Policy	Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update	New Policy	Annual Review or Formattin
1	QI	TBD	Clinical Practice Guidelines	Describes how the Alliance adopts, disseminates, and monitors theuse of preventive care and other clinical practice guidelines.	New Policy		X	
2	Quality	QI-101	Quality Improvement and Health Equity Program	Describes the Alliance Quality Improvement and Health Equity program as required by the Medi-Cal Contract	Added health diparity language to comply with the 2024 Medi-Cal Contract (R.0048) Added ICF/DD quality monitoring per APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities	X		
3	Quality	QI-104	Potential Quality Issues (PQIs)	Describes the system and process for identifying any PQI and the process of identifying severity of the issue identified.	Based on the DMHC comment letter for APL 22-026 1)Added definition "Subtantial Harm" to reflect APL 22-026 2) Updates Quality of Care (QOC) severity level 3 and 4 equate to substantial harm	x		
4	Quality	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.	Based on the DHCS Audit CAP-reformatted Timely Access Standard table for First Prenatal appointment "within 2 weeks of request"	X		
5	Quality	QI-114	Monitoring of Access and Availability Standards	Describes how the Alliance has established a mechanism for ongoing monitoring of its provider network to ensure timely access to and availability of quality health care services for all members within the Alliance and delegae network.	1)Based on the DHCS Audit CAP-revised QI-114 to ensure members receive timely access to first prenatal visits "within two week upon request" 2)Based on the DMHC J-13A comment Letter - revised P&P to describe our process to improve our provider respository when ineligible provider is found as a result of PAAS 3)DMHC J13A comment letter - added "pattern of non copliance" as part of our monitoring/CAPs process	x		
6	QI	QI-135	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	To define Alameda Alliance for Health's (Alliance) responsibility to provide Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to all Medi-Cal eligible members under the age of 21.	Added the following wording to meet 2024 DHCS Contract: The Alliance regularly reviews encounter and administrative data as necessary, and may be as frequently as quarterly, for appropriateness, utilization, timeliness of child preventive care services, and completed screenings. This includes and not limited to HEDIS/MCAS quality measures, Facility Site Reviews/Medical Record Reviews, or chart reviews, etc. See P&P QI-101 Quality Improvement Health Equity Program	x		

7	UM	UM-018	Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment	TCM and EPSDT	Addition of details on LGAs and information exchange with LGAs	X		
8	UM	UM-036	Continuity of Care	Policy that governs continuity of care procedures for newly enrolled members or members with a terminated/OON provider	Addition of language that reflects processes to adhere the 2024 MCal MCP Transition Policy Guide regulatory requirements for the transition to a Single Plan Model county, including management of Special Populations.	X		
9	UM	UM-057	Authorization Service Request	Policy that governs the overall processes for authorizing care.	Addition of language that reflects processes to adhere the 2024 MCal MCP Transition Policy Guide regulatory requirements for the transition to a Single Plan Model county, including management of Special Populations.	X		
10	UM	UM-059	CoC for MCal Beneficiaries Who Transition into MCal Managed Care	Policy specifically governing the CoC requirements to manage members transitioning into AAH from other coverage or are newly enrolled.	Addition of language that reflects processes to adhere the 2024 MCal MCP Transition Policy Guide regulatory requirements for the transition to a Single Plan Model county, including management of Special Populations.	X		
11	HED	TBD	Doula Services	Describes how the Alliance implements the doula services benefit to eligible members.	New Policy		X	
12	HED	001	Health Education Program	Descibes Alliance Health Education Program elements.	Updated to align with 2024 Contract requirements, connect to the Population Health Management program, connecting members to preventive services and community health worker.	X		
13	PH	004	Community Health Workers	Describes how the Alliance implements the community health worker benefit and how CHWs are integrated into the Population Health Management program.	Updated policy to expand how the Alliance assesses member needs and determine priority popuations for services, conducts outreach, communicates with providers and members regarding availability of services, and monitors the services.	X		
14	CLS	002	Community Engagement	Describes role, function and policies for Alliance Community Engagement and the Alliance Member Advisory Committee.	Updated to comply with the 2024 MCP Contract including member feedback on health equity, documentation and integration of member feedback, selection of MAC members, role of CHEO, topics MAC members advise on, and reporting structure of the MAC. Updated Subcommittee approval to QIHEC.	X		

15	CLS	011	CLS Program - Compliance Monitoring	Describes how the Alliance ensures quality lanuage assistance services through monitoring of staff, providers and language services vendors.	Updated to comply with the 2024 MCP Contract and DMHC statutory compliance with CRR 1300.67.2.2., including soliciting member and provider feedback on interpreter services through surveys. Updated Subcommittee approval to QIHEC.	X		
16	CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Addition of language to ensures no duplication of services information sharing processes IHSS referrals Children with Special Health Care Needs (CSHCN) Direct Observed Therapy for TB Addition of language to ensure regular communication with IHSS regarding open medical issues and related social issues. BPHM reqs.	X		

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POLICY AND PROCEDURE

Policy Number	QI - TBD
Policy Name	Clinical Practice Guidelines
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Quality Medical Director
Line(s) of Business	Medi-Cal and Group Care
Effective Date	TBD
Approval/Revision Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) adopts, disseminates, and monitors the use of preventive care and other clinical practice guidelines in alignment with DHCS contract requirements. The Alliance adheres to and requires providers to follow the most current preventive care and behavioral health guidelines. The Alliance adopts and reviews other clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances and support Alliance wellness and prevention services.

PROCEDURE

1. Preventive Care Guidelines
   - 1.1. The Alliance requires that all network and delegate providers follow the most current preventive care guidelines.
     - 1.1.1. For adults ages 21 and older, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) clinical preventive services to adults ages 21 and older. All preventive services identified as USPSTF “A” and “B” recommendations must be provided.
     - 1.1.2. For children and adolescents under 21 years old, Alliance providers are required to follow the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule.
     - 1.1.3. 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).
     - 1.1.4. The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP)

and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations.

1.2. Mental and Behavioral Health Guidelines

1.2.1. The Alliance uses the following criteria for provision of Behavioral and Mental Health services: Milliman Clinical Guidelines, CALOCUS, LOCUS, ECSII and the APA Board Guidelines for Autism Spectrum Disorders.

1.3. Alliance providers must document the status of recommended services.

1.4. The Alliance informs providers about required preventive care guidelines through:

1.4.1. Alliance clinical practice guidelines webpage

1.4.2. Quarterly provider communications

1.5. The Alliance monitors the use of required preventive care guidelines through the Facility Site Review and Medical Record Review process. See Alliance policy *QI-005 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS).*

2. Clinical Practice Guidelines

2.1. The Alliance adopts other clinical practice guidelines to support providers and Alliance staff. Adopted guidelines:

2.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field.

2.1.2. Consider the needs of Members.

2.1.3. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines or are developed with involvement of board-certified Providers from appropriate specialties.

2.2. The guidelines are reviewed by the Quality Improvement Medical Director, subcontractors, and other network providers as appropriate. They are approved for adoption by the Internal Quality Improvement Committee (IQIC) and Health Care Quality Committee (HCQC).

2.3. The guidelines are reviewed and updated at least every two years.

2.4. The Alliance distributes the adopted clinical practice guidelines through the Alliance clinical practice guidelines webpage, provider communications, and on request.

DEFINITIONS / ACRONYMS

AAP – American Academy of Pediatrics
ACIP - Advisory Committee on Immunization Practices
ACOG – American College of Obstetrics and Gynecology
CDC - Centers for Disease Control and Prevention
DHCS - California Department of Health Care Services
HCQC – Health Care Quality Committee
IQIC – Internal Quality Improvement Committee
PHM - Population Health Management
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Case Management

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
UM-025 Guidelines for Obstetrical Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

[List related documents]

REVISION HISTORY

TBD

REFERENCES

DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract

MONITORING

This Policy will be reviewed annually,

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POLICY AND PROCEDURE

Policy Number	QI-101
Policy Name	Quality Improvement and Health Equity Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	Medi-Cal, GroupCare
Original Effective Date	9/28/2006
Approval / Revision Date	TBD

POLICY STATEMENT

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

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

PROCEDURE

A. Scope

The Alliance ensures that Network Providers, Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors (if an existing contract exists), participates and are updated on the QIHE Program and Population Needs Assessment activities, findings, and recommendations by the Quality Improvement Health Equity Committee (QIHEC). The QIHE Program encompasses quality of care, quality of services, patient safety, member experience, including health equity principles.

B. Board of Governors (BOG)

1. The Alliance's Board of Governors (BOG) maintains the ultimate authority and

responsibility for the QIHE Program.

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

Quality Improvement Health Equity Committee (QIHEC)

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

The QIHEC is responsible for the following activities:

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

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

C. QIHE Program Description

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

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

care, specialty, emergency, inpatient, and ancillary care services.

D. QIHE Communications

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

E. QIHE Work Plan and Evaluation

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

2. The Quality Improvement Department are made up of Clinical Quality, Access and Availability, Health Education, Population Health, and Cultural and Linguistic Services will prepare an annual written evaluation of the QIHE Program that includes:
    a. A description of completed and ongoing QIHE activities that address quality, health disparities and equity and safety of clinical care and quality of service
    b. Trending of measures to assess performance in the quality and safety of clinical care and quality of service
    c. Analysis of the results of QIHE initiatives, including barrier analysis
    d. Evaluation of the overall effectiveness of the QIHE Program, including progress toward influencing safe clinical practices
    e. Methods to address External Quality Review technical report and evaluation report recommendations.
    f. Methods for equity-focused interventions to identify patterns for over- or under-

utilization of physical and behavioral health care services

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

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

Quality Monitoring Activities

F. Managed Care Accountability Sets (MCAS) and HEDIS

1. The Alliance will calculate and report all HEDIS measures and other quality and health equity performance measures as specified by DHCS, DMHC, CMS and NCQA.
2. The results of these performance measures shall be audited by an external MCAS/HEDIS Compliance Auditor.

G. Quality Improvement and Health Equity Projects

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

H. Consumer Satisfaction Survey

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

I. Network Adequacy Validation

The Alliance participates in the EQRO's validation of Contractor's Network adequacy

representations from the preceding 12 months in compliance with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358. Refer to policy PRV-003 *Provider Network Capacity Standards.*

J. Encounter Data Validation

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

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

The Alliance maintains a comprehensive SNF/LTC QAPI program to comply with APL 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care and described in policy LTC- 001 *Long Term Care Program.* In addition, the Alliance maintains a quality monitoring program to comply with APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities.

L. Focused Studies

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

M. Technical Assistance

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

N. Site Review

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

O. Potential Quality Issue (PQI)

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Quality Improvement Program Description
Quality Improvement Work Plan
Quality Improvement Program Evaluation
QI-117 Member Satisfaction Survey (CAHPS)
PRV-003 Provider Network Capacity Standards
LTC- 001 Long Term Care Program
QI -105 Facility site Reviews, Medical Record Reviews, and Physical Accessibility Reviews.
QI-104 Potential Quality Issues

REVISION HISTORY

9/28/2006, 7/13/2007, 1/1/2008, 10/28/2009, 2/26/2010, 9/18/2012, 11/6/2014, 11/10/2016, 10/18/2018, 3/21/19, 3/19/2020, 3/22/2022, 4/18/2023

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment 3
MMCD All Plan letter 19-017
MMCD All Plan Letter 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
MMCD APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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POLICY AND PROCEDURE

Policy Number	QI-101
Policy Name	Quality Improvement and Health Equity Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	Medi-Cal, GroupCare
Original Effective Date	9/28/2006
Approval / Revision Date	TBD

POLICY STATEMENT

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

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

~~The Alliance's QIHE Program complies with all standards, regulations, and contract requirements subject to evaluation by appropriate external quality review organizations. Quality and Health Equity measurement is consistent, valid and reliable. Program activities are designed to result in improvement in the quality and equity of health care.~~

PROCEDURE

A. Scope

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

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by the Quality Improvement Health Equity Committee (QIHEC). The QIHE Program encompasses quality of care, quality of services, patient safety, member experience, including health equity principles.

~~A.~~B. Board of Governors (BOG)

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

Quality Improvement Health Equity Committee (QIHEC)

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

The QIHEC is responsible for the following activities:

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

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

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affected by health disparities, Limited English Proficiency (LEP), and Children with Special Health Care Needs (CSHCN).~~.~~

~~8.~~9. All providers participating in the QIHEC or any of its subcommittees, or other QIHE program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements.

~~B.~~C. QIHE Program Description

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

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availability and access to care, clinical services and care management.

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

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

~~C.~~D. QIHE Communications

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

~~D.~~E. QIHE Work Plan and Evaluation

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

2. The Quality Improvement Department are made up of Clinical Quality, Access and Availability, Health Education, Population Health, and Cultural and Linguistic Services will prepare an annual written evaluation of the QIHE Program that includes:
    a. A description of completed and ongoing QIHE activities that address quality, health disparities and equity and safety of clinical care and quality of service

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

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

~~3.~~4. The QIHEC and BOG will annually review and approve the QIHE Work Plan and QIHE Program Evaluation

Quality Monitoring Activities

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~~E.~~F. Managed Care Accountability Sets (MCAS) and HEDIS

1. The Alliance will calculate and report all HEDIS measures and other quality and health equity performance measures as specified by DHCS, DMHC, CMS and NCQA.
2. The results of these performance measures shall be audited by an external MCAS/HEDIS Compliance Auditor.

~~F.~~G. Quality Improvement and Health Equity Projects

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

~~G.~~H. Consumer Satisfaction Survey

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

~~H.~~I. Network Adequacy Validation

~~1.~~ The Alliance participates in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months in compliance with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358. Refer to policy PRV-003 *Provider Network Capacity Standards.*

~~I.~~J. Encounter Data Validation

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

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

The Alliance maintains a comprehensive SNF/LTC QAPI program to comply with APL 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care and described in policy LTC- 001 *Long Term Care Program.* In addition, the Alliance maintains a quality monitoring program to comply with APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities.

~~J.~~L. Focused Studies

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

~~K.~~M. Technical Assistance

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

N. Site Review

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

O. Potential Quality Issue (PQI)

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

QIHE-101 Quality Improvement

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Quality Improvement Program Description
Quality Improvement Work Plan
Quality Improvement Program Evaluation
QI-117 Member Satisfaction Survey (CAHPS)
PRV-003 Provider Network Capacity Standards.
LTC- 001 Long Term Care Program
QI -105 Facility site Reviews, Medical Record Reviews, and Physical Accessibility Reviews.
QI-104 Potential Quality Issues

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REVISION HISTORY

9/28/2006, 7/13/2007, 1/1/2008, 10/28/2009, 2/26/2010, 9/18/2012, 11/6/2014, 11/10/2016, 10/18/2018, 3/21/19, 3/19/2020, 3/22/2022, 4/18/2023

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment 3
MMCD All Plan letter 19-017
MMCD All Plan Letter 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
MMCD APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities

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MONITORING

This policy will be reviewed annually to ensure effectiveness.

ALAMEDA Alliance FOR HEALTH

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

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	Medi-Cal and Group Care
Effective Date	11/20/2006
Subcommittee	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	03/21/2023

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 Program.

POLICY

The purpose of this policy is to describe the system and process for identifying any PQI that:

a. is not consistent with plan operations
b. indicates a potential or suspected deviation form accepted standards of medical and/or clinical care
c. 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***
   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 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, 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: 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 Acces***s 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 / (Senior) Director of Behavioral Health 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:

Quality of Care (QOC) Issue	
Severity Level	**Description**
C0	No QOC Issue
C1	Appropriate QOC - May include medical / surgical complication in the *absence of negligence* Examples: Medication or procedure side effect
C2	Borderline QOC - With potential for adverse effect or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC (substantial harm) - *Actual* adverse effect or outcome (non-life or limb threatening) Examples: Delay in unnecessary test *resulting in* poor outcome
C4	Serious QOC (substantial harm) - With significant adverse effect 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 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 (via barrier analysis, provider CAPs, enhanced monitoring, 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 letter 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 CAP. 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 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. Quarterly, the Internal Quality Improvement Committee (IQIC) reviews reports of all potential quality of care issues. The report is then reviewed by HCQC 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 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 QI Department Sr. Director or Supervisor will review a minimum of 100 randomly selected exempt grievances per quarter that were 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. Dir. of Quality and QI Manager are responsible for resolving any discrepancy between the number of PQIs within the PQI Application and those sent by email with IT.

2. Sr. Director of Quality will audit determined QOAs, QOS PQIs, and Exempt Grievance files reviewed by the QI Nurse Supervisor during the audit month for accurate and appropriate documentation:
   i. Timely review within 120 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.

INTER-RATER RELIABILTIY (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 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 health outcomes.

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 different 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 completely its full investigation and leveling of all PQIs that are referred to QI for review within 120 days of receipt.

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.doc

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

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.

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	Medi-Cal and Group Care
Effective Date	11/20/2006
Subcommittee	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	03/21/2023

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 Program.

POLICY

The purpose of this policy is to describe the system and process for identifying any PQI that:

a. is not consistent with plan operations
b. indicates a potential or suspected deviation form accepted standards of medical and/or clinical care
c. 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***
   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

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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 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, 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: 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).

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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 / (Senior) Director of Behavioral Health 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:

Quality of Care (QOC) Issue	
Severity Level	**Description**
C0	No QOC Issue
C1	Appropriate QOC - May include medical / surgical complication in the *absence of negligence* Examples: Medication or procedure side effect
C2	Borderline QOC - With potential for adverse effect or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC (substantial harm) ~~(substantial harm)~~ - *Actual* adverse effect or outcome (non-life or limb threatening) Examples: Delay in unnecessary test *resulting in* poor outcome
C4	Serious QOC (substantial harm) ~~(substantial harm)~~ - With significant adverse effect 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 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 (via barrier analysis, provider CAPs, enhanced monitoring, 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 letter 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 designe~~ed~~ 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.

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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 CAP. 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 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. Quarterly, the Internal Quality Improvement Committee (IQIC) reviews reports of all potential quality of care issues. The report is then reviewed by HCQC 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 for further evaluation and action
2. Providers with significant PQI issues, as determined by PRC, are subject to termination from the AAH network
2.3. 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

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EXEMPT GRIEVANCES

1. The QI Department Sr. Director or Supervisor will review a minimum of 100 randomly selected exempt grievances per quarter that were 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. Dir. of Quality and QI Manager are responsible for resolving any discrepancy between the number of PQIs within the PQI Application and those sent by email with IT.

2. Sr. Director of Quality will audit determined QOAs, QOS PQIs, and Exempt Grievance files reviewed by the QI Nurse Supervisor during the audit month for accurate and appropriate documentation:
   i. Timely review within 120 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.

INTER-RATER RELIABILTIY (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 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 health outcomes.

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 different 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 indicates loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain.~~

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 completely its full investigation and leveling of all PQIs that are referred to QI for review within 120 days of receipt.

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

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Grievance and Appeals
Peer Review and Credentialing
Compliance
Case Management
___Provider Services

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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.doc

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

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)

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MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards.

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	Medi-Cal, Group Care
Effective Date	3/31/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/2/2023
Compliance Committee Approval Date	09/19/2023

POLICY STATEMENT

Alameda Alliance for Health ("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), and the National Committee for Quality Assurance (NCQA).

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

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

A. Provider education/re-education and outreach (face-to-face, verbal, and/or written)
B. Written corrective action plans (CAPs)

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

PROCEDURE

A. Appointment Access Standards

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

Life-Threatening Emergency:

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

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

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

Non-Life-Threatening Emergency

- Within six (6) hours of the request

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

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* require PA	48 Hours of the Request
Urgent Appointment that *requires* PA[1]	96 Hours of the Request
Non-Urgent **Primary Care** Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent **Specialist** Appointment	15 Business Days of the Request
Non-Urgent **Behavioral Health** Appointment	10 Business Days of the Request
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

[1] Prior authorization

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

B. LTSS Timely Access Network Standards

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

LTSS TIMELY ACCESS NETWORK STANDARDS	
Provider Type:	**Standard:**
Skilled 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

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 DHCS regulatory requirements. Providers are required to meet minimum standards for access to after-hours care by including the following information in their after-hours message:

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

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

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

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

G. Missed Appointments

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

Alliance physicians 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 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.
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 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 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.

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).

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

UM-029 Sensitive Services
UM-048 Triage and Screening Services

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

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

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

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 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	Medi-Cal, Group Care
Effective Date	3/31/2016
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	82/217/2023
Compliance Committee Approval Date	093/1921/2023

POLICY STATEMENT

Alameda Alliance for Health ("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), and the National Committee for Quality Assurance (NCQA).

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

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

A. Provider education/re-education and outreach (face-to-face, verbal, and/or written)
B. Written corrective action plans (CAPs)

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

PROCEDURE

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

Life-Threatening Emergency:

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

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

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

Non-Life-Threatening Emergency

- Within six (6) hours of the request

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

APPOINTMENTS WAIT TIMES	
Appointment Type:	**Appointment Within:**
Urgent Appointment that *does not* require PA	48 Hours of the Request
Urgent Appointment that *requires* PA[1]	96 Hours of the Request
Non-Urgent **Primary Care** Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request~~10 Business Days 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

[1] Prior authorization

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

B. LTSS Timely Access Network Standards

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

LTSS TIMELY ACCESS NETWORK STANDARDS	
Provider Type:	**Standard:**
Skilled 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 ~~month~~months

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

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Commented [MB1]: What is IPC? I looked it up.. Individual Plan of Care (IPC) Has IPC been defined elsewhere in this policy? If not, I would suggest doing it here or creating a footnote

Commented [TL2R1]: Hi Marie, most likely under UM policy since they monitor our LTSS

Commented [MB3]: Because this is an ongoing benefit, would it be more accurate to state "every six months"

Commented [TL4R3]: I leave it as it is since the since the table was provided to me by UM

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~~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 DHCS regulatory requirements. Providers are required to meet minimum standards for access to after-hours care by including the following information in their after-hours message:

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

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

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

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

G. Missed Appointments

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

Alliance physicians 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 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.
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 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 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~~Health Care Quality Committee~~ (QIHEC~~HCQC~~).

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

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

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

Handbook.

DEFINITIONS / ACRONYMS

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Commented [MB5]: It looks like something was left off. E.g., "obtaining an appointment"??

See Rule 1300.68(e)(2) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:
(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

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broken bones).

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

UM-029 Sensitive Services
UM-048 Triage and Screening Services

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION HISTORY

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

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

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 QIHEC~~HCQC~~ 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-114
Policy Name	Monitoring of Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	Medi-Cal, Group Care
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	3/21/2023

POLICY STATEMENT

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

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

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

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

The Alliance will take all necessary steps and appropriate actions to maintain compliance with

established Access and Availability standards within its provider network. When non-compliance or deficiencies are identified through the monitoring process, prompt investigation and corrective action is implemented to rectify identified deficiencies.

PROCEDURE

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

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

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

Access & Availability Reports

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

1. Provider Network Capacity

A. Provider Services department staff review network providers whose member assignments are approaching the 2,000:1 capacity ratio of members to PCPs (PRV-003 Provider Network Capacity Standards).
   i. Monthly provider capacity reports are developed after the monthly auto-assignment procedures are completed.
      a. Providers nearing the 2,000 capacity mark (≥1,900)) are flagged and auto-assignment enrollment is closed.
   ii. Provider Services department staff review and track network providers who are at 80% of capacity and above to ensure they do not exceed their capacity threshold.
   iii. As appropriate, Provider Services department staff will notify those network providers who are at 80% of capacity and above and will continuously monitor them on a monthly basis. For those network providers who have reached 90% capacity, Provider Services department staff will close them to auto assignment.
   iv. For those network providers identified by Provider Services as being below 80% of capacity, Provider Services department staff will remove the flag and enrollment will be reopened to allow the provider to have additional membership assignment up to the 2,000: 1 capacity level.

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

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

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

2. Provider Appointment Availability Survey (PAAS)

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

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

3. DHCS First Prenatal Visits (Non-PAAS)

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

Providers who may be excluded from the survey include:

- Hospitalists

4. After-Hours Survey

The Alliance, in conjunction with its QI department and its vendor Symphony Performance Health (SPH), at least annually conducts an After-Hours Survey to ensure provider compliance with after-hours (post normal business hours) access and emergency instructions standards, per the DHCS, DMHC, and NCQA regulatory and accreditation requirements. The surveys assess compliance with timely access to a physician or an appropriate licensed professional, as well as with availability of member instructions when experiencing a medical emergency. Based on

survey results, QI staff will outreach to providers found to be non-compliant with the after-hours standards, inform them of the survey results, provide re-education on the standards, and issued CAPs accordingly. For those providers identified in the surveys as having potential issues with accurate contact information, QI staff communicate interdepartmentally (Provider Services and Data Analytics to ensure provider information accuracy for future surveys, as well as consider conducting confirmatory surveys as appropriate to ensure provider compliance with the after-hours standards.

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

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

5. Facility Site Reviews (FSRs)

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

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

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

7. High-Volume and High-Impact Specialists

On a quarterly basis, the Alliance reviews the geographic access ratio standards of a subset of

specialists identified as high-volume specialists for monitoring of specialist availability within the network (PRV-003 Provider Network Capacity Standards).

Specialists that are reviewed include but are not limited to:

- Cardiologists
- Endocrinologists
- Gastroenterologists
- OB/GYNs
- Psychiatrists

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

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

Specialists that are reviewed include:

- Oncologists

8. Geographic Accessibility

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

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

9. Access-Related Potential Quality Issues (PQIs)

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

- Review the QOA issues, check claims data to ensure that the member was not admitted nor went to an Emergency Department. If the member was admitted or went to the ED, the case will be sent to the QI RN Supervisor.
- In addition, the A&A staff member will review MRs if available to ensure that the Member's medical record notes that a longer waiting time will not have a detrimental impact on the health of the Member. MRs may be available through G&A and / or if there is a corresponding QOC case. If this is not properly documented, A&A staff will ensure appropriate provider education.
- Finally, A&A staff will conduct confirmatory surveys calls toprovider office to assess timely access compliance. All QOAs requiring confirmatory survey outreach are tracked and trended for compliance performance improvement and issuance of CAPs as warranted.

- For additional information, please see the QOA Workflow. For QOC / QOA cases, the A&A team will randomly select cases on a semi-annual basis to appropriate documentation if a member's appointment was extended. The medical record but document that longer waiting time will not have a detrimental impact on the health of the member. This report will be brought to the A&A Sub-committee for review and appropriate escalation.

10. Extending Member Appointment Timeframe

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

11. Grievances & Appeals Related to Access

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

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

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

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Confirmatory surveys are conducted internally and on an ad-hoc basis to assess a random selection of providers against a timely access standard. The selection of providers may include,

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

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

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

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

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

Follow-up Actions

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

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

Corrective Action Plans (CAPs)

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

The written CAP includes the following:

1. A description of the identified deficiencies
2. The rationale for the CAP
3. The name and telephone number of the QI staff member authorized to respond to provider concerns regarding the CAP issued
4. The due date (within 60 calendar days).
5. For SNC, delegates has six months to correct all deficiencies and action steps that delegates is undertaking to address the CAP.

CAP responses are required to include the following:

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2. Supporting documentation demonstrating how the deficiency will be/has been corrected and processes that will be/have been put in place to ensure compliance with regulatory standards and/or contractual requirements
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Where CAP responses have been satisfactorily received within the identified timeframe, non-clinical CAPs will be reviewed and closed by A&A management staff within ten (15) business

days of receipt of the CAP response. Facility Site Review (FSR) Clinical CAPs will be escalated according to the "Escalation Process for Providers Non-Responsive to Critical Element CAPs."

The Access & Availability Committee will report during each meeting:

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

DEFINITIONS / ACRONYMS

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

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

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

SPH - Symphony Performance Health, Inc.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

PRV-003 Provider Network Capacity Standards
QI-104 Potential Quality Issues

QI-105 Primary Care Provider Site Reviews

QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services

QI-115 Access and Availability Committee

QI-116 Provider Appointment Availability Survey (PAAS)
QI-117 Member Satisfaction Survey (CAHPS)

QI-118 Provider Satisfaction Survey

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

Access-Related PQIs
Workflow
After-Hours Survey Tool
After Hours Access Methodology

Provider Appointment Availability Survey Tool
First Prenatal Visit Survey Tool

Facility Site Review Tool
Medical Record Review Tool
CG-CAHPS Survey Tool
CAHPS 5.1H Survey Tool

Provider Satisfaction Survey Tool
Alliance Timely Access

Standards

REVISION HISTORY

12/17/2015, 11/10/2016, 3/9/2017, 10/17/2017, 3/01/2018, 11/16/2018, 3/21/2019, 5/16/2019, 3/19/2020, 5/20/2021, 6/28/2022, 11/15/2022,11/15/2022,2/17/2022,3/21/23

REFERENCES

QI-114 Monitoring of Access and Availability Standards

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

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

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

DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

MONITORING

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

QI-114 Monitoring of Access and Availability Standards

POLICY AND PROCEDURE

Policy Number	QI-114
Policy Name	Monitoring of Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	Medi-Cal, Group Care
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	3/21/2023

POLICY STATEMENT

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

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

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

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

The Alliance will take all necessary steps and appropriate actions to maintain compliance with

established Access and Availability standards within its provider network. When non-compliance or deficiencies are identified through the monitoring process, prompt investigation and corrective action is implemented to rectify identified deficiencies.

PROCEDURE

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

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

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

Access & Availability Reports

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

1. Provider Network Capacity

A. Provider Services department staff review network providers whose member assignments are approaching the 2,000:1 capacity ratio of members to PCPs (PRV-003 Provider Network Capacity Standards).
   i. Monthly provider capacity reports are developed after the monthly auto-assignment procedures are completed.
      a. Providers nearing the 2,000 capacity mark (≥1,900)) are flagged and auto-assignment enrollment is closed.
   ii. Provider Services department staff review and track network providers who are at 80% of capacity and above to ensure they do not exceed their capacity threshold.
   iii. As appropriate, Provider Services department staff will notify those network providers who are at 80% of capacity and above and will continuously monitor them on a monthly basis. For those network providers who have reached 90% capacity, Provider Services department staff will close them to auto assignment.
   iv. For those network providers identified by Provider Services as being below 80% of capacity, Provider Services department staff will remove the flag and enrollment will be reopened to allow the provider to have additional membership assignment up to the 2,000: 1 capacity level.

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

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

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

2. Provider Appointment Availability Survey (PAAS)

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

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

3. DHCS First Prenatal Visits (Non-PAAS)

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

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Providers who may be excluded from the survey include:

- Hospitalists

4. After-Hours Survey

The Alliance, in conjunction with its QI department and its vendor Symphony Performance Health (SPH), at least annually conducts an After-Hours Survey to ensure provider compliance with after-hours (post normal business hours) access and emergency instructions standards, per the DHCS, DMHC, and NCQA regulatory and accreditation requirements. The surveys assess compliance with timely access to a physician or an appropriate licensed professional, as well as with availability of member instructions when experiencing a medical emergency. Based on

survey results, QI staff will outreach to providers found to be non-compliant with the after-hours standards, inform them of the survey results, provide re-education on the standards, and issued CAPs accordingly. For those providers identified in the surveys as having potential issues with accurate contact information, QI staff communicate interdepartmentally (Provider Services and Data Analytics to ensure provider information accuracy for future surveys, as well as consider conducting confirmatory surveys as appropriate to ensure provider compliance with the after-hours standards.

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

- Pathologists
- Radiologists
- Emergency Medicine Providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser Providers
- Applied Behavorial Analysis (ABA) Providers
- Board Certified Behavior Analyst (BCBA) Providers
- Chiropractors
- Registered Dieticians
- Hospitalists
- Medical Geneticists
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5. Facility Site Reviews (FSRs)

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

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

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

7. High-Volume and High-Impact Specialists

On a quarterly basis, the Alliance reviews the geographic access ratio standards of a subset of

specialists identified as high-volume specialists for monitoring of specialist availability within the network (PRV-003 Provider Network Capacity Standards).

Specialists that are reviewed include but are not limited to:

- Cardiologists
- Endocrinologists
- Gastroenterologists
- OB/GYNs
- Psychiatrists

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

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

Specialists that are reviewed include:

- Oncologists

8. Geographic Accessibility

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

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

9. Access-Related Potential Quality Issues (PQIs)

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

- Review the QOA issues, check claims data to ensure that the member was not admitted nor went to an Emergency Department. If the member was admitted or went to the ED, the case will be sent to the QI RN Supervisor.
- In addition, the A&A staff member will review MRs if available to ensure that the Member's medical record notes that a longer waiting time will not have a detrimental impact on the health of the Member. MRs may be available through G&A and / or if there is a corresponding QOC case. If this is not properly documented, A&A staff will ensure appropriate provider education.
- Finally, A&A staff will conduct confirmatory surveys calls toprovider office to assess timely access compliance. All QOAs requiring confirmatory survey outreach are tracked and trended for compliance performance improvement and issuance of CAPs as warranted.

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- On review of the medical records, the record must indicate that:
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AFFECTED DEPARTMENTS/PARTIES

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QI-104 Potential Quality Issues

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QI-108 Access to Behavioral Health Services

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QI-118 Provider Satisfaction Survey

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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Provider Satisfaction Survey

Tool
Alliance Timely Access Standards

REVISION HISTORY

12/17/2015, 11/10/2016, 3/9/2017, 10/17/2017, 3/01/2018, 11/16/2018, 3/21/2019, 5/16/2019, 3/19/2020, 5/20/2021, 6/28/2022, 11/15/2022,11/15/2022,2/17/2022,3/21/23

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DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

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QI-114 Monitoring of Access and Availability Standards

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	QI-135
Policy Name	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Line(s) of Business	Medi-Cal
Effective Date	8/01/2020
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	03/21/2023

POLICY STATEMENT

To define Alameda Alliance for Health's (Alliance) responsibility to provide Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to all Medi-Cal eligible members under the age of 21.

PROCEDURE

A. The Alliance will cover and ensure the provision by subcontractors (if a contract exists) and network providers of exams, screening, diagnostic testing and treatment for preventative and all medically necessary services for members under the age of 21 in accordance with the EPSDT (Medi-Cal for Kids and Teens) program benefit

B. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventative, diagnostic, and treatment services for low-income individuals under the age of 21. Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services to include the following:

1. **Screening services** provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. The Alliance utilizes and promotes the AAP/Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventative Care and United States Preventive Services Taskforce (USPSTF) guidelines. This

periodic assessment also includes identifying Children with Special Health Care Needs (CSHCN). Screening services, at a minimum must include:

i. Comprehensive health and developmental history (including assessment of both physical and mental health development).
ii. Comprehensive unclothed exam.
iii. Appropriate immunizations according to the AAP Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care
iv. Laboratory tests (including blood lead level assessment appropriate for age and risk factors). See P&P **QI-125 Blood Lead Screening for Children**
v. Health education (including anticipatory guidance).
vi. Dental screenings/oral health assessments, including fluoride varnish treatment and referral. See P&P QI-124 Initial Health Appointments and UM-024 Care Coordination

2. **Vision services** provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum:
   i. Diagnosis and treatment for defects in vision, including eyeglasses.

3. **Dental services** provided at intervals which meet reasonable standards of dental practice and other intervals indicated as medically necessary to determine the existence of a suspected illness or condition and shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services must include, at a minimum:
   i. Treatment of relief of pain and infections, restoration of teeth, and maintenance of dental health.

4. **Hearing services** provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum:
   i. Diagnosis and treatment for defects in hearing, including hearing aids.

5. Other necessary health care, diagnostic services, treatment, and measures as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan for adults.

C. The EPSDT benefit in California is set forth under the California Code of Regulations (CCR). The following is outlined under Title 22, CCR, Sections 51340, 51340.1, and 51184:

1. Screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. All Members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. 2.

Includes all medically necessary services described in Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services."

3. The service-specific requirements as set forth in Title 22, CCR, Section 51340.1 must meet of the following criteria where applicable:
   a. The services are necessary to screen, diagnose, correct, or ameliorate defects in physical illnesses and mental illnesses and conditions. Mental health services for those children with serious and persistent mental health issues and conditions are the responsibility of the Alameda County Behavioral Health Care Services. See P&P **UM - 012**
   b. Children with mild to moderate mental health issues or conditions receive services through the Alliance. For Behavioral Health Therapy (BHT) refer to P&P **BH-001**. If a member is assigned to Kaiser Permanente as his/her Primary Care Provider (PCP), mental health services are available through Kaiser Permanente.
   d. The services are not requested solely for the convenience of the member, family, physician, or other provider of service(s).
   e. The services are not unsafe for the individual and are not experimental.
   f. The Alliance ensures compliance with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws. See P&P **QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS).**

D. The services to be provided must meet all the following criteria:
   1. Must be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence consisting of well-designed and well-conducted investigations published in peer-review journals and have opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can screen, diagnose, correct, or ameliorate the conditions for which they are prescribed.
   2. Are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the health condition of the member.
   3. The predicted beneficial outcome of the services outweighs the potential harmful effects.
   4. Timely access to all Medically Necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up

E. The Alliance will review and authorize medically necessary shift nursing services for members under the age of 21 in accordance with CCR, Title 22, section 51340€. See P&P **UM-018 Targeted Case Management (TCM) and EPSDT Supplemental Service**

F. The EPSDT benefit includes case management and Targeted Case Management (TCM) services designed to assist the member in gaining access to necessary medical, social and educational and other services. See P&P UM-018 **Targeted Case Management (TCM) and EPSDT Supplemental Service**

H. Upon adequate evidence that a member has a CCS eligible condition, the Alliance will refer the member to the local county CCS office for determination of CCS eligibility. If the local CCS program does not approve eligibility, the Alliance remains responsible for the provision of all medically necessary covered services for the member. See P&P **UM-008 Coordination of Care – California Children's Services**

I. Alameda Alliance for Health provides appointment scheduling assistance and the following transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance:

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

NEMT services are authorized under SSA Section 1902 (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), Plans must cover NEMT for members to obtain 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. See P&P **UM-16 Transportation Guidelines**

J. **Carved – Out Services**

1. Dental services provided by Medi-Cal Denti-Cal Program
2. Non-medical services provided by the Regional Center(s) to a member with developmental disabilities, including but not limited to respite, out-of-home placement, and supportive living.
4. Specialty mental health services listed in Title 9, CCR, Section 1810.247 or members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, or 1830.210, which must be provided by a mental health plan.
5. Other services listed as services that are not "covered services" under Alliance's contract with DHCS
6. Alliance does not reimburse families or caregivers for care.

K. **Provider and Member Outreach and Education**

- 1. Member Outreach - beginning in 2023, the Alliance will update their Member-facing materials as needed with "Medi-Cal for Kids & Teens" and mail DHCS supplied outreach and education materials consisting of the age-appropriate materials for members

under the age of 21 years old (or their families/primary caregivers). This will include the benefits of preventive care, services available, and how to obtain these services, including transportation and scheduling assistance. The Alliance website includes the DHCS materials and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter. ~~EPSDT~~ Health ~~educational materials~~ education materials related to EPSDT are available to members via the Alliance website and member handbook/evidence of coverage to members. .

- Beginning in 2024 and on an annual basis by January 1 of each calendar year, the Medi-Cal Kids & Teens DHCS supplied materials will be sent mailed or shared electronically for existing members 0-21 years.
- The Med-Cal Kids & Teens mailer will be sent out to new members 0-21 years within seven calendar days of enrollment with the Alliance.
- The mailing of the Med-Cal Kids & Teens mailers will be distributed to members according to policy C&O-001.

2. Provider Training – starting January 2024 the Alliance shall promote and train network providers with assigned members between the ages of 0-21 years regarding the Medical for Kids & Teens benefits no less than every two years.

   a. In collaboration with Provider Services, on an annual basis, by February 15 of each calendar year, the Alliance will submit to DHCS a comprehensive plan and attestation to ensure all Network Providers receive proper education and training regarding EPSDT.
   b. At a minimum, the Alliance will use the Provider training program developed by DHCS to promote a more uniform and shared understanding of the benefit throughout the State. For any augmented training with additional information, the Alliance will submit the training materials with edits highlighted to DHCS for review and approval prior to use.
   c. To reduce Network Providers contracted with multiple Managed Care Plans (MCP) from completing duplicative trainings, the Alliance has the option to share training records with other MCPs.
   d. The annual comprehensive plan will also include:
      i. How many Network Providers serve Members under the age of 21
      ii. How many Network Providers are not in compliance, and
      iii. An outline of the steps the MCP has taken to ensure Network Providers are fully compliant

3. The Alliance provides information that meets language and accessibility standards, including translation, font, and format requirements, as set forth in federal and state law; the Alliance Contract; and APLs, including APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, and APL 18-016, Readability and Suitability of Health Education Materials, or subsequent updates to these APLs.

4. The Alliance provides health education services according to policy **HED-001 Health Education Program.**
5. To ensure that updated information is provided, on-going communication and education will be provided on EPSDT requirements to providers and members for all covered areas.

L. **Monitoring Services**

1. The Alliance review utilization of primary care visits and developmental screenings to monitor access to services and identifies strategies as needed to fill gaps in access.
2. The Alliance relies on its BPHM program to ensure any follow-up and care coordination needs identified from screenings are delivered. See P&P **UM-002 and CM-032 Care Coordination – Local Education Agencies**

3. The Alliance regularly reviews encounter and administrative data as necessary, and may be as frequently as quarterly, for appropriateness, utilization, timeliness of child preventive care services, and completed screenings. This includes and not limited to HEDIS/MCAS quality measures, Facility Site Reviews/Medical Record Reviews, or chart reviews, etc. See P&P **QI-101 Quality Improvement Health Equity Program**

ACRONYMS / DEFINITIONS

A. CCS: California Children's Services
B. DHCS: Department of Health Care Services
D. TCM: Targeted Case Management
E. **Ameliorate:** To make more tolerable
F. **Maintenance:** Services that sustain or support rather than those that cure or improve health problems
G. **Medically Necessary or Medical Necessity:** When a service is necessary to correct or Ameliorate: defects and physical and mental illnesses and conditions that are discovered by screening services. **See P&P 001**

AFFECTED DEPARTMENTS/PARTIES

A. Utilization Management
B. Case Management
C. Claims
D. Member Services
E. Provider Services

RELATED POLICIES AND PROCEDURES

A. QI-101 Quality Improvement Program
B. UM-001 Utilization Management Program
C. UM-002 Coordination of Care
D. UM-008 Coordination of Care – California Children's Services
E. UM-016 Transportation Guidelines
F. UM-018 Targeted Case Management (TCM) and EPSDT Supplemental Services
G. QI-125 Blood Lead Screening for Children

H. QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
I. CM-032 Care Coordination – Local Education Agencies

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

03/22/2022, 03/21/2023

REFERENCES

A. Title 42 United States Code (USC), Section 1396d(a) and (r)
B. Title 22 California Code of Regulation (CCR) Sections 51003, 51184, 51303, 51340, 51340.1
C. Title 9, California Code of Regulation (CCR), Section 1810.247, 1820.205, 1830.210
D. Mental Health Parity and Addiction Equity Act
E. Social Security Act Section 1905 (a) and (r)
F. Department of Health Care Services All Plan Letter 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21.

MONITORING

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

The Alliance will ensure its contracted providers, delegates, and subcontractors comply with blood lead screening and reporting requirements by monitoring encounter data submissions and periodic medical record review of assessments.

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POLICY AND PROCEDURE

Policy Number	QI-135
Policy Name	Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Line(s) of Business	Medi-Cal
Effective Date	8/01/2020
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	03/21/2023

POLICY STATEMENT

To define Alameda Alliance for Health's (Alliance) responsibility to provide Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to all Medi-Cal eligible members under the age of 21.

PROCEDURE

A. The Alliance will cover and ensure the provision by subcontractors (if a contract exists) and network providers of exams, screening, diagnostic testing and treatment for preventative and all medically necessary services for members under the age of 21 in accordance with the EPSDT ~~and~~ (Medi-Cal for Kids and Teens) program benefit ~~.~~

B. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventative, diagnostic, and treatment services for low-income individuals under the age of 21. Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services to include the following:

1. **Screening services** provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. The Alliance utilizes and promotes the AAP/~~-~~Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventative Care and United States Preventive Services Taskforce (USPSTF) guidelines. This

periodic assessment also includes identifying Children with Special Health Care Needs (CSHCN). Screening services, at a minimum must include:

i. Comprehensive health and developmental history (including assessment of both physical and mental health development).
ii. Comprehensive unclothed exam.
iii. Appropriate immunizations according to the AAP Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care
iv. Laboratory tests (including blood lead level assessment appropriate for age and risk factors). See P&P **QI-125 Blood Lead Screening for Children**
v. Health education (including anticipatory guidance).
vi. Dental screenings/oral health assessments, including fluoride varnish treatment and referral. See P&P QI-124 Initial Health Appointments and UM-024 Care Coordination

2. **Vision services** provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum:
   i. Diagnosis and treatment for defects in vision, including eyeglasses.

3. **Dental services** provided at intervals which meet reasonable standards of dental practice and other intervals indicated as medically necessary to determine the existence of a suspected illness or condition and shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services must include, at a minimum:
   i. Treatment of relief of pain and infections, restoration of teeth, and maintenance of dental health.

4. **Hearing services** provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum:
   i. Diagnosis and treatment for defects in hearing, including hearing aids.

5. Other necessary health care, diagnostic services, treatment, and measures as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan for adults.

C. The EPSDT benefit in California is set forth under the California Code of Regulations (CCR). The following is outlined under Title 22, CCR, Sections 51340, 51340.1, and 51184:
   1. Screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. All Members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as

possible. ~~Screening services must identify developmental issues as early as possible.~~

2. Includes all medically necessary services described in Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services."
3. The service-specific requirements as set forth in Title 22, CCR, Section 51340.1 must meet of the following criteria where applicable:
   a. The services are necessary to screen, diagnose, correct, or ameliorate defects in physical illnesses and mental illnesses and conditions. Mental health services for those children with serious and persistent mental health issues and conditions are the responsibility of the Alameda County Behavioral Health Care Services. See P&P **UM - 012**
   b. Children with mild to moderate mental health issues or conditions receive services through the Alliance. For Behavioral Health Therapy (BHT) refer to P&P **BH-001**. If a member is assigned to Kaiser Permanente as his/her Primary Care Provider (PCP), mental health services are available through Kaiser Permanente.
   d. The services are not requested solely for the convenience of the member, family, physician, or other provider of service(s).
   e. The services are not unsafe for the individual and are not experimental.
   f. The Alliance ensures compliance with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws. See P&P **QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS).**

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D. The services to be provided must meet all the following criteria:
   1. Must be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence consisting of well-designed and well-conducted investigations published in peer-review journals and have opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can screen, diagnose, correct, or ameliorate the conditions for which they are prescribed.
   2. Are within the authorized scope of practice of the provider and are an appropriate mode of treatment for the health condition of the member.
   3. The predicted beneficial outcome of the services outweighs the potential harmful effects.
   4. Timely access to all Medically Necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up

E. The Alliance will review and authorize medically necessary shift nursing services for members under the age of 21 in accordance with CCR, Title 22, section 51340€. See P&P **UM-018 Targeted Case Management (TCM) and EPSDT Supplemental Service**

F. The EPSDT benefit includes case management and Targeted Case Management (TCM) services designed to assist the member in gaining access to necessary medical, social and educational and other services. See P&P UM-018 **Targeted Case Management (TCM) and EPSDT Supplemental Service**

H. Upon adequate evidence that a member has a CCS eligible condition, the Alliance will refer the member to the local county CCS office for determination of CCS eligibility. If the local CCS program does not approve eligibility, the Alliance remains responsible for the provision of all medically necessary covered services for the member. See P&P **UM-008 Coordination of Care – California Children's Services**

I. Alameda Alliance for Health provides appointment scheduling assistance and the following transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance:

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

NEMT services are authorized under SSA Section 1902 (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), Plans must cover NEMT for members to obtain 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. See P&P **UM-16 Transportation Guidelines**

J. **Carved – Out Services**

1. Dental services provided by Medi-Cal Denti-Cal Program
2. Non-medical services provided by the Regional Center(s) to a member with developmental disabilities, including but not limited to respite, out-of-home placement, and supportive living.
4. Specialty mental health services listed in Title 9, CCR, Section 1810.247 or members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, or 1830.210, which must be provided by a mental health plan.
5. Other services listed as services that are not "covered services" under Alliance's contract with DHCS
6. Alliance does not reimburse families or caregivers for care.

K. **Provider and Member Outreach and Education**

- 1. Member Outreach - beginning in 2023, ~~on an annual basis,~~ the Alliance will update their Member-facing materials as needed with "Medi-Cal for Kids & Teens" and mail DHCS supplied outreach and education materials consisting of the age-appropriate materials for members under the age of 21 years old (or their families/primary caregivers). ~~and "Medi-Cal Kids & Teens~~This will include the benefits of preventive care, services available ~~to members under the age of 21~~, and how to obtain these services, including transportation and scheduling assistance. ~~on an annual basis.~~ The Alliance website includes the DHCS materials and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter. ~~EPSDT~~ Health ~~educational materials~~ education materials related to EPSDT are available to members via the Alliance website and member handbook/evidence of coverage to members. ~~For new members, materials will be mailed within seven calendar days of enrollment. EPSDT educational materials are available to members via the Alliance website.~~
- Beginning in 2024 and on an annual basis by January 1 of each calendar year, the Medi-Cal Kids & Teens DHCS supplied materials will be sent mailed or shared electronically for existing members 0-21 years.
- The Med-Cal Kids & Teens mailer will be sent out to new members 0-21 years within seven calendar days of enrollment with the Alliance.
- The mailing of the -Med-Cal Kids & Teens mailers will be distributed to members according to policy C&O--001.

2. Provider Training – starting January 2024 the Alliance shall promote and train network providers with assigned members between the ages of 0-21 years regarding the Medical for Kids & Teens benefits no less than every two years.

a. In collaboration with Provider Services, on an annual basis, by February 15 of each calendar year, the Alliance will submit to DHCS a comprehensive plan and attestation to ensure all Network Providers receive proper education and training regarding EPSDT.

b. At a minimum, the Alliance will use the Provider training program developed by DHCS to promote a more uniform and shared understanding of the benefit throughout the State. For any augmented training with additional information, the Alliance will submit the training materials with edits highlighted to DHCS for review and approval prior to use.

c. To reduce Network Providers contracted with multiple Managed Care Plans (MCP) from completing duplicative trainings, the Alliance has the option to share training records with other MCPs.

d. The annual comprehensive plan will also include:

   i. How many Network Providers serve Members under the age of 21

   ii. How many Network Providers are not in compliance, and

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iii. An outline of the steps the MCP has taken to ensure Network Providers are fully compliant

3. The Alliance provides information that meets language and accessibility standards, including translation, font, and format requirements, as set forth in federal and state law; the Alliance Contract; and APLs, including APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, and APL 18-016, Readability and Suitability of Health Education Materials, or subsequent updates to these APLs.
4. The Alliance provides health education services according to policy **HED-001 Health Education Program.**
5. To ensure that updated information is provided, on-going communication and education will be provided on EPSDT requirements to providers and members for all covered areas.

L. **Monitoring Services**
1. The Alliance review utilization of primary care visits and developmental screenings to monitor access to services and identifies strategies as needed to fill gaps in access.
2. The Alliance relies on its BPHM program to ensure any follow-up and care coordination needs identified from screenings are delivered. See P&P **UM-002 and CM-032 Care Coordination – Local Education Agencies**
3. The Alliance regularly reviews encounter and administrative data as necessary, and may be as frequently as quarterly, for appropriateness, utilization, timeliness of child preventive care services, and completed screenings. This includes and not limited to HEDIS/MCAS quality measures, Facility Site Reviews/Medical Record Reviews, or chart reviews, etc. See P&P **QI-101 Quality Improvement Health Equity Program**

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ACRONYMS / DEFINITIONS

A. CCS: California Children's Services
B. DHCS: Department of Health Care Services
D. TCM: Targeted Case Management
E. **Ameliorate:** To make more tolerable
F. **Maintenance:** Services that sustain or support rather than those that cure or improve health problems
G. **Medically Necessary or Medical Necessity:** When a service is necessary to correct or Ameliorate: defects and physical and mental illnesses and conditions that are discovered by screening services. **See P&P 001**

AFFECTED DEPARTMENTS/PARTIES

A. Utilization Management
B. Case Management

C. Claims
D. Member Services
E. Provider Services

RELATED POLICIES AND PROCEDURES

A. QI-101 Quality Improvement Program
B. UM-001 Utilization Management Program
C. UM-002 Coordination of Care
D. UM-008 Coordination of Care – California Children's Services
E. UM-016 Transportation Guidelines
F. UM-018 Targeted Case Management (TCM) and EPSDT Supplemental Services
G. QI-125 Blood Lead Screening for Children
H. QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
I. CM-032 Care Coordination – Local Education Agencies
~~G.~~

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

03/22/2022, 03/21/2023

REFERENCES

A. Title 42 United States Code (USC), Section 1396d(a) and (r)
B. Title 22 California Code of Regulation (CCR) Sections 51003, 51184, 51303, 51340, 51340.1
C. Title 9, California Code of Regulation (CCR), Section 1810.247, 1820.205, 1830.210
D. Mental Health Parity and Addiction Equity Act
E. Social Security Act Section 1905 (a) and (r)
F. Department of Health Care Services All Plan Letter ~~18-007~~23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21.

MONITORING

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

The Alliance will ensure its contracted providers, delegates, and subcontractors comply with blood lead screening and reporting requirements by monitoring encounter data submissions and periodic medical record review of assessments.

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POLICY AND PROCEDURE

Policy Number	UM-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

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

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

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

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service

limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

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

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

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

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

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

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

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

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

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that

are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will share minimum necessary information with the entity to ensure the specific needs of the member at met, through secure resources (for example, but not limited to, secure email or sFTP shared site).

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

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

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

Targeted Case Management Services

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

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

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

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

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

    1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.
    2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.
        - This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication

with the other entity regarding the delegation of services needed by the member.

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

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

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

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

Behavioral Health Services

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

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

B. Criteria for BHT Services:

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

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

C. BHT Covered Services:

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

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

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

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
    1. Services rendered when continued clinical benefit is not expected.
    2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
    3. Treatment whose sole purpose is vocationally- or recreationally-based.
    4. Custodial care. For purposes of BHT services, custodial care:
        a. Is provided primarily for maintaining the member's or anyone else's safety.
        b. Could be provided by persons without professional skills or training.
    5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
    6. Services rendered by a parent, legal guardian, or legally responsible person.
    7. Services that are not evidence-based behavioral intervention practices.

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

    1. Be developed by a BHT Service Provider for the specific member being treated.
    2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
    3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
    4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
    5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
    6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
    7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
    8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
    9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation

needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.

10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
13. Include an exit plan/criteria.

G. Continuity of care:

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

e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

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

OUTBOUND CALL CAMPAIGN:

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

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

REPORTING AND MONITORING:

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

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

DEFINITIONS

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

AFFECTED DEPARTMENTS/PARTIES

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

DHCS Contract Exhibit A, Attachment 1, Provision 3 and 11
Title 22, CCR, Sections 51184, 51303, 51340, 51340.1, and 51351
Welfare and Institutions Code, CCR, Section 14132.44
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

REVISION HISTORY

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

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 Healthcare Quality Committee annually.

POLICY AND PROCEDURE

Policy Number	UM-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

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

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

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

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service

limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

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

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

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

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

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

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

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

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that

are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

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

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

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

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

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

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

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

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

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

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A. Alliance CM is required to provide all necessary CM services for Members accessing EPSDT (Medi-Cal for Kids and Teens,) supplemental services including at a minimum:
    1. Arranging for all approved services including out-of-network practitioners as needed;
    2. Coordination of care between all practitioners (PCPs, specialists, other EPSDT (Medi-Cal for Kids and Teens,) providers);
    3. Transferring medical information as necessary between practitioners; and
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B. Alliance UM/CM staff are responsible for assessing a Member's need for EPSDT (Medi-Cal for Kids and Teens,) CM services. The criteria to be used in determining the necessity for EPSDT (Medi-Cal for Kids and Teens,) CM services include whether or not:
    1. The Member has a complicated medical condition and/or behavioral health condition resulting in significant impairment.
    2. The Member has one or more environmental risk factors (primary care giver under 18 years or primary care giver has a disability).
    3. Any environmental stressors would compromise the primary care giver's ability to assist the Member in gaining access to necessary medical, social, educational, or other services.

C. Alliance CM must determine if the Member is eligible or is already receiving targeted CM through a participating local governmental agency or through an entity or organization ~~such as~~including but not limited to the following:

1. RCEB~~.~~
2. Children's Hospital
3. City of Fremont – Linkages
4. City of Fremont - FFRC
5. City of Oakland
6. Covenant House California
7. Public Health Department
8. Roots Community Health Center
9. Probation Department
10. Tiburcio Vasquez Health Center~~.~~

~~C.~~ If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will ~~also~~ share minimum necessary information with the entity to ensure the specific needs of the member at met, ~~receives all necessary services~~ through secure resources (for example, but not limited to, secure email or sFTP shared site).

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

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

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

Targeted Case Management Services

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

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

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

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

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

   1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.
   2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.

      ~~2.~~• This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication

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with the other entity regarding the delegation of services needed by the member.

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

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

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

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

Behavioral Health Services

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

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

B. Criteria for BHT Services:

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

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

C. BHT Covered Services:

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

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

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

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
    1. Services rendered when continued clinical benefit is not expected.
    2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
    3. Treatment whose sole purpose is vocationally- or recreationally-based.
    4. Custodial care. For purposes of BHT services, custodial care:
        a. Is provided primarily for maintaining the member's or anyone else's safety.
        b. Could be provided by persons without professional skills or training.
    5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
    6. Services rendered by a parent, legal guardian, or legally responsible person.
    7. Services that are not evidence-based behavioral intervention practices.

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

    1. Be developed by a BHT Service Provider for the specific member being treated.
    2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
    3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
    4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
    5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
    6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
    7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
    8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
    9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation

needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
13. Include an exit plan/criteria.

G. Continuity of care:

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

e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

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

OUTBOUND CALL CAMPAIGN:

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

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

REPORTING AND MONITORING:

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

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

DEFINITIONS

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

DHCS Contract Exhibit A, Attachment 1, Provision 3 and 11
Title 22, CCR, Sections 51184, 51303, 51340, 51340.1, and 51351
Welfare and Institutions Code, CCR, Section 14132.44
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

REVISION HISTORY

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

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 Healthcare Quality Committee annually.

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POLICY AND PROCEDURE

Policy Number	UM-036
Policy Name	Continuity of Care for Terminated and Non-Participating Providers
Department Name	Health Care Services
Department Owner	Sr. Director Health Care Services
Lines of Business	Medi-Cal and Group Care
Effective Date	1/1/2008
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	TBD

Overview

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

Policy Statement

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

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

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

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

professional practice. Completion of covered services

under this paragraph shall not exceed 12 months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

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

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

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

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

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

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

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

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

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

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

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

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

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

Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Communication to Members:

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

I. Any newly enrolled Member request COC or may obtain a copy of this policy upon written request to Alliance or by calling Member Services at (510) 747-4567.

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

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

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

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

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

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

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

PROCEDURE

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

1. Former Covered California members transitioning into Medi-Cal, Seniors and Persons with Disabilities with active Treatment Authorization Requests, and individuals identified

on the Exemption Transition Data Report will receive additional outreach regarding continuity of care from the Member Services Department.

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

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

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

D. UM Nurse Specialist 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 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 MHP UM staff to facilitate the timely exchange for co-management.UM Nurse Specialist or designee will contact the requested NPP to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information is obtained, the request is forwarded to The Alliance Medical Director to confirm CoC exists and meets criteria.

    a. If criteria met, the UM Coordinator will notify the Alliance Contracts Management team via Health Suite SR process with all applicable information to begin rate negotiations.

    b. The UM coordinator will generate an approval level for Continuity of Care as outlined by regulation to all applicable parties.

    c. If criteria is not met, the Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.

        i). The UM Coordinator will create communication to the member and provider(s) as scribed by the Medical Director.UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

G. For Mental Health Services

1. The Behavioral Health (BH) department staff are responsible for ensuring the review of request for CoC with a NPP mental health provider.

2. For services that require co-management, the BH staff are responsible for ensuring communication among the providers between all levels of care (e.g., inpatient care, partial hospitalization, outpatient care, day, and residential treatment) and will facilitate the timely exchange of information for co-management.

3. When needed, the BH staff will ensure communication between and among BH and medical providers to ensure appropriate evaluation, screening, diagnosis, and treatment of serious mental health illness, serious emotional disturbances, and autism conditions.

H. Rates of Payment and Agreement of Terms

1. Through a Letter of Rate Agreement, Alliance Contracts Management will offer the non-contracting providers who may continue services:

    a. The rates and methods of payment similar to those used by the Alliance or the provider group for currently contracted providers providing similar services or the Medi-Cal fee for service rate, whichever is higher.

    b. The rates offered will be for providers who are not capitated and who are practicing in the same similar geographic areas as the non-contracting provider.

    c. The NPP will be subject to the same contractual terms and conditions as contracting providers.

2. If the NPP agrees to the rate, terms and conditions, Contract Management notifies Medical Services and Medical Services sends to the member and the provider a notice authorizing the continued services.

3. If the NPP does not agree to the rates, or terms and conditions or fails to respond to the Alliance within 30 calendar days of the request for continuity of care, the following will occur:

    a. Contract Management will notify Alliance Medical Services to reverse the authorization.

    b. Alliance Medical Services will send the member and the provider a notice that continuity of care services have been denied because the Alliance and the non-contracted provider were unable to reach agreement.

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

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

1. Once information obtained,

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

    b. If rates not agreed upon,

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

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

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

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

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

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

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

        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.

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

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

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

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

N. Delegated Providers

1. The Alliance will ensure compliance with the regulatory requirements for continuity of care by delegated groups and oversee the compliance through the delegation oversight process; i.e., quarterly reporting, annual on-site review, investigation of complaints, and review of denials.

2. Any written, printed, or electronic notification to the Member regarding a contract termination or block transfer (transfer of all of a provider's Members) must include the following language: "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact The Alliance's Member Service Department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov".

O. Continuity of Care Reporting Requirements:

1. The Analytics, IT and Medical Services Departments will work together in order to ensure the Alliance submits all required quarterly continuity of care reports.

2. On a monthly basis, the UM Manager or designee will review CoC data and reporting requirements to ensure data is available for internal and regulatory reporting.

3. On a quarterly basis, the UM Manager and Director of Health Services will review the CoC data and provide a summary report with identification of opportunities to improve the UM experience to the UM Committee.

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

DEFINITIONS

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

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Member Services
Provider Relations
Contract Management
Health Analytics
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Behavioral Health

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. PRV-002 Block Transfers
2. BH-002 Behavioral Health Services
3. UM-001 UM Program
4. UM-058 CoC for New Enrollees with MER
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REFERENCES

- Health & Safety Code Sections 1371.8, 1373.65, 1373.95 & 1373.96
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- Continuity of Care Authorization Workflow for Medical Services Department
- Continuity of Care Workflow for Member Services Department
- Letter of Agreement Process in Policy and Procedure NTM-CON-002
- MediCal and Group Care Evidence of Coverage

MONITORING

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

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

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

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

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POLICY AND PROCEDURE

Policy Number	UM-036
Policy Name	Continuity of Care for Terminated and Non-Participating Providers
Department Name	Health Care Services
Department Owner	Sr. Director Health Care Services
Lines of Business	Medi-Cal and Group Care
Effective Date	1/1/2008
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	~~6/20/2023~~TBD

Overview

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

Policy Statement

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

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

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

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

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the terminated provider or non-contracting provider, consistent with good professional practice. Completion of covered services

under this paragraph shall not exceed 12 months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

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

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

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

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

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

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

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

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

3. This policy is not applicable for current Members if the provider was terminated for medical disciplinary cause, fraud, abuse of the Medi-Cal program or any patient, convicted of a felony or other criminal activity, suspended from the federal Medicare or Medicaid programs for any reason, lost or surrendered a license certificate or approval to provide

health care or newly covered enrollees with individual coverage.

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

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

b. Particular attention and resources will be focused on members in Special Populations:

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

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- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

~~3.~~c See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

~~B.~~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.

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

1. Maintains a process for block transfers of enrollees from a terminated provider group to a new provider group or hospital.
2. Maintains a process to facilitate the CoC for a new enrollee who has been receiving services from a NPP mental health provider for an acute, serious, or chronic mental health condition when an employer changed health plans. This includes a reasonable transition period to continue the course of treatment with the NPP prior to transferring to a participating provider and includes the provision of mental health services on a timely, appropriate, medically necessary basis from the NPP. The process provides that the length of time of the transition period take into account on a cases-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The process ensures that reasonable considerations are given to the potential clinical effect of a change of provider on the Member's treatment of the condition. The process describes the process to review a Member's request to continue the course of treatment with the NPP mental health provider.
3. NPP mental health are not required to be contracted with The Alliance or its delegate but will require a written contract as a condition of the right to treatment an Alliance Member defining the same contractual terms and conditions that are imposed upon the participating providers, including location within the service area, reimbursement methodologies and rates of payment. This will include a quality review assessment of the NPP mental health provider.
    a. When The Alliance determines that a member's health care treatment should temporarily continue with an existing provider or NPP mental health provider, the Alliance shall not be liable for actions resulting solely from the negligence, malpractice, or the tortious or wrongful acts arising out of the provisions of service by the existing provider or a NPP mental health provider.
4. Facilitates the completion of covered services pursuant to H&S Section 1373.96.
5. Provides an Evidence of Coverage for Member communication describing the policy and informing Members of their rights to the completion of covered services.
6. Maintains processes to ensure that reasonable consideration is given to the potential clinical effects on a Member's treatment caused by a change in provider.

~~D.~~E. In the event a provider is terminated, all assigned Members are notified in writing

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(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.~~F. The Alliance maintains mechanisms to facilitate transition of care (including enrollee notification when:

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

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

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

~~G.~~H. Communication to Members:

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

~~H.~~I. Any newly enrolled Member request COC or may obtain a copy of this policy upon written request to Alliance or by calling Member Services at (510) 747-4567.

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

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

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

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

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

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

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

PROCEDURE

A. All newly enrolled Members receive the Alliance's notice of the continuity of care policy in

the Evidence of Coverage and Disclosure Form that is sent at time of enrollment.

1. Former Covered California members transitioning into Medi-Cal, Seniors and Persons with Disabilities with active Treatment Authorization Requests, and individuals identified

on the Exemption Transition Data Report will receive additional outreach regarding continuity of care from the Member Services Department.

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

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

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

D. UM Nurse Specialist 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 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 MHP UM staff to facilitate the timely exchange for co-management.UM Nurse Specialist or designee will contact the requested NPP to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information is obtained, the request is forwarded to The Alliance Medical Director to confirm CoC exists and meets criteria.

    a. If criteria met, the UM Coordinator will notify the Alliance Contracts Management team via Health Suite SR process with all applicable information to begin rate negotiations.

    b. The UM coordinator will generate an approval level for Continuity of Care as outlined by regulation to all applicable parties.

    c. If criteria is not met, the Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.

        i). The UM Coordinator will create communication to the member and provider(s) as scribed by the Medical Director.UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

G. For Mental Health Services

1. The Behavioral Health (BH) department staff are responsible for ensuring the review of request for CoC with a NPP mental health provider.

2. For services that require co-management, the BH staff are responsible for ensuring communication among the providers between all levels of care (e.g., inpatient care, partial hospitalization, outpatient care, day, and residential treatment) and will facilitate the timely exchange of information for co-management.

3. When needed, the BH staff will ensure communication between and among BH and medical providers to ensure appropriate evaluation, screening, diagnosis, and treatment of serious mental health illness, serious emotional disturbances, and autism conditions.

H. Rates of Payment and Agreement of Terms

1. Through a Letter of Rate Agreement, Alliance Contracts Management will offer the non-contracting providers who may continue services:

    a. The rates and methods of payment similar to those used by the Alliance or the provider group for currently contracted providers providing similar services or the Medi-Cal fee for service rate, whichever is higher.

    b. The rates offered will be for providers who are not capitated and who are practicing in the same similar geographic areas as the non-contracting provider.

    c. The NPP will be subject to the same contractual terms and conditions as contracting providers.

2. If the NPP agrees to the rate, terms and conditions, Contract Management notifies Medical Services and Medical Services sends to the member and the provider a notice authorizing the continued services.

3. If the NPP does not agree to the rates, or terms and conditions or fails to respond to the Alliance within 30 calendar days of the request for continuity of care, the following will occur:

    a. Contract Management will notify Alliance Medical Services to reverse the authorization.

    b. Alliance Medical Services will send the member and the provider a notice that continuity of care services have been denied because the Alliance and the non-contracted provider were unable to reach agreement.

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

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

1. Once information obtained,

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

    b. If rates not agreed upon,

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

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

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

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

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

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

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

        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.

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

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

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

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

N. Delegated Providers

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

O. Continuity of Care Reporting Requirements:

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

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

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REFERENCES

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~~4.~~ Continuity of Care Workflow for Member Services Department

~~5.~~ Letter of Agreement Process in Policy and Procedure NTM-CON-002

~~6.~~ MediCal and ~~IHSS~~ Group Care Evidence of Coverage

~~7. DHCS All Plan Letter 22-032 Continuity of Care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal FFS and for Medi-Cal Members who transition into a new Medi-Cal Managed Care plan on or after January 1, 2023~~

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MONITORING

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

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

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

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

POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Policy Owner	Medical Director
Lines of Business	All
Effective Date	11/02/2004
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Approval Date	TBD

OVERVIEW

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to CA Health and Safety Code 1367.01, 1374.141, and 42 CFR 438.900(d) and 42 CFR Subpart K.

POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt, direct, auto authorization and services that require prior authorization. Any procedure, treatment, or service not on these lists defaults to require prior authorization.

B. The Alliance develops, reviews, and approves at least annually, lists of services that are direct referrals, auto authorization and services that require clinical review for medical necessity. Any procedure, treatment, or service not on these lists defaults to require prior authorization.

C. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary

to obtain such authorizations.

- The communication shall include the data and information The Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) and that guide the UM decision-making process.
- The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
  - alamedaalliance.org/providers/provider-resources
  - alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
- The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

D. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as PA timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the EOC. If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service, and if the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, AAH will do the following:

(1) Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
(2) Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their PCP, unless the enrollee objects.
(3) Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
(4) Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

E. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. (These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria and disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management.)

F. Exempt - Prior authorization is not required (is exempt from prior authorization) for:
- Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network

- Primary Care Visits
- Preventative Services
- Immunizations/Vaccines
- Annual Cognitive Assessment for Medi-Cal members over 65 without MediCare.
- Mental Health Care and Substance Use treatment
- Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care.
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
- HIV testing and counseling.
- Minors do not need authorization for:
  - Sexual or physical abuse
  - Suicidal ideations
  - Pregnancy care
  - Sexual assault
  - Drug and alcohol abuse treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4.

G. Direct - Services for which UM requests are not required, include but are not limited to:
   - PCP visits
   - Specialty visits, direct network
   - Preventive health diagnostic services, i.e., mammogram, colonoscopy,

H. Auto authorization is authorization that does not require clinical review and can be completed by a non-clinical UM staff. UM staff will process requests in accordance with the UM Committee approved auto authorization guidelines (see attachment section of the policy).

I. Services for which UM requests for authorization is required include, but are not limited to:

   - Out-of-network providers/services/facilities.
   - Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
   - Selected behavioral health services, (ex. Applied Behavioral Analysis (ABA)
   - Selected major diagnostic tests.
   - Home health care/Private Duty Nursing care.
   - Selected durable medical equipment.
   - New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
   - Medications not on The Alliance approved drug list and/or exceeding The Alliance's monthly medication limit.

- CBAS services.
- Inpatient admissions (non-emergency).
- Inpatient hospice care.
- Inpatient abortions.
- Skilled nursing facilities admissions.
- Long term care (LTC) admissions.
- Second opinion
- Podiatry services
- Acupuncture, greater than 4 visits per month
- Chiropractic

J. Immunization/Vaccination
    - Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, AAH will provide available information on the status of the member's immunizations to the LHD clinic. AAH will pay claims from LHD clinics sent with supporting immunization records.

K. Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer or cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. AAH will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. AAH will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
    - Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the MediCal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the AAH coding list will be updated accordingly. Any updates are configured in the AAH UM and Claims systems to not require PA for in-network providers.

L. Standard Fertility Services
    - Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55[1]. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause [2] iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment) [3].

    - For Medi-Cal members the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos are not covered [4].

M. Indian Health Service Programs
    - The Alliance will ensure qualified Members have timely access to IHS Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in

the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

N. Appropriate Classification of Determination
- UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
- Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.
- Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

O. The Alliance service types are processed as:
- Prior Authorization
- Concurrent, inpatient
- Concurrent, Outpatient (care currently underway)
- Post-Service/Retrospective Review

P. The Alliance authorization determinations are documented as:
- Approved
- Modified
- Denied
- Delay

Q. UM Decision Making
- The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
  - Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
  - Decisions to deny or to authorize an amount, duration or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
  - A qualified physician, doctoral behavioral healthcare practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
  - A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
  - UM Reviewers make UM authorization approval decisions based on UM Committee

approved auto authorization criteria and other UM Committee approved UM criteria.
    - Qualified doctoral Behavioral Health Reviewer staff make BH authorization approval decisions based on HCQC approved BH UM criteria.
        - See UM-012 Care Coordination policy regarding approved BH UM criteria.
    - Authorization technicians make UM authorization approval decisions based on UM Committee approved auto authorization criteria.
    - Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility.
    - Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines.

R. In instances where The Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The Alliance shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as The Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if The Alliance extends the timeframe an additional 14 calendar days because either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.

S. The Alliance shall make all UM decisions and notifications within required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, The Alliance shall adhere to the strictest standard.

T. The Alliance shall process the assessment of appropriateness of medical services on a case-by-case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:
    - Determining and ensuring response appropriate to urgency of request.
    - Determining and ensuring adequate clinical information is provided to review the request and if not to call the requesting provider to ask for additional specific information needed to review the request.
    - Ensuring that correct UM criteria are selected for review of request.
    - Ensuring appropriate review of request by the appropriate level of UM staff and/or physician / doctoral Behavioral Health Practitioner.
    - Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member.

U. When determining medical necessity, The Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, The Alliance works with the requesting providers to obtain the information in a timely manner.

V. Rescission
    - No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when The Alliance did not make an accurate determination of the member's eligibility.

W. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

X. Authorization of Enhanced Care Management (ECM)
- 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.
- 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.
- AAH will authorize ECM for a minimum of 6 months for each request.
  - Delegated ECM Providers and/ or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.
- ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
- AAH will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.
- AAH will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

Y. Authorization of Community Supports Services
- Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:
  - Routine requests not to exceed 5 days.
  - Expedited requests not to exceed 72 hours.

- Notification time frames for authorization request determination decisions for CS 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.

Z. Post Service/Retrospective Review Process

The Alliance does not accept post-service or retrospective authorization requests for non-emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service may be considered are:

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

AA. On January 1, 2024, Alameda County will transition to a Single Plan Model county, and Medi-Cal recipients will transition from a previous MCP to Alameda Alliance for Health (AAH) as their Medi-Cal Managed Care Plan (MCP). Before and 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. The continuity of care authorization process for members transitioning into AAH will adhere to the requirements of the 2024 Managed Care Plan Transition Policy Guide and All Plan Letter (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.

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

- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

o 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.

BB.

CC. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

- Contracted providers are informed in the service agreements, by accessing the UM policies, information on the AAH website and the contracted Provider Manual.
- Non-contracted providers are informed via the AAH website/Section - Authorization (https://www.alamedaalliance.org/providers/authorization).

PROCEDURE

A. Pre-Service Review

1. Authorization requests are submitted by phone, fax or in writing.
2. Upon receipt of the authorization request, the UM Authorization Coordinator (AC) will review the request for:
   a) Member eligibility
   b) Completeness of the request
      i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
      ii. Presence of medical records.

3. Once the authorization request review is complete, the AC enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned AC reviews the pre-service authorization request against benefit grid, approved auto authorization criteria. The pre-service request workflow:
   a) For requests meeting auto authorization criteria, the AC approves the request following UM guidelines Auto Authorization.
   b) For requests not meeting Auto Authorization Criteria, the AC routes the request to the UM Nurse / BH Reviewer.

5. The UM Nurse / BH Reviewer performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, according to UM-001Utilization Management Policy or UM Program.

   a) The UM Nurse / BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must

include a review of the clinical information and application of the appropriate criteria used in the determination.

b) The UM Nurse /BH Reviewer workflow includes:
c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer approves the request and generates the Member and Provider approval notification.
d) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), not meeting UM / BH Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Medical Director/Physician / doctoral Behavioral Health Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
   a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
   b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   c) When making a determination of coverage based on medical necessity relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   d) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
      i. Office and hospital records
      ii. A history of the present problem
      iii. A clinical exam
      iv. Diagnostic testing results
      v. Treatment plans and progress notes
      vi. Patient psychosocial history
      vii. Information on consultations with the treating practitioner
      viii. Evaluations from the other health care practitioners and providers
      ix. Photographs
      x. Operative and pathological reports
      xi. Rehabilitation evaluations
      xii. A printed copy of criteria related to the request.
      xiii. Information regarding benefits for services of procedures
      xiv. Information regarding the local delivery system
      xv. Patient characteristics and information
      xvi. Information from responsible family members

B. Missing Clinical Information:
   1. Formal requests for missing information can be made either by phone or in writing.
      a) Missing information includes:
         i. Incomplete name, ID number, contact information.
         ii. Diagnosis or Service codes

iii. Incomplete Attachments

2. When clinical information is missing in the request and the information can be received within the same day, UM staff and the Medical Directors / doctoral Behavioral Health Reviewer shall contact the requesting provider by phone to request missing clinical information.
   a) Call attempts should be documented in the authorization request case. Up to three attempts will be made:
      i. The Authorization Coordinator shall make the first call, the UM Nurse / BH Reviewer the second call, and the Medical Director /doctoral Behavioral Health Reviewer the third call.

C. Request for additional information
   1. Requests for additional information are considered deferrals, delays, or extension to the authorization process.
   2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The UM Nurse / BH Reviewer will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.
   3. Formal requests for additional information must be made in writing to the provider and the member using the most recent DHCS or The Alliance templates.
   4. An extension of 14 calendar days may be granted if either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.
   5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
   6. Upon receipt of all information reasonably necessary and requested, UM Nurse / BH Reviewer may approve the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.
      a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
   7. A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.

D. Medical Director/Physician Reviewer Review
   1. The Medical Director/Physician /doctoral Behavioral Health Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director/Physician Reviewer /doctoral Behavioral Health reviews the information summary provided by the UM Nurse /BH Reviewer, the clinical information, and the appropriate UM Criteria.
      a) The Medical Director/Physician doctoral Behavioral Health Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
      b) To evidence appropriate professional review, each UM case must include one of the

following:

i. The reviewer's written signature or initials
ii. The reviewer's unique electronic signature or identifier on the denial notation
iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

2. Once the Medical Director/Physician doctoral Behavioral Health Reviewer makes the UM Decision, the case is returned to the UM Nurse /BH Reviewer for processing:

a) Approvals: The UM Nurse / BH Reviewer processes the request according to established processes and timeframes.
b) Delays, Denials, Modifications, or Terminations: The UM Nurse / BH Reviewer processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Peer to Peer Discussions

1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the AAH decision maker. Providers are notified of this process in the UM determination notifications.
   a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the AAH UM decision maker.
   b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the Notice of Action Letter.
      i. "AAH has reviewed your request for <<Insert Member Name>>. AAH made a determination that this service is not medically necessary. You may also contact the Medical Director reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit at (510) 747-4540."
2. AAH easy access for Providers and utilizes the AAH UM telephone number to serve as the entry point of contact.
3. UM / BH Staff will answer the UM calls and obtain the key information to have the UM decision maker return the call:
   a) Member name and ID#
   b) Referral #
   c) Name of the Physician requesting the return call.
   d) Contact number for the requesting Physician.
   e) Best time to reach the requesting Physician.
4. UM / BH Staff will note the request for the discussion in the TruCare Case and notify the appropriate UM decision maker.
   a) If the AAH UM decision maker is not available, the UM Staff will task the request to the UM decision-maker for the day.
5. Every attempt is made to return calls on the same day.
   a) Two attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
   b) AAH Physician / doctoral Behavioral Health Reviewer will document all outreach attempts in TruCare.
6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:

- In the denial notification, ***or***
- By telephone, ***or***
- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

7. The organization includes the following information in the denial file:
   - The denial notification, if the treating practitioner was notified in the denial notification.
   - The time and date of the notification, if the treating practitioner was notified by telephone.
   - Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Medical Director/Physician / doctoral Behavioral Health Reviewer does not have the clinical expertise in treating the requested serviced to render the UM determination, the Medical Director/Physician / doctoral Behavioral Health Reviewer may consult with a Board Certified Consultant to assist in making the medical necessity determination.
   1. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Medical Director/Physician / doctoral Behavioral Health Reviewer will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers
   1. The Alliance requires services to be provided within the contracted network.
      a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which AAH does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or LTC capacity:

   2. When services are not available within the network:
      a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue.
      b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes case.
      c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer to determine if the service is medically necessary and the status of available providers within the network to provide the service.
      d) The UM Nurse / BH Reviewer reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.
         i. If determined services are medically necessary but not available within The Alliance network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews with the Medical Director/Physician /doctoral Behavioral Health Reviewer to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time letter of agreement through Provider Network Operations.

ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews case with the Medical Director/Physician /doctoral Behavioral Health Reviewer to possible re- direct into the network.
(i) If determination is to re-direct, the UM Nurse / BH Reviewer will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.

e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that **meet** the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH Department using medical necessity review criteria.
   a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Medical Director /doctoral Behavioral Health Reviewer and changed to a routine urgency status.
2. Post-Service requests that **do not meet** the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.
   a) UM Coordinator will review post-service request to ensure:
      i. Member was eligible at the time of services.
      ii. Services required prior authorization.
      iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.
   b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Medical Director /doctoral Behavioral Health Reviewer for potential denial.
   c) If documentation found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer to confirm the services authorized match the services requested.
      i. UM Nurse / BH Reviewer will assess the documentation and confirm the prior authorization was related to the requested service.
         (i) If the services match, the case will be completed as approved and closed according to policy.
3. Post Service/Retrospective requests that meet the exception criteria **and** are submitted <u>greater than 90 calendar days</u> from the date of service.
   a) Services are reviewed for medical necessity or exemption to prior authorization based on UM Policy.
4. Post Service/Retrospective requests that do not meet the exception criteria **and** are submitted greater <u>than 90 calendar days</u> from the date of service:
   a) Services will be denied as "no authorization obtained for service that required prior authorization."

i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.

b) UM Coordinator will route request to the Medical Director /doctoral Behavioral Health Reviewer for potential denial.

c) The Medical Director /doctoral Behavioral Health Reviewer will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.

i. If documentation supports prior authorization was required and not obtained, Medical Director /doctoral Behavioral Health Reviewer will document findings and deny case as "no prior authorization obtained."

ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Medical Director /doctoral Behavioral Health Reviewer will document findings for approval along with the reasons.

d) Case is routed back to the UM Coordinator to complete the member and provider notifications.

e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.

I. Potential Quality Indicator (PQI)

1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH staff will fill out the PQI Service Request (SR) referral via Health and forwards to the QI dept. for review in accordance QI Policy Potential Quality of Care Issues.

J. Referrals to Care Management

1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with obtaining services from an In-Network or Out of Network Provider, UM staff will complete the Care Management / BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department /BH for review and assistance in accordance with Care Management /BH Policies.

K. Reporting and Tracking

1. All pre-service requests are entered into The Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.
2. HealthCare Analytics has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.
3. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

L. The Alliance Medical Management Referrals for Autism Services

1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
2. All behavioral health related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946

will be routed to the BH Team for referral processing.

3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
   a) Behavioral Health team will submit any request for non-behavioral health services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
   b) UM Staff will process referral request as defined in Sections 3.1
   c) UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

M. The Alliance UM / BH departments 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 various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations** – pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

C. **Behavioral Healthcare Practitioner (BHP)** 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 arear of practice.

D. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

F. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer** is a licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

I. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

J. **Medically Necessary (Group Care Program):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

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

   i) Consistent with nationally accepted standards of medical practice:

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

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

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

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

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

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

L. **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.

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

N. **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.

O. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH.

P. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

Q. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

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

i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses

the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

S. **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.

T. **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.

U. **UM /BH Reviewer** is a Registered Nurse, Physician Assistant, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. They apply HCQC approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on AAH Website, Provider Section,
2. UM-012 Care Coordination-Behavioral Health
3. UM-013 Care Coordination-Substance Abuse
4. BH-001 Behavioral Health Services
5. BH-002 Behavioral Health Services
6. CM-002 Coordination of Care
7. CM-009 ECM Program Infrastructure

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023

REFERENCES

- [1] SB 600, Section 1374.551. (a)
- [2] “May directly or indirectly cause” means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- [3] Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- [4] DHCS Provider Manual, Family Planning, August 2020, page 1.

- DHCS Contract, Exhibit A, Attachments 5, 9, 13
- Title 22, Section 51159
- 28 CCR, §1300.51 (d)(I-6)
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- All Plan Letter (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
- 2024 Medi-Cal Managed Care 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
- All Plan Letter 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- 11.NCQA Standards, Utilization Management
- WIC Section 14197
- APL 22-010 Cancer Biomarking Testing

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
    b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Policy Owner	Medical Director
Lines of Business	All
Effective Date	11/02/2004
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Approval Date	~~6/20/2023~~TBD

OVERVIEW

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to CA Health and Safety Code 1367.01, 1374.141, and 42 CFR 438.900(d) and 42 CFR Subpart K.

POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt, direct, auto authorization and services that require prior authorization. Any procedure, treatment, or service not on these lists defaults to require prior authorization.

B. The Alliance develops, reviews, and approves at least annually, lists of services that are direct referrals, auto authorization and services that require clinical review for medicalnecessity. Any procedure, treatment, or service not on these lists defaults to require prior authorization.

C. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary

to obtain such authorizations.

- The communication shall include the data and information The Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) and that guide the UM decision-making process.
- The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
  - alamedaalliance.org/providers/provider-resources
  - alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
- The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

D. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as PA timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the EOC. If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service, and if the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, AAH will do the following:

(1) Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
(2) Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their PCP, unless the enrollee objects.
(3) Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
(4) Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

E. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. (These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria and disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management.)

F. Exempt - Prior authorization is not required (is exempt from prior authorization) for:
- Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network

- Primary Care Visits
- Preventative Services
- Immunizations/Vaccines
- Annual Cognitive Assessment for Medi-Cal members over 65 without MediCare.
- Mental Health Care and Substance Use treatment
- Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care.
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
- HIV testing and counseling.
- Minors do not need authorization for:
  - Sexual or physical abuse
  - Suicidal ideations
  - Pregnancy care
  - Sexual assault
  - Drug and alcohol abuse treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4.

G. Direct - Services for which UM requests are not required, include but are not limited to:
   - PCP visits
   - Specialty visits, direct network
   - Preventive health diagnostic services, i.e., mammogram, colonoscopy,

H. Auto authorization is authorization that does not require clinical review and can be completed by a non-clinical UM staff. UM staff will process requests in accordance with the UM Committee approved auto authorization guidelines (see attachment section of the policy).

I. Services for which UM requests for authorization is required include, but are not limited to:

   - Out-of-network providers/services/facilities.
   - Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
   - Selected behavioral health services, (ex. Applied Behavioral Analysis (ABA)
   - Selected major diagnostic tests.
   - Home health care/Private Duty Nursing care.
   - Selected durable medical equipment.
   - New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
   - Medications not on The Alliance approved drug list and/or exceeding The Alliance's monthly medication limit.

- CBAS services.
- Inpatient admissions (non-emergency).
- Inpatient hospice care.
- Inpatient abortions.
- Skilled nursing facilities admissions.
- Long term care (LTC) admissions.
- Second opinion
- Podiatry services
- Acupuncture, greater than 4 visits per month
- Chiropractic

J. Immunization/Vaccination
    - Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, AAH will provide available information on the status of the member's immunizations to the LHD clinic. AAH will pay claims from LHD clinics sent with supporting immunization records.

K. Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer or cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. AAH will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. AAH will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
    - Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the MediCal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the AAH coding list will be updated accordingly. Any updates are configured in the AAH UM and Claims systems to not require PA for in-network providers.

L. Standard Fertility Services
    - Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55[1]. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause [2] iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment) [3].

    - For Medi-Cal members the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos are not covered [4].

M. Indian Health Service Programs
    - The Alliance will ensure qualified Members have timely access to IHS Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in

the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

N. Appropriate Classification of Determination
- UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
- Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.
- Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

O. The Alliance service types are processed as:
- Prior Authorization
- Concurrent, inpatient
- Concurrent, Outpatient (care currently underway)
- Post-Service/Retrospective Review

P. The Alliance authorization determinations are documented as:
- Approved
- Modified
- Denied
- Delay

Q. UM Decision Making
- The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
  - Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
  - Decisions to deny or to authorize an amount, duration or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
  - A qualified physician, doctoral behavioral healthcare practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
  - A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
  - UM Reviewers make UM authorization approval decisions based on UM Committee

approved auto authorization criteria and other UM Committee approved UM criteria.
    - Qualified doctoral Behavioral Health Reviewer staff make BH authorization approval decisions based on HCQC approved BH UM criteria.
        - See UM-012 Care Coordination policy regarding approved BH UM criteria.
    - Authorization technicians make UM authorization approval decisions based on UM Committee approved auto authorization criteria.
    - Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility.
    - Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines.

R. In instances where The Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The Alliance shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as The Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if The Alliance extends the timeframe an additional 14 calendar days because either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.

S. The Alliance shall make all UM decisions and notifications within required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, The Alliance shall adhere to the strictest standard.

T. The Alliance shall process the assessment of appropriateness of medical services on a case-by-case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:
    - Determining and ensuring response appropriate to urgency of request.
    - Determining and ensuring adequate clinical information is provided to review the request and if not to call the requesting provider to ask for additional specific information needed to review the request.
    - Ensuring that correct UM criteria are selected for review of request.
    - Ensuring appropriate review of request by the appropriate level of UM staff and/or physician / doctoral Behavioral Health Practitioner.
    - Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member.

U. When determining medical necessity, The Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, The Alliance works with the requesting providers to obtain the information in a timely manner.

V. Rescission
    - No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when The Alliance did not make an accurate determination of the member's eligibility.

W. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

X. Authorization of Enhanced Care Management (ECM)
- 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.
- 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.
- AAH will authorize ECM for a minimum of 6 months for each request.
  - Delegated ECM Providers and/ or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.
- ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
- AAH will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.
- AAH will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

Y. Authorization of Community Supports Services
- Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:
  - Routine requests not to exceed 5 days.
  - Expedited requests not to exceed 72 hours.

- Notification time frames for authorization request determination decisions for CS 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.

Z. Post Service/Retrospective Review Process

The Alliance does not accept post-service or retrospective authorization requests for non-emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service may be considered are:

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

AA. On January 1, 2024, Alameda County will transition to a Single Plan Model county, and Medi-Cal recipients will transition from a previous MCP to Alameda Alliance for Health (AAH) as their Medi-Cal Managed Care Plan (MCP). Before and 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. The continuity of care authorization process for members transitioning into AAH will adhere to the requirements of the 2024 Managed Care Plan Transition Policy Guide and All Plan Letter (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.

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

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- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

  - 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.

BB.

CC. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

- Contracted providers are informed in the service agreements, by accessing the UM policies, information on the AAH website and the contracted Provider Manual.
- Non-contracted providers are informed via the AAH website/Section - Authorization (https://www.alamedaalliance.org/providers/authorization).

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PROCEDURE

A. Pre-Service Review

1. Authorization requests are submitted by phone, fax or in writing.
2. Upon receipt of the authorization request, the UM Authorization Coordinator (AC) will review the request for:
   a) Member eligibility
   b) Completeness of the request
      i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
      ii. Presence of medical records.

3. Once the authorization request review is complete, the AC enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned AC reviews the pre-service authorization request against benefit grid, approved auto authorization criteria. The pre-service request workflow:
   a) For requests meeting auto authorization criteria, the AC approves the request following UM guidelines Auto Authorization.
   b) For requests not meeting Auto Authorization Criteria, the AC routes the request to the UM Nurse / BH Reviewer.

5. The UM Nurse / BH Reviewer performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, according to UM-001Utilization Management Policy or UM Program.

   a) The UM Nurse / BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must

include a review of the clinical information and application of the appropriate criteria used in the determination.

b) The UM Nurse /BH Reviewer workflow includes:
c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer approves the request and generates the Member and Provider approval notification.
d) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), not meeting UM / BH Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Medical Director/Physician / doctoral Behavioral Health Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
   a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
   b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   c) When making a determination of coverage based on medical necessity relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   d) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
      i. Office and hospital records
      ii. A history of the present problem
      iii. A clinical exam
      iv. Diagnostic testing results
      v. Treatment plans and progress notes
      vi. Patient psychosocial history
      vii. Information on consultations with the treating practitioner
      viii. Evaluations from the other health care practitioners and providers
      ix. Photographs
      x. Operative and pathological reports
      xi. Rehabilitation evaluations
      xii. A printed copy of criteria related to the request.
      xiii. Information regarding benefits for services of procedures
      xiv. Information regarding the local delivery system
      xv. Patient characteristics and information
      xvi. Information from responsible family members

B. Missing Clinical Information:
   1. Formal requests for missing information can be made either by phone or in writing.
      a) Missing information includes:
         i. Incomplete name, ID number, contact information.
         ii. Diagnosis or Service codes

iii. Incomplete Attachments

2. When clinical information is missing in the request and the information can be received within the same day, UM staff and the Medical Directors / doctoral Behavioral Health Reviewer shall contact the requesting provider by phone to request missing clinical information.
   a) Call attempts should be documented in the authorization request case. Up to three attempts will be made:
      i. The Authorization Coordinator shall make the first call, the UM Nurse / BH Reviewer the second call, and the Medical Director /doctoral Behavioral Health Reviewer the third call.

C. Request for additional information
   1. Requests for additional information are considered deferrals, delays, or extension to the authorization process.
   2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The UM Nurse / BH Reviewer will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.
   3. Formal requests for additional information must be made in writing to the provider and the member using the most recent DHCS or The Alliance templates.
   4. An extension of 14 calendar days may be granted if either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.
   5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
   6. Upon receipt of all information reasonably necessary and requested, UM Nurse / BH Reviewer may approve the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.
      a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
   7. A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.

D. Medical Director/Physician Reviewer Review
   1. The Medical Director/Physician /doctoral Behavioral Health Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director/Physician Reviewer /doctoral Behavioral Health reviews the information summary provided by the UM Nurse /BH Reviewer, the clinical information, and the appropriate UM Criteria.
      a) The Medical Director/Physician doctoral Behavioral Health Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
      b) To evidence appropriate professional review, each UM case must include one of the

following:
   i. The reviewer's written signature or initials
   ii. The reviewer's unique electronic signature or identifier on the denial notation
   iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

2. Once the Medical Director/Physician doctoral Behavioral Health Reviewer makes the UM Decision, the case is returned to the UM Nurse /BH Reviewer for processing:

   a) Approvals: The UM Nurse / BH Reviewer processes the request according to established processes and timeframes.
   b) Delays, Denials, Modifications, or Terminations: The UM Nurse / BH Reviewer processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Peer to Peer Discussions
   1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the AAH decision maker. Providers are notified of this process in the UM determination notifications.
      a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the AAH UM decision maker.
      b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the Notice of Action Letter.
         i. "AAH has reviewed your request for <<Insert Member Name>>. AAH made a determination that this service is not medically necessary. You may also contact the Medical Director reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit at (510) 747-4540."
   2. AAH easy access for Providers and utilizes the AAH UM telephone number to serve as the entry point of contact.
   3. UM / BH Staff will answer the UM calls and obtain the key information to have the UM decision maker return the call:
      a) Member name and ID#
      b) Referral #
      c) Name of the Physician requesting the return call.
      d) Contact number for the requesting Physician.
      e) Best time to reach the requesting Physician.
   4. UM / BH Staff will note the request for the discussion in the TruCare Case and notify the appropriate UM decision maker.
      a) If the AAH UM decision maker is not available, the UM Staff will task the request to the UM decision-maker for the day.
   5. Every attempt is made to return calls on the same day.
      a) Two attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
      b) AAH Physician / doctoral Behavioral Health Reviewer will document all outreach attempts in TruCare.
   6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:

- In the denial notification, ***or***
- By telephone, ***or***
- In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.

7. The organization includes the following information in the denial file:
   - The denial notification, if the treating practitioner was notified in the denial notification.
   - The time and date of the notification, if the treating practitioner was notified by telephone.
   - Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Medical Director/Physician / doctoral Behavioral Health Reviewer does not have the clinical expertise in treating the requested serviced to render the UM determination, the Medical Director/Physician / doctoral Behavioral Health Reviewer may consult with a Board Certified Consultant to assist in making the medical necessity determination.
   1. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Medical Director/Physician / doctoral Behavioral Health Reviewer will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers
   1. The Alliance requires services to be provided within the contracted network.
      a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which AAH does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or LTC capacity:

   2. When services are not available within the network:
      a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue.
      b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes case.
      c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer to determine if the service is medically necessary and the status of available providers within the network to provide the service.
      d) The UM Nurse / BH Reviewer reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.
         i. If determined services are medically necessary but not available within The Alliance network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews with the Medical Director/Physician /doctoral Behavioral Health Reviewer to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time letter of agreement through Provider Network Operations.

ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews case with the Medical Director/Physician /doctoral Behavioral Health Reviewer to possible re- direct into the network.
(i) If determination is to re-direct, the UM Nurse / BH Reviewer will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.

e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that **meet** the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH Department using medical necessity review criteria.
   a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Medical Director /doctoral Behavioral Health Reviewer and changed to a routine urgency status.
2. Post-Service requests that **do not meet** the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.
   a) UM Coordinator will review post-service request to ensure:
      i. Member was eligible at the time of services.
      ii. Services required prior authorization.
      iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.
   b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Medical Director /doctoral Behavioral Health Reviewer for potential denial.
   c) If documentation found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer to confirm the services authorized match the services requested.
      i. UM Nurse / BH Reviewer will assess the documentation and confirm the prior authorization was related to the requested service.
         (i) If the services match, the case will be completed as approved and closed according to policy.
3. Post Service/Retrospective requests that meet the exception criteria **and** are submitted <u>greater than 90 calendar days</u> from the date of service.
   a) Services are reviewed for medical necessity or exemption to prior authorization based on UM Policy.
4. Post Service/Retrospective requests that do not meet the exception criteria **and** are submitted greater <u>than 90 calendar days</u> from the date of service:
   a) Services will be denied as "no authorization obtained for service that required prior authorization."

i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.

b) UM Coordinator will route request to the Medical Director /doctoral Behavioral Health Reviewer for potential denial.

c) The Medical Director /doctoral Behavioral Health Reviewer will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.
   i. If documentation supports prior authorization was required and not obtained, Medical Director /doctoral Behavioral Health Reviewer will document findings and deny case as "no prior authorization obtained."
   ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Medical Director /doctoral Behavioral Health Reviewer will document findings for approval along with the reasons.

d) Case is routed back to the UM Coordinator to complete the member and provider notifications.

e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.

I. Potential Quality Indicator (PQI)
   1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH staff will fill out the PQI Service Request (SR) referral via Health and forwards to the QI dept. for review in accordance QI Policy Potential Quality of Care Issues.

J. Referrals to Care Management
   1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with obtaining services from an In-Network or Out of Network Provider, UM staff will complete the Care Management / BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department /BH for review and assistance in accordance with Care Management /BH Policies.

K. Reporting and Tracking
   1. All pre-service requests are entered into The Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.
   2. HealthCare Analytics has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.
   3. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

L. The Alliance Medical Management Referrals for Autism Services
   1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
   2. All behavioral health related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946

will be routed to the BH Team for referral processing.

3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
   a) Behavioral Health team will submit any request for non-behavioral health services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
   b) UM Staff will process referral request as defined in Sections 3.1
   c) UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

M. The Alliance UM / BH departments 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 various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations** – pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

C. **Behavioral Healthcare Practitioner (BHP)** 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 arear of practice.

D. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

F. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer** is a licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

I. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

J. **Medically Necessary (Group Care Program):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

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

   i) Consistent with nationally accepted standards of medical practice:

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

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

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

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

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

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

L. **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.

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

N. **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.

O. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH.

P. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

Q. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

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

i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses

the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

S. **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.

T. **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.

U. **UM /BH Reviewer** is a Registered Nurse, Physician Assistant, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. They apply HCQC approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on AAH Website, Provider Section,
2. UM-012 Care Coordination-Behavioral Health
3. UM-013 Care Coordination-Substance Abuse
4. BH-001 Behavioral Health Services
5. BH-002 Behavioral Health Services
6. CM-002 Coordination of Care
7. CM-009 ECM Program Infrastructure

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023

REFERENCES

~~1.~~ [1] SB 600, Section 1374.551. (a)
~~2.~~ [2] "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
~~3.~~ [3] Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
~~4.~~ [4] DHCS Provider Manual, Family Planning, August 2020, page 1.

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~~5.~~ DHCS Contract, Exhibit A, Attachments 5, 9, 13
~~6.~~ Title 22, Section 51159
- ~~7.~~ 28 CCR, §1300.51 (d)(I-6)
- ~~8.~~ Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- All Plan Letter (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
- 2024 Medi-Cal Managed Care 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
- All Plan Letter 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

- ~~9.~~ 42 CFR 438.900(d)
- ~~10.~~ 42 CFR Subpart K
- 11.NCQA Standards, Utilization Management
- ~~12.~~ WIC Section 14197
- ~~13.~~ APL 22-010 Cancer Biomarking Testing

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MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
    b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-059
Policy Name	Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Health Care Services
Line(s) of Business	Medi-Cal
Effective Date	5/3/2018
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

All Alliance members, including Seniors and Persons with Disabilities, who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) or whose contracts are expiring/terminating to AAH as of January 1, 2023, with pre-existing provider relationships (medical or behavioral health,) may make a continuity of care request to the Alliance. For the 1/1/2024 transition of Alameda County to a Single Plan Model, AAH will ensure that continuity of care policies will protect Members access to care in accordance with the DHCS 2024 MCP Transition Policy Guide. Members may request up to 12 months of CoC with a Provider if a verifiable pre-existing relationship exists with that provider for any covered Medi-Cal service, with an out-of-network/nonparticipating Medi-Cal provider, when in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization. Members will have access to services consistent with the access they previously had.

1. Continuity of Care (CoC) protections extend to Primary Care Providers, Specialists and select ancillary providers as follows:

    a. Physical therapy
    b. Occupational therapy

c. Speech therapy
d. Respiratory therapy
e. Behavioral health
f. Durable medical equipment (DME)

2. The Alliance will provide continuity of care with an out-of-network (OON) provider when:

   a. The provider is providing a service that is eligible for Continuity of Care (CoC) for Providers.
   b. The Alliance is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).

   c. An existing relationship means the member has seen an out-of-network primary care provider (PCP,) specialist, or behavioral health provider at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified in this policy or by state or federal law.

   d. If the Provider is an OON Provider, the Alliance will contact the Provider and make a good faith attempt to establish COC for the beneficiary.

   e. The Provider accepts the higher of the Alliance contract rates or Medi-Cal FFS rates.

   f. The Provider meets the Alliance's applicable professional standards and has no disqualifying quality of care issues.

      i. For the purpose of the DHCS All Plan Letter, a quality of care issue means The Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Alliance members.

   g. The Provider is a California State Plan Approved Provider

   h. The Provider supplies the Alliance with relevant treatment information for the purposes of determining Medical Necessity, as well as a current treatment plan as allowable under applicable federal and state privacy laws and regulations.

3. During the 2024 Managed Care Transition to Single Plan Model, the following policies and procedures apply:

a. For members identified as belonging to Special Populations, AAH will focus attention and resources on transitioning members to minimize the risk of harm from disruptions in their care:

(a) Special Populations include:

- Adults and children with authorizations to receive Enhanced Care Management (ECM) services
- Adults and children with authorizations to receive Community Supports (CS).
- Adults and children receiving Complex Care Management (CCM)
- Enrolled in 1915(c) waiver programs
- Receiving in-home supportive services (IHSS)
- Children and youth enrolled in California Children's Services (CCS)
- Children and youth receiving foster care, and former foster youth through age 25
- In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- Taking immunosuppressive medications, immunomodulators, and biologics
- Receiving treatment for end-stage renal disease (ESRD)
- Living with an intellectual or developmental disability (I/DD) diagnosis
- Living with a dementia diagnosis
- In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
- Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- Receiving specialty mental health services (adults, youth, and children)
- Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- Receiving hospice care
- Receiving home health
- Residing in Skilled Nursing Facilities (SNF)
- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023

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

b) The Previous MCP transitioning Members will transfer supportive information that is important to the incoming Members' care coordination and management.
c) AAH will work with the Previous MCP to transfer and share supportive information important for the Members' care coordination and management.
d) AAH will process CoC for provider requests and notify members according to the requirements of the DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide:
    - If a member's current provider is a network provider in both the Previous MCP and AAH, the member may continue to see their provider when the member transitions to AAH on 1/1/24. No action is required by the member to continue seeing their provider in this case.
    - Some members who transition to AAH on January 1, 2024, will be receiving care from providers who are OON providers for AAH. If members wish to switch their care to an AAH network provider on January 1, 2024, AAH will facilitate that switch. For other members, transitioning to a new provider on January 1, 2024, may disrupt their care. CoC for Providers will enable transitioning members to continue receiving care from their existing providers for 12 months if certain requirements are met. This CoC for Providers protection is intended to maintain trusted member/provider relationships until the member can transition to a network provider with AAH. All transitioning members may request CoC for Providers with an eligible provider for up to 12 months.
        - Eligible Provider Types:
            - Primary Care Providers (PCP)
            - Specialists
            - Enhanced Care Management Providers
            - Community Supports Providers
            - Skilled Nursing Facilities (SNFs)
            - Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
            - Community-Based Adult Services Providers
            - Select ancillary Providers
                - Dialysis centers
                - Physical therapists
                - Occupational therapists
                - Respiratory therapists
                - Mental health Providers

- Behavioral health treatment (BHT) Providers
- Speech therapy Providers
- Doulas
- Community Health Workers

- Ineligible Provider Types:

  - All other ancillary Providers, such as:
    - Radiology
    - Laboratory
    - Non-emergency medical transportation (NEMT)
    - Non-medical transportation (NMT)
    - Other ancillary services
  - Non-enrolled Medi-Cal Providers

e) AAH will ensure that there is no disruption to the relationships between all transitioning members and their PCPs. All transitioning members may request CoC for eligible providers for up to 12 months. AAH will provide more than 12 months of CoC for Providers as needed for members living with a terminal illness, acute condition, or a pregnancy (including three trimesters of pregnancy, the immediate postpartum period, and 12 months following diagnosis of maternal mental health condition or end of pregnancy, whichever is later). The postpartum period is defined as 12 months AAH will retain at least 90% of the transitioning members' PCPs either as network providers or through CoC for provider agreements. If AAH is unable to enter into a contract with a member's PCP, and the member requests to continue with their PCP, AAH will offer a Letter of Agreement (LOA) if all requirements are met. AAH will ensure that the members have the same PCP assignment as they had through their previous MCP, either through the providers' network participation or an LOA. Since the member is already included in the PCP's panel, a closed panel nor a status that the PCP is not accepting new members will affect the assignment of the member to their PCP. If a member wishes to change their PCP, they must notify AAH to assist with obtaining a new PCP.

f) For coordination of care and care transition efforts, AAH will adhere to the requirements of HCS 1373.96, and will allow non-contracted providers to continue a member's treatment plan for ineligible provider types that are delivering non-contracted services.

g) To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting AAH. The requester may contact AAH prior to the date of service up until December 31, 2024. If the services

were rendered prior to the CoC request, the requester must contact AAH within 30 calendar days after the date of service. Upon receiving the request, AAH will confirm that the request meets the CoC requirements listed in section 2 above.

h) AAH will accept requests made over the telephone, electronically, or in writing, according to the requester's preference. AAH will ensure that transitioning members are able to access assistance from AAH's call center starting November 1, 2023, prior to their enrollment with AAH before January 1, 2024. AAH will confirm that the requirements in the DHCS Managed Care Plan Transition Policy Guide, section on CoC for Providers are met. If requirements are met, AAH will contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into an LOA for the member's care and notify the provider and member. AAH will notify the member of the date the request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of AAH's decision using the member's preferred form of communication or, if not known, by telephone call, text message, or email. The timeframe for processing requests and notifying the member and provider will be within the following timeframes appropriate to the member's condition:

Request	Description	Timeframe for Processing Request	Timeframe for Notifying Member and Provider After Processing the Request
Urgent	There is identified risk of harm to the member	As soon as possible, but no longer than 3 calendar days	Within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days
Immediate	The member's medical condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar days	7 calendar days

- These timeframes apply to requests made prospectively. If the prospective request is made in advance of January 1, 2024, then AAH will complete

processing the request by January 1, 2024, or according to these timeframes, whichever is later.
- Retroactive requests are not considered urgent or immediate.

4. AAH will ensure that transitioning members who seek assistance before January 1, 2024, while not yet enrolled in AAH are offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

5. Provider Agreements

    a. When a CoC for Providers agreement is established, AAH will work with the eligible provider to ensure no disruption in services for the member.
    b. AAH will direct the eligible provider not to refer the member to other OON providers without prior approval from AAH.
    c. After establishing a CoC for Providers agreement with the eligible provider, AAH will reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and the DHCS Medi-Cal Managed Care Plan Policy Guide, and as agreed upon with the provider.
    d. As the end of the agreed-upon CoC period approaches, AAH will establish a process to transition the member to a network provider.
    e. Sixty calendar days before the end of the CoC for Providers period, AAH will notify the member and the eligible provider about the process for transitioning the member's care.
    f. AAH will identify a network provider, will engage the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within 60 days to ensure continuity of covered services through the transition to the network provider.
    g. If AAH and the eligible provider are unable to reach an LOA, AAH will offer the member an alternative network provider in a timely manner, so the member's service is not disrupted.
    h. If the member does not actively choose an alternative network provider, AAH will refer the member to a network provider
    i. If there is no network provider to provide the Covered Service, AAH will arrange for an OON provider.

6. Enhanced CoC Protections for Special Populations:

    a. Upon receiving data for Special Populations, AAH will proactively begin the Continuity of Care for Providers process
    b. AAH will review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024, by January 1, 2024, or within 30 calendar days of receiving data for Special Populations, whichever is sooner.
    c. AAH will contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement if requirements in Section V.C of the 2024 MCP Transition Policy Guide are met.

d. AAH will notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:
e. If the member's provider is in Network or is brought in Network as a result of AAH's outreach, then AAH will send notification that the member may continue with his or her provider.
f. If the member's provider is OON and AAH establishes an LOA, then AAH will notify the member that the length of time that they can stay with their provider.
g. If the provider is OON and cannot establish an LOA, AAH will send notification that the member must change to a network provider and assign the member a new network provider.
h. In all cases, the notification will include that the member may choose to change providers and comply with the notification requirements in DHCS 2024 MCP Transition Policy Guide Section V.C. Expectations of the Receiving MCP, and with the required timeline in Figure 6 of the DHCS 2024 MCP Transition Policy Guide
i. During the 6-month CoC for Services period, AAH will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations.

7. Enhanced Protections for Members Accessing the Transplant Benefit

    a. If AAH is unable to bring a Transplant Program in Network, AAH will make a good faith effort to:
        1. Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in the DHCS 2024 MCP Transition Policy Guide, section V.C and according to the following terms:
            i. Make explicit the existing statutory requirement that AAH will pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)
            ii. Permit the LOA agreement to continue for the duration of the member's access to the transplant benefit.
        2. If AAH is unable to enter into a CoC for Providers agreement, AAH will:
            i. Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in Figure 6 of the DHCS Medi-Cal Managed Care Plan Transition Policy Guide:

	Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers

Special Populations	30 calendar days from receipt of Special Populations data	7 calendar days

ii. Explain in writing to DHCS why the provider and AAH could not execute an LOA.

b. AAH will start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date (beginning July 1, 2024)

c. AAH will ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

8. Continuity of Care for Covered Services

   a. AAH will ensure that all transitioning members continue receiving Covered Services (Services) without seeking a new authorization from AAH during the 6-month CoC for Services period from January 1, 2024, to July 1, 2024.

   b. AAH will honor active Prior Authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and AAH obtains documentation of the Prior Authorization within the 6-month CoC for Services period. If the request is received before transitioning members are enrolled with AAH on January 1, 2024, AAH will be able to accept and process requests beginning November 1, 2023. Upon receipt of Prior Authorization data, AAH and the member will work together to continue the member's authorized service with a network provider if the member's provider is OON and does not enter a LOA. If the member needs to continue the service after 6 months, the provider will need to request a new authorization from AAH. AAH will allow members to continue an Active Course of Treatment without Prior Authorization for the 6-month CoC for Services period. AAH and the member will work together to continue the member's Active Course of Treatment with a network provider if the member's provider is OON and does not enter a LOA.

      i. An Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024, and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

   c. During the 6-month CoC for Services period, AAH will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations.

9. AAH will allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use.

   a. This policy applies to DME or medical supplies that have been arranged for but not yet delivered, in which case AAH allows the delivery and permits the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.

10. Transportation Benefits: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
    a. If a network provider is not available to provide the transitioning member's scheduled NEMT/NMT service, then AAH will make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider.
    b. AAH will work with the Previous MCP to support continuation of NEMT/NMT services for transitioning members by the Previous MCP providing authorization data and transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to AAH on November 12, 2023, and refresh weekly starting in December 2023.
11. Continuity of Care and Management of Information during the transition to a Single Plan Model.
    a. The Previous MCP will transfer share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

    b. The Previous MCP will provide to AAH, by November 21, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members.

    c. AAH will proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care.

    d. The Previous MCP will share complete the transfer of supportive data for these members before January 1, 2024, or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

    e. AAH will receive the members known to be receiving inpatient care by December 22, 2023, from the Previous MCP, and will refresh that information daily through January 9, 2024, including holidays and weekends.

        i. Once a member is known to AAH as being in inpatient hospital care, either through the Previous MCP or via other means, AAH will contact the hospital to provide for completion of and coordination of the member's care. AAH will also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.
    f. AAH will obtain confirmation from the Previous MCP to ensure that they completed all data transfer sharing activities as described below in the Continuity of Care Data Sharing Policy:
        i. The Previous MCP will transmit DHCS required utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to AAH.

12. Acceptance of requests may be from the Member, authorized representative, or Provider. The Alliance will not require the requester to complete and submit a paper or online form if the requester prefers to make the request by phone, electronically or in writing, according to their preference. To complete a telephone, electronic or written request, the Alliance will take any necessary information required to complete the request using the members' preferred method..

4. Retroactive Continuity of Care

a. Members are able to receive retroactive continuity of care – meaning they can see their prior provider(s) while the Alliance processes a continuity of care request. All continuity of care requirements continue to apply, including a validated pre-existing relationship between the member and provider. The Alliance will retroactively approve and reimburse providers for continuity of care for services that were already rendered if requirements are met.

b. The member, authorized representative, or provider submitting the continuity of care request must submit the request within 30 calendar days of the first service provided after the member joins the Alliance. The provider can continue to treat the member for those 30 days and will be reimbursed if all continuity of care requirements are met.

c. Once the Alliance and provider have agreed to terms, the provider must agree to follow the Alliance's utilization management requirements.

5. Validating Pre-existing Relationship

The Alliance will determine if a relationship exists through use of data provided by DHCS to the Alliance, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the Alliance that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the Alliance makes this option available to the member.

6. Acknowledgment of CoC request

The acknowledgement will advise the member that the CoC request has been received, the date of receipt and the estimated timeframe for resolution. Communication will be done using the Member's know preference of communication or by telephone or mail within the following timeframes:

- For non-urgent requests, within seven calendar days of the decision.
- For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision

7. Request Completion Timeline

Continuity of care begins when the Alliance receives the CoC request. The Alliance will determine if the member has a pre-existing relationship with the provider, the provider is willing to accept the Alliance contract rates or Medi-Cal FFS rates, has no disqualifying quality of care issues and is a CA State Plan approved provider.

a. Each continuity of care request are completed within the following timelines: (all decisions will be communicated to the member by mail)

i. Thirty calendar days from the date AAH received the request for non-urgent requests.

ii. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

iii. Three calendar days for urgent requests if there is risk of harm to the member.

b. A continuity of care request is considered completed when:

i. The member is informed of his or her right of continued access.

ii. The Alliance and the out-of-network FFS or prior MCP provider are unable to agree to a rate;

iii. The Alliance has documented quality of care issues; or

iv. The Alliance makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

8. Requirements after the Request Process is Completed.

a. If the Alliance and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate, or the Alliance has documented quality of care issues with the provider, the Alliance will offer the member an in-network alternative.

b. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

c. If a provider meets all of the necessary requirements, including entering into a Letter of Agreement or contract with the Alliance, the Alliance will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with Alliance for a shorter timeframe. In this case, the Alliance allows the member to have access to that provider for the shorter period of time.

d. At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the Alliance works with the provider to establish a care plan for the member.

e. Upon approval of a continuity of care request, the Alliance notifies the member by mail of the following within seven calendar days and no more than 3 calendar days for urgent requests:

- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period.
- The member's right to choose a different provider from the Alliance's provider network.

f. Upon denial for CoC services the Alliance will notify the member by mail and provider by fax within seven (7) days with:
    - A statement of the denial decision.
    - A clear and concise explanation for the reasons for denial.
    - Rights and responsibilities to file a grievance and/or appeal.

g. The Alliance notifies the member 60 calendar days before the end of the continuity of care period, using the member's preferred method of communication, about the process that will occur to transition the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

h. if the member does not continue services from their pre-existing provider the Alliance will arrange for CoC covered services without delay with an in network provider or if there is no network provider with an OON provider.

9. The Alliance's Extended Continuity of Care Option: The Alliance may choose to work with the member's out-of-network provider past the 12-month continuity of care period, but the Alliance is not required to do so to fulfill its obligations under state contractual requirements. Extended CoC will be provided to following Special Populations:

Special Population	Duration
Receiving Hospice Care	For the duration of the terminal illness
Pregnancy or Postpartum	Within 12 months of pregnancy completion or maternal mental health diagnosis
Receiving hospital inpatient care	For the duration of the acute condition

10. Member and Provider Outreach and Education

The Alliance will inform members of their continuity of care protections and includes information about these protections in member information packets and handbooks and on the Alliance website. This information includes how the member and provider initiate a continuity of care request with the Alliance. The Alliance will translate these documents into threshold languages and make them available in alternative formats, upon request. The Alliance provides training to call center and other staff who come into regular contact with members about continuity of care protections.

b. Provider Referral Outside of the Alliance's Network

a. An approved out-of-network provider must work with the Alliance and its contracted network and must not refer the member to another out-of-network provider without authorization from the Alliance. In such cases, the Alliance will make the referral, if medically necessary, and if the Alliance does not have an appropriate provider within its network.
b. The Alliance will work with the approved OON provider and communicate its requirements on letters of agreement, referral, and authorization processes.

11. Medi-Cal FFS to Managed Care Transition:

- The Alliance will use treatment authorization requests (TAR)data or prior authorization (PA) data to identify PA authorizations, including authorized procedures, surgeries, DME, medical supplies, OP rehab, respiratory therapy, or behavioral health
- Active prior treatment authorizations for services remain in effect for 90 days and will be honored by the Alliance without a request by the member, authorized representative, or provider;

- The Alliance will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an OON provider;
- After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by an Alliance network provider, whichever is shorter;
- If the Alliance does not complete a new assessment, the active treatment authorization remains in effect and after 90 days
- the Alliance may reassess the member's prior treatment authorization at any time
- A new assessment is considered complete if the Member has been seen in person and/or via synchronous telehealth by a network provider and the provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization
- Where a service has been rendered with an OON provider and that provider satisfies the CoC requirements, the Member, authorized representative, or provider may request CoC retroactively to cover the service. (see #4)
- If reassessing Enhanced Care Management (ECM) authorizations after 90 days, the Alliance will reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria. The Alliance will provide continuity of care with an out-of-network provider for FFS members who voluntarily transition to the Alliance to receive Enhanced Care Management (ECM) services.

12. Mental Health Plan Transition into Medi-Cal Managed Care:

- The Alliance covers required outpatient mental health services for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for beneficiaries who meet the medical necessity criteria for SMHS.

- A member can request continuity of care with an out-of-network SMHS provider in instances where the member's mental health condition has stabilized such that the member no longer qualifies for SMHS and the responsibility for the member's mental health services transitions from the MHP to Alameda Alliance for Non-Specialty Mental Health Services (NSMHS). CoC only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medi-Cal State Plan, to provide NSMHS. The Alliance will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements mandated by the state. After 12 months the member must choose a mental health provider in the Alliance network for NSMHS. If the member later requires additional specialty mental services, the 12-month CoC period may start over one time. If the Member requires SMHS from the MHP subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to the AAH or changes MCPs (i.e., the Member does not have the right to a new 12 months of Continuity of Care).

13. Behavioral Health Treatment for Members Under the Age of 21 Upon Transition:

a. The Alliance is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

b. In accordance with existing contract requirements for Behavioral Health Treatment Coverage for Members Under the Age of 21, the Alliance will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this policy are met.

c. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to AAH or the date of the member's initial enrollment AAH if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the Alliance will assign the member to that provider to continue BHT services.

d. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into the Alliance, or the date of the member's enrollment into the Alliance, if the enrollment date occurred after the transition.

e. The Alliance will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

c. 14. Transition of BHT Services from Regional Centers (RCs) to Alameda Alliance

a. At least 45 days prior to the transition date, DHCS will provide the plan with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data.

b. The Alliance considers every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide the Alliance with member utilization and assessment data from the RC prior to the service transition date. AAH uses the DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care

process, regardless of whether a member's parent or guardian files a request for continuity of care.

c. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the Alliance will attempt to contact the member's parent or guardian to determine their preference. If the Alliance does not have access to member data that identifies an existing BHT provider, the Alliance will contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the Alliance in offering continuity of care.

d. If the RC is unwilling to release specific provider rate information, then the Alliance may negotiate rates with the continuity of care provider without being bound by the usual requirement that the Alliance offer at least a minimum FFS-equivalent rate. If the Alliance is unable to complete a continuity of care agreement, the Alliance ensures that all ongoing services continue at the same level with an Alliance in-network provider until the Alliance has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

e. AAH uses the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

15. Existing Continuity of Care Provisions Under California State Law:

In addition to the protections set forth above, the Alliance members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), the Alliance will allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the Alliance, until the prescribed therapy is no longer prescribed by the Alliance-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code (HSC) §1373.96 and require the Alliance to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are required to complete services for the following conditions: acute (for the duration of the condition), serious chronic (for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider up to 12 months), pregnancy (all trimesters, delivery and 12 months post- partum), terminal illness (for the duration of the terminal illness which may

exceed 12 months), the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the health plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

To maintain compliance with the law, the Alliance allows for completion of covered services as required by HSC §1373.96, to the extent that doing so allows member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this policy. The Alliance allows for the completion of these services for certain timeframes which are specific to each condition and defined under HSC §1373.96.

16. Pregnant and Post-Partum Beneficiaries:

As required by law (reference: HSC §1373.96) the Alliance will, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and the post-partum period (which is 12 months) and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. This process will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC §1373.96 for additional information about applicable circumstances and requirements.

The Alliance allows Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance's contract and the general requirements. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this policy (continuity of care for members transitioning from FFS to managed care).

17. Medical Exemption requests (MER):

a. A Medical Exemption Request is a request for temporary exemption from enrollment into a MediCal Managed Care Plan (MCP) only until the Member's medical condition has

stabilized to a level that would enable the Member to transfer to an AAH provider of the same specialty without deleterious medical effects.

b. A MER only applies to Members transitioning from Medi-Cal FFS to AAH.

c. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under these circumstances.

d. AAH is only required to consider MERs that have been denied as an automatic continuity of care request to allow to the Member to complete a course of treatment with a Medi-Cal FFS provider

e. The Alliance considers MERs that have been denied as an automatic continuity of care request to allow the member to complete a course of treatment with a Medi-Cal FFS provider.

18. Covered California Medi-Cal Transitioning members:

a. This section specifies provisions for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year.

b. To ensure that continuity of care and coordination of care requirements are met, the Alliance asks these members if there are upcoming health care appointments or treatments scheduled and assist them. If the member requests CoC, the Alliance will help in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights.

c. When a new member enrolls in the Alliance, the Alliance contacts the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this section are included in this initial member contact process.

d. The Alliance will make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

e. The Alliance will honor any active prior treatment authorizations for up to 90 days After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by AAH, whichever is shorter. FFA new assessment is considered completed by the

Alliance if the member has been seen by an Alliance contracted provider, (in person and/or via synchronous Telehealth,) and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations are honored without a request by the member or the provider

f. The Alliance will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this policy.

19. When the Alliance and the OON treating provider are unable to reach an agreement with the terminated or OON provider because they cannot agree to a rate or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, the Alliance is not required to continue the provider's services. If the Alliance has documented quality of care issues with the provider, the Alliance will offer an in-network alternative.

a. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.
b. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

20. DME equipment rentals and medical supplies will be honored without a request by a member or provider. If the DME or medical supplies have been arranged, but the equipment or supplies shave not been delivered, the Alliance will allow for the delivery of the equipment and supplies for a minimum of 90 days following enrollment until the Alliance can complete a new assessment. The original authorization will remain in effect for the duration of the treatment authorization. After 90 days, the Alliance may reassess at any time and move the member to a network DME provider.

21. For Non-emergency medical (NEMT) and non-medical (NMT) transportation services the member will be allowed to keep the modality of transportation under their previous prior authorization with a network provider until a new assessment can be made.

22. For Enhanced Care Management (ECM) authorizations after 90 days are reassessed using the ECM discontinuation criteria and not the ECM population of focus eligibility criteria.

23. 12-Month continuity of Care Period Restart

a. if a member changes MCPs by choice following the initial enrollment or if a member loses and then later eligibility during the 12-month CoC period, the 12-month CoC for a pre-existing provider may start over one time. For example, if a member enrolls in on 1/1/23, but then changes to a different MCP by choice on 5/1/23, the CoC may start over one time and the member may see that provider until May of the following year.

b. If a beneficiary changes their Medi-Cal MCP a second time or more, the COC period does not start over. The beneficiary does not have the right to a new COC 12-month period. If the beneficiary returns to Medi-Cal FFS and later reenrolls in a Medi-Cal MCP, the COC period does not start over. If the member changes their Medi-Cal MCP,

this COC policy does not extend to Providers they utilized under their other managed care plan.

24. Scheduled Specialty Appointments

a. the Alliance will allow transitioning members to keep authorized and scheduled specialist appointments with OON providers when CoC has been established and the appointments occur during the 12-month CoC period.

b. if a member or provider requests to keep scheduled specialist appointments with an OON provider and the member has not seen the provider in the previous 12 months and there is no established relationship with the OON provider, the Alliance make a good faith effort to arrange for the member to keep the appointment with a network provider on or before the appointment with the OON provider. If the Alliance is unable to do so, since the appointment is after transitioning to the Alliance and there is no pre-existing relationship, CoC would not apply.

25. Delegates are required to comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidance, including All Plan Letters.

PROCEDURE

1. Initiation of non-MER request:

    a. Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to the Alliance for continuity of care.

    b. When this occurs, the Alliance begins to process the request within five working days following the receipt of the request, however, the request is completed in three calendar days if there is a risk of harm to the member. For the purposes of this policy, "risk of harm" is defined as an imminent and serious threat to the health of the member.

    c. The continuity of care process begins when the Alliance starts the process to determine if the member has a pre-existing relationship with the provider.

    d. The UM Coordinator receives request for CoC through the HealthSuite Service Request, facsimile, or telephone call from provider.

        i. The Alliance accepts requests for continuity of care over the telephone, according to the requester's preference, and does not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the Alliance may take any necessary information from the requester over the telephone.

e. The UM Coordinator verifies eligibility and product line, creates a shell authorization request in the Clinical Information System (TruCare), selects indicator for non-MER CoC and routes request to appropriate UM Clinical Specialist.

f. The UM Clinical Specialist reviews the request, contacts the Member or Provider for any additional information to determine the type of CoC service required and document existence of an existing relationship.

i. Existing relationships can be validated through data provided by DHCS to The Alliance, such as Medi-Cal FFS utilization data.

ii. A Member or his or her provider may also provide information demonstrating a pre-existing relationship with a provider.

iii. A Member may not attest to a pre-existing relationship; actual documentation must be provided.

g. The UM Clinical Specialist obtains all necessary information to assist in making the initial determination, i.e., medical records, eligibility segments, claims.

h. The UM Clinical Specialist documents determination in authorization requests.

i. Approvals – UM Clinical Specialist contacts Member to inform them of the approval determination and next step. The UM Clinical Specialist:

1. Contacts requested provider to ensure they will see member and provides the "statement of reimbursement."

2. Reviews applicable websites to verify Provider does not have any quality of care restrictions.

3. Notifies Provider Relations (PR) to begin Letter of Agreement process, initiates PR communications.

4. Once approved by all parties, UM Clinical Specialist completes authorization request, generates, and sends Approval

Notification to Member, Provider, assigned PCP and assigned Provider Group.

ii. For potential denials based on request not meeting service criteria or Provider refusing to see Member or accept rates, the UM Clinical Specialist routes case to the UM Medical Director/doctoral Behavioral Health Practitioner with all of the information documented in TruCare authorization requests.

i. The UM Medical Director/ doctoral Behavioral Health Practitioner will review all available information and make a final determination.

i. If determination is to approve, the UM Medical Director/doctoral Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete communications. Documentation should include the type of CoC applicable to case and why services are met.

ii. If determination is to deny, the UM Medical Director/doctoral Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete Member communications. Documentation should include:

1. type of CoC applicable, why services are not met and the applicable denial reason; documents the applicable denial reason in the authorization request.

2. confirmation that the services can be provided in-network and communication with PCP to obtain the necessary services and authorizations.

j. Development of Plan of Care

i. The Alliance UM Department UM staff or Behavioral Health staff as appropriate will coordinate with OON Provider to obtain a copy of the plan of care during the OON service. The Plan of Care will be shared with the assigned PCP and/or Provider Group to ensure all services necessary to manage the identified treatment plan are in place or arranged.

k. Transition to In-Network Services

i. The Member may change their provider to an in-network provider at any time regardless of whether or not the CoC relationship has been established.

ii. For approved CoC, Members will be informed of the approved services, frequency, and duration for services with the OON provider.

1. The Alliance will monitor open existing authorizations with OON providers by the identified UM report.

2. One month prior to the expiration of the OON authorization, the UM and CM/BH Departments will coordinate with the Provider and the Member to begin transitioning back services to the in-network provider.

iii. When the Alliance and the OON treating provider are unable to reach an agreement because they cannot agree to a rate or the Alliance has documented quality of care issues with the provider, the Alliance will coordinate with the PCP or assigned Provider Group to identify an in-network alternative.

1. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.

2. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

l. The Alliance submits reports related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents.

m. Delegation

i. For services that are the responsibility of the delegate, the UM Clinical Specialist will facilitate and coordinate with the assigned delegate CoC contact. The UM Clinical Specialist documents in the TruCare authorization request the name and phone number of the delegate contact, and the PG outcome. The authorization request determination is documented as a "deny – responsibility of PPG" and case is closed.

Delegates are required to process the CoC request as defined by policy or regulation.

DEFINITIONS / ACRONYMS

Medical Exemption Request (MER) means a request for temporary exemption from enrollment into a managed care plan (MCP) only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to a managed care plan. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above.

Applied Behavioral Treatment (ABA): means services provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider.

Authorized Representative: means a person other than the plan member who is authorized to receive confidential information related to the member, and who may speak on the member's behalf.

Autism Spectrum Disorder (ASD): means a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome. These conditions are now all called ASD.

Behavioral Health Treatment (BHT): means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

California State Plan: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130©, the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 to include BHT services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of ASD to the extent required by the federal government.2 BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a beneficiary with ASD.

Continuity of Care (COC): means a process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transition in care throughout the course of the disease.

Department of Health Care Services (DHCS): means the State agency responsible for administration of the federal Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.

Durable Medical Equipment (DME): means any medical equipment necessary to use in the home to aid a better quality of living.

Early, Periodic Screening, Diagnosis, and Treatment Services (EPSDT): means the federal program requiring states to provide screening, preventive, and medically necessary diagnostic and treatment services, to members of Medicaid Managed Care Programs.

Fee-for-Service (FFS): means a method of payment based upon per unit or per procedure billing for services rendered to an eligible beneficiary.

Managed Care Provider (MCP): means a participating provider or a contracted provider in a Medi-Cal Managed Care Health Plan.

Medically Necessary or Medical Necessity: Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

1. Consistent with nationally accepted standards of medical practice:

    a. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
    b. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
    c. For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    d. When determining the medical necessity of Covered Services for a Medi-Cal member under the age of 2, "medical necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.
2. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the Alliance will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards as follows:

    a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 CFR §1395y.

b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code of Regulations (CCR) Section 51303.

Members: Any eligible beneficiary who is enrolled in any of the Alliance's product lines of business.

Out of Network (OON): means a non-participating provider or a non-contracted provider in a Medi-Cal Managed Care Health Plan.

Primary Care Provider (PCP): means a primary care physician or clinic responsible for coordinating, supervising, and providing primary health care services to a member, including but not limited to initiating specialty care referrals and maintaining continuity of care.

Provider: means primary care physicians, specialists, ancillary providers, clinics, and hospitals.

Quality of Care Issue (DHCS definition) means The Alliance can document its concerns with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other Alliance members.

Risk of Harm is defined as an imminent and serious threat to the health of the member.

Seniors and People with Disabilities (SPD): means person(s) 65 years or older and/or individual(s) meeting one of the following criteria: he or she has a physical or mental impairment that substantially limits one or more of his/her major life activities; he or she has a record of such an impairment; he or she is regarded as having such an impairment.

Treatment Authorization Request (TAR): means a referral or request for services. Services may be initial or ongoing.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Member Services
Provider Relations
Compliance

RELATED POLICIES AND PROCEDURES

- UM-036, "Cont. Covered Services for Members with Terminated Providers"
- UM-058, "COC for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption".

- UM-002 Behavioral Health Services

REVISION HISTORY

5/3/2018, 4/19/2019, 5/21/2020, 3/18/2021, 3/22/2022, 06/20/2023

REFERENCES

- All Plan Letter (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
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023. (Supersedes All Plan Letters 22-032, 18-008, 15-019, 14-021 and 13-023)
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

- All Plan Letter 17-007 (Supersedes APL 15-001 and 13-013 revised) Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption
- All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data
- Duals Plan Letter 15-003 Continuity of Care
- All Plan Letter 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- Health and Safety (H&S) Code §1373.96, 1371.8, 1373.65, 1373.95
- Welfare and Institutions Code §14185

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups for continuity of care.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Logs/Reports of the various continuity of care requests. Quarterly audits are performed on selected files to ensure compliance with the regulatory requirements.
    b. Complaints and grievances for continuity of care are reviewed to identify problems and trends that will direct the development of corrective actions plans to improve performance.
    c. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM

Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

3. Monthly Reports
   a. Department of Health Care Services (DHCS)

The Alliance submits monthly reports for Continuity of Care following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.

POLICY AND PROCEDURE

Policy Number	UM-059
Policy Name	Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Health Care Services
Line(s) of Business	Medi-Cal
Effective Date	5/3/2018
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	~~6/20/2023~~TBD

POLICY STATEMENT

All Alliance members, including Seniors and Persons with Disabilities, who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) or whose contracts are expiring/terminating to ~~a new MCP~~AAH as of January 1, 2023, with pre-existing provider relationships (medical or behavioral health,) may make a continuity of care request to the Alliance. For the 1/1/2024 transition of Alameda County to a Single Plan Model, AAH will ensure that continuity of care policies will protect Members access to care in accordance with the DHCS 2024 MCP Transition Policy Guide. Members may request up to 12 months of CoC with a Provider if a verifiable pre-existing relationship exists with that provider for any covered Medi-Cal service, with an out-of-network/nonparticipating Medi-Cal provider, when in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization. Members will have access to services consistent with the access they previously had.

1. Continuity of Care (CoC) protections extend to Primary Care Providers, Specialists and select ancillary providers as follows:

   a. Physical therapy
   b. Occupational therapy

c. Speech therapy
d. Respiratory therapy
e. Behavioral health
f. Durable medical equipment (DME)

2. The Alliance will provide continuity of care with an out-of-network (OON) provider when:

a. The provider is providing a service that is eligible for Continuity of Care (CoC) for Providers.

~~a.~~b. The Alliance is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).

~~b.~~c. An existing relationship means the member has seen an out-of-network primary care provider (PCP,) specialist, or behavioral health provider at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified in this policy or by state or federal law.

~~c.~~d. If the Provider is an OON Provider, the Alliance will contact the Provider and make a good faith attempt to establish COC for the beneficiary.

~~d.~~e. The Provider accepts the higher of the Alliance contract rates or Medi-Cal FFS rates.

~~e.~~f. The Provider meets the Alliance's applicable professional standards and has no disqualifying quality of care issues.

i. For the purpose of the DHCS All Plan Letter, a quality of care issue means The Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Alliance members.

~~f.~~g. The Provider is a California State Plan Approved Provider

~~g.~~h. The Provider supplies the Alliance with relevant treatment information for the purposes of determining Medical Necessity, as well as a current treatment plan as allowable under applicable federal and state privacy laws and regulations.

3. During the 2024 Managed Care Transition to Single Plan Model, the following policies and procedures apply:

a. For members identified as belonging to Special Populations, AAH will focus attention and resources on transitioning members to minimize the risk of harm from disruptions in their care:

(a) Special Populations include:

- Adults and children with authorizations to receive Enhanced Care Management (ECM) services
- Adults and children with authorizations to receive Community Supports (CS)
- Adults and children receiving Complex Care Management (CCM)
- Enrolled in 1915(c) waiver programs
- Receiving in-home supportive services (IHSS)
- Children and youth enrolled in California Children's Services (CCS)
- Children and youth receiving foster care, and former foster youth through age 25
- In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- Taking immunosuppressive medications, immunomodulators, and biologics
- Receiving treatment for end-stage renal disease (ESRD)
- Living with an intellectual or developmental disability (I/DD) diagnosis
- Living with a dementia diagnosis
- In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
- Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- Receiving specialty mental health services (adults, youth, and children)
- Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- Receiving hospice care
- Receiving home health
- Residing in Skilled Nursing Facilities (SNF)
- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023

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

b) The Previous MCP transitioning Members will transfer supportive information that is important to the incoming Members' care coordination and management.

c) AAH will work with the Previous MCP to transfer and share supportive information important for the Members' care coordination and management.

d) AAH will process CoC for provider requests and notify members according to the requirements of the DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide:

- If a member's current provider is a network provider in both the Previous MCP and AAH, the member may continue to see their provider when the member transitions to AAH on 1/1/24. No action is required by the member to continue seeing their provider in this case.
- Some members who transition to AAH on January 1, 2024, will be receiving care from providers who are OON providers for AAH. If members wish to switch their care to an AAH network provider on January 1, 2024, AAH will facilitate that switch. For other members, transitioning to a new provider on January 1, 2024, may disrupt their care. CoC for Providers will enable transitioning members to continue receiving care from their existing providers for 12 months if certain requirements are met. This CoC for Providers protection is intended to maintain trusted member/provider relationships until the member can transition to a network provider with AAH. All transitioning members may request CoC for Providers with an eligible provider for up to 12 months.
    - Eligible Provider Types:
        - Primary Care Providers (PCP)
        - Specialists
        - Enhanced Care Management Providers
        - Community Supports Providers
        - Skilled Nursing Facilities (SNFs)
        - Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
        - Community-Based Adult Services Providers
        - Select ancillary Providers
            - Dialysis centers
            - Physical therapists
            - Occupational therapists
            - Respiratory therapists
            - Mental health Providers

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- Behavioral health treatment (BHT) Providers
- Speech therapy Providers
- Doulas
- Community Health Workers

- Ineligible Provider Types:

  - All other ancillary Providers, such as:
    - Radiology
    - Laboratory
    - Non-emergency medical transportation (NEMT)
    - Non-medical transportation (NMT)
    - Other ancillary services
  - Non-enrolled Medi-Cal Providers

e) AAH will ensure that there is no disruption to the relationships between all transitioning members and their PCPs. All transitioning members may request CoC for eligible providers for up to 12 months. AAH will provide more than 12 months of CoC for Providers as needed for members living with a terminal illness, acute condition, or a pregnancy (including three trimesters of pregnancy, the immediate postpartum period, and 12 months following diagnosis of maternal mental health condition or end of pregnancy, whichever is later). The postpartum period is defined as 12 months AAH will retain at least 90% of the transitioning members' PCPs either as network providers or through CoC for provider agreements. If AAH is unable to enter into a contract with a member's PCP, and the member requests to continue with their PCP, AAH will offer a Letter of Agreement (LOA) if all requirements are met. AAH will ensure that the members have the same PCP assignment as they had through their previous MCP, either through the providers' network participation or an LOA. Since the member is already included in the PCP's panel, a closed panel nor a status that the PCP is not accepting new members will affect the assignment of the member to their PCP. If a member wishes to change their PCP, they must notify AAH to assist with obtaining a new PCP.

f) For coordination of care and care transition efforts, AAH will adhere to the requirements of HCS 1373.96, and will allow non-contracted providers to continue a member's treatment plan for ineligible provider types that are delivering non-contracted services.

g) To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting AAH. The requester may contact AAH prior to the date of service up until December 31, 2024. If the services

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were rendered prior to the CoC request, the requester must contact AAH within 30 calendar days after the date of service. Upon receiving the request, AAH will confirm that the request meets the CoC requirements listed in section 2 above.

h) AAH will accept requests made over the telephone, electronically, or in writing, according to the requester's preference. AAH will ensure that transitioning members are able to access assistance from AAH's call center starting November 1, 2023, prior to their enrollment with AAH before January 1, 2024. AAH will confirm that the requirements in the DHCS Managed Care Plan Transition Policy Guide, section on CoC for Providers are met. If requirements are met, AAH will contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into an LOA for the member's care and notify the provider and member. AAH will notify the member of the date the request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of AAH's decision using the member's preferred form of communication or, if not known, by telephone call, text message, or email. The timeframe for processing requests and notifying the member and provider will be within the following timeframes appropriate to the member's condition:

Request	Description	Timeframe for Processing Request	Timeframe for Notifying Member and Provider After Processing the Request
Urgent	There is identified risk of harm to the member	As soon as possible, but no longer than 3 calendar days	Within the shortest applica timeframe that is appropri for the member's condition, but no longer than 3 calendar days
Immediate	The member's medical condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar days	7 calendar days

- These timeframes apply to requests made prospectively. If the prospective request is made in advance of January 1, 2024, then AAH will complete

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processing the request by January 1, 2024, or according to these timeframes, whichever is later.
- Retroactive requests are not considered urgent or immediate.

4. AAH will ensure that transitioning members who seek assistance before January 1, 2024, while not yet enrolled in AAH are offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

5. Provider Agreements

   a. When a CoC for Providers agreement is established, AAH will work with the eligible provider to ensure no disruption in services for the member.
   b. AAH will direct the eligible provider not to refer the member to other OON providers without prior approval from AAH.
   c. After establishing a CoC for Providers agreement with the eligible provider, AAH will reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and the DHCS Medi-Cal Managed Care Plan Policy Guide, and as agreed upon with the provider.
   d. As the end of the agreed-upon CoC period approaches, AAH will establish a process to transition the member to a network provider.
   e. Sixty calendar days before the end of the CoC for Providers period, AAH will notify the member and the eligible provider about the process for transitioning the member's care.
   f. AAH will identify a network provider, will engage the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within 60 days to ensure continuity of covered services through the transition to the network provider.
   g. If AAH and the eligible provider are unable to reach an LOA, AAH will offer the member an alternative network provider in a timely manner, so the member's service is not disrupted.
   h. If the member does not actively choose an alternative network provider, AAH will refer the member to a network provider
   i. If there is no network provider to provide the Covered Service, AAH will arrange for an OON provider.

6. Enhanced CoC Protections for Special Populations:

   a. Upon receiving data for Special Populations, AAH will proactively begin the Continuity of Care for Providers process
   b. AAH will review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024, by January 1, 2024, or within 30 calendar days of receiving data for Special Populations, whichever is sooner.
   c. AAH will contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement if requirements in Section V.C of the 2024 MCP Transition Policy Guide are met.

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d. AAH will notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:
e. If the member's provider is in Network or is brought in Network as a result of AAH's outreach, then AAH will send notification that the member may continue with his or her provider.
f. If the member's provider is OON and AAH establishes an LOA, then AAH will notify the member that the length of time that they can stay with their provider.
g. If the provider is OON and cannot establish an LOA, AAH will send notification that the member must change to a network provider and assign the member a new network provider.
h. In all cases, the notification will include that the member may choose to change providers and comply with the notification requirements in DHCS 2024 MCP Transition Policy Guide Section V.C. Expectations of the Receiving MCP, and with the required timeline in Figure 6 of the DHCS 2024 MCP Transition Policy Guide.
i. During the 6-month CoC for Services period, AAH will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations.

7. Enhanced Protections for Members Accessing the Transplant Benefit

a. If AAH is unable to bring a Transplant Program in Network, AAH will make a good faith effort to:
    1. Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in the DHCS 2024 MCP Transition Policy Guide, section V.C and according to the following terms:
        i. Make explicit the existing statutory requirement that AAH will pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)
        ii. Permit the LOA agreement to continue for the duration of the member's access to the transplant benefit.
    2. If AAH is unable to enter into a CoC for Providers agreement, AAH will:
        i. Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in Figure 6 of the DHCS Medi-Cal Managed Care Plan Transition Policy Guide:

Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers

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Special Populations	30 calendar days from receipt of Special Populations data	7 calendar days

ii. Explain in writing to DHCS why the provider and AAH could not execute an LOA.

b. AAH will start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date (beginning July 1, 2024)

c. AAH will ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

8. Continuity of Care for Covered Services

a. AAH will ensure that all transitioning members continue receiving Covered Services (Services) without seeking a new authorization from AAH during the 6-month CoC for Services period from January 1, 2024, to July 1, 2024.

b. AAH will honor active Prior Authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and AAH obtains documentation of the Prior Authorization within the 6-month CoC for Services period. If the request is received before transitioning members are enrolled with AAH on January 1, 2024, AAH will be able to accept and process requests beginning November 1, 2023. Upon receipt of Prior Authorization data, AAH and the member will work together to continue the member's authorized service with a network provider if the member's provider is OON and does not enter a LOA. If the member needs to continue the service after 6 months, the provider will need to request a new authorization from AAH. AAH will allow members to continue an Active Course of Treatment without Prior Authorization for the 6-month CoC for Services period. AAH and the member will work together to continue the member's Active Course of Treatment with a network provider if the member's provider is OON and does not enter a LOA.

i. An Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024, and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

c. During the 6-month CoC for Services period, AAH will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations.

9. AAH will allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use.

a. This policy applies to DME or medical supplies that have been arranged for but not yet delivered, in which case AAH allows the delivery and permits the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.

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10. Transportation Benefits: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
    a. If a network provider is not available to provide the transitioning member's scheduled NEMT/NMT service, then AAH will make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider.
    b. AAH will work with the Previous MCP to support continuation of NEMT/NMT services for transitioning members by the Previous MCP providing authorization data and transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to AAH on November 12, 2023, and refresh weekly starting in December 2023.
11. Continuity of Care and Management of Information during the transition to a Single Plan Model.
    a. The Previous MCP will transfer share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

    b. The Previous MCP will provide to AAH, by November 21, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members.

    c. AAH will proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care.

    d. The Previous MCP will share complete the transfer of supportive data for these members before January 1, 2024, or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

    e. AAH will receive the members known to be receiving inpatient care by December 22, 2023, from the Previous MCP, and will refresh that information daily through January 9, 2024, including holidays and weekends.

        i. Once a member is known to AAH as being in inpatient hospital care, either through the Previous MCP or via other means, AAH will contact the hospital to provide for completion of and coordination of the member's care. AAH will also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.
    f. AAH will obtain confirmation from the Previous MCP to ensure that they completed all data transfer sharing activities as described below in the Continuity of Care Data Sharing Policy:
        i. The Previous MCP will transmit DHCS required utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to AAH.

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~~3.~~12. Acceptance of requests may be from the Member, authorized representative, or Provider. The Alliance will not require the requester to complete and submit a paper or online form if the requester prefers to make the request by phone, electronically or in writing, according to their preference. To complete a telephone, electronic or written request, the Alliance will take any necessary information required to complete the request using the members' preferred method. ~~over the phone~~.

4. Retroactive Continuity of Care

a. Members are able to receive retroactive continuity of care – meaning they can see their prior provider(s) while the Alliance processes a continuity of care request. All continuity of care requirements continue to apply, including a validated pre-existing relationship between the member and provider. The Alliance will retroactively approve and reimburse providers for continuity of care for services that were already rendered if requirements are met.

b. The member, authorized representative, or provider submitting the continuity of care request must submit the request within 30 calendar days of the first service provided after the member joins the Alliance. The provider can continue to treat the member for those 30 days and will be reimbursed if all continuity of care requirements are met.

c. Once the Alliance and provider have agreed to terms, the provider must agree to follow the Alliance's utilization management requirements.

5. Validating Pre-existing Relationship

The Alliance will determine if a relationship exists through use of data provided by DHCS to the Alliance, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the Alliance that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the Alliance makes this option available to the member.

6. Acknowledgment of CoC request

The acknowledgement will advise the member that the CoC request has been received, the date of receipt and the estimated timeframe for resolution. Communication will be done using the Member's know preference of communication or by telephone or mail within the following timeframes:

- For non-urgent requests, within seven calendar days of the decision.

- For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision

7. Request Completion Timeline

Continuity of care begins when the Alliance receives the CoC request. The Alliance will determine if the member has a pre-existing relationship with the provider, the provider is willing to accept the Alliance contract rates or Medi-Cal FFS rates, has no disqualifying quality of care issues and is a CA State Plan approved provider.

a. Each continuity of care request ~~must be~~are completed within the following timelines: (all decisions will be communicated to the member by mail)

i. Thirty calendar days from the date ~~the MCP~~AAH received the request for non-urgent requests.

ii. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

iii. Three calendar days for urgent requests if there is risk of harm to the member.

b. A continuity of care request is considered completed when:

i. The member is informed of his or her right of continued access.

ii. The Alliance and the out-of-network FFS or prior MCP provider are unable to agree to a rate;

iii. The Alliance has documented quality of care issues; or

iv. The Alliance makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

8. Requirements after the Request Process is Completed.

a. If the Alliance and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate, or the Alliance has documented quality of care issues with the provider, the Alliance will offer the member an in-network alternative.

b. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

c. If a provider meets all of the necessary requirements, including entering into a Letter of Agreement or contract with the Alliance, the Alliance will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with Alliance for a shorter timeframe. In this case, the Alliance ~~must~~ allows the member to have access to that provider for the shorter period of time.

d. At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the Alliance ~~must~~ works with the provider to establish a care plan for the member.

e. Upon approval of a continuity of care request, the Alliance ~~must~~ notifiesy the member by mail of the following within seven calendar days and no more than 3 calendar days for urgent requests:

- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of the continuity of care period.
- The member's right to choose a different provider from the Alliance's provider network.

f. Upon denial for CoC services the Alliance will notify the member by mail and provider by fax within seven (7) days with:
- A statement of the denial decision.
- A clear and concise explanation for the reasons for denial.
- Rights and responsibilities to file a grievance and/or appeal.

g. The Alliance ~~must~~ notifiesy the member ~~30~~ 60 calendar days before the end of the continuity of care period, using the member's preferred method of communication, about the process that will occur to transition the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

h. if the member does not continue services from their pre-existing provider the Alliance will arrange for CoC covered services without delay with an in network provider or if there is no network provider with an OON provider.

9. The Alliance's Extended Continuity of Care Option: The Alliance may choose to work with the member's out-of-network provider past the 12-month continuity of care period, but the Alliance is not required to do so to fulfill its obligations under state contractual requirements. Extended CoC will be provided to following Special Populations:

Special Population	Duration
Receiving Hospice Care	For the duration of the terminal illness
Pregnancy or Postpartum	Within 12 months of pregnancy completion or maternal mental health diagnosis
Receiving hospital inpatient care	For the duration of the acute condition

10. Member and Provider Outreach and Education

The Alliance will inform members of their continuity of care protections and ~~must~~ includes information about these protections in member information packets and handbooks and on the Alliance website. This information ~~must~~ includes how the member and provider initiate a continuity of care request with the Alliance. The Alliance will translate these documents into threshold languages and make them available in alternative formats, upon request. The Alliance ~~must~~ provides training to call center and other staff who come into regular contact with members about continuity of care protections.

b. Provider Referral Outside of the Alliance's Network

a. An approved out-of-network provider must work with the Alliance and its contracted network and must not refer the member to another out-of-network provider without authorization from the Alliance. In such cases, the Alliance will make the referral, if medically necessary, and if the Alliance does not have an appropriate provider within its network.
b. The Alliance will work with the approved OON provider and communicate its requirements on letters of agreement, referral, and authorization processes.

11. Medi-Cal FFS to Managed Care Transition:

- The Alliance will use treatment authorization requests (TAR)data or prior authorization (PA) data to identify PA authorizations, including authorized procedures, surgeries, DME, medical supplies, OP rehab, respiratory therapy, or behavioral health

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- Active prior treatment authorizations for services remain in effect for 90 days and will be honored by the Alliance without a request by the member, authorized representative, or provider;
- The Alliance will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an OON provider;
- After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by an Alliance network provider, whichever is shorter;
- If the Alliance does not complete a new assessment, the active treatment authorization remains in effect and after 90 days
- the Alliance may reassess the member's prior treatment authorization at any time
- Aa new assessment is considered complete if the Member has been seen in person and/or via synchronous telehealth by a network provider and the provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization
- Wwhere a service has been rendered with an OON provider and that provider satisfies the CoC requirements, the Member, authorized representative, or provider may request CoC retroactively to cover the service. (see #4)
- If reassessing Enhanced Care Management (ECM) authorizations after 90 days, the Alliance will reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria. The Alliance will provide continuity of care with an out-of-network provider for FFS members who voluntarily transition to the Alliance to receive Enhanced Care Management (ECM) services.

12. Mental Health Plan Transition into Medi-Cal Managed Care:

- The Alliance covers required outpatient mental health services, for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for beneficiaries who meet the medical necessity criteria for SMHS.

- A member can request continuity of care with an out-of-network SMHS provider in instances where the member's mental health condition has stabilized such that the member no longer qualifies for SMHS and the responsibility for the member's mental health services transitions from the MHP to Alameda Alliance for Non-Specialty Mental Health Services (NSMHS). CoC only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medi-Cal State Plan, to provide NSMHS. The Alliance will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-

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network MHP provider in accordance with the requirements mandated by the state. After 12 months the member must choose a mental health provider in the Alliance network for NSMHS. If the member later requires additional specialty mental services, the 12-month CoC period may start over one time. If the Member requires SMHS from the MHP subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to the AAH or changes MCPs (i.e., the Member does not have the right to a new 12 months of Continuity of Care).

13. Behavioral Health Treatment for Members Under the Age of 21 Upon Transition:

~~e.~~a. The Alliance is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

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~~d.~~b. In accordance with existing contract requirements for Behavioral Health Treatment Coverage for Members Under the Age of 21, the Alliance will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this policy are met.

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~~e.~~c. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to ~~the MCP~~AAH or the date of the member's initial enrollment ~~in the MCP~~AAH if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the Alliance will assign the member to that provider to continue BHT services.

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~~f.~~d. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into the Alliance, or the date of the member's enrollment into the Alliance, if the enrollment date occurred after the transition.

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~~g.~~e. The Alliance will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

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c. 14. Transition of BHT Services from Regional Centers (RCs) to Alameda Alliance

a. At least 45 days prior to the transition date, DHCS will provide the plan with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data.

b. The Alliance considers every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide the Alliance with member utilization and assessment data from the RC prior to the service transition date. AAH uses the DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care.

c. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the Alliance will attempt to contact the member's parent or guardian to determine their preference. If the Alliance does not have access to member data that identifies an existing BHT provider, the Alliance will contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the Alliance in offering continuity of care.

d. If the RC is unwilling to release specific provider rate information, then the Alliance may negotiate rates with the continuity of care provider without being bound by the usual requirement that the Alliance offer at least a minimum FFS-equivalent rate. If the Alliance is unable to complete a continuity of care agreement, the Alliance ~~must~~ ensures that all ongoing services continue at the same level with an Alliance in-network provider until the Alliance has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

e. AAH uses the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

15. Existing Continuity of Care Provisions Under California State Law:

In addition to the protections set forth above, the Alliance members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), the Alliance will allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the Alliance, until the prescribed therapy is no longer prescribed by the Alliance-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code (HSC) §1373.96 and require the Alliance to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are required to complete services for the following conditions: acute (for the duration of the condition), serious chronic (for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider up to 12 months), pregnancy (all trimesters, delivery and 12 months post- partum), terminal illness (for the duration of the terminal illness which may exceed 12 months), the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the health plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

To maintain compliance with the law, the Alliance allows for completion of covered services as required by HSC §1373.96, to the extent that doing so allows member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this policy. The Alliance allows for the completion of these services for certain timeframes which are specific to each condition and defined under HSC §1373.96.

16. Pregnant and Post-Partum Beneficiaries:

As required by law (reference: HSC §1373.96) the Alliance will, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and the post-partum period (which is 12 months) and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. This process will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC §1373.96 for additional information about applicable circumstances and requirements.

The Alliance allows Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance's contract and the general requirements. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this policy (continuity of care for members transitioning from FFS to managed care).

17. Medical Exemption requests (MER):

a. A Medical Exemption Request is a request for temporary exemption from enrollment into a MediCal Managed Care Plan (MCP) only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to an ~~MCP~~ AAH provider of the same specialty without deleterious medical effects.

b. A MER only applies to Members transitioning from Medi-Cal FFS to AAH.

c. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under these circumstances.

d. AAH is only required to consider MERs that have been denied as an automatic continuity of care request to allow to the Member to complete a course of treatment with a Medi-Cal FFS provider

e. The Alliance considers MERs that have been denied as an automatic continuity of care request to allow the member to complete a course of treatment with a Medi-Cal FFS provider.

18. Covered California Medi-Cal Transitioning members:

a. This section specifies provisions for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year.

b. To ensure that continuity of care and coordination of care requirements are met, the Alliance asks these members if there are upcoming health care appointments or treatments scheduled and assist them. If the member requests CoC, the Alliance will help in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights.

c. When a new member enrolls in the Alliance, the Alliance ~~must~~ contacts the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this section ~~must be~~are included in this initial member contact process.

d. The Alliance will make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

e. The Alliance will honor any active prior treatment authorizations for up to 90 days After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by ~~the MCP~~AAH, whichever is shorter. FFA new assessment is considered completed by the Alliance if the member has been seen by an Alliance contracted provider, (in person and/or via synchronous Telehealth,) and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations are honored without a request by the member or the provider

f. The Alliance will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this policy.

19. When the Alliance and the OON treating provider are unable to reach an agreement with the terminated or OON provider because they cannot agree to a rate or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, the Alliance is not required to continue the provider's services. If the Alliance has documented quality of care issues with the provider, the Alliance will offer an in-network alternative.

a. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.
b. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

20. DME equipment rentals and medical supplies will be honored without a request by a member or provider. If the DME or medical supplies have been arranged, but the equipment or supplies shave not been delivered, the Alliance will allow for the delivery of the equipment and supplies for a minimum of 90 days following enrollment until the Alliance can complete a new assessment. The original authorization will remain in effect for the duration of the treatment authorization. After 90 days, the Alliance may reassess at any time and move the member to a network DME provider.

21. For Non-emergency medical (NEMT) and non-medical (NMT) transportation services the member will be allowed to keep the modality of transportation under their previous prior authorization with a network provider until a new assessment can be made.

22. For Enhanced Care Management (ECM) authorizations after 90 days are reassessed using the ECM discontinuation criteria and not the ECM population of focus eligibility criteria.

23. 12-Month continuity of Care Period Restart

a. if a member changes MCPs by choice following the initial enrollment or if a member loses and then later eligibility during the 12-month CoC period, the 12-month CoC for a pre-existing provider may start over one time. For example, if a member enrolls in on 1/1/23, but then changes to a different MCP by choice on 5/1/23, the CoC may start over one time and the member may see that provider until May of the following year.
b. If a beneficiary changes their Medi-Cal MCP a second time or more, the COC period does not start over. The beneficiary does not have the right to a new COC 12-month period. If the beneficiary returns to Medi-Cal FFS and later reenrolls in a Medi-Cal MCP, the COC period does not start over. If the member changes their Medi-Cal MCP, this COC policy does not extend to Providers they utilized under their other managed care plan.

24. Scheduled Specialty Appointments
a. the Alliance will allow transitioning members to keep authorized and scheduled specialist appointments with OON providers when CoC has been established and the appointments occur during the 12-month CoC period.
b. if a member or provider requests to keep scheduled specialist appointments with an OON provider and the member has not seen the provider in the previous 12 months and there is no established relationship with the OON provider, the Alliance make a good faith effort to arrange for the member to keep the appointment with a network provider on or before the appointment with the OON provider. If the Alliance is unable to do so, since the appointment is after transitioning to the Alliance and there is no pre-existing relationship, CoC would not apply.

25. Delegates are required to comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidance, including All Plan Letters.

PROCEDURE

1. Initiation of non-MER request:

    a. Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to the Alliance for continuity of care.

    b. When this occurs, the Alliance ~~must~~ begins to process the request within five working days following the receipt of the request, however, the request ~~must be~~is completed in three calendar days if there is a risk of harm to the member. For the purposes of this policy, “risk of harm” is defined as an imminent and serious threat to the health of the member.

    c. The continuity of care process begins when the Alliance starts the process to determine if the member has a pre-existing relationship with the provider.

d. The UM Coordinator receives request for CoC through the HealthSuite Service Request, facsimile, or telephone call from provider.

    i. The Alliance accepts requests for continuity of care over the telephone, according to the requester's preference, and does not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the Alliance may take any necessary information from the requester over the telephone.

e. The UM Coordinator verifies eligibility and product line, creates a shell authorization request in the Clinical Information System (TruCare), selects indicator for non-MER CoC and routes request to appropriate UM Clinical Specialist.

f. The UM Clinical Specialist reviews the request, contacts the Member or Provider for any additional information to determine the type of CoC service required and document existence of an existing relationship.

    i. Existing relationships can be validated through data provided by DHCS to The Alliance, such as Medi-Cal FFS utilization data.

    ii. A Member or his or her provider may also provide information demonstrating a pre-existing relationship with a provider.

    iii. A Member may not attest to a pre-existing relationship; actual documentation must be provided.

g. The UM Clinical Specialist obtains all necessary information to assist in making the initial determination, i.e., medical records, eligibility segments, claims.

h. The UM Clinical Specialist documents determination in authorization requests.

    i. Approvals – UM Clinical Specialist contacts Member to inform them of the approval determination and next step. The UM Clinical Specialist:

        1. Contacts requested provider to ensure they will see member and provides the "statement of reimbursement."

2. Reviews applicable websites to verify Provider does not have any quality of care restrictions.

3. Notifies Provider Relations (PR) to begin Letter of Agreement process, initiates PR communications.

4. Once approved by all parties, UM Clinical Specialist completes authorization request, generates, and sends Approval Notification to Member, Provider, assigned PCP and assigned Provider Group.

ii. For potential denials based on request not meeting service criteria or Provider refusing to see Member or accept rates, the UM Clinical Specialist routes case to the UM Medical Director/doctoral Behavioral Health Practitioner with all of the information documented in TruCare authorization requests.

i. The UM Medical Director/ doctoral Behavioral Health Practitioner will review all available information and make a final determination.

i. If determination is to approve, the UM Medical Director/doctoral Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete communications. Documentation should include the type of CoC applicable to case and why services are met.

ii. If determination is to deny, the UM Medical Director/doctoral Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete Member communications. Documentation should include:

1. type of CoC applicable, why services are not met and the applicable denial reason; documents the applicable denial reason in the authorization request.

2. confirmation that the services can be provided in-network and communication with PCP to obtain the necessary services and authorizations.

j. Development of Plan of Care

i. The Alliance UM Department UM staff or Behavioral Health staff as appropriate will coordinate with OON Provider to obtain a copy of the plan of care during the OON service. The Plan of Care will be shared with the assigned PCP and/or Provider Group to ensure all services necessary to manage the identified treatment plan are in place or arranged.

k. Transition to In-Network Services
   i. The Member may change their provider to an in-network provider at any time regardless of whether or not the CoC relationship has been established.

   ii. For approved CoC, Members will be informed of the approved services, frequency, and duration for services with the OON provider.

      1. The Alliance will monitor open existing authorizations with OON providers by the identified UM report.

      2. One month prior to the expiration of the OON authorization, the UM and CM/BH Departments will coordinate with the Provider and the Member to begin transitioning back services to the in-network provider.

   iii. When the Alliance and the OON treating provider are unable to reach an agreement because they cannot agree to a rate or the Alliance has documented quality of care issues with the provider, the Alliance will coordinate with the PCP or assigned Provider Group to identify an in-network alternative.

      1. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.

      2. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

l. The Alliance submits reports related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents.

m. Delegation

i. For services that are the responsibility of the delegate, the UM Clinical Specialist will facilitate and coordinate with the assigned delegate CoC contact. The UM Clinical Specialist documents in the TruCare authorization request the name and phone number of the delegate contact, and the PG outcome. The authorization request determination is documented as a "deny – responsibility of PPG" and case is closed.

Delegates are required to process the CoC request as defined by policy or regulation.

DEFINITIONS / ACRONYMS

Medical Exemption Request (MER) means a request for temporary exemption from enrollment into a managed care plan (MCP) only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to a managed care plan. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above.

Applied Behavioral Treatment (ABA): means services provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider.

Authorized Representative: means a person other than the plan member who is authorized to receive confidential information related to the member, and who may speak on the member's behalf.

Autism Spectrum Disorder (ASD): means a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome. These conditions are now all called ASD.

Behavioral Health Treatment (BHT): means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

California State Plan: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130©, the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 to include BHT services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of ASD to the extent required by the federal government.2 BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional

services, and treatment programs, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a beneficiary with ASD.

Continuity of Care (COC): means a process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transition in care throughout the course of the disease.

Department of Health Care Services (DHCS): means the State agency responsible for administration of the federal Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.

Durable Medical Equipment (DME): means any medical equipment necessary to use in the home to aid a better quality of living.

Early, Periodic Screening, Diagnosis, and Treatment Services (EPSDT): means the federal program requiring states to provide screening, preventive, and medically necessary diagnostic and treatment services, to members of Medicaid Managed Care Programs.

Fee-for-Service (FFS): means a method of payment based upon per unit or per procedure billing for services rendered to an eligible beneficiary.

Managed Care Provider (MCP): means a participating provider or a contracted provider in a Medi-Cal Managed Care Health Plan.

Medically Necessary or Medical Necessity: Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

1. Consistent with nationally accepted standards of medical practice:

    a. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
    b. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
    c. For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    d. When determining the medical necessity of Covered Services for a Medi-Cal member under the age of 2, "medical necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and

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

2. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the Alliance will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards as follows:

    a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 CFR §1395y.
    b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code of Regulations (CCR) Section 51303.

Members: Any eligible beneficiary who is enrolled in any of the Alliance's product lines of business.

Out of Network (OON): means a non-participating provider or a non-contracted provider in a Medi-Cal Managed Care Health Plan.

Primary Care Provider (PCP): means a primary care physician or clinic responsible for coordinating, supervising, and providing primary health care services to a member, including but not limited to initiating specialty care referrals and maintaining continuity of care.

Provider: means primary care physicians, specialists, ancillary providers, clinics, and hospitals.

Quality of Care Issue (DHCS definition) means The Alliance can document its concerns with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other Alliance members.

Risk of Harm is defined as an imminent and serious threat to the health of the member.

Seniors and People with Disabilities (SPD): means person(s) 65 years or older and/or individual(s) meeting one of the following criteria: he or she has a physical or mental impairment that substantially limits one or more of his/her major life activities; he or she has a record of such an impairment; he or she is regarded as having such an impairment.

Treatment Authorization Request (TAR): means a referral or request for services. Services may be initial or ongoing.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management

Member Services
Provider Relations
Compliance

RELATED POLICIES AND PROCEDURES

- UM-036, "Cont. Covered Services for Members with Terminated Providers"
- UM-058, "COC for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption".
- UM-002 Behavioral Health Services

REVISION HISTORY

5/3/2018, 4/19/2019, 5/21/2020, 3/18/2021, 3/22/2022, 06/20/2023

REFERENCES

- All Plan Letter (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
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023. (Supersedes All Plan Letters 22-032, 18-008, 15-019, 14-021 and 13-023)
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

- All Plan Letter 17-007 (Supersedes APL 15-001 and 13-013 revised) Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption
- All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data
- Duals Plan Letter 15-003 Continuity of Care
- All Plan Letter ~~15-025~~23-010 ~~(Supersedes APL 14-011 Interim Policy)~~ Responsibilities for Behavioral Health Treatment Coverage for ~~Children Diagnosed with Autism Spectrum Disorder~~Members Under the Age of 21
- Health and Safety (H&S) Code §1373.96, 1371.8, 1373.65, 1373.95
- Welfare and Institutions Code §14185

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MONITORING

1. Delegated Medical Groups
   a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
   b. The Alliance reviews reports from delegated groups for continuity of care.

2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Logs/Reports of the various continuity of care requests. Quarterly audits are performed on selected files to ensure compliance with the regulatory requirements.
    b. Complaints and grievances for continuity of care are reviewed to identify problems and trends that will direct the development of corrective actions plans to improve performance.
    c. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

3. Monthly Reports
    a. Department of Health Care Services (DHCS)

The Alliance submits monthly reports for Continuity of Care following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	HED-XXX
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
Effective Date	TBD
Subcommittee Name	QIHEC
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) 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 22-031.

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 order for doula services by a physician group, or other group by a licensed Provider.
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 or the Alliance doula services recommendation form
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 all of 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 Alliance Member Services Department for assistance with doula access.

5. Service and Billing Parameters

5.1. The Alliance provides doula services for prenatal, perinatal, and postpartum members.
5.2. Doula visits are limited to one per day, per member.
5.3. Services can be provided virtually or in-person with various locations including, but not limited to: homes, office visits, hospitals or alternative birth centers.
5.4. A doula can bill for a prenatal or postpartum visit on the day of labor/delivery, stillbirth, abortion or miscarriage support.
5.5. Extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation.
5.6. The extended visits are limited to two visits per pregnancy per individual on separate days and are billed in 15-minute increments, up to three hours.
5.7. Doulas will work with the Member's Primary Care Provider (if information is available) or with the Alliance for coordination of care for any services available through Medi-Cal by referring the member to an Alliance provider to render the service. These services include but not limited to:
5.7.1. Behavioral health services
5.7.2. Belly binding after cesarean section by clinical personnel
5.7.3. Clinical case coordination
5.7.4. Health care services related to pregnancy, birth, and the postpartum period
5.7.5. Childbirth education group classes
5.7.6. Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)
5.7.7. Hypnotherapy (non-specialty mental health service)
5.7.8. Lactation consulting, group classes, and supplies
5.7.9. Nutrition services (assessment, counseling, and development of care plan)
5.7.10. Transportation
5.7.11. Medically appropriate Community Supports services
5.8. Doula services **DO NOT** include diagnosis of medical conditions, provision of medical advice or any type of clinical assessment, exam or procedure.
5.9. Services that **ARE NOT** covered under Medi-Cal or as doula services include:
5.9.1. Belly binding (traditional/ceremonial)
5.9.2. Birthing ceremonies (sealing, closing the bones etc.)
5.9.3. Group classes on babywearing
5.9.4. Massage (maternal or infant)
5.9.5. Photography
5.9.6. Placenta encapsulation
5.9.7. Shopping
5.9.8. Vaginal steams
5.9.9. Yoga
5.10. 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. 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. The Member cannot be billed for the assistive or supportive service.

5.11. Doulas **ARE NOT** prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services.

5.12. Doula Documentation:

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

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

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

5.12.5. 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.

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

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

6.4. Doulas **CANNOT** double bill, as applicable, for doula services that are duplicative to services that are 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 and identified health disparities as well as 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 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.
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
PH-002 Basic Population Health Management
UM-002 Coordination of Care

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alliance Population Health Strategy

REVISION HISTORY

TBD

REFERENCES

APL 22-031 Doula Services or superseding All Plan Letters
APL 22-013 Interoperability and Patient Access Final Rule or superseding All Plan Letters

MONITORING

This policy will be reviewed annually to ensure effectiveness.

ALAMEDA Alliance FOR HEALTH

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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
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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 Population Health and Equity Director at the Alliance provides administrative oversight of the Health Education Program. It is a full-time position held by a health educator with a master's degree in public health or community health, with a specialization in health education. The Population Health and Equity Director is a member of the Health Care Services Department and specifically is a part of the Quality Improvement team to ensure coordination and integration.

2. The Alliance provides evidence-based health education programs to all members.
   2.1. The Health Education Program aligns health education interventions for addressing health categories and topics within Population Health Management.
   2.2. The Alliance uses Population Needs Assessment (PNA) findings, HEDIS results, 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 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.

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 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, sexuality issues and alcohol and drug 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 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 PHM 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, 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.

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.
9.2. On-line health education materials in threshold languages culturally appropriate health education resources and referrals that can be shared with members.
9.3. A provider health education listing of health referrals available to Alliance members.
9.4. *Provider Wellness Request Form* available for download or through the Alliance Provider Portal to request Alliance health education programs and materials for members.
9.5. Provider communication, training, and education regarding delivery of health education services through provider quarterly packets and Alliance website resources.

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

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 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 Department
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

RELATED POLICIES AND PROCEDURES

HED-002 Health Education Materials
HED-009 Diabetes Prevention Program
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 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, TBA

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)

MONITORING

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

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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
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

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 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~~n individual~~ with a master's degree in public health or community health, with a specialization in health education. The Population Health and Equity Director is a member of the Health Care Services Department and specifically is a part of the Quality Improvement team to ensure coordination and integration.

2. The Alliance provides evidence-based health education programs to all members.

2.1. The Health Education Program aligns health education interventions for addressing health categories and topics within Population Health Management.

2.2. The Alliance uses Population Needs Assessment (PNA) findings, HEDIS results, 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. ~~The~~

~~2.~~2.3. Health Education updates its program goals, objectives, activities, and resource needs annually.

3. The ~~Health Education Program~~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 ~~reviews~~ relevant literature and best practices

3.1.2. Offering accredited programs

3.1.3. Evaluating health education programs

~~2.1. , program accreditations, educational methodology, and evaluations of Alliance health education programs to ensure intervention appropriateness and effectiveness in lifestyle/behavioral change for members.~~

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.

~~3.~~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.

~~4.~~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 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.

~~5.~~7. The Alliance health education program covers the following program interventions:

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5.1.7.1. ~~Effective~~ 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.

5.2.7.2. **Risk Reduction and Healthy Lifestyles** including, but not limited to ~~programs for tobacco use and cessation; alcohol and drug use; injury prevention, prevention of sexually transmitted diseases, HIV, and unintended pregnancy;~~ nutrition ~~; weight control~~ and physical activity~~; and parenting~~.

5.2.1.7.2.1. Member confidentiality regarding family planning, sexuality issues and alcohol and drug use is protected.

5.2.2.7.2.2. 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.

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

5.4.7.4. **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 ~~over formula and strategies to overcome common barriers and~~ and referral to Women Infants and Children (WIC).

5.4.1.7.4.2. Eligible members are referred to WIC.

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

5.4.3.7.4.4. International Board-Certified Breastfeeding Consultants (IBCLC) are available to Alliance members by phone or for in-person visits.

~~5.4.4. Provider education on making WIC referrals.~~

~~5.4.5. Breastfeeding handouts, guides and referral flyer for lactation supports are available on the Alliance website for members and providers, periodically distributed to providers, and mailed out to members upon request.~~

~~5.4.6. The Alliance does not perform marketing functions for formula companies, nor does the plan distribute formula samples, coupons, and materials from infant formula companies.~~

6.8. 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:

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

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

6.3.8.3. Maintaining a library of health education handouts covering health topics listed in ~~items 6.1 to 6.4~~Alliance program interventions above, topics that align to the PHM 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, 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.

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

6.5.8.5. 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.

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

6.5.2.8.5.2. Health Education Cases are closed after 4 months of non-activity.

6.6.8.6. 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. ~~supports providers with culturally appropriate health education resources and referrals that can be shared with members~~

9.2. ~~because of findings from the Initial Health Appointment (IHA). The Alliance maintains~~ On-line health education materials in threshold languages culturally appropriate health education resources and referrals that can be shared with members.

9.3. A provider health education ~~and makes available to providers a~~ listing of health referrals available to Alliance members.

9.4. *Provider Wellness Request Form* ~~in~~ available for download or through the Alliance Provider Portal to request Alliance health education programs and materials for members. ~~PD~~

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

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~~7.~~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.

~~8.~~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:

~~8.1.~~11.1. Making available to 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.

~~8.2.~~11.2. Information on accessing health education resources is included in the New Provider Orientation and Provider Manual.

~~8.3.~~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.

~~8.4.~~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.

~~9.~~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.

~~9.1.~~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:

~~9.2.~~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.

9.3.12.3. Reviewing Alliance program satisfaction surveys and/or collection of survey information from contracting providers.

9.4.12.4. Monitoring of providers contracted to deliver health education ~~providers~~ 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 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 Department
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

RELATED POLICIES AND PROCEDURES

HED-002 Health Education Materials
HED-009 Diabetes Prevention Program
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 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, TBA

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)

MONITORING

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

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	PH-004
Policy Name	Community Health Worker (CHW) Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	6/20/2023
Approval/Revision Date	6/20/2023

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) offers Community Health Worker (CHW) services as a preventive health benefit to members. These services may assist with a variety of concerns including but not limited to, the prevention and management of chronic conditions, behavioral health services, navigation and referral to community resources, and mitigation of health-related social needs. CHWs support the Alliance's Population Health Management (PHM) Strategy. The Alliance CHW benefit is guided by the Department of Health Care Services (DHCS) All Plan Letter 22-016.

PROCEDURE

1. Alliance CHW services require a written recommendation submitted to the Alliance by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.
   1.1. The licensed practitioner will submit a written recommendation with the claim.
   1.2. The recommending licensed provider does not need to be enrolled in Medi-Cal or be an Alliance Network Provider.

2. The recommending licensed provider ensures that a member meets eligibility criteria before recommending CHW services according to the following guidelines:
   2.1. CHW services are considered medically necessary for members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health

exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

2.2. The recommending provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following:

2.2.1. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.

2.2.2. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.

2.2.3. Any stressful life event presented via the Adverse Childhood Events screening.

2.2.4. The presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.

2.2.5. Results of a SDOH screening, indicating unmet health-related social needs, such as housing or food insecurity.

2.2.6. One or more visits to a hospital emergency department (ED) within the previous six months.

2.2.7. One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.

2.2.8. One or more stays at a detox facility within the previous year.

2.2.9. Two or more missed medical appointments within the previous six months.

2.2.10. Member expressed the need for support in health system navigation or resource coordination services.

2.2.11. Need for recommended preventive services, including updated immunizations, annual dental visits, and well childcare visits for children.

3. Alliance members are also eligible for CHW violence prevention services.

3.1. Members must meet any of the following circumstances as determined by a licensed practitioner:

3.1.1. The member has been violently injured as a result of community violence.

3.1.2. The member is at significant risk of experiencing violent injury as a result of community violence.

3.1.3. The member has experienced chronic exposure to community violence.

3.2. CHW violence prevention services are specific to community violence (e.g., gang violence), and that CHW services can be provided to members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

4. In addition to recommending providers identifying a member's need for CHW services, the Alliance uses data driven approaches to determine and understand priority populations eligible for CHW services, including but not limited to, using past and current member utilization/encounters, frequent hospital admissions or ED visits, demographic and SDOH data, referrals from the community (including provider referrals), and needs assessments, etc.

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

attempt outreach to qualifying members and their providers to encourage utilization of CHW services.

4.2. Priority populations are selected based on the unique needs of the Alliance membership and identified health disparities as well as the DHCS Clinical Quality Strategy priorities.

4.3. The Alliance may also receive referrals from licensed practitioners for CHW benefits.

5. CHWs are required to document the dates and time/duration of services provided to Members. Documentation must be accessible to the Supervising Provider upon their request.

6. The Alliance will not establish unreasonable or arbitrary barriers for accessing CHW services.

6.1. The Alliance does not require prior authorization for CHW services for the first 12 units; however, quantity limits after the first 12 units may be applied based on goals detailed in the plan of care.

6.2. The plan will not reimburse for CHW services that are duplicative to services that are reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit.

6.3. Tribal clinics may bill the Alliance for CHW services at Fee-for-Service rates using the CPT codes as outlined in the Provider Manual.

7. For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan will be written by one or more individual licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW supervising provider. No prior authorization will be required.

7.1. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services.

7.2. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the member's care team and/or other Providers referenced in this section.

7.3. The plan of care will not exceed a period of one year.

7.4. The plan of care will:

7.4.1. Specify the condition that the service is being ordered for and be relevant to the condition;

7.4.2. Include a list of other health care professionals providing treatment for the condition or barrier;

7.4.3. Contain written objectives that specifically address the recipient's condition or barrier affecting their health;

7.4.4. List the specific services required for meeting the written objectives; and

7.4.5. Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.

7.5. A licensed provider will review the Member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider will

determine if progress is being made toward the written objective and whether services are still medically necessary.

8. CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits. Services include:

    8.1. Health Education: Promoting a member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a member's health or ability to self-manage their health conditions.

    8.2. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
        8.2.1. Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
        8.2.2. Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
        8.2.3. Help a member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.
    8.3. Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a member with connecting to appropriate services to improve their health.
    8.4. Individual Support or Advocacy: Assisting a member in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.
    8.5. CHW services provided to a parent or legal guardian of a member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed provider. A service for the direct benefit of the Member will be billed under the Member's Medi-Cal ID.
    8.6. Street medicine and bill the Alliance for appropriate and applicable services when within their scope of service.

9. Covered CHW services *do not* include the following:
    9.1. Any service that requires a license, including clinical case management/care management that requires a license
    9.2. Childcare
    9.3. Chore services, including shopping and cooking meals
    9.4. Companion services
    9.5. Employment services

9.6. Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
9.7. Delivery of medication, medical equipment, or medical supply
9.8. Personal Care services/homemaker services
9.9. Respite care
9.10. Services that duplicate another covered Medi-Cal service already being provided to a member
9.11. Socialization
9.12. Coordinating and assisting with transportation
9.13. Services provided to individuals
9.14. Although CHWs may provide CHW services to members with mental health and/or substance use disorders, CHW services are distinct from and do not include peer support services covered under Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services Programs.

10. PHM CHW Integration Plan:
10.1. Member assessment and identification for needed CHW services: The Alliance uses a variety of tools to assess member needs and determine priority populations for CHW services.
10.1.1. Review of the Population Needs Assessment results
10.1.2. Review of Risk Stratification and Segmentation results
10.1.3. Member underutilization reports
10.1.4. Input from the Alliance Member Advisory Committee
10.1.5. Analysis of HEDIS and gap in care results
10.1.6. Trends identified in Appeals/Grievances
10.1.7. Disparities identified through health equity analysis
10.1.8. Review of assessment results
10.1.9. Referrals for CHW services from providers
10.2. Alignment with DHCS Comprehensive Quality Strategy (CQS): The Alliance strives to leverage the CHW to address the DHCS CQS clinical priorities.
10.2.1. The Alliance will identify, outreach, and collaborate with community partners that work with populations that align with the CQS clinical priorities and have potential to grow the CHW network.
10.3. The Alliance's CHW strategy will include the use of CHWs to help address gaps in member engagement, population health, quality and health equity and program efficiencies.
10.4. Alliance Enhanced Care Management (ECM) and Community Supports (CS) programs may use CHWs to provide services. The Alliance ensures non-duplication of services through claims processes safeguards to prevent non-duplication of services.
11. Referral pathways to CHW services include, but are not limited to:
11.1. Agreements with community and/or county public health agencies
11.2. Alliance care management staff referral, including referrals from ECM, CS, transitional care services, disease management, and complex case management programs.
11.3. Provider referral
11.4. Member self-referral

12. The Alliance collaborates with provider and community partners to develop a network of CHW providers to meet identified needs including the following outreach efforts:
    12.1. Aligning CHW network with current providers, hospitals and community partners who offer CHW services.
    12.2. Promoting the benefit and requirements with the provider network. Communications are sent by fax, included on the Alliance public website and/or included in quarterly packets mailed to providers.
    12.3. The Alliance will leverage the skills and assets of external organizations such as providers, health systems, community-based organizations, and local health jurisdictions to support CHWs. Activities include:
        12.3.1. Assessment of the availability and uses and capacities of CHWs in Alameda County.
        12.3.2. Participation in CHW workgroups in Alameda County to create support for training, hiring and development of CHWs.

13. The Alliance communicates to members about the scope of practice, benefits and availability of CHW services.
    13.1. The Alliance communicates member benefits and services through the evidence of coverage, newsletters, new member orientations, member calls and call center scripts, the provider directory, and the Alliance website and social media.
    13.2. Alliance member communications are culturally and linguistically appropriate and available in member threshold languages. Alliance member informing materials also include the 19 language assistance taglines to help members understand how to receive assistance reading the communication in a different language or an alternative format at no cost to the member.

14. The Alliance communicates with providers about the scope of practice, benefits, and availability of CHW services.
    14.1. The CHW scope of service is included in the Alliance Provider Manual.
    14.2. Provider communications also include how a provider can bill for CHW services according to Medi-Cal guidelines and how to complete and submit the Supervision Provider Attestation for Community Health Workers Form.
    14.3. During the credentialling process (see P&P CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications) providers supervising CHW services will complete an attestation form informing providers of the DHCS requirements for providing CHW services.
    14.4. Provider communications will be sent by fax, posted to our public website, and included in our quarterly provider packets mailed to providers.

15. The Alliance will monitor utilization of services and comply with all reporting and oversight requirements stipulated by DHCS. The Alliance will monitor:
    15.1. Utilization including, at the minimum, an annual review of claims and encounters for CHW services and grievances related to CHW services.
    15.2. Compliance with billing requirements.
    15.3. Short term outcomes including:

15.3.1. The required DHCS BPHM-CHW Integration measure, percentage of members who received CHW benefit.
15.3.2. Tracking CHW utilization and services among member groups by race/ethnicity, age, location, language, and gender to ensure equitable utilization and access.
15.3.3. Tracking communications and educational offerings to providers in our effort to expand services.
15.4. Tracking of provider network expansion. The Alliance will take action as needed to ensure sufficient provider networks for CHW services.
15.5. Long term outcomes, including an analysis of HEDIS measures and utilization goals addressed through CHW services to determine if there was a reduction in the health disparity.

DEFINITIONS / ACRONYMS

CAP – Corrective Action Plans
CHW – Community Health Worker
CHW Services – Services delivered by a CHW to prevent disease, disability and other health conditions or their progression; to prolong life; and to promote physical and mental health.
ED – Emergency Department
Licensed practitioner/provider -For the purposes of the CHW 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.
PHM: Population Health Management
SDOH – Social Determinants of Health
Supervising provider – An organization employing or otherwise overseeing the CHWs with which the Alliance contracts (additional details are found in CRE-023).
Recommending provider – the licensed provider who recommends a member for CHW services, and ensures the member meets medical necessity for CHW services.

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications
PH-001 Population Health Management (PHM) Program

PH-XXX Community Health Worker (CHW) Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

TBD

REFERENCES

DHCS APL 22-016 Community Health Worker Services

MONITORING

This policy will be reviewed annually. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance.

POLICY AND PROCEDURE TEMPLATE

Policy Number	PH-~~XXX~~004
Policy Name	Community Health Worker (CHW) Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	6/20/2023~~TBD~~
Approval/Revision Date	6/20/2023~~TBD~~

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) offers Community Health Worker (CHW) services as a preventive health benefit to members. These services may assist with a variety of concerns including but not limited to, the ~~control and prevention~~prevention and management of chronic conditions, ~~or infections disease,~~ behavioral health services, navigation and referral to community resources, and mitigation of health-related ~~and the need for preventive services.~~ social needs. CHWs support the Alliance's Population Health Management (PHM) Strategy. The Alliance CHW benefit is guided by the Department of Health Care Services (DHCS) All Plan Letter 22-016.

PROCEDURE

1. Alliance CHW services require a written recommendation submitted to the Alliance by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.
   1.1. The licensed practitioner will submit a written recommendation with the claim.
   ~~1.1.~~1.2. The recommending licensed provider does not need to be enrolled in Medi-Cal or be an Alliance Network Provider.

2. The recommending licensed provider ensures that a member meets eligibility criteria before recommending CHW services according to the following guidelines:
   2.1. CHW services are considered medically necessary for members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health

exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

2.2. The recommending provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following:

2.2.1. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.

2.2.2. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.

2.2.3. Any stressful life event presented via the Adverse Childhood Events screening.

2.2.4. The presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.

2.2.5. Results of a SDOH screening, indicating unmet health-related social needs, such as housing or food insecurity.

2.2.6. One or more visits to a hospital emergency department (ED) within the previous six months.

2.2.7. One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.

2.2.8. One or more stays at a detox facility within the previous year.

2.2.9. Two or more missed medical appointments within the previous six months.

2.2.10. Member expressed the need for support in health system navigation or resource coordination services.

2.2.11. Need for recommended preventive services, including updated immunizations, annual dental visits, and well childcare visits for children.

3. Alliance members are also eligible for CHW violence prevention services.

3.1. Members must meet any of the following circumstances as determined by a licensed practitioner:

3.1.1. The member has been violently injured as a result of community violence.

3.1.2. The member is at significant risk of experiencing violent injury as a result of community violence.

3.1.3. The member has experienced chronic exposure to community violence.

3.2. CHW violence prevention services are specific to community violence (e.g., gang violence), and that CHW services can be provided to members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

4. In addition to recommending providers identifying a member's need for CHW services, the Alliance uses data driven approaches to determine and understand priority populations eligible for CHW services, including but not limited to, using past and current member utilization/encounters, frequent hospital admissions or ED visits, demographic and SDOH data, referrals from the community (including provider referrals), and needs assessments, etc.

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

attempt outreach to qualifying members and their providers to encourage utilization of CHW services.

4.2. Priority populations are selected based on the unique needs of the Alliance membership and identified health disparities as well as the DHCS Clinical Quality Strategy priorities.

4.3. The Alliance may also receive referrals from licensed practitioners for CHW benefits.

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6. The Alliance will not establish unreasonable or arbitrary barriers for accessing CHW services.
   6.1. The Alliance does not require prior authorization for CHW services for the first 12 units; however, quantity limits after the first 12 units may be applied based on goals detailed in the plan of care.
   6.2. The plan will not reimburse for CHW services that are duplicative to services that are reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit.
   6.3. Tribal clinics may bill the Alliance for CHW services at Fee-for-Service rates using the CPT codes as outlined in the Provider Manual.

7. For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan will be written by one or more individual licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW supervising provider. No prior authorization will be required.
   7.1. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services.
   7.2. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the member's care team and/or other Providers referenced in this section.
   7.3. The plan of care will not exceed a period of one year.
   7.4. The plan of care will:
      7.4.1. Specify the condition that the service is being ordered for and be relevant to the condition;
      7.4.2. Include a list of other health care professionals providing treatment for the condition or barrier;
      7.4.3. Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
      7.4.4. List the specific services required for meeting the written objectives; and
      7.4.5. Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.
   7.5. A licensed provider will review the Member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider will determine if progress is being made toward the written objective and whether services are still medically necessary.

8. CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits. Services include:

    8.1. Health Education: Promoting a member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a member's health or ability to self-manage their health conditions.

    8.2. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
    - 8.2.1. Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
    - 8.2.2. Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
    - 8.2.3. Help a member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.

    8.3. Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a member with connecting to appropriate services to improve their health.

    8.4. Individual Support or Advocacy: Assisting a member in preventing the onset or exacerbation of a health condition or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

    8.5. CHW services provided to a parent or legal guardian of a member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed provider. A service for the direct benefit of the Member will be billed under the Member's Medi-Cal ID.

    8.6. Street medicine and bill the Alliance for appropriate and applicable services when within their scope of service.

9. Covered CHW services *do not* include the following:
    - 9.1. Any service that requires a license, including clinical case management/care management that requires a license
    - 9.2. Childcare
    - 9.3. Chore services, including shopping and cooking meals
    - 9.4. Companion services
    - 9.5. Employment services
    - 9.6. Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
    - 9.7. Delivery of medication, medical equipment, or medical supply

9.8. Personal Care services/homemaker services
9.9. Respite care
9.10. Services that duplicate another covered Medi-Cal service already being provided to a member
9.11. Socialization
9.12. Coordinating and assisting with transportation
9.13. Services provided to individuals
9.14. Although CHWs may provide CHW services to members with mental health and/or substance use disorders, CHW services are distinct from and do not include peer support services covered under Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services Programs.

~~10. The Alliance integrates CHWs into the Population Health Management Strategy through the following activities:~~
~~10.1. The Alliance uses the following approaches to identify priority populations for CHW services:~~
~~10.1.1. The Population Needs Assessment,~~
~~10.1.2. Risk Stratification and Segmentation results~~
~~10.1.3. Underutilizations reports~~
~~10.1.4. Input from the Community Advisory Committee~~
~~10.1.5. Analysis of HEDIS and gap in care results~~
~~10.1.6. Trends identified in Grievances and appeals~~
~~10.1.7. Alignment with DHCS Clinical Quality Strategy priorities~~
~~10.1.8. Opportunities to address inequities.~~
~~10.2. The Alliance includes CHW services as a part of the overall Alliance Population Health Management Program to address member care needs across the continuum of care.~~
~~10.3. The Alliance collaborates with provider and community partners to develop a network of CHW providers to meet identified needs.~~

10. ~~The Alliance includes the integration plan as a part of theintegrates CHW in its PHM Strategy.~~PHM~~:~~ CHW I~~i~~ntegration P~~p~~lan:
- Member assessment and identification for needed CHW services:

10.1. ~~PHM Readiness Deliverable, submitted on 10/21/2022.~~The Alliance uses a variety of tools to assess member needs and determine priority populations for CHW services.
- 10.1.1. Review of the Population Needs Assessment results
- 10.1.2. Review of Risk Stratification and Segmentation results
- 10.1.3. Member underutilization reports
- 10.1.4. Input from the Alliance Member Advisory Committee
- 10.1.5. Analysis of HEDIS and gap in care results
- 10.1.6. Trends identified in Appeals/Grievances
- 10.1.7. Disparities identified through health equity analysis
- 10.1.8. Review of assessment results

~~10.4.~~ 10.1.9. Referrals for CHW services from providers ~~Review of results from member nts conducted by Providers and/or Alliance staff.~~
~~Referrals for CHW services from providers. The Alliance will educate providers of the benefit and member eligibility criteria.~~

10.2. Alignment with DHCS Comprehensive Quality Strategy (CQS): The Alliance strives to leverage the CHW ~~integrate CHWs into the PHM strategy in ways t~~o~~hat~~

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address~~align with~~ the DHCS CQS ~~Comprehensive Quality Strategy~~ clinical priorities ~~including:~~.

~~Priorities include:~~

10.2.1. The Alliance will identify, outreach, and collaborate with community partners that work with populations that align with the CQS clinical priorities and have potential to grow the CHW network.

10.3. The Alliance's CHW strategy will include the use of CHWs to help address gaps in member engagement, population health, quality and health equity and program efficiencies.

10.4. Alliance Enhanced Care Management (ECM) and Community Supports (CS) programs may use CHWs to provide services. The Alliance ensures non-duplication of services through claims processes safeguards to prevent non-duplication of services.

11. Referral pathways to CHW services include, but are not limited to:

11.1. Agreements with community and/or county public health agencies

11.2. Alliance care management staff referral, including referrals from ECM, CS, transitional care services, disease management, and complex case management programs.

11.3. Provider referral

11.4. Member self-referral

12. The Alliance collaborates with provider and community partners to develop a network of CHW providers to meet identified needs including the following outreach efforts:~~.~~

12.1. Aligning CHW network with current providers, hospitals and community partners who offer ~~Community Health workers~~CHW services~~.~~~~CHW~~

12.2. Promoting the benefit and requirements with the provider network. Communications are sent by fax, included on the Alliance public website and/or included in quarterly packets mailed to providers.

12.3. The Alliance will leverage the skills and assets of external organizations such as providers, health systems, community-based organizations, and local health jurisdictions to support CHWs. Activities include:

12.3.1. Assessment of the availability and uses and capacities of CHWs in Alameda County.

12.3.2. Participation in CHW workgroups in ~~Participation in collaborative efforts~~ Alameda County ~~with Alameda County Health Care Services Agency and their partners~~ to create support for training, hiring and development of CHWs.

13. The Alliance communicates to members about the scope of practice, benefits and availability of CHW services.

13.1. The Alliance communicates member benefits and services through the evidence of coverage, newsletters, new member orientations, member calls and call center scripts,~~,~~ the provider directory, and the Alliance website and social media.

13.2. Alliance member communications are culturally and linguistically appropriate and available in member threshold languages. Alliance member informing materials also include the 19 language assistance taglines to help members understand how to receive assistance reading the communication in a different language or an alternative format at no cost to the member.

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14. The Alliance communicates with providers about the scope of practice, benefits, and availability of CHW services.
    14.1. The CHW scope of service is included in the Alliance Provider Manual.
    14.2. Provider communications also include how a provider can bill for CHW services according to Medi-Cal guidelines and how to complete and submit the Supervision Provider Attestation for Community Health Workers Form.
    14.3. During the credentialling process (see P&P CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications) providers supervising CHW services will complete an attestation form informing providers of the DHCS requirements for providing CHW services.
    14.4. Provider communications will be sent by fax, posted to our public website, and included in our quarterly provider packets mailed to providers.

~~11.~~

~~12.~~15. The Alliance will monitor utilization of services and comply with all reporting and oversight requirements stipulated by DHCS. The Alliance will monitor:
    15.1. Utilization ~~monitoring will~~ includinge~~,~~ at the minimum, an annual review of claims and encounters for CHW services and grievances related to CHW services.
    15.2. Compliance with billing requirements.
    15.3. Short term outcomes including:
        15.3.1. The required DHCS BPHM-CHW Integration measure, percentage of members who received CHW benefit.
        15.3.2. Tracking CHW utilization and services among member groups by race/ethnicity, age, location, language, and gender to ensure equitable utilization and access.
        15.3.3. Tracking communications and educational offerings to providers in our effort to expand services.
    15.4. Tracking of provider network expansion. The Alliance will take action as needed to ensure sufficient provider networks for CHW services.
    15.5. Long term outcomes, including an analysis of HEDIS measures and utilization goals addressed through CHW services to determine if there was a reduction in the health disparity.

~~12.1.1.~~

~~12.1.2.~~
~~12.2. bBased on monitoring of CHW services, the Alliance will take action as needed to ensure sufficient provider networks for CHW services~~

DEFINITIONS / ACRONYMS

CAP – Corrective Action Plans
CHW – Community Health Worker
CHW Services – Services delivered by a CHW to prevent disease, disability and other health conditions or their progression; to prolong life; and to promote physical and mental health.
ED – Emergency Department
Licensed practitioner/provider -For the purposes of the CHW benefit, a licensed practitioner includes physician assistants, nurse practitioners, clinical nurse specialists,

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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.

PHM: Population Health Management

SDOH – Social Determinants of Health

Supervising provider – An organization employing or otherwise overseeing the CHWs with which the Alliance contracts (additional details are found in CRE-023).

Recommending provider – the licensed provider who recommends a member for CHW services, and ensures the member meets medical necessity for CHW services.

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AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

CRE-023 Community Health Workers Supervising Providers, Required CHW Minimum Qualifications
PH-001 Population Health Management (PHM) Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

TBD

REFERENCES

DHCS APL 22-016 Community Health Worker Services

MONITORING

This policy will be reviewed annually. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance.

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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	Medi-Cal and Group Care
Effective Date	4/1/1999
Subcommittee	Quality Improvement and Health Equity Committee
Subcommittee Approval Date	TBD
Approval / Revision Date	TBD

POLICY STATEMENT

The Alameda Alliance for Health (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. The Alliance Community

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 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 that meets regularly to provide diverse member and family input into Alliance policies, procedures, and programs. The findings and recommendations inform Alliance activities and interventions. The Member Advisory Committee (MAC) acts as the Community Advisory Committee (CAC).

1.9. The MAC 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 MAC's input is actively utilized in policies and decision-making.

2. Member Advisory Committee Membership

2.1. The Alliance convenes a selection committee tasked with selecting the members of the MAC. The Alliance makes a good faith effort to ensure that the MAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the MAC.

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 member population in Alameda 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

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

2.3.1. Populations who experience health disparities

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

2.3.3. Persons with chronic conditions

2.3.4. Limited English Proficient (LEP) Members

2.4. The MAC is comprised of up to 20 members, as follows:

2.4.1. Alliance members

2.4.2. Community advocates for hard-to-reach populations

2.4.3. Safety-net provider (minimum of one)

2.4.4. Traditional provider (minimum of one)

2.5. At least 51% of the committee is Alliance members (and/or the parents/caregivers of Alliance members).

2.6. At least one MAC member serves on the Alliance Board of Governors.

2.7. The Alliance's selection committee selects the MAC members no later than 180 calendar days from the effective date of the contract.

2.8. Should a MAC member resign, is asked to resign, or is otherwise unable to serve on the MAC, the Alliance will make its best effort to promptly replace the vacant seat within 60 calendar days of the MAC vacancy.

2.9. One member of the MAC or another Alliance member designated by the MAC will be appointed to serve as the Alliance's representative to DHCS' Statewide Consumer Advisory Committee.

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

3. MAC Coordinator

3.1. The Alliance designates the Health Education Coordinator as the MAC Coordinator and maintains a detailed job description detailing the MAC Coordinator's responsibility to manage the operations of the MAC 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 MAC 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 MAC.

3.1.3. Actively facilitating communications and connections between the MAC and

Alliance leadership, including ensuring MAC members are informed of Alliance decisions relevant to the work of the MAC.

3.1.4. Ensuring that MAC 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 MAC meetings.

3.1.5. Ensuring compliance with all MAC reporting and public posting requirements.

3.1.6. The MAC coordinator is an employee of the Alliance and not a member of the MAC or member enrolled with the Alliance.

4. MAC Terms of Service and Attendance:
   - 4.1. The term of service for each Member Advisory Committee member is one (1) year.
   - 4.2. Committee members may serve more than one term, at the discretion of the Chief Executive Officer (CEO).
   - 4.3. A member may be dismissed from the committee if he or she fails to attend two meetings of the committee within one year for reasons other than illness.
   - 4.4. Members must notify the Alliance of expected absences.
   - 4.5. Plan members receive compensation or a stipend for each meeting attended to cover time and participation, including participation in the MAC, the Alliance Board of Governors and participation in the DHCS' Statewide Consumer Advisory Committee. Stipends for in-person meetings cover transportation costs for members. Members may also may request and receive a childcare reimbursement.
   - 4.6. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.

5. MAC Committee Meetings:
   - 5.1. Regularly scheduled MAC 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 MAC 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 MAC 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 MAC Chair and Vice Chair are the Alliance's CEO's designees. The CEO does not vote at MAC meetings.
   - 5.5. A quorum, defined as a simple majority (50% + 1) of voting members, must be

present for the MAC to vote on any matter.

5.6. The Alliance will hold its first regular MAC meeting promptly after all initial MAC members have been selected by the MAC selection committee and quarterly thereafter.

6. Alliance MAC Support
   6.1. The Alliance will provide the following to the Member Advisory Committee:
      6.1.1. Educate MAC members to ensure they can effectively participate in MAC meetings.
      6.1.2. Support to address barriers to participation of MAC members, including childcare, transportation, flexible meeting times and formats so the highest MAC member participation is possible, convenient location, and format.
      6.1.3. Sufficient resources, within budgetary limitations, to support Member Advisory Committee 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 MAC 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 MAC and supports the work of the MAC through consultation and reports as needed.

7. Duties of the MAC
   7.1. Provide input into annual reviews and updates to relevant policies and procedures, and in particular those affecting quality improvement and health equity.
      7.1.1. MAC feedback is incorporated into the Cultural and Linguistic Services Program, the Population Heath Management Strategy and the Quality Improvement and Health Equity Program.
   7.2. Identify and advocate for preventive care practices to be utilized by the Alliance.
   7.3. 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.
   7.4. Provide and make recommendations regarding cultural appropriateness of communications, partnerships, and services.
   7.5. 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.
   7.6. Provide input and advice, including, but not limited to, the following:
      7.6.1. Culturally appropriate service or program design
      7.6.2. The Alliance's diversity, equity, and inclusion strategy
      7.6.3. Priorities for health education and outreach programs

7.6.4. Member satisfaction survey results
7.6.5. Findings of the PNA
7.6.6. Plan marketing materials and campaigns
7.6.7. Communication of needs for Network development and assessment
7.6.8. Community resources and information
7.6.9. Population health management and health equity
7.6.10. Quality Improvement, including:
7.6.10.1. Member satisfaction survey results pertinent to timely access standards
7.6.10.2. Quality improvement activities and interactions
7.6.11. Health Delivery Systems Reforms to improve health outcomes
7.6.12. Carved Out Services
7.6.13. Coordination of Care
7.6.14. Health Equity
7.6.15. Accessibility of Services

8. Annual MAC Demographic Report
8.1. The Alliance will submit an annual demographic report regarding the MAC on April 1st of each year with descriptions of the following.
8.1.1. The demographic composition of MAC 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 MAC membership aligns with the Alliance's Member demographics
8.1.4. Barriers to and challenges in meeting or increasing alignment between MAC'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 MAC membership recruitment to address the barriers and challenges to achieving alignment between MAC membership with the demographics of the Members within Alliance's Service Area.
8.1.6. A description of the MAC'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 MAC input impacted and shaped Alliance's initiatives and/or policies.

9. Reporting structure for the MAC
9.1. The MAC's activities and feedback are reported to the Cultural and Linguistic Services Committee, which reports 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 Healthcare Services
Health Disparity - Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, 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
MAC –Member Advisory Committee
PNA – Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

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

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)

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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

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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	Medi-Cal and Group Care
Effective Date	4/1/1999
Subcommittee	Quality Improvement and Health Equity Committee
Subcommittee Approval Date	TBD
Approval / Revision Date	TBD

POLICY STATEMENT

The Alameda Alliance for Health (the Alliance) c~~C~~ommunity e~~E~~ngagement strategy ensures that members and families are partners in the delivery of ~~Covered~~ covered ~~Services~~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~~to~~ 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. The Alliance Community.

PROCEDURE

1. The Alliance ~~Community~~ community ~~Engagement~~ engagement ~~Strategy~~ 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~~ health ~~Equity~~ equity initiatives routinely ~~incorporate feedback from~~engage members and families through focus groups, listening sessions, surveys and/or interviews. ~~This feedback~~ The findings, recommendations, and results ~~is~~ 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 and family input into policies and decision-making.

~~1.5.~~1.6. Member engagement and input is incorporated into the ~~Quality~~ Quality ~~Improvement~~ Improvement and ~~Health~~ Health E~~E~~quity ~~annual plan~~Program Evaluation ~~-~~to measure and monitor the impact of the input. (*QI-101 Quality Improvement Program*)

~~1.6.~~1.7. The Alliance conducts member surveys and incorporates the results in ~~Quality~~ quality ~~Improvement~~ improvement and ~~Health~~ health ~~Equity~~ equity activities. (*QI-117 Member Satisfaction Survey)*

1.8. The Alliance has a Community Advisory Committee that meets regularly to provide diverse member and family input into Alliance policies, procedures, and programs. The findings and recommendations inform Alliance activities and interventions. The Member Advisory Committee (MAC) acts as the Community Advisory Committee (CAC).

1.9. The MAC 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 MAC's input is actively utilized in policies and decision-making.

~~1.7.~~

2. Member Advisory Committee Membership

2.1. The Alliance convenes a selection committee tasked with selecting the members of the MAC. The Alliance makes a good faith effort to ensure that the MAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the MAC.

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 member population in Alameda 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

~~2.3.~~ The make up of the MAC is adjusted as the community changes to ensure the community is represented and engaged and makes a good faith effort to include representatives from d

~~2.4.~~2.3. ~~D~~iverse and hard to reach populations, with a specific emphasis on:

~~2.4.1.~~2.3.1. Populations who experience h~~H~~ealth ~~Disparities~~disparities

~~2.4.2.~~ Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities. ~~Individuals of diverse racial and ethnic backgrounds~~

~~2.4.3. Individuals with diverse genders, gender identity, and sexual orientation~~

~~2.4.4. Individuals with physical disabilities~~

~~2.4.5.~~2.3.2. ~~Seniors and persons with disabilities~~

~~2.4.6.~~2.3.3. Persons with chronic conditions

~~2.4.7.~~2.3.4. Limited English Proficient (LEP) Members

~~2.5.~~2.4. The MAC is comprised of up to 20 members, as follows:

~~2.5.1.~~2.4.1. Alliance members

~~2.5.2.~~2.4.2. Community advocates for hard-to-reach populations

~~2.5.3.~~2.4.3. Safety-net provider (minimum of one)

~~2.5.4.~~2.4.4. Traditional provider (minimum of one)

~~2.6.~~2.5. At least 51% of the committee is Alliance members (and/or the parents/caregivers of Alliance members).

~~2.7.~~2.6. At least one MAC member serves on the Alliance Board of Governors.

2.7. The Alliance's selection committee selects the MAC members no later than 180 calendar days from the effective date of the contract.

2.8. Should a MAC member resign, is asked to resign, or is otherwise unable to serve on the MAC, the Alliance will make its best effort to promptly replace the vacant seat within 60 calendar days of the MAC vacancy.

2.9. One member of the MAC or another Alliance member designated by the MAC will be appointed to serve as the Alliance's representative to DHCS' Statewide Consumer Advisory Committee.

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

might be a conflict. ~~any financial or other relationship to an Alliance competitor. A member's affiliations with outside interests do not impair the responsible exercise of his or her duties as a MAC member.~~

3. MAC Coordinator
   3.1. The Alliance ~~has~~ designates ~~a MAC coordinator~~the Health Education Coordinator as the MAC Coordinator and maintains a detailed job description detailing the MAC Coordinator's responsibility to ~~whose responsibility is to~~ manage the operations of the MAC 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 MAC 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 MAC.
      3.1.3. Actively facilitating communications and connections between the MAC and Alliance leadership, including ensuring MAC members are informed of Alliance decisions relevant to the work of the MAC.
      3.1.4. Ensuring that MAC 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 MAC meetings.
      3.1.5. Ensuring compliance with all MAC reporting and public posting requirements.
      3.1.6. The MAC coordinator is an employee of the Alliance and not a member of the MAC or member enrolled with the Alliance.
   ~~3.2.~~

4. MAC Terms of Service and Attendance:
   4.1. The term of service for each Member Advisory Committee member is one (1) year.
   4.2. Committee members may serve more than one term, at the discretion of the Chief Executive Officer (CEO).
   4.3. A member may be dismissed from the committee if he or she fails to attend two meetings of the committee within one year for reasons other than illness.
   4.4. Members must notify the Alliance of expected absences.
   4.5. Plan members receive ~~a~~ compensation or a stipend for each meeting attended to cover time and participation, including participation in the MAC, the Alliance Board of Governors~~OG~~ and participation in the DHCS' Statewide Consumer Advisory Committee. Stipends for in-person meetings ~~are greater to~~ cover transportation costs for members. Members may also may request and receive a childcare reimbursement.
   4.6. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.

5. MAC Committee Meetings:
   5.1. Regularly scheduled MAC 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 MAC 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 MAC 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 MAC Chair and Vice Chair are the Alliance's CEO's designees. The CEO does not vote at MAC meetings.
   5.5. A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the MAC to vote on any matter.
   5.6. The ~~MAC~~ Alliance will hold its first regular MAC meeting promptly after all initial MAC members have been selected by the MAC selection committee and quarterly thereafter.
   ~~5.6. holds regular meetings on a quarterly basis.~~

6. Alliance MAC Support
   6.1. The Alliance will provide the following to the Member Advisory Committee:
      6.1.1. Educate MAC members to ensure they can effectively participate in MAC meetings.
      6.1.2. Support to address barriers to participation of MAC members, including childcare, transportation, flexible meeting times and formats so the highest MAC member participation is possible, convenient location, and format.
      6.1.3. Sufficient resources, within budgetary limitations, to support Member Advisory Committee 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 MAC 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 MAC and supports the work of the MAC through consultation and reports as needed.

7. Duties of the MAC
   7.1. Provide input into annual reviews and updates to relevant policies and procedures, and in particular those affecting ~~Quality~~ quality improvement and ~~Health~~ health ~~Equity~~equity.
      7.1.1. MAC feedback is incorporated into the Cultural and Linguistic Services Program, the Population Heath Management Strategy and the Quality

Improvement and Health Equity Program.

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

7.3. Provide input into developing and updating cultural and linguistic policy and procedure decisions including those related to ~~Quality~~ quality ~~Improvement~~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.

7.4. Provide and make recommendations regarding cultural appropriateness of communications, partnerships, and services.

7.5. 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.

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

7.6.1. Culturally appropriate service or program design

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

~~7.6.1.~~

~~7.6.2.~~7.6.3. Priorities for health education and outreach programs

~~7.6.3.~~7.6.4. Member satisfaction survey results

~~7.6.4.~~7.6.5. Findings of the PNA

~~7.6.5.~~7.6.6. Plan marketing materials and campaigns

~~7.6.6.~~7.6.7. Communication of needs for Network development and assessment

~~7.6.7.~~7.6.8. Community resources and information

~~7.6.8.~~7.6.9. Population ~~Health~~ health ~~Management~~management and health equity

7.6.10. Quality Improvement, including:

7.6.10.1. M~~m~~ember satisfaction survey results pertinent to timely access standards

~~7.6.8.1.~~7.6.10.2. Quality improvement activities and interactions

~~7.6.9.~~7.6.11. Health Delivery Systems Reforms to improve health outcomes

~~7.6.10.~~7.6.12. Carved Out Services

~~7.6.11.~~7.6.13. Coordination of Care

~~7.6.12.~~7.6.14. Health Equity

~~7.6.13.~~7.6.15. Accessibility of Services

8. Annual MAC Demographic Report

8.1. The Alliance will submit an annual demographic report regarding the MAC on April 1st of each year with descriptions of the following.

8.1.1. The demographic composition of MAC 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 MAC

membership aligns with the Alliance's Member demographics

8.1.4. Barriers to and challenges in meeting or increasing alignment between MAC'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 MAC membership recruitment to address the barriers and challenges to achieving alignment between MAC membership with the demographics of the Members within Alliance's Service Area.

8.1.6. A description of the MAC'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 MAC input impacted and shaped Alliance's initiatives and/or policies.

9. Reporting structure for the MAC

9.1. The MAC's activities and feedback are reported to the Cultural and Linguistic Services Committee, which reports to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.

~~8.2.~~

DEFINITIONS / ACRONYMS

CEO – Chief Executive Officer
CHEO – Chief Health Equity Officer
BOG – Board of Governors
CAC – Community Advisory Committee
DHCS – Department of Healthcare Services
Health Disparity - Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, 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
MAC –Member Advisory Committee
PNA – Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

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, ~~TBA~~3//2023

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, ~~Exhibit A, Attachment 9, Section 15~~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)

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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

POLICY AND PROCEDURE

Policy Number	CLS-011
Policy Name	Compliance Monitoring of Cultural and Linguistic Services Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement and Health Equity Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") monitors, improves, and evaluates the established Cultural and Linguistic Services (CLS) Program as a part of the Alliance's Quality Improvement Program. As part of the examination, all processes related to providing cultural and linguistic services are monitored including:

A. Quality Improvement Program Work Plan activities related to language assistance programs.
B. Reports on Alliance provision of language services to members, including interpretation, translation, and request for alternative formats.
C. Member and provider grievances and complaints and potential quality issues related to cultural and linguistic services.
D. Information with regards to the Alliance's member language needs and demographic profile.
E. The Alliance's staff bilingual qualifications, training requirements and training materials
F. Network providers' compliance to requirements and ability to meet the cultural and linguistic needs of members.

The Alliance's Quality Improvement (QI) Department is responsible for monitoring the Cultural and Linguistic Services Program and evaluating its effectiveness. The Alliance's Quality

Improvement Program and Language Assistance Program work plan updates are reported to the Health Care Quality Committee (HCQC) for recommendations. Additionally, the Alliance's Compliance Department oversees external cultural and linguistic services delegated to entities through annual auditing activities to ensure compliance is met with regulatory and contractual standards. If deficiencies are cited, the Alliance will issue a corrective action plan (CAP) to the delegate entity to ensure those deficiencies are fully resolved prior to closing out the audit.

The QI Department monitors the language assistance services of its directly contracted provider network to ensure they 1) meet the cultural and linguistic needs of Alliance members and 2) that Alliance providers continuously abide by the standards set forth in the Alliance's Department of Health Care Services (DHCS) contract and all state and federal regulatory requirements. The Alliance takes immediate action when deficiencies are identified, and when necessary, CAPs are created for providers and monitored to ensure ongoing problematic issues are addressed.

PROCEDURE

1. Language Assistance Services Monitoring

1.1. Through facility site reviews, the following are reviewed, and CAPs are put into place per *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs) and Physical Accessibility Review Surveys (PARS)* as needed:

1.1.1. Twenty-four/seven (24/7) access to interpreter services for LEP members.

1.1.2. Interpreter services are made available in identified threshold languages.

1.1.3. Persons providing language interpreter services on site demonstrate training in medical interpretation, including conversational fluency, medical terminology for medical staff and non-medical staff. This must be documented.

1.1.4. The Medical Record Review (MRR) checks if the primary language and linguistic services needs of non- or limited-English proficient (LEP) or hearing-impaired persons as well as any refusal to use professional interpreter services are prominently noted.

1.1.5. Documentation of site personnel receiving information and/or training on cultural and linguistic appropriate services.

1.1.6. Verified evidence of staff training or written cultural and linguistic information on site and explanation of how to use the information.

1.1.7. Confirmation that site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act. Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings.

1.2. The QI Department reviews monthly reports of language services provided to members. The report includes services provided by language, as well as number of unfilled requests. The Cultural and Linguistic Services Subcommittee (CLSS) and the Health Care Quality Committee (HCQC) review a quarterly language services trending report and make recommendations when there is non-compliance. Provider or vendor education

and/or CAPs may be put into place to address non-compliance and monitored by the CLSS.

1.3. Member experience surveys include questions regarding the experience of limited English proficient members in obtaining interpreter services. Surveys solicit feedback from members regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services received.

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1.3.1. The Alliance conducts ongoing CG-CAHPS surveys post primary care appointments and annual CAHPS surveys. See Alliance policy *QI-117 Member Satisfaction Survey.*

1.3.1.1. The CG-CAHPS and CAHPS surveys are translated into the Alliance threshold languages and sent in the member's preferred language.

1.3.2. The Alliance also conducts an annual timely access survey focused on language assistance services designed to satisfy § 1300.67.2.2 California Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements. The survey will:

1.3.2.1. Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services.

1.3.2.2. Inform enrollees of their right to obtain an appointment within each of the time-elapsed standards, and their right to receive interpreter services at that appointment.

1.3.2.3. Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:

1.3.2.3.1. Coordination of appointments with an interpreter;

1.3.2.3.2. Availability of interpreters who speak the enrollee's preferred language; and

1.3.2.3.3. Quality of interpreter services received.

1.3.2.4. Be translated into the enrollee's preferred language, in those situations where the plan is aware of the enrollee's preferred language; and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by the Department of Health Care Services.

1.3.3. All surveys are sent with the Non-Discrimination Notice and Taglines members are invited to communicate with the Alliance to complete the survey by telephone in their preferred language. The taglines are written in the top 15 languages spoken by limited English proficient individuals as determined by DHCS.

1.4. The Alliance provider satisfaction survey includes questions to receive provider perspectives and concerns with the Alliance language assistance program. Questions include soliciting feedback regarding coordination of appointments with an interpreter, the availability of interpreters based on the needs of an enrollee and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

1.4.1. The Alliance conducts a provider satisfaction survey annually.

1.4.2. See Alliance policy *QI-118 Provider Satisfaction Survey* for details.

1.5. Grievance and Appeals addresses C & L grievances according to their timelines (See *G&A-003 Grievance Receipt, Review and Resolution*) and creates a quarterly report of member grievances and appeals related to cultural and linguistic access to services and quality of services. The CLSS and the HCQC review a quarterly C & L related grievances trending report and make recommendations when there is non-compliance. When necessary, concerns are presented at Joint Operations Meetings (JOMs), providers receive reeducation and/or CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

1.6. Potential quality issues (PQIs) related to quality of language (QOL) may be reported by any member, staff, or provider as a part of our PQI process (See policy and procedure *QI-104 – Potential Quality of Care Issues (PQIs).* QOL PQIS are addressed to ensure quality concerns are investigated, member's interpreter services need and any re-education for providers is addressed. When necessary, CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

1.7. Provider Services keeps an updated list of all contracted providers, which include their gender and their language and disability access capacity. Providers report any updates to language and access capacity at least quarterly. Changes are updated monthly in the Alliance data systems and made available to members, potential members, and the public in the Provider Directory online or in print upon request. The CLSS and HCQC review a quarterly trending report on provider language capacity and make and monitor recommendations for network changes to meet the language needs of the Alliance membership.

2. Bilingual Staff and Vendor Language Capacity. The Alliance also monitors the linguistic capabilities of interpreters and bilingual staff.

2.1. All bilingual employees must complete an assessment prior to offering any interpretation services to members. The Human Resources Department conducts the assessments. See *CLS-010 CLS Staff Training* for details. Each assessed employee must:

2.1.1. Demonstrate proficiency in both English and the other language(s) being assessed

2.1.2. Reveal a fundamental knowledge in health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed Demonstrate training and education in interpreting ethics, conduct and confidentiality

The Alliance's Human Resources Department maintains a report listing all assessed bilingual employees, their linguistic capabilities, and their qualifications as clinical or non-clinical interpreters. The report is reviewed by the CLSS annually.

2.2. The QI Department monitors the contract with our languages service vendors and requests documentation on capacity and assessment of their interpreter staff.

2.2.1. A receipt/log of all requested interpretation services is kept demonstrating the availability of interpreter services to all members including the interpretative language being requested, date of service, and who provided the interpretation services.

2.2.2. The QI Department requests and reviews a yearly update of certifications of interpreters used through interpreter services vendors.

2.2.3. The Communications and Outreach Department keeps a log of all translated documents and attestation of translation accuracy.

3. Availability of Practitioners to meet the Cultural, Ethnic, Racial and Linguistic needs of members.

3.1. Annually, the Alliance assesses the cultural, ethnic, racial and linguistic needs of its members. Elements assessed include:
- 3.1.1. Member preferred language
- 3.1.2. Member Race/Ethnicity
- 3.1.3. Member Cultural Needs

3.2. Annually, the Alliance assesses the characteristics of network providers and determines if the member needs are met by the network. Elements assessed include:
- 3.2.1. Provider language capacity
- 3.2.2. Member survey results
- 3.2.3. Cultural and linguistic services grievances

3.3. Adjustments are made to the practitioner network to meet the cultural, ethnic, racial, and linguistic needs of members within defined geographical areas. Adjustments may include:
- 3.3.1. Requiring the completion of the cultural competency and sensitivity training
- 3.3.2. Making culturally and linguistically appropriate health education materials available to providers
- 3.3.3. Recruiting practitioners whose cultural and ethnic background are similar to the underrepresented member population.
- 3.3.4. The Alliance documents areas for improvement and recommendations in the annual "Availability of Practitioners to meet the Cultural Needs and Preferences and Preferences" report.

4. C & L Monitoring Reporting Structure

4.1. The QI Department receives all monitoring reports.

4.2. Reports are presented to the CLSS and forwarded to the HCQC for input and approval.

4.3. A summary of the results is shared with the Member Advisory Committee (MAC) for input and suggested improvements.

4.4. The Quality Department collaborates with internal Alliance departments and external providers to provide and implement new approaches or enhancements to existing services to ensure appropriate access and language assistance services and implements CAPs when necessary.

DEFINITIONS / ACRONYMS

CLS	Cultural and Linguistic Services
CAP	Corrective Action Plan
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CG – CAHPS	Clinician and Group CAHPS survey
CLSS	Cultural and Linguistic Services Subcommittee – a subcommittee of the HCQC
DHCS	Department for Health Care Services
HCQC	Health Care Quality Committee – a committee of the Alliance Board of Governors
JOM	Joint Operations Meetings

MAC	Member Advisory Committee
MRR	Medical Record Review
LEP	Limited English Proficient
PQI	Potential Quality Issues: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.
QI	Quality Improvement
QOL	Quality of Language

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

REVISION HISTORY

2/13/2015, 3/24/2016, 3/9/2017, 5/25/2017, 10/12/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023

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	Compliance Monitoring of C & L Program
G&A-003	Grievance Receipt, Review and Resolution
QI-101	Quality Improvement Program
QI-104	Potential Quality of Care Issues
QI-105	Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-117	Member Satisfaction Survey
QI-118	Provider Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Title 28, CCR 1300.67.04;1300.67.2.2
California Code, Health and Safety Code – HSC 1367.03
DHCS Contract, Exhibit A, Attachment 9, Section 14

MONITORING

This policy will be reviewed annually to ensure effectiveness and it meets contractual and regulatory standards.

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

POLICY AND PROCEDURE

Policy Number	CLS-011
Policy Name	Compliance Monitoring of Cultural and Linguistic Services Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	~~Health Care Quality~~Quality Improvement and Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") monitors, improves, and evaluates the established Cultural and Linguistic Services (CLS) Program as a part of the Alliance's Quality Improvement Program. As part of the examination, all processes related to providing cultural and linguistic services are monitored including:

A. Quality Improvement Program Work Plan activities related to language assistance programs.
B. Reports on Alliance provision of language services to members, including interpretation, translation, and request for alternative formats.
C. Member and provider grievances and complaints and potential quality issues related to cultural and linguistic services.
D. Information with regards to the Alliance's member language needs and demographic profile.
E. The Alliance's staff bilingual qualifications, training requirements and training materials
F. Network providers' compliance to requirements and ability to meet the cultural and linguistic needs of members.

The Alliance's Quality Improvement (QI) Department is responsible for monitoring the Cultural and Linguistic Services Program and evaluating its effectiveness. The Alliance's Quality Improvement Program and Language Assistance Program work plan updates are reported to the Health Care Quality Committee (HCQC) for recommendations. Additionally, the Alliance's Compliance Department oversees external cultural and linguistic services delegated to entities through annual auditing activities to ensure compliance is met with regulatory and contractual standards. If deficiencies are cited, the Alliance will issue a corrective action plan (CAP) to the delegate entity to ensure those deficiencies are fully resolved prior to closing out the audit.

The QI Department monitors the language assistance services of its directly contracted provider network to ensure they 1) meet the cultural and linguistic needs of Alliance members and 2) that Alliance providers continuously abide by the standards set forth in the Alliance's Department of Health Care Services (DHCS) contract and all state and federal regulatory requirements. The Alliance takes immediate action when deficiencies are identified, and when necessary, CAPs are created for providers and monitored to ensure ongoing problematic issues are addressed.

PROCEDURE

1. ~~Provider~~ Language Assistance ~~Compliance~~Services Monitoring

1.1. Through facility site reviews, the following are reviewed, and CAPs are put into place per *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs) and Physical Accessibility Review Surveys (PARS)* as needed:

1.1.1. Twenty-four/seven (24/7) access to interpreter services for LEP members.

1.1.2. Interpreter services are made available in identified threshold languages.

1.1.3. Persons providing language interpreter services on site demonstrate training in medical interpretation, including conversational fluency, medical terminology for medical staff and non-medical staff. This must be documented.

1.1.4. The Medical Record Review (MRR) checks if the primary language and linguistic services needs of non- or limited-English proficient (LEP) or hearing-impaired persons as well as any refusal to use professional interpreter services are prominently noted.

1.1.5. Documentation of site personnel receiving information and/or training on cultural and linguistic appropriate services.

1.1.6. Verified evidence of staff training or written cultural and linguistic information on site and explanation of how to use the information.

1.1.7. Confirmation that site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act. Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings.

1.2. The QI Department reviews monthly reports of ~~in-person~~ language services provided to members. The report includes services provided by language, as well as number of unfilled requests. The Cultural and Linguistic Services Subcommittee (CLSS) and the Health Care Quality Committee (HCQC) review a quarterly language services trending

report and make recommendations when there is non-compliance. Provider or vendor education and/or CAPs may be put into place to address non-compliance and monitored by the CLSS.

1.3. Member experience surveys include questions regarding the experience of limited English proficient members in obtaining interpreter services. Surveys solicit feedback from members regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services received.

~~1.1.8.~~1.3.1. The Alliance conducts ongoing CG-CAHPS surveys post primary care appointments and annual CAHPS surveys. See Alliance policy *QI-117 Member Satisfaction Survey*.

1.3.1.1. The ~~member experience~~CG-CAHPS and CAHPS surveys are~~y is~~ translated into the Alliance threshold languages and sent in the member's preferred language.

1.3.2. The Alliance also conducts an annual timely access survey focused on language assistance services designed to satisfy § 1300.67.2.2 California Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements. The survey will:

1.3.2.1. Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services.

1.3.2.2. Inform enrollees of their right to obtain an appointment within each of the time-elapsed standards, and their right to receive interpreter services at that appointment.

1.3.2.3. Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:

1.3.2.3.1. Coordination of appointments with an interpreter;

1.3.2.3.2. Availability of interpreters who speak the enrollee's preferred language; and

1.3.2.3.3. Quality of interpreter services received.

1.3.2.4. Be translated into the enrollee's preferred language, in those situations where the plan is aware of the enrollee's preferred language; and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by the Department of Health Care Services.

~~1.1.9.~~1.3.3. All surveys are sent with the Non-Discrimination Notice and Taglines members are invited to communicate with the Alliance to complete the survey by telephone in their preferred language. The taglines are written in the top 15 languages spoken by limited English proficient individuals as determined by DHCS.

1.4. The Alliance provider satisfaction survey includes questions to receive provider perspectives and concerns with the Alliance language assistance program. Questions include soliciting feedback regarding coordination of appointments with an interpreter, the availability of interpreters based on the needs of an enrollee and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

1.4.1. The Alliance conducts a provider satisfaction survey annually.

~~1.2.~~1.4.2. See Alliance policy *QI-118 Provider Satisfaction Survey* for details.

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~~1.3.~~1.5. Grievance and Appeals addresses C & L grievances according to their timelines (See *G&A-003 Grievance Receipt, Review and Resolution*) and creates a quarterly report of member grievances and appeals related to cultural and linguistic access to services and quality of services. The CLSS and the HCQC review a quarterly C & L related grievances trending report and make recommendations when there is non-compliance. When necessary, concerns are presented at Joint Operations Meetings (JOMs), providers receive reeducation and/or CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

~~1.4.~~1.6. Potential quality issues (PQIs) related to quality of language (QOL) may be reported by any member, staff, or provider as a part of our PQI process (See policy and procedure *QI-104 – Potential Quality of Care Issues (PQIs)*. QOL PQIS are addressed to ensure quality concerns are investigated, member's interpreter services need and any re-education for providers is addressed. When necessary, CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

~~1.5.~~1.7. Provider Services keeps an updated list of all contracted providers, which include their gender and their language and disability access capacity. Providers report any updates to language and access capacity at least quarterly. Changes are updated monthly in the Alliance data systems and made available to members, potential members, and the public in the Provider Directory online or in print upon request. The CLSS and HCQC review a quarterly trending report on provider language capacity and make and monitor recommendations for network changes to meet the language needs of the Alliance membership.

2. **Bilingual Staff and Vendor Language Capacity**. The Alliance also monitors the linguistic capabilities of interpreters and bilingual staff.
   2.1. All bilingual employees must complete an assessment prior to offering any interpretation services to members. The Human Resources Department conducts the assessments. See *CLS-010 CLS Staff Training* for details. Each assessed employee must:
      2.1.1. Demonstrate proficiency in both English and the other language(s) being assessed
      2.1.2. Reveal a fundamental knowledge in health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed Demonstrate training and education in interpreting ethics, conduct and confidentiality

      The Alliance's Human Resources Department maintains a report listing all assessed bilingual employees, their linguistic capabilities, and their qualifications as clinical or non-clinical interpreters. The report is reviewed by the CLSS annually.

   2.2. The QI Department monitors the contract with our languages service vendors and requests documentation on capacity and assessment of their interpreter staff.
      2.2.1. A receipt/log of all requested interpretation services is kept demonstrating the availability of interpreter services to all members including the interpretative language being requested, date of service, and who provided the interpretation services.

2.2.2. The QI Department requests and reviews a yearly update of certifications of interpreters used through interpreter services vendors.
2.2.3. The Communications and Outreach Department keeps a log of all translated documents and attestation of translation accuracy.

3. Availability of Practitioners to meet the Cultural, Ethnic, Racial and Linguistic needs of members.

3.1. Annually, the Alliance assesses the cultural, ethnic, racial and linguistic needs of its members. Elements assessed include:
3.1.1. Member preferred language
3.1.2. Member Race/Ethnicity
3.1.3. Member Cultural Needs

3.2. Annually, the Alliance assesses the characteristics of network providers and determines if the member needs are met by the network. Elements assessed include:
3.2.1. Provider language capacity
3.2.2. Member survey results
3.2.3. Cultural and linguistic services grievances

3.3. Adjustments are made to the practitioner network to meet the cultural, ethnic, racial, and linguistic needs of members within defined geographical areas. Adjustments may include:
3.3.1. Requiring the completion of the cultural competency and sensitivity training
3.3.2. Making culturally and linguistically appropriate health education materials available to providers
3.3.3. Recruiting practitioners whose cultural and ethnic background are similar to the underrepresented member population.
3.3.4. The Alliance documents areas for improvement and recommendations in the annual "Availability of Practitioners to meet the Cultural Needs and Preferences and Preferences" report.

4. C & L Monitoring Reporting Structure

4.1. The QI Department receives all monitoring reports.
4.2. Reports are presented to the CLSS and forwarded to the HCQC for input and approval.
4.3. A summary of the results is shared with the Member Advisory Committee (MAC) for input and suggested improvements.
4.4. The Quality Department collaborates with internal Alliance departments and external providers to provide and implement new approaches or enhancements to existing services to ensure appropriate access and language assistance services and implements CAPs when necessary.

DEFINITIONS / ACRONYMS

CLS	Cultural and Linguistic Services
CAP	Corrective Action Plan
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CG – CAHPS	Clinician and Group CAHPS survey
CLSS	Cultural and Linguistic Services Subcommittee – a subcommittee of the HCQC
DHCS	Department for Health Care Services

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HCQC	Health Care Quality Committee – a committee of the Alliance Board of Governors
JOM	Joint Operations Meetings
MAC	Member Advisory Committee
MRR	Medical Record Review
LEP	Limited English Proficient
PQI	Potential Quality Issues: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.
QI	Quality Improvement
QOL	Quality of Language

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

REVISION HISTORY

2/13/2015, 3/24/2016, 3/9/2017, 5/25/2017, 10/12/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023

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	Compliance Monitoring of C & L Program
G&A-003	Grievance Receipt, Review and Resolution
QI-101	Quality Improvement Program
QI-104	Potential Quality of Care Issues
QI-105	Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-117	Member Satisfaction Survey
QI-118	Provider Satisfaction Survey

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Title 28, CCR 1300.67.04~~; Language Assistance Program~~1300.67.2.2
California Code, Health and Safety Code – HSC 1367.03
DHCS Contract, Exhibit A, Attachment 9, Section 14

MONITORING

This policy will be reviewed annually to ensure effectiveness and it meets contractual and regulatory standards.

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

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

POLICY STATEMENT

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

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

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

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

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

PROCEDURE

Scope

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

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

Referral Screening

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

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

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

ii. Routine – referral opened within 5 calendar days.

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

Case Manager Role in Care Coordination Case

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

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

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

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

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

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

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

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

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

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

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

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

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

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

r. Ensuring no duplication of services occur

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

for a specific identified care gap such as medication affordability or environmental safety. The assistance that the CC staff provides towards a CCM case is generally of a short-term nature and is directed as specified in the Plan of Care.

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

Referral Processing Timeframes

1. The CC designee processes referral requests within one working day from receipt of the request for care coordination services.
2. Recipients of the CC referral shall open the referral according to the case priority classification:
    a. Urgent – referral opened and started within 1 working day
    b. Routine – referral opened and started within 5 calendar days

c. Unknown at time of referral.

3. Follow-up to referrals will be made as specified by the referral need, but no later than 30 calendar days after the referral is made.

Children with Special Health Care Needs (CSHCN)

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

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

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

Direct Observed Therapy for TB

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

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

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

Coordination with IHSS

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

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

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

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

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

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

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

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

Referrals to CCM

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

A CCM Referral Form is at Attachment 1. However, a referral form is not necessary, and all information can be taken by phone or any other means.

5. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on data entry are described in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.

1. **Referrals from CCM to CC**

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

DEFINITIONS

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

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

CM-004 Care Coordination of Services

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, 2/24/2023

REFERENCES

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

MONITORING

Referrals to and from CCM are monitored through:

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

Monitoring for IHSS referrals:

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

ALAMEDA Alliance FOR HEALTH

Case Management (CM) Program Referral Form

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

INSTRUCTIONS

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

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

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

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

SECTION 2: PATIENT INFORMATION

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

SECTION 3: REFERRAL INFORMATION

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

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

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

Specific action item request(s):

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

CMDM_PRVDRS_ PROG REF FORM 03/2021

POLICY AND PROCEDURE

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

POLICY STATEMENT

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

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

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

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

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

PROCEDURE

Scope

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

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

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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.

~~Care Coordination~~Case Manager Role in Care Coordination Case

1. CM staff assignments ~~of assessments~~ will be made based on workload and specialization.

~~1.~~ CM referrals meeting ~~:~~

a. Care Ceoordination criteria will be assigned to ~~the~~ appropriate CC ~~Care Coordination~~ staff (Nurse Case Manager, Health Navigator, or Social Worker) for assessment.

~~a.~~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 ~~Health Navigator~~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;

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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;

~~b. Health Navigators~~Arranging ~~may arrange~~ ~~for~~ of services not directly related to medical needs, i.e., non-medical transportation, and community resources;

h.

~~c. This includes but is not limited to referring~~Referring a member for In-Home Supportive Services (IHSS);

i.

~~d. Members will be reassessed~~Reassing as necessary per the population RSS and Risk Tiering requirements;~~.~~

j.

k. ~~When a member is provided IHSS services,~~ Continuing to provide coordination of care and ~~Basic Population Health Management (~~BPHM ~~) will continue to be provided~~ 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;

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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

~~1.~~r. Ensuring no duplication of services occur

~~2.~~3.The ~~Health Navigator~~CC staff provides ~~case management~~care coordination for members not meeting criteria for CCM. The ~~Health Navigator~~CC staff also assists ~~the CM staff~~ 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 ~~Health Navigator~~CC staff provides ~~to the member~~towards a CCM case is generally of a short-term nature and is directed as specified in the Plan of Care.

~~3.~~4.The ~~Health Navigator~~CC staff shall arrange these services and document such within the Clinical Information System.

5. ~~Health Navigators~~CC staff may also assist CM staff with care coordination needs. Referrals are made from the CM process to the following:

~~4.~~

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.

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~~5.~~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

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

1. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;
2. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies AAH that IHSS is no longer needed for the Member;
3. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;
4. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements
5. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.
6. To facilitate coordination, AAH has MOUs with each county IHSS agency within AAH's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*). The MOU delineates the roles and responsibilities of AAH and IHSS in providing IHSS to the Members.

~~1.~~

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

~~f~~

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.

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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*.

Referrals from CCM to CC

1. ~~1.~~ 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.*

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DEFINITIONS

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

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

REVISION HISTORY

12/05/2012, 03/01/2016, 03/21/2019, 04/16/2019, 05/21/2020, 05/21/2021, 9/16/2021, 3/22/2022, 2/24/2023

REFERENCES

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

MONITORING

Referrals to and from CCM are monitored through:

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

Monitoring for IHSS referrals:

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

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ATTACHMENT 1

ALAMEDA Alliance FOR HEALTH

Case Management (CM) Program Referral Form

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

INSTRUCTIONS

Please return the completed form via mail, email or fax:
Alameda Alliance for Health
ATTN: Case and Disease Management Department (CMDM)
1240 South Loop Road, Alameda, CA 94502
Email: **deptcmdm@alamedaalliance.org**
Fax: **1.510.747.4130**

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

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

SECTION 2: PATIENT INFORMATION

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

SECTION 3: REFERRAL INFORMATION

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

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

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

Specific action item request(s):

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

CMDM_PRVDRS_ PROG REF FORM 03/2021