environment. It includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:~~

~~2.2.1 Assessing the Member's housing needs and presenting options.~~

~~2.2.2 Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.~~

~~2.2.3 Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).~~

~~2.2.4 Communicating with facility administration and coordinating the move.~~

~~2.2.5 Establishing procedures and contacts to retain facility housing.~~

~~2.2.6 Coordinating with the Alliance to ensure that the needs of Members who need enhanced services to be safely and stably housing in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.~~

~~2.3 Member Identification~~

~~2.3.1 Referrals Based CS~~

~~2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~

~~2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929 (TTY) during normal business hours or the AAH Nurse Advice Line at 1-~~

888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

~~2.4 Request for Nursing Facility Diversion/Transition to Assisted Living Facilities~~

~~2.4.1 Once AAH verifies a member's health plan eligibility:~~

~~2.4.1.1 Request is reviewed:~~

~~2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request:~~

~~2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request:~~

~~2.4.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits:~~

~~2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented:~~

~~2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources:~~

~~2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow):~~

~~2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services:~~

~~2.5 Continuity of Care~~

~~2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member:~~

~~2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.5.2.1 AAH offers the CS service which the member received through their prior MCP:~~

Formatted: Right: 0.44"

Formatted: Tab stops: 1.68", Left + 1.68", Left + Not at 0.63" + 2"

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 1", Tab stops: 1.68", Left + 1.68", Left + Not at 0.63" + 1.5"

Formatted

Formatted: Tab stops: 1.68", Left + 1.68", Left + 5.94", Left + 6.19", Left

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 1"

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

I. Eligibility

a) Members residing in a nursing facility who:

1. Have resided 60+ days in a nursing facility and
2. Are willing to live in an assisted living setting as an alternative to a nursing facility; and
3. Are able to reside safely in an ALF.

b) Members residing in the Community who:

1. Are interested in remaining in the community; and
2. Are willing and able to reside safely in an ALF; and
3. Meet the minimum criteria to receive nursing facility LOC services, and, in lieu of going into a facility, choose to remain in the community and continue to receive medically necessary nursing facility LOC services at an ALF.

Members residing in the community” includes Members living in a private residence or public subsidized housing and Members already residing in an ALF who are at risk of institutionalization.

Members who are receiving facility level health care services on an acute or postacute care basis (such as hospitalization or a short-term skilled nursing facility stay) may be eligible for this Community Support, provided they otherwise meet the eligibility criteria.

II. Referrals

a. Referrals to the Assisted Living Facility Community support can be received from:

- i. The member themselves
- ii. A members representative
- iii. A Members Provider
- iv. Other internal departments at the Alliance
- v. Through Analytic data ran by the Alliance

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

c. Members may call AAH Member Services at 1-877-932-2738 or 1-800-

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Not Bold

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.5"

Formatted: Font: 12 pt, Bold

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

735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1- 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

Formatted: Font: Bold

III. Review

Formatted: Font: 12 pt, Bold

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

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

1. Documentation that the member has resided in a nursing facility for 60+ days or meet the criteria for a nursing facility admission
2. Documentation that the member is willing and able to safely reside in the assisted living facility
3. Documentation of waiver submission

Formatted: Normal, No bullets or numbering

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

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

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

Formatted: Normal, No bullets or numbering

IV. Closed Loop Referral

Formatted: Font: 12 pt, Bold

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

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

Formatted: Indent: Left: 2.75", No bullets or numbering

2.5.3

Formatted: Font: 12 pt

2.6V. Data Sharing

Formatted: No bullets or numbering

2.6.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

Formatted: Font: 12 pt, Bold

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

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

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS

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

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

~~2.6.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.~~

~~2.6.4c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.~~

~~2.6.5d) AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.~~

~~2.7 Eligibility~~

~~2.7.1 For Nursing Facility Transition:~~

~~1.1 The Member has resided 60+ days in a nursing facility;~~

~~2.1 The Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and~~

~~3.1 The Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.~~

~~2.7.2 For Nursing Facility Diversion:~~

~~1.1 The Member is interested in remaining in the community;~~

~~2.1 The Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and~~

~~3.1 The Member must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.~~

~~2.8 Payment~~

~~2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.~~

~~2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.8.3 AAH will adhere to standard claims processing turn around times for claims, invoices or encounter data that will be reimbursed on a fee for service basis as follows:~~

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

~~2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.8.42.1.2 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.9VI. Restrictions and Limitations~~

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

~~1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service,~~

~~2) beneficiaries are not required to use the Community Supports and~~

~~3) the Community Supports is authorized and identified in the AAH managed care plan contracts.~~

~~b) Room and board expenses are not included in this service. Members may receive assistance with room and board from other sources at the same time as receiving this service.~~

~~c) The ALW is not considered a state-level enrollment pathway for the purpose of enrolling these operators as Medi-Cal Providers offering Community Supports. The ALW is a distinct program authorized under the 1915(c) Waiver and is available to Medi-Cal managed care Members, with restrictions as a Medi-Cal FFS benefit, and is carved out of the Medi-Cal managed care program authority.~~

~~2.9.1~~

~~2.9.2 Individuals are directly responsible for paying their own living expenses.~~

~~2.9.3c) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.~~

~~2.10VII. Discontinuing Services~~

~~2.10.1a) Discontinuing of CS services will be based on:~~

~~2.10.1.1• Goals met/improved health status~~

~~2.10.1.2• Termination of coverage~~

~~2.10.1.3• No longer meets criteria~~

~~2.10.1.4• Member/caregiver declines services~~

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 1"

Formatted: Font: Bold

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

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

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

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

Formatted: Font: Bold

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

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

Formatted: Font: 12 pt

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

~~2.10.1.5~~ • ~~_____~~ –Death of member

~~2.10.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.~~

~~2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

~~2.11.VIII. Licensing / Allowable Providers~~

~~2.11.1a)~~ AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Assisted Living Facility Transitions~~Nursing Facility Transition/Diversion to Assisted Living Facilities.~~

~~2.11.2b)~~ AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

- ~~• 2.11.2.1~~ Case management agencies
- ~~• 2.11.2.2~~ Home Health agencies
- ~~• 2.11.2.3~~ ARF/RCFE Operators
- ~~• 1915c Home & Community Based Alternatives (HCBA)s/ALW providers~~

~~2.11.3c)~~ AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

~~2.11.4d)~~ CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

~~2.11.5e)~~ AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.11.6f)~~ AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

Formatted: Font: Bold

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

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

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 1.68" + Indent at: 1.93"

Formatted: Font: 11 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 1.68" + Indent at: 1.93"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 3 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

DEFINITIONS / ACRONYMS

CS Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

New Policy: 9/18/2024
Revisions: 05/03/2025

REFERENCES

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

MONITORING

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

Formatted: Font: Bold



POLICY AND PROCEDURE

Policy Number	CS-012
Policy Name	Community Supports – <u>Community or Home Transition Services</u> ~~Transition Services/Nursing Facility Transition to a Home~~
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~ <u>Long Term Services and Supports</u>
Line(s) of Business	~~D-SNP~~ , MCAL
Effective Date	9/18/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ <u>TBD</u>
Administrative Oversight Committee Approval Date	~~9/18/2024~~ <u>TBD</u>

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health processes the Community or Home Transition Services (formerly known as “Community Transition Services/Nursing Facility Transition to a Home”) Community Support.

Community or Home Transition Services (formerly known as “Community Transition Services/Nursing Facility Transition to a Home”) helps individuals to live in the community and avoid further institutionalization in a nursing facility.

Community or Home Transition Services support Members in transitioning from a licensed nursing facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household.

This service includes two components, as follows:

~~CM-039~~ CS-012 Community Supports – Community or Home Transition Services ~~Transition Services/Nursing Facility Transition to a Home~~

1. Time-limited transition services and expenses to enable a Member to transition from a licensed facility to a private residence or public subsidized housing. Each transitional period will vary in length and services provided based on a Member's unique circumstances. Includes services such as:

a. Assessing the Member's housing needs and presenting options.

b. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

c. Communicating with the landlord (if applicable) and coordinating the move.

d. Establishing procedures and contacts to retain housing.

e. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

2. Non-recurring set-up expenses are those necessary to enable a Member to establish a basic household that does not constitute room and board and include:

a. Security deposits required to obtain a lease on an apartment or home. Security deposits should be in alignment with AB-12.25 enacted in 2024;

b. Set-up fees for utilities or service access and up to six months' payment in utility arrears, as necessary to secure the unit;

c. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, and necessary repairs to meet Housing Choice Voucher program quality standards where those costs are not the responsibility of the landlord under applicable law;

d. Air conditioner or heater;

e. Adaptive aids designed to preserve an individual's health and safety in the home, such as hospital beds, Hoyer lifts, bedside

Formatted: Normal, Indent: Left: 1.5"

commode, shower chair, traction, or non-skid strips, etc., that are necessary to ensure access and safety for the individual upon move-in to the home, when they are not otherwise available to the Member under Medi-Cal (e.g., State Plan, HCBS waiver, etc.).

Formatted: Character scale: 105%

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

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

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

~~1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Transition Services/Nursing Facility Transition to a Home for their CS clients.~~

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

~~1.4 Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.~~

~~1.5 Community Transition Services/Nursing Facility Transition to a Home are non-recurring set up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.~~

~~1.6 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.~~

~~1.6.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.~~

~~1.6.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~

~~1.6.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~

~~1.6.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.~~

PROCEDURE

~~2.1 Allowable expenses are those necessary to enable a person to establish a basic~~
~~CM-039CS-012 Community Supports – Community or Home Transition Services/Transition~~
~~Services/Nursing Facility Transition to a Home~~

household that do not constitute room and board and include:

- ~~2.1.1 Assessing the Member's housing needs and presenting options.~~
- ~~2.1.2 Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).~~
- ~~2.1.3 Communicating with landlord (if applicable) and coordinating the move.~~
- ~~2.1.4 Establishing procedures and contacts to retain housing.~~
- ~~2.1.5 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.~~
- ~~2.1.6 Identifying the need for and coordinating the funding for environmental modifications to install necessary accommodations for accessibility.~~
- ~~2.1.7 Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or services access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.~~

~~2.2 Member Identification~~

~~2.2.1 Referrals Based CS~~

- ~~2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~
- ~~2.2.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~
- ~~2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

- ~~2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-~~

~~CM-039CS-012 Community Supports – Community or Home Transition ServicesTransition Services/Nursing Facility Transition to a Home~~

888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

~~2.3 Request for Community Transition Services/Nursing Facility Transition to a Home~~

~~2.3.1 Once AAH verifies a member's health plan eligibility:~~

~~2.3.1.1 Request is reviewed:~~

~~2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.~~

~~2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.~~

~~2.3.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.3.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources:~~

~~2.3.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.3.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

~~2.4 Continuity of Care~~

~~2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.4.2.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.4.3 AAH will automatically authorize the CS service when the above conditions are met.~~

I. Eligibility

a) Members who:

1. Are currently receiving medically necessary nursing facility Level of Care (LOC) services and in lieu of remaining in the nursing facility or Recuperative Care setting are choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
2. Have lived 60+ days in a nursing home and/or Recuperative Care setting; and
3. Are interested in moving back to the community; and
4. Are able to reside safely in the community with appropriate and cost-effective supports and services.

II. Referrals

a. Referrals to the Community or Home Transition Services Community support can be received from:

- i. The Member themselves
- ii. A Members representative
- iii. A Members Provider
- iv. Other internal departments at the Alliance
- v. Through Analytic data ran by the Alliance

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

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

III. Review

a) When the Alliance receives a request for Community or Home Transition Services, they will review the documentation submitted by the provider. This will include the following:

~~CM-039CS-012 Community Supports – Community or Home Transition ServicesTransition Services/Nursing Facility Transition to a Home~~

Formatted: Font: 12 pt, Bold

Formatted: Font: Not Bold

Formatted: Font: 12 pt, Bold

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

Formatted: Font: 12 pt

Formatted: Font: Bold

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

1. Documentation that the member has resided in a nursing facility for 60+ days or meet the criteria for a nursing facility admission
2. Documentation that the member is willing and able to safely reside in the assisted living facility

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

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

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

IV. Closed Loop Referral

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

1.

2.5V. Data Sharing

2.5.1a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

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

2.5.3b) AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5d) AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

~~CM-039~~CS-012 Community Supports – Community or Home Transition Services~~Transition Services/Nursing Facility Transition to a Home~~

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

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 2.25" + Indent at: 2.5"

Formatted: Font: 12 pt, Bold

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

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt, Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

2.6 Eligibility

- ~~2.6.1 The Member is currently receiving medically necessary nursing facility Level of Care (LOC) services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition to home and continue to receive medically necessary nursing facility LOC services; and~~
- ~~2.6.2 The Member has lived 60+ days in a nursing home and/or Medical Respite setting; and~~
- ~~2.6.3 The Member is interested in moving back to the community; and~~
- ~~2.6.4 The Member is able to reside safely in the community with appropriate and cost-effective supports and services.~~

2.7 Payment

- ~~2.7.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.~~
- ~~2.7.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~
- ~~2.7.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~
 - ~~2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~
 - ~~2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~
 - ~~2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~
- ~~2.7.4 PMPM payments will be provided for applicable CS services (e.g., housing).~~

2.8 VI. Restrictions and Limitations

- a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:
 - 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service,
 - 2) beneficiaries are not required to use the Community Supports and
 - ~~2.8.1~~ 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

- ~~2.8.2b) Community or Home Transition Services~~
~~Services~~ do not include monthly rental or mortgage expense, food, regular

~~CM-039CS-012 Community Supports – Community or Home Transition Services~~
~~Transition Services/Nursing Facility Transition to a Home~~

Formatted: Font: Bold

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

Formatted: Normal, Indent: Left: 1.5", No bullets or numbering

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

~~2.8.3c) Community~~ Non-recurring set-up expenses are payable up to a total lifetime maximum amount of \$7,500.00. The transitional coordination cost is excluded from this total lifetime maximum. The only exception to the \$7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence or public subsidized housing through circumstances beyond his or her control. ~~Transition Services are payable up to a total lifetime maximum amount of \$7,500.00. The only exception to the \$7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.~~

~~2.8.4d) Community or Home Transition Services~~ ~~Community Transition Services~~ must be necessary to ensure the health, welfare and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

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

~~2.8.5~~

2.9VII. Discontinuing Services

~~2.9.1a)~~ Discontinuing of CS services will be based on:

- ~~2.9.1.1•~~ Goals met/improved health status
- ~~2.9.1.2•~~ Termination of coverage
- ~~2.9.1.3•~~ No longer meets criteria
- ~~2.9.1.4•~~ Member/caregiver declines services
- ~~2.9.1.5•~~ Death of member

~~2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.~~

~~2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

2.10VIII. Licensing / Allowable Providers

~~2.10.1a)~~ AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other

CM-039CS-012 Community Supports – ~~Community or Home Transition Services~~ ~~Transition Services/Nursing Facility Transition to a Home~~

Formatted: Indent: Left: 1.5", No bullets or numbering

Formatted: Font: Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

Formatted: Font: Bold

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Transition Services/Nursing Facility Transition to a Home .

~~2.10.2b)~~ AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

- ~~2.10.2.1~~ Case management agencies
- ~~2.10.2.2~~ Home Health agencies
- ~~2.10.2.3~~ County mental health providers
- ~~2.10.2.4~~ 1915c HCBA/ALW providers

~~2.10.2.5~~ ~~CCT/Money Follows the Person providers~~

~~2.10.3c)~~ AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

~~2.10.4d)~~ CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

~~2.10.5c)~~ AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.10.6f)~~ AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program ([See Credentialing/Recredentialing and Screening/Enrollment APL 22-013](#)) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

~~CM-039~~CS-012 Community Supports – ~~Community or Home Transition Services~~Transition Services/Nursing Facility Transition to a Home

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 2" + Indent at: 2.25"

Formatted: Indent: Left: 1.29", No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 3 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

New Policy: 9/18/2024

Revisions: 05/03/2025

Formatted: Font: Bold

Formatted: Font: Bold

REFERENCES

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

MONITORING

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

~~CM-039~~ CS-012 Community Supports – ~~Community or Home Transition Services~~ ~~Transition Services/Nursing Facility Transition to a Home~~

POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL, ~~D-SNP~~
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

POLICY STATEMENT

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

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

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

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

The Alliance provides these transportation services in accordance with time and distance and

timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed-, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

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

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

Non-Emergency Medical Transportation

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

Prior Authorization – Trips over 50 miles

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

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form, not to exceed 12 months. Once the member's treating provider prescribes the mode of NEMT, neither AAH nor its subcontractor modify the PCS Form.

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

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

has prior authorization for the NEMT.

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

AAH's transportation coordinators facilitate the acquisition and completion of PCS form by the member's treating providers before the trip occurs. AAH reviews and approved the PCS form. AAH has a process in place to share PCS data with the transportation subcontractor.

Prior Authorization Exceptions

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

Transportation Liaison

AAH has a direct line to its transportation liaison for providers and members to call to ensure eligible urgent and non-urgent transportation requests are authorized and scheduled. The direct line to the transportation liaison is listed in the member handbook and provider handbook.

Non-Emergency Medical Transportation Modalities

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

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests. AAH informs members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

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

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately

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

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

Non-Emergency Medical Transportation Physician Certification Statement Forms

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

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

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

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

Non-Medical Transportation

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

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

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

AAH provides the following NMT services:

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

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

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

Conditions for Non-Medical Transportation Services:

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

Non-Medical Transportation Private Vehicle Authorization Requirements

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

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

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

transportation.

Non-Medical Transportation Authorization

AAH does not require prior authorization for NMT services.

Minor Requirements

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

Transportation Brokers

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

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

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy [VMG-005CMP-040](#) Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.

AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

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

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

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.

A member is- eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment

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

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

Lodging

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

Meals

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

Other Necessary Expenses

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

Enrollment of Transportation Providers

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy [VMG-005CMP-040](#) Transportation Provider Registration with DHCS.

Spot Checking of Trips

To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker.

Major Organ Transplant

AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.

AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.

AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight

AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.

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

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

PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and

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

- i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.
- ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

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

- ii) At a minimum, the following components are included in the PCS form:
 - (a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
 - (b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
 - (c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
 - (i) Ambulance services will be provided for:
 1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
 2. Transfers from an acute care facility to another acute care facility.
 3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
 4. Transport for members with chronic conditions who require oxygen if monitoring is required.
 - (ii) Litter van services will be provided when both of the following are met:
 1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
 2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
 - (iii) Wheelchair van services will be provided when any of the following are met:

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

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

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

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

- (d) The signed PCS form with the required fields will be considered completed.
 - (e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.
 - (f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.
 - (g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.
- iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.
- (a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:
 - (i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a

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

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

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

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

- (i) Medically necessary covered services
 - (ii) Members picking up drug prescriptions that cannot be mailed directly to the member
 - (iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

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

- (c) Conditions for NMT services:

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

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

consent for the minor's service.

- ii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:
 - (a) Public transportation/mass transit (bus passes)
 - (b) East Bay Paratransit
 - (c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)
 - (d) Door-to-door passenger vehicle
 - (e) Train tickets
 - (f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.
 - (i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:
 - 1. Valid driver's license,
 - 2. Valid vehicle registration, and
 - 3. Valid vehicle insurance.
- iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

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

- i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.
- i) Ground Emergency Medical Transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.
- ii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.
- iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

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

3. Prior Authorization Process

- i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.
 - (a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.
- ii) For transportation trips that exceed the 50-mile limit, the requesting provider/hospital will submit the AAH Prior Authorization Form to the AAH UM team via Portal or Fax.
 - (a) The UM team will process the request within the required time frame and fax a copy of the authorization to the Transportation Vendor once a decision is rendered.

4. Emergency Arising during Transport of a member

- a. Emergencies arising in the course of a transport may include, but not be limited to the following:
 - i. Sudden onset of a new emergency medical condition
 - ii. Motor vehicle accident resulting in the injury of a member.
 - iii. Member elopement during the transport
 - iv. Member attempt of or actual self-harm or harm of others
 - v. Other unexpected events that have the potential to result in harm to the member.
- b. In the event that an emergency arises during the transport of a member, the transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and mitigation of potential harm to the member.
- c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the ~~Grievance Department~~ by email to grievances@alamedaalliance.org, and by phone to the ~~Grievance and Appeal Department~~ at [Transportation Liaison](tel:5107474531) (510) ~~747-4531~~ [373-5654](tel:5107474531).
- d. The ~~Grievance and Appeal staff member~~ [Transportation Liaison](#) receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.
- e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

5. ~~RideShare Pilot~~

~~In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow~~

~~member to use a car, bus or taxi to get to appointments. Member cannot request~~

~~that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.~~

DEFINITIONS / ACRONYMS

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

UM-002 Coordination of Care

RELATED WORKFLOW DOCUMENTS AND OTHER RELATED DOCUMENTS

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

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023, 7/17/2024, 8/28/2024, **4/16/2025**

Blue = material updates

REFERENCES

AB 2394, Chapter 615, Statutes of 2016 California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)
DHCS APL 21-011 Grievance and Appeals Requirements, Notice and “Your Rights” Templates

DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services
DHCS APL 22-013 Provider Credentialing/ Re-Credentialing and Screening/ Enrollment
DHCS APL 23-006 Delegation and Subcontractor Network Certification
DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CM-009
Policy Name	Enhanced Care Management Program Infrastructure
Department Name	Health Care Services Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024 TBD
Administrative Oversight Committee Approval Date	12/18/2024 TBD

POLICY STATEMENT

Alameda Alliance for Health (AAH) leverages existing relationships and communications with our provider network to facilitate care planning, care coordination, and care transition coordination as stated in the Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Program Guide.

AAH's ECM is structured as a network which includes AAH contracted ECM Providers, and relationships with other Community-Based Organizations and providers to provide linkages to healthcare, community, and social support services.

The ECM Provider serves as the primary coordinator for overseeing the patient-centered care for assigned ECM eligible/enrolled members.

AAH will perform duties/responsibilities as outlined per the DHCS CalAIM Enhanced Care Management Program Guide.

AAH requires our subcontracted plans (delegates) use the same process for informing members, family member(s), guardian, caregiver and/or other authorized support person(s) about ECM, how to request ECM and that the status of the request is communicated back to inquiring party.

PROCEDURE

1.0 The ECM network will be developed and continually monitored to meet the following goals:

1.1 Ensure sufficient ECM funds are available to support care management at the point of care in the community.

- 1.2 Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available.
- 1.3 Leverage existing county and community provider care management infrastructure and experience.
- 1.4 Forge new relationships with community provider care-management entities.
- 1.5 Utilize community health workers in appropriate roles.
- 2.0 The goal of ECM includes:
 - 2.1 Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based services & supports, palliative care, and social support needs, including housing;
 - 2.1.1 In order to identify risks and improve member outcomes, the ECM Provider is responsible for conducting a Health Action Plan, defined as a comprehensive risk assessment and care plan, within ninety (90) calendar days of the member's enrollment into the ECM.
 - 2.2 Reducing avoidable health costs, including hospital admissions/readmission, Emergency Department (ED) visits, and nursing facility stays.
 - 2.2.1 AAH manages and monitors key metrics reports compiled by the AAH Analytics team. The ECM dashboard is distributed to the appropriate ECM Provider on a routine basis.
 - 2.3 AAH performs the following duties/responsibilities:
 - 2.3.1 AAH will inform the providers and entities who serve the Members of this Population of Focus as follows:
 - 2.3.1.1 Inclusion of ECM information in Quarterly Provider Packets sent to providers either through mail or delivered in-person
 - 2.3.1.2 Posting of ECM materials and announcements on the Alliance website
 - 2.3.1.3 Instructions on to whom/how to initiate ECM referrals- (referral form) on Alliance website
 - 2.3.1.4 Instructions on how to contact Alliance Case Management Department on the Alliance website
 - 2.3.1.5 Newsletter on Alliance website
 - 2.3.1.6 In addition, AAH will be hosting community-based stakeholder meetings to include nursing homes, home health agencies, Community Based Adult Services (CBAS) Providers, the Senior Services Coalition, Alameda County Health Care Services Agency (HCSA), and Centers for Independent Living.
 - 2.3.1.7 Provide ongoing technical support for billing and reporting requirements.
 - ~~2.3.1.8 Encourage providers to apply for IPP funding to facilitate network expansion and capacity building.~~
 - ~~2.3.1.9 Through IPP funds, AAH as partnered with UCSF's THE Collective (Alameda County Training Development Unit) to provide ongoing soft skills development and additional training for providers.~~
 - 2.3.2 Assigns ECM eligible members to ECM Providers
 - 2.3.2.1 AAH Analytics team produces monthly eligibility lists based on defined criteria for each population of focus.

2.3.2.2 AAH Analytics team distributes eligibility lists across the network of ECM Providers

2.3.2.3 AAH also reviews referrals coming in from other AAH departments, ECM Providers, providers, members, and other entities serving adults living in the community who are at risk of Long-Term Care institutionalization and nursing facility residents transitioning to the community. Members may self-refer into ECM and/or dis-enroll at any time. AAH has a no wrong door policy. AAH will accept an ECM referral from PCPs, clinics, community & county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, CCS, foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

2.3.2.4 AAH ~~uses~~ will ensure a closed loop referral ~~system~~ process for all ECM referrals.

This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of focus the member is authorized for (if different from initial referral request), which ECM provider will be assigned to this member and confirmation that ECM services have started.

~~2.3.2.4.1 For Children/Youth and Pregnant/Postpartum populations of focus, a regular report is generated to monitor these vulnerable populations.~~

~~2.3.2.4.2~~ 2.3.2.4.1 Monitoring the referral report will improve communication between AAH and ECM providers to ensure members are being served appropriately.

2.3.3 Contracts with ECM Providers for provision of ECM services and ensures ECM Providers fulfill required duties and achieve ECM goals (See CM-013 ECM Oversight, Monitoring and Controls).

2.3.4 Notifies ECM Providers of inpatient admissions and ED visits through the following mechanisms:

2.3.4.1 Daily census reports distributed by the AAH Analytics team; includes the admission and discharge status.

2.3.4.2 AAH Utilization Management (UM), Case Management (CM) or ECM Staff outreach to ECM Provider staff through phone, email, or a combination.

2.3.4.3 AAH and ECM Providers access available data exchange platform(s), when possible.

2.3.5 Tracks and shares data with ECM Providers regarding each member's health history.

2.3.5.1 AAH Analytics team distributes relevant, available health history data to each ECM Provider within the eligibility list.

2.3.5.2 AAH ECM Clinical Staff and Analytics Staff support the ECM Providers with additional data on member's health histories, as needed.

2.3.6 Tracks and reports Centers for Medicare and Medicaid Services

- (CMS) required quality measures as outlined in DHCS guidelines.
- 2.3.7 Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported per DHCS guidelines.
 - 2.3.8 Provides resources relating to ECM as needed.
 - 2.3.9 Adds functionality to AAH Member Services Team and the AAH Nurse Advice Line.
 - 2.3.9.1 AAH conducts ECM refresher trainings and comprehensive trainings on a regular cadence.
 - 2.3.10 Receives payment from DHCS and disperses funds in a timely manner to ECM Providers through collection and submission of data by the ECM Provider, and through the contractual agreement made between AAH and the ECM Provider.
 - 2.3.11 Establishes and maintains a data-sharing agreement with contracted providers with whom AAH shares ECM member health information which is compliant with all federal and state laws and regulations, including member's parent/guardian ECM related data sharing regulations. Contracted providers are expected to obtain and document member agreement and data sharing authorization. Contracted providers shall notify AAH of the members' parent/guardian authorization of data sharing authorization preferences. As part of the ECM Provider pre-certification process, AAH requires tools and processes for obtaining and managing member authorizations for the sharing of Personally Identifiable Information. In addition, the standard provider contract includes a Business Associate Agreement (BAA), which Providers will be required to follow to obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between AAH, ECM, ILOS, and other Providers involved in the provision of Member care. AAH conducts auditing and oversight of ECM Provider activities that includes the review of protection methods for Personally Identifiable Information.
 - 2.3.12 Ensures timely access to services for ECM members, including follow-up with ECM members after discharge from an acute care setting.
 - 2.3.13 Encourages participation by network primary and specialty providers who are not included formally on the ECM Providers multi-disciplinary care team but who are responsible for coordinating with the ECM Provider.
 - 2.3.13.1 The AAH Provider Services Staff outreaches to all contracted primary care, specialty, and other community-based providers about ECM.
 - 2.3.13.2 The AAH ECM Staff outreaches to contracted hospitals, skilled nursing facilities, and urgent care facilities.
 - 2.3.14 Develops training tools for ECM Providers.
 - 2.3.14.1 AAH coordinates in-person/virtual trainings with ECM Providers and additional webinars, as needed. AAH will continue to provide training and education through monthly learning collaboratives with ECM Providers. In addition, materials will be updated on the AAH Provider Portal and information will be included in the AAH Provider newsletter.
 - 2.3.14.2 AAH ECM staff are available to provide technical

- assistance and training to ECM Providers as needed.
- 2.3.15 Partners with ECM Providers to develop reporting capabilities for ECM Providers using their available data/patient tracking systems.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
CM	Case Management
UM	Utilization Management
DHCS	Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 02/21/2023, 9/19/2023, 10/19/2023, 12/18/2024

REFERENCES

[ECM Policy Guide \(ca.gov\)](https://www.ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control



POLICY AND PROCEDURE

Policy Number	CM-011
Policy Name	Enhanced Care Management – Care Management & Transitions of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	02/01/2000
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ TBD
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

POLICY STATEMENT

Outreach and engagement are ensured and Enhanced Care Management (ECM) services are prioritized according to risk grouping tiers by ECM Providers. ECM Members are thoroughly assessed, including complex medical conditions, behavioral conditions and/or social needs. Health Action Plans (HAPs) are developed to assist in the management of the Member's needs including housing (instability, homelessness), Transition of Care support and Referral tracking and follow-up. Improving Quality of Care, patient safety and prevention of unnecessary hospital or emergency department admissions/visits are a key focus.

PROCEDURE

- 1.0 Pre-enrollment Member Outreach and Engagement
 - 1.1 Each ECM Provider is responsible for developing and implementing outreach and engagement strategies for the purpose of enrolling Members into ECM.
 - 1.2 ECM Providers routinely obtain and review information about newly eligible Members. If the ECM Provider is not the ECM Member's Primary Care Provider (PCP), the ECM Provider reaches out to confirm the ECM Member's PCP and informs the PCP of the Member's assignment to the ECM Provider. The ECM Provider coordinates care with the PCP and assigns an appropriate team member (Lead Care Manager) who is responsible for developing and implementing an outreach and engagement plan for each eligible ECM Member. Lead Care Managers who serve adults living in the community who are risk of Long Term Care (LTC) institutionalization and nursing facility residents transitioning to the community will be trained on person-centered planning, as required by federal law (Per [42 CFR § 438.208](#) the care plan

CM-011 Enhanced Care Management – Care Management & Transitions of Care

must be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR [§ 441.301\(c\)\(1\) and \(2\)](#) for members with long-term services and supports (LTSS) needs. If the ECM Member contacts the ECM Provider or AAH to request a change of Lead Care Manager, AAH will work with the ECM Provider to re-assign the ECM Member to another Lead Care Manager. ECM Providers will have a defined process, approved by AAH, for assigning and changing a Lead Care Manager. This process is the same for subcontracted plans (delegates).

- 1.2.1 Care team assignments for conducting outreach and enrollment should be customized for the Member, taking into consideration a Member's health needs, conditions, culture, language, location and other characteristics, as appropriate.
- 1.2.2 Individuals assigned to conduct outreach and engagement for enrollment and ongoing engagement may include, but are not limited to, community health workers and care coordinators.
- 1.2.3 Engagement plans are individualized using various approved strategies most appropriate for each Member, including provisions for Members experiencing homelessness.
- 1.2.4 Outreach and engagement plans take into account any background information available from care records, claims, or other providers regarding physical and behavioral health conditions, history of trauma, Member's language and cultural preferences, health literacy, preferred modes of communication (e.g., phone versus text), housing and work history, current housing status other social factors that may have historically been barriers to locating and contacting the Member, and any patterns of behaviors relevant to when/where/how the Member has sought care in the past.
- 1.2.5 Active outreach strategies may include but not be limited to:
 - 1.2.5.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;
 - 1.2.5.2 With member permission, direct communications with Members by letter, email, texts, telephone;
 - 1.2.5.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or
 - 1.2.5.4 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.
- 1.2.6 Outreach efforts will progress over ninety (90) days from the ECM Provider's receipt of the attributed ECM Member list. Outreach efforts will consist of:

All attempts to contact will be documented within the ECM Provider's care management platform or equivalent platform.

 - 1.2.6.1 During initial contact by an ECM Provider care team member conducting outreach, each Member is fully informed about ECM and terms of their participation, in accordance with this policy, and asked to either consent or decline to participate in ECM. A successful outreach contact shall consist of the following:
 - 1.2.6.1.1 Confirm Member eligibility for ECM.
 - 1.2.6.1.2 At initial assessment and each assessment thereafter, verify if Member is receiving any care management/coordination services with any other

program that interferes with enrollment into ECM due to duplication of services.

1.2.6.1.2.1 If the Member confirms enrollment in another program, they will be advised to choose only one of the programs.

~~1.2.6.1.3~~

1.2.6.2 . Consent not required according to DHCS ECM policy. Rather, member can decline participation into ECM at any time for any reason.

1.2.6.3 Notify and coordinate care with the Member's PCP and relevant specialty providers of Member's enrollment in ECM.

1.2.6.4 Either initiate or plan to complete the HAP with Member.

1.2.6.5 If the Member declines to participate in ECM:

1.2.6.5.1 Member is informed regarding continuing care with their PCP and obtaining assistance with coordination, as appropriate.

1.2.6.5.2 Member is informed that they may re-engage and receive ECM services at any time in the future if he or she continues to meet ECM eligibility requirements.

1.2.6.5.3 Declination is documented in the ECM Provider's care management platform or system of record.

1.2.6.6 ECM Providers will submit necessary data to AAH to meet the closed loop referral requirements, per DHCS guidelines.

1.2.6.6.1 AAH will send out notification to recipients as appropriate per guidelines.

~~1.2.6.6.1.2.6.7~~ AAH monitors, documents, and reports the progress and results of all ECM activities required to be reported to the Department of Health Care Services (DHCS), in accordance with provisions of this policy and any DHCS Program Guide.

2.0 Health Action Plan

2.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resulting Care Plan. The combination is known as the HAP. . ECM Assessment

2.1.1 The ECM Assessment is administered to provide a deeper base of knowledge needed to address complex medical conditions, longer-standing psychosocial or health care needs and gaps. Assessment information will include, but is not limited to:

2.1.1.1 Physical health;

2.1.1.2 Mental health;

2.1.1.3 Substance Use Disorder (SUD);

2.1.1.4 Community-based Services;

2.1.1.5 Palliative care;

2.1.1.6 Trauma-informed care needs;

2.1.1.7 Social Supports;

2.1.1.8 Housing and other Social Determinants of Health; and

2.1.1.9 Utilization

2.1.2 Addressing palliative care and trauma informed care needs

2.1.2.1 The ECM Assessment addresses the following palliative care domains: pain; difficulty taking medications; physical

Formatted: Indent: Left: 3.5", No bullets or

Formatted

function; social connections; and advance (directive) planning. The Alliance incorporates the elements of palliative care into the ECM Assessment without using the word “palliative.”

2.1.2.2 The ECM Assessment addresses the following trauma-informed care domains: safety, mental health, substance use disorder, pain, utilization, and disease burden. The Alliance incorporates the components of trauma-informed care into the ECM Assessment without using the word, “trauma” and uses open-ended questions designed to elicit responses that could include experiences considered to be traumatic.

2.1.2.3 Recognizing that palliative care and trauma-informed-care may be new skill sets for ECM Provider staff, training to address and improve palliative care and trauma-informed care assessments will be regularly offered to ECM Providers.

2.1.3 ECM Providers make multiple efforts to contact newly enrolled ECM Members to conduct the ECM Assessment which will be repeated yearly and with any transition in care or other major event.

~~2.1.4 Following Member consent to enroll, Members identified as higher risk will be prioritized for the outreach and engagement to conduct and complete the ECM Assessment.~~

~~2.1.5~~ 2.1.4 If unable to contact the Member by phone or mail, every avenue is researched to secure a valid phone number (e.g. the PCP office, specialty care provider office, a vendor where durable medical equipment is rented from, current pharmacy used, or data available on other data exchange platforms, etc.).

~~2.1.6~~ 2.1.5 The ECM Provider will document all contact attempts in their care management platform or system of record.

~~2.1.7~~ 2.1.6 To facilitate communication among the Member’s health care Providers, the completed ECM Assessment is made available to the entire ECM Provider team and the Member’s PCP.

~~2.1.8~~ 2.1.7 AAH ECM Providers will track, trend, monitor, and report ECM Assessment administration and reassessment practices for all eligible members.

2.2 Care Plan

2.2.1 Once the ECM Assessment is completed, the designated ECM Provider team member develops the Care Plan for each Member enrolled in ECM services in collaboration with the Member, caregiver, and other members of the ECM Provider team.

2.2.2 The designated ECM Provider team member works with the Member to develop and prioritize goals according to the Member’s priorities and preferences. Individualized goals will have timeframes and strategies for addressing each goal. Members are involved in the development, review, and approval of the Care Plan and any amendments to the Care Plan, as appropriate.

2.2.3 The Care Plan is developed using the ECM Assessment data as well as other information available from various sources such as utilization data, pharmacy data, or notes from any AAH Care Management (CM) activities.

2.2.4 The Care Plan will include, but is not limited to, the following elements, as appropriate:

- 2.2.4.1 Language and communication preferences;
- 2.2.4.2 Risk level or complexity tier;
- 2.2.4.3 Housing status;
- 2.2.4.4 Care team supports, including contact information;
- 2.2.4.5 Emergency Department (ED)/hospital utilization;
- 2.2.4.6 Medications and dosage;
- 2.2.4.7 Any care needs identified on the ECM Assessment pertaining to chronic physical condition, behavioral health status including cognitive functions, developmental health and dementia, trauma-informed care, palliative care needs, and specific goals and action plan;
- 2.2.4.8 Self-management goals, including barriers to success, interventions, and goal status;
- 2.2.4.9 Timeframes for reassessment and ECM Provider follow-up frequency;
- 2.2.4.10 Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies such as In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS);
- 2.2.4.11 Care coordination and social support needs such as arranging transportation, obtaining appointments, referral tracking and status updates (including housing referrals), coordinating interpreter services, and educating on the importance of preventative services.
- 2.2.5 The HAP is accessible to all members of the care team:
 - 2.2.5.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each followup.
 - 2.2.5.2 The PCP will be given a copy of the Member's HAP.
 - 2.2.5.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.
- 2.2.6 The ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status or health care needs and/or according to the HAP follow up plan. A clinician at the ECM Provider reviews the HAP. AAH clinician ensures that appropriate ECM clinicians have provided oversight to ensure the HAP is maintained and updated as appropriate through bi-annual audits.
 - 2.2.6.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission, discharge or ED visit. This will alert them to contact the Member, as appropriate, to review the current HAP and make changes as necessary.
 - 2.2.6.2 The ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.
 - 2.2.6.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met, or is no longer applicable.

2.2.6.4 The HAP will be completed within ninety (90) days of ECM enrollment.

3.0 Member Ongoing Engagement and Care Management Services

- 3.1 ECM Provider team members provide ongoing care management support in person and telephonically at a frequency determined by the Member's complexity and desired level of involvement in ECM.
 - 3.2 The ECM Lead Care Manager serves as the primary point of contact and supports activities provided by ECM Providers which include, but are not limited to:
 - 3.2.1 Assessing and managing Members using evidence-based clinical protocols and resources;
 - 3.2.2 Ensuring completion of HAP within specified timeframe;
 - 3.2.3 Documenting Member's choice of caregiver or family/support persons and assisting Members and chosen family/support persons with access to appropriate resources;
 - 3.2.4 Assisting Members and chosen family/support persons with scheduling appointments;
 - 3.2.5 Tracking and monitoring internal and external referrals;
 - 3.2.6 Developing and communicating self-management plans with input from the Member and caregiver(s)/family, as well as helping the member to identify and build on successes and potential family and/or support networks;
 - 3.2.7 Providing appropriate, timely, and actionable Member education to improve self-management skills;
 - 3.2.8 Empowering Members to enhance self-management using Motivational Interviewing techniques;
 - 3.2.9 Using problem-based, comprehensive case planning, with measurable, prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments;
 - 3.2.10 Providing care management that is Member-centric and culturally aware;
 - 3.2.11 Interacting with Members and family and / or support persons from a holistic perspective, promoting collaboration and coordination, through all levels of the health care continuum including physical and behavioral health programs, pharmaceutical management, and community-based programs;
 - 3.2.12 Monitoring and supporting treatment adherence (including medication management and reconciliation);
 - 3.2.13 Assisting in attainment of the Member's goals as described in the HAP;
 - 3.2.14 Encouraging the Member's decision-making and continued participation in ECM; and
 - 3.2.15 Accompanying Members to appointments, as needed.
 - 3.2.16 AAH ensures that the ECM Member's acuity will be the basis for the appropriate provision of ECM services by the assigned ECM Provider.
- This includes:
- 3.2.16.1 On-going communication with PCP regarding HAP updates and information-sharing;
 - 3.2.16.2 Monthly case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member's HAP, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their Care Plan; and
 - 3.2.16.3 Documentation of each contact and updates to the HAP will

be made in the care management platform or system of record.

3.2.16.4 ECM Provider staff can utilize a combination of telephonic and face-to-face encounters, based on Member's preference, and as documented in the HAP. In person meetings may be temporarily suspended during a declared public health emergency; however, alternative means of communication with member should be employed to contact member during this time including securing teleconferencing and telehealth visits.

3.2.16.5 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

4.0 Housing

4.1 ECM Members in need of housing services may be identified as follows:

4.1.1 ECM Providers conduct an ECM Assessment upon enrollment, annually, and with any change in status. The ECM Assessment includes questions that identify Members' homelessness or housing instability concerns.

4.1.2 Care team may be alerted to Members' housing concerns through the regular course of providing comprehensive care management services.

4.2 Members experiencing homelessness or housing instability will include goals related to housing on their HAP. Goals may address:

4.2.1 Housing navigation;

4.2.2 Transitional support;

4.2.3 Tenancy support;

4.2.4 Assistance in finding permanent housing.

4.2.4.1 Referrals to housing navigation (Community Supports services) is a component of the ECM Provider care coordinator's functions.

4.3 AAH will provide the following support to ECM Providers:

4.3.1 Cultivate relationships with local housing agencies including permanent housing providers;

4.3.2 Cultivate relationships with homeless service providers;

4.3.3 Provide advocacy for Members through housing agencies and coalitions; and

4.3.4 Partner with Alameda County Health (AC Health) and Corporation for Supportive Housing to create and provide educational offerings and technical assistance around housing navigation and tenancy supports, as needed.

5.0 Referral Management

5.1 Referral management is a component of the ECM Provider care coordinator's primary responsibilities. The ECM Provider care coordinator will track, monitor and provide referral coordination for all new, pending or completed referrals captured within the web-based care management platform or equivalent platform.

5.1.1 The ECM Assessment is the opportunity to gather and document relevant information regarding a member's needs, including medical health, behavioral health, palliative care, and social needs.

5.1.2 A member-centered plan of care is generated from the ECM Assessment which includes referrals agreed to by the ECM Member. These referrals may link ECM Members to medical specialty care, primary care, behavioral health, long term care services, palliative care, housing, community supports and any community resources which address the

- Member's needs.
- 5.1.3 Referrals may be placed to various services and appropriate community agencies via fax, telephone, in person or through secure electronic methods.
- 5.1.4 ECM Providers ensure that referrals were received and processed by the receiving agencies or providers, track whether services were received by the ECM Member and document the outcomes of the referrals.
- 5.1.5 Referrals will be followed up by phone, fax, in person or via secure electronic pathways, at scheduled intervals, to ensure that a referral has been completed and the ECM Member appropriately linked to services.
- 5.2 Referral and transition coordination include the following activities:
 - 5.2.1 Provide system navigation and serve as the point of contact for ECM Members and families for questions or concerns related to internal or external referrals;
 - 5.2.2 Review details and expectations about the referral with the Member and/or caregivers;
 - 5.2.3 Gather and send necessary medical information such as clinical background, diagnosis, prognosis, and referral needs, as appropriate, to referral source(s);
 - 5.2.4 Assist Members in problem-solving potential barriers (e.g., request interpreters as appropriate, transportation assistance or community resource assistance);
 - 5.2.5 Ensure that referrals are addressed in a timely manner, as specified by the ordering Provider;
 - 5.2.6 Remind patients of scheduled appointments based on the Member's preference and as documented in the HAP;
 - 5.2.7 Monitor referral activity daily, providing additional assistance to Members who have not completed referrals within specified timeframe, have cancellations, missed appointments, or other reasons for an incomplete referral;
 - 5.2.8 Maintain ongoing tracking and appropriate documentation of referrals to promote care team communication and continuity of care; and
 - 5.2.9 Ensure the Member's health record is up to date with information on specialist consults, hospital summaries, diagnostic results, ED visits and community organization information related to the health of the Member.

6.0 Transitional Care Services

- 6.1 AAH collaborates with ECM Provider staff to coordinate care across all healthcare settings, providers, and services to assure continuity of care.
- 6.2 ECM Providers, in partnership with AAH, continuously work with all facilities to ensure that Members are receiving comprehensive quality care in the least restrictive setting.
- 6.3 AAH ensures that ECM Providers have access to daily hospital admission, discharge and ED visit information for ECM Members.
- 6.4 AAH ensures for members already enrolled in ECM, the member's assigned ECM Lead Care Manager provides all Transitional Care Services (TCS).
- 6.4.1 In alignment with DHCS' Population Health Management Policy Guide, the ECM provider will:

- 6.4.1.1 Identify the Care Manager responsible for TCS. This single point of contact will be responsible for providing longitudinal support and

ensuring completion of all TCS across all settings and delivery systems, and that members are supported in a culturally and linguistically appropriate manner from discharge planning until they have been successfully connected to all needed services and supports.

6.4.1.2 Communication of assignment to the care manager

- 6.4.2 AAH will ensure the ECM provider is notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the MCP being aware of any admissions, discharges or transfers where no ADT feed visits.

6.5 Care Manager Responsibilities

- 6.5.1 The care manager responsible for TCS is responsible for coordinating and verifying members receive all appropriate TCS.

- 6.5.2 They must coordinate and ensure completion of the following TCS tasks:

6.5.2.1 Coordinating with discharging facility to ensure member engagement and comprehensive information sharing and coordination of care. The care manager must complete the following:

○ Risk Assessment:

The care manager must assess member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g. the discharge summary). The care manager may supplement this risk assessment as needed through member engagement.

○ Discharge Instructions:

- Care Managers must receive and review a copy of the discharging facility's discharge instructions given to the member, including the medication reconciliation completed upon discharge by the discharging facility.
- After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
- A best practice (not required) is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.

○ Discharge Summary and Clinical Information Sharing:

- Care Managers must receive and review a copy of the discharging facility's discharge summary once it is complete
- Care Managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.

● Necessary Post-Discharge Services and Follow-Ups:

○ Member Outreach:

- The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers

○ Ensuring needed post-discharge services are provided and follow-ups

are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different); and arranging transportation.

- SUD and mental health treatment initiation or continuation for those who have identified SUD or mental health condition.
- Medical reconciliation, post discharge
 - Care manager must ensure this is completed after individual is discharged. This can be broken down by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate licensure or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.
 - Completion of referrals to social service organizations (county First 5s, etc.) and referrals to necessary at-home services (DME, home health, etc.).
 - Connection to community supports as needed
 - For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
 - Ensure outpatient appointments are scheduled prior to discharge
 - Verify that members arrive safely and have their medical needs met
 - Follow-up members to ensure all TCS needs and requirements have been met.

6.5.3 The ECM Provider care coordinator will update the ECM Provider team, or the multidisciplinary care team, who will assist with the coordination and delivery of services or schedule case conferences to discuss supportive measures needed, changes to the HAP, and discussions to prevent future utilization.

6.5.4 ECM Providers have ongoing communication with facilities to monitor Members' needs and the services provided to them. AAH prevents readmissions by utilizing evidence-based best practices for Transitional Care Services and encouraging ECM Providers to follow the same.

7.0 Member Transition to Lower Level of Care/Disenrollment

7.1 ECM Provider teams will continue to reassess the Member's risk status level and programmatic appropriateness.

7.1.1 When Members have experienced a 6-month period of stability, defined by well managed clinical measures, no hospital or ED utilization and have successfully met their self-management goals on the HAP, they are ready to transition to a lower level of care and disenroll or "graduate" from ECM.

7.1.2 If a Member agreed to ECMs services and initially engaged in ECM but has had no active participation for ninety (90) days, despite ongoing outreach and engagement efforts by the ECM Provider team, the Member will be disenrolled.

7.1.3 If a Member chooses to disenroll for any reason, the Member will be

- disenrolled.
- 7.1.4 If a Member is now participating in another program excluding them from ECM eligibility, the Member may choose the alternate program and be disenrolled from ECM.
 - 7.1.5 The disenrollment reason will be documented in the web-based care management platform or equivalent platform.
 - 7.1.6 The ECM provider will notify AAH when the member is ready to transition to a lower level of care. The ECM Provider will use the Alameda Alliance Graduation/Reauthorization Checklist to determine when an ECM Member is ready for graduation and ready to transition to a lower level of care. AAH will not be determining the member's readiness for graduation but will follow the recommendation of the ECM Provider who is providing the direct services. AAH will follow the standard Grievance & Appeals process when a member disputes ECM graduation and transition to a lower level of care.
 - 7.1.7 The provider will provide a warm handoff, when appropriate, to the receiving lower level Care Management provider. Lower level Care Management may include programs at the ECM Provider, or other community Care Management entities, including AAH telephonic Care Management. If the ECM Provider has difficulty locating an appropriate lower level of care provider, the Alliance will assist in identifying an appropriate provider, including acceptance of the member into the AAH telephonic care management program. AAH will work with ECM Provider to graduate the member and transition to a lower level of care when needed.
- 7.2 The process ECM Providers are expected to use to notify the Alliance when discontinuation criteria are met is through the monthly submission of the DHCS Return Transmission File (RTF). This file includes Disenrollment Reason codes notifying the Plan of discontinuation of delivery (e.g. graduation, disenrollment, unwilling to engage, provider unable to connect after multiple attempts). Upon notification from the ECM Provider, AAH will issue a Notice of Termination of ECM services to Members disenrolled from ECM for specific situations AAH will send the Termination letter to the Member, ECM provider and PCP within thirty (30) days after the ECM provider notifies AAH of the effective date of ECM disenrollment. AAH will send a termination letter that includes grievance rights to the Member, the ECM Provider, and the Member's PCP (if the ECM Provider is not the Member's PCP) if:
- 7.2.1 The Member develops a change in eligibility such as an exclusionary condition;
 - 7.2.2 The Member's eligible chronic condition(s) become well-managed (for six consecutive months);
 - 7.2.3 The Member has met all care plan goals;
 - 7.2.4 The Member is ready to transition to a lower level of care;
 - 7.2.5 The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or
 - 7.2.6 A Member agrees to ECM services and initially engages, but there is no documented active participation for ninety (90) days despite outreach and engagement efforts as part of care management.
 - 7.2.7 When ECM services are discontinued; the Member or the ECM Provider may request the member be transitioned to a lower level of care

management. AAH will work with the ECM Provider to complete a warm handoff to AAH's telephonic Case Management or to a community-based case management program.

- 7.3 AAH will not send a termination letter to a member who chooses to disenroll from ECM.

DEFINITIONS / ACRONYMS

AAH Alameda Alliance for Health
NOA Notice of Action
ECM Enhanced Care Management
HAP Health Action Plan
TCS Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
CM-041 Enhanced Care Management – Outreach/Member Engagement
CM-042 Enhanced Care Management – IT/Data Sharing
UM-016 Transportation Guidelines

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023, 10/19/2023, 12/18/2024, [2/14/2025](#)

[Blue](#) = material updates

REFERENCES

[ECM Policy Guide August 2024 \(ca.gov\)](#)

[PHM Policy Guide May 2024](#)

[42 CFR § 441.301 - Contents of request for a waiver. | CFR | US Law | LII / Legal Information](#)

[Institute \(cornell.edu\)](#)

[APL17-013.pdf \(ca.gov\)](#)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls



POLICY AND PROCEDURE

Policy Number	CM-018
Policy Name	Enhanced Care Management – Member Notification
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/14/2025~~ <u>TBD</u>
Administrative Oversight Committee Approval Date	~~4/16/2025~~ <u>TBD</u>

POLICY STATEMENT

- 1.1. Alameda Alliance for Health (AAH) is responsible for the development, implementation and distribution of requirements for the Enhanced Care Management (ECM) services and related activities to contracted entities, including member identification and member notification.
- 1.2. Member Identification: Members are identified through two methodologies:
 - 1.2.1. ECM Eligibility List: Every month, AAH produces an eligibility list based on the defined criteria of the ECM populations of focus.
 - 1.2.2. -Referrals: Referral can be made into ECM at any time by contacting AAH Member Services, ECM Provider, or any AAH Staff. Member's family member(s), guardian, caregiver, and/or authorized support person(s) may also contact AAH Member Services, ECM Provider, or any AAH Staff. Member must provide authorization to speak with someone on their behalf.
 - 1.2.3. AAH has a no wrong door policy. AAH will accept an ECM referral from Primary Care Providers (PCPs), clinics, community, and county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, California Children's Services (CCS), foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

1.2.4. AAH ~~uses a will ensure a~~ closed loop referral ~~system process~~ for all ECM referrals as per DHCS policy for closed loop referrals. This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of focus the member is authorized for (if different from initial referral request), which ECM provider will be assigned to this member and confirmation that ECM services have started.

~~1.2.4.1. For Children/Youth and Pregnant/Postpartum populations of focus, a regular report is generated to monitor these vulnerable populations.~~

~~1.2.4.2. Monitoring the referral report will improve communication between AAH and ECM providers to ensure members are being served appropriately.~~

1.3. Member Notification

1.3.1. Initial and ongoing Member communications regarding the ECM services will be made in accordance with existing AAH policies and procedures for Member communication including consideration of individual Member communication needs.

1.3.2. Members and Providers will be informed of ECM and how to access the program through all usual communication venues listed in the AAH's Marketing & Communications Plan that the Department of Health Care Services (DHCS) approves annually and per AAH policies and procedures. For Providers, these notifications will include the Provider Newsletter, Provider Manual and Quarterly Updates which are all published on AAH's website and Provider Portal. The Quarterly Updates are also printed and mailed to provider offices.

1.3.3. Member communications will be provided in accordance with requirements by DHCS including those for cultural competency and health literacy standards.

1.3.3.1. AAH requires that subcontracted plans (delegates) use the same process for:

1.3.3.1.1. Informing members, family member(s), guardian, caregiver, and/or other authorized support person(s) about ECM, requesting ECM, status of the request and returned communication.

1.3.3.1.2. Implementing presumptive authorization or pre-authorization of ECM

1.3.4. AAH ensures verbal and written communications to the Provider, Member, family member(s), guardian, caregiver, and/or other authorized support person(s) for UM decisions, are provided using the appropriate approved templates and within the UM timeliness standards.

1.3.4.1. For minors, ECM providers will be required to follow the

regulations for minor consent services to obtain, document, and manage the Member's parent/guardian authorization for sharing of Personally Identifiable Information between AAH, ECM and other providers involved in the provision of member care and communicate data sharing authorization preferences back to AAH.

1.3.5. Authorization of Enhanced Care Management (ECM)

1.3.5.1. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:

- Routine requests not to exceed 5 days
- Expedited requests not to exceed 72 hours

1.3.6. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:

- Provider notification not to exceed 24 hours (oral or written), after decision
- Written notification to provider and member not to exceed 2 working days, after decision

1.4. Members Transitioning from Health Homes & Whole Person Care (WPC)

1.4.1. AAH worked in conjunction with the WPC Lead Entity to develop a list of expected WPC Care Management-enrolled members who transitioned to ECM. These Members were enrolled into ECM. As members stabilize, re-authorization is measured against graduation criteria and/or lower level of care needs.

PROCEDURE

2.1 Member Notification AAH Members are notified of the ECM benefit through standard communication venues: Member Handbook: Evidence of Coverage (EOC), AAH website, member portal, etc.

2.1.1 Providers will be notified through provider quarterly material, provider orientation, and provider portal on the AAH website.

2.1.2 Notification includes (but is not limited to):

- 2.1.2.1 A description of the ECM benefit;
- 2.1.2.2 Eligibility Criteria;
- 2.1.2.3 How to access ECM; and

- 2.1.2.4 Explanation that participation is voluntary, and that the Member may discontinue participation at any time
- 2.1.3 Members may change their ECM Provider by contacting AAH Member Services at 1- 877-932-2738 or 1-800-735-2929 (TTY) or the Enhanced Care Management (ECM) team at 510-747-4546, during normal business hours. AAH will accommodate such requests within thirty (30) days, or as soon as possible to meet the Member's needs. AAH staff will facilitate a warm handoff between ECM Providers.
- 2.1.4 AAH Member and Provider materials are made available through a variety of communication venues listed in AAH's Marketing & Communication Plan that DHCS approves annually. Applicable materials will be updated to incorporate content describing the ECM benefit including the DHCS template for Evidence of Coverage/Disclosure Form. Content will include describing ECM, providing guidance about where to obtain additional information and how to refer Members who may be potentially eligible for the ECM.

DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
AAH – Alameda Alliance for Health
DHCS – Department of Health Care Services
TCM – Targeted Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Operations
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-041 Enhanced Care Management – Outreach/Member Engagement
CM-042 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 6/20/2022, 10/19/2023, 12/18/2024, [4/16/2025](#)

[Blue](#) = material updates

CM-018 Enhanced Care Management – Member Notification
Page 4 of 4

REFERENCES

[ECM Policy Guide August 2024](#)

[PHM Policy Guide May 2024](#)

[ECM-Referral-Standards-and-Form-Templates August 2024](#)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls



Lease

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

POLICY AND PROCEDURE

Policy Number	CM-041
Policy Name	Enhanced Care Management – Outreach/Member Engagement
Department Name	Case Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	05/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/21/2024TBD
Administrative Oversight Committee Approval Date	9/18/2024TBD

POLICY STATEMENT

AAH is responsible for engaging Enhanced Care Management (ECM) eligible members, using state determined, Centers for Medicare & Medicaid Services (CMS) approved criteria.

PROCEDURE

1. AAH links ECM members to one of our contracted ECM Providers.
 - 1.1.1 If the ECM member's assigned primary care provider (PCP) is affiliated with an ECM Provider, the ECM member will be assigned to that ECM Provider, unless the member chooses another ECM Provider or a more appropriate ECM Provider is identified given the member's individual needs and conditions.
 - 1.1.2 AAH and/or the ECM Provider's notification will inform the ECM member that they are eligible for ECM services and will identify both AAH and the ECM Provider. This notification will explain that ECM participation is voluntary, members have the opportunity to choose a different ECM Provider, and ECM members can discontinue participation at any time. It will also explain the process for participation.

2. AAH has the ability to perform the following duties/responsibilities or delegate to ECM Providers and provide appropriate oversight.

1.2.1 AAH has the capacity to engage and provide services to eligible members, including:

1.2.1.1 Develop an ECM eligibility list ~~including HHP/WPC enrolled members transitioning to ECM or HHP/WPC eligible members actively being outreached by ECM Providers transitioning to ECM;~~

1.2.1.2 Review the members on the eligibility list for homelessness;

1.2.1.3 Attribute eligible ECM members to ECM Providers. (See CM- 010 Enhanced Care Management: Member Identification, Grouping & Eligibility List Management);

1.2.1.4 When possible, refer eligible members known to be homeless to ECM Providers with expertise in outreach/engagement of people experiencing homelessness;

1.2.1.5 For homeless members assigned to ECM Providers without expertise in outreaching people who are homeless, AAH will attempt to coordinate support from street outreach or other homeless service providers;

1.2.1.6 Ensure attempts at the engagement of members on the ECM Eligibility List;

1.2.1.7 Secure and maintain record of the member's consent to participate in the program (which can be verbal); and

1.2.1.8 Provide member resources (e.g. customer service, member grievance process) relating to ECM.

1.2.2 AAH has the ability to engage members or delegate proper engagement processes to ECM Providers, including:

1.2.2.1 Identifying, locating, and engaging ECM-eligible members. AAH uses a model outreach protocol as the primary guidance to ECM Providers in locating and engaging members.

~~3.~~ The number of contacts and usual progression of steps for various modalities includes five attempts to contact the member within 90 days after the ECM Provider receives the ECM Eligibility List.

~~Outreach efforts will consist of:~~

~~1.3.1 Assigned Members in High Tier will receive a minimum of every other week outreach contacts/attempts.~~

~~1.3.23. Assigned Members in Low Tier will receive a minimum of monthly outreach contacts/attempts.~~

1.3.1 All attempts to contact will be documented within the ECM Provider's care
CM-041 Enhanced Care Management - Member Engagement

management record system.

~~4.3.3~~4.3.1.1 Data (including, but not limited to, closed loop referral information)
will be shared in alignment with the DHCS guidance as appropriate.

Formatted

~~4.3.4~~4.3.2 Active outreach strategies may include but not be limited to:

~~4.3.4.1~~4.3.2.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

~~4.3.4.2~~4.3.2.2 Direct communications with Members by letter, email, social media, texts, telephone;

~~4.3.4.3~~4.3.2.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or

~~4.3.4.4~~4.3.2.4 When possible, available data exchange platform to obtain information to help locate and contact the Member; and/or

~~4.3.4.5~~4.3.2.5 Outreach to SNF's and inpatient facilities. The MCP will share ADT feeds and census information with ECM Providers to help direct this outreach;

~~4.3.4.6~~4.3.2.6 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

~~4.3.5~~4.3.3 Active outreach strategies will be done primarily through in-person contact.

Active, meaningful and progressive attempts at member engagement must be shown each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face to face, mail, email, telephone), follow up if the member presents to another partner agency or facility in the ECM network or if able to contact through teleconferencing or telehealth services, or using claims data to identify and contact providers the member is known to use. Examples of acceptable engagement include:

~~4.3.5.1~~4.3.3.1 If member prefers and is available, teleconferencing may be used. Due to public health restrictions, telehealth, teleconferencing could be used to supplement in-person contact.

~~4.3.5.2~~4.3.3.2 Letter to member followed by phone call to member.

~~4.3.5.3~~4.3.3.3 Phone call to member, outreach to care delivery partners and social service partners.

~~4.3.5.4~~4.3.3.4 Street level outreach, including, but not limited to, where the member lives or is accessible.

~~4.3.5.5~~4.3.3.5 After five (5) unsuccessful attempts, the ECM Provider and the MCP will note and document the challenges with the active outreach and ask the PCP to discuss ECM with the member at the next PCP visit.

~~4.3.5.5.1~~4.3.3.5.1 If the member declines ECM enrollment at the PCP visit, this will be noted in the ECM Provider's system of record and the MCP will be notified.

~~4.3.5.5.2~~4.3.3.5.2 If the ECM Provider or the MCP learns that the member contact information is out of date, efforts will be made to update that information using

recent provider records and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations.

~~1.3.5.5.3~~1.3.3.5.3 For members who are homeless, the ECM provider will also review members' housing and utilization history and work with the MCP and appropriate County agencies to determine if that member can be reached at a shelter, alternative housing site or through a community-based organization.

~~1.3.5.6.1~~1.3.3.6 Establish a process for reviewing and excluding people from the ECM Eligibility list. Those members to be excluded are the following:

~~1.3.5.6.1~~1.3.3.6.1 Members whose condition management cannot be improved because the member is uncooperative;

~~1.3.5.6.2~~1.3.3.6.2 Members whose behavior or environment is unsafe for ECM staff;

~~1.3.5.6.3~~1.3.3.6.3 Members determined to be more appropriate for an alternate care management program;

~~1.3.5.6.4~~1.3.3.6.4 Members receiving hospice care;

~~1.3.5.6.5~~1.3.3.6.5 Members receiving pediatric palliative care;

~~1.3.5.6.6~~1.3.3.6.6 Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month;

~~1.3.5.6.7~~1.3.3.6.7 Members enrolled in any other program deemed to have duplication of care management/care coordination services;

~~1.3.5.6.8~~1.3.3.6.8 Duplicated Targeted Case Management services (excluding Severe Mental Illness TCM);

~~1.3.5.6.9~~1.3.3.6.9 Members determined through further assessment to be sufficiently well-managed through self-management, or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria. AAH deems members as "well-managed" based upon graduation criteria, i.e. whether the HAP goals have been met; whether the patient was linked with supportive or community services and feels as though there has been improvement; whether the patient has been linked with a housing referral and plan for monitoring if the member is experiencing homeless, and finally, whether there has been evidence of decreasing utilization of emergency services.

~~1.3.5.7.1~~1.3.3.7 Report Members determined not appropriate for ECM, along with a reason code, to DHCS.

~~1.3.5.8.1~~1.3.3.8 DHCS will evaluate AAH-enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the ECM Eligibility list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.

~~1.3.5.9.1~~1.3.3.9 Include housing navigators in the engagement process, at AAH's discretion.

~~1.3.5.10.1~~1.3.3.10 Document the member engagement process.

~~1.3.5.11~~ 1.3.3.11 Develop a methodology and criteria used by AAH or the ECM Provider to stratify high, low need members.

~~1.3.5.12~~ 1.3.3.12 Develop educational materials or scripts to engage the member.

~~1.3.5.13~~ 1.3.3.13 Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma informed care standards.

~~1.3.5.14~~ 1.3.3.14 Have policies and procedures for the following:

~~1.3.5.14.1~~ 1.3.3.14.1 Required number and modalities of attempts made to engage member AAH's protocol for follow up attempts.

~~1.3.5.14.2~~ 1.3.3.14.2 AAH's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate.

~~1.3.6.1~~ 1.3.4 After AAH has screened people who are inappropriate for ECM from the ECM Eligibility list based on the ECM requirements, AAH will create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

~~1.3.6.1.1~~ 1.3.4.1 This group, or members in order or priority rank, would be the first focus for AAH engagement efforts. The criteria and size of the group for priority engagement status will be at AAH's discretion.

DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
AAH – Alameda Alliance for Health
SNF – Skilled Nursing Facility
DHCS – Department of Health Care Services
PCP – Primary Care Provider
MCP – Managed Care Plan
ADT – Admission Discharge Transfer

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-041 Enhanced Care Management - Member Engagement

CM-018 Enhanced Care Management – Member Notification
CM-037 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 12/19/2023, 9/18/2024

REFERENCES

[California Advancing & Innovating Medi-Cal \(CalAIM\) Proposal February 2021](#)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control



POLICY AND PROCEDURE

Policy Number	CM-001
Policy Name	Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL, IHSS
Effective Date	06/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/14/2025
Administrative Oversight Committee Approval Date	~~4/16/2025~~ TBD

Formatted: Line spacing: Multiple 1.08 li

POLICY STATEMENT

- The Alliance will:
 - Ensure that all Alliance members are identified and, as appropriate, screened, assessed and triaged for Complex Case Management (CCM).
 - Identify members using evidence-based algorithms, utilization data and referrals.
 - Assess identified members for care barriers in order to determine appropriate service delivery.
 - Maintain procedures for documenting the identification, screening, assessment and triage process using a Clinical Information System.
 - Refer members to other services or other case management programs, as appropriate, if the member does not meet the criteria for enrollment in CCM.
- The Alliance delegates CCM for a small proportion of its population. The delegates are required to follow the Department of Health Care regulations, the Department of Health Care Services' contractual obligations, and National committee for Quality Assurance (NCQA) standards. Routine reports are submitted to the Alliance regarding the delegates' performance and, at a minimum, an annual delegation audit of CCM operations is conducted.

PROCEDURE

Scope

This Policy and Procedure addresses the Identification, Screening, Assessment and Triage steps of the Complex Case Management (CCM) process. Definitions of Identification, Screening, Assessment and Triage steps are included within this Policy and Procedure. Clinical Information System

Identification

1. Monthly, the Analytics Department runs a Risk Stratification Population Health Management (PHM) report using medical, mental health, substance use disorder and the Johns Hopkins ACG modeler risk screening data for all members using specific criteria to identify members.

The Johns Hopkins ACG modeler risk screening scores and reports generated by the AAH Analytics team to identify members who may be appropriate for other Case Management Programs (CCM, Transitions of Care and ECM). Examples of data sources includes but is not limited to:

- a. Hospital Admission/Discharge data
- b. Pharmacy data
- c. Health risk appraisal data
- d. Data collected through the Utilization Management process
- e. Data provided from state agencies – medical assistance category codes
- f. Data supplied by practitioners
- g. Data supplied by member or caregiver

2. The Population Health Report is provided to the Case Management (CM) department monthly for further processing as outlined in this procedure.
3. A list of members who receive and complete Health Risk Assessments and whose scores are high risk will be provided for further processing. The score for referral to CCM will be reviewed and potentially adjusted on at least an annual basis.
4. On an ongoing basis, CCM referrals will be made from members, caregivers, practitioners, hospital discharge planners, health information line, Utilization Management (UM) staff, and other CM programs for further processing. In addition, CCM members are also identified through the daily hospital discharge report.

Practitioner data from medical records and concurrent review information is also used to identify members for CCM.

For transplant members, they may benefit from CCM services as identified by meeting CCM criteria.

In general, cases should be referred for CCM that meet the following criteria:

- a. Presence of chronic, serious conditions

- b. Multiple ER and hospital admissions
- c. Members have multiple chronic medications
- d. The amount of resources required for member to regain optimal health or improved functionality is typically extensive.
- e. Further information regarding referral policy and procedures is documented in CM-004 - *Care Coordination of Services*.

5. CM staff will:

- a. Receive referrals by phone, fax, or e-mail from other departments and enter them into Clinical Information System on a daily basis. Referrals will be entered into the referral summary for further assessment. *Reference CM - 004- Care Coordination of Services*.
- b. Create a CCM Referral in Clinical Information System using the monthly Population Health Report and the Health Risk Appraisal Report.
- c. Log the referral in the Clinical Information System with relevant information such as the referral source, urgency of referral, and any corresponding details.

Referral Screening

1. After the Referral is created as outlined above, the referral is assigned out to the appropriate CM staff who will begin the screening process.
2. Referral screening consists of the following
 - a. Determination of current eligibility of the member.
 - b. Delegate medical group affiliation
 - c. If eligible, the CM Staff will review existing programs the member is enrolled in, including CCM.
 - d. Referrals will be processed according to the following time frames:
 - i. Urgent – referral opened within 24-72 hours (1 business day).
 - ii. Routine - referral opened within 5 calendar days.

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

Enrollment

1. Prior to the assessment, the Case Management staff evaluates whether a member should be enrolled in CCM by completing the Complex Criteria Checklist. The checklist is completed based on information gathering from clinical notes, member self-reporting and other data sources, or the individual clinical judgment of the Case Manager. Generally, members are deemed to be eligible for CCM if they exhibit one of the following traits:

- a. Medically unstable – uncontrolled or poorly controlled symptoms at significant risk for inpatient admit or ER visit; or new or occasional exacerbation of symptoms with moderate risk for inpatient admit or ER visit.
 - b. Necessary resources are not in place or limited or ineffective resources are in place.
 - c. Care requires complex or moderate coordination with multiple providers involved and member/caretaker education/teaching is needed.
 - d. Non-compliance with treatment plan requiring significant or ongoing monitoring.
 - e. Case management opportunities exist for the member. In general, there will always be CM opportunities; however, the CM will determine if the opportunities are such that warrant CCM resources or other Alliance resources may be more appropriate. The enrollment of a member into CCM is based on individual clinical judgment of the Case Manager and member's willingness to enroll. See CM - 004 – *Care Coordination of Services*.
2. After documenting the decision to enroll the member, but prior to enrolling the member in the CCM program, the Case Management staff will explain CCM services to the member and obtain consent. CCM service explanation will include:
- a. A description of the proposed services provided and the benefits of the program, i.e., designated nurse, collaborative setting of and attainment of goals, assistance with coordinating benefits, etc.
 - b. The program is offered at no-cost to the member.
 - c. The right of the member to refuse case management services, alternatives to CCM and the consequences, if any, of refusing services.
 - d. Confidentiality of information per the Alliance Notice of Privacy Practices which allows for sharing of information with practitioners for treatment, quality of care and/or payment purposes.
 - e. The right for the members to file a grievance.
3. The decision by the member to participate in the CCM program will be recorded on the assessment form in the Clinical Information System or in a Consent Note in the Clinical Information System. The Care Plan process and upcoming outreach attempts are also communicated to the member through telephone outreach and via an enrollment letter.

Assessment

1. CM staff assignments of assessments will be made based on work-load and specialization.
 - a. CCM cases meeting Disease Management (DM) criteria will be tasked to CMs designated for DM.

- b. For transplant members, an additional transplant assessment will be completed to identify any additional needs related to the member's transplant.
- 2. The information gathered from these assessments is used to identify problems that the Case Manager will need to add to the member's care plan.
- 3. Initial member telephonic outreach includes at least 3 attempts made during working hours Monday through Friday from 8:00 AM-5:00 PM within the priority standards outlined above. If CM staff is still not able to reach the member, a letter is mailed to the member as a third attempt using the priority standards.
- 4. An assessment will be started on each member within 30 days of identification or referral from screening and will include the following:
 - i. Evaluation of the member's health status, including any condition-specific issues and comorbidities.
 - ii. Review and documentation of complete clinical, medication and utilization history. If this information is not present in the Clinical Information System, the CM shall review the external utilization data source.
 - iii. Assessment of the member's functional capacity using specific questions to assess the activities of daily living (ADLs), including the member's eating, bathing and mobility capacity.
 - iv. Assessment questions related to impairment of cognitive functions, including the ability to communicate, understand instructions and process information about their illness.
 - v. Screening for depression, anxiety, alcohol, drug use and psychosocial issues.
 - vi. Assessment of life planning activities (Advance Directives, Living Will and Power of Attorney) or documentation explaining why this assessment was not appropriate. If appropriate, member will be mailed information regarding life planning activities, along with beneficial follow up instructions.
 - vii. Confirmation or collection of information from the member on preferences for communication, religious and cultural preferences that may impact care delivery.
 - viii. Assessment of language, vision, hearing or other impairments impacting care delivery and communication.
 - ix. Availability of caregiver resources and their involvement with the member.
 - x. Assessment of the available benefits and needs for community and financial resources.
 - xi. Assessment of Preventive Health screening and reminders appropriate to age and gender.
- 5. At any time during the Assessment process, the case will be referred to a Behavioral Health Clinician if the case meets the following criteria:

- a. Behavioral Health (BH) diagnosis meeting identification criteria without acute co-morbidities.
- b. BH diagnosis that meets identification criteria with medical co-morbidities well managed
- c. Members with BH diagnosis of such acuity that the member is unable to understand or comply with medical treatment plans. Examples may include: drug or alcohol dependency, major depressive disorder and bipolar disorders.
- d. For members who do not meet the above criteria, Case Management will continue to provide all necessary case management services.

Refer to policy and procedure *CM-004 - Care Coordination of Services*, for the details on making behavioral health referrals.

The evaluation for enrollment, completion of the Assessment, and scheduling of follow up appointments, as applicable completes the CCM Identification, Screening, Enrollment and Assessment processes.

Monitoring

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

Formatted: Justified, Line spacing: Multiple 1.08 li

Formatted: Font: Not Bold

DEFINITIONS/ACRONYMS

Active Complex Case Management: A member is defined as in Active Complex Case Management at the time an Assessment is completed and the member is entered into complex case management by the case manager

Assessment Process: Assessment is a process of compiling data including claims and medication history, HRA data and member questions to provide the basis to analyze services needed and to assist in creating a care plan. There are numerous assessment tools pre-built in the Clinical Information System that can be used to compile data.

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

Case Identification: Identification is the initial process of selecting cases for review for complex case management. Identification is the first step in the process where members are identified from data sources and referrals are taken for members meeting defined criteria. This step does not involve clinical judgment to identify the people who meet defined criteria.

Complex Case Management (CCM): The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services

CCM Enrollment: Decision making to determine whether the member proceeds to Care Plan Development and Management. The decision is based on several factors. These include the member's agreement to participate, the acuity score, and/or clinician judgment based on the individual circumstances of the case.

Referral Screening: Referral Screening is the process where an initial non-clinical decision is made to determine whether a member proceeds to the Enrollment stage of processing for Complex Case Management. This entails screening against identification criteria, eligibility status and whether the member is already in existing programs.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics
Provider Relations
Utilization Management
Quality Oversight
Case and Disease Management
Alliance Members
Alliance Delegated Groups
Alliance Directly Contracted Physicians

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Complex Case Management (CCM) Program Description
CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-004 Policy and Procedure, Care Coordination of Services
[CM-006 Internal Audit and Monitoring](#)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Population Health Report
Health Risk Assessment
How to Submit a Referral (training document)

REVISION HISTORY

12/05/2012, 3/1/2016, 09/06/2018, 5/21/2020, 5/21/2021, 9/16/2021, 03/22/2022, 1/11/2023, 3/19/2024, 4/16/2025

REFERENCES

1. National Committee on Quality Assurance Quality Improvement QI 5: Complex Case Management

MONITORING

- ~~1. CCM Identification and Screening is monitored by the following:~~
 - ~~a. Conversion rates by referral source~~
 - ~~b. Data entry auditing of Intake and CM staff~~
 - ~~c. Time frames to complete identification, screening, assessment and triage tasks.~~
 - ~~d. a. Member grievances specific to identification, screening, assessment and triage process~~



POLICY AND PROCEDURE

Policy Number	CM-002
Policy Name	Complex Case Management Plan Development and Management
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Director of Social Determinants of Health
Line(s) of Business	MCAL, IHSS
Effective Date	6/1/2012
Administrative Oversight Committee Approval Date	~~5/21/2025~~ TBD

Formatted: Line spacing: Multiple 1.08 li

POLICY STATEMENT

The Alliance offers Complex Case Management (CCM) services to all identified members who are assessed as appropriate for needing these services. The Alliance CCM services help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

The Alliance assists members to obtain this level of functional capability through the use of a Care Plan. Care Plans should be individualized, utilize evidenced-based care plans, and establish measurable goals and outcomes. The Case Manager (CM) and/or Social Worker (SW) collaborates with the member and/or their representative and care providers to establish a realistic time frame to achieve the goals and outcomes set by the Care Plan.

Care Plans are a guide for care management activities and focus on member interventions to achieve specific care management health goals to resolve identified problems and issues. Care Plans are based on the problems recommended from the Assessment process and continued management of the member’s plan of care.

The Care Plan, and all associated documentation and correspondence, is documented in the Alliance Clinical Information System.

The Alliance will:

- 1. Ensure that all Alliance members are selected, as appropriate, for Complex Case Management.
- 2. Develop an individualized Care Plan based on an analysis of the General Assessment and Specialty Assessments, as applicable, and in collaboration with the member and/or their representative, and care providers using Person-Center Planning.
 - Person-Centered Planning:

- Upon enrollment, the Case Manager (CM) and/or Social Worker (SW) provides or ensures the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the member's continuing health care needs.
 - Person-Centered Planning includes identifying each member's preferences and choices regarding treatments and services, and abilities.
 - The CM and/or SW will ensure the participation of the member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatment and services.
 - Additional individuals may include (but not limited to), the member's parents, legal guardians, authorized representatives, caregivers or other authorized support persons.
 - The CM and/or SW will communicate to members' parents, family members, legal guardians, authorized representatives, caregivers, or other authorized support persons all care coordination provided to members, as appropriate.
 - The CM and/or SW will ensure that members receive all necessary information regarding treatment and services so that they can make an informed choice.
3. Coordinate the interventions specified in the Care Plan using evidence-based care plans.
 4. Establish measurable goals and outcomes as part of the Care Plan. Establish time frames for review and perform follow up on the achievement of these goals and outcomes according to those established time frames.
 5. Maintain procedures for documenting the CCM plan of care using a Clinical Information System.
 6. Refer members to other services, as appropriate.

Complex Case Management Services are provided by the Alliance, in collaboration with the primary care provider and shall include, at a minimum:

1. Basic Population Health Management Services (See CM-004 Care Coordination of Services P&P for more details.)
2. Management of acute or chronic illness, including emotional and social support issues and social determinants of health needs by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optimal health or improved functionality
4. With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
5. For transplant members, additional collaboration will occur with the member's transplant center in order to best meet the individual needs of the member

PROCEDURE

Scope:

This Policy and Procedure addresses the Care Plan Development and Care Plan Management steps of Complex Care Management (CCM). Refer to *CM-001, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment* for information on the initial steps of the CCM process. Utilization Management determinations are not included in the scope of the CCM program.

Care Plan Development

1. Case Manager and/or Social Worker develops a Care Plan for members who indicated willingness to participate in CCM from the Enrollment process. Care plan development entails the following:
 - a. Development of case management goals, including prioritized goals
 - b. Identification of barriers to meet the goals and complying with the plans
 - c. Development of schedules for follow-up and communication with members
 - d. Development and communication of member self-management plans
 - e. Assessment of progress against CCM plans and goals, and modifications as needed
2. The CM and/or Social Worker, using the member's input, will assign a target goal date. Short term goals are defined as achievable within 30 days. Long term goals are achievable within 31 to 90 days. Goals should not be set greater than 90 days in order to facilitate re-assessment and review or resetting of member's goal. The goals will be prioritized based on the discussion with the member and/or caregiver and will be documented accordingly in the Clinical Information System. Goal priorities will be assigned on a scale from 1 (High) to 10 (Low). These priorities will be assigned based on potential impact on future hospitalizations, Emergency Department visits or quality of life. The member's preferences are taken into consideration in determining the priorities.
3. Within the Goal setting screens, an option exists to select barriers to achievement of the goal. The CM and/or SW should select barriers as appropriate to the case. The CM and/or SW should document issues of barriers were assessed, even if no barriers were identified.
4. Finally, interventions should be selected, created, and added. The goals and priorities of the goals are evaluated at the next scheduled call with the member.
5. Care Plan activities should be thoroughly documented within the Clinical Information System and additional notes added as necessary to ensure that the assessment and resultant Care Plan addresses each identified problem. There should be a minimum of 3 goals with corresponding problem(s) prioritized through collaboration of the member and the CM/SW care team. One goal must be related to self-management.
6. When planning for transitions of care, the CM and/or SW will contact the place of transfer and follow-up with the member and/or caregiver within 1 business day of notification of transfer.

Collaboration and Communication with the Member and Provider

1. Once the Care Plan has been developed, the CM and/or SW shall schedule a time and create a Contact Member task to self, if not already done at the close of the Assessment, to review the plan with the member and obtain agreement on the goals and interventions. During the follow-up call, motivational interviewing techniques should be used to engage the client and obtain agreement on the Care Plan. Changes to the Care Plan should be made as appropriate documenting member's readiness to change and agreement with the Plan.
2. After the Care Plan is agreed upon with the member, a letter summarizing CCM services and the Care Plan (member's self-management plan) should be mailed to the member and/or caregiver.
3. With the member's permission, the provider of care (primary provider and/or specialist managing care) should be notified that the member is receiving care management services.
 - a) A summary of draft Initial Care Plan is sent to the provider with a request to review and provide input into the final Care Plan.
 - b) For updates to the Care Plan or the annual reassessments, the Providers are provided with the revised Care Plan to allow opportunities to provide input into the final Care Plan.

Care Plan Management

1. The Care Plan, its goals and interventions schedule for completion shall guide the CM and/or SW in managing the case. Additionally, the member shall be provided the name and number of the CM to contact as needed.
2. In managing the case, the CM and/or SW shall:
 - a. Evaluate cultural, linguistic needs, preferences, or limitations in building the Care Plan and interacting with the member.
 - b. Evaluate visual and hearing needs, preferences, or limitations in building the Care Plan and interacting with the member.
 - c. Address the availability of caregiver resources and their involvement with the member.
 - d. Address available benefits and any needs for community and financial resources.
 - e. Provide the member with available programs, resources and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.
 - f. Supporting and assisting the member in accessing all needed services and resources, including across the physical and behavioral health delivery system.
 1. Make and follow up on referrals to resources. Follow up on all referrals will be scheduled at the time of the referral and can be combined as part of the next monthly contact, if not considered urgent.
 - ii. Follow up will include ensuring members receive all medically necessary services including Community Supports.
 - g. Contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Each contact includes an assessment of the member's progress towards the goals, evaluation of the barriers to the goals and adjusting the care plan and its goals, as needed.

- i. The CM and/or SW will facilitate and encourage the member's adherence to recommended interventions and treatment.
- h. Conduct case staffing (Case Rounds) with members of the care team (Medical Director, Director of CM/DM, Behavioral Health clinicians, Health Coaches and others) to ensure that the best thinking and specialized expertise is available in care plan decisions.
- i. Cases that remain open after 90 days require review at Case Rounds. Cases where the CM deems multi-disciplinary assistance is needed can be referred at any time to bi-weekly Case Rounds.
- j. Coordinate with the providers of care about progress towards or lack thereof with the plan of care.
 - i. This includes documenting in the member's medical record all the member's services and treating providers.
- k. Continually update and evaluate the Care Plan based on member need (to address unmet service needs) and using information from ongoing screenings and assessments. Promptly close the case per *CM-003, Complex Case Management Plan Evaluation and Closure*.

Additional CCM Care Plan Guidelines

1. All interactions with the member and/or providers of care concerning the Care Plan shall be documented in the Clinical Information System. In the event that a template or field entry is not available, Complex Note entries shall be used in the Clinical Information System.
2. In the absence of system generated recommendations of care the CM and/or SW will review applicable, evidenced-based guidelines published or referenced by the Alliance and/or from The National Guideline Clearinghouse (www.guideline.gov) and/or medical and behavioral healthcare specialty societies to determine the goals and interventions of the Care Plan. The Clinical Information System's recommendations are also based on professionally recognized standards of care, including industry standards and, where appropriate, based upon competent evidence-based practices such as the National Guideline Clearinghouse and other credible sources.
3. Care Plan development and monitoring time frame standards are as follows:
 - a. Obtain consent to CCM services within 5 calendar days of completing all sections of the Assessment. If unable to contact member, Unable to Reach (UTR) protocols are followed.
 - b. Complete Care Plan within 60 calendar days of enrollment. Enrollment is defined as when the member consents to Complex Case Management and a Complex Case is opened in the Clinical Information System.
 - c. At least monthly contact from time of consent.
 - d. Referrals are made within 5 calendar days of identifying need.
 - e. Case closure within 90 days of Care Plan development unless otherwise extended at Case Rounds.

Monitoring

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

Formatted: Justified

DEFINITIONS / ACRONYMS

Active Complex Case Management: A member is defined as in Active Complex Case Management at the time a General Assessment is completed and the member is entered into complex case management by the Case Manager and/or Social Worker.

Assessment Process: Assessment is a process of compiling data including claims and medication history, HRA data and member questions to provide the basis to analyze services needed and to assist in creating a care plan. There are numerous assessment tools that can be used to compile data. Alliance uses a General Assessment, Diabetes and Asthma Assessments and Health Risk Assessments for the SPD and ACC populations.

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

Care Plan Barriers: Issues that could impede the progress in completing a care plan goal.

Care Plan Goal: Goals are specific aims to which the Care Plan is directed. Goals are measurable and are based on the assessment of the member's needs.

Care Plan Intervention: Interventions are strategies or actions taken to assist the member in achieving their goals.

Case Management (CM): A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. (Case Management Society of America).

Complex Case Management (CCM): The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services. (NCQA).

CCM Enrollment: Decision making to determine whether the member proceeds to Care Plan Development and Management. The decision is based on several factors. These include the member's agreement to participate, the acuity score, and/or clinician judgment based on the individual circumstances of the case.

AFFECTED DEPARTMENTS/PARTIES

Provider Relations
Utilization Management
Quality Oversight
Case and Disease Management
Alliance Members
Alliance Delegated Groups

RELATED POLICIES AND PROCEDURES

CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment

CM-003 Complex Case Management Plan Evaluation and Closure

CM-004 Policy and Procedure, Care Coordination of Services

[CM-006 Internal Audit and Monitoring](#)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment 1. CM Member Welcome Letter

Attachment 2. Provider Notification of member enrollment in CCM

REVISION APPROVAL HISTORY

12/05/2012, 3/1/2016, 1/4/2018, 5/3/2018, 04/16/2019, 05/21/2020, 05/21/2021, 09/16/2021, 03/22/2022, 6/20/2023, 6/12/2024, [5/21/2025](#)

[Blue](#) = materials updates

REFERENCES

1. DHCS Two Plan Model Contract Exhibit A, Attachment 11 Case Management and Coordination of Care, Section B
 2. NCQA QI 5: Complex Case Management
-

MONITORING

~~The Chief Medical Officer, Sr. Director, Health Care Services, and Director, Social Determinants of Health review:~~

- ~~1) Timeliness of follow on Referrals, Care Plan Development initiation and completion~~
 - ~~2) Monthly member contact rates~~
 - ~~3) Case Rounds~~
 - ~~4) Care Plan audits using NCQA file review forms~~
 - ~~5) Readmission and hospitalization rates of members in CCM~~
 - ~~6) Satisfaction with CCM services~~
-

ATTACHMENT 1



Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Case and Disease Management Department
Phone Number: 1.510.747.4512
Toll-Free: 1.877.251.9612
People with hearing and speaking impairments
(CRS/TTY): 711/1.800.735.2929
www.alamedaalliance.org

[Date]

[Member First Name] [Member Last Name] Member ID: [Member ID]
[Member Address]
[City], [State] [Zip Code]

Dear [Member First Name] [Member Last Name],

Thank you for choosing Alameda Alliance for Health (Alliance) for your healthcare needs. We are here to help you stay healthy and active. We are sending you this letter to invite you to join our Complex Case Management (CCM) Program. We designed this program to help you reach your health goals to the highest level of wellness and function possible.

The Alliance will follow up with you on [Follow-Up Date] to discuss your personalized *Care Plan*.

If you have any questions about our CCM program, you can find out more at www.alamedaalliance.org or call:

Alliance Case and Disease Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: 1.510.747.4512
Toll-Free: 1.877.251.9612
People with hearing and speaking impairments (CRS/TTY): 711/1.800.735.2929

The program is designed to help you:

- Better manage your health and take care of yourself.
- Find programs to meet your health care needs.
- Help you reach health goals.
- Understand your illness, and when and how to ask for help.

While you are in the CCM Program, we will have frequent phone calls. During the calls, we can discuss concerns you may have with your health and getting the services you need. What we discuss and any handouts mailed to you do not replace your doctor's advice or orders. We will send a letter to your doctor to inform them that you are part of the program. It is vital that you keep your appointments and inform your doctor about any changes in your health.

Enclosed is the Advance Health Care Directive form for you to fill out. This form lets your doctor, family, and friends know how you want to be treated if you get too sick to make medical decisions for yourself.

We suggest that you:

- 1) Discuss how you want to answer the questions on the form with your family, doctor, or others who are close to you.
- 2) Complete the parts of the form that are important to you.
- 3) Share the complete and signed form with your family and doctor.

This service is available for Alliance members at no cost. You do not have to join the program if you do not want to. Your health plan benefits, and coverage remain the same.

You may also leave the CCM Program at any time if you find that it is not right for you, without consequence. We are here to support you achieve your personal health goals.

If you have a problem with your health care services, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: 1.510.747.4567
Toll-Free: 1.877.932.2738
People with hearing and speaking impairments (CRS/TTY): 711/1.800.735.2929

Best of Health,
Health Care Services
Alameda Alliance for Health

Enclosed:

- Advance Health Care Directive Form
- Alliance Notice of Privacy Practices

2/2

CM00M_MBRSS_WELCOME LTR MACAL 05/2021

«Image_CM
Letterhead»«SentDate»«MemberFirstName»«MemberLastName»«MemberAddressL
ine1»«MemberAddressLine2»«MemberId»«MemberAddressLine3»«MemberFirstNa
me»«MemberLastName»«UserNoteStart»«UserNoteEnd»«Image_Language Bar
MediCal and OTHERS CU»«Image_SIGNATURE»

ATTACHMENT 2



Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Case and Disease Management Department
Phone Number: 1.510.747.4512
Toll-Free: 1.877.251.9612
People with hearing and speaking impairments
(CRS/TTY): 711/1.800.735.2929
www.alamedaalliance.org

[Date]

[Provider First Name] [Provider Last Name]

[Provider Address 1]

[Provider Address 2]

[City], [State] [Zip Code]

RE: Member Name: [Member First Name] [Member Last Name]

Member DOB: [Member DOB]

Alliance Member ID #: [Member ID]

Dear Provider,

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. The Alliance has a Complex Case Management (CCM) Program to identify and work with at-risk patients who could benefit from case management services.

The Alliance has identified your patient, [Member First Name] [Member Last Name], for case management services. The initial Care Plan for the above-named member accompanies this letter. Please review the care plan and your input will be included in the final care plan.

The goal of our Care Plan is to work with the provider to improve the status of high-risk patients with our CCM Program.

We will address their special medical and psychosocial needs by:

- Identifying members who are at-risk for preventable poor health outcomes.
- Assessing their health care needs through an Assessment.
- Coordinating care, including referrals to support services and community agencies.
- Developing a Care Plan with individualized goals and action steps.

To include your additional input, concerns, or observations that you may have, please call or fax:

Alliance Case and Disease Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
Fax: **1.510.747.4130**

Please provide the member's full name, date of birth, and Alliance member ID number. Members may opt out of the CCM Program at any time by calling the toll-free number above.

If you or our members have a complaint about the program, please call or visit our website:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org/providers/provider-resources/grievances-appeals

Thank you for your continued partnership and the high-quality care that you provide to our members. Together we are creating a healthier community for all.

Sincerely,
Health Care Services
Alameda Alliance for Health

Enclosed: Care Plan

2/2

CM002_PROVIDER_PROVIDER NOTICE 05/2021



POLICY AND PROCEDURE

Policy Number	CM-003
Policy Name	Complex Case Management Plan Evaluation and Closure
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL, IHSS
Effective Date	12/5/2012
Administrative Oversight Committee Approval Date	~~5/21/2025~~ TBD

POLICY STATEMENT

The Alliance offers Complex Case Management (CCM) services to all identified members who are assessed as appropriate for needing these services. The Alliance CCM services help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

The Alliance will ensure that all CCM cases are closed in a timely manner using criteria for case closure. The Case Manager will ensure follow-up services are arranged prior to case closure.

The Alliance will maintain procedures for evaluating and documenting the decision to close the case using a Clinical Information System.

PROCEDURE

Scope

This Policy and Procedure addresses the Care Plan Evaluation and Closure steps of the Complex Case Management (CCM) process. This policy does not address overall CCM program evaluation, but rather evaluation of the individual case to determine whether to close the case to CCM and the arrangement, as necessary, of any follow up services the member may require.

Care Plan Closure Evaluation

1. The Case Management (CM) staff will close a case whenever the following criteria has been met:
 - a. Goals met/Improved health status

- b. Interventions not successful/all resources exhausted
 - c. Termination of coverage
 - d. Unable to establish or maintain contact with a member
 - e. No longer meets criteria other than eligibility requirements
 - f. Member/caregiver declines services.
 - g. Death of member
 - h. Other reasons, after consultation with the Manager of CM/DM, plan Medical Director, the Primary Care Physician, and caregiver, as applicable, and may include following:
 - i. Member refuses psychosocial services that are necessary to successfully participate in the CCM program.
 - ii. Member is repeatedly or consistently not compliant with Plan of Care.
 - iii. Determination by the CM staff that he/she is no longer able to provide services in a constructive manner, e.g., member is threatening to CM staff.
 - iv. Any other case reviewed where benefit of CCM is not being attained after a considerable period of time (over a year).
2. The Care Plan's short and long term goals and accompanying interventions will drive the evaluation of the case. CM staff will review on a routine basis, prompted follow up tasks within the Clinical Information System to evaluate progress on individual cases. The CM/DM Director will review reports from the Clinical Information System regarding case progress and also intervene as necessary.
 3. In general, CM staff will strive to complete short term interventions within thirty days of completion of Care Plan and for long term interventions within 90 days.
 4. Barriers to achievement of the goals should be documented within the Clinical Information System.
 5. Cases that fail to close within 90 days will be reviewed at Case Rounds as scheduled by the Manager of CM/DM. At that time, the case may be extended for an additional time defined period, but no greater than 90 additional days. After this period, if the case is still opened, the case will return to Case Rounds for review.
 6. During the last contact with the member, the CM staff will mail out a case closure letter which includes a brief satisfaction survey about their experience with the case management services. Once returned the survey will be inputted into Clinical Information System for analysis.
 7. To close a case, the CM will select the case for closure and then select Start Case Closure. Any relevant details to the case closure are also documented. All tasks associated with that case must be closed to proceed with the case closure process. Any intervention tasks must be closed from the Care Plan.
 8. Follow up services should be arranged that ensure continuity of care and allow for closure of the case. The CM staff should include these within the Plan of Care as a new short term intervention.

9. ~~The CM staff will participate in case reviews and case audits to evaluate individual performance and improve the services provided to Alliance members.~~

Monitoring

~~Please refer to CM-006 – Internal Audit and Monitoring, for details on productivity monitoring and quality auditing of CCM cases, including identification and assessment timeframes.~~
9.

Formatted: Left, Indent: Left: 0.58"

Formatted: Justified, Line spacing: Multiple 1.07 li

Formatted: Justified

DEFINITIONS / ACRONYMS

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

Care Plan Barriers: Issues that could impede the progress in completing a care plan goal.

Care Plan Goal: Goals are specific aims to which the Care Plan is directed. Goals are measurable and are based on the assessment of the member's needs.

Care Plan Intervention: Interventions are strategies or actions taken to assist the member in achieving their goals.

Complex Case Management (CCM): The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services. (NCQA).

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management

RELATED POLICIES AND PROCEDURES

CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment

CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management

CM-004 Policy and Procedure, Care Coordination of Services

CM-006 Internal Audit and Monitoring

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Complex Case Management (CCM) Program Description

REVISION HISTORY

12/05/2012, 03/01/2016, 09/06/2018, 04/16/2019, 04/24/2020, 5/21/2021, 03/22/2022, 6/20/2023, 6/12/2024, **5/21/2025**

Blue = material updates

REFERENCES

1. NCQA QI 5: Complex Case Management

MONITORING

~~The Chief Medical Officer, Sr. Director, Health Care Services, Director, Social Determinants of Health, and Manager of Case and Disease Management regularly reviews:~~

- ~~1) Timeliness of Case Closure Reports from Clinical Information System~~
- ~~2) Progress of Cases at Case Rounds~~
- ~~3) Care Plan audits using NCQA file review forms~~



POLICY AND PROCEDURE

Policy Number	CM-004
Policy Name	Care Coordination of Services
Department Name	Case and Disease Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal and Group Care
Effective Date	06/01/2012
Administrative Oversight Committee Approval Date	<u>TBD9/18/2024</u>

POLICY STATEMENT

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

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

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

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

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

PROCEDURE

Scope

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

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

Referral Screening

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

- d. Referrals will be processed according to the following time frames:
 - i. Urgent – referral opened within 24 – 72 hours (1 business day).
 - ii. Routine – referral opened within 5 calendar days.

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

Case Manager Role in Care Coordination Case

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

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

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

- g. Ensuring member health education on the importance of Primary Care for members who have not had any contact with their PCP or have not been seen within the last 12 months, particularly members less than 21 years of age;
 - h. Arranging of services not directly related to medical needs, i.e., non-medical transportation, and community resources;
 - i. Referring a member for In-Home Supportive Services (IHSS);
 - j. Reassessing as necessary per the population RSS and Risk Tiering requirements;
 - k. Continuing to provide coordination of care and BPHM based on member needs when a member is receiving IHSS services;
 - l. Coordinating health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (such as Targeted Case Management and Specialty Mental Health Services), with external entities outside of the Plan's Network, with Community Supports, and other community-based resources, even if they are not covered services;
 - m. Coordinating warm hand-offs to other public benefits programs including CalWORKs, CalFresh, WIC, Early Intervention Services, SSI, and all other programs;
 - n. Assisting members, members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons with navigating health delivery systems, including the Plan's subcontractor and downstream subcontractor networks, to access covered services as well as services not covered;
 - o. Providing members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;
 - p. Communicating to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all the care coordination provided to members, as appropriate;
 - q. Facilitating exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and
 - r. Ensuring no duplication of services occur
3. The CC staff provides care coordination for members not meeting criteria for CCM. The CC staff also assists with components of CCM cases by arranging for services per an identified Complex Care Plan. Examples include, but are not limited to, evaluating the member for further needs, and arranging services for a specific identified care gap such as medication affordability or environmental

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

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

Referral Processing Timeframes

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

Children with Special Health Care Needs (CSHCN)

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

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

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

Direct Observed Therapy for TB

1. The Plan has an MOU in place with the LHD to ensure joint case management and care coordination for members with active TB.
2. Members with active TB and members who have treatment resistance or non-compliance issues will be referred to the TB control office of the LHD for DOT.
3. CM staff will collaborate/joint case manage with the LHD TB Control Officer.

Coordination with IHSS

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

1. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;
2. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies AAH that IHSS is no longer needed for the Member;
3. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;
4. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements
5. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

6. To facilitate coordination, AAH has MOUs with each county IHSS agency within AAH's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*). The MOU delineates the roles and responsibilities of AAH and IHSS in providing IHSS to the Members.
7. Regular communication with IHSS regarding member status for open medical issues and related social issues.

Referrals to CCM

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

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

5. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on

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

1. Referrals from CCM to CC

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

Monitoring

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

Formatted: Justified, Line spacing: Multiple 1.07 li

Formatted: Justified

DEFINITIONS

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Attachment 1. Referral Form

CM-004 Care Coordination of Services

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

REVISION HISTORY

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

REFERENCES

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

MONITORING

~~Referrals to and from CCM are monitored through:~~

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

~~Monitoring for IHSS referrals:~~

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

ATTACHMENT 1



Case and Disease Management (CMDM) – Program Referral Form

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

INSTRUCTIONS

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

*If you have questions about how to send a secure email, please visit www.alamedaalliance.org

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

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

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

SECTION 2: MEMBER INFORMATION

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

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

- ☐ Case Management (including Complex Case Management (CCM), Care Coordination, and Transitional Care Services (TCS))
- ☐ Asthma Disease Management ☐ Depression Disease Management
- ☐ Cardiovascular Disease Management ☐ Diabetes Disease Management
- ☐ Other (please provide details in Section 4)

SECTION 4: REASON FOR REFERRAL

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

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

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

CMDM_PRIVDR_FORMS_PROG REF 09/2023



POLICY AND PROCEDURE

Policy Number	CM-006
Policy Name	Internal Audit and Monitoring
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	01/04/2018
Administrative Oversight Committee Approval Date	~~5/21/2025~~ TBD

POLICY STATEMENT

In connection with any of its product lines, Alameda Alliance for Health (The Alliance) Case Management Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state statutory, regulatory, contractual, and National Committee for Quality Assurance (NCQA) accreditation requirements. It is the responsibility of the entire management team to ensure ongoing auditing and monitoring is properly executed, documented, and evidenced.

The Alliance must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, to evaluate internal compliance with regulatory, contractual and accreditation requirements and the overall effectiveness of the compliance program.

The Alliance will establish a monitoring process to rapidly detect potential issues and establish and implement an effective system to identify compliance risks. This includes:

- Routine internal monitoring of compliance risk areas
- Routine internal monitoring
- ~~Periodic internal auditing to confirm results of monitoring~~

The Alliance will maintain processes to perform monitoring of key reporting requirements and assist in identifying areas that may qualify for “self-reporting” due to over or under performance metrics.

The Alliance Health ~~Care Services-Case Management~~ Department is responsible for the

oversight of the monitoring and auditing efforts for ~~Utilization Management and~~ Case Management (CM). The Alliance's Compliance Committee is responsible for the compliance activities of the organization and will receive reports regarding performance, updates to processes through the Utilization Management Committee to the Compliance Committee

PROCEDURE

1. ~~Health Care Services (HCS)-Case Management~~ staff will participate with Compliance in the annual audits of Alliance delegated Providers overseen by CM department. ~~HCS Case Management, in collaboration with the Alliance's Compliance Department,~~ will audit and monitor the delegated Providers' compliance with state and federal laws and regulations, ~~t~~The Alliance policies, procedures, contractual requirements, and NCQA accreditation requirements related to functions including but not limited to case management, ~~and utilization management.~~
2. Case Management leadership staff will develop and maintain a monitoring plan for the Case Management Department. The monitoring plan details monitoring reports, performance indicators, monitoring methods and monitoring frequency.
3. Monitoring reports will be identified based on internal, regulatory, contractual and accreditation standard requirements. At least annually, and as needed, reports will be identified along with the applicable performance metrics:
 - 3.1 Case Management Leadership will assess the various types of reports required for Case Management.
4. Case Management will identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations, and company policies. Examples of possible performance indicators include initiation of assessment, completion of assessment, completion of care plan, etc.
5. Monitoring methods are determined by the type of ~~report and the performance indicators. Examples include risk assessments, data reviews, charts, graphics, spot checks, random sampling, staff interviews, etc.~~case. Examples include: call monitoring and case audits via system of record.
6. Monitoring frequency is defined by regulation, contract or department policy but should be appropriate to the nature of the process and relative risk it represents. Examples:
 - ~~6.1 Monthly to ensure compliance is met for Complex Case Management assessment timeframes.~~
 - ~~6.2 Monthly to determine compliance with Case Management assessment completion with required timeframe.~~
 - ~~6.3~~6.1 Monthly to determine compliance with productivity and quality of cases, including call monitoring and reviewing documentation in the system of record.
 - ~~6.4 Quarterly for Health Risk Assessment completion within the required timeframes.~~

~~Annually for programmatic reporting.~~

Formatted: Normal, Indent: Left: 0"

7. Case-Staff Productivity Monitoring and Quality Auditing by CM Staff Title:
Goals and scores are established in standard operating procedure (SOP) CM- Productivity
and Quality Monitoring SOP.

7.1 CM Coordinator

7.1.1 Productivity – CM Non-Clinical Supervisor to monitor volume of inbound calls answered by CM Coordinator each month ensuring meeting monthly baseline volume goal met.

7.1.2 Quality – Audit three (3) phone call recordings per staff per month for appropriate charting and call handling ensuring passing quality score.

7.2 HRA Coordinator

7.2.1 Productivity – CM Non-Clinical Supervisor to monitor volume of Health Risk Assessments (HRA) and HIF/METs processed by HRA Coordinator each month ensuring monthly baseline volume goal met.

7.2.2 Quality – Audit two (2) HRA cases and two (2) HIF/MET cases per staff per month for appropriate processing of HRA and HIF/MET ensuring passing quality score.

7.3 Transportation Coordinator

7.3.1 Productivity – CM Non-Clinical Supervisor to monitor volume of transportation cases closed per month ensuring meeting monthly baseline volume goal met.

7.3.2 Quality – Audit three (3) transportation cases per staff per month for appropriate processing of physician certification statement (PCS) form ensuring passing quality score.

7.4 Case Management Lead

7.4.1 Productivity – CM Supervisor to monitor volume of referrals processed (referred out) by CM Lead ensuring monthly baseline volume goal met.

7.4.2 Quality – Audit daily assignment completed and sent out to department timely by CM Lead each month, ensuring passing monthly score.

7.5 Health Navigator

7.5.1 Productivity – CM Non-Clinical Supervisor to monitor volume of phone calls and notes for CM case types including but not limited to care coordination and transitional case services. CM Non-Clinical Supervisor ensures monthly baseline phone call and case note goal met.

7.5.2 Quality – Audit three (3) care coordination cases and three (3) transitional care services per staff per month for appropriate processing of case ensuring passing monthly score.

7.6 Medical Social Worker

7.6.1 Productivity – CM Supervisor to monitor volume of phone calls and notes for CM case types including but not limited to care coordination cases. CM Supervisor ensures monthly baseline phone call and case note goal met.

7.6.2 Quality – Audit three (3) care coordination cases per staff per month for appropriate processing of case, ensuring passing monthly score.

7.7 Registered Nurse

7.7.1 Productivity – CM Supervisor to monitor volume of phone calls and notes for CM case types including but not limited to care coordination, transitional care services, and complex. CM Supervisor ensures monthly

baseline phone call and case note goal met.

7.7.2 Quality – Audit three (3) care coordination cases, three (3) transitional care services cases per staff per month for appropriate processing of case ensuring passing monthly score. Audit all Complex Case Management (CCM) cases open over 30 days for charting and up to three (3) CCM cases per staff per month for phone call quality.

~~7.1–~~

~~7.2 CM Leadership will randomly select 3 files per reviewer per case type~~

~~7.3 Case Types include (but are not limited to):~~

~~7.3.1 Transitional Care Services (TCS)~~

~~7.3.2 Care Coordination~~

~~7.3.3 Complex Case Management (CCM) (For RNs only)~~

~~7.4 If 3 files are unable to be selected, all files of the case type are selected per reviewer~~

- ~~i. CCM—100% of the files are reviewed using the NCQA worksheet or approved CCM file review tool~~
- ~~ii. Cases review for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the CM-001-Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment policy.~~
- ~~iii. For all other case types—100% of the files are reviewed using the audit tool~~
 - ~~■ The audit tool includes the following (but is not limited to):~~
 - ~~■ Addressing the referral timely~~
 - ~~■ Completion of appropriate assessment(s)~~
 - ~~■ Linking appropriate pieces to the case (notes, assessment, authorizations, etc.)~~
 - ~~■ Timely follow-up on the case~~
 - ~~■ Appropriate letters/notifications sent out (case closure letter, educational materials if appropriate, etc.)~~

~~8. Phone Call Auditing~~

~~8.1 CM Leadership will review phone calls associated with randomly selected cases as described above~~

~~8.2 If no phone calls were made during the audit window, another phone call will be selected~~

~~8.3 Phone calls will be reviewed to confirm documentation is accurate with the system of record~~

~~For Health Risk Assessment~~

~~9. Each month Case Management Leadership will randomly select up to 2 HRA files per staff person.~~

- ~~i. 100% of the files are reviewed using directions identified in the most recent All Plan Letter (APL) for HRAs for SPD beneficiaries. File review will be completed using an approved HRA assessment Tool.~~
- ~~ii. HRA files are reviewed for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the APL and~~

~~CM-008, Policy and Procedure, SPD-HRA—Survey and Interventions policy. If member is noted as High Risk, the file should contain the assessment by a clinician, individualized care plan, care team discussions and communication with the PCP.~~

8. Follow-up and Corrective Actions

Formatted: Outline numbered + Level: 1 + Numbering
Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at:
0.09" + Indent at: 0.59"

9.18.1 Any monitoring result indicative of a potential issue, problem or noncompliance must be adequately and timely addressed.

~~9.1.18.1.1~~ All monitoring is discussed routinely with individual staff

9.28.2 Case Management Leadership is responsible for identifying issues/problems found in the monitoring activities and reporting it to the Director, Social Determinants of Health for recommendations/corrective actions.

8.3 Non-compliance monitoring results may be reported to the Sr. Director, Health Care Services. Based on the scope and severity of the issues, the Sr. Director, Health Care Services may notify the Compliance Officer for recommendations of the next appropriate steps.

~~9.3~~

a. Non-compliance monitoring results may trigger a targeted or focused audit

~~b.~~

e. When there are severe monitoring results (repeat deficiencies or Immediate Corrective Action required), the Compliance Officer and Sr. Director, Health Care Services will follow action recommendations as defined in Compliance policies.

Formatted: Normal, No bullets or numbering

Formatted: Normal, Justified, Indent: First line: 0.5", No
bullets or numbering

9.48.4 Monthly reports of the monitoring activities will be reported to the ~~SD~~ Director, Health Care Services.

9.58.5 Repeat deficiencies or Immediate Corrective Actions Required are identified which impact member safety are reported expeditiously to the Chief Medical Officer for recommendations.

DEFINITIONS / ACRONYMS

Auditing: Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures.

CCM: Complex Case Management

Formatted: Font: Not Bold

CM: Case Management

HIF/MET: Health Information Form / Member Evaluation Tool

HRA: Health Risk Assessment

Internal Audits: Internal Audits are audits of the Alliance or delegates conducted by an employee or by an affiliate of the Alliance.

Monitoring Activities: A process of regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Oversight: Oversight means monitoring and directing a set of activities, resulting in a desired outcome.

SOP: Standard Operating Procedure

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Case Management
Compliance Department

RELATED POLICIES AND PROCEDURES

CM-001 –Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment

CM-008 ~~–~~ Policy and Procedure, SPD HRA – Survey and Interventions

SOP: CM – Productivity and Quality Monitoring SOP

REVISION HISTORY

01/04/2018, 04/16/2019, 05/21/2020, 3/22/2022, 6/20/2023, 6/12/2024, 5/21/2025, TBD

Blue = material updates

REFERENCES

~~APL-17-001~~

MONITORING

~~Monthly monitoring report for UM authorizations and processing turn-around time.~~
~~Monthly monitoring HRA~~
~~Monthly monitoring Complex Case Management~~



POLICY AND PROCEDURE

Policy Number	CM-008
Policy Name	SPD HRA – Survey and Interventions
Department Name	Case and Disease Management Division
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	MCAL, IHSS
Effective Date	1/1/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/21/2024
Administrative Oversight Committee Approval Date	<u>9/18/2024TBD</u>

POLICY STATEMENT

OVERVIEW

Alameda Alliance for Health (the Alliance) provides an assessment of every newly enrolled Seniors and Persons with Disabilities (SPD) member through a process that differentiates members who are at high or low risk for medical complications, deteriorating health conditions or in need of special assistance from the Alliance, mental health or community-based services.

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual SPD members, the Alliance makes every effort to identify each member's individual medical and resource needs.

The assessment is conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

POLICY

The Alliance performs a Health Risk Assessment (HRA) survey, which includes a Health Information Form/Member Evaluation Tool (HIF/MET) within the required timeframe for the

purposes of developing individualized care plans for members as follows:

- a. Within 45 days of enrollment for those initially stratified as higher risk per CM-007 SPD High Risk Stratification.
- b. Within 105 days of enrollment for those initially stratified as lower risk per CM-007 SPD High Risk Stratification.

The HRA includes specific Long-Term Services and Supports (LTSS) referral questions intended to assist in identifying members who may qualify or benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk members. After completion of the HRA, the Alliance develops an Individualized Care Plan (ICP) for members and coordinates referrals, including referrals for LTSS, as needed.

If a SPD member disenrolls from the Alliance, the Plan will make the results of the HIF/MET available to the new Managed Care Plan upon request.

PROCEDURE

1. Development of the HRA questions

- 1) At the initial time of the HRA development the Alliance Health Care Analytics Department will work with the Compliance Department and the Community Advisory Committee (CAC) to provide input into the development of the HRA questions pertinent to the membership.
- 2) Long Term Services and Supports (LTSS) questions in the HRA are mandated and must be used verbatim.
- 3) Any changes to the HRA will be approved internally at the Utilization Management Sub-Committee meeting and subsequently through the Health Care Quality Committee meeting.
- 4) Updates to the HRA go through a formal approval process from the Department of HealthCare Services (DHCS) before changes are implemented.
- 5) The Alliance Case Management/HRA Clinic Team is responsible for ensuring the appropriate questions are developed and weighted appropriate to identify member's needs.

2. The Alliance HRA has specific questions to:

- A. identify a member's need for help in facilitating timely access to primary care, specialty care, DME, medications, and other health services,
- B. identify the referrals a member needs to appropriate community resources and other agencies for services outside of the Alliance's scope of responsibility
- C. identify a member's need for and appropriate level of involvement of caregivers
- D. identify a member's need for help in facilitating communication among the member's health care providers,
- E. identify a member's need for other activities or services that would help the member to optimize his or her health status
- F. identify a member's need for coordination of care across all settings, including those outside the Alliance's provider network;
- G. ensure that a member admitted to a hospital or institution receives appropriate discharge planning;

and

- H. ensure the standardized LTSS referral questions are used to refer members who may qualify for and benefit from LTSS services.

3. Each HRA Survey includes HIF/MET questions. Per APL 17-013 HIF/MET process, the HRA process will include:

- A. A process to include the HIF/MET questions in each newly enrolled SPD member's HRA survey, mailed to them upon enrollment and annually thereafter including a postage paid envelope for mailing back the completed form;
- B. Within 90 days of each new SPD member's date of enrollment, at least two telephone call attempts will be made to remind new SPD member to return the HRA survey and/or collect the HRA with HIF/MET information from new SPD members;
- C. When the HRA survey is completed or returned, within 90 days of enrollment for each SPD member, the Alliance will utilize the information to complete a screening of each new SPD member's needs.
- D. A process, upon an SPD member's disenrollment, to make any HIF/MET assessment results available to the SPD member's new MCP upon request.

4. Two Telephone Call Attempts

- A. Low Risk Members: The Alliance sends a data file including all annual and new, non-SPD members that have been stratified as low risk as per CM-007 to the internal IT department to complete two call attempts, one week apart, within 90 days of enrollment or their annual anniversary.
 - 1) The IT department uses the Alliance Member Services phone number as the Caller ID and members are provided Member Services phone number to call if they have questions.
 - 2) Member Services will assist any member in completing the HRA survey if they call and request assistance.
- B. High Risk Members: Data Analytics will send a monthly list of members that have been stratified as high risk as per CM-007 to Case Management to complete phone call outreach attempts. Case Management staff will call the member twice in an attempt to remind or assist the member in completing their HRA survey. If the first call attempt is successful, there will be a second call attempt if the HRA survey is not received within 1 month of the first call. Each call attempt is entered into the existing Clinical Information System.

5. Scoring of HRA Surveys

- A. The responses to the HRA survey, which includes HIF/MET questions, are input into the existing Clinical Information System and are used in the re-stratification of the member's health and care needs.
 - 1) The HRA questions are designed to identify certain risk factors for each patient. At the end of the assessment process, based on responses to questions, the existing Clinical Information System automatically re-stratifies and assigns a new risk stratification score.
 - 2) Scoring methodology: See attachment
 - 3) Combinations of questions and responses are used to stratify the risk of each member in the following categories:
 - a) High Risk: member receives a score of 9 or greater on their Health Risk

- Assessment Survey.
 - b) Low Risk: member receives a score of 8 or less on their Health Risk Assessment Survey.
- B. For some members, the re-classification based on answers to the HRA survey may be different from their earlier classification based on the initial stratification method.
- C. The CM staff will identify any SPD members who may not have been identified initially as high risk due to the lack of data and will re-classify them as high risk.

6. Care Plan Development and Mailing

- A. For members identified as low risk through their responses to the HRA survey, regardless of their risk level at initial stratification, or who do not complete their HRA survey, a system generated care plan is developed. The care plan populates with education resources based on preventive health reminders. The care plan includes information encouraging members to schedule an appointment with their assigned primary care provider for ongoing care needs.
- B. A copy of the care plan is sent to the member along with educational resources.
- C. A copy of the care plan is sent to the primary care provider.
 - 1) For members without an assigned primary care provider at the time of mailing, the member information will be sent to the Case Management Department to assess next steps.
- D. Members identified as high risk through their responses to the HRA survey, regardless of their risk level at initial stratification, are assigned to an Alliance Nurse CM for Care Plan development.
 - 1) Care plans are generated by Case Managers based on the HRA responses and other available clinical information. An individualized care plan is developed in collaboration with the member and/or the member's caregiver. The care planning process is per CM-002 Complex Case Management Plan Development and Management.
 - 2) Case Managers assigned a high-risk member may revise the member's risk category after assessing the member's needs and determining the member does not meet the criteria for high risk.

7. High Risk Care Planning and Interventions

- A. The care plan contains the following components:
 - 1) Appropriate involvement of caregivers
 - a) The assessment will include process for identifying a member's need for and appropriate level of involvement of caregivers interventions with identified problem and goals are placed into the care plan from a database pool of interventions. Through conversations with CM staff and/or Alliance staff and/or providers, members and caregivers can add interventions and or make customizations to existing interventions.
 - 2) Facilitating timely access to primary care, specialty care, durable medical equipment, medications, mental health and substance abuse providers or other health services including any physical or cognitive services. The need for referrals to resolve any physical or cognitive barriers to access will also be assessed.
 - 3) Services needed to assist members in optimizing their health status, including assisting with self-management skills or techniques and health education.

- 4) Coordinated care across all settings including those outside the provider network
 - a) Regardless of risk level, the plan's Case Manager, Member Service Unit and the PCP share a common responsibility for coordination of care across multiple settings, including those outside of the medical network. The CM/DM staff and Member Services representative staff are trained to assist members with issues that involve accessing community resources, including but not limited to food insecurity, SSI and other social services questions, behavioral health, housing and support groups for various conditions and needs.
 - b) The care plan is shared across the appropriate entities (i.e. PCPs, mental health provider, etc.) who may serve the member. At each encounter, the responsible entity reviews the member's care plan with the member or their authorized representative to validate if the member has any unmet needs or additional needs for other types of services.
 - 5) Referrals to appropriate community resources and other agencies for services outside the scope of responsibility of the managed care health plan including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs and services for the intellectual and developmental disabilities.
- B. Referrals to Long Term Support Services
- 1) Using the standardized questions from the HRA, the Alliance staff will identify members who qualify for or who could benefit from LTSS.
 - 2) The Alliance maintains a listing of community resources, Long-Term Services and Supports (LTSS) and health education resources. This resource listing and health education directory are updated as new resources are identified and older ones become invalid.
 - 3) Both the Alliance and its contracted Provider Groups may identify and refer members for LTSS services.
- C. Interventions may be developed specific to the required care management of high risk members. The interventions are grouped into the following eight categories:
- 1) Complex Case Management
 - 2) Physician Services
 - 3) Medication Management
 - 4) Behavioral, Mental & Cognitive Health
 - 5) Nutrition
 - 6) Education
 - 7) Advance Care Planning
 - 8) Daily Activity Management
- D. Care Plan process will follow the procedure as outlined in CM-002 Complex Case Plan Development and Management.

~~8. Effectiveness of the HRA assessment~~

- ~~A. Annually, the Health Care Analytics Department and Medical Services Department review the HRA to ensure the tool is identifying members appropriately for the various stratification levels.~~
- ~~B. Results of the report are presented to the UM Sub Committee and, when necessary, Health Care Quality Committee.~~

~~9. Oversight~~

~~A. The Alliance will monitor compliance through analysis of routine reporting.~~

~~E. Quarterly reports will be reported to the Utilization Management Sub-Committee and subsequently to the Health Care Quality Committee (HCQC).~~

Monitoring

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

Formatted: Justified, Line spacing: Multiple 1.07 li

Formatted: Justified

DEFINITIONS/ACRONYMS

Health Information Form (HIF)/Member Evaluation Tool (MET): The information collected from a health information form and completed by members at the time of enrollment by which members may self-identify disabilities, acute and chronic health conditions and transitional service needs.

Health Risk Assessment Risk Stratification: Mechanism or algorithm designed for identify newly enrolled members

High Risk: MediCal members who are at increased risk of having adverse health outcome or worsening of their health status if they do not have an individualized care management plan

Lower Risk: MediCal members who need basic care management.

CAC: Community Advisory Committee

This classification methodology is consistent with the guidelines defined in Department of Health Care Services (DHCS) All Plan Letter: 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities.

AFFECTED DEPARTMENTS/PARTIES

Case Management
Health Care Analytics
Member Services
Utilization
Management
Quality Improvement

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment

CM-002 Complex Case Management Plan Development and Management

CM-003 Complex Case Management Plan Evaluation and Closure

UM-002 Coordination of Care

CM-004 Care Coordination of Services

CM-008 SPD HRA Survey and Interventions

CM-006 Internal Audit and Monitoring

CM-007 SPD Health Risk Initial Stratification

**RELATED WORKFLOW DOCUMENTS OR OTHER
ATTACHMENTS**

Health Information Form/Member Evaluation Tool (HIF/MET)
HRA Scoring Methodology

REVISION HISTORY

1/4/2018, 11/15/18, 4/16/19, 04/24/2020, 11/23/2021, 03/22/2022, 9/19/2023, 9/18/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 10
DHCS All Plan Letter17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors
and Persons with Disabilities
Welfare & Institutions Code § 14182

MONITORING

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



POLICY AND PROCEDURE

Policy Number	CM-034
Policy Name	Transitional Care Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director of Social Determinants of Health
Lines of Business	MCAL, IHSS
Effective Date	01/01/2023
Administrative Oversight Committee Approval Date	<u>5/21/2025</u> <u>TBD</u>

Formatted: Line spacing: Multiple 1.08 li

POLICY STATEMENT

Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings.

Under Population Health Management (PHM) and in line with CalAIM, the Alliance is accountable for providing strengthened Transitional Care Services (TCS) beginning on January 1, 2023 and be fully implemented for all members by January 1, 2024 across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact, herein referred to as a care manager, can assist members throughout their transition and ensure all required services are complete.

The transitional care policies are consistent with the DHCS' Comprehensive Quality Strategy (CQS) and are being measured through quality reporting. This includes ensuring timely follow-up for members with emergency department (ED) visits for mental health issues or SUD. The Alliance will implement future DHCS policy guidance ongoing.

The Alliance implements timely prior authorizations and when informed that members are admitted, discharged or transferred.

The Alliance also ensures that all TCS are complete (including assigning a care manager/single point of contact who will complete all required responsibilities) for all high-risk members. For Transitional Care Services, high risk members are defined as the following populations:

- Any "high risk" members as identified through the Alliance's' RSS mechanisms or through the PHM Service once the statewide RSS and risk tiers are available;

- Any other populations who require assessments, including but not limited to:
 - Those who are in ECM or CCM (TCS must be provided by the ECM or CCM Care Manager); and
 - Those who received LTSS.

By January 1, 2024 the Alliance will ensure all TCS (as required below) are completed for all members.

PROCEDURE

Admission, Discharge, and Transfer (ADT)

The Alliance is responsible for knowing, in a timely manner, when all members have planned admissions, and when they are admitted, discharged, or transferred, and therefore experiencing a transition, through the following mechanisms:

- The Alliance is responsible for ingesting and utilizing ADT feeds when they exist.
- The Alliance enters agreements with all contracted general acute care hospitals and emergency departments, as defined by HSC § 1250 to receive ADT notifications from them whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible.
- The Alliance provides up to date Member rosters to their contracted general acute care facilities, emergency departments, and skilled nursing facilities (together “Participating Facilities”) so that such facilities can send notifications to the Alliance whenever one of their members is admitted, discharged or transferred to or from their facility.
 - To meet this expectation, The Alliance receives these ADT notifications from “intermediaries”, defined as a health information exchange network, health information organization, or technology vendor that assists a “Participating Facility” in the Exchange of Health and Social Services Information.
- When ADT feeds are not available (for example, many SNFs do not create ADT data feeds), the Alliance identifies other mechanisms or establishes other data-sharing agreements to know when members are expected to be/admitted, discharged, or transferred. These can include but are not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests.

Prior Authorizations and Timely Discharges

The Alliance will ensure timely prior authorizations and discharges for all members, which includes, but is not limited to, ensuring that prior authorizations required for a member’s discharge are processed in a timely manner.

Identification of High- vs. Lower-risk Transitioning Members

“High-risk” transitioning members means all members listed below:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).
- Those entering CCM (per NCQA).
- Those entering ECM.
- Children with Special Health Care Needs (CSHCN).
- Pregnant individuals.
- Seniors and persons with disabilities who meet the definition of “high risk” as established in existing APL requirements, namely:
 - Members who have been authorized to receive:

- IHSS greater than, or equal to, 195 hours per month;
- Community-Based Adult Services (CBAS), and/or
- Multipurpose Senior Services Program (MSSP) Services.
- Members who:
 - Have been on oxygen within the past 90 days;
 - Are residing in an acute hospital setting;
 - Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
 - Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
 - Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
 - Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
 - Have cancer and are currently being treated;
 - Are pregnant;
 - Have been prescribed antipsychotic medication within the past 90 days;
 - Have been prescribed 15 or more prescriptions in the past 90 days;
 - Have a self-report of a deteriorating condition; and
 - Have other conditions as determined by the MCP, based on local resources.

In addition to these groups, and in recognition of high risk of poor outcomes in transition for Alliance members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured by the above categories, the Alliance also considers the following members “high-risk” for the purposes of TCS:

- Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility
- Any member transitioning to or from a SNF
- Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.

Alliance Oversight of Facility Discharge Planning Process

TCS requirements build on, rather than supplant, existing requirements on facilities. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.

The Alliance is accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. The Alliance ensures discharging facilities complete a discharge planning process that:

- Engages members, and/or members’ parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution or facility.

- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Uses a consistent assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently already required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
 - For high-risk members, the Alliance ensures the discharging facility shares this information the Alliance's assigned care manager and that the discharging facilities have processes in place to refer members to ECM or Community Supports as needed.
 - For members not already classified as high-risk by the Alliance, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to the Alliance for:
 - Any member who has a specialty mental health need or substance use disorder.
 - Any member who is eligible for an ECM Population of Focus
 - Any member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
 - This must include a medication reconciliation upon discharge that includes education and counseling about the member's medications.
- Coordinates care with:
 - The member's designated family caregiver(s). The Alliance ensures they are notified of the member's discharge or transfer to another facility.
 - Post-discharge providers. The Alliance ensures they are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.

Care Manager Responsible for TCS

Once a member has been identified as being admitted, including SNFs, the Alliance identifies the care manager, who is the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

- This requirement applies to high-risk members starting on January 1, 2023, including members with long-term services and supports (LTSS) needs, those entering CCM, those entering ECM, Children with Special Health Care Needs (CSHCN), Pregnant

individuals, and Seniors and persons with disabilities (SPD). This requirement applies to all members starting on January 1, 2024.

- For members enrolled in CCM or ECM, the Alliance ensures that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who must provide all TCS.
- "Longitudinal support" means that a single relationship must span the whole transition. For members not enrolled in ECM or CCM, this single point of contact ("care manager") does not need to be employed by the plan and can be provided by contracted entities (e.g. the primary care practice, an Accountable Care Organization or, the hospital). The Alliance ensures that a single point of contact is assigned until needs are met and that all TCS can be completed.
- Working with a care manager is optional for members. The Alliance ensures that the member is offered the direct assistance of the care manager, but members may choose to have limited or no contact with the care manager. In these cases, at a minimum, the Alliance ensures that discharging facilities comply with federal and state discharge planning requirements (listed above) and that the care manager assists in all care coordination among the discharging facility, the PCP, or any other identified follow-up providers, and the follow-up is complete.

Communication of Assignment to the Care Manager

The Alliance communicates both with the responsible care manager (or contracted care manager) and with the facility, including SNFs where the patient is admitted (referred to as the "discharging facility") in a timely manner so that the care manager can participate in discharge planning and support access to available services. This requirement applies to high-risk members starting on January 1, 2023, and to all members starting on January 1, 2024.

For members receiving TCS, their assigned care managers (including ECM and CCM) are notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the Alliance being aware of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists (such as for SNF admissions).

However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

The Alliance notifies the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number, of the identified care manager in the discharge planning document. The member must be given the care manager's contact information as part of the discharge planning document, as described below.

Care Manager Responsibilities

The care manager responsible for TCS is responsible for coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. Hospital and nursing home staff who help with discharge plans should work with, but do not supplant the need for, a care manager unless the responsibility for TCS is fully contracted out.

The care manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must ensure all transitional care management

activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services and follow-ups, noted below. Based on the phased implementation timeline, the care manager is responsible for completing all required responsibilities outlined below for high-risk members starting on January 1, 2023, and for all members starting on January 1, 2024.

The Alliance and the assigned care managers ensure Member transitions to and from a SNF are timely and do not delay or interrupt any Medically Necessary services or care, and that all required transitional care activities are completed.

Discharge Risk Assessment and Discharge Planning

A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:

- Risk Assessment:
 - The care manager must assess the member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The care manager may supplement this risk assessment as needed through member engagement. During this process the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM) and/or Community Supports and make appropriate referrals.
 -
- Discharge Instructions:
 - Care managers must receive and review a copy of the discharging facility's discharge instructions given to the member, including medication reconciliation completed upon discharge by the discharging facility.
 - After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
 - A best practice (not required) is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.
- Discharge Summary and Clinical Information Sharing:
 - Care managers must receive and review a copy of the discharging facility's discharge summary once it is complete.
 - Care managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.

Necessary Post-Discharge Services and Follow-Ups

Knowing that immediately post-discharge is an especially vulnerable time for high-risk members, support and follow-up post-discharge are critical aspects for the care manager responsible for TCS, including tasks in the Alliance contract and as described below:

- Member Outreach:
 - The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS

care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.

- Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different); and arranging transportation.
- SUD and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition.
- Medication reconciliation, post discharge:
- Care manager must ensure this is complete after individual is discharged. This can be done by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate license, or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.
- Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.).
- Connection to community supports as needed.
- For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
 - Ensure outpatient appointments are scheduled prior to discharge;
 - Verify that Members arrive safely and have their medical needs met;
 - Follow-up with Members to ensure all TCS needs and requirements have been met.

End of TCS

TCS for high-risk members extends until the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. TCS for high-risk members should always extend at least 30 days post-discharge. If the MCP has delegated TCS, the MCP must ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM and/or Community Supports should be reconsidered.

For members who may not respond to the MCP's outreach attempts or did not attend scheduled follow-up ambulatory visits, the MCP must make reasonable effort to ensure members are engaged and that the follow-up ambulatory visits are completed. For example, the care manager must ensure the members know that TCS support is available for at least 30 days or use CHWs to conduct outreach and attempt to engage the members in person.

For members with multiple care transitions within a 30-day period, the MCP must ensure the same care manager is assigned to support them through all these transitions. If the second transition is within 7 days of the first transition, then the care manager must ensure the follow up visit is completed within 7-days post discharge after the last transition. The care manager must also provide TCS support for at least 30 days after the last transition. These members should be considered for ECM/CCM and/or Community Supports eligibility.

Minimum TCS Elements and Processes for Lower-Risk Members

Lower-risk members in transition are defined as those not included in the high-risk definition above. The Alliance ensures that:

- The member has access to a specialized TCS team for a period of at least 30 days from the discharge; and
- Ambulatory follow-up occurs.

Dedicated Team/Phone Number for Member Contact and Support

The Alliance ensures that it has a dedicated team and phone number to support the transitioning members telephonically when they request help. The required features of this dedicated support service are as follows:

- Minimum Requirements for the Dedicated TCS Team:
 - First point of member contact may be a trained customer service representative or similar unlicensed team member. However, the team must consist of additional staff and support to provide an escalation pathway to allow the member to reach care management/clinical staff, who can address any of their issues that require licensed care providers. This may include nurse care managers or physicians.
 - The team is able to access discharge planning documents, if needed, to assist members with questions regarding care at the discharging facility, including medication changes.
 - The team must be able to provide assistance for any TCS need, including (but not limited to) help with access to ambulatory care, appointment scheduling, referrals/handoffs to needed social services or community-based resources, including arranging NEMT.
 - The team must be able to place and coordinate referrals to longer term care management programs (ECM/CCM) and/or Community Supports at any point during the transition.
- Minimum Requirements for the Phone Line:
 - The Alliance offers, at minimum, dedicated telephonic support services for members experiencing a transition of care. The Alliance leverages existing member support telephone services to meet this requirement. During business hours, the Alliance ensures that members are able to connect with a live team dedicated to TCS.
 - Outside of business hours, the Alliance ensures that:
 - Members are referred to emergency services if needed;
 - Members can leave a message;
 - Messages are shared with the dedicated TCS team. A TCS team staff responds to members within 1 business day after the initial phone call.
- Member Communication of TCS Support:
 - The Alliance ensures lower risk members in transition receive direct communication about the dedicated TCS team and phone line and how to access it. The Alliance makes best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge.

Necessary Post-Discharge Services and Follow-Ups for Lower-Risk Members

In addition to the dedicated call line, the Alliance ensures that each lower-risk member in transition completes a follow-up ambulatory visit with a physician or advanced practice provider (with prescribing authority) within 30 days of discharge for necessary post-discharge care and services, such as medication reconciliation post-discharge, which is a critical TCS requirement. In addition, for any members who have open preventive services care gaps or have not had a PCP visit within 12 months, the Alliance ensures that each lower-risk member has PCP follow up in addition to any other non-PCP ambulatory visits that may be needed.

End of TCS for Lower-Risk Members

The Alliance continues to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point during the transition, the Alliance uses data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.

Guidance for Members Enrolled with Multiple Payors

Given that the Alliance is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the Alliance or its contracted care manager is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the Alliance is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MHP).

For all members enrolled with multiple payors undergoing any transition, the Alliance is informed when their members are admitted, discharged, or transferred; the Alliance notifies existing Medi-Cal care managers (ECM or CCM) of admissions, discharges, and transfers; and the Alliance conducts prior authorizations and coordinates, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor. However, there are specific modifications to the assignment of a care manager and care manager responsibilities as follows:

- Requirements for Members Dual-Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):
 - For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/ D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Alliance is not responsible for assigning a transitional care manager or any transitional care manager responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the Alliance is responsible for notifying that care manager of the admission, discharge or transfer.
 - For admissions, transfers and discharges involving Alliance members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), the Alliance remains responsible for ensuring all transitional care requirements are complete, including assigning or delegating a care manager or having a dedicated TCS team/phone number.
- Requirements for When County MHPs or DMC-ODS Are the Primary Payors:
 - For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge. However, MHPs and DMC-ODS have limited access/ability to coordinate across the Alliance or physical health care needs, therefore:
 - In addition to the core Alliance responsibilities noted above, the Alliance assigns or contracts with a care manager to coordinate with behavioral

health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as CCM, ECM, or Community Supports.

- The Alliance has MOUs with required entities, including Alameda County Behavioral Health Services, to facilitate care coordination and ensure non-duplication of services. In 2024, Alliance will be implementing the expanded MOU requirements to include additional entities, including local alcohol and SUD treatment services.
- Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:
 - For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital):
 - The Alliance is responsible for all TCS during the transfer/discharge to the behavioral health facility.
 - TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete.
 - After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, the Alliance follows the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

Scope

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

Referral Screening

1. CM staff will:
 - a. Receive referrals from:
 - i. Admission, Discharge, and Transfer (ADT) reports,
 - ii. Inpatient Utilization Management and other departments
 - iii. Phone, fax or email
 - b. Log the referral in the Clinical Information System with relevant information such as the referral source, urgency of referral (if appropriate), and any corresponding details.
 - c. Review direct referrals received via the Clinical Information System Provider Portal to ensure appropriate program is selected to address the identified concerns:

- i. Care coordination concerns
 - ii. Complex medical care concerns
 - iii. Disease Management, Asthma, Diabetes, COPD
 - iv. Managed Long Term Services – CBAS, Custodial Care
 - v. Behavioral Health Referral
- 2. After the Referral is created as outlined above, the CM staff will begin the screening process.
- 3. Referral screening consists of the following
 - a. Determination of current eligibility of the member.
 - b. Delegate medical group affiliation
 - c. If eligible, the CM Staff will review existing programs the member is enrolled in, including CCM.
 - d. Referrals will be processed within 24 – 72 hours (1 business day).

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

Triage and Assignment of TCS case

- 1. CM staff assignments will be made based on workload, discipline and risk stratification of case.
- 2. Assignment will be made within 24 hours of admission transfer or discharge when an ADT feed is available, or within 24 hours of the Alliance notification of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists.
- 3. The notification timeframe will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.
- 4. For members enrolled in CCM or ECM, the Alliance will ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who will provide all TCS.

Outreach

- 1. The assigned care manager will ensure the discharging facility has the name and contact information, including the phone number of the assigned care manager in the discharge planning document.
- 2. The assigned care manager will ensure the member is given the care manager's contact information as part of the discharge planning document.
- 3. The assigned care manager will send a letter to the member and the member's PCP to inform them of the member's facility admission and inform them of the care manager's contact information.

Care Manager Responsibilities

- 1. Discharge Risk Assessment
 - a. The assigned care manager will ensure that the discharge risk assessment is complete.

- b. Will be completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental condition, and/or SUD relapse.
 - c. The assigned care manager will ensure the member is assessed to determine if they are newly eligible for ongoing care management services, such as ECM or CCM.
- 2. Discharge Planning Document
 - a. The assigned care manager will ensure that the discharge planning document is complete, accurately coordinated, shared with appropriate parties and that the member does not receive two different discharge documents from discharging facility and from the care manager.
 - b. The Assigned care manager must ensure that this document is shared with the member, member's parents or authorized representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider.
 - c. The discharge planning document shall use language that is culturally, linguistically, and literacy-level appropriate, and will include:
 - i. preadmission status, predischARGE support needs, discharge location, barriers to post-discharge plans, and information regarding available care and resources after discharge.
 - d. The discharge planning document will also include the care manager's name and contact information and a description of TCS.
- 3. Necessary Post-Discharge Service and Follow-Ups
 - a. Assigned care managers will ensure needed post-discharge services are provided, and follow-ups scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary services.
 - b. Members will be offered the direct assistance of the care manager, but members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager will act as a liaison coordinating care among the discharging facility, the PCP and the Alliance.

End of TCS

- a. TCS will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document.
- b. For delegation, the Alliance will ensure the delegate follows and coordinates services for the members until all activities are completed.
- c. For members who have ongoing unmet needs, eligibility for ECM or CCM will be reconsidered.

Referrals to CCM

- 1. CCM referrals may originate from any source including, but not limited to, self-referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities, health information line referrals, and internal department referrals such as UM, Disease Management and Member Services.

2. For TCS cases opened initially as transitional care, but after the initial or subsequent CM staff interventions is found to be of a higher risk, the CM staff will contact the Department Management or CCM staff to discuss case needs in accordance with CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment.

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

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

Monitoring

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

Formatted: Justified, Line spacing: Multiple 1.07 li

Formatted: Justified

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER DOCUMENTS

CM-001 CCM Identification Screening Enrollment and Assessment
CM Referral Form
CM-006 Internal Audit and Monitoring

REVISION APPROVAL HISTORY

02/21/2023, 9/19/2023, 8/21/2024, 5/21/2025

Blue = Material Updates

REFERENCES

1. Population Health Management (PHM) Policy Guide

2. CM-001, Policy and Procedure, Complex Case Management Identification, Screening, Enrollment and Assessment

MONITORING

~~Policy is reviewed at a minimum annually.~~



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

POLICY AND PROCEDURE

Policy Number	CM—D-001
Policy Name	California Integrated Care Management - Program Infrastructure
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members. The CICM Lead Care Manager serves as the primary coordinator for patient-centered care, overseeing care planning, coordination, and transitions for assigned members.

This policy applies to Alameda Alliance Wellness D-SNP member who meet DHCS population of Focus criteria as indicated in the D-SNP Policy Guide.

PROCEDURE

The goal of CICM includes:

- 1) Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based services & supports, palliative care, and social support needs, including housing;
 - a) To identify risks and improve member outcomes, the CICM team is responsible for conducting a Health Action Plan, defined as a comprehensive risk assessment and care plan, within ninety (90) calendar days of the member's enrollment into CICM.
- 2) Reducing avoidable health costs, including hospital admissions/read-mission, Emergency Department (ED) visits, and nursing facility stays.

PROCEDURE

1. Alliance manages and monitors key metrics reports compiled by the Alliance Analytics team.
 - 2) 1.
 2. Assigns CICM eligible members to the CICM team
 - a. Alliance Analytics team produces monthly eligibility lists based on defined criteria for each population of focus.
 - a.
 - b. Alliance Analytics team distributes the eligibility list accordingly
3. Alliance also reviews referrals coming in from other Alliance departments, providers, members, and other community entities.
 3. a. Members may self-refer into CICM and/or ~~dis-enroll~~opt-out at any time.
 - a.
 - b. The Alliance has a no wrong door policy.
 - b) 4. The Alliance will accept a CICM referral from PCPs, clinics, community & county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, CCS, foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.
4. Notifies CICM team members of inpatient admissions and ED visits through the following mechanisms:
 5. a. Daily census reports distributed by the AAH Analytics team;
 - a.
 - b. ADT feeds

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: Font: (Default) Times New Roman

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: (Default) Times New Roman

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

Formatted: Font: (Default) Times New Roman

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

Formatted: Font: (Default) Times New Roman

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

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

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

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

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

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

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman

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

- e)6. The Alliance Utilization Management (UM), or Case Management (CM) can outreach to CICM staff through phone, email, or a combination.
- d)7. Alliance Analytics team distributes relevant, available health history data to the CICM team within the eligibility list.
- e)8. Tracks and reports Centers for Medicare and Medicaid Services (CMS) required quality measures as outlined in DHCS guidelines.
- d)9. Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported per DHCS guidelines.
- e)10. Adds functionality to Alliance Member Services Team and the Alliance Nurse Advice Line.
- h)11. Alliance conducts CICM refresher trainings and comprehensive trainings on a regular cadence.

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

Member Engagement

- a)1. For CICM populations, member interactions are encouraged to be provided primarily either in-person or through a visual, real-time interactive telehealth encounter.
- b)2. When in-person communication is unavailable or does not meet the needs of the member, alternate methods (including telehealth) are used to provide culturally appropriate and accessible communication in accordance with member choice.

Formatted: Font: (Default) Times New Roman

Formatted: List Paragraph, Outline numbered + Level: 7 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.31" + Indent at: 0.56"

Additional Requirements for Specific CICM Populations

- 1) Certain CICM populations require consideration regarding how to provide care management for these members.
 - a. Adults Experiencing Homelessness
 - i. For members experiencing homelessness, CICM is provided in-person
 - b. Adults with Documented Dementia Needs
 - i. The Alliance will have trained dementia care specialists on Interdisciplinary Care Teams (ICTs) for members living with dementia who also have:
 - 1. Two (2) or more co-existing conditions, or
 - 2. Moderate to severe behavioral issues, or
 - 3. High utilization, or
 - 4. Live alone, or
 - 5. Lack adequate caregiver support, or
 - 6. Moderate to severe functional impairment
 - ii. Dementia care specialists will be trained in:
 - 1. Understanding Alzheimer's Disease and Related Dementias (ADRH)
 - 2. Symptoms and progression
 - 3. Understanding and managing behaviors and communication caused by ADRD

- 4. Caregiver stress and its management
- 5. Community resources for members and caregivers
- iii. The Alliance will leverage available training content from organizations such as Alzheimer's Los Angeles, Alzheimer's Orange County, or similar organizations when developing training content for dementia care specialists

DEFINITIONS / ACRONYMS

CICM California Integrated Care Management
Alliance Alameda Alliance Wellness CM Case Management
UM Utilization Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-002 California Integrated Care Management (CICM) – Member Identification and Grouping
CM-D-003 California Integrated Care Management (CICM) – Care Management
CM-D-004 California Integrated Care Management (CICM) – Staffing
CM-D-005 California Integrated Care Management (CICM) – Member Notification
CM-D-007 California Integrated Care Management (CICM) – IT/Data Sharing
CM-D-008 California Integrated Care Management (CICM) – Outreach/Member Engagement
CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

MONITORING

CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls



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

POLICY AND PROCEDURE

Policy Number	CM—D-002
Policy Name	California Integrated Care Management – Member Identification and Grouping
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members identified.

Alameda Alliance Wellness (the Alliance) is committed to accurately identifying and appropriately grouping D-SNP members eligible for CICM services in alignment with the D-SNP Policy Guide. This policy ensures that the Alliance prioritizes the identification of D-SNP members with complex medical, behavioral, and social needs per the D-SNP Policy Guide.

This policy applies to Alameda Alliance Wellness D-SNP member who meet DHCS population Focus criteria as indicated in the D-SNP Policy Guide.

PROCEDURE

California Integrated Care Management (CICM) methodology

Members are identified for CICM through three (3) different methodologies:

- Health Risk Assessment (HRA) – the HRA includes questions designed to identify members who qualify for CICM
- Data and eligibility reports – identify members based in predefined criteria for each CICM population of focus
- Community, self and provider referrals:
 - A non-provider community entity, the member, or a member's caregiver/family member may refer a member for CICM services at any time, by contacting:
 - Alliance Member Services at 1-888-882-DNSP (3767) or 1-800-735-2929 (TTY), or
 - Alliance Case Management at 1-877-251-9612 or 510-747-4512 during normal business hours, or
 - Alliance Nurse Advise Line, at 1-888-433-1876 or 1-800-735-2929 (TTY) after hours to inquire about CICM
 - Providers may refer members also using the same mechanisms.

Newly enrolled members

- Continuity of Care
 - If/when the Alliance becomes aware through other means (such as engagement with the member's prior Medi-Cal Manager Care Plan (MCP), or Using the 90-day historical data, members who were previously receiving either ECM or CICM through their previous MCP will continue to receive CICM services through the Alliance per policy *CM-012 California Integrated Care Management (CICM) – Continuity of Care*.
 - The Alliance will outreach to the member's previous MCP, the member and/or the previous ECM/CICM provider to obtain access to the member's Care Management plan to mitigate any gaps in care.

DEFINITIONS / ACRONYMS

CICM California Integrated Care Management

Alliance Alameda Alliance Wellness CM Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-001 California Integrated Care Management (CICM) – Program Infrastructure
CM-D-003 California Integrated Care Management (CICM) – Care Management
CM-D-004 California Integrated Care Management (CICM) – Staffing
CM-D-005 California Integrated Care Management (CICM) – Member Notification
CM-D-007 California Integrated Care Management (CICM) – IT/Data Sharing
CM-D-008 California Integrated Care Management (CICM) – Outreach/Member Engagement
CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

MONITORING

CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

collaboration



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

POLICY AND PROCEDURE

Policy Number	CM—D-003
Policy Name	California Integrated Care Management – Care Management & ~~Transitions of Care~~
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members identified.

Alameda Alliance Wellness (the Alliance) is committed to accurately identifying and appropriately grouping D-SNP members eligible for CICM services in alignment with the D-SNP Policy Guide. This policy ensures that the Alliance prioritizes the identification of D-SNP members with complex medical, behavioral, and social needs per the D-SNP Policy Guide.

This policy applies to Alameda Alliance Wellness D-SNP member who meet DHCS population Focus criteria as indicated in the D-SNP Policy Guide.

PROCEDURE

Member Outreach and Engagement

- The CICM team is responsible for:
 - Developing and implementing outreach and engagement strategies for the purpose of enrolling members into CICM.
 - Routinely obtains and reviews information about newly eligible members.
 - Reaching out to confirm the CICM member's PCP and inform the PCP of the member's assignment to the CICM Lead Care Manager.
 - Coordinate care with the PCP
- Lead Care Managers who serve adults living in the community who are at risk for long-term care (LTC) institutionalization and nursing facility residents transitioning to the community will be trained on person-centered planning, as required by federal law (per 42 CFR § 438.208 the care plan must be developed by a person in person-centered planning using a person-centered process and plan as defined in 42 CFR § 441.301(c)(1) and (2)) for members with long-term services and supports (LTSS) needs.
- Care team assignments for conducting outreach and enrollment are customized for the member, taking into consideration a member's health needs, conditions, culture, language, location and other characteristics, as appropriate.
- Engagement plans are individualized using various approved strategies most appropriate for each member, including (but not limited to):
 - In-person encounters for members experiencing homelessness
 - Trained dementia care specialists on Interdisciplinary Care Team (ICTs) for members in the population of focus of Dementia Needs (please see policy, regarding Dementia Care)
- Outreach efforts will progress over ninety (90) days from the CICM team member's receipt of the referral.
- Outreach efforts will include:
 - All contact attempts to be documented in the system of record
 - During the initial contact:
 - Member is fully informed about CICM and terms of their participation and asked to either consent or decline to engage/participate in CICM.
 - A successful outreach contact includes:
 - Confirm member's eligibility for CICM
 - At initial assessment and each assessment thereafter, verify member is receiving any care management/coordination services with any other program (to prevent duplication of services).

- If the member confirms enrollment in another program, the member ~~will~~ may be advised to choose only one of the programs if concurrent enrollment with CICM is not permissible.
- The member can decline participation in CICM at any time for any reason.
- Notifying and coordinating care with member's PCP and relevant specialty providers
- Initiate or plan to complete the assessment with the member
- If the member declines:
 - The ~~member is~~ members are informed regarding continuing care with their PCP and obtaining assistance with coordination as appropriate.
 - The member is informed they may re-engage and receive CICM services at any time in the future if he or she continues to meet CICM eligibility requirements.
- Appropriate documentation in the system of record

Health Action Plan

- The Health Action Plan (HAP) is a combination of the assessment and resulting care plan. -The combination is known as the HAP.
- The assessment is administered to provide a deeper base of knowledge to address medical, behavioral and social needs.

Care Plan

- Once the assessment is completed, the designated team member develops the care plan. The care plan is developed for each member enrolled in CICM services in collaboration with the member, caregiver, and other members of the care team.
- The designated care team member works with the member to develop and prioritize goals according to the member's priorities and preferences. Individualized goals will have timeframes and strategies for addressing each goal.
- The care plan is developed to manage members' needs, including housing, care transitions and referral tracking.
- The goals of the care plan is to work collaboratively with the member and care team to focus on improving the quality of care, member safety, and preventing unnecessary hospital or emergency department admissions.

Formatted: Font: (Default) Times New Roman

Formatted: List Paragraph, Bulleted + Level: 3 +
Aligned at: 1.5" + Indent at: 1.75"

CICM California Integrated Care Management
Alliance Alameda Alliance Wellness CM Case Management
UM Utilization Management
DHCS Department of Health Care Services

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-001 California Integrated Care Management (CICM) – Program Infrastructure
CM-D-002 California Integrated Care Management (CICM) – Member Identification & Grouping
CM-D-004 California Integrated Care Management (CICM) – Staffing
CM-D-005 California Integrated Care Management (CICM) – Member Notification
CM-D-007 California Integrated Care Management (CICM) – IT/Data Sharing
CM-D-008 California Integrated Care Management (CICM) – Outreach/Member Engagement
CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

MONITORING

CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

collaboration



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

POLICY AND PROCEDURE

Policy Number	CM-D-004
Policy Name	California Integrated Care Management – Staffing
Department Name	~~Health Care Services~~ Case Management Department
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members. CICM policy applies to members who may be eligible to receive Enhanced Care Management (ECM) from Alameda Alliance Wellness (Alliance).

The CICM Team is required to deliver CICM services through a team-based approach through the following core services:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;

5. Individual and Family Support Services; and
6. Referral to Community and Social Supports.

2. The CICM team is multi-disciplinary and includes a director, clinical consultant (Primary Care Providers [PCPs] served), a Nurse Care Manager, a Behavioral Health Care Manager, ~~a Care Coordinator~~, and a ~~Community Health Worker~~Health Navigator. The CICM team may add additional staff to the team (e.g. Pharmacist, Dietician) to meet CICM Members' needs.

The table below describes the roles, functions and minimum credentials of CICM team members.

Team Member	Qualifications	Role
Dedicated Lead Care Manager (LCM)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	- Oversees provisions of CICM services and implementation of Health Action Plan (HAP) - Offer services where CICM member lives, seeks care or find most easily accessible and within the Managed Care Plan (MCP) guidelines - Connect CICM member to other social services and supports he/she may need - Advocate on behalf of members with health care professionals - Use motivational interviewing and trauma-informed care practices - Work with hospital staff on discharge plan - Engage eligible CICM members - Accompany CICM member to office visits, as needed and according to MCP guidelines - Monitor treatment adherence (including medication) - Provide health promotion and self- management training - Arrange transportation - Call CICM member to facilitate CICM Member visit with the CICM care coordinator
Director	Ability to manage multi-disciplinary care teams	- Has overall responsibility for management and operations of the team - Has responsibility for quality measures and reporting for the team
Clinical Consultant	May be: Primary care physician Specialist physician Psychiatrist Psychologist	- Review and inform HAP - Act as a clinical resource for ~~care coordinator~~health navigator, as needed - Facilitate access to primary care and behavioral health providers, as needed, to assist care coordinator

Commented [TM1]: @Hunter, Lily @Lam, Allison Will this remain the HAP? or will it be the HRA? @Vallejo, Yani @Williams, Mollie

Commented [HL2R1]: HAP = Health Action Plan, which is a combination of an assessment and a care plan
HRA = Health Risk Assessment

these are two very different things

	Registered nurse Pharmacist Advanced practice nurse Nutritionist Licensed clinical social worker, or other behavioral health care professional	
Community Health Worker Health Navigator (CHWHN) (recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	- Engage eligible CICM members - Accompany CICM member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines - Health promotion and self-management training - Arrange transportation - Assist with linkage to social supports - Distribute health promotion materials - Call CICM member to facilitate CICM visit with care coordinator - Connect CICM member to other social services and supports he/she may need - Advocate on behalf of members with health care professionals - Use motivational interviewing and trauma-informed care practices - Monitor treatment adherence (including medication)

~~The aggregate minimum care coordinator ratio requirement is 40:1 for the whole enrolled CICM population in a county as measured at any point in time. Staffing ratios for the number of members who can be served by each care manager is not required, but the Alliance understands that CICM is an intensive case management program where greater success will occur with a smaller caseload.~~

PROCEDURE

- Alameda Alliance for Health Wellness (The Alliance) ~~attests that the~~ has a CICM team ~~that can meet~~ the care team qualifications and roles ~~listed above.~~
- The multi-disciplinary care team consists of staff employed by the Alliance ~~the Alliance~~ that provides ~~ECM-CICM funded~~ services. The team will primarily be located at the ~~ECM~~

Commented [AL3]: We don't have CHWs on our internal CICM team. Did we mean health navigators here?

Commented [HL4R3]: correct. change has been made.

Commented [AL5]: Are we required to state this ratio in the P&P? Will we meet this ratio?

Commented [HL6R5]: great catch. Edits made to reflect ECM Policy Guide wording (not required) and a recommendation.

Commented [HL7R5]: removed

Commented [AL8]: Are we stating a staffing ratio or not? If not, I would recommend remove the last sentence that references 40:1

Commented [HL9R8]: removed

Alliance unless there is insufficient staffing to provide the full range of ~~ECM-CICM~~ duties. ~~AAH-The Alliance~~ may subcontract with other entities to perform these duties. In addition, ~~AAH-the Alliance~~ may provide, or subcontract with another community-based entity to provide, specific ~~ECM-CICM~~ Provider duties to assist as a ~~ECM-CICM~~ Provider to provide the full range of ~~ECM-CICM~~ Provider duties.

3. ~~AAH-The Alliance~~ requires that CICM ~~Provider~~ care teams ~~not based within Federally Qualified Health Centers (FQHC)~~ and will partner with the ~~ECM-CICM~~ Member's PCP, and that licensed clinical social work (LCSW) supervisors or registered nurses (RNs) will provide clinical and programmatic oversight. Non-licensed staff will liaise with community ~~and health plan~~, pharmacist and nurses as needed.

Commented [TM10]: @Hunter, Lily @Lam, Allison This sentence is confusing to me, are we requiring that CICM providers not be based in FQHC?

Commented [HL11R10]: ECM Policy and DSNP Policy guide reviewed. not sure where this came from. This has been edited to be in alignment with where we are going.

4. The CICM team uses a team-based, person-centered approach, where staff collectively uses their skills and knowledge to ensure that culturally and linguistically competent evidence-based services and supports are employed to address the overall health and wellness of each Member. Each Member should be actively involved with the CICM team in setting goals and participating in his/her care planning. The Member's decisions should drive service needs to be addressed within the written Health Action Plan (HAP), ~~which includes the~~ CICM Assessment and Care Plan.

5. ~~Staffing Ratios and estimated caseloads will be actively managed by the Alliance through the bi-annual audit process post program launch.~~

Commented [AL12]: What is the bi-annual audit process? We audit our internal teams monthly, correct?

Commented [HL13R12]: removed

6. ~~The Alliance CICM team will meet the required aggregate minimum care manager ratio of 40:1 for the entire enrolled population. Leadership will work with the CICM team to monitor the staffing ratios.~~

Commented [AL14]: Are we retaining the 40:1 staffing ratio here?

Commented [HL15R14]: no, no need. it has been removed.

5. The Alliance leadership will use tools, such as DHCS assessments and membership information provided by the State, to determine appropriate CICM and internal staffing levels other than care managers to meet CICM member needs.

Formatted: List Paragraph, No bullets or numbering

7.

8. ~~The Alliance will continuously collaborate with the CICM team to fill positions to meet the contract requirements and staffing conditions of DHCS.~~

DEFINITIONS / ACRONYMS

The Alliance	Alameda Alliance Wellness
CICM	California Integrated Care Management
DHCS	Department of Health Care Services
LCSW	Licensed Clinical Social Worker
PCP	Primary Care Provider

HAP Health Action Plan
MCP Managed Care Plan

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-D-001 California Integrated Care Management (CICM) – Program Infrastructure
CM-D-002 California Integrated Care Management (CICM) – Member Identification & Grouping
CM-D-003 California Integrated Care Management (CICM) – Care Management
CM-D-005 California Integrated Care Management (CICM) – Member Notification
CM-D-007 California Integrated Care Management (CICM) – IT/Data Sharing
CM-D-008 California Integrated Care Management (CICM) – Outreach/Member Engagement
CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

[ECM Policy Guide \(ca.gov\)](#)
~~[CalAIM Dual Eligible Special Needs Plans Policy Guide](#)~~~~[CalAIM Dual Eligible Special Needs Plans Policy Guide](#)~~

MONITORING

CM-D-010 California Integrated Care Management – Oversight, Monitoring, & Control

Commented [AL16]: Update hyperlink to current policy guide

Commented [HL17R16]: can we remove the hyperlink?

Commented [AL18R16]: Yes, feel free to remove

Commented [HL19R16]: removed



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

POLICY AND PROCEDURE

Policy Number	CM-D-005
Policy Name	California Integrated Care Management – Member Notification
Department Name	~~Health Care Services~~ Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) is responsible for providing high-quality, person-centered, and integrated care management for D-SNP members in accordance with the DHCS California Advancing and Innovating Medi-Cal (CalAIM) initiative and Centers for Medicare and Medicaid Services (CMS) requirements. This policy ensures timely, accessible, and culturally appropriate member notifications regarding California Integrated Care Management (CICM) eligibility, enrollment, and care coordination services. Notifications will align with DHCS and CMS guidelines to promote seamless integration of benefits, reduce access to care boundaries, and support members with complex and social needs.

This policy applies to Alliance care management staff, contracted providers, and Community Based Organizations (CBOs) who may be involved in member outreach and notification.

1. Member Identification

1.1. Members are identified through two methodologies:

1.1.1. CICM Eligibility List: Every month, the Alliance produces an eligibility list based on the defined criteria of the CICM populations of focus.

1.1.2. Referrals: Referral can be made into CICM at any time by contacting the Alliance Member Services, or any Alliance Staff. Member's family member(s), guardian, caregiver, and/or authorized support person(s) may also contact Alliance Member Services, or any Alliance Staff. A member must provide authorization to speak with someone on their behalf.

1.1.2.1. The Alliance has a no wrong door policy. The Alliance will accept a CICM referral from the following (including, but not limited to): Primary Care Providers (PCPs), clinics, community, and county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, California Children's Services (CCS), foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

~~1.1.2.2. The Alliance uses a closed loop referral system for all CICM referrals as per DHCS policy for closed loop referrals. This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of focus the member is referred for (if different from initial referral request), and confirmation that CICM services have started.~~

~~1.1.2.3-1.1.2.2.~~ Monitoring the referral report will improve communication within the Alliance to ensure members are being served appropriately.

2. Member Notification

2.1. Initial and ongoing Member communications regarding the CICM services will be made in accordance with existing Alliance policies and procedures for Member communication including consideration of individual Member communication needs.

2.2. Members and Providers will be informed of CICM and how to access the program through all usual communication venues listed in the Alliance's Marketing & Communications Plan that the Department of Health Care Services (DHCS) approves annually and per Alliance policies and procedures. For Providers, these notifications will include (but are not limited to): the Provider Newsletter, Provider Manual and Quarterly Updates which are all published on the Alliance's website and Provider Portal. The Quarterly Updates are also printed and mailed to provider offices.

2.3. Member communications will be provided in accordance with requirements by DHCS including those for cultural competency and health literacy standards.

2.4. The Alliance requires that subcontracted plans (delegates) use the same process for:

2.4.1. Informing members, family member(s), guardian, caregiver, and/or other authorized support person(s) about CICM, requesting CICM, status of the request and returned communication.

Commented [AL1]: Will the DHCS closed loop referral process apply to CICM, the same way it applies to ECM? (I don't recall CICM mentioned in the CLR guidance, but please correct me if I'm wrong).

Commented [HL2R1]: This is moot, right?

Commented [AL3R1]: Yes, please remove.

Commented [HL4R1]: done.

2.4.2. ~~Implementing Coordinating with~~ C1CM case managers

2.5. The Alliance ensures verbal and written communications to the Provider, Member, family member(s), guardian, caregiver, and/or other authorized support person(s).

2.6. Notification time frames

2.6.1. Once the referral has been accepted and referred to the Lead Care Manager

- 2.6.1.1. i. Urgent – referral opened within 24—72 hours (~~1 business day~~).
- 2.6.1.2. ii. Routine – referral opened within 5 calendar days.

Formatted: Normal, Indent: Left: 0"

PROCEDURE

1. Notification of C1CM benefit

- 1.1. Alliance Members are notified of the C1CM benefit through standard communication venues: Member Handbook: Evidence of Coverage (EOC), Alliance website, member portal, etc.
- 1.2. Providers will be notified through provider quarterly ~~material~~communications, provider orientation, and provider portal on the AAH website.
- 1.3. Notification includes (but is not limited to):
 - 1.3.1. A description of the C1CM benefit;
 - 1.3.2. Eligibility criteria;
 - 1.3.3. How to access C1CM; and
 - 1.3.4. Explanation that participation is voluntary, and that the Member may discontinue participation at any time
- 1.4. Members may change their assigned C1CM Lead Care Manager by contacting the Alliance Member Services at 1- ~~877-932-2738~~888-882-3767 or 1-800-735-2929 (TTY) or the California Integrated Care Management (C1CM) team at 510-747-4546, during normal business hours.
- 1.5. The Alliance will accommodate such requests ~~within thirty (30) days, or~~ as soon as possible to meet the Member's needs. Alliance staff will facilitate a warm handoff between C1CM Lead Care Managers.
- 1.6. The Alliance Member and Provider materials are made available through a variety of communication venues listed in the Alliance's Marketing & Communication Plan that DHCS approves annually. Applicable materials will be updated to incorporate content describing the availability of C1CM, including the Evidence of Coverage/Disclosure Form. Content will include describing C1CM, providing guidance about where to obtain

Commented [LH5]: This needs to be updated with Member Services new phone number for D-SNP

Commented [AL6R5]: D-SNP member services: 1.888.882.3767

Commented [HL7R5]: done.

Commented [AL8]: Do we specify this for any of our other D-SNP programs that they can call to change their care manager?

Commented [HL9R8]: this is not specified with any other program, but members can do this for those programs too. Are you thinking we should remove this?

Commented [AL10R8]: Ok to leave it.

Commented [AL11]: Would it take 30 days to switch a care manager?

Commented [HL12R11]: no. Likely much shorter. A week at most. (that's being cautious)

Commented [HL13R11]: i think we should remove 1.4 and 1.5, since we don't have it anywhere else.

Commented [AL14R11]: Revised it to align with 1.4

additional information and how to refer Members who may be potentially eligible for CICM.

DEFINITIONS / ACRONYMS

The Alliance	Alameda Alliance Wellness
CICM	California Integrated Care Management
DHCS	Department of Health Care Services
LCSW	Licensed Clinical Social Worker
PCP	Primary Care Provider
HAP	Health Action Plan
MCP	Managed Care Plan
-	

Formatted: Indent: Left: 0"

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Operations
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-001 California Integrated Care Management (CICM) – Program Infrastructure
CM-D-002 California Integrated Care Management (CICM) – Member Identification & Grouping
CM-D-003 California Integrated Care Management (CICM) – Care Management
CM-D-004 California Integrated Care Management (CICM) – Staffing
CM-D-007 California Integrated Care Management (CICM) – IT/Data Sharing
CM-D-008 California Integrated Care Management (CICM) – Outreach/Member Engagement
CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

~~[CalAIM Dual Eligible Special Needs Plans Policy Guide](#)~~
~~[CalAIM Dual Eligible Special Needs Plans Policy Guide](#)~~

Field Code Changed

Commented [AL15]: Feel free to remove hyperlinks as with the other policies

MONITORING

CM-D-010 California Integrated Care Management – Oversight, Monitoring, & Control

collaboration



POLICY AND PROCEDURE

Policy Number	CM-D-007
Policy Name	~~Enhanced~~ CICM – IT/Data Sharing
Department Name	Case Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, SDOH
Line(s) of Business	~~MCA~~ DSNP
Effective Date	~~05/16/2019~~ TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~ TBD
Administrative Oversight Committee Approval Date	~~9/18/2024~~ TBD

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members.

This policy describes how information is shared across the entire care team for the ~~Enhanced~~ California Integrated Care Management (~~CICM~~) Program, including the member, the ~~ECM-CICM Provider/lead care manager~~, Primary Care Providers (PCPs) and Alameda Alliance for Health Wellness (~~AAH~~Alliance). It addresses all of the following elements of provision of care including: Comprehensive Care Management, Care Coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Support Services.

PROCEDURE

1.0 Comprehensive Care Management

1.1 Identify cohort and integrate risk stratification information.

1.2 Member Identification: See CM-D-010 ~~Enhanced~~ California Integrated Care Management (~~CICM~~) – Member Identification and Grouping.

1.3 Shared Care Plan Management

1.3.1 The Health Action Plan (HAP) is a combination of the ~~ECM-CICM~~ Assessment and the ~~resultant~~ resulting Care-care Planplan. The combination is known as the HAP. ~~The A copy of the~~ HAP is accessible to all members of the care team ~~at the ECM Provider via their internal~~

CM-042 Enhanced Care Management– IT/Data Sharing

~~system of record and to AAH via fax or secure email upon request. The HAP is stored in the system of record with the Alliance's lead care manager. If When the ECM lead care manager Provider needs to share with an external PCP, then that sharing would be through either a minimum of, but not limited to: fax, secure email or postal mail:~~

1.3.1.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each follow up.

1.3.1.2 The PCP will be given a copy of the Member's HAP.

Commented [AL1]: Should we add the provider portal here? This is the same as the care plan that we'll be uploading to the portal, correct?

Commented [HL2R1]: I rephrased it. Do we want to call it out now, or wait until the provider portal has it up and running? Will it be ready by go-live?

1.3.1.3 Other ~~ECM-CICM Provider~~ care team members ~~have access~~ can request a copy of the HAP and have the ability to ~~update and modify~~ contribute to the HAP.

1.4 The ~~ECM lead care manager~~ Provider reviews the HAP ~~with each~~ with each Member and will reassess and update it ~~with any changes in the Member's progress, status, or health care needs and/or according to the HAP follow up plan and at least quarterly.~~

~~1.4.1~~ A care team member reviews utilization reports identifying a Member who has had a recent hospital admission or discharge or Emergency Department (ED) visit. This will alert them to contact the Member as appropriate, to ~~review the current HAP and make changes as necessary.~~

1.4.2 ~~ECM-CICM Provider team member~~ lead care managers will reviews the HAP with the Member at each contact to assess the progress made towards the goals identified ~~in the~~ in the HAP- as well as tracks referrals made and follow-up on completion and communication on each referral.

1.4.3 The ~~ECM-Provider~~ CICM team will make updates to the HAP if a goal has changed priority, has been met or is no longer applicable.

1.5 The HAP will be completed within ninety (90) days of ~~ECM-CICM~~ enrollment.

1.6 Clinical decision support tools to ensure appropriate care is delivered.

~~1.6.1~~ Medical Directors and Nurses use Milliman Care Guidelines (MCG) for clinical review and to conduct advisor reviews/make decisions. AAH's clinical management team uses "Up To Date" tools to ensure all clinical decisions are made appropriately.

~~1.6.2~~ 1.6.1 Additional data>Data exchange solutions within ~~AAH the~~ Alliance to facilitate care management and safe transitions of care include the following:

~~1.6.2.1~~ 1.6.1.1 Daily census file delivered to ~~each the~~ ECM-CICM Provider team (admissions of enrolled and eligible members).

~~1.6.2.2~~ 1.6.1.2 Communication from inpatient UM (concurrent review) team members and case managers to ~~ECM-CICM Providers~~ lead care manager.

~~1.6.2.3~~ 1.6.1.3 Additionally, AAH the Alliance is in the process of updating its Admission, Discharge, Transfer (ADT) feeds to improve the quality and accuracy of our reporting.

~~1.6.2.4~~ 1.6.1.4 When available, a data exchange platform.

~~1.6.3~~ 1.6.2 Electronic capture of clinical quality measures to support quality improvement, including, but not limited to HEDIS/Stars measures.

~~1.6.3.1~~ Utilization Management (UM) Nurses utilize MCG and Medi-Cal Guidelines for clinical review and MDs conduct advisor reviews/decisions. Inter-rater reliability (IRR) is conducted on an annual basis for UM nurses and Medical Directors.

2.0 Care Coordination and Health Promotion

~~2.1~~ Ability to electronically capture and share the patient-centered care plan across care team members. ~~Include other methods if electronic means of collection are not used.~~

~~2.1.1~~ Patient-centered care will be provided by the CICM team and documented in the Alliance's system of record. This will include the HAP. ~~is not electronically captured at present. AAH Information Technology (IT) has been working with the~~

CM-042 Enhanced Care Management- IT/Data Sharing

Page 3 of 5
2.2 Tools to support shared decision-

Formatted: List Paragraph, Right: 0.17", Space Before: 0.15 pt, Line spacing: Exactly 12.8 pt, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.07" + Indent at: 1.57", Tab stops: 1.57", Left + 1.57", Left

Commented [AL3]: Who is the CICM provider team? Is that Heather's team?

Commented [HL4R3]: good catch. thank you. fixed.

Commented [AL5]: Would HEDIS/Stars quality measures go here, as well?

Commented [HL6R5]: yes, I added more language to include that.

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.57", Hanging: 0.25", Right: 0.17", Space Before: 0.75 pt, Line spacing: Multiple 0.92 li, Tab stops: 0.82", Left + Not at 1.57" + 1.57"

~~ECM program staff to receive HAP data from ECM Provider systems and will load them into the AAH medical management system which can be used for patient-centric care. In the interim, HAPs will be shared, as needed, though fax, making approaches with patients. The ECM Providers, with the coordination of the managed care plan, shall make shared~~

collaboration

~~decision(s) on patients care coordination.~~

~~2.2.1 AAH uses the following tools to help support the recommendations for care: The HAP, updated quarterly, is accessible to all members of the care team at the ECM Provider via their internal system of record and to AAH via fax or secure email. If the ECM Provider needs to share with an external PCP, then that sharing would be through either fax or postal mail. In addition, UM Nurses utilize MCG and Medi-Cal Guidelines for clinical review and MDs conduct advisor reviews/decisions. Inter-rater reliability (IRR) is conducted on an annual basis for UM nurses and MDs.~~

~~2.2 Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used. Additional methods of communication:~~

~~2.2 All information sharing by Alliance with members will occur via phone, letter or in-person.~~

~~2.3 2.3.1 Presently, all information sharing by AAH with members occurs via phone and letter.~~

~~2.4.2.1 Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.~~

~~2.4.1 E-prescribing, drug formulary checks, and medication reconciliation are managed by ECM community providers. Providers. AAH shall provide patient claims data to ECM~~

~~2.2.2 Providers, and they internally. The CICM team will have a process to check the drug formulary, e-prescribing, and medication reconciliation.~~

~~2.5.2.2.3 Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.~~

~~2.5.1.2.2.4 Current member portal allows patients to view their claims, eligibility, and provider information. AAH-The Alliance has a customer service call center where patients can call and update their own health information.~~

~~2.6 2.3 Telehealth services, including remote patient monitoring~~

~~2.6.1.2.2.5 Telehealth services are available only through the ECM some CICM encounters (members who meet the criteria for homelessness/homelessness will have in-person encounters for CICM) Provider sites. The ECM-CICM team acting as an ECM-Provider will not provide telehealth services but rather work with the member's assigned PCP or Specialist who will provide telehealth services.~~

3.0 Comprehensive Transitional Care

3.1 Automated care transition notifications/alerts, e.g., when a patient is admitted, transferred or discharged from the hospital or receives care in an ED. Include other methods if an electronic process is not used (Fax, Email, Texts, Telephone Calls). Additionally, ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the Electronic Health Record (herEHR). Include other methods if electronic sharing is not used.

3.1.1 Daily census file delivered to each ECM-CICM Provider lead care manager (admissions of enrolled and eligible members).

3.1.2 Communication from inpatient UM (concurrent review) team members and case managers to ECM-CICM Providers lead care managers.

Formatted: List Paragraph, Indent: Left: 0", Space Before: 0 pt, Line spacing: single

Formatted: List Paragraph, Left, Indent: Left: 0.57", Hanging: 0.25", Right: 0.17", Space Before: 0.75 pt, Line spacing: Multiple 0.92 li, Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 0 + Alignment: Left + Aligned at: 0.07" + Indent at: 0.47", Tab stops: 0.82", Left + Not at 1.57"

Commented [AL7]: What does this mean? Is this referring to a doctor's office's portals to communicate with members?

Commented [HL8R7]: removed, dunno.

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.57", Hanging: 0.25", Right: 0.17", Space Before: 0.75 pt, Line spacing: Multiple 0.92 li, Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 0 + Alignment: Left + Aligned at: 0.07" + Indent at: 0.47"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.07" + Indent at: 1.57"

Formatted: Font: 12 pt

Formatted: List Paragraph, Right: 0.13", Line spacing: Multiple 0.99 li, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.07" + Indent at: 1.57", Tab stops: 1.57", Left + 1.57", Left

Commented [AL9]: What is e-prescribing referring to? How does our CICM team access it?

Commented [HL10R9]: unsure, I was thinking this would be in collaboration with Pharmacy. Otherwise, I can take it out.

Formatted: Font: 12 pt

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.07" + Indent at: 1.57"

Formatted: Indent: Hanging: 0.5", Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.07" + Indent at: 1.57"

Formatted: Indent: Left: 0.47", No bullets or numbering

Formatted: Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.07" + Indent at: 1.57"

- 3.1.3 ~~Additionally, AAH the Alliance is in the process of updating its ADT feeds for members who are admitted to a hospital or have an ER visit to improve the quality and accuracy of our reporting. AAH Alliance receives a real time electronic ADT feed from several hospitals.~~
- 3.1.4 In partnership with Alameda County's Health ~~(AC Health Care Services Agency (HCSA))~~, ~~AAH the Alliance~~ has given ~~ECM-CICM lead care managers Providers~~ access to Alameda County's Community Health Record (CHR) platform, ~~which - The CHR launched in Fall 2019. The CHR~~ serves as ~~an ADT feed and~~ a shared social and health information exchange to facilitate care management, care coordination, and safe transitions.

~~3.2 Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.~~

~~3.2.1 E-referrals and e-consults are done by the ECM Providers in coordination with AAH Alliance.~~

3.2

4.0 Individual and Family Support Services

4.1 Patient specific education resources tailored to specific conditions and needs.

4.1.1 Patient specific education resources are ~~customized-provided~~ by the ~~ECM Provider/CICM lead care manager~~ and in coordination with AAH.

5.0 Referral to Community and Social Support Services

5.1 Electronic capture of social, psychological, and behavioral data (e.g., education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.

5.1.1 ~~AAH-The Alliance~~ relies on external sources to provide data. At this time, this capability is not automated.

5.2 Ability to electronically refer patients to necessary services. ~~Include other methods if electronic referral is not used.~~ All patient referrals are done by the ~~ECM-CICM Provider/lead care manager~~.

6.0 Encounter Data

~~6.1 AAH can collect and transmit encounter data for ECM Providers in the X12 837 or paper format or online submission. All electronic transmission occurs in secure format via Secure File Transfer Protocol (SFTP).~~

~~6.2 If there are continuous errors in an ECM Provider's data submission, AAH will develop a Corrective Action Plan (CAP) for the ECM Provider.~~

DEFINITIONS / ACRONYMS

~~AAH Alliance~~ Alameda Alliance for
~~WellnessHealth~~ ECM—CICM
~~Enhanced California Integrated~~ Care
Management
HAP Health Action Plan

AFFECTED DEPARTMENTS/PARTIES

~~Information Technology~~
~~Health Care Services~~
~~Analytics~~

RELATED POLICIES AND PROCEDURES

CM-D-001 California Integrated Care Management (CICM) – Program Infrastructure
CM-D-002 California Integrated Care Management (CICM) – Member Identification & Grouping
CM-D-003 California Integrated Care Management (CICM) – Care Management
CM-D-004 California Integrated Care Management (CICM) – Staffing
CM-D-005 California Integrated Care Management (CICM) – Member Notification
CM-D-008 California Integrated Care Management (CICM) – Outreach/Member Engagement
CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls
CM-042 Enhanced Care Management– IT/Data Sharing

Formatted: Left

Commented [AL11]: What are e-referrals and e-consults?

Commented [HL12R11]: Old language. All electronic versions. should I just take out the 'e'.

Formatted: Indent: Left: 0.57", Hanging: 0.25", Right: 0.39", Space Before: 4 pt, Line spacing: Multiple 0.92 li, Tab stops: 0.82", Left + Not at 1.57" + 1.57"

Commented [AL13]: Please clarify what education resources the case managers will be customizing?

Are these the health education resources, and do the CMs edit these resources?

Commented [HL14R13]: health ed resources, not customized, but share appropriately depending on the condition. So we won't send them all, because the member may not want or have a need to see them all, for all diagnoses.. Let me re-word this.

Commented [AL15]: Is this referring to incoming assessment data we receive from providers?? Why is it nested under the "referral to community and social support services" section?

Commented [HL16R15]: not assessment data, but referral data. we don't receive any.

~~CM-009 Enhanced Care Management—Infrastructure~~
~~CM-010 Enhanced Care Management—Member Identification and Grouping~~
~~CM-011 Enhanced Care Management—Care Management & Transitions of Care~~
~~CM-013 Enhanced Care Management—Oversight, Monitoring, & Controls~~
~~CM-014 Enhanced Care Management—Operations Non-Duplication~~
~~CM-016 Enhanced Care Management—Staffing~~
~~CM-018 Enhanced Care Management—Member Notification~~
~~CM-036 Enhanced Care Management—Outreach/Member Engagement~~

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

~~05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023, 9/18/2024~~

REFERENCES

[ECM Policy Guide](#)

[CalAIM Dual Eligible Special Needs Plan Policy Guide](#)

MONITORING

CM-D-010 California Integrated Care Management (CICM) – Oversight, Monitoring, & Controls

~~CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls~~

Collaboration



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

vi

POLICY AND PROCEDURE

Policy Number	CM -D-009
Policy Name	CICM: Adults at Risk for Long-Term Care Institutionalization
Department Name	Care Management / ~~Long Term Services and Supports (LTSS)~~
Department Officer	~~fe.g., "Compliance Officer"~~ Chief Medical Officer
Policy Owner	Director, Social Determinants of Health ~~(Title of Owner)~~
Line(s) of Business	MCARE, DSNP
Effective Date	TBD
Subcommittee Name	~~Quality Improvement Health Equity Committee;~~
Subcommittee Approval Date	<u>TBD</u>
Administrative Oversight Committee Approval Date	<u>TBD</u>

Commented [AL1]: Assuming that CM will be primary and LTSS will be listed in affected departments? ~~Trainer, Ed~~ ~~Chishy, Kimberly~~, please confirm

Commented [HL2R1]: ok.

Commented [GK3R1]: If they are in LTC, LTC will be primary, not CM... or that was my understanding.

POLICY STATEMENT

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. Per federal guidance, D-SNPs must provide robust care coordination to members. Alameda Alliance Wellness (Alliance) is responsible for engaging California Integrated Care Management (CICM) eligible members, using state ~~determined~~ determined Centers for Medicare & Medicaid Services (CMS) approved criteria.

Formatted: Indent: Left: 0.16", Right: 0.4", Space Before: 0.05 pt, Line spacing: Multiple 0.97 li

The Alliance is committed to providing integrated care management to members at risk for Long-Term Care (LTC)-institutionalization by:

- Identifying at-risk members using standardized criteria.
- Developing person-centered care plans.
- Coordinating services across medical, behavioral, and social domains.
- Engaging community-based organizations (CBOs) to provide additional support.
- Monitoring and adjusting care plans to address evolving needs.

Purpose

To establish a comprehensive approach for identifying and managing The Alliance DSNP

members who are living in the community and at risk for long-term care institutionalization, ensuring they receive appropriate, integrated services to maintain their independence and improve health outcomes.

Scope

This policy applies to all Alliance DSNP members identified as at risk for LTC institutionalization and to all care management staff responsible for coordinating their care.

PROCEDURE

+

Step 1: Identification of Alliance Members at Risk for LTC Institutionalization

Criteria for Identification:

Adults who:

- Are living in the community who meet the SNF level of care (LOC) criteria, or who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury AND
- Are actively experiencing at least one complex social or environmental factor influencing their health (including but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring) AND
- Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns)

- Multiple chronic medical conditions.
 - Functional impairments affecting activities of daily living (ADLs).
 - Recent hospitalizations or emergency department visits.
 - Lack of adequate social support or caregiver assistance.
 - Cognitive impairments, including documented dementia needs.
- Department of Health Care Services

Methods of Identification:

- Health Risk Assessments (HRAs) conducted within 90 days of enrollment and annually thereafter.
- Analysis of claims and utilization data indicating frequent hospital or ED use.
- Referrals from healthcare providers, social services, or caregivers.
- Internal care management Other internal assessments
- Utilization management Referrals from other internal departments

Step 2: Comprehensive Assessment

- Assessment Components:
 - Evaluation of medical history and current health status.

Formatted: Indent: Left: 0.25", No bullets or numbering

Commented [AL4]: Clarify, Kimberly - please also review from an LTC perspective (this is for D-SNP CICM)

Commented [GK5R4]: What is the expectation here? LTC is not identifying members at risk for LTC.

Commented [AL6R4]: For awareness of expectations when coordinating with the CICM team who's doing assessment, care plan, etc. for these members. The P&P goes through all steps of the process, not just identification criteria.

Formatted

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

Formatted: List Paragraph, No bullets or numbering

Formatted: List Paragraph, Indent: Left: 0"

- Assessment of functional abilities and limitations.
- Identification of social determinants of health (SDOH) impacting the member, such as housing, transportation, and social support.
- Evaluation of cognitive status and mental health needs.
- Review of current support systems and services utilized.

Step 3- Development of Person-Centered Care Plan

- Care Plan Elements:
 - Member's personal health goals and preferences.
 - Identified needs and corresponding interventions.
 - Coordination of medical, behavioral, and social services.
 - Engagement of CBOs ~~for additional support services.~~
 - Emergency and contingency plans addressing immediate needs.

Step 4- Implementation and Coordination

- Care Manager Responsibilities:
 - Coordinate services among healthcare providers and CBOs.
 - Facilitate communication among all parties involved in the member's care.
 - Ensure timely delivery of services as outlined in the care plan.
- Engagement with Community-Based Organizations (CBOs):
 - Contract with CBOs that provide services such as in-home support, adult day health care, and respite care.
 - Ensure appropriate CBO services are integrated into the ~~member's~~ members' care plan.

Step 5- Monitoring and Reassessment

- Ongoing Monitoring:
 - Regular follow-ups based on the member's risk level (e.g., ~~monthly~~ higher frequency for high-risk members).
 - Tracking progress toward care plan goals.
 - Monitoring service utilization and addressing any barriers to care.
- Reassessment:
 - Conduct reassessments at least annually or as needed due to changes in the member's condition.
 - Update the care plan accordingly to reflect any changes.

Step 6- Documentation and Reporting

- Care Management System:
 - Document all assessments, care plans, interventions, and communications in the electronic health record (EHR) system.
 - Ensure documentation is accurate, timely, and complies with regulatory requirements.
- Reporting Requirements:
 - Generate regular reports on key performance indicators (KPIs) such as hospitalization rates, emergency department visits, and adherence to care plans.

- Share outcomes with stakeholders to inform quality improvement initiatives.

~~Step 7.~~ Training and Competency

- Staff Training:
 - Provide initial and ongoing training for care management staff on various topics, such as Topics may include, but are not limited to chronic disease management, functional assessments, integrated care approaches, and cultural competence.
- Competency Evaluation:
 - Regularly assess staff competencies to ensure effective delivery of integrated care management services.
 - Offer additional training or support as needed to address identified gaps.

~~Step 8.~~ Quality Improvement

- Continuous Improvement:
 - Implement a quality improvement program to regularly evaluate the effectiveness of care management interventions.
 - Collect and analyze data to identify trends, successes, and areas for improvement.
- Member Feedback:
 - Solicit feedback from members regarding their satisfaction with services and outcomes.
 - Incorporate ~~member input~~ members input into program enhancements to better meet their needs.

~~Step 9.~~ Confidentiality and Compliance

- Privacy Protection:
 - Ensure all member information is handled in compliance with HIPAA and other relevant privacy laws.
 - Train staff on confidentiality policies and procedures to safeguard member data.
- Regulatory Compliance:
 - Stay informed about federal and state regulations governing integrated care management and long-term care services.
 - Update policies and procedures as necessary to maintain compliance.

~~Roles and Responsibilities~~

- ~~Care Manager (AAH and/or CBO assigned):~~
 - ~~Lead the development and implementation of the care plan.~~
 - ~~Serve as the primary point of contact for the member and their support network.~~
 - ~~Coordinate services across all domains.~~
- ~~Interdisciplinary Care Team (ICT):~~
 - ~~Collaborate on care plan development and updates.~~
 - ~~Provide expertise from various disciplines to address the member's needs.~~

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

- ~~Facilitate seamless communication among team members.~~
- ~~Engage in regular team meetings to evaluate member progress and adjust care strategies.~~
- ~~Support care transitions to ensure continuity and prevent lapses in care.~~
- ~~Educate and empower members and their families to actively participate in care decisions.~~
- ~~Monitor and evaluate care outcomes to ensure effectiveness.~~
- ~~Ensure cultural competence in all interactions and interventions.~~
- ~~Community Based Organizations (CBOs):~~
 - ~~Provide services such as in-home support, adult day health care, respite care, and other community resources.~~
 - ~~Collaborate with the care manager and ICT to ensure services are aligned with the member's members' care plan.~~
 - ~~Offer additional support to address social determinants of health.~~

DEFINITIONS / ACRONYMS

- At Risk for Long-Term Care Institutionalization: Individuals living in the community with complex medical or social needs that, without additional support, may lead to placement in a long-term care facility- ealhospital.org
- Integrated Care Management (ICM): A coordinated approach to healthcare that combines services across various domains to meet the comprehensive needs of members.

Roles and Responsibilities

- Care Manager (Alliance):
 - Lead the development and implementation of the care plan.
 - Serve as the primary point of contact for the member and their support network.
 - Coordinate services across all domains.
- Care Manager (CBO assigned)
 - Contribute to development and implementation of the care plan in collaboration with the Alliance Care Manager.
 - Coordinate services in collaboration with the Alliance Care Manager.
- Interdisciplinary Care Team (ICT):
 - Collaborate on care plan development and updates
 - Provide expertise from various disciplines to address the member's needs.
 - Facilitate seamless communication among team members.
 - Engage in regular team meetings to evaluate member progress and adjust care strategies.
 - Support care transitions to ensure continuity and prevent lapses in care.

Commented [AL7]: [@Thomsen, Michelle](#) [@Hunter, Lili](#) [@Glasby, Kimberly](#) - Since Alliance CM and CBO CM need are both assigned to a case, recommend separating roles.

Alliance CM is primary owner of assessment/care plan, and CBO CM contributes to the care plan.

Commented [HL8R7]: This has been updated.

- Educate and empower members and their families to actively participate in care decisions.
- Monitor and evaluate care outcomes to ensure effectiveness.
- Ensure cultural competence in all interactions and interventions.
- Community-Based Organizations (CBOs):
 - Provide services such as in-home support, adult day health care, respite care, and other community resources.
 - Collaborate with the care manager and ICT to ensure services are aligned with the members' care plan.
 - Offer additional support to address social determinants of health.

AFFECTED DEPARTMENTS/PARTIES

Care and Disease Management
California Integrated Care Management (CICM)
Long-Term Services and Supports (LTSS)

Formatted: Left

Formatted: Left

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide – Contract year 2026 Exclusively Aligned Enrollment D-SNP Boilerplate 2025:
<https://www.dhcs.ca.gov/provgovpart/Documents/CY2025-EAE-SMAC-Boilerplate-7-8-2024.pdf>

Commented [AL9]: Please list references: SMAC, D-SNP policy guide, etc.

Commented [HL10R9]: update complete.

Formatted: Font: Not Bold

Formatted: Left

Formatted: Font: Not Bold

MONITORING

CM-D-010 California Integrated Care Management (CICM) - Oversight, Monitoring, & Controls

Commented [AL11]: Monitor 100 please add the same monitoring statement used in other P&Ps (ie: at least annual updates via committee, etc.)

Commented [HL12R11]: will referencing CM-D-013 suffice?

Commented [AL13R11]: That works. Thank you.

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Left



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

POLICY AND PROCEDURE

Policy Number	CM—D-103
Policy Name	DSNP Individualized Care Plan Components
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) Case Management team provides care management to all members in the dual eligible special needs plan. The case management team assists members to optimize their health potential.

An Individualized Care Plan (ICP) is developed for each member regardless of their level of engagement in the program. The ICP process and components, at a minimum, meet Federal and State regulatory requirements. The degree of the ICP's complexity varies depending on the member's risk level and identified goals, when applicable.

The care plan represents the framework for care management activities and focuses on care coordination activities and other interventions to achieve specific goals that are intended to resolve barriers, problems or other issues members may face.

PROCEDURE

1. Health Risk Assessment

- a. The information in the Health Risk Assessment (HRA) provides the foundation of the Individualized Care Plan (ICP).
- b. The case management team is responsible for:
 - i. Developing the ICP and working with the member and/or the member's representative when available along with the Interdisciplinary Care Team (ICT) to develop an ICP.
 - ii. Collaborating with community-based organizations and palliative care teams supporting members to develop an ICP that is comprehensive and specific to the members' unique and complex needs.
- c. The ICP is initiated by the completion of the HRA.
 - i. If the member's Agent of Record (AOR) is unable to be reached or declines completion of the HRA, the ICP can be generated by using other data elements such as risk stratification, claims (medical, behavioral, and/or dental), or data collected through internal and community partner programs.
 - ii. When there is no data available and the member contact was unsuccessful, the case management team sends the member a care plan around the following elements:
 1. Problems, goals and interventions focused on informing the members that the care management team has tried to reach them for the ICP discussion.
 - a. Encouraging the members to contact the Alliance Case Management team to include them in their care plan development.
 - b. Members are encouraged to contact their PCP and their assigned care manager at the Alliance to discuss healthcare, services and supply needs.

2. Communication

- a. The care management process and ICP includes communication and regular meetings with the Interdisciplinary Care Team (ICT).
 - i. The ICT is made up of:
 1. The member
 2. The members' Agent of Record (AOR)
 3. The member's primary care provider
 4. Community partners and other disciplines involved in the member's care delivery including palliative care teams

3. Components

- a. The following components are included in the ICP process:
 - i. Development and status of member-directed goals, including prioritized goals
 - ii. Review of the HRA and the information collected through the HRA process

- iii. Review of the clinical assessment completed by the care manager
- iv. Evaluation of the member risk stratification results
 - v. The member's personal health care preferences
- vi. Description of the services specially tailored to the members' needs
- vii. The role of the Interdisciplinary Care Team (ICT)
- viii. The role of the member, member's AOR, or the member's caregiver
 - ix. Identification of barriers to meet the goals and complying with the plans
 - x. Development of schedules for follow-up and communication with members
 - xi. Development and communication of member self-management plans
 - xii. Assessment of progress against plans and goals, and modifications as needed

b. Additional components addressed in the ICP include:

- i. Medical
- ii. Social determinants of health (SDOH)
- iii. Psychosocial
- iv. Functional
 - v. Cognitive needs
- vi. Mental and medical health history

c. Overall the ICP:

- i. Person-centered
- ii. Sensitive to disability, cultural, religious and linguistic preferences
- iii. Specific to the amount, frequency, duration of services and the type of provider rendering services
- iv. Includes strategies to address health and safety risks, offering members options to manage their risks and contingency plans for emergencies

4. Engagement

a. Initial Process

- i. Three (3) outreach attempts to engage the member and/or the member's AOR
 - 1. All attempts are documented in the enterprise case management system.
- ii. If there is no success with member engagement, please see P&P, *Support Services* for more information.

b. Interdisciplinary Care Team

- i. Meetings are scheduled regularly with the member and other members of the care team
- ii. Invitation to the meeting and given appropriate notice of the time and date of the meeting occurrence:
 - 1. The member
 - 2. The member's AOR

Formatted: Font: Italic

3. Other members of the ICT

5. Individualized Care Plan (ICP)

- a. The member and/or the member's representative is made aware that the ICP is separate and distinct from the medical and/or behavioral health plan of care developed and maintained by their primary care or specialty care provider.
- b. Updates occur by the case management team when a change in the plan occurs
 - i. This may occur after a meeting with the member and/or the member's AOR, any change in the member's health status, and after each ICT meeting
 - ii. Documentation of the ICP is completed within the enterprise care management system.
 1. Case notes are used to document additional information discussed in meetings with the member and during ICT meetings.
 2. Care goals discussions are captured in the enterprise care management system.
- c. Copies provided
 - i. The Initial and updated ICP are sent to (as appropriate):
 1. The member
 2. PCP
 3. Specialist
 4. Community-based resources
 5. Palliative care teams
 6. Other members of the ICT
 - ii. Sent by using multiple modalities, including, but not limited to, mail, secure email, portals, and facsimile.
- d. The care plan is reviewed and updated by the case management team at least annually.

6. Data sources

- a. Multiple data sources are utilized in evaluating Individualized Care Plan (ICP) goals, interventions and outcomes. Sources include, but are not limited to:
 - i. Medical, behavioral health, pharmacy, and dental claims
 - ii. Emergency department and inpatient utilization
 - iii. Member provided inputs, assessments, and other information
 - iv. Documentation provided by community partners
 - v. Case management assessments and documentation
 - vi. Annual Health Risk Assessments (HRAs)
 - vii. Risk stratification outcomes
- b. All available health data, including medical, prescription drug, and behavioral health claims, emergency department and inpatient utilization, member inputs, and

community resources are used to assess ICP goals and objectives. Analysis occurs during ongoing ICT meetings and through interactions with providers and the case management team.

7. ICP Modifications

- a. If member directed goals are not met, the ICP is reassessed including goals and interventions.
 - i. The member, the member's AOR, and the ICT are involved in adjusting the goals and providing an updated plan, including alternative interventions.
- b. Additional modifications can occur under the following circumstances:
 - i. Lack of goal progress – the case management team will collaborate with the member or representatives to identify and address barriers, adjusting goals as necessary. This may include increasing the frequency of touch points with the member as needed.
 - ii. Significant change in health status: based on internal data, proactive steps are taken to coordinate services and minimize unplanned transitions and health declines. Changes are recognized by an ICT participant may also prompt a care plan review.
 - iii. Annual review – the ICP is evaluated and updated at least annually regardless of whether changes have occurred or not.

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

MONITORING

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



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

POLICY AND PROCEDURE

Policy Number	CM—D-105
Policy Name	DSNP Individualized Care Plan Documentation, Maintenance, Updates and Notifications
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance Wellness (the Alliance) Case Management team provides care management to all members in the dual eligible special needs plan. The case management team assists members to optimize their health potential.

The Individualized Care Plan (ICP) is documented by the case management team in the enterprise care management system. This is a centralized repository and services as an electronic medical record (EMR) for each member including demographic data, assessments, case notes and the Individualized Care Plan (ICP). It provides the means to assign members to case management work queues, document, track tasks and alerts the team that interventions are due.

PROCEDURE

1. Documentation Process

- a. Annually every member undergoes comprehensive reassessment using the Health Risk Assessment (HRA) tool.
- b. Once entered into the care management system, the case management team evaluates the reassessment for any changes compared to the previous HRA and assesses for any new health or social needs, any changes in the member's health status, or gaps in care.
- c. The case management team collaborates with the Interdisciplinary Care Team (ICT) to review the annual HRA reassessment results. This includes collaborating on any needed updates to the ICP
- d. The case manager documents the updates in the care management system.
 - i. The Individualized Care Plan (ICP) is updated regularly, and the specific goals, interventions, and timelines are tailored to address the unique needs of the member at that time.
 1. The ICP serves as a foundational document, guiding the care process and ensuring all team members are aligned in their approach to the member's care.

2. Updating the Individualized Care Plan (ICP)

- a. The Individualized Care Plan (ICP) is not a static document; it is designed to be updated regularly to reflect the member's evolving health status.
- b. At a minimum, the ICP is updated annually based on the results of the most recent HRA.
- c. If significant changes in the member's health status occur, such as hospitalization, new diagnoses, or changes in functional status, the ICP is updated upon notification of such change.
 - i. The case manager will evaluate the new information, collaborate with community partners, palliative care teams, review with the ICT and integrate the new information into the existing care plan.
- d. Based on the assessment, the care manager carefully reviews the results of the assessment and may choose to complete a new HRA and update the ICP to reflect the member's current needs.
 - i. The care manager will review and validate all system triggered goals and interventions.
- e. Updates may arise from various sources including clinical evaluations, member or caregiver feedback, and recommendations from Interdisciplinary Care Team (ICT) members.
 - i. For members identified in the CICM population of focus, Individuals with Dementia Care Needs, a trained dementia care specialist participates in the Individualized Care Plan (ICP) development and when updates are made.

- ii. For members in the Palliative Care program, the ICP review is completed through the palliative care Interdisciplinary Care Team (ICT).

3. Maintenance & Accessibility

- a. The documentation of the Individualized Care Plan (ICP) is maintained in the member's secure electronic medical record (EMR) system within the enterprise care management system.
- b. The Individualized Care Plan (ICP) is available to the members of the internal Interdisciplinary Care Team (ICT) within the enterprise care management system.
- c. When updates are made, a copy is shared:
 - i. With the member, the member's PCP ~~or other~~and/or specialist participating in the member's care as appropriate.
 - ii. Different modalities are used to share the ICP, including, but not limited to: mail, email, member and provider portals.
 - 1. Modalities chosen are based on the member's preferences

DEFINITIONS / ACRONYMS

Alliance Alameda Alliance Wellness CM Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-D-

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

REFERENCES

CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract Year 2026

MONITORING

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



POLICY AND PROCEDURE

Policy Number	CM-D-106
Policy Name	Developmental Disabilities
Department Name	Case and Disease Management ~~Division~~ Department
Department Chief	Chief Medical Officer
Department Owner	~~Medical Director~~ Director of Social Determinants of Health
Lines of Business	MCAL, IHSSD-SNP/Medicare
Effective Date	11/4/2005TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/21/2024TBD
Administrative Oversight Committee Approval Date	9/18/2024TBD

POLICY STATEMENT

- 1) Alameda Alliance for Health (the Alliance):
- Maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of services for eligible members suspected of having developmental disabilities.
 - Collaborates with the Regional Center of the East Bay (RCEB) to establish mutually agreeable policies and procedures for problem resolution that include the following:
 - Appoints a liaison, as needed, to review and resolve complaints concerning conflicts between the Alliance and RCEB regarding program eligibility, diagnostic testing, plan of treatment, and associated benefits for the member's care;
 - Refers unresolved problems to the Alliance's DHCS contract manager and to the State Department of Developmental Services or California Department of Education (CDE) office.
 - Determination of medically necessary diagnostic and preventative services and treatment plans for members.
 - Case management and care coordination to ensure the provision of all medically necessary covered services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

- c) Implements and maintains systems to identify members with developmental disabilities that may meet requirements for participation in a Home and Community Based Services (HCBS) Waiver program and ensures that these members are referred to the appropriate HCBS Waiver program administered by the State Department of Developmental Services;
 - i) AAH refers members with developmental disabilities to Regional Center of the East Bay (RCEB) for evaluation and access to non-medical services provided by RCEB, including, but not limited to, respite, out-of-home placement, and supportive living.
 - d) Continues to provide comprehensive case management services and cover all medically necessary services for the members who meet criteria and are placed in a HCBS Waiver program while remaining enrolled with the Alliance;
 - e) Continues to provide comprehensive case management services and cover all medically necessary services for the members who do not meet criteria for placement in a HCBS Waiver program while remaining enrolled with the Alliance;
- 2) Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/behavioral health disorders outside their scope of practice as follows:
- a) ~~Medi-Cal members~~Members referred to the Regional Center of the East Bay (RCEB)-); ~~The Alliance RCEB~~ collaborates with ~~the plan~~RCEB regarding Behavioral Health referrals and informs families how to ~~reach out to the plan for~~ referral to the ~~designated appropriate~~ Behavioral Health organization.
 - b) Other line of business members referred to the designated Behavioral Health organization.
 - c) Preventive care will be provided according to the most recent ~~American Academy of Pediatrics (AAP) Guidelines for Children and the~~ Guidelines of the United States Preventive Services Task Force (USPTF) for adults.
- 3) Members identified with or suspected of having developmental disabilities receive all medically necessary and appropriate developmental screening, primary preventive services, and diagnostic and treatment services.
 - 4) The Alliance provides genetic counseling and other covered prenatal genetic testing services when medically indicated for Members at risk of parenting a child with a developmental disability.
 - 5) Data files identifying plan members receiving RCEB services will be forwarded to the appropriate assigned PCPs and delegated medical groups.

Commented [MT1]: @Hunter, Lily @Lam, Allison Do we need to add this to our contracts for DSNP?

Commented [MT2R1]: @Vallejo, Yani

Commented [AL3R1]: Let's confirm with contracting that our existing Medi-Cal MOUs will cover us for the D-SNP population.

Commented [TM4R1]: @Vallejo, Yani

Commented [MT5]: @DeRochi, Andrea please review for BH @Vallejo, Yani

Commented [AD6R5]: No changes. Done.

PROCEDURE

Primary Care and Specialty Referrals

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

1. Wellness Exam

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78"

1. Well Child Exams

Commented [AL7]: Replace with "Wellness Exams"?

Commented [TM8R7]: Done

Formatted: Font: 12 pt

Formatted: Right: 1.02", Space Before: 5.2 pt, Line spacing: Multiple 0.98 li, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78", Tab stops: 0.54", Left + 0.54", Left + Not at 0.78" + 0.78"

collaboration

~~1.~~ Immunizations;

~~2.~~

~~2.~~ Developmental status screening;

~~3.~~

~~3.~~ Illness or Injury Care;

~~4.~~

~~4.~~ Diagnostic testing (laboratory, x-rays) as needed;

~~5.~~

~~5.~~ Health Education as needed; and

~~6.~~

~~2.7.~~ Other primary care services as needed.

~~B.A.~~ PCPs are required to arrange for and/or request from the Alliance all medically necessary specialty practitioner, diagnostic, or therapeutic services including:

1. Referral to specialist or sub-specialist practitioners (e.g., neurologists, physiatrists);
2. Referrals for occupational ~~or~~ physical ~~or~~ speech therapy
3. Orders for medically necessary durable medical equipment (DME) or home health services; and
4. Referrals/authorizations for specialized diagnostic testing (e.g., CT or MRI).

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

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

~~E.D.~~ PCPs and ~~the~~ Alliance ~~UM~~ are responsible for referral to RCEB for Members in need of non- medical, home, and community-based services such as:

1. Family support;
2. Day habilitation;
3. Respite care; and/or
4. Residential care or assisted living.

~~F.E.~~ PCPs and ~~the~~ Alliance ~~UM~~ are responsible for referral to ~~the appropriate~~ Behavior Health organization for members in need of non-medical, home and community-based services such as:

1. Training in skills for daily living;
2. Acquisition of skills and behavior and/or;
 - a. Exception: if a family requests American Disabilities Act (ADA) services, the family will be referred back to RCEB.

~~G.F.~~ PCPs and ~~the~~ Alliance ~~UM~~ are responsible for referrals of ~~children (over 36 months of age)~~ and adults suspected of having developmental disabilities to RCEB when requested by the Member, or his/her family if a minor.

1. The Member's disability must originate before the 18th birthday, be expected to

Formatted: Space Before: 5 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78", Tab stops: Not at 0.78" + 0.78"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Space Before: 5 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78", Tab stops: Not at 0.78" + 0.78"

Formatted: Font: 12 pt

Formatted: Space Before: 5 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78", Tab stops: Not at 0.78" + 0.78"

Formatted: Font: 12 pt

Formatted: Space Before: 5 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78", Tab stops: Not at 0.78" + 0.78"

Formatted: Font: 12 pt

Formatted: Space Before: 5 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.53" + Indent at: 0.78", Tab stops: Not at 0.78" + 0.78"

Formatted: Font: 12 pt, Condensed by 0.15 pt

Formatted: Font: 12 pt

continue indefinitely, and constitute a substantial disability.

2. A list of definitions and eligibility criteria can be found in the California Code of Regulations (CCR) Title 22 Sections 54000, 54001, 54002, and 54010.
3. RCEB reviews referrals to determine RCEB eligibility and considers the need for developmental programs or family support services that are not available from other resources.
4. ~~For referral procedures for children aged 0 to 36 months see~~ [Policy UM-021 Early Start](#).

collaboration

G.

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

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

~~a. For children 3 years old and under:~~

~~▲ Early Start Program~~

~~Phone: 510-618-6195~~

~~Fax: 510-678-4156~~

~~Email: EarlyStartReferrals@rceb.org~~

~~b. For children over 3 years old:~~

~~Phone: 510-618-6122~~

~~Fax: 510-678-4122~~

~~Email: intakeoverthree@rceb.org~~

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

- I. Intake staff reviews the referral to the RCEB within 15 working days of receipt. Evaluations must be performed within 120 days following review of referral, or sooner if a delay in assessment would expose the Member to unnecessary risk to health and safety. RCEB notifies the Member and the Alliance (if the Alliance provides RCEB with a release of information form signed by the Member) within 120 days after the referral is made regarding the Member's eligibility and recommendations for services.
- J. Alliance UM is responsible for approving medically necessary referrals, as needs are identified.
- K. Alliance CM is responsible for the following activities:
 1. Providing care coordination services for Members regardless of whether or not they receive services from RCEB.
 2. Assisting the PCP as needed with the referral to RCEB, including arranging for transfer of medical information, and contact with RCEB.
 3. Coordinating necessary follow-up as needed between the PCP, specialty practitioners, and RCEB to assure an organized care plan and delivery for the Member.
 4. Participating with RCEB staff, as indicated, in the development of the Individual Program Plan required for all persons with developmental disabilities to include identification of medical care services that need to be provided to the member.
 5. Maintaining liaison with the Regional Center of the East Bay to:
 - a. Assist members with developmental disabilities to understand and access services.
 - ~~b. Act as a central point of contact for questions, access and care concerns, and~~

| problem resolution as required by Welfare and Institutions Code 14182 (c)
(10)-

collaboration

- L. See CM-033 Home and Community Based Services (Waiver) Programs for policy and procedures pertaining to HCBS.

Formatted: Font: 12 pt

M. Delegation Oversight

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

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.66", Space Before: 0.3 pt, Line spacing: Multiple 0.96 li

DEFINITIONS

Developmental Disability - defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

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

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

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

Formatted: Font: (Default) +Body (Calibri), Not Bold

Commented [AL9]: Add definition of Developmental Disability from DHCS contract:

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

Commented [HL10R9]: done

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directors - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

Utilization Mgmt.
Member Services
Provider Services
Case Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

UM-008 Coordination of Care – California Children's Services (CCS)

~~D-SNP Behavioral Health Services for UM-012 Coordination of Care Behavioral Health~~

CM-033 Home and Community Based (Waiver) Services

CM-030 Early Start

CM-029 Developmental Disabilities

Page 8 of 5

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

**REVISION
HISTORY**

1/1/2008, 1/20/2009, 6/9/2009, 4/1/2011, 6/1/2011, 8/30/2012, 4/14/2014, 01/10/2016,
12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 3/22/2022, 6/28/2022, 6/20/2023, 9/19/2023,
9/185/2024

Formatted: Highlight

collaboration

REFERENCES

1. ~~MMCD~~ APL 07-012 Identification of Regional Center Consumers.
2. ~~MMCD~~ Policy Letter 97-03 Services for Members with Developmental Disabilities
3. DHCS Contract Exhibit A, Attachment 11, Provision 10
- 3-4. APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities

Commented [AL11]: Add reference to DHCS [APL 23-029](#) (Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities)

Commented [HL12R11]: done

MONITORING

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

collaboration



POLICY AND PROCEDURE

Policy Number	UM-000-New
Policy Name	Out of Area/Out of Network Utilization Management Review
Department Name	~~Health Care Service~~ Utilization Management
Department Officer	Chief Medical ~~Director~~ Officer
Policy Owner	~~Senior Director of Health Care Services~~ Director, Utilization Management
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD</u>
Administrative Oversight Committee Approval Date	<u>TBD</u>

Commented [FM1]: @Thomsen, Michelle all of our policies state the subcommittee is the QIHEC- is there a reason this one is listed for UMC?

Commented [WM2R1]: edited

Formatted: Font: Not Bold

POLICY STATEMENT

Alameda Alliance for ~~Wellness~~Health ensures access to medically necessary care for D-SNP enrollees seeking or receiving services from out-of-area (OOA) or out-of-network (OON) providers, in compliance with CMS and DHCS regulations. Emergency services are covered without prior authorization, while non-emergency OOA/OON services require prior authorization to confirm medical necessity and appropriateness, except when in-network providers cannot meet the member's needs. Care coordination integrates Medicare and Medi-Cal benefits, prioritizing quality, cost-effectiveness, and seamless service delivery. Coverage of OOA care is limited to six months for members residing outside the service area, unless authorized or exempt, to maintain plan integrity and compliance.

Commented [MW3]: Need to confirm with contract.

Commented [TM4R3]: @Meyers, Tome is this correct? @Vallejo, Yani

PROCEDURE

1. Prior Authorization for Non-Emergency OOA/OON Services
 - 1.1. Submission: OON providers or members submit requests via portal, fax, or phone, including the member IDs, clinical documentation, provider NPI and service details.
 - 1.2. Review: UM staff assess requests using CMS NCD/LCD, ~~Alameda~~The Alliance policies, and Medi-Cal criteria, evaluating medical necessity, in-network availability, and appropriateness. Requests are denied if in-network providers can meet needs, with re-direction offered.

1.3. Decision: Decisions are issued within 5 business days from the receipt of request ~~7 days~~ (Standard) ~~or 72 hours~~ (Expedited), with approvals including authorization codes and billing instructions, and denials including appeal rights. Notifications are sent to members and providers.

2. Emergency Care OOA/OON

~~1.4.2.1.~~ OOA/OON emergency services do not require prior authorization.

~~1.5.2.2.~~ Retrospective Review: OON facilities may submit claims within up to 180 days from service date. UM/Claims staff review claims, discharge summaries, and notes to confirm emergency status (per CMS definition) and medical necessity.

~~1.6.2.3.~~ Care Coordination: When care for the member requires inpatient admission ~~Athe~~ UM nurse may assist with ~~care coordinator facilitates~~ transfer to in-network facilities (if appropriate) and arranges follow-up care.

2.3. Outpatient OON Services

~~2.1.3.1.~~ Evaluation: OON providers submit prior authorization requests for outpatient services. UM staff assess clinical necessity, in-network provider availability, and proximity.

~~2.2.3.2.~~ Outcome: Approved services receive authorization ~~codes~~; otherwise, members are redirected to in-network providers with care coordinator support.

3.4. OOA Residency Monitoring

~~3.1.4.1.~~ Notification: Members residing OOA for over 30 days are notified of coverage limits and disenrollment risks, with instructions to update their address.

~~3.2.4.2.~~ Disenrollment: After six month OOA, disenrollment is initiated unless member returns, ~~care is authorized~~, or an exception applies (e.g., full-time students). CMS, DHCS, and the member are notified per CMS protocols.

4.5

DEFINITIONS

- Out of Area (OOA): Services provided outside the defined service area.
- Out of Network (OON): Services provided by providers or facilities not contracted with the D-SNP network
- Utilization Management: The evaluation of medical necessity, appropriateness, and efficiency of the healthcare services through prospective, concurrent, or retrospective reviews.
- Medical Necessity: Services deemed reasonable and necessary based on CMS National/Local Coverage Determinations (NCD/LCD) or the plan's medical policies.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department: Conducts UM reviews, ensures compliance with CMS/DHCS timelines, and processes authorizations/denials.
- Care Coordination Team: Facilitates transitions to in-network care, coordinates Medicare and Medi-Cal benefits, and supports OOA/OON follow-up.
- Claims Department: Processes OOA/OON claims, ensuring accurate Medicare and Medi-Cal billing.

Commented [FM5]: @Thomsen, Michelle @Williams, Mollie where is the 14 days coming from?

Commented [WM6R5]: edited

Commented [FM7]: @Williams, Mollie I believe because we are a Knox plan- we need to follow the 5 business days from receipt of all clinicals and 14 days from date of initial request.

Provide timely notice of standard Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 14 calendar days from when it receives the request in accordance with 42 CFR section 422.631(d)(2)(i)(B).

For Knox-Keene licensed plans, make Integrated Organization Determinations in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from D-SNP Contractor's receipt of information reasonably necessary to make the Integrated Organization Determination, and no later than 14 calendar days from the receipt of request in accordance with H&S section 1367.01(h)(1) and 42 CFR section 422.631(d)(2)(i)(B).

Ensure deadlines for integrated organization determinations are not extended in accordance with H&S section 1367.01.

Commented [TM8R7]: Edited.

Commented [HC9]: Do we need to include a statement or bullet point that states emergency services do not require prior authorization? The two points here cover retro requests and care coordination.

Commented [TM10R9]: @HealyLondon, Carla do we do this? If not lets remove @Williams, Mollie

Commented [HC11R9]: @Thomsen, Michelle Yes. IP UM Nurse assists with transfer to in network facilities and appropriate next level/follow up care. Recommend keeping this.

Commented [FM12]: We do not currently have a re-patriation process- we have purposefully left the process vague in other policies- and I think it looks ok here- but wanted to make sure its noted that is not a typical practice

Commented [AL13]: Do we mean letters here?

Commented [WM14R13]: authorization number; i.e. the service is approved- will just take out the word "codes"

Commented [FM15]: @Hunter, Lily @Lam, Allison how will this work with the current process- we are very liberal in our current disenrollment process- and do not follow this 6 month standard. Will the CM process also change to align?

Commented [AL16R15]: What timeframe do we allow today? Is there a reason we would not submit a disenrollment request immediately after we have documented confirmation that member is residing out-of-area with no intention to return to county?

Is the disenrollment process for Medicare the same as Medi-Cal?, a do we need to consider the deeming period for Medicare?
@Thomsen, Michelle @Williams, Mollie

Commented [WM17R15]: @Lam, Allison
If the member moves counties, remains in state but is outside the DSNP services area; their Medi-Cal benefits are still in place, but ...

Commented [FM18R15]: Our current process mainly defers to the way in which we refer to CM- if they are unable to connect with the member- or if the member says they are only visiting the other ...

Commented [HL19R15]: from the CM perspective, if the member is unable to provide us with an address out of area and date of move, we do not submit for disenrollment from AAH. We hav ...

Commented [WM20R15]: @Lam, Allison @Thomsen, Michelle just tagging for further discussion before it moves to SL ...

Commented [AL21R15]: Recommend leaving as is. Just because the disenrollment process is initiated after 6 months, it is ...

Formatted: Normal

- Member Services: Assists members with OOA/OON inquiries, address updates, and appeals.
- OON Providers: Submit clinical documentation, authorization requests, and claims; comply with billing requirements.
- Members: Notify the plan of OOA residency and adhere to authorization process.

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

TBD

REFERENCES

- CMS Medicare Managed Care Manual, Chapter 4 (Benefits and Beneficiary Protections).
 - DHCS Medi-Cal Managed Care Contract, Sections 4.1.1 (Service Delivery) and 4.2.1 (Care Coordination).
 - California Code of Regulations, Title 22, Division 3 (Health Care Services).
 - CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).
 - DHCS Medi-Cal Rx Billing Guidelines (Magellan).
-

MONITORING

- Compliance Audits: The UM Department conducts quarterly audits of OOA/OON UM reviews to ensure adherence to CMS and DHCS timelines, with findings reported to the UM Committee.
- Performance Metrics: Key indicators (e.g., authorization turnaround time, appeal resolution rates) are tracked monthly and reviewed by the Quality Improvement Committee.
- Member Feedback: Member Services collects feedback on OOA/OON experiences via surveys, with results analyzed biannually to identify improvement areas.
- Provider Compliance: Claims Department monitors OON provider billing accuracy, with discrepancies reported to the Provider Relations team for resolution.
- Policy Review: This policy is reviewed annually or upon regulatory changes, with updates approved by ~~the UM Committee and communicated to stakeholders~~ QIHEC.

Commented [FM22]: Checking again on alignment with the QIHEC rather than UMC

Commented [WM23R22]: edited.



POLICY AND PROCEDURE

Policy Number	UM-000-New
Policy Name	Prior Authorization/Concurrent Review/Organization Determination Audit Process Policy (RGR)
Department Name	~~Health Care Services; Quality Utilization Management~~
Department Officer	Chief Medical Officer
Policy Owner	~~Senior Director~~ Director, Utilization Management of Health Care Services
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD</u>
Administrative Oversight Committee Approval Date	<u>TBD</u>

Formatted: Font: Not Bold

POLICY STATEMENT

Alameda Alliance for Wellness is committed to ensuring compliance with federal and state regulations governing Prior Authorization (PA), Concurrent Review (CR), and Organization Determination (OD) processes. This policy establishes a standardized audit process to evaluate the accuracy to evaluate the accuracy, timeliness, and compliance of these activities, promoting high-quality care and adherence to CMS and DHCS requirements.

This policy applies to all PA, CR, OD processes conducted by the Alliance including internal staff, contracted providers, and delegated entities involved in utilization management.

PROCEDURE

1. Audit Planning

- 1.1. Frequency: Audits ~~are to be~~ conducted ~~quarterly~~monthly, with an annual comprehensive review
- 1.2. Audit Team: Composed of licensed nurses, clinical pharmacists, physicians, and compliance officers with expertise in UM and D-SNP regulations
- 1.3. Scope: All PA, CR, and OD processes, including decision timeliness, medical necessity documentation, and adherence to Evidence of Coverage (EOC)
- 1.4. Sample: Random sampling of at least ~~10% 30~~ of PA, CR, and OD cases ~~monthly~~per quarter, stratified by service types (e.g., inpatient, outpatient, Part B drugs)

Commented [AL1]: ~~@HealyLondon, Carly~~ - I believe our audits are monthly, correct?

Commented [2R1]: @Lam, Allison, correct, audits are conducted monthly.

Commented [MT3]: ~~@Lam, Allison~~ @Findlater, Michelle this percentage can be changed

Commented [AL4R3]: ~~@Thomson, Michelle~~ since there was another P&P that mentioned Pre-service audits, are we including "Prior Authorization" cases in this P&P, as well? If so, then we will need to include Hope in the review.

Commented [HC5R3]: UM Audits consist of 30 random case files monthly NCQA elements reviewed and reported out at UMC

Commented [HC6R3]: ~~@Lam, Allison~~ @Williams, Molly

Commented [TM7R3]: ~~@Desrosiers, Hope~~ please review...see above comments

Commented [DH8R3]: OP reviews for denials mo. reported qtrly to UMC. TAT reported qtrly.

2. Audit Execution

- 2.1. Data Collection: Extract data from ~~electronic health records~~ the clinical documentation systems, UM system, and claims databases and verify completeness.
- 2.2. Criteria Review: CMS MA regulations, Nationally recognized standards (e.g., ~~InterQual~~, MCG, NCDs and LCDs), DSNP EOC and internal UM policies
- 2.3. Timeliness Check: Confirm compliance with standard (14 days for PA/OD, 72 hours for expedited) and CR timeframes (~~daily~~ 2 to 5 times per week during in-patient stays).
- 2.4. Medical Necessity: Ensure decisions are made by qualified professionals and supported by clinical documentation.
- 2.5. Denial Review: Verify that denials (benefit or medical necessity) include clear rationale and appeal rights.

3. Audit Reporting

- 3.1. Documentation of Findings: ~~Compile results~~ Audit results are compiled in a report detailing compliance rates, discrepancies, trends.
- 3.2. Corrective Action Plans (CAPs): For non-compliance, ~~develop~~ CAPs are developed with timelines and responsible parties. CAPs are implemented internally in preparation to share with CMS or ~~DEHCS~~ during oversight activities.
- ~~3.3.~~ 3.4. Stakeholder Communication: Share findings with UM staff, providers, and delegated entities. Present summary to the Compliance Committee.
- ~~3.3-3.4.~~ Audit results are reported to the D-SNP Utilization Management Committee.

4. Follow-Up:

- 4.1. CAP Monitoring: Track CAP implementation quarterly until resolved.
- 4.2. Re-Audit: Conduct targeted re-audits for areas with significant findings within 90 days.
- 4.3. Continuous Improvement: Incorporate audit findings into UM training and policy updates.

DEFINITIONS

- Prior Authorization (PA): A UM process requiring approval before certain medical services, items, or Part B drugs are provided, ensuring medical necessity and coverage compliance.
- Concurrent Review (CR): UM conducted during an inpatient stay to assess ongoing medical necessity and coordinate care transitions.
- Organization Determination (OD): A decision by the DSNP plan regarding coverage, payment, or provision of medical services, items, or Part B drugs.

AFFECTED DEPARTMENTS/PARTIES

Behavioral Health
Utilization Review

Which departments will this policy affect

RELATED POLICIES AND PROCEDURES

BH-XXX Behavioral Health Services, D-SNP Any policies referred to in the policy, and any policies that will be affected by this policy.

Commented [MT9]: [@HealyLondon, Carla](#) need your input on this?

Commented [HC10R9]: Per our existing policy UM-003 Concurrent Review: Concurrent reviews are conducted on admission and 2-5 times per week depending on the clinical scenario (ie, change of condition, LOC would indicate need for review)

Commented [HC11R9]: [@Williams, Mollie](#)

Commented [MT12R9]: Updated [@Vallejo, Yan](#)

Commented [MW13]: Is there already a report in place that they use similarly in other LOBs

Commented [HC14R13]: Multiple Analytics reports such as AuthTAT, AuthAging are generated for monitoring TAT at regular intervals, for daily oversight and monitoring and on a monthly basis for report out at UMC (UM Committee). Individual departments (IP UM, OP UM, etc) conduct internal audits and file reviews of randomly selected cases and results are reported at UMC.

Commented [HC15R13]: [@Williams, Mollie](#)

TBD

REVISION HISTORY

REFERENCES

- Centers for Medicare & Medicaid Services (CMS). (2024). Medicare Advantage Regulations, 42 CFR § 422.101.
- California Code of Regulations, Title 8, Section 9792.6.1. Utilization Review Standards.
- CMS. (2024). Final Rule to Expand Access to Health Information and Improve the Prior Authorization Process.

MONITORING

- Compliance Officer: Oversees audit execution and CAP implementation.
- Quality Management Committee: Reviews audit reports quarterly and approves policy updates.
- External Oversight: Submits audit results to CMS and DHCS during program audits.
- Metrics Tracking: Monitors key performance indicators (KPIs), including:
 - Percentage of eases-authorizations meeting timeliness standards (>95% target).
 - Rate of overturned appeals (<25% target).
 - Documentation completeness (>98% target).

Commented [AL16]: @Williams, Mollie @Thomsen, Michelle
– please confirm the target with Alma in G&A department

Commented [MT17R16]: @Pena, Alma Is this correct?
@Vallejo, Yana

Commented [18R16]: Rate of overturned appeals (<25% target). This is the target goal.

Commented [WM19R16]: @Vallejo, Yana updated

Commented [TM20R16]: Done



POLICY AND PROCEDURE

Policy Number	UM-000-NEW
Policy Name	Readmission Review Policy
Department Name	Health Care Services Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Commented [MT1]: @HealyLondon, Carla @Lam, Allison This policy is new and is just a jumping off point please redline as needed - Also is this a UM policy or a CM policy for AAH?

Commented [AL2R1]: @Fridlander, Michelle - please review as well. This would be UM policy

Formatted: Font: Not Bold

POLICY STATEMENT

Alameda Alliance for Wellness (the Alliance) is committed to reviewing all readmissions within 30 days. The Readmission Review Policy establishes a process to evaluate readmissions for members, ensure medical necessity, optimize resource utilization, and reduce potentially preventable readmissions (PPRs). This policy complies with Centers for Medicare & Medicaid Services (CMS) regulations and California Department of Health Care Services (DHCS) requirements under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

This policy applies to all Alameda Alliance for Wellness D-SNP members readmitted to an acute care hospital or skilled facility within 30 days of a prior discharge. It governs UM staff, contracted providers, and network facilities.

PROCEDURE

1. Readmission Notification
 - 1.1. Providers notify The Alliance UM and CM teams within 24 hours via Admission, Discharge and Transfer (ADT) feed, portal, fax, telephone (admission date, diagnosis, prior discharge date, facility, reason for readmission).
 - 1.2. Verify member eligibility and document readmission in the Clinical information system.
2. Initial Medical Necessity Assessment

Commented [MT3]: @HealyLondon, Carla is this correct? If not please edit. Thanks MT

Commented [AL4R3]: I added the CM team here, since they will get notified, as well.

Commented [HC5R3]: @Thompson, Michelle yes, this is correct. @Lam, Allison @Fridlander, Lily for visibility, agreement

Commented [HL6R3]: Does anything need to be addressed if we don't get an ADT Feed from the facility?

- 2.1. Within 48 hours, the UM team reviews clinical documentation (e.g., admission records, prior discharge summary, HRA) to confirm medical necessity of the readmission.
 - 2.2. The team applies CMS Hospital-Wide Readmission Measure and DHCS PPR criteria to classify the readmission as potentially preventable or non-preventable.
 - 2.3. Utilization patterns, including frequency of covered services (e.g., SNF care, outpatient visits) are evaluated via claims data/previous authorizations.
 - 2.4. Findings, including SDOH factors (e.g., lack of transportation), are documented in the Clinical Information System.
3. Root Cause Analysis for PPR Determination
 - 3.1. Upon notification of readmission, and Within 75 business days of readmission or prior to date of discharge (whichever occurs sooner), the UM and CM teams conducts a detailed review to identify factors that contributed to the readmission.
 - 3.1.1. Clinical appropriateness of the prior discharge (e.g., incomplete medication reconciliation)
 - 3.1.2. Adherence to prescribed treatment plans, verified through claims and provider records.
 - 3.1.3. SDOH impacts (e.g., transportation, housing instability), cross referenced with HRA data.
 - 3.2. The team consults the discharging facility and primary care provider for additional clinical context.
 - 3.3. PPR status and root causes are documented in the Clinical Information System
 4. UM/CM Recommendations
 - 4.1. Within 7 days, the UM/CM team issues recommendations to providers to optimize utilization.
 - 4.2. Recommendations include:
 - 4.2.1. Increased utilization of Medi-Cal services (e.g., non-emergency medical transportation, home health).
 - 4.2.2. SDOH interventions (e.g., referral to housing navigation programs), aligned with CalAIM.
 - 4.3. Recommendations are distributed to the discharging facility and primary care provider via secure communication.
 5. Monitoring and Evaluation of UM interventions
 - 5.1. Readmission patterns are analyzed 30 days post-readmission to evaluate the effectiveness of UM interventions.
 - 5.2. The UM team tracks provider adherence to recommendations using claims data and provider-submitted reports.
 - 5.3. Outcomes are documented in the Clinical Information System, identifying trends in PPR reduction and persistent utilization issues.
 6. Referral to Case Management
 - 6.1. UM specialist Nurse to ensure member is referred to Case Management for care coordination in order to prevent readmission.

DEFINITIONS

- Readmission: An unplanned admission to a hospital or skilled nursing facility within 30 days of discharge from a prior acute care hospitalization.

Commented [MW7]: Does not necessarily need to be every 5 days, but we need to determine a time-frame

Commented [MW8]: Need to determine if this is a "Team" or perhaps the team lead/manager or is there already someone who is doing this?

Commented [AL9R8]: This would be a team effort between UM and CM, part of the care transitions process described in the MOC.

Commented [AL10R8]: [@Hunter, Lili](#) - FYI for your awareness

Commented [HL11R8]: are we tied to the deadline of identifying factors that contributed to the readmission? I think given one business week, may be too short.

Commented [WM12R8]: [@Hunter, Lili](#) the 5 days is just an example, does not necessarily need to be 5 days but there does need to be a time frame in place with the goal being to figure out how to prevent readmissions as this is a big measure- this is an internal team decision ultimately

Commented [AL13R8]: Broadened language to within 7 days of readmission and prior to date of discharge, whichever occurs first. - resolving comment.

Commented [AL14]: Do we mean to say how often we're monitoring readmission rates? If so, readmission rates are monitored monthly, and reported out quarterly at UMC.

Commented [AL15]: [@HealyLondon, Carl](#) [@IndiraMichelle](#) [@Hunter, Lili](#) - please update this statement to reflect current state. Please ensure it aligns with other P&Ps where we discuss care transitions.

Commented [HC16R15]: [@Hunter, Lili](#) can you confirm this aligns with TCS and CM policies

Commented [HL17R15]: happy to have CM receive referrals, is there a workflow process that UM performs to confirm that a member has been referred to CM? (e.g. check referral summary?)

Commented [HC18R15]: IP UM, as part of review process, checks to see that CM referral was sent/received-whether triggered by ADT or manual. Yes, they check the referral summary

- Potentially Preventable Readmission: A readmission that could have been avoided through appropriate clinical interventions, such as improved discharge planning or follow-up care.

AFFECTED DEPARTMENTS/PARTIES

Which departments will this policy affect

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

TBD

REFERENCES

- CMS Medicare Managed Care Manual, Chapter 4.
- 42 CFR Part 422 (Medicare Advantage Regulations).
- DHCS D-SNP Contract, Exhibit A.
- MCG Guidelines.
- CMS D-SNP Model of Care Requirements (42 CFR §422.101(f)).
- CMS Hospital-Wide Readmission Measure.

MONITORING

- Track utilization outcomes via claims data and Clinical Information System.
- Analyze readmission trends quarterly to address inefficiencies (e.g., overutilization).
- Implement corrective actions (e.g., provider training on medical necessity).
- Submit data to CMS and DHCS.
- Provider non-compliance may result in corrective action or contract termination.
- Share reports with UMC quarterly for oversight.



POLICY AND PROCEDURE

Policy Number	UM-000-New
Policy Name	Review of Admissions, Discharge, and Transfer Files
Department Name	Health Care Services
Department Officer	Chief Medical Director
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Wellness is committed to systematically reviewing admissions, discharge and transfer files (ADT) to ensure compliance with federal and state regulations, promote seamless care coordination, and enhance health outcomes for D-SNP members. This policy supports the California Advancing and Innovating Medi-Cal (CalAIM) initiative and Centers for Medicare & Medicaid Services (CMS) requirements by facilitating timely utilization oversight, reducing preventable readmissions, and ensuring adherence to the D-SNP Model of Care (MOC).

This policy governs the review of hospital admission, discharge, and transfer (ADT) logs and related utilization data for D-SNP members. It applies to all processes involving the collection, review, and analysis of ADT feeds to support care coordination, quality improvement, and regulatory compliance. The policy encompasses interactions with contracted hospitals, Independent Practice Associations (IPAs), and internal teams responsible for managing D-SNP member care.

PROCEDURE

1. Data Collection
 - 1.1. Contracted hospitals/IPAs submit ADT logs within 24 hours of an event via a secure, HIPAA-compliant platform (EREX).

- 1.2. Logs must include member ID, admission/discharge dates, primary diagnosis, and discharge disposition.
 - 1.3. UM staff verify ADT accuracy against member records within 48 hours, resolving discrepancies with hospitals promptly.
 2. Concurrent Review
 - 2.1. UM staff review daily ADT to confirm medical necessity using evidence-based criteria (e.g., NCD, LCD and MCG).
 - 2.2. Collaborate with hospital case managers and the Alliance case manager to align care with the member's Interdisciplinary Care Plan (ICP).
 - 2.3. Document findings, including prior authorizations for medications or durable medical equipment (DME), in the clinical documentation system.
 - 2.4. Frequency: Daily for active inpatient cases.
 3. Discharge Planning Review
 - 3.1. The CM /Transitional Care Services staff review ADT files to confirm:
 - 3.1.1. Alignment of discharge plan with ICP and CalAIM community support requirements.
 - 3.1.2. Arrangement of medications, DME, and follow-up appointments within 7 days.
 - 3.1.3. Contact members/caregivers within 3 business days post-discharge to verify plan execution.
 - 3.1.4. Update ICP based on findings.
 4. Data Privacy and Compliance
 - 4.1. Log reviews adhere to HIPAA and HITECH standards for protecting health information.
 - 4.2. Access is limited to authorized personnel with role-based permissions.
 - 4.3. Non-compliance or breaches are reported to the Compliance Department, CMS and DHCS within 72 hours.
-
-

DEFINITIONS

- Hospital Logs: Electronic or written records documenting D-SNP member admissions, discharges, transfers, diagnoses, and discharge dispositions.
 - CalAIM: California Advancing and Innovating Medi-Cal, a DHCS framework to integrate and improve care for dual-eligible populations.
 - HRA: Health Risk Assessment, a tool to assess members' physical, psychosocial, and functional needs.
 - ICP: Individualized Care Plan, a tailored plan based on HRA findings to address member-specific needs.
-
-

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management (UM) Department: Reviews logs for medical necessity and discharge planning.

- Care Coordination Department: Updates ICPs and coordinates post-discharge services based on log data.
- Quality Improvement (QI): Analyzes logs for utilization trends and quality metrics.
- Compliance Department: Ensures regulatory adherence and oversees audits.
- Contracted Hospitals/IPAs: Submit timely and accurate hospital logs to the D-SNP plan.
- Information Technology (IT) Department: Maintains secure systems for log submission and storage.

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

REVISION HISTORY

TBD

REFERENCES

- CMS Medicare Advantage D-SNP Regulations (42 CFR Part 422)
 - DHCS CalAIM Strategic Plan (2023-2027)
 - Bipartisan Budget Act of 2018 (Hospital Admission Notification Requirements)
 - California Health and Safety Code
 - HIPAA and HITECH Act
-
-

MONITORING

- Internal Audits: The Compliance Department conducts quarterly audits of log review processes to verify adherence to CMS, DHCS, and CalAIM requirements.
- Hospital/IPA Audits: Annual audits ensure contracted entities submit timely and accurate logs.
- Performance Metrics: Monthly reports track admission rates, readmission rates (within 30 days), and discharge plan compliance, reviewed by the QI Committee.
- Corrective Actions: Audit findings trigger corrective action plans, monitored by the Compliance Officer.
- Continuous Improvement: Log review outcomes inform quality improvement initiatives, targeting care gaps and health equity per CalAIM goals.



Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	DSNP UM-001
Policy Name	DSNP Utilization Management Program
Department Name	Utilization Management Department
Department Officer	Chief Medical Officer
Policy Owner	Director of Utilization Management
Line(s) of Business	MediCal, IHSS, D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

- I. Alameda Alliance for Health and Alameda Alliance Wellness (“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) or designee 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.
 1. The UM Program Description, Program Evaluation and Workplan are reviewed and updated 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.

2. 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:

1. Authorization is not required prior to the provision of emergency services and care needed to stabilize a member's emergent medical condition.
2. The Alliance covers all emergency room services and does not deny any emergency room claims.
3. 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.
4. 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 Alliance , and the Member's covered services. For D-SNP all Medicare and Medi-Cal benefits are coordinated, and authorization/determinations are integrated.
5. 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:
 - a. The Alliance distributes an affirmative statement to all practitioners, providers, staff, and members regarding incentives to ensure appropriate utilization and discourage underutilization.
 - b. The Alliance does not use incentives to encourage barriers to care and service.
 - c. The plan will ensure that a Medical Director's authorization decisions avoid any conflict of interest situations.
6. Second opinions from a qualified health professional are at no cost to Medi-Cal, D-SNP or fee-for service health plan in accordance with the AAH policy and procedure for Second Opinion (UM-005)

7. 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.
 - a. 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.
 - National Coverage Determinations (NCD)
 - Local Coverage Determinations (LCD)
 - 2) Evidence based guidelines.
 - 3) Alliance specific guidelines
 - 4) National medical association consensus
 - 5) Independent Medical Review (UM-046)
 - 6) Medical necessity/medical judgment
 - b. Documentation will be maintained evidencing the use of providers involved in the development and or adoption of specific criteria utilized by the UM program.
 - c. 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
8. 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.
9. 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:

1. 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.
 - a. In Alignment with HR-017 the HR department conducts license verification and re-verification for all new hires, promotions, transfers and 30 and 60 days prior to license expirations.
2. 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.
3. Qualified health professionals supervise medical necessity review processes and documentation as described in Section II in the procedure section of this policy and procedure.
4. 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

1. 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. • 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.

2. Supervision

- a. The Board of Governors delegates oversight of Utilization Management functions to the CMO and the Quality Improvement Health Equity Committee (QIHEC)
- b. A Medical Director/Doctoral Behavioral Health Practitioner must review any authorization request that may result in a denial due to medical necessity.
- c. The Supervisor of Utilization Management provides day-to-day supervision of the UM Coordinator and/or 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.

3. Behavioral Health Care UM Decisions

- a. 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.

- b. Behavioral healthcare services for the Group Care line of business is delivered through the Behavioral Health department.
- c. For 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.
- d. 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.
- e. 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.

4. Pharmacy Prior Authorization/UM Decisions: See policy RX-013 Physician/Facility-Administered Drugs (PAD) Prior Authorization Review Process or RX-D-023 Part B Medication Coverage.

5. 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.

6. 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:

- 1. 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.
- 2. 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:
1. **Prior Authorization Review:** Submissions received prior to the Date of Service will be reviewed for medical necessity.
 2. **Retrospective Authorization Review:** Submissions received up to 90 days from the date of service will be reviewed for medical necessity.
 - a. **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.
 - b. 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.
 - c. 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.
 3. 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.
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, Department of Health Care Services (DHCS), National Committee for Quality Assurance (NCQA) and the Centers for Medicare (CMS) strictest timeframe.
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
- 11.** 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. 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

BH-001, Behavioral Health Services, Medi-Cal
BH-008, Behavioral Health Services, Group Care
BH-XXX, Behavioral Health Services, D-SNP
CMP-019 Delegation Oversight
HR-017 License Verification and Reverification
QI-101 Quality Improvement Program
UM-005 Second Opinions
UM-007 New and Experimental Technology Review Process
UM-051 Timeliness of UM Decision Making and Notification
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, 7/18/2025

REFERENCES

1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
 2. Title 22, Section 51159
 3. 28 CCR, §1300.51 (d)(I-6)
 4. Health & Safety Code, Section 1367.01
 5. 42 CFR 438.900(d)
 6. CMS Managed Care Manual
 7. CY 2026 DHCS Medi-Cal and DSNP Policy Guide
-

MONITORING

1. Delegated Medical Groups
 - a. The Alliance UM team in collaboration with the Compliance Delegation Oversight Department continuously monitor 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 monthly authorization audit conducted by the Utilization Management Leadership Team. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
 - ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
 - iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
 - b. Inter-Rater Reliability - At least annually and upon hire, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria requiring at a 90% pass rate. The Alliance will immediately provide remediation if the passing threshold is not met. New staff require testing prior to conducting utilization reviews without supervision.



POLICY AND PROCEDURE

Policy Number	UM-004
Policy Name	Over and Under Utilization
Department Name	Health Care Services
Department Officer	Chief Medical Director
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, DSNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Purpose:

To establish a systematic approach for identifying, monitoring and addressing patterns of healthcare over and underutilization to ensure appropriate allocation of healthcare resources, improve quality of care and promote cost-effectiveness while meeting members' healthcare needs.

Scope:

This policy applies to all clinical and non-clinical staff involved in utilization management activities, including but not limited to utilization review nurses, physicians, medical directors, quality improvement specialists and network management.

POLICY

1. Alameda Alliance maintains processes and mechanisms to monitor, detect, and correct Over/Under Utilization of Medi-Cal and Group Care services to ensure appropriate access, quality, and appropriateness of care.
2. The over- and under- utilization review process is a component of the UM Program Evaluation and Work Plan.
3. Over/Under Utilization Monitoring/Detection/Correction processes shall include, but are not limited to:
 - a. Review of services for appropriate and cost-effective patient care for detecting/correcting over- and under-utilization.
 - b. Review for inappropriate utilization and/or care provided in an inappropriate setting(s) that may be indicative of barriers to health care services.
 - c. Monitoring over- and under- utilization for selected activities using UM

measures to identify potential patterns and trends.

4. The UM Committee (UMC) is responsible for the review and analysis of network trend reports to identify potential areas of under- and over- utilization of services. These reports include, but are not limited to:
 - a. Ambulatory services (e.g., primary care visits, specialist services, preventive health care services and emergency room visits.)
 - b. Acute hospitalization (e.g., bed days, average length of stay and discharges, **readmission rates within 30 days**)
 - c. Out of network activities (e.g., specialist services, behavioral health care)
 - d. Behavioral health utilization data
 - e. Pharmacy utilization (e.g., antibiotics, emergency service usage, opioid use, medication management, etc. **CMS star rating for prescription adherence**)
 - f. **Denied services and appeals**
 - g. HEDIS use of service metrics.
5. The UMC is responsible for identifying and adopting available industry benchmarks to measure network performance.
- ~~6.~~ The UMC is responsible for developing and monitoring corrective action plans developed to address noted deficiencies.
- ~~6.~~
- ~~7.~~ For Alameda Alliance Wellness D-SNP, a dedicated Utilization Management Committee (UMC) has been established. This stand-alone committee is specifically designed to oversee and manage utilization review processes for the ~~Wellness D-SNP~~ program.
- ~~7.~~
- ~~8.~~ Reports will be presented to the UM Sub-Committee and Quality Improvement Health Equity Committee (QIHEC) for review, comment, and consideration of utilization control strategies.
- ~~8.~~ The internal reporting mechanisms used to detect member utilization patterns shall be reported to the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid (CMS) upon request.
- ~~9.~~ 10. The Compliance and Utilization Management Department are responsible for the review and annual update to policies for compliance with regulatory and contractual requirements.
 - a. All policies will be presented and approved by the UM Sub-Committee and Quality Improvement Health Equity Committee.

Formatted: Indent: First line: 0"

Formatted: Character scale: 100%

Formatted: Indent: Left: 0.83", No bullets or numbering

Formatted: Font: Not Bold, Font color: Auto, Character scale: 100%

Formatted: Font: Not Bold, Character scale: 100%

Formatted: Character scale: 100%

Formatted: Right: 0", Space Before: 0 pt, Line spacing: single, Tab stops: Not at 0.83"

Formatted: Font: 11 pt

Formatted: List Paragraph

Formatted: List Paragraph, Space Before: 0 pt

Formatted: Character scale: 100%

Formatted: List Paragraph, Indent: Left: 0", First line: 0", Right: 0", Line spacing: single

PROCEDURE

1. Reports are generated from data from various sources:
 - a. Authorization data systems
 - b. Claims and payments.

- c. Encounter data
 - d. Medical records
2. The data is compared to available sources of comparable data and benchmarks that are external to Alameda Alliance:
 - a. Internally developed performance measures e.g., Admits per 1000, Bed-days per 1,000, ER Visits per 1000.
 - b. DHCS-established Minimum Performance Levels (MPLs) and High Performance Levels (HPLs).
 - c. National Medicaid HEDIS results for the 25th and 75th percentiles for measures related to over and under-utilization.
 - d. Previous year's network performance
 - e. CMS benchmarks for Medicare Advantage Plans when applicable
 - f. CMS Star Rating benchmarks
 - g. NCQA 75th percentile for industry standards
 - h. MCG criteria when applicable
 3. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services in accordance with CMS parity requirements for mental health and substance use disorder services.
 - a. Out of Network Behavioral Health Data is collected by Behavioral Health department and is submitted to The Alliance UMC on a quarterly basis.
 1. These data are reviewed by the Utilization Management Committee, which oversees the process for appropriate utilization of services
 2. Findings are reported at both the Utilization Management and the Quality Improvement Health Equity Committee meetings because both quality and utilization components are included.
 3. Detailed analysis may be conducted to determine the root cause of an identified trend.
 4. Interventions are developed and approved by the Utilization Management and Quality Improvement Health Equity Committees and carried out by assigned departments.
 4. Aggregation of all out of network data including Alameda Alliance and delegates per required CMS network adequacy standards.
 5. Alameda Alliance generates monthly reports to monitor the network performance with the established measures, which is reported at least quarterly.
 - a. A statistical report is generated for outlier practitioners.
 1. Practitioner Corrective Action Plan is developed as appropriate for outlier providers.
 - b. A statistical report of network adequacy is generated.
 1. A referral to Provider Services is made when network adequacy problems are identified.
 6. Data from the monthly analysis is submitted as part of the UM Work Plan to the UMC for discussion and recommendations for addressing outlier results.
 7. The results and the UMC recommendations are forwarded to the Quality Improvement Health Equity Committee.

Commented [MT1]: @DeRochi, Andres please review for BH - @Vallejo, Yan

Commented [AD2R1]: Done

Formatted: Tab stops: 5.69", Left

- a. For the process of measuring potential under-utilization of primary and preventive services in capitated setting, UM and Data Analytics collaborate to perform the following selected measures Out of Network specialty utilization.

- 1. Out of Network behavioral health utilization

Monthly or bi-monthly encounter data are reviewed

8.

Formatted

approval

DEFINITIONS

Utilization Management (UM): set of techniques used by or on behalf of healthcare providers and health plans to manage healthcare costs through case-by-case assessments of the appropriateness of care.

Over-utilization: The provision of services that exceed evidence-based guidelines, have limited or no clinical benefit, expose patients to risk that outweighs potential benefits.

Under-utilization: Failure to provide medically necessary services or provision of an inadequate quality or lower level of services than is medically indicated.

CMS Star Rating: A quality rating system developed by CMS to measure the experiences members have with their health plans and healthcare systems.

Healthcare Effectiveness Data and Information Set (HEDIS): A tool used by health plans to measure performance on dimensions of care

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Quality Management
Health Care Analytics
Behavioral Health

RELATED POLICIES AND PROCEDURES

1. UM Program Description
2. UM-001 Utilization Management Program
3. UM-047 UM Sub-Committee
4. Quality Improvement Health Equity (QIHE) Program Description
5. QI-101 Quality Improvement Health Equity Program
6. QI-111 Delegation Management and Oversight
7. [BH-001 Behavioral Health Services for Medi-Cal](#)
8. [BH-008 Behavioral Health Service for Group Care](#)
9. [BH-XXX Behavioral Health Service for D-SNP](#)
- 7.10. [BH-001 Behavioral Health Services 2 Behavioral Health Services](#)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

1/1/2008, 10/28/2009, 8/24/2012, 4/4/2014, 1/10/2016, 12/15/2016, 10/12/2017, 5/3/2018, 7/19/2019, 3/18/2021, 3/22/2022, 6/20/2023, 7/17/2024, [5/9/25](#)

REFERENCES

1. 28 California Code of Regulations 28 CCR 1300.70(a)(l); 28 CCR 1300.70(b)(2)(G)(5); 1300.70(b) (H)(2)
2. DHCS Contract Exhibit A, Attachment 4, Section 9.B
3. [42 CFR 438.330 \(b\)\(3\)](#)

4. 42 CFR 438.240 (b)(3)
5. 42 CFR 438.66
6. CMS Part C Reporting requirements

MONITORING

The Utilization Management (UM) team monitors, tracks, and analyzes utilization statistics to detect over and under-utilization and reports its findings, with recommendations quarterly to the UM Committee and Quality Improvement Health Equity Committee (QIHEC) in accordance with CMS quality improvement requirements.

The QIHEC will develop corrective action plans for UM team implementation, when appropriate, based upon that analysis following CMS Program Audit protocols and compliance requirements.



POLICY AND PROCEDURE

Policy Number	UM-005
Policy Name	Second Opinions
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Formatted: Justified, Indent: Left: 0.08", Right: 6.55", Space Before: 11.05 pt, Line spacing: Multiple 0.67 li

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Font color: Auto

Purpose:

The Alliance will ensure patients have access to second opinions [from qualified health care professionals within the Alliance's provider network](#) for healthcare decisions. This policy establishes guidelines for requesting, processing and documenting second opinions to promote patient-centered care and informed decision-making.

Scope:

The policy applies to all healthcare providers, staff, and members of Alameda Alliance for Health (The Alliance).

POLICY STATEMENT

Formatted: Centered

- A. PCP (Primary Care Physician)/BH (Behavioral Health) Providers, Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from a qualified health professional, at no cost to the Member from the Alliance, (Per 42 CFR section 438.206,) regarding proposed medical, surgical or behavioral health treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.
- B. Eligibility Criteria:
1. ~~+~~ Questioning the reasonableness or necessity of recommended surgical procedures
 2. Conditions threatening loss of life, limb, bodily function and substantial impairment of health
 3. Unclear or complex clinical indications
 4. Conflicting diagnostic test results
 5. Lack of improvement with current treatment plans

Formatted: Font color: Auto

Formatted: Font color: Auto

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: 11 pt, Font color: Auto

Formatted: Font color: Auto

Formatted: Font: 11 pt, Font color: Auto

Formatted: Font color: Auto

Formatted: Font: 11 pt, Font color: Auto

Formatted: Font color: Auto

Formatted: Font: 11 pt, Font color: Auto

Formatted: Font color: Auto

Formatted: Font: 11 pt, Font color: Auto

6. Concerns over diagnosis or plan of care

- C. Second opinions from contracted providers do not require authorization and are arranged through the Member's assigned PCP or BH Provider.
- D. When indicated, The Alliance provides for a second opinion from a qualified health care professional in network or arranges for the enrollee to obtain one out of network, at no cost to the enrollee.
- E. A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.
- F. The urgent second opinion authorization or a denial shall be provided in an expeditious manner appropriate to the nature of the member's condition, not to exceed 72 hours after the Alliance's receipt of the request.

Formatted: Font color: Auto

Formatted: Font: 11 pt, Font color: Auto

PROCEDURE

- A. Members should request a second opinion through their PCP, specialist, or BH Provider. If the PCP, specialist, or BH Provider refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through the Alliance Member Services.
- B. Second opinions rendered by a contracted Alliance provider does not require prior authorization; the member's PCP, specialist, or BH Provider can coordinate the referral directly with a provider in the same of equivalent specialty ~~the provider rendering~~ to render the second opinion. Members can call the Alliance Member Services department to obtain assistance with this coordination.
- C. Second opinions rendered by a non-contracted Alliance provider do require prior authorization. The PCP, specialist, or BH Provider submits the authorization request for a second opinion to the Alliance including documentation regarding the Member's condition and proposed treatment.
- D. If the referral for a second opinion is approved, the Alliance assists with making arrangements for the Member to see a physician/BH Provider in the appropriate specialty.
- E. If the referral for an out of network 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:

Formatted: Font color: Auto

Formatted: Font color: Auto

Commented [MT1]: Is this supposed to be BH?

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/BHR 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/BHR 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/BHR Provider, the second opinion must be provided by an appropriately qualified physician/BHR 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 5 working days ~~five working days~~ of obtaining only the information

Formatted: Indent: Left: 0.45", Right: 0"

Formatted: Indent: Left: 0.45", Hanging: 0.25", Right: 0", Line spacing: single

Formatted: Left, Right: 0.18"

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 14 five-calendar day timeframe. 3).

4). Practitioners must be initially notified within 24 hours of the decision by telephone or in writing. Telephonic communications of decisions must be

Commented [AL2]: Is this referring to the TAT after a "delay" notification has been sent due to requesting additional information?

The decision TAT should be 14 calendar days from the request data.

Commented [MT3R2]: You are right it is no longer than 14 days. Updating policy to reflect @Lam, Allison @Vallero, Yoni

Formatted: Normal, Indent: Left: 0", First line: 0", Right: 0.23", Space Before: 6.25 pt, Line spacing: Multiple 1.01 li

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Font color: Auto, Character scale: 100%

3). documented including date, time, name of contact person, and initials of the person making the call.

5-4). The Alliance must notify both the Member and practitioner in writing of all decisions, within 5 business days of the request of 14 calendar days if requesting additional information. 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 orelectronic 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. In the event of a denial. 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. Tim#reframes for decisions and notifications of the decisions to the Member and the practitioner regarding the expedited review are as follows:

Formatted: Font color: Auto, Character scale: 100%

Formatted: List Paragraph, Indent: Hanging: 0.33", Right: 0.23", Space Before: 6.25 pt, Line spacing: Multiple 1.01 li, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 2 + Alignment: Left + Aligned at: 1.21" + Indent at: 1.54", Tab stops: 1.53", Left + 1.53", Left

Commented [AL4]: D-SNP doesn't different notification from decision turn around times.

We must use strictest TAT parameters, so members/providers should be notified of decision within 5 business days of request (or 14 calendar days if requesting additional info).

Commented [MF5R4]: Corrected

1). Decisions must be made within 72 hours of the initiation of the

approval

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

Second opinion: A medical opinion provided by a qualified healthcare professional other than the patient's initial provider regarding diagnosis, treatment options or medical necessity of a procedure or service.

Formatted: Font: Bold, Font color: Auto

Formatted: Font color: Auto

In-network provider: A healthcare provider who has contracted with the Alliance

Formatted: Font: Bold, Font color: Auto

Out-of-network provider: A healthcare provider who has not contracted with the Alliance

Formatted: Font color: Auto

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Program

UM-057 Authorization Service Requests BH-

001 Behavioral Health Services Medi-Cal

~~2 Behavioral Health Services~~

CMP-019 Delegation Oversight

Formatted: Right: 3.31"

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, ~~FBD~~04/29/2025

REFERENCES

~~1.~~ California Health & Safety Code, Section 1383.15

~~2.~~ 42 CFR Section 438.206

Formatted: Indent: Left: 0.35", No bullets or numbering

Formatted: Indent: Left: 0.35", No bullets or numbering

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. ~~Healthcare Quality~~

Formatted: Indent: Left: 0.13"

~~Committee annually.~~

Formatted: Indent: Left: 0.13", Hanging: 0", Right: 0.43", Space Before: 0.25 pt

Formatted: Indent: Left: 0.14"

approval

Approval

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, D-SNP
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).

Formatted: Normal, Indent: Left: 0"

Formatted: Highlight

- 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

ee

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:
 - a. Medical and Surgical procedures, including transplants
 - b. Drugs and pharmaceuticals
 - c. Behavioral healthcare procedures
 - d. Diagnostic and screening tests
 - e. Alternative therapies
 - f. Medical devices/equipment
 - g. Clinical interventions
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 (QHIEC). 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 QHIEC 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 QHIEC the subject areas to be evaluated.
 The CMO will obtain input from the (QHIEC) 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 QHIEC for discussion and approval.
 - a. Once the QHIEC 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

Formatted

Formatted: Right: 0.05"

Commented [FM1]: Review all new drugs that come onto the market within 6 months

Formatted: Space Before: 0 pt

(including pharmacy and behavioral health staff where relevant), will review all relevant research on the service, technology, or procedure, from available resources.

5. 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.
6. 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.
7. 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.
8. 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.
9. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.
10. Following CMO approval, each Coverage Policy Statement will be:
 - a. 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~~
- e. ~~The service is not in wide usage.~~

Formatted: Indent: Left: -0.1", Right: 0.27"

~~**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.~~



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, D-SNP
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Formatted: Highlight

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) has an established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.

The Alliance reviews new technology and new application of existing technology for inclusion in plan benefits. This review encompasses the following:

- Medical and/ or Surgical procedures
- Behavioral healthcare procedures
- Clinical Trials
- Pharmaceuticals
- Devices

The Alliance's new technology evaluation process will include:

- The process and decision variables the plan uses to make determinations, including review of:
 - Member access to services
 - Utilization patterns
 - Patient safety
 - Provider consistency in scope of utilization requests
 - A review of information from appropriate government regulatory bodies, including the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
 - A review of information from published scientific evidence.
 - Obtaining input from relevant specialists and professionals with expertise in the technology.
 - The Alliance's coverage decisions will be based on an assessment of new technology and new applications of existing technology, or on a review of special cases.
-
-

PROCEDURE

A. New and Experimental Technology Criteria Implementation Process

1. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to address recognizing and evaluating advances in medical, surgical, pharmaceutical, and behavioral health care technologies and includes review of the following:
 - a. Medical and Surgical procedures, including transplants
 - b. Drugs and pharmaceuticals
 - c. Behavioral healthcare procedures
 - d. Diagnostic and screening tests
 - e. Alternative therapies

- f. Medical devices/equipment
- g. Clinical interventions
- h. Clinical Trials

B. Annual Review

1. Formal medical policy review (including medical, behavioral health and pharmacy) is conducted once a year using a two-step process requiring input from the Alliance Health Quality Improvement Health Equity Committee (QIHEC).
 - a. The first step in the process is to propose the technologies and changes to technologies to be evaluated
 - b. The second step is the actual revision of existing, or creation of new, policies using special case reviews are conducted throughout the year which are then They are then approved by the CMO in accordance with review processes and timelines. The information from both processes is used for benefit determinations and coverage decisions.

C. UM Medical Director providing a proposed list of services for consideration at QIHEC to CMO

1. The UM Medical Director will provide the proposed list of services and technologies to the CMO along with a summary and rationale for why the services should be evaluated.
2. The CMO, and the appropriate Medical Directors will identify benefit topics for which coverage policy development is indicated, i.e. sufficient benefit guidance/criteria for new or experimental technology are lacking.
3. The Alliance uses appropriate industry resources to develop unbiased, evidenced-based assessments of the safety and efficacy of new, emerging, and controversial health technologies and evaluation of the impact of these technologies on healthcare quality, utilization, and cost.
4. The Alliance Pharmacy Department will evaluate all new drugs that come onto the market within 6 months.

D. Process for the QIHEC preparation and proposal

1. In preparing for the policy review, the UM Medical Director will coordinate the collection of necessary information about new and/or experimental technology and new uses of existing technology for review by the CMO, who will then propose to the QIHEC the subject areas to be evaluated:
2. The CMO will present the list to the QIHEC for discussion and approval.
3. 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.

E. Process following QIHEC Approval

1. 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.

F. Development of specific coverage policies

1. The UM Medical Director, Pharmacy Director and BH Director will develop an initial assessment for specific each new or experimental technology topic consisting of an evaluation of scientific evidence to form conclusions about the benefits/risks of a particular device, therapy, procedure, diagnostic test, or preventive strategy in relation to its potential clinical use for a defined group of individuals.

G. CMO Review and approval of draft coverage policies and final approval at QIHEC

1. The CMO reviews the draft coverage policies that are developed and presents the review of new and/or experimental technology research findings to the QIHEC (and P&T for applicable pharmaceutical technology) for discussion and decision.
2. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

H. Policy Distribution to Providers

1. Following CMO approval, each Coverage Policy Statement will be made available to providers through:
 - a. Announcement of policy publication and availability in the next scheduled Provider Bulletin
 - b. Contacting the UM Department at to request policy copies
 - c. Posting on Alliance website Provider Portal (when feature is available).

I. Clinical Trials Coverage

1. For D-SNP coverage of Clinical Trials, the Alliance is responsible for verifying the proposed Clinical Trial falls into one of two categories:
 - a. Trials that are automatically covered are trials that meet one of the following criteria:
 - i. Funded by NIH, CDC, AHRQ, CMS, DOD, or VA;
 - ii. Supported by groups funded by those agencies;
 - iii. Conducted under FDA-reviewed INDs;
 - iv. IND-exempt drug trials (temporarily covered until self-certification is implemented).
 - b. Other trials may be considered but they must meet all of the following:
 - i. Study an item/service within a Medicare benefit category;
 - ii. Have therapeutic intent (not just testing toxicity or pathophysiology);
 - iii. Enroll patients with diagnosed disease (except healthy controls in

diagnostic trials).

2. Clinical Trials must also meet the following characteristics to be considered medically necessary for the members:

- a. The Aim must be to improve health outcomes;
- b. They must be supported by scientific literature;
- c. They do not create a duplication of existing studies;
- d. They must be properly designed and conducted with scientific and regulatory integrity.

3. The Alliance must be responsible for covering the Routine Costs associated with the Clinical Trials. These include:

- a. Standard care patients would receive outside a trial;
- b. Items/services needed to deliver or monitor the investigational service;
- c. Treatment/prevention of complications.

4. The Alliance is not responsible for the following costs associated with the clinical trials:

- a. Investigational item/service (unless otherwise covered);
- b. Eligibility screenings not related to medical care;
- c. Extra tests for data collection;
- d. Items/services typically provided free by study sponsors;
- e. Statutorily non-covered services (unless treating complications).

~~11. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to address recognizing and evaluating advances in medical, surgical, pharmaceutical, and behavioral health care technologies and includes review of the following:~~

- ~~a. Medical and Surgical procedures, including transplants~~
- ~~b. Drugs and pharmaceuticals~~
- ~~c. Behavioral healthcare procedures~~
- ~~d. Diagnostic and screening tests~~
- ~~e. Alternative therapies~~
- ~~f. Medical devices/equipment~~
- ~~g. Clinical interventions~~
- ~~h. Clinical Trials~~

~~12. 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.~~

~~13. 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~~

Formatted: Centered

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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

21. Following CMO approval, each Coverage Policy Statement will be:

a. 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

Formatted: Normal, Centered, No bullets or numbering

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Centered, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: Centered, Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Indent at: 2"

Formatted: Centered, Indent: Hanging: 0.26", Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Indent at: 2"

Formatted: Centered

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 testing is not complete:

~~d.a.~~ The efficacy and safety of such services in human subjects is not yet established; and

~~e.b.~~ The service is not in wide usage.

Technology Assessment - A process established to evaluate the appropriate use of new technologies, new applications of existing technologies and the organizational or supportive systems within which such care is delivered. Services, procedures, pharmacological treatments, and behavioral health procedures are reviewed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES 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, 4/15/2025

REFERENCES

[CMS National Coverage Determination \(NCD\) for Routine Costs in Clinical Trials \(CMS Pub.100-03, Section 310.1\)](#)

NCQA UM 10 Evaluation of New Technology

Title 42, CFR, Section 422.202(b)

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.

approval

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, D-SNP
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).

Formatted: Normal, Indent: Left: 0"

Formatted: Highlight

- 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

ee

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:
 - a. Medical and Surgical procedures, including transplants
 - b. Drugs and pharmaceuticals
 - c. Behavioral healthcare procedures
 - d. Diagnostic and screening tests
 - e. Alternative therapies
 - f. Medical devices/equipment
 - g. Clinical interventions
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 (QHIEC). 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 QHIEC 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 QHIEC the subject areas to be evaluated.
The CMO will obtain input from the (QHIEC) 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 QHIEC for discussion and approval.
 - a. Once the QHIEC 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

Formatted

Formatted: Right: 0.05"

Commented [FM1]: Review all new drugs that come onto the market within 6 months

Formatted: Space Before: 0 pt

(including pharmacy and behavioral health staff where relevant), will review all relevant research on the service, technology, or procedure, from available resources.

5. 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.
6. 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.
7. 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.
8. 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.
9. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.
10. Following CMO approval, each Coverage Policy Statement will be:
 - a. 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~~
- e. ~~The service is not in wide usage.~~

Formatted: Indent: Left: -0.1", Right: 0.27"

~~**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.~~



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, D-SNP
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Formatted: Highlight

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) has an established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.

The Alliance reviews new technology and new application of existing technology for inclusion in plan benefits. This review encompasses the following:

- Medical and/ or Surgical procedures
- Behavioral healthcare procedures
- Clinical Trials
- Pharmaceuticals
- Devices

The Alliance's new technology evaluation process will include:

- The process and decision variables the plan uses to make determinations, including review of:
 - Member access to services
 - Utilization patterns
 - Patient safety
 - Provider consistency in scope of utilization requests
 - A review of information from appropriate government regulatory bodies, including the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
 - A review of information from published scientific evidence.
 - Obtaining input from relevant specialists and professionals with expertise in the technology.
 - The Alliance's coverage decisions will be based on an assessment of new technology and new applications of existing technology, or on a review of special cases.
-
-

PROCEDURE

A. New and Experimental Technology Criteria Implementation Process

1. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to address recognizing and evaluating advances in medical, surgical, pharmaceutical, and behavioral health care technologies and includes review of the following:
 - a. Medical and Surgical procedures, including transplants
 - b. Drugs and pharmaceuticals
 - c. Behavioral healthcare procedures
 - d. Diagnostic and screening tests
 - e. Alternative therapies

- f. Medical devices/equipment
- g. Clinical interventions
- h. Clinical Trials

B. Annual Review

1. Formal medical policy review (including medical, behavioral health and pharmacy) is conducted once a year using a two-step process requiring input from the Alliance Health Quality Improvement Health Equity Committee (QIHEC).
 - a. The first step in the process is to propose the technologies and changes to technologies to be evaluated
 - b. The second step is the actual revision of existing, or creation of new, policies using special case reviews are conducted throughout the year which are then They are then approved by the CMO in accordance with review processes and timelines. The information from both processes is used for benefit determinations and coverage decisions.

C. UM Medical Director providing a proposed list of services for consideration at QIHEC to CMO

1. The UM Medical Director will provide the proposed list of services and technologies to the CMO along with a summary and rationale for why the services should be evaluated.
2. The CMO, and the appropriate Medical Directors will identify benefit topics for which coverage policy development is indicated, i.e. sufficient benefit guidance/criteria for new or experimental technology are lacking.
3. The Alliance uses appropriate industry resources to develop unbiased, evidenced-based assessments of the safety and efficacy of new, emerging, and controversial health technologies and evaluation of the impact of these technologies on healthcare quality, utilization, and cost.
4. The Alliance Pharmacy Department will evaluate all new drugs that come onto the market within 6 months.

D. Process for the QIHEC preparation and proposal

1. In preparing for the policy review, the UM Medical Director will coordinate the collection of necessary information about new and/or experimental technology and new uses of existing technology for review by the CMO, who will then propose to the QIHEC the subject areas to be evaluated:
2. The CMO will present the list to the QIHEC for discussion and approval.
3. 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.

E. Process following QIHEC Approval

1. 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.

F. Development of specific coverage policies

1. The UM Medical Director, Pharmacy Director and BH Director will develop an initial assessment for specific each new or experimental technology topic consisting of an evaluation of scientific evidence to form conclusions about the benefits/risks of a particular device, therapy, procedure, diagnostic test, or preventive strategy in relation to its potential clinical use for a defined group of individuals.

G. CMO Review and approval of draft coverage policies and final approval at QIHEC

1. The CMO reviews the draft coverage policies that are developed and presents the review of new and/or experimental technology research findings to the QIHEC (and P&T for applicable pharmaceutical technology) for discussion and decision.
2. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

H. Policy Distribution to Providers

1. Following CMO approval, each Coverage Policy Statement will be made available to providers through:
 - a. Announcement of policy publication and availability in the next scheduled Provider Bulletin
 - b. Contacting the UM Department at to request policy copies
 - c. Posting on Alliance website Provider Portal (when feature is available).

I. Clinical Trials Coverage

1. For D-SNP coverage of Clinical Trials, the Alliance is responsible for verifying the proposed Clinical Trial falls into one of two categories:
 - a. Trials that are automatically covered are trials that meet one of the following criteria:
 - i. Funded by NIH, CDC, AHRQ, CMS, DOD, or VA;
 - ii. Supported by groups funded by those agencies;
 - iii. Conducted under FDA-reviewed INDs;
 - iv. IND-exempt drug trials (temporarily covered until self-certification is implemented).
 - b. Other trials may be considered but they must meet all of the following:
 - i. Study an item/service within a Medicare benefit category;
 - ii. Have therapeutic intent (not just testing toxicity or pathophysiology);
 - iii. Enroll patients with diagnosed disease (except healthy controls in

diagnostic trials).

2. Clinical Trials must also meet the following characteristics to be considered medically necessary for the members:

- a. The Aim must be to improve health outcomes;
- b. They must be supported by scientific literature;
- c. They do not create a duplication of existing studies;
- d. They must be properly designed and conducted with scientific and regulatory integrity.

3. The Alliance must be responsible for covering the Routine Costs associated with the Clinical Trials. These include:

- a. Standard care patients would receive outside a trial;
- b. Items/services needed to deliver or monitor the investigational service;
- c. Treatment/prevention of complications.

4. The Alliance is not responsible for the following costs associated with the clinical trials:

- a. Investigational item/service (unless otherwise covered);
- b. Eligibility screenings not related to medical care;
- c. Extra tests for data collection;
- d. Items/services typically provided free by study sponsors;
- e. Statutorily non-covered services (unless treating complications).

~~11. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to address recognizing and evaluating advances in medical, surgical, pharmaceutical, and behavioral health care technologies and includes review of the following:~~

- ~~a. Medical and Surgical procedures, including transplants~~
- ~~b. Drugs and pharmaceuticals~~
- ~~c. Behavioral healthcare procedures~~
- ~~d. Diagnostic and screening tests~~
- ~~e. Alternative therapies~~
- ~~f. Medical devices/equipment~~
- ~~g. Clinical interventions~~
- ~~h. Clinical Trials~~

~~12. 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 (QHIEC). 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 QHIEC 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.~~

~~13. 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~~

Formatted: Centered

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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

21. Following CMO approval, each Coverage Policy Statement will be:

a. 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

Formatted: Normal, Centered, No bullets or numbering

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Indent: Left: 0.15", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered

Formatted: Centered, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Centered, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Centered, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: Centered, Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Indent at: 2"

Formatted: Centered, Indent: Hanging: 0.26", Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Indent at: 2"

Formatted: Centered

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 testing is not complete:

~~d.a.~~ The efficacy and safety of such services in human subjects is not yet established; and

~~e.b.~~ The service is not in wide usage.

Technology Assessment - A process established to evaluate the appropriate use of new technologies, new applications of existing technologies and the organizational or supportive systems within which such care is delivered. Services, procedures, pharmacological treatments, and behavioral health procedures are reviewed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES 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, 4/15/2025

REFERENCES

[CMS National Coverage Determination \(NCD\) for Routine Costs in Clinical Trials \(CMS Pub.100-03, Section 310.1\)](#)

NCQA UM 10 Evaluation of New Technology

Title 42, CFR, Section 422.202(b)

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.

approval

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, S-SNP
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Purpose:

To establish a comprehensive, compassionate and regulatory-compliant approach to hospice and terminal illness care ensuring patient dignity, comfort and appropriate medical management.

Scope:

This policy applies to all healthcare professionals involved in the care of terminally ill members.

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. Family 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. Bereavement Services providing counseling to family members up to 12 months following the death of the member
 13. 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 or D-SNP elects the hospice benefit. See APL 13-014 for reimbursement guidelines.
- J. Hospice services provided for Alameda Alliance Wellness D-SNP are covered under traditional Medicare FFS. Alameda Alliance Wellness does not manage these services directly. Alameda Alliance Wellness D-SNP coordinates and facilitates transitions into hospice care to ensure members' needs are met during this period. Individualized Care Plans are updated to reflect the transition to hospice by the Care Management Team and the Interdisciplinary Care Team (ICT) is notified.
- K. For Medi-Cal 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
- UM-011 Coordination of Care - Hospice Services

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.
- L. Alameda Alliance for Wellness D-SNP services not covered by FFS Medicare Hospice include:
1. Curative treatments
 2. Non-Hospice provider care
 3. Room and board
 4. Emergency room visits unless coordinated by hospice for hospice related care
 5. Ambulance transport not coordinated by hospice for hospice related care
 6. Prescription drugs intended to cure the terminal illness
 7. Experimental treatments
- M. CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent non-palliative services. See DHCS APL 18-020 Palliative Care

Terminal Illness

The Alliance will comply with CA Health and Safety Code and Centers for Medicare and Medicaid (CMS) regulatory guidance when making service request decisions for enrollees who have been diagnosed with a terminal illness.

PROCEDURE



Hospice 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.

- A. 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 provider
 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 and D-SNP benefits are waived by the election.
 3. The effective date of the election
 4. The signature of the Member or representative.
- B. 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.
- C. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.
- D. 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. National Coverage Determinations and Local Coverage Determinations are also utilized for D-SNP members.
4. 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
 1. Documents to be submitted for authorization include:
 1. Certification of physician orders for general inpatient care.
 2. Justification for this level of care.
5. 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. Title 42, CFR §418.24 Election of Hospice Benefit
 3. 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. Terminal Illness: A medical condition where life expectancy is six months or less if the illness runs its normal course.
- D. 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)
- E. 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

CMP-019

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. DHCS APL 18-020 Palliative Care
 - B. CA Health and Safety Code §1368.1(a) (b)
 - C. DHCS Contract, Exhibit A, Attachment 10, Provision 8.
 - D. Health and Safety Code §1339.31(b)
 - 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. Title 42, CFR, §418.3
 - I. Title 42, CFR §418.24 Election of Hospice Benefit
 - J. Social Security Act §1905(0)(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.



Formatted: Font: 12 pt

POLICY AND PROCEDURE

Policy Number	UM-014
Policy Name	Identifying and Reporting Potential Child, Adult or Elder Abuse
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>5/17/2024TBD</u>
Administrative Oversight Committee Approval Date	<u>7/17/2024TBD</u>

POLICY STATEMENT

PCPs are responsible for the overall health care of assigned Members including the identification and reporting of suspected child, adult, or elder abuse cases.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Right: 0.15"

Formatted: Font: 12 pt

PROCEDURE

A. Information sources available to network practitioners to assist with the identification of possible Member abuse cases include the following:

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.47", Space Before: 0 pt, No bullets or numbering

1. Requests by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;

Formatted: Right, Indent: Left: 0.82", Space Before: 0 pt, No bullets or numbering

2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

3. Hospitalization of a Member for suspicious trauma, illness, or injury;

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

4. Office visits with Pediatricians, PCPs, Behavioral Health providers and other health care practitioners that reveal unusual physical or emotional findings;

Formatted: Normal, No bullets or numbering

Formatted: Space Before: 0 pt

a. During the administration of the ACES screen, the PCP, Pediatrician or Behavioral Health provider may identify instances of potential child abuse/neglect.

Formatted: Numbered + Level: 4 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.17" + Indent at: 1.42"

— Grievance and Appeal Process: D-SNPs must maintain accessible grievance

procedures per 42 CFR §§ 422.561–422.564 and § 422.630, enabling members to report abuse of neglect directly to the plan.

5.

6. Cases identified during the Utilization Management, Case Management, Long-Term Care, CCS, or Behavioral Health processes;

- D-SNP members receiving LTSS Services through the MCP are required to be asked questions during their Health Risk Assessment (HRA) related to Abuse and Neglect as a potential Social Determinante of Health Risk Factor.

B. Requests for assistance received by Member Services;

7.

Formatted: Font: 12 pt

Commented [WM1]: [@Finklater, Michelle](#) The only other thing I can think to add would be annual internal staff training on abuse recognition and reporting.

Also, this policy seems to be provider facing, but are there currently any resources that are provided or available to members to help recognize and report abuse on a general level? If so, this could be mentioned.

Commented [MF2R1]: [@Williams, Mollie](#) since this is a G&A requirement would it be a training provide/. Assigned by them? [@Pena, Alina](#)

Commented [PA3R1]: We comply with the requirements mentioned in these sections. They do not call for G&A to do training to members. Member's are informed of their grievance and appeals rights in the EOC, public website and member portal.

Commented [AL4R1]: [@Finklater, Michelle](#) [@Williams, Mollie](#) - can you please confirm whether this is ready to move into NAVEX for SLT review?

Commented [MF5R1]: [@Lam, Allison](#) Its ready- will update tracker.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Right, Indent: Left: 1.52", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Commented [MF6]: Abuse and Neglect (Social Determinants Risk Factor) Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No) Question 6b: Is anyone using your money without your ok? (Yes/No) This is in the DSNP Policy Guide 2025- seems appropriate here- but want to make sure [@Glasby, Kimberly](#) agrees. Also [@Hester, Jill](#) are there any specific abuse questions required in your HRAs?

Commented [MF7R6]: [@Glasby, Kimberly](#)

Commented [GK8R6]: [@Finklater, Michelle](#) I have not seen the HRA. [@Hester, Jill](#) Is this the HRA?

Commented [HL9R6]: I edited the sentence to read, "DSNP members receiving LTSS Services through the MCP are asked questions during their Health Risk Assessment (HRA) related to abuse and neglect as a potential social determinant of health risk factor."

There are a series of questions in the HRA that refer to various types of abuse (physical/emotional, financial, etc.).

Formatted: Right, Indent: Left: 1.52", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

B. Healthcare providers must be alert for signs of physical or mental abuse including, but not limited to, the following signs and symptoms:

C.

1. Abuse Perpetrated by Others (WIC 15610.07 & 15610.63)
 - a) Physical (e.g. assault/ battery, constraint or deprivation, chemical restraint, over/ under medication)
 - b) Sexual
 - c) Financial
 - d) Neglect (including Deprivation of Goods and Services by a Care Custodian)
 - e) Abandonment
 - f) Isolation
 - g) Abduction
 - h) Psychological/ Mental
2. Self-Neglect (WIC 15610.57 (b)(5)):
 - a) Neglect of physical care (e.g. personal hygiene, food, clothing, malnutrition/ dehydration)
 - b) Neglect of Residence (unsafe environment)
 - c) Financial Self-Neglect (e.g. inability to manage one's own personal finances)

D.

C. Alameda Alliance for Health and Alameda Alliance Wellness (The Alliance) network practitioners are responsible for filing reports of suspected child and elder abuse to the appropriate agencies as follows:

Child Abuse:

Alameda County

Social Services Agency, Child, and Family Services

Child Protective Services

(510) 259-1800

Adult and Elder Abuse:

Alameda County Social Services Agency

Department of Adult and Aging Services

Adult Protective Services

(510) 577-3500

D. Long-Term Care members residing in facilities such as Skilled Nursing Facilities, Sub-Acute Facilities, Long-Term Acute Care (LTAC) Facilities and Intermediate Care Facilities for the Developmentally Delayed (ICF/DD) are responsible to notify the Office of the Ombudsman with any reports of Abuse.

a-1.

- Long-Term Care Ombudsman representatives assist residents in Long-Term Care facilities with issues related to day-to-day care, health, safety, and personal preferences. Problems can include, but are not limited to:
- a. Violation of residents' rights or dignity
 - b. Physical, verbal, mental, or financial abuse
 - c. Poor quality of care
 - d. Dietary concerns
 - e. Medical care, therapy, and rehabilitation issues

Formatted: Indent: Left: 0.37", Space Before: 0 pt, No bullets or numbering

Formatted: Left, Space Before: 0 pt

Formatted: Left, Indent: Left: 0.37", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.52", Hanging: 0.2", Space Before: 0 pt

Formatted: Indent: Hanging: 0.2", Space Before: 0 pt

Formatted: Right, Indent: Left: 1", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.52", Hanging: 0.2", Space Before: 0 pt

Formatted: Indent: Left: 0.81", Hanging: 0.19", Space Before: 0 pt, Tab stops: 0.94", Left + Not at 0.72" + 0.72"

Formatted: Indent: Hanging: 0.25", Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Right, Indent: Left: 1.06", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.82", Space Before: 0 pt, No bullets or numbering

Formatted: Left, Space Before: 0 pt

Formatted: Space Before: 0 pt, Line spacing: single

Formatted: Line spacing: single

Formatted: Space Before: 0 pt, Line spacing: single

Formatted: Space Before: 0 pt

Formatted: Font: 11 pt, Not Italic

Formatted: Left, Indent: Left: 0", First line: 0", Right: 0"

Formatted: Font: Times New Roman, 11 pt, Font color:

Formatted: Font: Times New Roman, 11 pt, Font color:

Auto

Formatted: Font: Times New Roman, 11 pt, Font color:

Formatted: Right, Indent: Left: 0.47", Space Before: 0 pt, After: 0 pt, No bullets or numbering, No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Pattern: Clear

Formatted: Font: Times New Roman

Formatted: Space Before: 0 pt, After: 0 pt, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.47" + Indent at: 0.82"

Formatted: Space Before: 0 pt, After: 0 pt

- f. Medicare and Medi-Cal benefit issues
- g. Improper transfer or discharge of a resident
- h. Inappropriate use of chemical or physical restraints

b.2. Alameda Alliance for Health The Alliance Staff and Network Practitioners are responsible for filing reports of suspected child and elder abuse to the appropriate agencies as follows:

*Department of Adult and Aging Services
Long-Term Care Ombudsman
(510) 638-6878*

3. Alameda Alliance for Health The Alliance is also responsible to report any Critical Incidents as defined by DHCS on a quarterly basis for those members residing in a Long-Term Care Facility.

4. Alameda Alliance for Health The Alliance is responsible to ensure that the contracted network of providers are in compliance with 42 C.F.R. §§483.13(c)(2)(3) and (4).

a. Providers must report any alleged violations including:

- Mistreatment
- Neglect
- Abuse
- Injuries from an Unknown Source
- Misappropriation of resident Property

E. Reporting Timeframes:

1. The facility must follow the timeframes established in the regulations; that is, the facility must ensure that all alleged violations are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency in accordance with 42 C.F.R. §483.13(c)(2), and the results of all investigations must be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) within 5 working days of the incident in accordance with 42 C.F.R. §483.13(c)(4).

e-2. CMS believes “immediately” means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state timeframe requirement. Conformance with this definition requires that each state has a means to collect reports, even on off-duty hours (e.g., answering machine, voice mail, fax).

F. PCPs, Pediatricians or Behavioral Health providers may request assistance from the Case Management department to facilitate coordination of care for members for whom mandatory reporting is required.

F.G. Delegated Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management

Formatted: Font: Times New Roman

Formatted: Indent: Left: 1.5", Space Before: 0 pt, After: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.47" + Indent at: 0.82"

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Right, Indent: Left: 0.82", No bullets or numbering

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.47" + Indent at: 0.82"

Formatted: Indent: Left: 0.94", Hanging: 0.19", Outline numbered + Level: 3 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 2.25" + Indent at:

Formatted: Bulleted + Level: 4 + Aligned at: 1.17" + Indent at: 1.52"

Formatted: Right, Indent: Left: 1.52", No bullets or numbering

Formatted: Right, Indent: Left: 0.47", No bullets or numbering

Formatted: Right, Indent: Left: 0.82", No bullets or numbering

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.47" + Indent at: 0.82"

Formatted: Right, Indent: Left: 0.47", Space Before: 0 pt, No bullets or numbering

Formatted: Left, Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.17" + Indent at: 0.47"

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

1. **Critical Incidents:** Reportable to DHCS on a quarterly basis, Critical Incidents are defined as occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, and any instances of suspected or alleged abuse, neglect, exploitation and/or mistreatment.
2. **Mistreatment** - (A definition is not provided at this time.) •
3. **Neglect** - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 C.F.R. §488.301). •
4. **Abuse** - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. §488.301). •
5. **Injuries of unknown source** - An injury should be classified as an “injury of unknown source” when both of the following conditions are met:
 - The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and,
 - The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.
6. **Misappropriation of resident property** - The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent (42 C.F.R. §488.301).

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation OversightNone

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024, 5/20/25

REFERENCES

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Line spacing: single

Formatted: Line spacing: single, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Line spacing: single, Bulleted + Level: 2 + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: Bold

Formatted: Line spacing: single, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Line spacing: single

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Line spacing: single

Formatted: Space Before: 0 pt

Formatted: Line spacing: single

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

42 C.F.R. §§483.13(c)(2)(3) and (4).

42 C.F.R. §488.301

Adult Protective Services Program Form SOC 341A

CA Welfare and Institutions Codes WIC 15610.07 & 15610.63 & 15610.57 (b)(5));

DHCS APL 22-018

DHCS CalAIM D-SNP Policy Guide 2025

DHCS Contract Exhibit A, Attachment 11

(WIC 15610.07, WIC 15610.57 (b)(5)) & 15610.63)

DHCS APL 22-018

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 annually.

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt



Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-023
Policy Name	Communicable Disease Reporting and Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	10/12/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	<u>TBD 11/15/2024</u>
Administrative Oversight Committee Approval Date	<u>TBD 12/18/2024</u>

POLICY STATEMENT

- A. The Alliance requires that requires health care practitioners follow all applicable Federal, State, and local statutes, regulations, or ordinances for the reporting of communicable diseases, and to implement directives from public health authorities. Practitioners or Providers must ensure that any Member with a reportable communicable disease is reported to public health authorities according to the appropriate statutes, regulations, or ordinances
- B. Failure to report communicable diseases as required by statute, regulation or ordinance can result in negative action taken by the Medical Board of California or the Alliance as circumstances warrant.
- ~~C. Providers are informed of directives from public health authorities, including their responsibilities for reporting communicable diseases in the Provider Manual. As new directives, including reporting communicable disease are received from public health authorities, Providers will be informed of the new requirements through communication with their offices and the new requirements will be added to the Provider Manual.~~
- ~~D. PCPs are required to:~~
- ~~1. Perform skin testing for tuberculosis (TB) based on the most recent recommended guidelines from the Centers for Disease Control and Prevention (CDC) 'Core Curriculum on Tuberculosis', the American Thoracic Society (ATC) and/or the at-risk status of the Member. Copies of the CDC's curriculum can be downloaded~~

Formatted: Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Left, Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

from the Internet through the CDC web page at www.cdc.gov. California TB Control Guidelines are available through the California Tuberculosis Controllers Association's (CTCA) webpage: www.ctca.org.

- ~~2. Perform the initial diagnostic work-up for TB based on the latest recommended guidelines by the CDC guidelines "Core Curriculum on Tuberculosis".~~
- ~~3. Report all confirmed or suspected active TB cases to the Local Health Department (LHD).~~
- ~~4. Treat, diagnose, and coordinate care for Members with confirmed or suspected active TB.~~
- ~~5. Hospitals are required to report any Member with active TB admitted to an inpatient unit to the Alliance by the next normal business day (Monday-Friday).~~

~~E.C.~~ AAH provides all medically necessary covered services to members with TB while on Direct Observed Therapy (DOT).

PROCEDURE

- A. The date of public health authority contact, name of contact, and signature of contacting person is documented in the medical record. Reporting is conducted in accordance with the following:

- ~~1. State law requires that health care practitioners report specified communicable diseases. Physicians, nurses, dentists, coroners, laboratory directors, school officials and other people knowing of a case or suspected case of any of the diseases or conditions listed in Section C are required to report them to the local Department of Health. (California Administrative Code, Title 17, Sections 2500, 2502, 2503, 2504, 2505 and 2508).~~

- ~~2. The report to the public health authorities shall be documented in the Member's Medical Record and include the report date, the contact at the public health authority, and the reporter's signature.~~

- ~~3. Animal bites by a species susceptible to rabies are reportable in order to identify persons potentially requiring prophylaxis for rabies. Additionally, vicious animals are identified and may be controlled by this regulation and local ordinances (California Administration Code, Title 17, Sections 2606 et seq., and California Health and Safety Code sections 1900-2000). Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing your report.~~

~~Alameda County Animal Control Sites~~

Commented [WM1]: This can be removed, it is covered in the procedure.

Commented [MF2R1]: done

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Tab stops: 6.44", Left

Formatted: Left, Tab stops: 6.44", Left

Alameda City Animal Services Phone: 510-337-8565 https://www.alamedaca.gov/Departments/Animal-Services	Berkeley Animal Care Services Phone: 510-981-6600 http://www.ci.berkeley.ca.us/animalservices
Dublin Animal Shelter Phone: (925) 803-7040 https://dublin.ca.gov/113/Animal-Control	Fremont, Newark, Union City, San Leandro: Tri-City Animal Shelter Phone: (510) 790-6630 https://www.fremontpolice.gov/about-us/administrative-operations-division/animal
Hayward Animal Services Phone: (510) 293-7200 https://www.hayward-ca.gov/police-department/public-services/animal-services	Oakland Animal Services Phone: (510) 535-5602 http://www.oaklandanimalservices.org/services

Alameda Alliance's

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Tab stops: 6.44", Left

B. Providers and practitioners must use the following guidelines for Public Health reporting:

1. Extremely Urgent Conditions (*) - should be reported immediately by telephone, 24 hours a day, to the after-hour emergency number listed below.
2. Other Urgent Conditions (+) - should be reported by telephoning, mailing, or electronically submitting a report within one (1) working day of identification of case or suspected case.
3. All Other Non-Urgent Conditions may be reported by phone or by mail on confidential morbidity report cards within seven (7) days of identification.

C. PCPs are required to refer all confirmed (class III) or highly suspected (class V) active TB cases, pulmonary or extra pulmonary, to the Local Health Department (LHD) in Alameda County. The cases must be reported on the same day of suspicion or diagnosis, by phone.

D. PCPs are required to cooperate with any request from the LHD for medical records, diagnostic test results, and any other pertinent clinical, case contact, or administrative information.

E. Local Health Departments (LHDs) are responsible for receiving disease reports and coordinating follow-up action between local, regional, and state officials. ~~In some cases, reporting requirements may differ slightly from one county to the next. Questions about communicable disease reporting should be directed to your LHD.~~

F. Investigations of reportable communicable diseases by Local or State Health Departments (source case/case contact follow-up investigations) are exempt from HIPAA regulation and all information requests shall be provided.

D.I. No patient consent for release of information is needed.

Alameda County Public Health Department
Division of Communicable Disease Control & Prevention
1100 San Leandro Boulevard, San Leandro, CA 94577 Phone: (510) 267-3250 (M-F, 8-5) Phone: (925) 422-7595 (After hours, Weekends) Website: http://www.acphd.org/
A-Z Listing: Communicable Disease Control & Prevention
Alameda County Public Health Department
Tuberculosis Control Program
Phone: (510) 667-3096 www.acphd.org/tb/tb-control.aspx
A-Z Listing: Tuberculosis Control Program – (Clinicians)
City of Berkeley Public Health Department
Communicable Disease Reporting

Formatted: Left, Right: 0.59", Tab stops: 6.44", Left

Formatted: Left, Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

Formatted: Left, Right: 0.72", Space Before: 3 pt, Tab stops: 0.97", Left + 0.98", Left + 6.44", Left + Not at 0.78"

Formatted: Font: 12 pt

Formatted: Left, Tab stops: 6.44", Left

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Tab stops: 6.44", Left

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Tab stops: 6.44", Left

Formatted: Left, Tab stops: 6.44", Left

Formatted: Font: 12 pt

Guidelines for TB Diagnosis and Treatment

Alliance Providers are required to follow the most current TB diagnostic and treatment guidelines recommended by the CDC "Core Curriculum on Tuberculosis".

Screening for TB Infection

- For Members ages 0 to 21 years of age, an assessment for risk factors for developing TB and a TB skin test must be provided in compliance with American Academy of Pediatrics (AAP), American Thoracic Society, and Centers for Disease Control and Prevention guidelines and must be provided within 120 days of enrollment with the Alliance. Members are screened for risk of exposure to TB at each subsequent health assessment visit, thereafter.
- For adult Members, an assessment of risk for developing TB is performed as part of the Initial Health Assessment, required within 120 days of enrollment into the Alliance according to American Thoracic Society, and Centers for Disease Control and Prevention. All Alliance Members with an increased risk of TB are offered TB testing unless they have documentation of prior positive test results or TB disease.
- The Alliance requires PCPs to use the Mantoux tuberculin test screen for TB and/or QuantiFERON test when it becomes readily available. In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN or PA may read the skin test results. Per Title 16, CCR, Sections 2880.2884 and 1366 (b) (2), the Licensed Vocational Nurse (LVN) and the Medical Assistant (MA) are not legally authorized to perform independent analysis, interpretation, and evaluation of data; this regulation applies to the interpretation of TB test results. The LVN and MA are permitted to measure and record the results in millimeters in the Member's medical record, and report findings to the Provider.
- Members who test positive on the Mantoux skin test and have no evidence of active TB on chest x ray and/or symptom review, must be evaluated for TB preventive therapy and treated, if appropriate, per CDC guidelines "Core Curriculum on Tuberculosis".

Diagnosis of Active Tuberculosis

- PCPs are required to initiate the diagnostic work-up for Members suspected of having active TB. Diagnostic workups should be performed per the latest CDC guidelines "Core Curriculum on Tuberculosis".
- Potential cases of active TB can include PPD positive individuals (unless infected with HIV or are otherwise immunocompromised) with the following signs, symptoms, or findings:
 1. Abnormal chest x ray not typical for pneumonia, particularly upper lobe disease;
 2. Bronchitis or pneumonia unresponsive to antibiotics;
 3. Persistent unexplained constitutional symptoms such as unexplained weight loss, fever, drenching night sweats;
 4. Hemoptysis; or

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.48" + Indent at: 0.78", Tab stops: 6.44", Left

~~5. Persistent productive cough $\geq$ 3 weeks not due to asthma, bronchitis, or pneumonia.~~

~~• The diagnostic evaluation for potential active TB can include the following:~~

~~1. Chest x-ray, including lordotic views;~~

~~2. Sputum smear for mycobacteria;~~

3. Sputum culture for mycobacteria and anti-TB drug sensitivity testing;
 4. Bronchoscopy with biopsy, washings, smear and/or culture;
 5. Chest CT scan; and
 6. Lymph node or other TB-suspect biopsy sent for pathologic diagnosis and mycobacterium TB.
- PCPs are required to refer all confirmed (class III) or highly suspected (class V) active TB cases, pulmonary or extra-pulmonary, to the LHD in Alameda County. The cases must be reported on the same day of suspicion or diagnosis, by phone. A phone call must be made to the appropriate Tuberculosis Program (See page 6);
 - PCPs are required to cooperate with any request from the LHD for medical records, diagnostic test results, and any other pertinent clinical, case contact, or administrative information

G. Case Management

1. Alliance's Network of PCPs are required to inform their Delegated Medical Group or the Alliance's Medical Services staff of any Member referred to the LHD Tuberculosis Program for active or highly suspected active TB.
2. Alliance staff, with LHD Tuberculosis Program collaboration, must identify and address barriers to patient compliance with self-administered treatment. To improve adherence, The Alliance's formulary offers fixed-dose combination drug preparations.
3. Alliance Medical Services staff coordinates care for Members who have active TB and other co-morbid medical conditions such as those listed as reportable by California Department of Public Health. Reportable Disease and Conditions.

H. Direct Observed Therapy

1. Direct Observed Therapy (DOT) for the treatment of Tuberculosis is provided by the LHD and is not covered by the Alliance.
- PCPs must assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy. The following groups of individuals are at risk for non-compliance for treatment of TB:
 1. Members with any demonstrated drug resistance (especially multiple drug resistance to Isoniazid and Rifampin);
 2. Members whose treatment has failed or who have relapsed after completing a prior regimen;
 3. Children and Adolescents;
 4. Members with substance abuse or psychiatric diagnoses; and
 5. Members who have demonstrated non-compliance (those who failed to keep office appointments).
 6. The following groups of Members also must be monitored for potential noncompliance and for consideration for DOT: substance abusers, persons-

Formatted: Font: Not Bold

Formatted: Left, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

Commented [WM3]: @Findlater, Michelle Is this "co-morbid medical conditions" referring to the active TB member or members with other communicable disease processes. If it is specifically referring to the TB member, then I think we need to add a separate bullet under the Case Management heading to speak to other members having different communicable diseases that would still benefit from CM services.

Commented [AL4R3]: @Junier, Lily tagging you here for review, as well.

Commented [MF5R3]: @Rosales, Jorge

Commented [RJ6R3]: @Findlater, Michelle yes, we assist with other communicable diseases. put link to state site with full list. also added City of Berkeley Public Health Dept info above.

Commented [MF7R3]: Looks great- thank you Jorge!

Formatted: Indent: Left: 0.98", No bullets or numbering, Tab stops: 6.44", Left

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.48" + Indent at: 0.78", Tab stops: 6.44", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Indent: Left: 0.72", Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

- ~~with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.~~
- ~~• PCPs must inform the LHD's TB Control Program of Members with active TB and who have any of these risks.~~

approval

- *2. For Members receiving treatment for TB disease, the PCPs must share clinical information with the LHD's TB Control Program as needed and requested.
- *3. The PCP must promptly notify the LHD TB Control Program of any significant changes in the Member's condition, failure to keep appointments, decision to discontinue medications, change in address, or response to medical treatment including adverse drug reactions and dosage changes.
- *4. The Alliance provides all medically necessary medication for Members with TB, via the contracted pharmacies.
- 5. AAH: The Alliance provides all medically necessary covered services to members with TB while they are on DOT following the UM Hierarchy outlined in the UM Program Description and all DHCS and CMS regulations.

I. Hospital Transfers and Discharge

- *1. Hospital infection control staff, including the attending physician, are required to submit a hospital discharge plan to the LHD for approval prior to discharge or transfer of an inpatient case of active TB, per California Health and Safety Code, Section 121361. No patient will be discharged or transferred, unless the transfer is necessary for medical/surgical emergencies, without prior written approval of the LHD.
- 2. Hospital personnel must use the required form provided by the LHD. This form is available online.

J. Reporting

- 1. A list of reportable diseases, reporting timeframes and reporting methods are available from the California Department of Public Health Website under the Division of Communicable Disease Control, Reportable Diseases and Conditions Website.
- 2. Alliance Providers are required to comply with all State laws and regulations pertaining to reporting of confirmed and suspected TB cases to the LHD. Alliance Providers must report known or suspected cases of TB to the LHD TB control programs within one day of identification per Title 17, CCR, Section 2500. ~~(see Policy 10K, "Reporting Communicable Diseases to Public Health Authorities")~~.
- 3. The local health officer may, per State law, require Alliance practitioners at any time to report any clinical information deemed necessary by the local health officer to protect the Member's health or the health of the public.

K. Contact Investigation and Treatment

- 1. The Alliance requires that all PCPs and Delegated Medical Groups cooperate with the LHD in conducting contact and outbreak investigations potentially involving Members. The Alliance is available to facilitate and if necessary, direct the coordination efforts between the LHD and Alliance PCPs and Delegated Medical

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

Formatted: Indent: Left: 0.98", No bullets or numbering, Tab stops: 6.44", Left

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.48" + Indent at: 0.78", Tab stops: 6.44", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

Formatted: Indent: Left: 0.98", No bullets or numbering, Tab stops: 6.44", Left

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.48" + Indent at: 0.78", Tab stops: 6.44", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Tab stops: 6.44", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Indent: Left: 0.98", No bullets or numbering, Tab stops: 6.44", Left

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.48" + Indent at: 0.78", Tab stops: 6.44", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Groups.

1. The Alliance requires PCPs and Delegated Medical Groups to provide appropriate examination and treatment to Members identified by the LHD as contacts in a timely manner (usually within seven days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner. The Alliance coordinates with PCP and the Delegated Medical Groups to promptly notify the LHD Tuberculosis Program staff when contacts of Members are referred to the LHD Tuberculosis Program staff for care.

2.

L. Laboratory Services

1. Sputum smears and cultures must be obtained from Members with pulmonary TB at least monthly, or as clinically indicated, until culture results are documented negative for two consecutive months. More frequent monitoring may be required for multidrug-resistant TB or cases with poor treatment response, and alternative diagnostics may be used when sputum collection is not feasible.

M. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management

Formatted: Tab stops: 6.44", Left

Formatted: Indent: Left: 0.98", No bullets or numbering, Tab stops: 6.44", Left

Commented [WM8]: Added this blurb in to cover more clinical situations such as the multidrug resistance and pediatrics. If the testing once monthly is the only thing covered, then we can take it out.

Commented [MF9R8]: Looks good

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.73" + Indent at: 0.98", Tab stops: 6.44", Left

Formatted: Tab stops: 6.44", Left

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.48" + Indent at: 0.78", Tab stops: 6.44", Left

Formatted: Indent: Left: 0.72", Tab stops: 6.44", Left

responsibilities will also need to comply with the same standards. Refer to CMP- 019 for monitoring of delegation oversight.

Formatted: Tab stops: 6.44", Left

Formatted: Font: 12 pt

Formatted: Font: 12 pt

DEFINITIONS

Centers for Disease Control and Prevention (CDC) focuses national attention on developing and applying disease control and prevention.

Formatted: Indent: First line: 0", Right: 0.75"

Local Health Department (LHD) a governmental agency that provides public health services at the community level, focusing on promotion health and preventing disease among residents. None.

Formatted: Indent: Left: 0.46", First line: 0.04"

Formatted: Right: 0.75"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

Formatted: Font: 12 pt

Formatted: Font: 12 pt

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight and MonitoringNone.

Formatted: Font: 12 pt

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

Formatted: Font: 12 pt

REVISION HISTORY

Formatted: Font: 12 pt

Formatted: Font: 12 pt

1/1/2008, 1/16/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 12/18/2024, 05/19/2025

REFERENCES

Formatted: Font: 12 pt

1. California Health and Safety Code, Sections 1900-2000
2. DHCS Contract Exhibit A, Attachment 10.5.C and E; 10. 6. C and 8. F; 11.14 and16; and 12. 2
3. Title 17, CCR, Sections 2500, 2502, 2503, 2504, 2505 and 2508
4. UM Program Description

Formatted: Indent: Left: 0", First line: 0.46"

Formatted: Font: 12 pt

MONITORING

The Compliance and Utilization Department will review this policy annually and as needed for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee (QIHEC) annually.

Formatted: Font: 12 pt

Approval



POLICY AND PROCEDURE

<u>Policy Number</u>	<u>UM-029</u>
<u>Policy Name</u>	<u>Sensitive Services</u>
<u>Department Name</u>	<u>Health Care Services</u>
<u>Department Officer</u>	<u>Chief Medical Officer</u>
<u>Policy Owner</u>	<u>Director Utilization Management</u>
<u>Lines of Business</u>	<u>MCAL, IHSS, D-SNP</u>
<u>Effective Date</u>	<u>1/1/2008</u>
<u>Subcommittee Name</u>	<u>Quality Improvement Health Equity Committee</u>
<u>Subcommittee Approval Date</u>	<u>TBD</u>
<u>Administrative Oversight Committee Approval Date</u>	<u>TBD</u>

POLICY STATEMENT

This policy outlines the process and procedure for Sensitive Services including Family Planning, Sterilization, Sexually Transmitted Diseases (STD), HIV Testing and Counseling and Abortion in compliance with the Informed Consent, Minor Consent Services and freedom of choice regulations.

PROCEDURE

1. Informed Consent - Practitioners must furnish Members with sufficient information, in terms that a Member can understand, so that an informed decision can be made.
 - a. All Alliance and Out-Of-Network family planning services practitioners must obtain informed consent for all contraceptive methods, including sterilization for members <18 years old. Informed consent is also required in the provision of abortion services. In the event that the Member is unable to give consent, his/her legal guardian must make appropriate care decisions as needed.
2. Freedom of Choice
 - a. Members are to be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, and their right to access these services, including abortion services, in a timely and confidential manner.
3. Medi-Cal, Group Care and D-SNP Members are informed upon enrollment of their right to access family planning services and abortion services within and outside of Alliance's

Formatted: Heading 1, Centered, Right: 1.67", Space Before: 4.5 pt

Formatted: Space Before: 0.15 pt

Formatted Table

Formatted: Space Before: 0.4 pt

Formatted: Heading 1, Centered, Right: 1.67"

Formatted: Centered, Space Before: 0.1 pt

Formatted: Justified, Indent: Left: 0.83", Hanging: 0.3", Space Before: 6 pt

Formatted: Heading 1, Centered, Right: 1.67"

Formatted: Indent: Left: 0.22", Hanging: 0.3", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.78", Right: 0.15", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 0.78", Right: 0.15", Space Before: 0 pt, No bullets or numbering

Formatted: Not Highlight

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Network, without prior authorization, via the Member Explanation of Coverage Handbook (EOC), Member Newsletter and/ or their Member Services contacts. California Minor Consent

a. Minors of any age may consent to/receive 'Minor Consent Services' from any Network Provider or Out of Network Provider without a Prior Authorization:

- i. Family Planning services.
- ii. Medical care related to the prevention or treatment of pregnancy, except sterilization for members <18 years old.
- iii. Birth control.
- iv. Abortion.
- v. Emergency medical services when parent/guardian unavailable to give consent.
- vi. Medical care related to diagnosis, treatment and collection of medical evidence related to a sexual assault.
- vii. Medical care related to diagnosis, treatment and collection of medical evidence related to the rape of a minor under age 12.

b. Minors aged 12 and older may consent to/receive:

- i. Medical care related to diagnosis, treatment of a sexually transmitted disease (STD).
- ii. An HIV test and diagnosis, treatment of HIV/AIDS.
- iii. Drug or alcohol abuse
- iv. Non-Specialty Mental Health Services, when mature enough to participate in their health care.

4. Family Planning

a. Family planning services are defined as services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self- refer, without prior authorization, to a qualified family planning practitioner within the Alliance Network, or self-refer to qualified Out-Of-Network family planning practitioners, also without prior authorization as described in the member's Explanation of Coverage handbook

b. 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:

- i. Health education and counseling necessary to make informed choices and understand contraceptive methods;
- ii. Verbal history and physical examination limited to immediate problem;
- iii. Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods;
- iv. Follow-up care for complications associated with contraceptive methods issued by the family planning practitioner;
- v. Provision of contraceptive pills, devices, supplies;
- vi. Provision and insertion of Norplant;
- vii. Tubal ligation;
- viii. Vasectomies;
- ix. Pregnancy testing and counseling;
- x. Diagnosis and treatment of STDs if medically indicated (STD diagnosis and treatment, provided during a family planning encounter are considered part of family planning services); and
- xi. Screening, testing and counseling of at-risk individuals for HIV (HIV testing and counseling, provided during a family planning encounter, are considered

Formatted: Indent: Left: 0.53", Space Before: 0 pt

Formatted: Indent: Left: 1", Hanging: 0.16", Right: 0.69", Space Before: 0 pt

Formatted: Indent: Left: 0.94", Hanging: 0.22", Space Before: 0 pt

Formatted: Indent: Left: 0.94", Hanging: 0.22", Right: 0.23", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Space Before: 0 pt

Formatted: Indent: Left: 0.88", Hanging: 0.28", Right: 0.38", Space Before: 0 pt

Formatted: Indent: Left: 0.88", Hanging: 0.28", Space Before: 0 pt

Formatted: Indent: Left: 0.88", Hanging: 0.28", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 0.5", Space Before: 0 pt

Formatted: Tab stops: 0.52", Left

Formatted: Indent: Left: 0.5", Space Before: 0 pt

Commented [AL1]: Thomson, Michelle of Indiant, Michelle - can we confirm this list of family planning benefits/parameters will apply to D-SNP?

The 2025 D-SNP EOC says the below, but perhaps we will need to modify this to align with our benefit design?

"We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:

- treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)
- treatment for AIDS and other HIV-related conditions
- genetic testing"

Commented [TM2R1]: Meyers, Tom please confirm. This should be included because our benefits for D-SNP

Commented [TM3R1]: Edited to include D-SNP

Commented [MF4R1]: Looks good

Formatted: Indent: Left: 1", Right: 0.16", Space Before: 0 pt

Formatted: Indent: Left: 1", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.16", Space Before: 0 pt

Formatted: Indent: Left: 1", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

- part of family planning services).
- xii. Licensed Midwife Services
- c. The follow list of services are not included within the Family Planning Benefit provided to Alliance Members:
- i. Therapeutic and elective abortions are not considered a part of family planning services.
 - ii. Infertility studies, reversal of voluntary sterilization, and hysterectomy for sterilization<18 years old are not included under the Family Planning benefit. For D-SNP some treatments for infertility services may be covered (Not included are artificial ways to become pregnant.)
- d. Accessing Family Planning Services
- i. AAH does not infringe upon any member's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.
 - ii. AAH defers to the determination and judgment of the provider and provides coverage for an alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the member's provider.
 - iii. Out-of-Network family planning practitioners are expected to demonstrate a reasonable effort in coordinating services with Alliance Network practitioners, including educating Members to return to their PCP for continuity and coordination of care.
 - iv. Members should be encouraged to approve release of their medical records from the family planning provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services.
 - v. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but allows STD service practitioners adequate information to bill for the services. Practitioners must make such a form available to Members.
- e. Coordination of Care - Listed below are the roles and responsibilities of the member's healthcare team. Out-of-Network practitioners should encourage Members to sign release of information forms so that clinical information can be forwarded to the Member's PCP. If a release is signed, and the Member needs care as a follow-up to the family planning services or due to a complication of the family planning service, the Out-Of-Network practitioner must contact the PCP. This applies to Medi-Cal Members only.
- i. The Member's assigned PCP in conjunction with the Alliance is responsible for providing or coordinating any additional health care needed by the Member and/or documenting in the medical record any family planning services received by the Member (e.g., PAP smear, type of birth control method) upon receiving medical records from or being informed by the family planning practitioner or Member.
- f. Infertility Treatments For Alliance Group Care Members
- i. Infertility is defined as a condition or status characterized by any of the following:
 - 1) A licensed physician's findings, based on the patient's medical, sexual, and

Formatted: Indent: Left: 0.5", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.54", Space Before: 0 pt

Formatted: Indent: Left: 1", Space Before: 0 pt

Formatted: Indent: Left: 0.5", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.95", Hanging: 0.3", Right: 0.15", Tab stops: 1.18", Left

Formatted: Indent: Left: 0.5", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Not Highlight

Formatted: Indent: Left: 0.5", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Space Before: 0 pt, Pattern: Clear (Background 1)

reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.

2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular,unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

ii. For Group Care members: AAH contracts that provide coverage for infertility and fertility services from:

1) Excluding, limiting, or otherwise restricting coverage of fertility medications that are different from those imposed on other prescription medications.

2) Excluding or denying coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. "Third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.

3) Imposing any deductible, copayment, coinsurance, benefit maximums, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility that are different than those imposed upon benefits for services not related to infertility.

iii. Requires plans, consistent with Section 1365.5, to cover the treatment of infertility and fertility services without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

Formatted: Not Highlight

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

Formatted: Not Highlight

Formatted: Indent: Left: 1.25", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.25", Space Before: 0 pt, Pattern: Clear (Background 1)

Formatted: Indent: Left: 1", Right: 0.15", Space Before: 0 pt

5. 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 for members <18 years old (tubal ligation or vasectomy).

Formatted: Justified, Indent: Left: 0.95", Hanging: 0.3", Right: 0.15", Tab stops: 0.88", Left

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.23", Hanging: 0.3", Tab stops: 0.53", Left

Formatted: Indent: Left: 0.48", Space Before: 0 pt

b. Practitioners providing sterilization services to members must adhere to informed consent procedures as detailed in Title 22, Section 51305.(1), (2), (3), (4), and outlined below:

Formatted: Indent: Left: 0.5"

i. Informed consent may not be obtained while the Member is under the influence of alcohol, or any substance that affects the Members state of awareness.

Formatted: Indent: Left: 0.86", Right: 0.15", Space Before: 0 pt

ii. Consent may not be obtained while the Member is in labor, within 24 hours of delivery, post abortion, or if the Member is seeking to obtain or obtaining an abortion.

iii. Written informed consent must have been given at least 30 days and no more than 180 days before the procedure is performed.

Formatted: Indent: Left: 0.83", Hanging: 0.28", Right: 0.15", Space Before: 0 pt

1). A copy of the consent form and the booklet on sterilization published by the

- Department of Healthcare Services (DHCS) must be given to the Member.
- iv. A hysterectomy requires an additional consent form. A hysterectomy is not compensated under the Medi-Cal program if performed or arranged for the sole purpose of rendering the Member sterile.
 - v. Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the Member consented to sterilization at least 30 days prior to the intended date of sterilization or the expected date of delivery or at least 72 hours have passed between the time that written consent was given and the time of the emergency surgery or premature delivery. The consent must also have been signed 72 hours prior to the Member having received any preoperative medication.
 - vi. The PM 330 Consent Form must be fully completed at the time of the procedure.
 - vii. Original copies of the informed consent are filed in the Member's medical record.

c. Access to Sterilization Services

a. For Medi-Cal Members:

- 1). The Medi-Cal Member may select a qualified family planning practitioner of his/her choice within the Alliance network, or out of network.
- 2). Out-of-network family planning practitioners are expected to demonstrate a reasonable effort in coordinating services with Alliance network practitioners, including educating Members to return to their PCP for continuity and quality of care.

b. For D-SNP Members:

Under the D-SNP Program Guidelines the coverage of sterilization is limited to treatment of an illness or injury. Services that are not covered in the absence of medical necessity are elective hysterectomies, tubal ligation and vasectomies.

A nonemergency hysterectomy may be covered only if:

- (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile.
- (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and
- (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.

6. Sexually Transmitted Diseases

- 1. 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).
- 2. 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

Formatted: Indent: Left: 0.87", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.83", Hanging: 0.28", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.86", Space Before: 0 pt

Formatted: Indent: Left: 0.86", Hanging: 0.25", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.81", Hanging: 0.3", Tab stops: 1.12", Left + 1.13", Left

Formatted: Indent: Left: 0.48", Space Before: 0 pt

Formatted: Indent: Left: 0.83", Space Before: 0 pt

Formatted: Indent: Left: 1.23", Hanging: 0.3", Right: 0.15", Space Before: 0 pt

Formatted: Not Highlight

Formatted: Indent: Left: 0.83", Right: 0.15", Space Before: 0 pt

Formatted: Justified, Indent: Left: 1.08", Right: 0.15"

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.23", Hanging: 0.3", Space Before: 6 pt

Formatted: Indent: Left: 0.48", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.43", Hanging: 0.3", Tab stops: 0.52", Left + 0.53", Left

Formatted: Indent: Left: 0.48", Right: 0.25", Space Before: 0 pt

her scope of practice. Services may be obtained from a practitioner in or outside of the Alliance Network, without prior authorization.

- 3. Members age 12 years and older, may access STD services from practitioners noted above without parental consent, and without prior authorization.

- 4. Pursuant to California Health and Safety Code Section 120582, licensed physicians, nurse practitioners, certified nurse-midwives, or physician assistants who are practicing within their authorized scope of practice may prescribe, dispense, furnish, or otherwise provide prescription antibiotic medications to the sexual partner or partners of a Member with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, without examination of the Member's sexual partner or partners.

a. Access Within Network

- i. Medi-Cal Members may elect to receive STD services from their PCPs or qualified practitioners within the Alliance Network.
- ii. PCPs are required to offer all Members appropriate STD services, including screening, counseling, education, diagnosis and treatment.

b. Confidentiality and Reporting

- i. The expressed, written consent of the Member or legal representative is required for the release of medical records to another party outside of the practitioner. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but gives STD services practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members.
- ii. All practitioners providing STD services are required by law to report individuals with certain communicable diseases to the Local Health Department (LHD).
- iii. Medical records for Members presenting for STD evaluation must be maintained to protect the confidentiality of the Member. In-network practitioners must adhere to Alliance Medical Records policies and procedures.

c. Access Out-of-Network

- i. An Out-Of-Network practitioner may be a family planning practitioner, an LHD, or any other practitioner who provides STD services within their scope of licensure and practice. Members may access STD services through Out-Of-Network practitioners without prior authorization.
- ii. Medi-Cal Members may make their own appointment with the STD services practitioner of their choice. Members should return to their PCPs to maintain continuity of care.
- iii. STD services provided through Out-Of-Network practitioners must be reimbursed at the Medi-Cal fee-for-service (FFS) rate, unless otherwise negotiated in subcontracts with the Alliance.

d. Coordination of Care

PCPs are responsible for coordination of care and avoiding duplicate delivery of services for those Members who inform them and/or release medical records for Out-Of-Network STD treatment received.

- i. The reimbursement for Out-Of-Network practitioners not associated with an LHD for STD services is limited to one office visit per disease episode for:
 - 1) Diagnosis and treatment of vaginal discharge and urethral discharge.
 - 2) Evaluation and initiation of treatment of Pelvic Inflammatory Disease

Formatted: Tab stops: 0.52", Left + 0.53", Left

Formatted: Indent: Left: 0.48", Right: 0.06", Space Before: 0 pt

Formatted: Tab stops: 0.52", Left + 0.53", Left + 6.06", Left

Formatted: Indent: Left: 0.48", Right: 0.24", Space Before: 0 pt

Formatted: Indent: Left: 0.73", Space Before: 0 pt

Formatted: Indent: Left: 1.19", Hanging: 0.12", Right: 0.63", Space Before: 0 pt

Formatted: Indent: Left: 0.73", Space Before: 0 pt

Formatted: Indent: Left: 1.19", Hanging: 0.12", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.73", Right: 0.44", Space Before: 0 pt

Formatted: Indent: Left: 1.19", Hanging: 0.14", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.19", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.73", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.83", Hanging: 0.3"

Formatted: Indent: Left: 0", Hanging: 1.23", Space Before: 0 pt

Formatted: Indent: Left: 1.82", Space Before: 0 pt

- (PID)
- 3) Those STDs that are responsive to immediate diagnosis and treatment:
 - 4) Bacterial vaginosis
 - 5) Candidiasis
 - 6) Chancroid
 - 7) Chlamydia
 - 8) Gonorrhea
 - 9) Granuloma inguinale
 - 10) Herpes simplex
 - 11) Human papilloma virus
 - 12) Lymphogranuloma venereum
 - 13) Non-gonococcal urethritis
 - 14) Syphilis
 - 15) Trichomoniasis

ii. Practitioners providing STD services who wish to register a grievance regarding non-payment, underpayment, or any billing related issue.

Formatted: Indent: Left: 0", Hanging: 1.23", Right: 0.15", Space Before: 0 pt

7. HIV Testing and Counseling

- a. PCPs are required to assess all Alliance Members for risk factors for HIV infection. Those Members determined to be at risk must be offered HIV testing and counseling by their PCP, or be referred to a LHD operated or contracted anonymous HIV testing site.
- b. Medi-Cal Members can access HIV testing and counseling as part of a family planning or STD visit, or at a LHD operated or contracted HIV testing site, without prior authorization regardless of the provider's contracting status with the Alliance.
- c. Alliance Providers are required to follow all State laws governing consent for testing and disclosure of HIV test results, as well as the latest "HIV Counseling, Testing, and Referral Standards and Guidelines" recommended by the U.S. Public Health Service (Guidelines may be found via the internet at www.cdcnpin.org).
- d. Access to HIV Counseling and Testing Services Overview
 - i. PCPs are required to assess Members for risk factors for HIV infection. The assessment can occur in the following situations:
 - 1) As part of a well-child or adult physical exam.
 - 2) At the time of a visit for illness or injury.
 - 3) At the request of a Member, Member's parent or guardian.
 - 4) Other appropriate circumstances.
 - ii. The assessment by the PCP should include the following:
 - 1) Obtaining a sexual history in sufficient detail to assess risk.
 - 2) Discussing any history of substance abuse including use of needles.
 - 3) History of significant blood transfusions in the past during period of infected blood supply.
 - 4) If a newborn or young child, the history above for mother of the child.
 - 5) Assessment for otherwise unexplained generalized signs and symptoms, or laboratory results suggestive of a chronic process with underlying immune deficiency
 - iii. Assessment for signs and symptoms of acute retroviral syndrome For those Members identified by the PCP as at risk for HIV infection, one of the following must occur:
 - 1) PCP provides HIV testing and counseling.

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Formatted: Justified, Indent: Left: 0.23", Hanging: 0.3", Tab stops: 0.52", Left + 0.53", Left

Formatted: Indent: Left: 0.53", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Right: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Right: 0.23", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Space Before: 0 pt

Formatted: Indent: Left: 1.06", Hanging: 0.1", Right: 0.48", Space Before: 0 pt

Formatted: Indent: Left: 1.06", Hanging: 0.1", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 1.23", Hanging: 0.3", Right: 0.16", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 1.13", Hanging: 0.03", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Space Before: 0 pt

- 2). For Medi-Cal Members, either the PCP refers the Member, or the Member can self-refer to a LHD operated or contracted HIV testing and counseling site for confidential or anonymous services.
- iv. Alliance Member Services is available to assist Members requesting access to HIV testing and counseling services by informing them of their options described above and/or referring them to LHD operated or contracted sites.
- v. PCPs and specialists caring for Members who are children must offer HIV counseling to parents or legal guardians and education, counseling and testing where appropriate to infants, children and adolescents in the following categories:
 - 1). Infants and children of HIV seropositive mothers.
 - 2). Infants and children of mothers at high risk for HIV infection with unknown HIV serologic status including:
 - a). Children born with a positive drug screen;
 - b). Children born to mothers who admit to present or past use of illicit drugs;
 - c). Children born with symptoms of drug withdrawal;
 - d). Children born to mothers who have arrests for drug-related offenses or prostitution;
 - e). Children born to mothers with any male partners at high risk for HIV and
 - f). Any abandoned newborn infants.
 - 3). Sexually abused children and adolescents.
 - 4). Children receiving blood transfusion/blood products between 1977-1985 or symptomatic children receiving transfusions since 1985.
 - 5). Adolescents who engage in high risk behaviors including unprotected sexual activity, illicit drug use, or who have had STDs.
 - 6). Other children deemed at high risk by a practitioner.
- e. HIV Testing, Counseling and Follow-up for Prenatal Women
 - i. Alliance network practitioners who provide women's health care services must comply with current law (California Health and Safety Code, Section 125107) that requires the health care professional primarily responsible for providing prenatal care to a pregnant Member to offer HIV information and counseling to every pregnant Member, including, but not limited to:
 - 1). Mode of transmission
 - 2). Risk reduction and behavior modification including methods to reduce the risk of perinatal transmission.
 - 3). Referral to other HIV prevention and psychosocial services
 - ii. The Alliance requires that all prenatal care practitioners offer HIV testing to every pregnant Member, unless the Member has a positive test result documented in the medical record or has AIDS as diagnosed by a practitioner.
 - iii. All Alliance prenatal care practitioners are required to discuss with the Member:
 - 1). The purpose of the test.
 - 2). Its potential risks and benefits, including treatment to reduce transmission to the newborn and that it is a voluntary test.
 - iv. Practitioners must document in the Member's medical record that education, counseling and testing was offered to the pregnant Member.
- f. Out-of-Network Reimbursement for Medi-Cal Members
 - i. HIV testing and counseling services provided through LHDs, sites subcontracted by LHDs or qualified family planning practitioners as part of a family planning

Formatted: Indent: Left: 1.23", Hanging: 0.3", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.13", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.13", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 1.23", Hanging: 0.3", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.58", Hanging: 0.4", Space Before: 0 pt

Formatted: Indent: Left: 1.58", Hanging: 0.4", Right: 0.25", Space Before: 0 pt

Formatted: Indent: Left: 1.58", Hanging: 0.4", Space Before: 0 pt

Formatted: Indent: Left: 1.58", Hanging: 0.4", Right: 0.17", Space Before: 0 pt

Formatted: Indent: Left: 1.58", Hanging: 0.4", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Right: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 1.22", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Space Before: 0 pt

Formatted: Indent: Left: 1", Hanging: 0.12", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 1.4", Hanging: 0.12", Space Before: 0 pt

Formatted: Indent: Left: 1.4", Hanging: 0.12", Right: 0.2", Space Before: 0 pt

Formatted: Indent: Left: 1.4", Hanging: 0.12", Space Before: 0 pt

Formatted: Indent: Left: 1.04", Hanging: 0.12", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.65", Hanging: 0.12", Space Before: 0 pt

Formatted: Indent: Left: 1", Hanging: 0.12", Right: 0.15", Space Before: 0 pt

visit must be reimbursed at the Medi-Cal fee-for-service rate, unless otherwise negotiated by the Alliance.

- ii. Out-of-network practitioners must provide proof of service adequate for audit purposes.
- iii. All out-of-network practitioner HIV testing and counseling claims grievances are resolved per the Alliance Provider Grievance Process (see Policy G&A-009 "Provider Grievances").
- iv. Also included for the D-SNP LOB: Pharmacists in a community pharmacy setting furnishing specified categories of drugs including HIV pre-exposure and post-exposure prophylaxis, and initiating and administering is a covered benefit under the D-SNP LOB. All documentation in Member's charts and release of information regarding HIV tests must conform to all provisions of California Health and Safety Code Division 105, Part 4, including Sections 120975, 120980, 120985, and 121010, 199.25, and Insurance Code Section 791.06. Confidentiality guidelines are set below:

- 1). The practitioner ordering the test may record the results in the subject's medical record and disclose the results to other practitioners for purposes of diagnosis, care or treatment without written authorization of the subject.
- 2). The practitioner ordering the test may NOT disclose the results of the test to Alliance or any other health care service plan.
- 3). All records reflecting HIV testing must be kept in a locked cabinet accessible only by authorized personnel.

g. Consent of HIV Testing and Disclosure of HIV Test Results

- i. All practitioners ordering HIV tests must either obtain written consent or informed verbal consent from the Member. Informed verbal consent is only sufficient when a treating practitioner orders the test.
- ii. Except in cases where direct health care practitioners are disclosing the results of an HIV test for purposes directly related to the health care of the Member, all Alliance network practitioners must obtain written consent from the Member to disclose results of an HIV test.

h. Reporting

- i. All practitioners are required to comply with state law and report all known AIDS cases to the LHD. (See UM-023 Communicable Disease Reporting and Services).

8. Abortion Services

- a. The Reproductive Privacy Act provides that the state and therefore the Alliance as a contractor, may not deny or interfere with a person's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life or health of the pregnant individual.
- b. Abortion services are a covered physician service and a sensitive service. Abortion is a covered benefit regardless of the gestational age of the fetus. All medical services and supplies incidental or preliminary to an abortion as defined in the DHCS Provider Manual will be covered. The Alliance and its delegates will maintain procedures that ensure confidentiality and timely access to these sensitive services. When necessary, the Alliance will help find the member find a Provider for these services.
- c. In order to access abortion services, Medi-Cal Members have the ability to self-refer, without prior authorization or medical justification, to a qualified practitioner within or outside of the Alliance Network, when performed in an outpatient setting. The Alliance will not impose any utilization management or utilization review

Commented [AL5]: To clarify: since we call out D-SNP as #4 here, do elements #1-3 also apply to D-SNP members?

Commented [TM6R5]: See edit.

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Indent: Left: 0.65", Hanging: 0.12", Space Before: 0 pt

Formatted: Indent: Left: 1.04", Hanging: 0.12", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.65", Hanging: 0.12", Space Before: 0 pt

Formatted: Indent: Left: 1.04", Hanging: 0.12", Right: 0.15", Space Before: 0 pt

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Space Before: 0 pt

Formatted: Indent: Left: 0.53", Right: 0.2", Space Before: 0 pt

requirements on coverage of outpatient abortion services. The Alliance will not impose any annual or lifetime limits on the coverage of outpatient abortion services. Deductibles, coinsurance, copayments or any other cost-sharing requirements for an abortion or abortion-related services is prohibited and not required.

d. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program.

Formatted: Indent: Left: 0.53", Right: 0.56", Space Before: 0 pt

e. The Alliance will notify members when they enroll with the Alliance that some providers, hospitals, and clinics do not perform abortion services, and that the Alliance will assist the member to obtain the services from a provider, hospital or clinic who will provide the service. The Alliance will ensure that members have timely access to abortion services.

i. Abortion services, the medical services and supplies incidental or preliminary to an abortion, which are consistent with the requirements outlined in the MediCal Provider Manual.

Formatted: Indent: Left: 1.03", Hanging: 0.4", Space Before: 0 pt

ii. All outpatient abortion services do not require prior authorization or annual or lifetime limits. The Alliance will not apply any utilization review requirements or utilization management on the coverage of outpatient abortion services.

iii. Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization under the same criteria as other medical procedures (see California Code of Regulations [CCR], Title 22, Section 51327).

iv. Line of Business: Group Care members can access abortion services without a referral or prior authorization; however, these services are not covered if performed by an Out-Of-Network practitioner.

f. Accessing Abortion Services

i. Medi-Cal Members can go to any Medi-Cal provider of their choice for abortion services, at any time for any reason, regardless of the network affiliation. The Alliance will ensure members have timely access to abortion services.

Formatted: Space Before: 0 pt, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

1) The Alliance or its delegates will not require a Physician, health care provider or person to participate in performance of abortion services. No person or provider who refuses to perform abortion services will be subject to penalty or discipline in any form for such a choice.

Formatted: Indent: Left: 1.03", Hanging: 0.4", Right: 0.15", Space Before: 0 pt, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

ii. Will inform members when they enroll that some hospitals, clinics, and other Providers in their Network may refuse to provide abortion services. In such case, the Alliance must help the member find another provider for the needed services.

g. Consent to Abortion Services

Formatted: Indent: Hanging: 0.4", Space Before: 6 pt

i. Minor consent – refer to the MediCal Minor Consent Program and CMP-015 Minor Consent to Medical Care

Formatted: Indent: Left: 0.65", Hanging: 0.4", Space Before: 0 pt, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

h. Prohibition Against Interfering with Abortion Services

i. The Reproductive Privacy Act (Health and Safety Code Section 123460, et seq.) provides that California, and plans as contractors, may not deny or interfere with a women's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life or health of the pregnant individual.

Formatted: Right: 0", Space Before: 0 pt

F. Delegation Oversight

UM-029 Sensitive Services

Formatted: Indent: Left: 0.23", Hanging: 0.3", Space Before: 0 pt

- 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.

Formatted: Justified, Indent: Left: 0.23", Hanging: 0.3", Tab stops: 0.38", Left

DEFINITIONS / ACRONYMS

None.

Formatted: Centered

Formatted: Heading 1, Centered, Right: 1.67"

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

Formatted: Heading 1, Centered, Right: 1.67"

RELATED POLICIES AND PROCEDURES

- CLM-010 Family Planning & Sensitive Services Claims Processing
CLM-011 Abortion Services Claims Processing
CMP-015 Minor Consent to Medical Care
CMP- 019 Delegation Oversight
UM-023 Communicable Disease Reporting and Services

Formatted: Heading 1, Centered, Right: 1.67"

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

Formatted: Heading 1, Indent: Left: 0.72"

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, 04/28/2025

Formatted: Heading 1, Centered, Right: 1.67"

REFERENCES

-
1. All Plan Letter 24-003
 2. Boilerplate 2025 SMAC EAE D-SNP
 3. California Family Code Sections 6925-6928
 4. DHCS Contract Exhibit A, Attachment 9, Provision 9.2.
 5. Health Care Coverage: Abortion Services: cost sharing, SB 245, (Chapter 11, Statutes of 2022), 2021-2022 Session, (2022)
 6. Health and Safety Code section 123420
 7. Reproductive Privacy Act
 8. Senate Bill 245 (Chapter 11, Statutes of 2022)

Formatted: Centered

Formatted: Space Before: 0 pt

UM-029 Sensitive Services

- 9. Senate Bill 729: Health Care Coverage: Treatment for Infertility and Fertility Services
- 10. The Medi-Cal Provider Manual for the Minor Consent Program
- 11. Title 22, California Code of Regulations (CCR), Section 51327
- 12. Title 22, Section 51305.(1), (2), (3), (4)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee and Administrative Oversight Committee.

Formatted: Indent: Left: 0"

Commented [MF7]: [@Thomsen, Michelle](#) do you know how to get rid of the Blue lines on pages 12 and 13? The formatting on this document got all rearranged- and I was able to fix all but this section.

approval

Approval

Formatted Table

approval

Formatted: Normal, Indent: Left: 0"

Formatted: Normal

Formatted: Normal, Left, Right: 0", Space Before: 0 pt

approval

- Commented [FM8]: [Boilerplate 2025 SMAC EAE D-SNP](#)
p 87
- Commented [FM9]: [Article - Sterilization \(A59060\)](#)
- Commented [FM10]: [Boilerplate 2025 SMAC EAE D-SNP](#) pg 96- Pharmacy should this be included?
- Formatted: Font: 11 pt, Not Expanded by / Condensed by , Highlight
- Formatted: Normal, Right: 0", Space Before: 0 pt, No bullets or numbering, Tab stops: Not at 0.52" + 0.53"



Health care you can count on.
Service you can trust.

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, <u>D-SNP</u>
Effective Date	1/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>TBD5/17/2024</u>
Administrative Oversight Committee Approval Date	<u>TBD7/17/2024</u>

Formatted: Font: 12 pt

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.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

Policy Statement

A. Current and Newly Enrolled Group Care, D-SNP and Medi-Cal Members

1. Upon their request, current Alliance Members or newly enrolled Members with specified conditions may continue to obtain an Active Course of Treatment and health care services from a terminated or non-contracted provider for a specific condition and time frame as noted below:
 1. **An acute condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
 2. **Serious chronic condition** is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

a course of active treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the Member and the terminated provider or non-contracting provider, consistent with good professional practice. Completion of covered services

under this paragraph shall not exceed 12 months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

3. **Pregnancy** is the three trimesters of pregnancy and the immediate postpartum period. Services shall be covered for the duration of the pregnancy and the immediate postpartum period of 12 months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
 4. **Terminal illness** is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services is provided for the duration of the terminal illness which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
 5. **Newborn childcare** is the care of a newborn child between birth and age thirty-six (36) months. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.
 6. **Performance of a surgery or other procedure** is a medical procedure that is authorized by the Alliance, if a current Member, or by a previous plan, if a new Member, as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of coverage for a newly enrolled Member, or within 180 days of the termination of the provider for a current Member.
 7. **Pediatric Palliative Care** is a patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering for children. Members currently enrolled in the Alliance or transitioning from Medi-Cal FFS, the Alliance will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network provider. The Alliance will not provide continuity of care for services that were excluded due to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT per DHCS requirements.
2. The terminated or NPP must agree to terms and conditions and rates consistent with those used by the Alliance or provider group in the same or similar geographic area.
- +a. If provider refuses rates or terms, The Alliance will make every effort to transition member to an appropriately qualified in-network provider.
- 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.
- b.
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

7.

Formatted: Right, Indent: Left: 1.36", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Left, Indent: Left: 0.81", Space Before: 0 pt

Formatted: Left, Indent: Left: 0.81", Numbered + Level: 4 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.78" + Indent at: 2.03"

Formatted: Font: 12 pt

Formatted: Left, Indent: Left: 0.81", Space Before: 0 pt

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.

- 1.** The AAH policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.
- 2.** Particular attention and resources will be focused on members in Special Populations:
 - a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services
 - b. Adults and children with authorizations to receive Community Supports (CS)
 - c. Adults and children receiving Complex Care Management (CCM)
 - d. Enrolled in 1915(c) waiver programs
 - e. Receiving in-home supportive services (IHSS)
 - f. Children and youth enrolled in California Children's Services (CCS)
 - g. Children and youth receiving foster care, and former foster youth through age 26~~5~~
 - 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

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Right, Indent: Left: 1.25", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 1", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Line spacing: single

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt, Line spacing: single

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt, Line spacing: single

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19"

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt, Line spacing: single

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt, Line spacing: single

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt, Line spacing: single

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt, Line spacing: single

December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services (CBAS)

3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

C. The Alliance will maintain standards of communication and processes for the appropriate sharing of information (e.g., adequate, timely feedback and consultation) and coordination of care between and among medical and mental health providers, general and specialty practitioners, and institutions, referring and consulting providers.

D. For Group Care Mental Health Services (employer-sponsored group health), The Alliance:

1. Maintains a process for block transfers of enrollees from a terminated provider group to a new provider group or hospital.
2. Maintains a process to facilitate the CoC for a new enrollee who has been receiving services from a NPP mental health provider for an acute, serious, or chronic mental health condition when an employer changed health plans. This includes a reasonable transition period to continue the course of treatment with the NPP prior to transferring to a participating provider and includes the provision of mental health services on a timely, appropriate, medically necessary basis from the NPP. The process provides that the length of time of the transition period take into account on a cases-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The process ensures that reasonable considerations are given to the potential clinical effect of a change of provider on the Member's treatment of the condition. The process describes the process to review a Member's request to continue the course of treatment with the NPP mental health provider.

- 2.
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.

Formatted: Indent: Left: 1.38", Hanging: 0.19", Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Right, Indent: Left: 1.56", Space After: 0 pt, No bullets or numbering

Formatted: Right, Indent: Left: 1.36", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

Formatted: Justified, Space Before: 0 pt

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Indent: Left: 1", Numbered + Level: 4 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1.78" + Indent at: 2.03"

Formatted: Right, Indent: Left: 2.03", Space Before: 0 pt, No bullets or numbering

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.36", Hanging: 0.25", Right: 0", Space Before: 6 pt, No bullets or numbering, Tab stops: Not at 0.61"

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

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.

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

E. On January 1, 2026 the Alliance will allow for Continuity of Care for Medicare Primary and Specialty Providers Upon a Member, authorized representative, or provider's request, D-SNPs must offer continuity of care with out-of-network Medicare providers to all Members if all of the following circumstances exist:

Formatted: Font: 12 pt

Formatted: Right, Indent: Left: 0.31", Right: 0", Space Before: 0 pt, No bullets or numbering, Tab stops: Not at 0.61"

1. A Member has an existing relationship with a primary or specialty care provider. An existing relationship means the Member has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of their initial enrollment in the D-SNP for a non-emergency visit;

Formatted: Font: 12 pt

Formatted: Right, Indent: Left: 0.63", Space Before: 0 pt, No bullets or numbering, Tab stops: 0.88", Left + Not at 0.61"

2. The provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule, as applicable; and

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering, Tab stops: 0.88", Left + Not at 0.61"

3. The provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering, Tab stops: 0.88", Left + Not at 0.61"

4. If the Member leaves the D-SNP and later rejoins the D-SNP, then the D-SNP must offer the Member a 12-month continuity of care period based on the date of re-enrollment, regardless of whether the Member received continuity of care in the past. If a Member changes D-SNPs, the continuity of care period may start over one time. If the Member changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the Member a new 12-month period.

6.

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering, Tab stops: 0.88", Left + Not at 0.61"

F. In the event a provider is terminated, all assigned Members are notified in writing (Attachment A) of the termination and their right to continue care 60 days prior to the termination effective date and are informed of the procedures for selecting another provider.

E.

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

G. The Alliance maintains mechanisms to facilitate transition of care (including enrollee notification when:

F.

Formatted: Font: 12 pt

Formatted: Normal, Left, No bullets or numbering

1. An individual in a course of treatment enrollees in the Plan and

+

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

2. When a medical group or provider is terminated from the network.

2.

Formatted: Font: 12 pt

Formatted: Normal, Space Before: 0 pt, No bullets or numbering

H. The Alliance reserves the right to make final decisions regarding continuity of care.

G.

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

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.

+

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

I. Communication to Members:

H.

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

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.

~~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.~~

J. Any newly enrolled Member request COC or may obtain a copy of this policy upon written request to Alliance or by calling Member Services

K. The Alliance is not required to cover services that are not otherwise covered by the Plan.

L. The Alliance notifies members of alternative resources in situations when members are receiving approved and medically necessary services but whose benefit coverage will? end or has ended.

M. The Alliance will manage the process of care transitions, identify problems that could cause transitions, facilitate safe transitions and, where possible, prevent or minimize unplanned transitions.

~~K.~~ N. The Alliance Medical Services, Case and Disease Management Departments and their supporting units as well as the Member Services Department will collaborate in the management of care transition processes. This process includes review to determine whether the member's current treatment/care is transferable to another provider without compromising quality of care.

~~L.~~ O. The Alliance utilizes evidenced based criteria, the application of medical necessity and reasonable consideration to the potential clinical effects on the Members' treatment caused by a change in Provider in consideration of a continuation of care.

~~M.~~ P. The Alliance may delegate this responsibility to a provider group and ensures that the requirements are met.

~~N.~~ Q. The Alliance reserves the right to make all final decisions regarding continuity of care for Alliance Members.

PROCEDURE

A. All newly enrolled Members receive the Alliance's notice of the continuity of care policy in the Evidence of Coverage and Disclosure Form that is sent at time of enrollment.

~~A.~~ I. 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.

Formatted: Right, Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: List Paragraph, Justified, Indent: Hanging: 0.49", Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.36" + Indent at: 0.61"

Formatted: Body Text, Right: 0", Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.36" + Indent at: 0.61", Tab stops: Not at 0.36"

Formatted: Indent: Left: 0.36", No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Normal, Indent: Left: 0.11", No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.13", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

~~B.~~
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.

Formatted: Indent: Left: 0.13", Space Before: 0 pt, No bullets or numbering

~~C.~~

Formatted: Font: 12 pt

1. Any such request is documented by Alliance Utilization Management Department with subsequent referral to an Alliance Medical Director, if necessary.

Formatted: Indent: Left: 0.36", Hanging: 0.25", Right: 0", Space Before: 6 pt, No bullets or numbering, Tab stops: Not at 0.36"

~~4.~~

2. The Alliance UM Department Standards to begin review of request for CoC within:

Formatted: Indent: Left: 0.13", Space Before: 0 pt, No bullets or numbering

a. Routine request within five (5) business days.

Formatted: Indent: Left: 0.38", Space Before: 0 pt, No bullets or numbering

b. Urgent matters are reviewed and responded to within 72 hours.

~~b.~~

Formatted: Space Before: 0 pt

3. Each continuity of care request must be completed within the following timeline:

Formatted: Indent: Left: 0.88", Space Before: 0 pt, No bullets or numbering

a. Thirty calendar days from the date The Alliance received the request;

b. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,

c. Three calendar days if there is risk of harm to the member.

d. Note: timeframes may be extended due NPP contracting phase; contracting should be completed within the standard timeframe but not to exceed 30 calendar days from the date of the receipt of the request.

e. For D-SNP, Retrospective Requests are reviewed and responded to within 30 calendar days from the first date of service for which the provider is requesting or has previously requested, continuity of care, retroactive reimbursement; and

f. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted.

~~d.~~

Formatted: Indent: Left: 0.88", Space Before: 0 pt, No bullets or numbering

4. Alliance Medical Services will evaluate the request based on the regulatory requirements outlined in Health and Safety Code Section 1373.96.

Formatted: Indent: Left: 0.13", Hanging: 0.31", Tab stops: 0.44", Left + Not at 0.61"

5. Alliance Medical Services will notify Alliance Contracts Management via a Health Suite Service Request of all approved authorizations.

Formatted: Font: 12 pt

~~4.~~

Formatted: Normal, Indent: Left: 0.13", No bullets or numbering, Tab stops: 0.44", Left

6. Alliance Medical Services will notify Alliance Contracts Management via a Health Suite Service Request of all approved authorizations.

Formatted: Space Before: 0 pt

~~5.~~

Formatted: Indent: Left: 0.38", Space Before: 0 pt, No bullets or numbering

7. UM Coordinators are responsible for daily monitoring Health-Suite Service Request email distribution inbox.

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Indent: Left: 0.86", Space Before: 0 pt

Formatted: Indent: Left: 0.86", Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.86", Space Before: 0 pt, Tab stops: 1.11", Left + Not at 0.36"

Formatted: Indent: Left: 1.11", Space Before: 0 pt, No bullets or numbering

~~6.~~

7.8. UM Coordinators will review each request for:

a. Eligibility

b. Confirmation of Provider network status

e. Obtaining medical records, if necessary

~~c.~~

d. Assignment to UM Nurse for review

~~d.~~

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.

Formatted: List Paragraph, Indent: Left: 0.86", Numbered + Level: 3 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.63" + Indent at: 0.88", Tab stops: 1.11", Left

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Normal, Indent: Left: 0.36", No bullets or numbering

Formatted: Indent: Hanging: 0.49", Space Before: 0 pt, Tab stops: 0.13", Left + Not at 0.36"

Formatted: Indent: Hanging: 0.49", Tab stops: 0.13", Left

Formatted: Font: 12 pt

Formatted: Normal, Space Before: 0 pt, No bullets or numbering, Tab stops: 0.13", Left + Not at 0.36"

Formatted: Space Before: 0 pt

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.

Formatted: Indent: Left: 0.88", Space Before: 0 pt

G. For Mental Health Services

Formatted: Indent: Left: 1.38", Space Before: 0 pt, No bullets or numbering

1. The Behavioral Health (BH) department staff are responsible for ensuring the review of request for CoC with a NPP mental health provider.

Formatted: Indent: Left: 0.13", Space Before: 0 pt, No bullets or numbering

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.

Formatted: Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

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.

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

H. Rates of Payment and Agreement of Terms

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

1. Through a Letter of Agreement, Alliance Contracts Management Department will offer the non-~~contracting~~ providers who may continue services:

Formatted: Indent: Left: 0.13", Space Before: 0 pt, No bullets or numbering

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.

Formatted: Space Before: 0 pt

- b. The rates offered will be for providers who are not capitated and who are practicing in the same similar geographic areas as the non-contracting provider.
- c. The NPP will be subject to the same contractual terms and conditions as contracting providers.

2. If the NPP agrees to the rate, terms and conditions, Contract Management notifies Medical Services and Medical Services sends to the member and the provider a notice authorizing the continued services.

3. If the NPP does not agree to the rates, or terms and conditions or fails to respond to the Alliance within 30 calendar days of the request for continuity of care, the following will occur:

- a. Contract Management will notify Alliance Utilization Management Medical Services to implement the administrative process to void reverse the authorization.
- b. Alliance Medical Services Utilization Management will send the member and the provider a notice that continuity of care services have been denied because the Alliance and the non- contracted provider were unable to reach agreement.
- c. Medical Services Utilization Management will coordinate with Case Management 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, t~~ 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.

a. ~~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).

J.

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.

Formatted: Indent: Left: 1.11", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Commented [MF1]: @Desrochers, Hope Can you please check this process- this is what is written in Policy, however I do not believe this is the current practice at this time. Can you please confirm steps if the LOA is not completed,

Commented [DH2R1]: if provider doesn't accept rates then CoC would not apply and we follow that process. If no response within 30 days then we would follow the admin denial process for provider not responsive.

Commented [PC3R1]: Same process for BH

Formatted: Indent: Left: 0.86", Right: 0.08", Space Before: 0 pt

Formatted: Indent: Left: 0.81", Hanging: 0.3", Right: 0.08", Space Before: 0 pt

Formatted: Indent: Left: 1.11", Right: 0.08", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 1.11", Right: 0.08", Space Before: 0 pt, No bullets or numbering

Formatted: List Paragraph, Indent: Left: 1.11", Right:

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 1.11", Right: 0.08", Tab stops: 1.11", Left

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, Space Before: 0 pt, No bullets or numbering

Formatted: Space Before: 0 pt

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.

Formatted: Indent: Left: 1.5", Hanging: 0.5", Space Before: 0 pt

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.

Formatted: Indent: Left: 1", Hanging: 0.5"

Formatted: Normal, Indent: Left: 1", Hanging: 0.5", Right: 0.08", Tab stops: 1.36", Left

Formatted: Space Before: 0 pt

~~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.

Formatted: Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

M.

Formatted: Space Before: 0 pt

N. Delegated Providers

~~N.~~

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.

Formatted: List Paragraph, Indent: Left: 0.36", Right: 0.08", Tab stops: 0.36", Left

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

~~1.~~

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”.

Formatted: Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.61", Space Before: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

~~2.~~

O. Continuity of Care Reporting Requirements:

~~O.~~

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.

~~1.~~

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.

~~2.~~

3. On a quarterly basis, the UM Manager and UM 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.

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

approval

4. On a monthly basis, the IT department and/ or Analytics department will provide data to the Compliance Department for regulatory reporting.

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

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.

Formatted: Font: 12 pt

Formatted: Normal, Indent: Left: 0.36", No bullets or numbering

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 Non-participating Provider (NPP)** - A provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

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.

Formatted: Normal, Indent: Left: 0.36", No bullets or numbering

8. **Provider** - any professional person, organization, health facility, or other person or institution licensed by the State to deliver or furnish health services.

Formatted: Normal, Indent: Left: 0.36", No bullets or numbering

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.

Formatted: Normal, Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

11. **Terminating Provider** - any Provider whose contract with the Alliance is in the process of termination, regardless of which entity initiated the termination process.

Formatted: Normal, Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

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.

Formatted: Normal, Indent: Left: 0.36", Space Before: 0 pt, No bullets or numbering

AFFECTED DEPARTMENTS/PARTIES

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Member Services
Provider Relations
Contract Management
Health Analytics
Medical Services
Behavioral Health

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

BH-002 Behavioral Health Services

~~3-~~

PRV-002 Block Transfers

~~4-~~ UM-001 Utilization Management Program

~~5-~~ UM-058 CoC for New Enrollees with MER

~~6-~~ UM-059 CoC for Enrollees Transitioning into Medi-Cal Managed Care

~~2-~~ PRV-002 Block Transfers

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, 5/6/2025

REFERENCES

- 2025 Medi-Cal Managed Care Plan Transition Policy Guide
- 42 CFR 422.112(b)
- Assembly Bill 133 (Chapter 143, Statutes of 2021)
- APL 21-003 Medi-Cal Network Provider and Subcontractor Terminations
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 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 & 14184.208
- Health Omnibus Budget Trailer Bill
- Letter of Agreement Process in Policy and Procedure NTM-CON-002
- Medi-Cal and Group Care Evidence of Coverage
- NCQA Standards

MONITORING

Formatted: Space Before: 0 pt

Formatted: Right, Indent: Left: 0.61", No bullets or numbering

Formatted: Normal, No bullets or numbering

Formatted: Not Expanded by / Condensed by

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font color: Auto, Pattern: Clear

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5", Tab stops: Not at 3" + 6"

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 11 pt, Font color: Auto, Pattern: Clear

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font color: Auto, Pattern: Clear

Formatted: Font: 11 pt

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5", Tab stops: Not at 0.61"

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Font: 11 pt

Formatted: Not Expanded by / Condensed by

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5", Tab stops: Not at 0.61"

Formatted

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted

Formatted: Font: 11 pt

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt

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 (QIHEC) annually.

Formatted: Indent: Left: 0.11", Right: 0.38"

Formatted: Space Before: 0 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.11", Right: 0.16", Space Before: 0 pt

approval

|

I.

Formatted: Font: 12 pt
Formatted: Space Before: 0 pt

approval



POLICY AND PROCEDURE

Policy Number	UM-045
Policy Name	Communication Services - UM
Department Name	Health Care Services
Department Owner	<u>Utilization Management</u> Medical Director
Lines of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	10/6/2011
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>2/16/2024TBD</u>
Compliance Committee Approval Date	<u>3/19/2024TBD</u>

PURPOSE

To establish and maintain procedures ensuring that members have timely access to Utilization Management (UM) staff for information about the UM process, authorization of care and status of requests in accordance with DHCS and CMS regulations.

Formatted: Font: Not Bold

Formatted: Justified, Indent: Left: 0", Right: 0.4"

POLICY STATEMENT

All Alameda Alliance for Health (AAH) members and providers can access UM staff when seeking information about the authorization/referral process and/or the UM process (such as criteria used and ability to speak with the reviewer). AAH uses multiple means of communication with members about their rights related to UM, benefits, and care. AAH is committed to providing clear, timely, and accurate communication regarding UM decisions to ensure appropriate access to care in accordance with DHCS and CMS regulations.

PROCEDURE

AAH provides the following communication services for members and providers related to the utilization management (UM) reviews and processes:

1. AAH provides the ability to speak with a UM staff member at least 8 hours a day during normal business hours for inbound calls regarding UM issues. This is provided by utilization review staff that is available by phone during normal business hours of 8 am 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. See UM-015 Emergency Services and Post Stabilization Services for policy and procedure. On-call UM staff shall respond to urgent post-stabilization requests/inquiries within 30 minutes, as required by DHCS Contract, Exhibit A, Attachment 9.

4. The Alliance maintains communication channels and provides multiple access methods for members and providers.

- a. Toll-free telephone number
- b. Fax number
- c. Secure email address
- d. Provider portal
- e. Member portal
- f. Physical mailing address for written requests.

5. 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 UM leadership prior to sending.

- a. UM staff are trained on how to coordinate UM decisions for D-SNP members integrating Medicare and Medi-Cal benefits to provide seamless access to care per all of the regulatory bodies.

- 4.6. 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. When applicable, members are notified that the call is being recorded for quality assurance purposes.

- 5.7. 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.

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: (Default) Times New Roman, 12 pt, Font color: Auto

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Commented [WM1]: Are calls recorded? "Our call is recorded for quality assurance purposes"- if so need to make sure this is in there as well

Commented [TM2R1]: added

Commented [AL3R1]: Health System, Care, and Facilities - please review for operational purposes. I believe staff are using cell phones outside of business hours, so will need to solution for call monitoring outside of business hours.

Commented [HC4R1]: Let's Allie correct, on call nurses use work cell phone after hours during rotating on call shift to receive calls so we may need to set up a line that may record as an alternative to cell phones.

Commented [FM5R1]: Let's Allie we can pull phone call logs from cell phones, but would not be able to record calls- it would be a script that we would inform the nurses they need to say for the recorded, but it wouldn't actually be recorded. At this time- I do not believe there is an alternative solution on how to complete this ask. Would the call logs be sufficient?

Commented [AL6R1]: OK, I add the verbiage "when applicable" in the P&P, for now, to cover the times during business hours and outside of business hours.

I will follow-up via email to discuss next steps required for SOP.

8. AAH has a dedicated Member Services phone line for D-SNP: 1.888.882.3767 (888-888ADSNP). The toll-free number is supplied in the Member Handbook, on the web site and in enrollment materials. The number will warm transfer calls to UM Department when appropriate.

6.9. AAH maintains a 24/7 telephone line for behavioral health clinical triage services. See policy BH-0021 and BH-008 for Group Care for additional details. Behavioral Health Services

10. Specific AAH UM staff ~~may be~~ and 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 to the UM Department 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.~~ ~~Include, expedited authorizations for telehealth or extended timelines as permitted by DHCS and CMS guidance, ensuring members maintain access to care. for telehealth or extended timelines as permitted by DHCS and CMS guidance, ensuring members maintain access to care.~~

a. AAH UM staff consider social determinants of health (SDOH), such as housing, transportation, and food insecurity, when reviewing authorization requests for D-SNP members, ensuring equitable access to care in alignment with CalAIM and CMS health equity goals.

7.11. AAH offers TDD/TTY and California Relay services for deaf, hard of hearing or speech-impaired members. All UM staff members are trained in how to assist members in accessing these services or UM staff may access these services themselves directly to assist a member. The information regarding the services is listed on the AAH website, in newsletters to members and providers and in enrollment and orientation materials.

8.12. AAH offers alternative formats for members with visual impairments, such as auxiliary aids and services, giving primary consideration to the member's request of a particular auxiliary aid or service. AAH will offer the alternative formats aids and services to the member and/or a family member, friend, or associate of a member if required by the ADA, including if said individual is identified as the member's authorized representative (AR), or is someone with whom it is appropriate for AAH to communicate (e.g., a disabled spouse of a member). AAH will accommodate the communication needs of all qualified members with disabilities, including members designated and confirmed ARs, and be prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20 point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate. AAH will inform a member who contacts AAH regarding an electronic alternative format, that unless the member requests a password protected format, the member will receive notices and information in an electronic format that is not password protected.

a. The member or 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.

Commented [MT7]: @DeRochi, Andrea Please review for BH and also add redlines to BH @Vallejo, Yani

Commented [DA8R7]: Our afterhours coverage is clinical in nature. It is not for UM purposes. For UM purposes, we utilize the RNs/MDs as described in the post-stabilization policy.

Commented [MT9R7]: @DeRochi, Andrea is there a BH-008? I don't have it in the tracker and it is not on navex.

Commented [DA10R7]: It is new and not yet published in Navex. It is loaded as a draft in Navex. I can show you how to find if you need to

Commented [AL11]: @HealyLondon, Cari @Finolater, Michelle - Does this mean onsite at the AAH office?

Commented [HC12R11]: This language is old, UM does not have established workflows or training to do face to face communication. We can take this out. Or leave it since it says "may be" in case we want to provide this in future.

Commented [FM13R11]: removed onsite reference- there is no formal reg and the statement still flows without it.

Commented [WM14]: 1. Are other platforms available here such as email?
2. Need to be specific as to what UM processes include during this time "UM processes may include expedited authorizations for telehealth or extended timelines as permitted by DHCS and CMS guidance, ensuring members maintain access to care"

Commented [MT15R14]: @HealyLondon, Cari please review addition and approve.

Commented [HC16R14]: Reviewed and approved.

Commented [HC17R14]: Addition approved

Formatted: Font: (Default) Times New Roman, 12 pt, Font color: Auto

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: 12 pt

Commented [FM18]: @Thomson, Michelle @HealyLondon, Cari Do we need to consider the D-SNP AOR information here? This is a little more broad and makes it seem as though we can speak to any family.

Commented [HC19R18]: @Finolater, Michelle, @Thomson, Michelle see my edits here

Commented [FM20R18]: sufficient

- 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.

9-13. AAH recognizes the diverse cultural and linguistic needs of our members. AAH hires staff in UM and other areas that are bi-lingual, and a list of those staff and their language abilities is kept in a resource guide for UM staff. If a staff member is not available to assist in translating or speaking with the member in their language, AAH has a contracted interpreter service with qualified interpreter services for threshold languages as defined by DHCS and CMS. UM staff are trained in how to access this service.

14. Information regarding how to access UM staff to discuss UM issues is provided in provider denial notifications, notice of action letters and coverage determination letters, the provider manual, and member denial of service notifications. 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.

~~10-15.~~ D-SNP All members receive a notice of availability of language assistance services and auxiliary aids and services (Notice of Availability) that states the Alliance provides language assistance services and appropriate auxiliary aids and services free of charge.

16. The Member Handbook/Evidence of Coverage is always available to members on the AAH website and will be sent to members upon request. The Handbook describes communication methods available to members regarding all aspects of their AAH membership, such as what services do or do not require prior authorization, how to get all types of care in and out of network, how to access emergency services, second opinions, and sensitive services, the availability of care coordination to assist members to obtain care, and how to access all rights, benefits, and resources available to members.

11.

DEFINITIONS

Accessibility – The extent to which a patient can obtain available services when they are needed. ‘Services’ refers to both telephone access and ease of scheduling an appointment, if applicable.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. ~~BH-001~~ Behavioral Health Services- Medi-Cal
2. ~~BH-002~~ Behavioral Health Services

Commented [MT21]: @HealyLondon, Carla do we have a workflow for this?

Commented [HC22R21]: The Alliance maintains workflows that align with APL-22-002 in order to remain compliant with Alternative Format selection, so that members with a visual impairment (for example) have access to materials that provide information needed.

Commented [HC23R21]: See CLS 003 for language assistance services-policy describes how members can access materials in alternative formats. MS Training Manual_4.1.2025.pdf UM workflows need to be developed as they do not exist in either IP or OP

Formatted: Font: 12 pt

Formatted: Left, Indent: Left: 0.32", Hanging: 0.25", Right: 0", No bullets or numbering, Tab stops: Not at 0.57"

Commented [MT24]: @HealyLondon, Carla @Lam, Allison this is new for D-SNP and replaces the MIL. @Vallejo, Yana we need to discuss with AFS workgroup to align on this notice.

Commented [AL25R24]: This applies to Medi-Cal, as well. See APL 25-005

Formatted: Left, Indent: Left: 0.32", Hanging: 0.25", Right: 0", No bullets or numbering, Tab stops: Not at 0.57"

Commented [WM26]: Staff training: Um staff must be trained to coordinate UM decisions for D-SNP members integrating Medicare and Medi-Cal benefits to provide seamless access to care per all of the regulatory bodies.

Commented [FM27R26]: Added this under bullet #5

Commented [WM28]: AAH UM staff consider social determinants of health (SDOH), such as housing, transportation, and food insecurity, when reviewing authorization requests for D-SNP members, ensuring equitable access to care in alignment with CalAIM and CMS health equity goals.

Commented [FM29R28]: Added to Bullet 10

Commented [MF30]: @DeRochi, Andrea Can you please double check these 2 policies- they are listed above 1 & 8 but 2 is not- can you please verify and add in the titles. Thanks!

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 11 pt

3. [BH 008- Behavioral Health Services- Group Care](#)
4. [BH XXX- Behavioral Health Services- DSNP](#)
- [UM-001 UM Authorization Process](#)
5. [BH 002 Behavioral Health Services](#)
- [UM-015 Emergency Services and Post Stabilization](#)
6. [UM-015 Emergency Services and Post Stabilization](#)

REVISION HISTORY

8/2/2012, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 3/19/2024, [4/30/25](#)

REFERENCES

- [42 CFR.210 - Coverage and Authorization of services](#)
- [42.CFR 438.10 - Information Requirements](#)
- [After-Hours Access CFR Title 42 422.112\(a\)\(7\)](#)
- [Alameda Alliance for Health Contract with DHCS, Exhibit A, Attachment 13 Member Services, I. A. 1 \(a\)](#)
- [DHCS APL 22-002: Alternative Format Selection for Members with Visual Impairments.](#)
- [DHCS APL 21-011: Requirements for utilization management and timely access.](#)
- [DHCS Contract, Exhibit A, Attachment 9 – Access and Availability: Requires plans to maintain procedures for members to obtain necessary health care services in a timely manner.](#)
- [DHCS APL 25-005 \(Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats\)](#)
- [Multilingual Access: CFR Title 42 438.10\(d\)](#)
- [NCQA 2014 Health Plan Standards, UM Standard 3.A.](#)
- [Regular Business Hours Access CFR Title 42 438.206\(c\)\(1\)\(ii\)](#)
- [Timely Access to Health Care Services 42 CFR 422.112](#)
- [Multilingual Access: CFR Title 42 438.10\(d\)](#)
- [Title 28, California Code of Regulations \(CCR\) 1300.67.2.2: ~~Timely Access to Health Care Services 42 CFR 422.112~~](#)
- [Regular Business Hours Access CFR Title 42 438.206\(c\)\(1\)\(ii\)](#)
- [42 CFR.210 – Coverage and Authorization of services](#)
- [42.CFR 438.10 – Information Requirements](#)

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.

Formatted: Font: 11 pt

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: 0.24", Left

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: 0.24", Left

Formatted: Font: 11 pt

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 11 pt

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: Not at 0.24"

Commented [AL31]: Please add reference to DHCS [APL 25-005](#) (Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats)

Formatted: Font: (Default) Times New Roman, 11 pt

Formatted: Font: (Default) Times New Roman, 11 pt

Formatted: Font: 11 pt

Formatted: Right: 1.07", Tab stops: 0.24", Left

Formatted: List Paragraph, Tab stops: 0.24", Left

Formatted: No bullets or numbering



POLICY AND PROCEDURE

<u>Policy Number</u>	<u>UM-046</u>
<u>Policy Name</u>	<u>Use of Board-Certified Consultants</u>
<u>Department Name</u>	<u>Utilization Management Department</u>
<u>Policy Owner</u>	<u>Utilization Management Medical Director</u>
<u>Lines of Business</u>	<u>MCAL, IHSS, D-SNP</u>
<u>Effective Date</u>	<u>11/1/2012</u>
<u>Subcommittee Name</u>	<u>Quality Improvement Health Equity Committee</u>
<u>Subcommittee Approval Date</u>	<u>TBD</u>
<u>Administrative Oversight Committee Approval Date</u>	<u>TBD</u>

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

Formatted: Body Text

+

POLICY STATEMENT

Purpose:

To establish guidelines for the effective utilization of board-certified physicians in a healthcare setting. To ensure that utilization management decisions are informed by appropriate clinical expertise, particularly in complex or specialized cases, by incorporating board-certified consultants into the UM decision-making process.

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Left

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt, Not Bold, Font color: Auto

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Scope:

This policy applies to all healthcare providers and all UM activities, including prior authorizations, concurrent reviews, and retrospective reviews, for services provided to the Alliance Medi-Cal, Group Care and D-SNP members.

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

POLICY STATEMENT

Formatted: Font: 12 pt

Formatted: Left

The Alliance's authorization process assures timely and efficient access to covered medical services that require authorization from the Plan.

All Organizational Determinations for MediCal, D-SNP, and potential denials for all Lines of Business, issued by the Alliance must be reviewed by the Alliance Chief Medical Officer and/or Medical Director who maintains a current list of ~~Board-Certified~~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~~Board-Certified consultants is outlined in Section One (1) below.

The Alliance Chief Medical Officer (CMO) maintains a current list of ~~Board-Certified~~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~~Board-Certified consultants is reviewed at Utilization Management Committee (UMC) and updated at least 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~~Board-Certified Consultants when needed, reviews and signs all denials that are made, whole or in part, on the basis of medical necessity.

Board certified consultants may also be engaged in the following circumstances:

- When the clinical aspects of a case fall outside the expertise of available utilization management and medical director staff.
- When standard medical necessity criteria do not adequately address the specifics of a case.
- When a provider requests a ~~peer-to-peer~~peer-to-peer discussion regarding a UM decision.

All board certified consultants hold an active unrestricted license to practice medicine. The ~~Health plan~~Alliance maintains business associate agreements with the contracted Independent Review Organization (IRO) or consultant, allowing for disclosure of protected Health information (PHI).

The ~~Health plan~~Alliance will ensure that the IRO performs verifications through their credentialing and recredentialing process that the consultant is licensed and board-certified in the appropriate specialties.

PROCEDURE

A. Section I. When to use a Board-Certified Consultant

Board Certified Consultants should- be used -whenver- a reviewer of the appropriate - specialty is not available to make a decision on a denial or appeal. These circumstances are

Commented [AL1]: Recommend removing this, because the list is not attached to the P&P

Formatted: Font: 12 pt

Formatted: Left

Formatted: Font: 12 pt, Font color: Custom Color(45,45,45))

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Font color: Custom Color(45,45,45))

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Font color: Custom Color(45,45,45))

Formatted: Font: 12 pt

Formatted: Left, Indent: Left: 0.69"

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Left

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Font: 12 pt, Font color: Auto

Commented [AL2]: What does this stand for?

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Left

Formatted: Font: 12 pt, Bold, Font color: Gray-95%

Formatted: Font: 12 pt, Bold, Font color: Gray-95%

Formatted: Font: 12 pt, Bold

Formatted

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.44", Right: 0.04"

described below.

1. **Independent Medical Review** - When the Medical Director reviewer is unable to apply medical necessity and regulatory guidelines (UM-001) for the Medical Director medical necessity review, particularly for non-covered benefits that require medical necessity review. Board Certified consultants will provide an independent medical review with medical necessity recommendations based on peer reviewed published journals, national organization guidelines, and expert opinion.
2. **High Complexity or Specialized Procedures and Services** - Board Certified Consultants should be used to review highly complex cases or procedures when the facts are not clearly defined and there are alternative decisions that may be made based upon assessment of the clinical condition
These procedures or services require the review of a professional in the same or similar specialty to the physician performing the procedure and the expertise is not readily available within the network of credentialed providers to give a nonbiased and evidence-based review
3. **Insufficient Levels of Certification** - Board-Certified-Consultants-should- be used when the physician performing the procedure or service is highly-credentialed-or board certified and internal review resources are not similarly credentialed or certified.
4. **Conflict of Interest** - Board Certified Consultants should be used if available internal reviewers have established personal or professional conflicts of interest.
5. Situations where there is disagreement between the treating provider and the health plan Medical Director or a Behavioral Health Medical Director about a treatment plan or a medical necessity appeal decision.
6. To review Appeals, when necessary.

B. 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.
 - a. Attach, fax or email necessary case information and identify the specific questions to be addressed.
 - b. Attach, fax or email necessary case information and identify the specific questions to be addressed.

Formatted: Font: 12 pt, Font color: Gray-95%, Character scale: 100%

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.69", No bullets or numbering

Formatted

Formatted

Formatted: Font: 12 pt, Font color: Auto

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.69", No bullets or numbering

Formatted: Font: 12 pt, Character scale: 100%

Formatted: Font: Times New Roman, 12 pt

Formatted: Indent: Left: 0.69", No bullets or numbering

Formatted: Font: 12 pt, Not Bold, Font color: Auto

Commented [MT3]: DeRochi, Andre review for BH
Valles, Yan

Formatted

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.44", Hanging: 0.25", Right: 0", Line spacing: single, No bullets or numbering, Tab stops: Not at 0.69" + 0.69"

Formatted: Font: Times New Roman, 12 pt, Font color: Auto

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.19" + Indent at: 0.44"

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: 12 pt

Formatted: Left

Formatted: Font: 12 pt, Font color: Auto

Formatted: Indent: Hanging: 0.37", Right: 0", Space Before: 0 pt, Line spacing: single, Tab stops: Not at 1.2" + 1.2"

Formatted: Font: 12 pt

Formatted

Formatted: Font: 12 pt, Font color: Auto

Formatted

- e.
- b. Receive decision and supporting explanations within 24 hours of their receipt of initial case information. The consultant will use the latest available knowledge to review the current treatment plan, define standards of care and identify deviations from or adherences to standards of care and recommend a plan.

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 1.19", Right: 0", Space Before: 0 pt, Line spacing: single, Tab stops: Not at 1.2" + 1.2"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.31", No bullets or numbering

Formatted: Left

Formatted: Left

Formatted: Font: 12 pt

Formatted: Left

Formatted: Font: 12 pt, Font color: Auto

Formatted: Font: 12 pt

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.

Independent Review Organization (IRO): An entity that conducts independent external medical or behavioral health reviews of medical necessity determinations and adverse health care treatment decisions.

Organization Determination: Any determination made by a health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a practitioner other than the health plan that the enrollee believes are covered under the plan, or, if not covered under the plan, should have been furnished, arranged for, or reimbursed by the health plan;
- The health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the health plan;
- Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary; or
- Failure of the health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: 12 pt

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: 12 pt

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: 12 pt

AFFECTED DEPARTMENT SIPARTIES

All Alliance Departments.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

RELATED POLICIES AND PROCEDURES AND OTHER RELATED

Formatted: Font: 12 pt

Formatted: Font: 12 pt

DOCUMENTS

1. AMR Board Certified Consultants List
2. PDR-001 Provider Dispute Resolution Mechanism
3. QI-104 Potential Quality of Care -Issues (PQI~~is~~)
4. UM-001 Utilization Management
5. Program UM-046 -Attachment A
6. UM-001 Utilization Management

AMR Board Certified Consultants List

REVISION IDSTORY

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, 4/30/2025

Red = substantive updates

REFERENCES

2025~~12~~ NCQA Standards A~~-~~UM 4- UM 7~~-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.

Formatted: Font: 12 pt, Font color: Gray-95%

Formatted: Font: 12 pt

Formatted: List Paragraph, Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Line spacing: single, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: Right: 0.04", Line spacing: single, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: 3.44", Left

Formatted: Font: 12 pt

Formatted: Space Before: 0 pt, Line spacing: single, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: Indent: Left: 0"

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Font color: Auto, Character scale: 105%

Formatted: Font: 12 pt, Not Bold, Font color: Auto, Character scale: 105%

Formatted: Font: Not Bold

Formatted: Font: 12 pt

Formatted: Body Text, Indent: Left: 0.19"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Commented [AL4]: Can we please update with current NCQA standards?

Commented [MF5R4]: Done

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt



POLICY AND PROCEDURE

Policy Number	UM-047
Policy Name	UM Sub-Committee
Department Name	Health Care Services
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	10/22/2015
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

- I. The Utilization Management (UM) Sub-Committee of the Quality Improvement Health Equity Committee (QIHEC) is a forum for the Alliance to evaluate current activities, processes, and metrics internal to the Inpatient and Outpatient UM department. The Sub-Committee also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. The UM Sub-Committee serves multiple purposes:
1. To ensure UM functions meet benchmark standards.
 2. To improve quality of care for the Alliance members.
 3. To identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.
 4. To provide a feedback mechanism to drive quality improvement efforts in Utilization Management.
 5. To increase cross functional collaboration and provide accountability across all departments in Health Care Services and other AAH departments.

The Sub-Committees will review and provide feedback regarding utilization trends, specialty referral reports, audit results, opportunities for improvement, and corrective actions plans (CAPs).

- II. For D-SNP the Utilization Management Sub-Committee is a stand-alone committee that is not combined with any other Alameda Alliance for Health business lines such as Medi-Cal and Group Care.
-
-

PROCEDURE

I. Committee Composition

- A. The MediCal Utilization Management Sub-Committee is chaired by the Chief Medical Officer (CMO) or designee and is composed of Directors and Managers from the following departments:

1. Utilization Management
2. Compliance
3. Quality Assurance/Grievance and Appeals (G&A)
4. Quality Improvement
5. Pharmacy
6. Case Management
7. Credentialing
8. Member Services
9. Provider Relations and Contracting
10. Behavioral Health
11. Analytics
12. A majority of members who are practicing physicians
13. At least one practicing physician who is independent and free of conflict relative to the MA organization and MA plan
14. At least one practicing physician who is an expert regarding care of elderly or disable individuals
15. Committee Members representing various clinical specialties to ensure a wide range of conditions are adequately considered in development of UM policies

Department	Regular Members
Utilization Management	• CMO • Medical Directors (UM and LTSS) • Senior Director, Health Care Services • UM Director • LTSS Director • UM Managers
Quality Improvement	• Quality Improvement Medical Director • Senior Director, Quality • Appeals and Grievances Manager
Quality Assurance/G&A	• Director, Quality, Accreditation, Audits, Reports and D-SNP Trainer
Pharmacy	• Senior Director of Pharmacy
Case Management	• Medical Director • Director of Social Determinants of Health • CM Managers

*Other subject matter experts from various departments and delegated entities may be asked to attend the UM Sub-Committee meeting which may include: CHCN, CFMG, IT, Compliance, etc.

II. Governance and Reporting Structure

- A. The Utilization Management Sub-Committee summary reports are reviewed at the Quality Improvement Health Equity Committee (QIHEC) at least once a year:

III. Committee Operations

- A. The Sub-Committee meets at minimum quarterly.
 - 1. Member attendance documented and records maintained.
- B. A quorum is 51% of the appointed members
- C. A simple majority of voting members make decisions.
- D. Meeting discussion, actions, follow up assignee and attendance is documented in meeting minutes. Approved meeting minutes are reported to QIHEC.
 - 1. Documentation is kept for a minimum of 10 years per CMS Record Retention Policy
- E. New deliverables identified in each meeting will be discussed in subsequent meetings.
- F. Responsibilities include, but are not limited to:
 - 1. Review utilization trends to identify over and underutilization for the Alliance Direct, Delegated Medical Groups and Vendors (CHCN, CFMG and CHME). Utilization of services will be compared against benchmark standards (refer to UM-004 Over and Underutilization for process). Areas of focus may include but are not limited to:
 - a. ER utilization
 - b. Inpatient admissions and readmissions
 - c. Radiology services and DME utilization
 - d. Specialty services and outpatient surgeries
 - e. Out of Network utilization
 - f. Ambulatory Services (PCP visits and Preventative Care Visits)
 - g. Pharmacy (retail and specialty injectables, Antibiotic and Opioid Utilization and Emergency Service Usage)
 - h. Behavioral Health Utilization
 - i. Long-Term Services and Supports (LTSS)
 - j. CalAIM Community Supports
 - k. Turn Around Time Compliance Metrics
 - l. All other services requiring a prior authorization
 - 2. Review of Delegate Quarterly performance reports to ensure adherence to UM policies, clinical criteria, and regulatory timelines. Discuss issuance of corrective action plans for deficiencies
 - 3. Review reports for overturned Clinical and Administrative denials through the Appeals and Grievance process and evaluate the appropriateness of authorization rules relative to the volume of appeals.
 - 4. Review PCP specialty referral patterns and assess referral performance and issues related to barriers to access. The rate of referrals by specialty will be tracked and evaluated for potential improvement (for process refer to UM-004 Over and Underutilization).

5. Review and monitor corrective action plans and opportunities for improvement for UM processes.
 - a. Review internal UM audit results conducted by UM.
 - b. Review Internal UM audit results from Compliance.
 - i. Evaluation of UM denial trends
 - c. Review UM CAPs issued by regulatory or accrediting bodies: DHCS, DMHC, NCQA and CMS
6. Review and approve the implementation or change of appropriate, currently medically necessary criteria
7. Review and approve UM Policies and Procedures annually and as needed.
8. Review Inter-Rater Reliability (IRR) reports and take corrective action
9. Evaluate grievances and appeals related to UM decisions
10. Review and monitor D-SNP Stars scores and opportunities for improvement to the UM Process
11. Review and approve the updates on the D-SNP Model of Care (MOC) document
12. Review and Monitor D-SNP member equity, language access and alternative format requests
13. Review of case management member satisfaction survey results
 - a. Develop interventions to address member concerns, improve staff training, and enhance overall care management experience
14. Review of the report summarizing the feedback that is shared with the care management team via the member satisfaction survey, Community Advisory Committee, Complaint and Grievance Tracker and Direct Feedback Mechanisms.

IV. Change Management Process

If the UM Sub-Committee decides to make any changes or refinements that will impact a specific department, UM will work with the affected stakeholder accordingly. All CAPs and opportunities for improvement will be reported to the Quality Improvement Health Equity Committee (QIHEC).

Any recommended changes from QIHEC will be taken into consideration. Ad Hoc meetings may be called by the CMO during which respective UM Sub-Committee members will review the recommendations made by QIHEC. A decision will be made by the Sub-Committee about implementing the requested change and report back to QIHEC.

DEFINITIONS

None

AFFECTED DEPARTMENTS

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Alliance D-SNP Model of Care
2. CLS 003 Nondiscrimination, Language Assistance Services and Effective Communication for Individuals with Disabilities
3. DHCS Contract Exhibit A, Attachment 4, Section 9.B
4. DHCS Contract Exhibit E, Attachment 2, Section B.1
5. UM-001 UM Program
6. UM-004 Over and Under Utilization
7. UM Program Description

REVISION HISTORY

01/10/2016, 12/15/2016, 5/25/2017, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 9/19/2023, 12/18/2024, 5/7/2025

REFERENCES

CFR 422.137 Medicare Advantage Utilization Management Committee
DHCS Contract Exhibit A, Attachment III

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-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, <u>D-SNP</u>
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 establishes a consistent, effective, and compliant approach to patient triage and screening. ensures that the Ttelephone 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. Patients will be sorted based on the severity of their condition and determining the priority of their treatment according to clinical urgency. Triage systems shall be standardized and evidence based in compliance with CMS

regulations and DHCS requirements.

A. **Provider Triage and Screening Procedures**

The providers must maintain the following procedures for triage and screening member telephone calls:

1. Employment, during and after hours, of a telephone answering machine and/or an answering service and/or office staff.
2. Notice to caller regarding length of wait for a return call from the provider.
3. Notice to caller regarding how they may obtain urgent or emergency care including, if applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

Commented [WM1]: DHCS differentiates between urgent (Evaluate within 30 minutes; refer to emergency services) and non-urgent (provide guidance within 1 business day). This policy is currently set up only using this 30 minute rule-wanted to just make sure we did not want to update this.

B-B. Nurse Advice Line

For cases when the providers are unable to meet the time-elapased standards, the Plan provides members the AlliancePlan'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.

Formatted: Underline

Formatted: Underline, Condensed by 0.15 pt

Formatted: Underline

The Alliance uses a nurse advice line to handle any calls that cannot be answered within the thirty (30) minute threshold for its Medi-Cal, ~~and~~ Group Care (IHSS) ~~and~~ D-SNP members. The phone number for the nurse advice line is included in the EOC and Alliance website. Members may access the nurse line by calling the customer service line, located on the membership card, and following the appropriate prompts. AAH has a dedicated Member Services phone line for D-SNP: 1.888.882.3767 (888-88ADSNP). The toll-free number is supplied in the Member Handbook, on the web site and in enrollment materials.

Commented [TM2]: @Lee, Allison please verify that we included in EOC for D-SNP and on website?

Formatted: Font color: Auto

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.

Commented [WM3]: What platform/training/questions are being utilized to ensure standard triage

Commented [HL4R3]: the Nurse Advise Line vendor has a standard audit tool

Commented [TM5]: @Lam, Allison @Findlater, Michelle Do we need a new policy or SOP for this for DSNP?

Commented [AL6R5]: the relationship with the Nurse Advise Line is managed by CM – tagging @Hunter, Lily

Commented [HL7R5]: This is correct. Is there an action here?

Commented [TM8]: @DeRochi, Andrea please redline these BH policies for D-SNP @Vallejo, Yani

Commented [DA9R8]: @DeRochi, Andrea Add in DSHP BH Program policy # when available

Commented [TM10]: @Lee, Allison verifying this is in the EOC and on Website for DSNP

For behavioral health care needs, AAH provides triage and screening services for members and providers. See policy BH-0012 Behavioral Health Services for Medi-Cal. BH-008 for Group Care, BH 00X for D-SNP and MBR-062 MS Referrals and Triage.

C. Member Distribution

The Alliance provides members with information about the availability of triage and screening services and how to obtain the services in its Evidence of Coverage (EOC). The Alliance's EOC is provided to members upon enrollment and annually thereafter. The Alliance's website also provides information on triage and screening services. The Providers are provided with the triage and screening requirements as a part of the orientation when contracted with the Alliance, and in the Provider Manual posted on the Alliance's website.

DEFINITIONS / ACRONYMS

Triage- the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care for the purpose of determining the urgency of the member's need of care.

Triage waiting time – the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Member Services
Case Management
Behavioral Health
Quality Management
Provider Services
Compliance

RELATED POLICIES AND PROCEDURES

QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring Access and Availability Standards QI-115 Access 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-001² Behavioral Health Services [for Medi-Cal](#)
[BH-008 Behavioral Health Service for Group Care](#)
[BH-XXX Behavioral Health Service for D-SNP](#)
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

UM-048 Triage & Screening Services UM-048 Triage and Screening Services
Page 3 of 3

DHCS Contract Exhibit A, Attachment 9 Access and Availability

[Title 22 CCR §53851 DHCS Timely Access to care standards](#)

[Title 22, CCR, §53855, Requirements for appointment scheduling and triage](#)

Title 28, CCR, §1300.67.2, Accessibility of Services

Title 28, CCR § 1300.67.2.2 Timely Access to Non-Emergency Health Care Services

[42 CFR §482.12, Governing body responsibilities for quality of care.](#)

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.



POLICY AND PROCEDURE TEMPLATE

Policy Number	UM-049
Policy Name	Utilization Management Satisfaction Survey
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	10/22/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	<u>5/17/2024TBD</u>
Administrative Oversight Committee Approval Date	<u>7/17/2024TBD</u>

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) conducts an annual provider and member satisfaction survey. The satisfaction survey is conducted in accordance with valid and reliable survey methodology, and complies with regulatory requirements established by DHCS and CMS. It is designed to solicit feedback from Alliance contracted physician / non- physician medical and mental health providers and from Alliance members about their experience with the plan's Utilization Management (UM) process, which includes Behavioral Health (BH) UM processes. The purposes of the annual survey ~~is~~are to:

- Inform the Alliance how well provider and member expectations and needs are being met;
- Assess provider and member satisfaction with the Alliance's UM program
- Analyze survey results, in order to:
- Identify improvement opportunities and;
- Support the design of actions to improve provider and member experience with the Alliance's UM services.

PROCEDURE

Commented [MT1]: DeRochi, Andrea please review for BH
Valencia, Yan

Commented [AD2R1]: Done

Formatted: Indent: Left: 0.4", Space Before: 0 pt, Line spacing: single, Bulleted + Level: 1 + Aligned at: 0.4" + Indent at: 0.65"

Formatted: Indent: Left: 0.4", Space Before: 0 pt, Bulleted + Level: 1 + Aligned at: 0.4" + Indent at: 0.65"

Formatted: Indent: Left: 0.4", Space Before: 0 pt, Line spacing: single, Bulleted + Level: 1 + Aligned at: 0.4" + Indent at: 0.65"

Formatted: Indent: Left: 0.1"

1. UM Satisfaction Surveys

a. Provider Survey

i. The Alliance contracts each year with a nationally certified survey vendor to conduct a Provider satisfaction survey;

ii. The survey consists of a two-wave mail and internet with phone follow-up survey methodology conducted over a 90-day period, using multiple distribution methods in order to maximize response rates;

iii. The survey vendor chooses a statistically valid and stratified sample of Alliance providers from the Alliance's provider database;

iv. Include providers from all specialties and practice types to ensure representative sampling;

v. The survey questions cover a variety of Alliance operations to include UM services;

v. The vendor submits a report that includes:

1. Summary Rate that is the proportion of respondents who selected the most positive response for the individual questions that focused on UM;
2. Rates that measure providers' access to knowledgeable UM/BH staff, procedures and timeliness for prior authorization information, health plan facilitation/support of appropriate clinical patient care, access to plan case managers, and the degree to which the plan encourages preventive care and wellness;
3. All Other Health Plans comparison allows providers to rate Alameda Alliance for Health versus all other health plans in the market;
4. Comparison to the vendor's Medicaid Book of Business and D-SNP/Medicare Book of Business is a benchmark containing data from all eligible provider satisfaction surveys; and
5. Provider Pass/Fail summaries.

b. Member Survey

1. Sources:

- a. Administer annually to comply with CMS and DHCS quality assessment requirements
- b. Distribute to members with UM decisions (both approvals and denials) in the survey period
- c. Make surveys available in threshold languages as defined by DHCS contract
- d. Provide accessible formats for members with disabilities

Formatted: List Paragraph, Left, Right: 0.15", Space Before: 4.5 pt, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 1.19" + Indent at: 1.4", Tab stops: 1.4", Left

Commented [MT3]: @Vallejo, Yani new task for workplan - add D-SNP as a LOB for vendor and survey.

Commented [AL4R3]: @Vallejo, Yani @Thomsen, Michelle Please confirm status with Michelle Stott (her team coordinates with Press Ganey for the provider satisfaction survey)

a-c. Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) conducted by the Department of Health Care Services (DHCS) contracted vendor for Medi-Cal Adults; and

b-f. Annual CAHPS conducted by the Alliance's contracted vendor for Medi-Cal Children and Adults.

g. Annual CAHPS conducted by the Alliance's contracted vendor for Group Care.

e-h. CMS survey methodology requirements

2. Sample members contacted by mail and/or phone are asked to respond to "Getting Needed Care" questions:

- a. How easy was it to get specialty appointments within last 6 months?
3. How easy was it to get the care, tests, or treatment you thought you needed within last 6 months?
4. The DHCS CAHPS report contains key findings, conclusions, and recommendations.
5. The Alliance Quality, Utilization Management and Behavioral Health Department staff reviews the findings of the Alliance vendor CAHPS report and develop conclusions and recommendations.

2. Annual UM Satisfaction Survey Analyses and Reports

a. Compile survey data within 60 days of survey completion date.

b. Analysis Methodology complies with CMS requirements for quality improvement and data analysis

c. Analyze results to assess:

i. Overall satisfaction rates

ii. Trends compared with previous years

iii. Areas of strength and opportunities for improvement

iv. Variability in satisfaction rates among different provider types or member demographics

d. Statistical analysis will include:

i. Response rates

ii. Mean scores for each question

iii. Statistical significance of results

iv. Correlation between satisfaction levels and UM decisions

a-c. Designated Quality, UM and BH Department staff review UM satisfaction survey results and prepare a report with findings, conclusions, and recommendations for Quality Improvement Health Equity Committee (QIHEC) review and approval;

f. The UM/BH Satisfaction Survey findings, conclusions and recommendations are

Commented [MT5]: @Yani Vallejo - add to workplan to verify that we have added DSNP to CAHPS Survey

Formatted: Justified, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.65" + Indent at: 0.9"

Formatted: List Paragraph, Justified, Right: 0.08", Space Before: 0.05 pt, Line spacing: Multiple 1.15 li, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Left + Aligned at: 1.19" + Indent at: 1.4", Tab stops: 0.82", Left

incorporated into the annual UM Program Evaluation and the UM Program Work Plan for the upcoming year.

b-g.

3. UM/BH Satisfaction reported in Member Grievance and Appeals Cases

- a. Member grievance and appeal cases may provide evidence of satisfaction or dissatisfaction with Alliance UM services;
- b. Designated Quality, UM, and BH Department staff will review quarterly Grievance and Appeal reports for cases involving UM/BH satisfaction or dissatisfaction and will:
 - i. Take appropriate follow-up action on individual cases;
 - ii. Monitor quarterly reports for trends and patterns; and
 - iii. Develop and implement improvement plans, when appropriate.

DEFINITIONS / ACRONYMS

Utilization Management (UM) is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of patient care (Kongstevdt, 2001). It is the process of evaluating the medical necessity, appropriateness, and efficiency of health care services, and includes behavioral health care.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments including but not limited to:
Quality Improvement
Utilization Management
Provider Relations
Member Services
Compliance
Behavioral Health
Grievance and Appeals

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Health Equity Program

QI-117 Member Satisfaction Survey

QI-118 Provider Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health Utilization Management Program Description

REVISION HISTORY

01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 03/22/2022, 6/20/2023, 7/17/2024, 5/14/2025

REFERENCES

[42 CFR § 438.236, Practice Guidelines](#)

[42 CFR § 438.330, Quality Assessment and Performance Improvement Program](#)

[42 CFR § 422.152, Quality Improvement Program](#)

[CMS Medicare Managed Care Manual, Chapter 5, Quality Assessment](#)

[DHCS All Plan Letter \(APL\) 17-014, Quality and Performance Improvement Requirements](#)

DHCS Contract for Medi-Cal 2011, Exhibit A, Attachment 4 Quality Improvement System,
§ 9. D. Customer Satisfaction Survey

[NCQA UM 1: Utilization Management Structure, Element G: Satisfaction with the UM process](#)

MONITORING

The Compliance, Utilization Management, and Behavioral Health 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 annually.

POLICY AND PROCEDURE

Policy Number	UM-050
Policy Name	Tracking and Monitoring of Services Prior Authorized
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	3/24/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Date	TBD

Purpose:

This policy establishes procedures for the systematic tracking and monitoring of healthcare services subject to prior authorization (PA) requirements. It ensures compliance with CMS and Medicaid services regulations for PA and safeguards against improper utilization.

Scope:

All clinical and administrative staff involved in requesting and processing healthcare services that require PA.

POLICY STATEMENT

- A. The Alliance maintains a specialty referral system to track and monitor referrals requiring prior authorization. The system includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system includes non-contracting providers.
- B. Services and specialist referrals that may require prior authorization include:
 - Out of network (OON) specialist referrals
 - Some In-network specialists
- C. Services which require PA are subject to change annually, or more often as needed, following approval from the Quality Improvement Health Equity Committee (QIHEC). The list will be based on Medicare Advantage and Medicaid requirements, CMS national coverage determinations (NDC), local coverage determinations (LCD) and Medicare/Medi Cal benefit policy manual guidelines.
- D. The Alliance ensures that all contracting health care practitioners are aware of

the referral processes and tracking procedures.

- E. The member's Primary Care Provider (PCP) or treating provider arranges and coordinates any specialty referrals or services which may require prior authorization.
- F. A monitoring process is in place to ensure those authorized services are completed in a timely manner.
- G. Prior authorization status will be monitored continuously to ensure compliance with regulatory requirements.
- H. Emergency services do not require prior authorization.

PROCEDURE

- A. The Alliance Utilization Management Program has an established tracking system for prior authorizations (PA) authorized, denied, deferred or modified for members assigned to a Directly Contracted Provider (DCP).
- B. The Alliance captures all inpatient and outpatient authorization requests for members assigned to a DCP in the Alliance Clinical Information Management system. Refer to Policy and Procedure UM-057 Authorization Service Requests process. The following information, at a minimum, is tracked:
 - 1. Service(s) requested
 - 2. Standard vs expedited
 - 3. Date of request
 - 4. Date(s) of service(s) requested
 - 5. Diagnosis
 - 6. Requesting provider
 - 7. Rendering provider
 - 8. Date(s) of service(s) authorized
 - 9. Member demographics
 - 10. Authorization tracking number
 - 11. Status of authorization (approved, denied, partially approved)
 - 12. Reasons for denials
 - 13. Appeal rates and outcomes
- C. HealthCare Analytics runs a report monthly using data from the Clinical Information System to track, at a minimum, the following:
 - 1. Authorization turn-around times
 - 2. Authorization decision approved, partial approved, denied, and deferred
 - 3. Prior authorizations never utilized
 - 4. Authorizations for specialist referrals, including out-of-network
- D. A monitoring report is in place to ensure those services authorized are utilized within the authorized time duration. The monitoring report identifies all authorizations without a corresponding claim by the mid-cycle of the authorization duration and 90 days following the end of the authorization period.
- E. On a monthly basis, the monitoring report for unused authorizations is reviewed by the assigned UM Specialist.
- F. For unused authorizations within 60 calendar days of the initial authorization, a

reminder letter will be sent to all the members with an authorized service without a corresponding claim. The letter is to remind the members to obtain the authorized services before authorization expiration.

1. A monthly report with applicable information is sent securely to our mail vendor to send out all letters. A confirmation report for each member is sent from the vendor to the Alliance for tracking
 2. A copy of reports and confirmation is maintained by the UM Manager.
- G. For unused authorizations that remain unused greater than 90 calendar days from the end of the authorization period with no corresponding claim, a reminder letter will be sent to the Member and/or Member's Representative and Requesting Provider informing them the authorization has expired and, if needed, how to obtain a new authorization.
- H. Expiration Monitoring
1. Weekly reports of authorizations expiring within 30 days
 2. For services not yet provided, determine if service is still needed
 3. Initiate renewal requests at least 14 days before expiration

Monitoring and Access

Every quarter, the monitoring report will be reviewed and presented to the UM Subcommittee to evaluate whether there are access constraints for certain providers and specialties. In addition, if there are certain members that have 100% open and unused authorizations, this may warrant case management to help address any Social Determinants of Health (SDOH) that may be causing barriers to care and to help coordinate the member's care.

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:

Delegated entity: entity the Alliance contracts with to perform utilization management functions.

Directly Contracted Provider (DCP): provider directly contracted with the Alliance; the Alliance manages the care for members with a PCP directly contracted with the Alliance.

Medical Necessity: services or supplies that are needed for the diagnosis or treatment of a medical condition that meet the standards of good medical practice and not for convenience.

Out of Network (OON): provider not contracted with the Alliance.

Prior Authorization: A process where approval for coverage of a service or treatment must be obtained from a payor before the service is provided

Quality Improvement Health Equity Committee (QIHEC): committee comprising of medical services.

Utilization Management Subcommittee: monthly committee comprising of management from UM, pharmacy, and appeals department to discuss utilization metrics; reports up to QIHEC.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics
Utilization Management

RELATED POLICIES AND PROCEDURES

- BH-001, Behavioral Health Services, Medi-Cal
 - BH-008, Behavioral Health Services, Group Care
 - BH-XXX, Behavioral Health Services, D-SNP
 - CMP-019 Delegation Oversight
 - UM-057 Authorization Service Request Process
-
-

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION IDSTORY

3/24/2016, 12/15/2016, 04/16/2019, 3/19/2020, 5/21/2020, 5/15/21, 5/20/2021, 6/28/2022, 9/18/2023, 7/17/2024, 6/21/25

REFERENCES

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 annually.



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 Utilization Management
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
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

PURPOSE

To establish standardized procedures for all staff involved in discharge planning, UM, and care coordination for Alliance members discharge planning to lower levels of care and appropriate utilization of administrative days for members with pending placement to lower levels of care.

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Left

POLICY STATEMENT

1. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.
2. The attending physician is responsible for evaluating the post - acute admission needs of the member and determining the type of recovery prior to discharge.
3. Administrative bed days will be reviewed under the inpatient authorization process. Administrative bed days will be reviewed for authorization by Alameda Alliance for Health (AAH) / Alameda Alliance Wellness while the member is in an acute care inpatient facility which provides a higher level of care than what is needed currently by the member. These 4 Days will be authorized when the appropriate guidelines below are followed while the patient remains in an acute care inpatient facility while patient and is awaiting for a placement in recovery care 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 within 24 hours of admission in accordance with 42 CFR § 482.43(a) for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care and provision of Transitional Care Services (TCS).
 - a) At the time of admission, the hospital discharge planner, case manager or social worker conducts a discharge planning evaluation as required by 42 CFR § 482.43(b) and documents the member's discharge planning and TCS needs and associated barriers to discharge in a note.
 - b) The discharge plan shall address the patient's goals and treatment preferences, in accordance with 42 CFR § 482.43(c)(5)
 - c) The discharge plan will include a comprehensive list of arrangements for post-acute care services the patient will need.
 - d) Transitional Care Services (TCS) includes:
 - i. Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
 - ii. Discharge Risk Assessment
 - iii. Discharge Planning document
- c) A full description of the Alliance TCS program is found in *CM-034 Transition of Care policy* and *CM-D-034 Transition of Care policy*

Formatted: Font: Italic

Formatted: Font: Italic

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~~s member's needs using the Medi-Cal guidelines and the MCG guidelines for recovery facility placement. Medically necessary services are reasonable, necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR § 440.230
4. The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.
5. When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs. Discharge barriers could include:
 - a) Bariatric Needs
 - b) Bedside Dialysis Needs
 - c) Isolation
 - d) Social Determinants of Health (Including Homelessness)
 - e) Long-Term Care (Custodial) Placements
 - f) Aggressive or Wandering Behaviors
 - g) History of Member Elopement/ AMA
6. The AAH UM staff will assist in contacting potential accepting facilities
 - a) If there are no INN options available, The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The procedure for discharge to the out 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, when:

- The patient no longer meets acute care criteria, as determined by utilization review
- Documented evidence shows that placement at an appropriate lower level of care is not immediately available
- The Alliance has actively engaged in placement efforts
- The patient requires a level of care not available in the community
- Administrative day criteria are consistent with Title 22, California Code of Regulations (CCR), Section 51124

AND 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:

Formatted: Indent: Left: 0"

- 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.

Authorization Process

1. The hospital shall submit request for administrative days to the health plan's utilization management department within 24 hours of determining that patient no longer meets acute care criteria.
2. The request must include:
 - a. Clinical summary demonstrating that patient no longer meets acute care criteria
 - b. Documentation of LLOC needs

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

- c. Documentation of placement efforts
- d. Barriers to discharge, if any
- 3. Initial authorization for administrative days will be for up to 5 days, with subsequent reviews conducted at minimum every 5 days.

Continued Authorization Requirements

- 1. For continued authorization of administrative days, the hospital must provide:
 - a. Documentation of ongoing placement efforts
 - b. Record of at least five appropriate facilities contacted within the past 7 days
 - c. Updates on the patient's condition and LLOC needs
 - d. Strategies to address identified barriers to placement.

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Not Bold

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.

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

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

Formatted: Left

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

[DHCS APL 13-005, Requirements for Hospital Administrative Days and Acute Administrative Days](#)

[California Welfare and Institutions Code Section 14132.3, Medi-Cal managed care plans and administrative days](#)

[CDPH AFL 10-21](#)

[42 CFR §440.230](#)

[42 CFR § 482.43\(a\) and \(b\)](#)

[Title 22, California Code of Regulations \(CCR\), Section 51124, Administrative Days](#)

[Title 22, California Code of Regulations, Section 51335, Skilled Nursing Facility Services](#)

Formatted: Normal, Space Before: 0 pt

Formatted: Left

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.



Policy Number	UM-055
Policy Name	Palliative Care
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, D-SNP
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Purpose:

This policy establishes guidelines for the provision of palliative care services in alignment with Medicare and Medicaid services (CMS)

Scope:

This policy applies to healthcare providers, staff and departments involved in delivering palliative care services within Alameda Alliance for Health (Alliance)

POLICY STATEMENT

The Alliance is committed to providing high-quality palliative care services. Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care manages symptoms, addresses psychosocial needs, and supports patients and their families through the course of illness, regardless of prognosis.

Pursuant to Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020, and under Alameda Alliance for Health's (Alliance) contract relative to the provision of the Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment [EPSDT]) services, the Alliance authorizes palliative care services to its members when those services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

Hospice care is both a Medi-Cal and a D-SNP benefit that serves terminally ill members. It consists of interventions that focus primarily on pain, stress and symptom management

rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.

In Dual Eligible Special Needs Plans (DSNPs), the hospice benefit is not managed by the DSNP itself. Instead, this benefit is carved out and provided through Medicare Fee-For-Service (FFS). This means that the responsibility for hospice care falls under Medicare FFS, rather than the DSNP.

Key Points:

- **Carved Out Benefit:** The hospice benefit is specifically excluded from the DSNP's coverage responsibilities.
- **Medicare Fee-For-Service:** Hospice services are administered and funded through Medicare FFS, ensuring that members receive the necessary end-of-life care directly from Medicare.
- **Coordination:** While the DSNP does not manage hospice care, it may still coordinate with Medicare FFS to ensure seamless transitions and continuity of care for members requiring hospice services.

This arrangement allows DSNPs to focus on other aspects of care while ensuring that members receive comprehensive hospice services through Medicare FFS.

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Section 1915(c) Home and Community Based Services waiver, known as the Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA). See APL 13-014, California Children's Services Numbered Letter 06-1011, and Managed Care Policy Letter #11-004.

Procedure

A. Eligibility Criteria

As outlined in APL 18-020, Alliance adopts the DHCS' SB 1004 Palliative Care Policy for the minimum eligibility criteria for palliative care and will authorize palliative care services when medically necessary for members who meet the eligibility criteria.

Members of any age are eligible to receive palliative care services if they meet all the criteria outlined in Section B. below, and at least one of the five requirements outlined in Section C. Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section D below, consistent with the provision of Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment (EPSDT)) services.

B. General Eligibility Criteria:

UM-055 Palliative Care

1. Member must meet all criteria listed in section A, and at least one of the criteria listed in B-E.
 - a. The member is likely to, or has started to, use the hospital or emergency department to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
 - b. The member has an advanced illness, as defined in the disease specific eligibility section below, with appropriate documentation of continued decline in health status, and is not eligible for hospice (adult only; 21 years old or older) or declines hospice enrollment.
 - c. The member's death within a year would not be unexpected based on clinical status.
 - d. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
 - e. The member and, if applicable, family member/ member-designated support person, agrees to:
 - i. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/ palliative care instead of first going to the emergency department; and
 - ii. Participate in Advance Care Planning discussions

C. Disease Specific Eligibility Criteria

1. **Congestive Heart Failure (CHF)**: Must meet (a) and (b)
 - a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
 - b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.
2. **Chronic Obstructive Pulmonary Disease**: Must meet (a) or (b)
 - a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
 - b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.
3. **Advanced Cancer**: Must meet (a) and (b)
 - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
 - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. **Liver Disease**: Must meet (a) and (b) combined or (c) alone.
 - a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and

- b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
 - c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.
- 5. Advanced Dementia/ Alzheimer's Dementia: Must meet four (4) of five (5) criteria:
 - a. Profound memory deficits
 - b. Functional impairment (ADL dependencies)
 - c. Minimal communication
 - d. Decreased oral intake and/or significant weight loss in last six (6) months.
 - e. Malnutrition
- 6. Progressive Neurological conditions
 - a. Difficulty breathing, eating or drinking
 - b. Respiratory muscle weakness
 - c. Nutritional impairment
 - d. Stroke patients with poor KPS (Karnofsky Performance Status) or PPS (palliative performance scale) score
- 7. End stage renal disease
- 8. Other life-limiting conditions causing significant symptom burden

D. Pediatric Palliative Care Eligibility Criteria

1. Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
 - a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
 - b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
 - i. Conditions for which curative treatment is possible, but may fail (e.g., advanced, or progressive cancer or complex and severe congenital or acquired heart disease); or
 - ii. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
 - iii. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
 - iv. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).
2. If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.
 - a. AAH has a process to identify members who are eligible for palliative care,

including a provider referral process. AAH will periodically assess the member for changes in the member's condition or palliative care needs. AAH may discontinue palliative care that is no longer medically necessary or no longer reasonable.

3. For children who have an approved CCS-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition, and AAH is responsible for the provision of palliative care services related to the CCS-eligible condition. AAH is also responsible for the provision of hospice services for pediatric members.

E. Palliative Care Services

1. When a member meets the minimum eligibility criteria for palliative care, AAH will authorize palliative care without regard to age. Palliative care includes, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:
 1. Advance Care Planning: Advance care planning for members includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.
 2. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advanced care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
 - a. Treatment plans, including palliative care and curative care.
 - b. Pain and medicine side effects
 - c. Emotional and social challenges
 - d. Spiritual concerns
 - e. Patient goals
 - f. Advance directives, including POLST forms.
 - g. Legally-recognized decision maker

Plan of Care: A plan of care should be developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care must include all authorized palliative care, including but not limited to pain, and symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program (e.g., CCS Program).

3. Palliative Care Team: The palliative care team is a group of individuals who

Commented [HL1]: Suggested removal, as this language is neither in the DHCS APL 18-020, nor the CY 2026 DSNP Policy Guide.

work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family, and/or legally- recognized decision maker and are able to assist in identifying the member's sources of pain, and discomfort.

This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members provide all authorized palliative care. DHCS recommends that the palliative care team include but is not limited to the following team members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that there is access to chaplain and/or spiritual care provider services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

4. Care Coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs, and implements the plan of care.
5. Pain and Symptom Management: The member's plan of care includes all services authorized for pain and symptom management. Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain, and other symptoms.
6. Mental Health and Medical Social Services: Counseling and social services must be available to the member to assist in minimizing 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.

2. AAH has a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. AAH has an adequate network of palliative care providers to meet the needs of members.
3. AAH may, at its discretion, authorize additional palliative care not described above. Examples of additional services offered by some community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 days a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

Commented [VY2]: @Hunter, Lily does this policy include AAH CM responsibilities in alignment with the DSNP policy guide per DHCS? @Lam, Allison @Thomsen, Michelle

F. Providers/ Network

1. Palliative care services may be authorized in the hospital, as part of the inpatient care treatment plan, outpatient (primary care, specialty care clinics), or by community-based settings, such as home health teams, or hospice entities. The Alliance offers a network of palliative care services to its members through various provider types and utilizes qualified providers who comply with the existing Medi-Cal requirements.
2. The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members as long as the provider complies with the existing Medi-Cal requirements.
3. The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.
4. The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website, Member Handbook, Member Services, Case Management, and member education materials.

G. Referrals and Authorizations

Referrals for palliative care consultation may be made by the following:

1. Attending physicians
2. Advanced practice providers
3. Nursing staff
4. Case Managers
5. Patients or family members with a physician order
6. The Alliance identifies members eligible for palliative care by the following:
 - a. Screening for palliative care eligibility in basic Case Management, Complex Case Management, ECM providers, CBAS designees, Transitions of Care, and 2024 Managed Care Plan Transition for Special Populations and CalAIM Dual Eligible Special Needs Plan Policy Guide.
 - b. Referrals from network providers, members/ family members/ legal-recognized decision-maker, including through case management. concurrent utilization review, and the general authorization process.
 - c. Population Health Management: Analysis of member data

H. Authorizations:

1. Palliative care services follow the general authorization process outlined in the Utilization Management (UM) policy and procedure UM-001 and UM-057 Authorizations Process. Authorizations for palliative care services are reviewed as outlined in UM-001 UM Authorizations Process and meet the timeliness standards as outlined in policy and procedure UM-051 Timeliness of UM Decisions.
2. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity.
3. Referral and care coordination for palliative services will be provided to the member within the time or distance access standard requirements.
4. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider manual, provider newsletters, educational materials and via the Alliance's website.

I. Grievance and Appeals

1. Member complaints related to the provision of palliative care services and authorization process are processed through the Alliance's Grievance and Appeals system in a manner consistent with grievance and appeals requirements set forth in APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments. The process is further described in policy and procedure G&A- D-001 Grievances and Appeals System Description.
2. The Alliance monitors and collects palliative care enrollment, provider, and utilization data to report to DHCS as specified. The Alliance ensures that their delegates comply with all applicable state and federal law and regulations and other contractual requirements as well as DHCS' guidance, including APLs. AAH communicates these requirements to all their delegated entities and subcontractors.

Delegation Oversight

The Alliance adheres to applicable state and federal laws and regulatory requirements, contractual requirements, other DHCS guidance, and accreditation standards for delegates and subcontractors. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS/ ACRONYMS

Hospice Care - defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

2024 MCP Transition - Refers to changes to the Medi-Cal Managed Care Plans (MCPs) operating in specific counties slated to take effect on January 1, 2024, as a result of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser direct contract.

Palliative Care - patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Interventions focus primarily on reduction and abatement of pain, stress, and other disease-related symptoms rather than interventions aimed at investigation and /or cure or prolongation of life. See Health and Safety Code §1339.31(b).

Special Populations - Members most at risk for harm from disruptions in care or who are least able to access Continuity of Care protections by request or who are identifiable in DHCS data or Previous MCP's data.

Terminally ill - defined in:

1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code § 1368.1(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.

Interdisciplinary Group (IDG): A team of qualified professionals who collectively provide palliative care services to patients and their families

Interdisciplinary Care Team (ICT): A team of qualified professionals. For D-SNP ICTs will have a trained dementia care specialist on the team

Plan of Care: A comprehensive, individualized care plan developed by the interdisciplinary group in consultation with the patient's provider, the patient, patient representative and primary caregiver.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Claims
Compliance
Provider Relations and Contracting

RELATED POLICIES AND PROCEDURES

CMP-019 for monitoring of delegation oversight
G&A-D-001 Grievances and Appeals System Description

UM-055 Palliative Care

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, 4/30/25,
6/20/2025

REFERENCES

- 42 CFR 418
 - CALAIM: Population Health Management (PHM) Policy Guide, May 2024
 - California Children's Services, #06-1011
 - CMS Quality Reporting Program Measure Specifications User Manual
 - DHCS APL13-014 Hospice Services and Medi-Cal Managed Care
 - DHCS APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
 - DHCS APL 18-020 Palliative Care and Medi-Cal Managed Care
 - DHCS APL 21-011 Grievance and Appeal Requirements and Notice and "Your Rights" Templates
 - DHCS APL 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
 - DHCS D-SNP Policy Guide 2025
 - Medi-Cal Provider Manual "Evaluation and Management (E&M)
 - Patient Protection and Affordable Care Act (ACA), Section 2302.
 - Senate Bill 1004 Palliative Care
 - Welfare and Institute Code (WIC) Section 14132.75
-
-

MONITORING

This policy will be reviewed on an annual basis to ensure it complies with regulatory and contractual requirements.



POLICY AND PROCEDURE

Policy Number	UM-063
Policy Name	Gender Affirming Surgery and Services
Department Name	~~Health Care Services~~ Utilization Management
Policy Owner	Director of Utilization Management
Line(s) of Business	MCAL, IHSS, <u>D-SNP</u>
Effective Date	11/21/2013
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	<u>TBD11/15/2024</u>
Administrative Oversight Committee Approval Date	<u>TBD12/18/2024</u>

POLICY STATEMENT

This policy outlines medically necessary gender-affirming care for transgender and gender-diverse members, in accordance with World Professional Association for Transgender Health (WPATH) standards, and state and federal regulations for Medi-Cal, IHSS and D-SNP beneficiaries. Covered services include mental health care, hormone therapy, and reconstructive surgery to address gender dysphoria or incongruence. Requests for gender-affirming medical and surgical services are evaluated based on medical necessity and reconstructive surgery criteria, with decisions made on a case-by-case basis. The Alliance must comply with federal and state laws prohibiting discrimination based on gender identity and cannot categorically exclude or limit coverage for gender-affirming treatments.

The Alliance is required to treat beneficiaries consistent with their gender identity (Title 42 United States Code §18116; see also 45 CFR § 156.125) and cannot deny services based on a member's gender assigned at birth including transgender diverse (TGD) beneficiaries. Gender diverse people includes but is not exhaustive to include non-binary, eunuch, and intersex individuals. While cosmetic surgery is generally excluded from Medi-Cal coverage, reconstructive surgeries that improve function or treat gender dysphoria are considered medically necessary and are covered. The evaluation process considers supporting documentation from qualified healthcare providers and ensures compliance with federal protections against discrimination.

Formatted: pf0

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 (ESCH).

Commented [AD1]: These are not relevant to TG care

Commented [PC2R1]: Agreed.

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.

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;

Commented [MF3]: coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local MACs on a case-by-case basis. To clarify further, the result of this decision is not national non-coverage rather it is that no national policy will be put in place for the Medicare program. In the absence of a national policy, MACs will make the determination of whether or not to cover gender reassignment surgery based on whether gender reassignment surgery is reasonable and necessary for the individual beneficiary after considering the individual's specific circumstances. For Medicare beneficiaries enrolled in Medicare Advantage (MA) plans, the initial determination of whether or not surgery is reasonable and necessary will be made by the MA plans.

Commented [MF4R3]: Gender Dysphoria and Gender Reassignment Surgery
CAG-00446N

Commented [MF5R3]: Date Action August 1, 1989 CMS published the initial NCD, titled "140.3, Transsexual Surgery" in the Federal Register. (54 Fed. Reg. 34,555, 34,572) May 30, 2014 The HHS Departmental Appeals Board (DAB) determined that the NCD denying coverage for all transsexual surgery was not valid. As a result, MACs determined coverage on a case-by-case basis. CMS does not currently have a NCD on gender reassignment surgery.

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: Indent: Left: 0.44", No bullets or numbering

Formatted: Normal, No bullets or numbering

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 provider (**Health and Safety Code section 1374.72 (3) (A)**).

Formatted: No bullets or numbering

3. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence:

- a. Mental health services, including psychotherapy;
- a. Gender affirming (GA) feminizing/masculinizing hormone therapy and/or puberty blocker/ hormone therapy with clinical monitoring for efficacy and adverse events;
- b. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services.

Formatted: Indent: Left: 0.44", No bullets or numbering

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)**).

Formatted: Indent: Left: 0.25", No bullets or numbering

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.

Formatted: Indent: Left: 0.25", No bullets or numbering, Tab stops: 1.84", Left

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.

Formatted: Indent: Left: 0.25", No bullets or numbering

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.

The Alliance is required to treat beneficiaries consistent with their gender identity (**Title 42 United States Code §18116; see also 45 CFR § 156.125**).

9. 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

Formatted: Indent: Left: 0.25", No bullets or numbering

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)**).

10. _____ 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**).

11. _____ 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.

12. _____ 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.

13. _____ 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.”

14. _____ In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).

15. _____ 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.

Formatted: Indent: Left: 0.25", No bullets or numbering, Tab stops: 1.84", Left

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: Indent: Left: 0.5", No bullets or numbering, Tab stops: Not at 1.84"

Formatted: List Paragraph

PROCEDURE

I. Definition of Medically Necessary Services

1. Medically necessary covered services are defined as services that meet the following qualifications:

- 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.)

Formatted: Indent: Left: 0.13"

Formatted: Indent: Left: 0.13"

Formatted: Indent: Left: 0.38", Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.19" + Indent at: 0.44"

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)).

Formatted: Indent: Left: 0.38"

d. For D-SNP Members, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local MACs on a case-by-case basis.

Formatted: Font: (Default) Times New Roman, 12 pt

Formatted: List Paragraph, Indent: Left: 0.38", Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.19" + Indent at: 0.44"

e. “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:

Formatted: Indent: Left: 0.38", Space After: 0 pt

i. In accordance with the current generally accepted standards of mental health and substance use disorder care.

Formatted: Space After: 0 pt

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)).

Formatted: Font: Not Bold

Formatted: Indent: Left: 1.13", Space After: 0 pt, No bullets or numbering

Formatted: Indent: Left: 0.13"

2. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence when services are requested by a licensed Practioner:

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 0.75" + Indent at: 1", Tab stops: Not at 1.84"

i. Mental health services, including psychotherapy;

ii. Gender affirming (GA) feminizing/masculinizing hormone therapy and/or puberty blocker/ hormone therapy with clinical monitoring for efficacy and adverse events;

iii. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services (CAG-00446N).

Formatted: Font: (Default) Times New Roman, 12 pt, Not Bold, Font color: Auto, Pattern: Clear

Formatted: Indent: Left: 0.38"

3. 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.

4. 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.

II. Guidance prohibiting Denials/ Limitations

Formatted: Font: Bold

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

Formatted: Indent: Left: 0", Hanging: 0.25", Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.75"

Formatted: Indent: Left: 0.25"

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)).

1. DHCS indicates that Federal regulations further ~~prohibits~~prohibit the Alliance from categorically excluding or limiting coverage for health care services related to gender transition (DHCS APL 20-018).

Formatted: Indent: Left: 0.38", Hanging: 0.19"

2. 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.

Formatted: Indent: Left: 0.38", Hanging: 0.19"

Formatted: Indent: Left: 0.38", Hanging: 0.19"

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

Formatted: Indent: Left: 0.38", Hanging: 0.19"

- 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

Formatted: List Paragraph, Indent: Left: 0", Hanging: 0.31", Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.75"

American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCH).

~~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.~~

III. Assess, Diagnose, and Discuss Treatment Options for Mental Health or Medical Conditions

1. 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.

Formatted: List Paragraph, Indent: Left: 0.38", Hanging: 0.19", Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

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.

IV. Written Assessment to Support Gender Affirming Hormone Therapy or Surgical Procedures.

I. (1 Letter/ Documentation)

1. 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.

Formatted: Font: Bold

Commented [MF6]: 1.The Alliance will cover medically necessary medications to treat gender dysphoria/incongruence, mental health or substance use disorders.

Commented [PC7R6]: Correct.

Formatted: Font: Bold

Formatted: Indent: Left: 0.31", No bullets or numbering

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

2. 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 feasible¹. 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.

Formatted: Font: Not Bold

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

3. 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:

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

- a. The client's general identifying characteristics
- b. 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
- c. 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
- d. The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy, or counseling to date
- e. A statement that informed consent has been obtained from the member or parent/ guardian.
- f. 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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

4. An assessment and psychosocial interventions for adolescents are often provided within a multidisciplinary gender identity specialty service.

Formatted: Font: Italic

a. 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.

Formatted: Indent: Left: 0.75"

b. 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

Formatted: Font: Italic

Formatted: List Paragraph, Indent: Left: 0.75", Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

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).

endocrinologist² for the purpose of assessment, education, and involvement in any GA decisions.

5. 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.

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

1. Eligibility Criteria for Gender Affirming Hormone Therapy or Puberty Blocker Hormones for Adolescents (<18 Years Old)

Formatted: Indent: Left: 0"

6. Feminizing/ masculinizing hormone therapy (or puberty blockers) may lead to irreversible physical changes. All of the criteria below must be met:

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

- 1.a. Gender dysphoria/ gender incongruence is marked and sustained for a minimum of six (6) months.
- 2.b. Meets the diagnostic criteria for gender dysphoria/ gender incongruence;
- 3.c. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives³.
- 4.d. 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.e. 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.f. The adolescent has reached Tanner stage 2

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

1. Eligibility Criteria Gender Affirming Hormone Therapy for Adults (≥ 18 Years Old)

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

7. All of the following criteria must be met:

- 1.a. Gender dysphoria/ gender incongruence is marked and sustained;
- 2.b. Meets diagnostic criteria for gender dysphoria/ gender incongruence prior to initiating GA hormone treatment;
- 3.c. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

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).

- 4.d. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;
- 5.e. Mental health and physical conditions that could negatively impact the outcome of the treatment have been assessed, with risks and benefits discussed;
- 6.f. Understands the effects of GA hormone treatment on reproduction and they have explored reproductive options.

V. Gender Affirming Surgery

1. 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 (a. through f.):

- a. Gender dysphoria/ gender incongruence is marked and sustained;
- b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
- c. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives;
- d. 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;
- e. Informed of the reproductive effects, including potential loss of fertility and the available options to preserve fertility;
- f. 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.2. 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 (a. through e.):

- a. Gender dysphoria/ gender incongruence is marked and persistent;
- b. Meets diagnostic criteria for gender incongruence prior to GA surgery interventions;
- c. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
- d. Understands the effect of GA surgical intervention on reproduction and they have explored reproductive options;
- e. Other possible causes of apparent gender dysphoria/ incongruence have been identified and excluded;

Formatted: Font: Not Bold

Commented [MF8]: 1. 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)).

Commented [MF9R8]: 1. 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.

Commented [MF10R8]: 1. 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.

Formatted: Font: 12 pt, Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: List Paragraph, Indent: Left: 0.31", Hanging: 0.19", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: Not Bold

Formatted: Indent: First line: 0", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted: Indent: Left: 0.75", Hanging: 0.31"

- f. 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;

3. 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).
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. 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.

VI. If requesting a GA Ggonadectomy Surgery Requests (i.e., Hysterectomy and/or salpingo-oophorectomy, or orchiectomy) although not an explicit criterion, it is recommended that:

1. 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 contraindicated⁴.
2. These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence.

VII. D-FACIAL FEMINIZATION SURGERY & VOICE AND COMMUNICATION THERAPY

1. Facial feminization surgery (including chondrolaryngoplasty/ vocal cord surgery) is considered a medically necessary to correct a significant physical functional

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.

Formatted: List Paragraph, Indent: Left: 0.25", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: (Default) Times New Roman, 12 pt, Not Bold

Formatted: Font: (Default) Times New Roman, 12 pt

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: List Paragraph, Indent: Left: 0.31"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: 1.06", Left

Formatted: Indent: Left: 0.25", Hanging: 0.25", Tab stops: 1.06", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: 1.06", Left

Formatted: Font: Not Bold

Formatted: Font: Bold, All caps

Commented [MF11]: 1. 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.”

Formatted: Font: Bold

Formatted: Font: Bold, All caps

Formatted: List Paragraph, Indent: Left: 0.38", First line: 0"

Formatted: Font: Not Bold

Formatted: List Paragraph, Indent: Left: 0.25", Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

impairment related to treating gender dysphoria/ gender incongruence, and/ or improve the physical functional impairment respectively.

1. 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).~~

2. 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.
3. 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 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.”
5. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).

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.

2. 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).

- a. 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~~ health and learn non-pitch related aspects of communication.

- b. 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.

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

Commented [MF12]: 1.In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).

Commented [PC13R12]: Agreed

Formatted: List Paragraph, Space Before: 0 pt, After: 0 pt

Formatted: Font: (Default) Times New Roman, 12 pt

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

Formatted: Font: Not Bold

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

3. 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.

Formatted: Font: Not Bold

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

VIII. ~~For the following~~ All basic GA reconstructive procedures:

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: List Paragraph, Indent: Left: 0"

Formatted: Font: Not Bold

All basic GA surgery criteria must be met ~~and (1-6). Additionally, all Procedures individually must be~~ they are medically necessary ~~and 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.

Formatted: List Paragraph, Indent: Left: 0"

Formatted: Font: Bold

~~1.2.~~ Blepharoplasty, Blepharoptosis Repair, and Brow Lift

—Upper eyelid blepharoplasty or blepharoptosis repair is considered medically necessary for ANY of the following conditions.

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.25"

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

Formatted: Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: Font: Not Bold

Formatted: List Paragraph, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: List Paragraph, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: List Paragraph, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

- ~~i. 2.~~ To treat gender dysphoria/gender incongruence;
 - ~~i. a.~~ Difficulty tolerating a prosthesis in an ophthalmic socket; or
 - ~~ii. b.~~ Repair of a functional defect caused by trauma, tumor, or surgery; or
 - ~~iii. c.~~ Periorbital sequelae of thyroid disease; or
 - ~~iv. d.~~ Nerve palsy
- ~~b.~~ Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted below are not met.
- ~~c.~~ 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.
- ~~d.~~ Lower lid blepharoplasty is considered not medically necessary.
- ~~e.~~ 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.

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

a. Unilateral or bilateral upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when the following criteria are met (~~ia~~ or ~~ii~~~~b~~, and ~~iii~~~~e-iv~~~~d~~):

- i. ~~a~~.—To treat gender dysphoria/gender incongruence; or
- ii. ~~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
- iii. ~~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
- iv. ~~d~~.—Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is:
 - 1) ~~1~~—less than or equal to 20 degrees, or there is a 30 percent loss of upper field of vision compared to normal; and
- f. ~~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)

a. Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when the following criteria are met (~~ai~~ or ~~ii~~~~b~~, ~~iii~~~~e~~ through ~~v~~~~e~~):

- i. To treat gender dysphoria/gender incongruence; or
- ii. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; and
- iii. 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
- iv. 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
- v. 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

a. 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):

Formatted: List Paragraph, Indent: Left: 1", First line: 0"

Formatted: Font: Not Bold

Formatted: List Paragraph, Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.38" + Indent at: 1.5"

Formatted: List Paragraph, Numbered + Level: 4 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.75" + Indent at: 2"

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: Not Bold

Formatted: Font: Not Bold

- i. a.—To treat gender dysphoria/gender incongruence; or
- ii. 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
- i. e.—Photographs show the eyebrow below the supraorbital rim.
- iii.

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.25" + Indent at: 1.5"

~~Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted above are not met.~~

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.25" + Indent at: 1.5"

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

- ~~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.~~

Formatted: Indent: Left: 0.75", Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

- ~~Lower lid blepharoplasty is considered not medically necessary.~~

Formatted: Indent: Left: 0.75", Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

- ~~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.~~

Formatted: Indent: Left: 0.75", Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"

6. Otoplasty

Formatted: Font: Not Bold

a. 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 (i.a or ii.b, and iii.e):

Formatted: Indent: Left: 0.75", Hanging: 0.19"

- i. a.—To treat gender dysphoria/gender incongruence; or
- ii. b.—The procedure is reasonably expected to improve the physical functional impairment; and
- iii. e.—An audiogram documents a loss of at least 15 decibels in the affected ear(s).

Formatted: Font: Not Bold

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.25" + Indent at: 1.5"

b. 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.

Formatted: Indent: Left: 0.75", Hanging: 0.19", Outline numbered + Level: 4 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.19" + Indent at: 0.44", Tab stops: 1.25", Left

c. 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.

d. 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.

- e. 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)

a. Rhinoplasty is considered medically necessary when both of the following criteria are met (i. a or ii. b, and iii. e):

- i. a. To treat gender dysphoria/gender incongruence; or
- ii. 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
- iii. e. The procedure can be reasonably expected to improve the physical functional impairment;

- 2. 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.

- 3. 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.

- 4. 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)

a. 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

Formatted: Font: Not Bold

Formatted: Indent: Left: 0.38", Hanging: 0.13"

Formatted: Font: Not Bold

Formatted: Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 1.25" + Indent at: 1.5"

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

Formatted: Indent: Left: 0.5"

Formatted: List Paragraph, Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

Formatted: Font: Not Bold

Formatted: Indent: First line: 0"

Formatted: Indent: Left: 0.75", Hanging: 0.2"

dysphoria/gender incongruence. Examples include, but are not limited to, significant burns or other significant major facial trauma.

- b. 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

a. 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 necessity⁵. Other medical reasons may include if the hair loss response has not been achieved after hormone therapy was trialed, or if hormone therapy is contraindicated. Hair reduction procedures include:

- i. **Laser Epilation/Hair Removal require:**
 - 1) to be provided by a physician, PA, NP, or RN (requires physician supervision);
 - 2) Informed consent;
 - 3) Documentation justifying laser hair removal for the specific body areas
- ii. **Electrolysis Hair Removal require:**
 - 1) Documentation of consultation by a physician, PA, NP, or RN (requires physician supervision);
 - 2) Informed consent;
 - 3) Documentation justifying laser hair removal for the specific body areas
 - 4) Electrolysis will be provided by a licensed electrologist.

IX.E. Additional Procedures for Body Feminization or Body Masculinization

1. 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).
2. 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.

⁵ <https://transcare.ucsf.edu/guidelines/hair-removal>

Formatted: Indent: Left: 0.75", Hanging: 0.19"

Formatted: List Paragraph, Indent: Left: 0.75", Hanging: 0.19", Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Not Bold

Formatted: Indent: Hanging: 0.25"

Formatted: Indent: Left: 0.75", Hanging: 0.2"

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Commented [MF14]: 1. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).

Formatted: Font: Bold

Formatted: Font: Not Bold

Formatted: List Paragraph, Indent: Left: 0.25"

Formatted: Indent: Left: 0.25", Hanging: 0.31"

Formatted: Indent: Left: 0.31"

3. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender

Formatted: Font: (Default) Times New Roman, 12 pt

4. Additional Surgeries may include:

Formatted: List Paragraph, Indent: Left: 0.31", Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

- a. Abdominoplasty
- b. Body contouring (liposuction, lipofilling, Implants, monsplasty/ mons reduction)
- c. Cheek surgery
- d. Chin Shaping
- e. Facial bone reconstruction
- f. Gluteal augmentation
- g. Hair removal/ hairplasty, when the criteria above have not been met.
- h. Jaw reduction (jaw contouring)
- i. Lip reduction/enhancement
- j. Suction-assisted Lipoplasty/ trunk contouring
- k. Otoplasty
- l. Tattoo (i.e., nipple/ areola)
- m. Penile prosthesis in the setting of proposed or completed phalloplasty
- n. Thyroid cartilage reduction/Tracheal shave feminization (larygeochondroplasty)
- o. Voice Modification Surgery

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

X. F-Revisions of Gender-Affirming Surgery (1 Letter Assessment)

Formatted: Font: Bold

1. 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:

Formatted: Indent: Left: 0", Hanging: 0.25", Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.75"

- a. ~~a.~~ Medical and/or functional complications of prior GA procedure;
- b. ~~b.~~ Measurements and/or photographs of deformity/asymmetry (if applicable);
- a. ~~e.~~ Members who regret their GA surgical intervention are to be managed by an expert multidisciplinary team.

Formatted: Font color: Auto, Pattern: Clear

Formatted: Font color: Auto, Pattern: Clear

a. ~~d.~~ Endorsement of medical necessity or reconstructive purpose from the performing surgeon.

c.

Formatted: Indent: Left: 0.69", Hanging: 0.19", Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", Tab stops: 0.75", Left

2. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

Formatted: Indent: Left: 0.88", Tab stops: 0.75", Left

Formatted: Indent: Left: 0.25", Numbered + Level: 2 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.79" + Indent at: 1.04"

XVI. 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 (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.

GENDER DYSPHORIA/ INCONGREUENCEIN IN CHILDREN⁶

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 ADULTS⁷

- 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).

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.

Commented [MF15]: 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.

Formatted: Font: 12 pt

Formatted: Font: (Default) Times New Roman, 12 pt

Formatted: Space Before: 0 pt, After: 0 pt

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 INFERTILITY

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-063 Gender Affirming Surgery and Services

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, [5/8/25](#)

REFERENCES

[CMS: NCA Gender Dysphoria and Gender Reassignment Surgery- CAG-00446N](#)

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:

WPATH [World Professional Association for Transgender Health], the current Standards of Care for the Health of Transgender and Gender Diverse People.

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation,

Formatted: Font: (Default) Times New Roman, 12 pt

gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry*. 2012; 51(9):957-974. Summary on National Guideline Clearinghouse [website].

American Psychiatric Association (APA). Gender Identity Disorder. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington DC: American Psychiatric Association; 2000.

UCSF Gender Affirming Hair Removal guidance : <https://transcare.ucsf.edu/guidelines/hair-removal>

Publications:

American Psychological Association. (2015). Guidelines for professional practice with transgender and gender non-conforming people. *American Psychologist*, 70(9), 832–864.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*, 94(9), 3132– 3154. doi:10.1210/jc.2009–0345

Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *Medical Journal of Australia*, 209(3), 132–136.

MONITORING

Annual audit based on CPT codes submitted.



POLICY AND PROCEDURE

Policy Number	QI-104
Policy Name	Potential Quality of Care Issues (PQIs)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	11/20/2006
Committee Name	Quality Improvement Health Equity Committee
Committee Approval Date	~~2/14/2025~~ 8/8/2025
Administrative Oversight Committee Approval Date	~~4/16/2025~~

OVERVIEW

Alameda Alliance for Health's (AAH) Quality Improvement (QI) Department will monitor, evaluate, and take appropriate action to address any potential quality of care (PQI) issue defined as:

An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.

The PQI review, evaluation and monitoring process applies to all providers rendering services to Alliance members/enrollees on the Plan's behalf, within all care settings. QI has the responsibility for ensuring and maintaining a timely PQI review process from the receipt of all Potential Quality Issues (PQI) through investigation, appropriate intervention, and resolution. AAH considers this system process a critical component of the Quality Improvement Health Equity Program.

POLICY

The purpose of this policy is to describe the system and process for identifying any PQI that:

- is not consistent with plan operations
- indicates a potential or suspected deviation from accepted standards of medical and/or clinical care
- may potentially or result in an adverse outcome for the member or enrollee

1. PQIs are referred to the Quality Improvement (QI) Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.
2. PQIs may be *reported* by anyone, and sources commonly include:
 - a. AAH staff
 - b. Contracted or non-contracted providers
 - c. Behavioral Health / ASD Staff / Providers
 - d. Health plan members/enrollees via the grievance process
3. PQIs may be *identified* internal and external to the organization:
 - a. Member/enrollee or provider complaints – ***Grievance and Appeals, Compliance***
 - b. Member or provider satisfaction surveys – ***Access and Availability***
 - c. Claim and encounter data – ***Claims and Data Analytics***
 - d. Prior authorization activities through concurrent, prospective, and retrospective review – ***Utilization Management***
 - e. Care Coordination and Management activities – ***Case Management or Long-Term Long-Term Care***
 - f. ASD / Behavioral Health Activities – ***Behavioral Health***
 - g. Reports on provider practice patterns – ***Data Analytics***
 - h. Pharmaceutical data and related studies – ***Pharmacy***
 - i. Information from provider regulatory agencies – ***State and County reporting***
 - j. Community and public sources – ***Delegate Reporting***
 - k. Facility Site and Medical Record Review audit results – ***Quality Improvement***
 - l. Notification and complaints from other provider sources – ***Provider Services Peer Review and Credentialing***
 - l. Quality Improvement Projects
 - Medical record audits
 - m. Preventable Provider Conditions – ***Claims, Quality Improvement***
 - n. Retrospective review of any of the above data sources
4. PQIs are submitted through the Alliance Health Suite member database and/or the Grievance and Appeals App with an auto feed directly into the PQI App internally. PQIs externally are received in writing, by fax, the provider portal, or by email to the QI department. PQI referrals received from external sources are manually entered into the PQI App. Each PQI referral received is evaluated by a Registered Nurse or Physician.
5. In accordance with ~~contractual~~the contractual agreement with AAH, participating delegates and its subcontracted providers will perform its PQI activities in compliance with this policy and procedure. Delegates not contracted to perform the PQI activities are responsible for reporting PQIs to AAH promptly for review and investigation.
6. AAH shall ensure that PQI assessments, planning, interventions, and evaluations are consistent with AAH policies, Medi-Cal benefit guidelines, medical/clinical evidence-based guidelines and accepted standards of care.

PROCEDURE

1. PQIs are identified through but not limited ~~to~~to the following methods or criteria:
 - a. Premature discharge from acute or ancillary services.

- b. Post-op and other unexpected complications.

- c. Alleged communication barriers, inappropriate comments, or rudeness of provider/staff.
 - d. Sentinel/adverse events ~~such as~~ such as inappropriate evaluation of medical care, allegation of inappropriate medical care, deviation from standard of care, misdiagnosis or unexpected member mortality.
 - e. Delay or omission of necessary service
 - f. Delay or barrier to care or service
2. Training for member-facing staff, including but not limited to, Member Services and Provider Relation staff, is conducted at least annually to ensure an understanding of the internal PQI reporting, investigation, and communication process.
3. PQI cases classified as Quality of Care (QOC) or Quality of Service (QOS) issues are investigated through the acquisition of medical records and/or other pertinent documentation where appropriate using the following process:
- a. QI clinical staff identify and coordinate with administrative staff to make medical record requests from providers/vendors/entities via fax/phone/secure email/mail.
 - b. When a provider fails to respond to a medical record request within the designated timeframe, staff follow the “Escalation Process for PQI Medical Request Requests” process.
4. Each PQI referral within the PQI App contains but is not limited to the following information:
- a. Current Status: Open - Closed
 - b. Service Request (SR) ID
 - c. Member ID
 - d. Member DOB
 - e. Member Name
 - f. Received Date
 - g. Closed Date
 - h. Referral source
 - i. Provider name
 - j. Name of RN Reviewer
 - k. Name of MD Reviewer
 - l. Case Type (QOA, QOC, QOS)
 - m. Recommended Case Leveling for QOC
 - n. Against Facility/Provider Name
 - o. Reason for referral
5. Using the APIE model of nursing documentation, the QI Review Nurse will review, and document case components as follows:
- a. A-assessment
 - b. P-planning
 - c. I- intervention
 - d. E- evaluation/Resolution

6. All PQI referrals will be triaged by the QI RN Supervisor or clinical staff designee to determine PQI type, ie, Quality of Care (QOC), Quality of Services (QOS), Quality of Access (QOA) or Quality of Language (QOL).

PQI Designations:

- **Quality of Access** PQIs are referred to the Access to Care team for appropriate intervention including but not limited to, tracking, trending, and confirmatory surveying. See P&P **QI-114**.
- **Quality of Language** PQIs are referred to the Cultural and Linguistics team for appropriate intervention including but not limited to tracking, trending, and confirmatory surveying.
- **Quality of Service** PQIs are reviewed by a QI RN Reviewer and may be discussed with vendors in weekly/ad hoc rounds and Joint Operations Meetings (JOM). These cases are investigated through the acquisition of medical records and/or other pertinent documentation requested from the provider(s) as appropriate. A referral to the Provider Services department is made for QOS PQIs related to suspected or substantiated access and service issues. A referral is made to the Compliance department for all QOS PQIs related to HIPAA, FWA, PHI violation allegations.
- **Quality of Care** PQIs are presented to the ~~QI~~ Medical Director or ~~designated Medical Director~~ post RN review and investigation for review, final resolution, and recommendations. These cases are investigated through the acquisition of medical records and/or other pertinent documentation requested from the provider(s) as appropriate. Based upon the outcome of the case review, each QOC case shall be leveled reflecting the severity of the outcome as follows:

Commented [DC1]: Change all "QI Medical Director" to just "Medical Director"

Quality of Care (QOC) Issue	
Severity Level	Description
C0	No QOC Issue
C1	Appropriate QOC - May include medical / surgical ~~complication~~ <u>complications</u> in the <i>absence of negligence</i> Examples: Medication or procedure side ~~effect~~ <u>effects</u>
C2	Borderline QOC - With potential for adverse ~~effect~~ <u>effects</u> or outcome Examples: Delay in test with <i>potential</i> for adverse outcome
C3	Moderate QOC (substantial harm) - <i>Actual</i> adverse effect or outcome (non-life or limb threatening) Examples: Delay in unnecessary test <i>resulting in</i> poor outcome
C4	Serious QOC (substantial harm) - With significant adverse ~~effect~~ <u>effects</u> or outcome (life or limb threatening) Examples: Life or limb threatening

- a. If the case is leveled as a C2, C3, or C4 by the ~~QI~~ Medical Director, he/she will determine if the case requires:
- i. external review (Advanced Medical Review)

- ii. a provider letter for response
- iii. a Corrective Action Plan (CAP) mailed to the provider for response, or
- iv. presentation to Peer Review Committee (PRC).

Clinical Review and Reporting of Potential PPCs

- A. Potential PPCs reported to Quality from Claims, Utilization or Case Management, or discovered during a PQI investigation will be reviewed to validate whether a reported incident meets the definition of a PPC.
- B. The scope of the PPC review by Quality shall include but not be limited to, both a medical record and claims history review.
- C. The potential PPC will be reviewed by the QI Nurse Reviewer to determine if the case is a potential quality issue (PQI) and will need to go through the PQI review process. See policy **QI-119**.
- D. All potential PPCs are forwarded to the Chief Medical Officer or physician designee for secondary review and final PPC validation.
- E. Medical Director validated PPC cases may be presented to and reviewed by the Peer Review Committee (PRC) for comment and/or any corrective actions
- F. Findings of all potential PPC ~~investigated cases~~ cases investigated will be reported to the claims department designee.
- G. Notification of the reported incidents is also sent to the Alliance internal Compliance Department.

CORRECTIVE ACTION PLAN (CAP)

AAH will ensure that effective follow-up action with providers (such as via barrier analysis, provider CAPs, enhanced monitoring, or re-measurement activities), is taken to address any needed improvements in quality of care (QOC) delivery to prevent the recurrence of identified issues.

- 1. The action taken on the completion of each QOC investigation is dependent on the leveling score. If the case levels as a C2, C3, or C4, the ~~QI~~ Medical Director will determine whether a letter or CAP will be mailed to the provider. When a CAP is sent to a provider for a requested response:
 - a. If a provider fails to provide additional information, either a written CAP response or requested medical records, within the required timeframe the RN Supervisor or designee will send a reminder notice with a request for an immediate response.
 - b. In addition to the content in the original CAP letter, the following will be included
 - i. A reminder that the provider/organization's Alliance contract requires them to adhere to Alliance policies and procedures, which includes timely response to potential quality incidents; and
 - ii. An additional 14 calendar day deadline for response.
 - iii. If no response from the provider/organization for a second time, the CMO or designee will contact the provider or organization to ensure that the letter was received.
 - c. If no response is received, the CMO or designee may choose to level the case using the information on hand.

2. After further review, the ~~QI~~ Medical Director will determine if the case and its findings are to be presented at the Peer Review Committee (PRC). The PRC will review the QOC findings and may determine an action plan, which may include a CAP or other further actions. CAP outcome letters are stored in a secure database. CAP decisions leading to a change in credentialing status are shared with Provider Services and decisions involving HIPAA, PHI, and fraud/waste/abuse are shared with Compliance.
 - a. As deemed appropriate for each case by the PRC, appropriate referrals are made to the regulatory/licensing agencies and per reporting requirements under the California Business and Profession code §805 (PRCC CRE-006).
 - b. The PRC recommends an ~~action~~action, and final action is rendered after ratification, and the provider is provided his or her process rights (PRCC CRE-006).

CONFIDENTIALITY

All PQI files, records, and proceedings are kept confidential. Access to the files, records, or minutes of proceedings shall be limited to QI staff involved in the review and PRC process when applicable. All records are securely retained and compliant with the record retention policies and procedures.

REPORTING

1. The Internal Quality Improvement Committee (IQIC) reviews reports of all potential quality of care issues. The report is then reviewed ~~by the~~by the Quality Improvement Health Equity Committee (QIHEC) for recommendations.
2. The QI Department is responsible for any follow-ups and /or corrective actions recommended by QI committee(s).
3. Cases for care or service providers that exceed three (3) PQIs leveled C2-4 in the previous 6 months will be escalated to PRC per Medical Director recommendations

TRACKING AND TRENDING

The QI Department is responsible for tracking and trending all PQI referrals, including retrospective trend analysis of the provider's practice patterns via history of complaints at least every 6 months.

1. Any trends are noted, summarized, and reviewed with the ~~QI~~ Medical Director and Provider Services Director via QI committees and ad hoc for further evaluation and action
2. Providers with significant PQI issues, as determined by PRC, are subject to termination from the AAH network
3. When deficiencies or patterns of non-compliance [as defined in Rule 1300.67.2.2(b)(12)] resulting in substantial harm to a member are found through the monitoring process, the Alliance will issue time sensitive CAPs to all identified contracted providers and delegates as appropriate

EXEMPT GRIEVANCES

1. The ~~Sr. Director of Quality or Quality Supervisor~~Sr Director of Quality or designee will review a minimum of 100 randomly selected exempt grievances per quarter that were
QI-104 Potential Quality Issues

Page 7 of 9

Commented [DC2]: Change to "Sr Director of QI or Quality Sup" to just "Sr Dir of Quality or designee"

NOT referred to the QI Department as a PQI. The purpose of these reviews will be to determine if these cases should have been routed as a PQI to the QI Department and whether the process followed the current training and policy guidelines. On review, cases identified as PQIs will be brought to the attention of the Director of Member Services. The Director of Member Services will then implement the appropriate training and correction steps.

2. QI Staff will hold regular trainings to ensure staff education and encourage clinical oversight of exempt grievances.

AUDITING AND OVERSIGHT

1. The Sr. Director of Quality or ~~designee-Quality Supervisor~~ is are responsible for resolving any discrepancies between the number of PQIs within the PQI Application and those sent by email with IT.
2. Sr. Director of Quality will review determined QOAs, QOS PQIs, and Exempt Grievance files reviewed by the ~~Sr Director of Quality or designee-QI-Nurse-Supervisor~~ during the audit month for accurate and appropriate documentation:
 - i. Timely review within ~~420~~ 150 days of receipt
 - ii. Type
 - iii. Assessment of problem/grievance – Hospital readmissions < 30 days, possible PPC
 - iv. Plan
 - v. Intervention
 - vi. Evaluation/Resolution
3. Pass rate of 90% must be met
4. Retraining of ~~QI-Supervisor~~/Review Nurse will be conducted for a score of less than 90%
5. Two (2) consecutive months of failure to achieve passing score will lead to progressive disciplinary action.

Commented [DC3]: Change QI Nurse Supervisor to Sr Dir of Quality or designee

INTER-RATER RELIABILITY (IRR): See QI 133

DEFINITIONS / ACRONYMS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the “Definitions” below:

1. **Corrective Action Plan (CAP)** – Action requested to correct a noted deficiency.
2. **High Priority** – This is an option within the PQI application to denote a PQI that needs to be a top priority for the assigned RN reviewer. This designation/determination is made during the clinical triage that is conducted during case assignment.
3. **Inter-Rater Reliability**- Assessment used to measure the level of consistency among the group of raters and adherence to the medical criteria standards.
4. **Peer Review** – In accordance with California Business and Professional Code section 805, Peer Review is a process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, to do either or both of the following:
 - a. Determine whether a licentiate may practice or continue to practice in a health care

facility, clinic or other setting providing medical services, and, if so, to determine the parameters of that practice

- b. Assess and improve the quality of care rendered in a health care facility, clinic or other setting providing medical services.

5. **Potential Quality of Care Issue (“PQI”)** – An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient’s health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.
6. **Provider Preventable Conditions** - A condition that meets the definition of a “health care-acquired condition” or an “other provider-preventable condition,” as defined in 42 CFR 447.26(b).
7. **Quality of Care** - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.
8. **Quality of Access** – The degree to which timely access and availability of care for members promotes positive health outcomes and are consistent with all regulatory standards.
9. **Quality of Service** – The degree to which timely health care services are available for members and promotes positive member satisfaction.
10. **Sentinel Event** - Any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof defined as any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
11. **Shadow Case** – This is a term within the PQI Application that is used to differentiate between the multiple issues that can exist in one complaint. As a result, this allows the QI Department to track and trend all the issues that exist within one interaction/complaint from a member.
12. **Substantial Harm** -- Substantial harm indicates loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.
13. **Task Owner** – This is a field within the PQI Application that denotes the individual within the QI Department who is responsible for completing an assigned task within the PQI workflow.
14. **Turn-Around-Time (TAT)** – The Plan intends to complete its full investigation and leveling of all PQIs that are referred to QI for review within ~~120~~ 150 days of receipt unless an extension on a case-by-case basis is deemed warranted by the CMO or Medical Director.
15. **Unsubstantiated PQI** – This option is selected within the PQI application to designate a QOS or QOA that cannot be supported based on clinical review.

AFFECTED DEPARTMENTS/PARTIES

Grievance and Appeals
Peer Review and Credentialing

Compliance
Case Management
Provider Services
Member Services
Utilization Management

RELATED POLICIES AND PROCEDURES

CRE-006 Reporting to Authorities
CRE-009 Ongoing Monitoring of Practitioners
QI-101 Quality Improvement Program
QI-111 Delegation Management and Oversight
QI-114 Monitoring of Access and Availability Standards
QI-116 Provider Appointment Availability
QI-119 Adverse - Sentinel Events and Provider Preventable Conditions
QI-133 Interrater Reliability

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

PQI Assignment Desktop Procedure

REVISION HISTORY

1/1/2008, 10/1/2009, 2/26/2010, 5/21/2012, 9/10/2012, 11/6/2014, 4/13/2015, 6/16/2016,
11/10/2016, 3/9/2016, 9/12/2017, 12/5/2017, 4/12/2018, 5/3/2018, 7/19/2018, 9/6/2018,
11/15/18, 1/17/19, 5/21/2020, 7/16/20, 11/18/21, 03/22/2022, 6/28/2022, 03/21/2023,
12/19/2023, ~~4/16/2025~~, 8/8/2025

Blue = material updates

REFERENCES

DHCS Contract Attachment 4-1, 14-2.B, C, D, F Title 28 CCR, Section 1300.70 (a) (1)
42CFR, Section 447.26
California Code, Civil Code - CIV § 3428
DMHC Rule 1300.67.2.2(b)(12)

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards.