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Section I: Care Management Programs and Community Support Services

I1: Utilization Management

CenCal Health maintains a Utilization Management (UM) Program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered services for members. "The UM program will be consistent and in accordance with DHCS guidelines (APL 21-011, *Grievance and Appeal Requirements, Notice and "Your Rights" Templates*; and the *H&S Code 1367.01*) The Chief Medical Officer, Medical Directors, and qualified licensed healthcare professionals are responsible for the utilization review process.

CenCal Health's Utilization Management Program helps members to get the best quality healthcare by assuring that medically necessary services are provided at the right time and at the most appropriate service level or care setting covered under their benefit package. UM staff work with providers to evaluate services for medical appropriateness and timeliness.

- Authorization decisions are made on Medical Necessity of a requested health care services and are consistent with criteria or guidelines supported by clinical principles that are evidenced based.
- UM does not pay, offer financial incentives, or reward providers, employees or other individuals for utilization management decisions.
- UM's policies and procedures related to authorization reviews are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- CenCal Health makes all relevant Utilization Management policies and procedures available upon request.
- UM activities are integrated into the Quality Improvement Systems to review requests, denials, deferrals, modifications, appeals and grievances to the medical director.
- CenCal Health maintains timelines and process that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Limitations (NQTL) more stringently in mental health or substance use disorder services than are imposed on medical/surgical services.

I2: Enhanced Care Management

Effective July 1, 2022, CenCal Health offers Enhanced Care Management (ECM) a new statewide Medi-Cal benefit available to selected "Populations of Focus" as part of CalAIMs multi year initiatives. ECM is designed to address the clinical and non-clinical needs of the highest-need Members through intensive whole person care coordination. ECM has a phased implementation approach based on Department of Health Care Services defined Populations of Focus (POF).

Phase 1: 7/1/2022

- Individuals & Families Experiencing Homelessness (POF 1)
- Adults At Risk for Avoidable Hospital and Emergency Department (ED) Utilization(POF 2)
- Adults with SMI/SUD Needs (POF 3)

Phase 2: 1/1/2023

- Adults Living in the Community At Risk for Institutionalization (POF 5)
- Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)

Phase 3: 7/1/2023

Children & Youth Populations of Focus

- Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness (POF 1)
- Children and Youth At Risk for Avoidable Hospital or ED Utilization (POF 2)
- Children and Youth with Serious Mental Health and/or SUD Needs (POF 3)
- Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition (POF 7)
- Children and Youth Involved in Child Welfare (POF 8)
- Children and Youth with Intellectual/Developmental Disability (I/DD) (POF 9)
- Pregnant or Postpartum Youth (POF 10)

Phase 4: 1/1/2024

- Individuals Transitioning from Incarceration (POF 4)
- Birth Equity Population of Focus (Adults and Youth) (POF 10)

ECM has been available for adults with intellectual or developmental disabilities (I/DD) and Pregnant and Postpartum from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus

Members who are eligible for ECM are assigned to an ECM provider who has the expertise in serving the various populations of focus and will provide Outreach to engage member to enroll in the program. Members who agree to participate in ECM will be assigned a Lead Care Manager who will meet the member wherever they are (e.g., Street, Shelter, Skilled Nursing Facility) and who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for Members to get the right care at the right time.

The ECM provider will offer the following seven (7) ECM core components

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion Activities
- Comprehensive Transitional Care Planning
- Member and Family Supports
- Coordination of and Referral to Community and Support Services

Primary Care Providers (PCP) are an integral part of the member's care coordination team and will be notified when an ECM eligible member has been enrolled in the ECM program. The notification will include name and contact information of the member's assigned ECM provider.

Referring Members to Enhanced Care Management

Providers are welcome to refer members who may benefit from ECM. ECM Referrals can also be submitted by but not limited to members or their Authorized Representatives, Community and Government agencies. To submit a referral request for ECM or to learn more about the Population of Focus criteria, Click here, or call our Member Services Department at 1-877814-1861. We ask that you please allow ten (10) business days to determine eligibility and assign an ECM provider for Member Outreach.

To learn more about ECM please click here www.cencalhealth.org/providers/calaim/

CenCal Health Policy Reference:
MM-CM121 Enhanced Case Management (ECM)

I3: Care Management (Complex and Care Coordination)

CenCal Health's care management programs support members with the appropriate level of care management through person-centered interventions and individualized care plans based on the intensity of health and social needs and services required. Assessments are completed to ensure members who are identified as having medical, behavioral, oral, Long Term Services and Supports and social determinants of health needs receive the necessary services to gain optimum health.

CenCal Health has five variations of care management and care coordination services:

- Enhanced Care Management (ECM)
- Case Management (Complex and Care Coordination)
- Care Transitions
- Pediatric Whole Child Program
- Disease Management Program

Each of the Care management services promote quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational heath of individuals. It includes on going assessing of needs, planning, implementing, coordinating, and evaluating health-related service options. Members may self-refer to the Care Management programs. Referrals can also come from a variety of sources, such as the PCP, Specialist Physician, Utilization Management team members, Medical Director, member/family, internal departments, and community based organizations. Providers may request assistance in the development of care plans for the treatment of members with complex or serious medical conditions.

To learn more about ECM please see the Enhanced Care Management Section I2.

To refer a member to any of our Care Management Programs, providers can complete and submit a Case Management Referral Form located at www.cencalhealth.org. The completed referral form may be faxed to (805) 681-8260 or the provider can call the Health Services Central Line at (805) 562-1082, option # 2 to obtain assistance with referring a member. The CM department will acknowledge referral and providers will be informed of the member's appropriateness for CM services. Once CM determines a member is appropriate for case management services and the member or authorized representative agrees to the service, CM will begin to work collaboratively with the member, the member's family, physician(s), and other healthcare professional(s).

Reference Link:
Case Management Referral Form
https://www.cencalhealth.org/providers/case-management/

Care Management

CenCal Health Care Management ensure that the needs of member are met across the continuum of care. Members are provided appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. Coordination of care is done collaboratively with member and their PCP, specialists and other members of the interdisciplinary team. Coordination of care also includes coordinating health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of CenCal Health's Provider Network, and with Community Supports and other community-based resources, even if they are not Covered Services under CenCal Health , to address Members' needs and to mitigate impacts of Social Determinants of Health .

Referrals to Care Management

Members may be eligible for Care management Services if they meet one of the following criteria:

- Have complex or chronic medical conditions, including those affecting multiple organ systems or complicated therapy that warrant closer monitoring (e.g. CHF, uncontrolled diabetes, transplants, cancer, exacerbating asthma, ESRD or COPD),
- Have suffered a traumatic/ catastrophic injury or illness.
- Is non-adherent to medical or treatment regimen (e.g., two or more missed appointments, misuse of medications, poor dietary adherence).
- Are high utilizers of EDs (e.g., two visits in three months).
- Over/under utilize medical services that are available to them.
- Have frequent hospital admissions (same or different diagnosis) and readmissions. (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year).
- Need coordination of care for medically necessary services outside of the provider network.
- Require assistance following a particular medical regimen (e.g., pre-surgical).
  Have self-care deficits requiring one-to-one or group health education to promote well- being.
- Have high psychosocial risk factors that have or can result in significant negative health outcomes.
- Assistance with coordination to community resources (e.g. Food Bank, Meals on Wheels, Family resource Centers, and/or Unity Shop)
- Members with fragile conditions, including cognitive changes needing assistance with care coordination or care transitions.
- Require care coordination with specialized programs, such as Local Education Agency, Regional Centers, Drug Medi-Cal Organization Delivery System and County Mental Health.
- Members who need transition from one care setting to another (e.g. from acute care facility to skilled nursing facility (SNF), SNF to home or other alternative living situations, home to SNF, and non-contracted to Contracted SNF).
- Or, if a member's estimated health risk is high based on the integration of utilization-based and/or non-utilization-based member attributes that, upon CenCal Health Case Management team's verification, indicate a need for Case Management support.

CenCal Health's Care Management (CM) services are provided by Care Managers that consist of registered nurses, social workers, and clinical support associates via telephone. Care Management services are offered available to all members, both adult and pediatric members. Care management programs vary depending on the needs of the member.

CenCal Health's CM program includes physical and psychosocial assessment, planning, facilitation, care coordination, evaluation and advocacy for service and support options to meet a member's and/or their

family/representative's comprehensive healthcare needs to promote quality and cost- effective outcomes. The complexity and intensity of the member's needs determines the level of service. The CM team not only provides education materials and encourages the member to learn self-management skills; they also coordinate access to appropriate services and resources.

A Care Manager will work with the Provider, the member and the member's family in an effort to help decrease the risk of complications, support coordination of care and provide education. The Care Manager will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury.

CenCal Health Policy Reference:
MM-CM114 Care Management Program Planning and Coordination

Reference Links:
DHCS All Plan Letter (APL 23-018, *Managed Care Health Plan Transition Policy Guide*).
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-018.pdf

I4: Care Transitions

CenCal Health provides Transitional Care Services (TCS) to Members transferring to one setting, or level of care, to another. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities to home or community-based settings, Community Supports (e.g. Recuperative Care), post-acute care facilities or Long-Term Care settings. The goal of this program is to improve transitions of care for our members by improving quality of care and avoid preventable readmissions.

The Transitional Care team will collaborate with the facility staff and/or Member family/caregiver to facilitate the transition of care and ensure members identified as high risk per the CalAIM: population Health Management (PHM) Policy Guide criteria, are receiving care at the right setting and will receive the necessary services upon discharge. Transitional Care Services includes:

A. Completion of a discharge risk assessment to evaluate a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse.
B. Completion of a discharge planning document
C. Medication reconciliation
D. Post-discharge services and follow-up for PCP/ambulatory appointments.
E. Linkage if needed to longer-term care coordination services, such as Enhanced Care Management, Complex Care Management, and Community Supports etc.

CenCal Health Policy Reference:
HS-MM44 Transitional Care Policy

Reference Links:
DHCS All Plan Letter (APL 21-005, *California Children's Services Whole Child Model Program*)
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-005.pdf

I5: Pediatric Whole Child Model

The Pediatric Whole Child Program has dedicated nurses and nonclinical professionals who assist providers with timely processing of necessary specialty referrals and service requests, as well as provide care coordination and care transition services to members. The Pediatric Program is designed as a "one-stop shop" for providers to obtain covered services for children and youth under the age of 21. The Pediatric team is

comprised of a group of specialized staff who perform both utilization review and case management activities. Like CenCal Health's Adult Case Management Program, pediatric care coordination and care transition services are dependent on active family and/or caregiver participation.

The Pediatric Team processes, facilitates, and/or coordinates:

- Referrals (RAF)
- Prior authorization requests (50-1, 18-1, 20-1)
- Care management and coordination of healthcare services or with specialized programs, such as CCS, TCRC, LEA, etc.
- Care transition from one setting to another
- Individualized (or family) guidance, education, community resources
- Transition Planning to adulthood

Providers can refer a child or youth under the age of 21 to the Pediatric Whole Child Program care management team by completing a CM Referral Form which can be found at www.cencalhealth.org, under the Provider tab. Authorization requests (50-1, 18-1, 20-1) and referrals (RAF) be submitted via the Provider Portal.

CenCal Health Policy Reference:
MM-CM14 Program Planning and Coordination

I6: Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations. Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members.

Community Supports are optional services for CenCal Health to offer and are optional for members to receive. As of January 1, 2024, CenCal Health has elected to offer the following Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals
- Sobering Center
- Recuperative Care
- Short-term Post Hospitalization Housing
- Day Habilitation
- Respite Services Personal Care and Homemaker Services

Supportive Services

Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers, if they have appropriate experience.

Members Eligible to Receive Community Supports

CenCal Health must determine eligibility for a pre-approved Community Supports using the DHCS Community Supports definitions, which contain specific eligibility criteria for each Community Supports. CenCal Health is also expected to determine that a Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, CenCal Health must apply a consistent methodology to all members within a particular county.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, an CenCal Health member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports provider. Community Support Information and Referral Forms are on CenCal Health's website.

Community Supports Authorizations

Authorization through CenCal Health is required for members to obtain Community Supports. CenCal Health staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, the required Information and Referral form associated to that specific Community Supports service, completion of a Member Care Plan by the ECM Provider (if receiving ECM services), and decision-making by CenCal Health. If approved after CenCal Health's assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime.

Utilization management procedures will consider the goals of each Community Supports and CenCal Health will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the Utilization Management Department, along with any necessary documentation for review. Documentation for the reauthorization may be submitted through the Provider Portal.

CenCal Health Policy Reference:

HS-MM23 Recuperative Care
HS-MM24 Medically Tailored Meals Program
HS-MM25 Housing Transition Navigation Services
HS-MM26 Housing Deposits
HS-MM27 Housing Tenancy and Sustaining Services
HS-MM28 Sobering Centers

Reference Links:

DHCS APL 21-017 Community Supports Requirements
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-017.pdf