CenCal HEALTH®
Local. Quality. Healthcare.

2024

Quality Improvement and Health Equity Transformation Program (QIHETP) Description

Review
Quality Improvement and Health Equity Committee:
2/29/2024

Board of Directors:
3/20/2024

Table of Contents

Table of Contents (continued)

I. CENCAL HEALTH OVERVIEW

CenCal Health is the nation's oldest locally administered Medicaid Managed Care plan of its kind, having launched in 1983. Initially founded under the name *Santa Barbara Regional Health Initiative*, CenCal Health was created as a pilot program by the local Santa Barbara County medical community and the County Board of Supervisors. Utilizing the County Organized Health System (COHS) model, the California Department of Health Care Services (DHCS) contracts with CenCal Health to be the exclusive health plan serving full-scope Medi-Cal beneficiaries in Santa Barbara and San Luis Obispo counties. In 2008, CenCal Health assumed responsibility for the Medi-Cal program in San Luis Obispo County.

CenCal Health provides access to high-quality medical services and benefits to one in three people in Santa Barbara County and one in four in San Luis Obispo County, totaling over 240,000 members. CenCal Health contribute approximately $85 million monthly to the local economy, primarily through payments to healthcare providers who serve our membership.

CenCal Health works in partnership with its contracted network, which consists of over 5,000 local primary and specialty providers, hospitals in both counties, the local health departments, distinguished healthcare systems, Federally-Qualified Health Centers (FQHCs), Indian Health Centers, medical groups and individual physicians. This expansive provider network ensures that members have access to culturally and linguistically appropriate health care.

CenCal Health's work results in the delivery of innovative community-based health care services, better medical outcomes, and cost savings. CenCal Health is proof that a community-accountable, not-for-profit health plan can enhance the delivery of local, quality healthcare to the most vulnerable populations.

Commitment to Advance Quality and Health Equity for All

To meet the evolving goals of Medi-Cal as a whole person care program, CenCal Health will serve as a partner with health and social service organizations, facilitator of community integration and coordination, and leader in understanding and addressing issues of health equity.

CenCal Health embraces its role in partnership with other health providers, practitioners, social service leaders and government agencies to advance a coordinated approach to California Advancing and Innovating Medi-Cal (CalAIM) reforms. Through a focus on population health and greater emphasis on prevention and overall wellness, the reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve member health outcomes, including for members with the most complex needs. CalAIM drives fundamental changes in expectations for managed care and behavioral health systems, expanding services and supports, and improving transitions for high-risk patients whose health outcomes are driven, in part, by unmet social needs and systemic racism.

Led by DHCS, CalAIM has three primary goals:

1. Identify and manage member risk through whole person care approaches to address social drivers of health.
2. Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
3. Make Medi-Cal a more consistent and seamless system by reducing complexity and increasing flexibility.

A cornerstone to CalAIM, and CenCal Health's QIHETP, is the implementation of CenCal Health's Population Health Management (PHM) Program, a plan of action for addressing member needs across the continuum of care based on data-driven risk stratification, predictive analytics, identifying gaps in care, and standardized assessment processes. PHM aims to effectively help all Medi-Cal members by keeping them healthy via preventive and wellness services, assessing and identifying member risks to guide care management and care coordination needs, and identifying and mitigating social drivers of health to reduce disparities.

CenCal Health will continue its work to meet and exceed increasing quality standards and expectations, including achieving National Committee for Quality Assurance (NCQA) Health Plan and Health Equity accreditation status, ensuring PHM requirements are met, and expanding quality strategies as a top-quality performer among Medicaid plans nationally. CenCal Health's commitment to advancing health equity is further delineated in its 2024 QIHETP Work Plan.

II. MISSION, VISION, AND VALUES

Mission

To improve the health and well-being of the communities we serve by providing access to high quality health services, along with education and outreach, for our members.

Vision

To be a trusted leader in advancing health equity so that our communities thrive and achieve optimal health together.

Values

CenCal Health is guided by four key values:

- **Compassionate Service:** Serving and advocating for all customers with excellence.
- **Collaboration:** Coming together to achieve exceptional results.
- **Integrity:** Doing the right thing, even and especially when it is hard.
- **Improvement:** Continually improving to ensure our growth, success, and sustainability.

III. PURPOSE AND SCOPE

Purpose
The QIHETP's purpose is to establish objective methods for monitoring and systematically evaluating, and addressing necessary improvements to ensure CenCal Health members receive high quality and equitable health care (physical and behavioral). Through the QIHETP and in collaboration with providers and community partners, CenCal Health will work to continuously improve the structure, processes, and outcomes of care delivered to members in any setting on CenCal Health's behalf.

The process is illustrated and described in detail below:

- Assign responsibility for monitoring and evaluating quality improvement and health equity activities.
- Delineate the scope of quality of care, quality of service, patient safety, and member experience provided.
- Identify important aspects of quality of care, quality of service, patient safety, healthequity, and member experience provided.
- Use measurable indicators to routinely and systematically measure and monitor quality of care, quality of service, patient safety, and member experience based on current knowledge or proven industry methodologies.
- Identify comparable benchmarks and/or thresholds and goals for meaningful, industry-standard, performance indicators.
- Evaluate when benchmarks and/or when measurements fall outside thresholds or goals are met or unmet.
- Identify barriers and opportunities to improve or address problems and assess the potential for CenCal Health to mitigate each barrier and resolve identified problems.
- Based on identified barriers, design relevant, strong and timely interventions, and take action to improve or address identified problems.
- Evaluate the effectiveness of those actions using comparable measurements.
- Communicate results to the relevant committees, CenCal Health's Administration, departments, providers, members, and the public.
- At an appropriate interval re-evaluate performance based on the aforementioned process to assess quality. Based on findings implement new and/or adapted interventions as necessary.
- Continue quality improvement cycle (e.g., plan-do-study-act).

The QIHETP serves to ensure that all CenCal Health annual planned quality improvement and health equity activities focus on quality of care and delivery of services, patient safety, and member experience.

Scope
The scope of QIHETP process as it is performed at CenCal Health encompasses the following:

- Quality of clinical care services including, but not limited to:
  - Preventive services
  - Chronic disease
  - Perinatal care
  - Family planning services
  - Behavioral health care services

- Quality of nonclinical services including, but not limited to:
  - Availability
  - Accessibility
  - Coordination and continuity of covered services
  - Grievance process
  - Information standards

- Standards for patient safety including, but not limited to:
  - Facility site reviews
  - Credentialing of practitioners
  - Quality of care/peer review
  - Coordination and continuity of care (medical and behavioral)
  - The entire range of care provided, including all demographic groups, care settings, and types of services offered to members with diverse cultural, linguistic, and/or complex health needs.

- Standards in member experience including, but not limited to:
  - Satisfaction surveys and assessments
  - Monitoring of member complaints
  - Phone queue monitoring
  - Access measurement
  - Member grievance timeliness

IV. GOALS AND OBJECTIVES

CenCal Health's QIHETP aims to improve the quality, equity, and safety of clinical care and services provided to members through the plan's provider network and its programs and services. Specific goals are established through CenCal Health's quality committee structure that support of the overall QIHETP purpose. The goals and objectives focus on structure, process, and outcomes. All goals are reviewed annually and revised as needed to ensure compliance with regulatory requirements and to meet evolving membership needs.

Mechanisms to identify goals include, but are not limited to:

- Activities to monitor and evaluate quality of care and service delivered

- Issues or opportunities for improvement identified through trending data over time
- Outcomes based on the prior year's evaluation process
- Monitoring of key performance indicators (e.g., Medi-Cal Accountability Care Set, HEDIS measures)
- Member and provider partner feedback
- Regulatory requirements
- NCQA accreditation standards

CenCal Health aligns its goals with DHCS' Comprehensive Quality Strategy Goals and Guiding Principles identified below.

Quality Strategy Goals	Quality Strategy Guiding Principles
Engage members as owners of their own care. Keep families and communities via prevention. Provide early interventions for rising risk and patient-centered chronic disease management. Provide whole person care for high-risk populations, addressing social drivers of health.	Eliminate health disparities through anti-racism and community-based partnerships. Implement data-driven improvements that address the whole person. Ensure transparency, accountability, and member involvement.

Goals

- Develop and mainten program resources, program structure, and program processes that align with CenCal Health's unwavering commitment to the equitable quality care delivered in a timely and appropriate manner.
- Use a multidisciplinary committee structure to further achievement of QIHETP goals.
- Enhance the quality of clinical care (medical and behavioral health) delivery through the implementation of evidence-based practices, fostering a culture of continuous improvement, and ensuring patient-centered approaches that optimize health outcomes and member satisfaction.
- Ensure effective credentialing and re-credentialing processes compliant regulatory and accreditation requirements.
- Strengthen the safety of clinical care by implementing proactive measures to identify and mitigate risks, promoting a culture of transparency and open communication among network providers, and fostering rigorous adherence to clinical standards and best practices.
- Implement interventions that address the varied cultural, racial, ethnic, linguistic, and additional unique needs of members.

- Identify, develop, and implement mechanism to measure, monitor, and assess quality of care and services provided to members.
- Report quality improvement and health equity activities, including outcomes.
- Identify opportunities for improvement to take action on.
- Maintain and ensure provider network adequacy and access to care.
- Provide oversight of delegated entities, when applicable, to ensure compliance with regulatory requirements and the organization's standards.
- Elevate the quality of service provided to members through the implementation of patient-centered approaches, enhancing communication and responsiveness to needs and preferences, optimizing efficiency in service delivery processes, and continuously soliciting feedback to drive improvements.
- Measure and enhance the overall member experience by ensuring seamless navigation through healthcare services, providing personalized support and resources tailored to individual needs, fostering trust and satisfaction, and continuously refining processes to exceed member expectations and promote long-term engagement.
- Maintain compliance with federal/state requirements and accreditation requirements.

Objectives
QIHETP objectives focus on staffing, completion of quality improvement and health equity activities, and resources needed to reach program goals. Objectives will address:

- Planned activities and interventions that address the quality and safety of clinical care, service, and member experience.
- Improvement methodologies and assessments.
- Responsible staff.
- Timeframe.
- Monitoring of previously identified issues.
- Coordinated strategies within the organization to implement QIHETP.
- Completion of an annual evaluation.

QIHETP activities are tracked and recorded in the annual QIHETP Work Plan (see *Section XII. Work Plan* for additional detail).

V. AUTHORITY AND RESPONSIBILITY

A. Governing Body

CenCal Health's the Board of Directors is the Plan's governing body that promotes, supports, and has ultimate accountability, authority, and responsibility to ensure CenCal Health has a comprehensive and integrated Quality Improvement and Health Equity Transformation Program (QIHETP). On September 20, 2006, CenCal Health's Board of Directors approved delegation of quality activity oversight and responsibility to CenCal Health's Quality Improvement and Health Equity Committee (QIHEC), with the direct supervision of QIHETP activities by CenCal Health's Chief Medical Officer (CMO) in

collaboration with the Chief Health Equity Officer/Chief Customer Experience Officer. The Board of Directors promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations.

Board of Directors' Function

The Board of Directors' oversight of quality improvement and health equity functions require the following, including but not limited to:

- Appointing an accountable entity or entities responsible for the oversight of the QIHETP.
- Appointing a Board of Directors liaison to the accountable entity to assure effective oversight of the QIHETP and facilitate communication between the Board of Directors and the accountable entity.
- Review and annual approval of CenCal Health's overall QIHETP, including the:
    1. QIHETP Description
    2. QIHETP Work Plan
    3. Annual Evaluation of the preceding year's Work Plan
- Receiving, at minimum quarterly, written accountable entity progress reports subsequent to each meeting of the accountable entity that describe actions taken, progress in meeting QIHET Program objectives, and improvements made.
- Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards of the California Department of Health Care Services (DHCS) Contract and the DHCS Comprehensive Quality Strategy.

Board of Directors' Membership

CenCal Health is governed by a 13-member Board of Directors who are appointed for two year terms, with staggered member terms. The composition is determined in accordance with the following membership requirements as established by Health and Safety Code 101700.

- Three (3) members are elected or appointed officers or employees of Santa Barbara County, at least one of whom is a member of the Board of Supervisors.
- Two (2) members are elected or appointed officers or employees of San Luis Obispo County, at least one of whom is a member of the Board of Supervisors.
- Eight (8) members, are appointed from three (3) groups:
    1. Two (2) non-provider Santa Barbara County residents:
        a. A Medi-Cal or Medicare or Medi-Cal/Medicare recipient.
        b. A representative of a community business.
    2. One non-provider San Luis Obispo resident.
        a. A Medi-Cal or Medicare or Medi-Cal/Medicare recipient.
    3. Five (5) representatives of health care providers:
        a. A physician from a list provided by the Santa Barbara County Medical Society
        b. A physician from a list provided by the San Luis Obispo County Medical Society
        c. Two hospital administrators who are appointed from a list established by the local hospital councils.

d. A non-hospital or non-physician health care provider

Each hospital administrator appointed is unaffiliated with the hospital group, network, or corporate entity of the other hospital board appointee. Each physician appointee to the Board of Directors is unaffiliated with the group, network, or corporate entity of the other physician board appointee. With respect to the two non-provider resident directors, the appointments will not result in two members who are both recipients of Medi-Cal only or both recipients of Medi-Care only.

Board of Directors' Meeting Frequency

The Board of Directors meet on at least a quarterly basis. Meeting agendas include recommendations for action as proposed by staff and advisory committees. The meetings are open to the public and are publicized.

B. Role of Chief Executive Officer (CEO)

Reporting to the Board of Directors, the CEO is responsible for CenCal Health's overall strategic direction, management and administration of programs and services while ensuring that CenCal Health fulfills its mission, goals and objectives. This position is responsible for ensuring ongoing, efficient operations of CenCal Health, overseeing all operational decisions; ensuring its continued success through effective planning; oversight of contract negotiation, settling managerial disputes and prudent management of financial resources.

C. Role of Chief Medical Officer (CMO)

CenCal Health's CMO reports to and is supervised by the CEO. The CMO's job description specifies that they have the ability and responsibility to inform the CEO, and as necessary the Board of Directors, if at any time there is concern that their clinical decision-making ability is being adversely hindered by administrative or fiscal considerations.

The CMO or physician designee:

- Provide overall clinical direction of CenCal Health's QIHETP, ensuring that the program is adequate to monitor the full scope of clinical services rendered, identified problems are resolved, and corrective action plans are initiated when necessary and appropriate.
- Serves as the Chair of the QIHEC, in collaboration with the Chief Health Equity Officer (CHEO). The CMO annually oversees the approval of the clinical appropriateness of the QIHETP, including medical and behavioral health considerations.
- Supervises CenCal Health's Medical Directors.
- Ensures that medical and other health services decisions are rendered by qualified medical personnel; and not influenced by fiscal or administrative management considerations.

- Ensures that the medical and other health care provided meets acceptable standards of care.
- Ensures that CenCal Health's medical personnel follow medical protocols and rules of conduct.
- Develops and implements medical policy consistent with applicable standards of quality of care.
- Participates actively in the execution of Grievance and Appeal procedures, and resolves grievances related to potential and confirmed quality of care concerns.
- Participates directly in the implementation of quality improvement and health equity activities.
- Participates directly in the implementation of the Population Health Management (PHM) Strategy and initiatives.
- Ensures that CenCal Health engages with the local health departments in the service area.

D. Role of Chief Health Equity Officer (CHEO)

CenCal Health's CHEO reports to and is supervised by the CEO. The CHEO is accountable for the effectiveness of processes that engage and support members, communicate with members and community partners, develop and implement programs, and promote health equity. This position provides the vision, leadership, strategy, and general management of Member Services, Program Development, including the Health Equity Program, and Marketing and Communications Departments. This position has the authority to oversee and supervise the design and implementation of policies that ensure health equity is prioritized and addressed within CenCal Health. The CHEO responsibilities may not be delegated to subcontractors.

Additional responsibilities include providing consultation to the CMO, Health Services Officer and Quality and Population Health Officer on the Population Health Needs Assessment, QIHETP, and Population Health Program related to access, quality and equity objectives, although does not direct these functions.

E. Role of Behavioral Health Practitioner

Reporting to the CMO, the Behavioral Health Medical Director is CenCal Health's designated behavioral health care practitioner involved in the QIHETP. The behavioral healthcare practitioner is a licensed psychiatrist that participates in developing clinical and service activities for behavioral health. The designated behavioral health practitioner key responsibilities include, but are not limited to:

- A QIHEC voting member who actively participates and advises the committee.
- Participating in review and adoption of clinical behavioral health guidelines;
- Providing consult and recommendations on strategies related to behavioral health activities to support healthcare disparity reduction and continuous quality improvement
- Clinical review of potential and confirmed behavioral health quality of care concerns and member safety issues; providing recommendations for further action for behavioral health quality of care concerns.

F. Quality Improvement and Health Equity Committee (QIHEC)

QIHEC Purpose

CenCal Health maintains a QIHEC appointed and overseen by its Board of Directors as an accountable entity responsible for the oversight of the QIHETP. Associated committees and subcommittees may also participate in these activities. CenCal Health's Board of Directors appoints a liaison to the QIHEC to assure effective oversight of the QIHETP and facilitate communication between the Board of Directors and QIHEC.

The QIHEC's activities are supervised by CenCal Health's CMO or the CMO's designee, in collaboration with CenCal Health's Chief Customer Experience Officer/Chief Health Equity Officer. The QIHEC is responsible for the monitoring, and enhancement of organization-wide quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services. The QIHEC assures that all quality improvement and health equity activities represent the entire range of care provided, including all demographic groups, care settings, and types of service. The QIHEC is CenCal Health's medical advisory body charged with evaluating clinical policies and reviewing and approving all significant clinical initiatives and programs to assure appropriate clinical input from contracted provider network practitioners prior to and/or during implementation.

The QIHEC continually strives to ensure the provision of quality and equity in health care delivery and service to CenCal Health's members, providers, internal customers, and the community through pursuit of meaningful and measurable activities to improve processes, outcomes, and satisfaction. The activities, findings, recommendations, and actions of the QIHEC are reported to CenCal Health's Board of Directors in writing on at least a quarterly basis

QIHEC Objectives and Responsibilities

- Analyze and evaluate the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other CenCal Health committees.
- Institute actions to address performance deficiencies, including policy recommendations.
- Ensure appropriate follow-up of identified performance deficiencies.
- Ensure practitioner participation in the QIHETP through planning, design, implementation or review.
- Advise CenCal Health's leadership to assure the relevance, applicability, and soundness of clinical policy to proactively promote excellence and equity in quality of care and service, and patient safety.

- Recommend pertinent policy decisions to CenCal Health's Administration and Board of Directors.
- Advise CenCal Health of topic-specific strategies to achieve ongoing improvement in clinical practice among CenCal Health's provider network, including but not limited to facility site review.
- Oversight of all activities assigned to each Quality Sub-committee reporting to the QIHEC as laid out in *Section VI.A Quality Committee Organizational Chart*.
- Monitoring and proactive promotion of excellence in quality and safety of clinical care, quality of service, and customer experience.
- Ensure quality committees have access to timely information regarding requirements to ensure prompt implementation of processes and programs.
- Ensure QIHEC members can have a candid discussion about barriers to achieve goals and objectives, and to facilitate the removal of such barriers.
- Review of Pharmacy & Therapeutics Committee formulary design and quality improvement initiatives.
- Review of Provider Credential & Peer Review Committee summary-level statistics regarding network management, provider quality improvement, and provider corrective action.
- Review of policy recommendations from the Customer Experience Committee (CEC).
- Ensure the proper delegation of responsibilities by the CEC to the appropriate quality committees.
- Review of reports from the CEC regarding monitoring of health plan functions and activities, including but not limited to non-clinical activities to improve quality of care, if any.
- Annual approval of CenCal Health's adoption of preventive health and clinical care guidelines, utilization management coverage criteria, clinical condition support strategies, and new medical technologies when requested by the Benefits Committee.
- Oversight of the development and annual review of the QIHETP Description.
- Oversight of the evaluation of the previous year's Work Plan including analysis and evaluation of the effectiveness of activities.
- Oversight and the development of the current year's Work Plan to determine priorities and goals regarding quality of care, health equity, service, and patient safety.
- Maintain and ensure member confidentiality.

<u>QIHEC Membership</u>

- Board of Directors liaison to assure effective oversight and facilitate communication between the Board of Directors and QIHEC.
- CenCal Health's CMO or the CMO's designee chair the QIHEC, in collaboration with CenCal Health's Chief Health Equity Officer.
- Behavioral Healthcare practitioner (Psychiatrist, clinical PhD, or PsyD).

- Broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and members, who actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The committee's representation is changed as necessary to provide expertise relevant to CenCal Health's QI objectives.
- Participating Subcontractors, Downstream Subcontractors, and Network Providers are representative of the composition/specialties of CenCal Health's Provider Network and include, at a minimum, Network Providers who provide health care services to:
    1) Members affected by Health Disparities
    2) Limited English Proficiency (LEP) members
    3) Children with Special Health Care Needs (CSHCN)
    4) Seniors and Persons with Disabilities (SPDs)
    5) Persons with chronic conditions
- Be comprised of at least seven practitioners from CenCal Health's provider network, and CenCal Health's CMO. A quorum is a minimum of 7 QIHEC members or greater than 50% of the prevailing membership, including at least 4 network practitioners.
- To select members, CenCal Health staff make recommendations for committee appointment based on factors including, but not limited to, attendance, contribution, regional and professional representation, relevant expertise, and knowledge of the quality improvement process. All members must sign a confidentiality statement.
- The membership of the QIHEC is comprised of:

Committee Member (voting) * External to CenCal Health
Chief Medical Officer, Health Services CenCal Health (Chair)
Sr. Medical Director, CenCal Health (Co-Chair)
Behavioral Health Medical Director, Psychiatrist, CenCal Health
Board of Directors Liaison, Gastroenterologist, Santa Barbara
Chief Executive Officer, CenCal Health
Chief Health Equity Officer/Chief Customer Experience Officer, CenCal Health
Chief Operating Officer, CenCal Health
Quality and Population Health Officer, CenCal Health
Family Practice Physician, Santa Barbara*
Family Practice Physician, Community Health Centers of the Central Coast*
Medical Director, Santa Barbara County Public Health Department*
Pediatrician, Santa Maria*
Optometrist, Optometric Care Associates, San Luis Obispo*
Director of Quality, Community Health Centers of the Central Coast*
Hospital Representative*
Health Plan Member*

Staff Member
Health Services Officer, CenCal Health
Director of Quality, CenCal Health
Director of Member Services, CenCal Health
Director of Provider Services, CenCal Health
Associate Director, Pharmacy, CenCal Health
Provider Quality & Credentialing Manager, CenCal Health
Executive Assistant, CenCal Health

QIHEC Reporting Structure
The Chair of QIHEC ensures quarterly reports from the QIHEC to the Board of Directors are submitted in accordance with CenCal Health's contract with DHCS.

QIHEC Meeting Frequency
The committee meets at minimum on a quarterly basis.

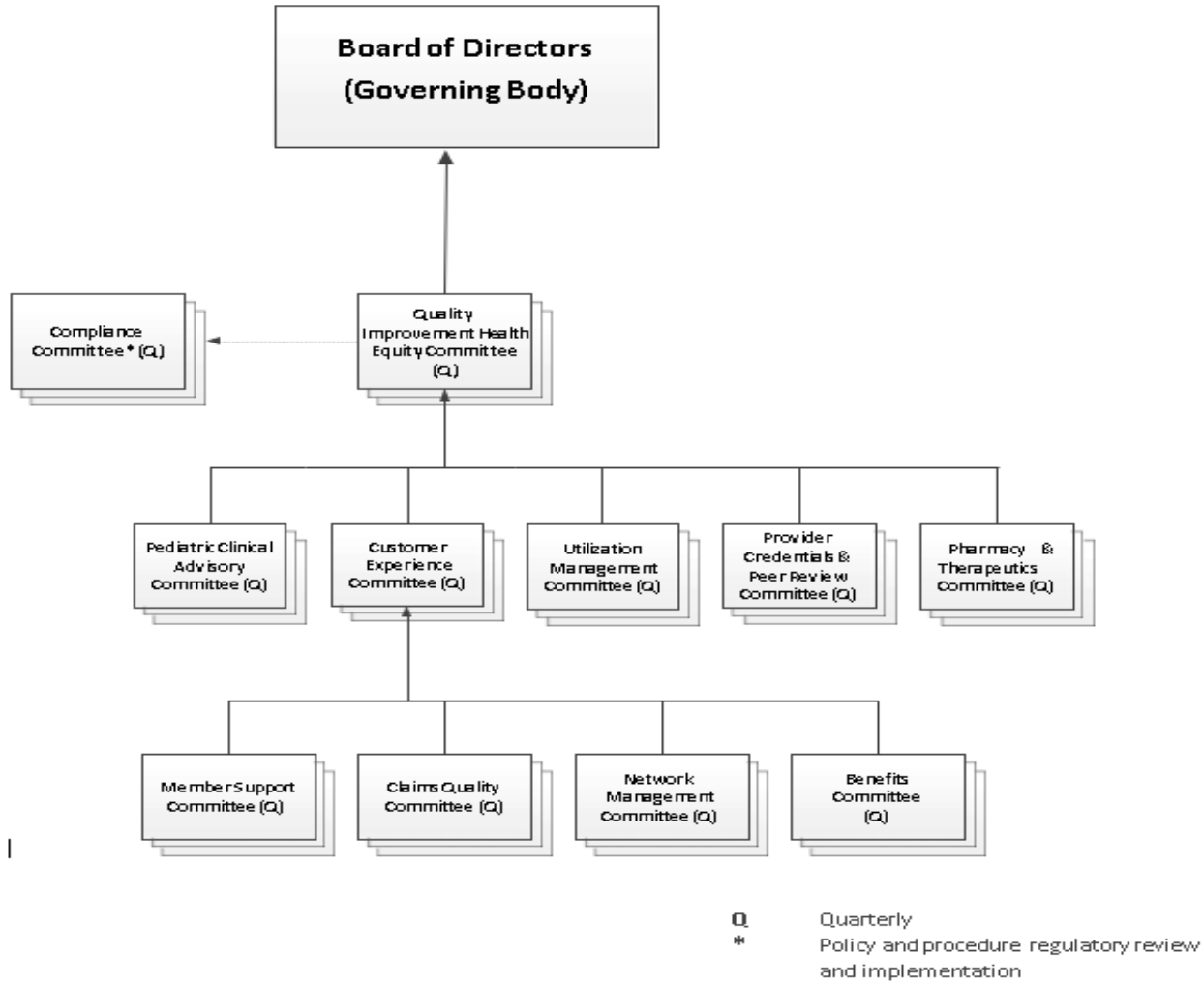
VI. QUALITY COMMITTEE STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

CenCal Health utilizes a quality committee structure that leverages the multidisciplinary expertise of staff and practitioners that serve on distinct quality committees to provide oversight and implementation of specific continuous quality improvement and health equity activities. This approach enhances communication throughout the organization and integrates processes, thereby increasing the quality and efficacy of CenCal Health's QIHETP.

CenCal Health's Board of Directors appoints and oversees the QIHEC, Pediatric Clinical Advisory Committee, Customer Experience Committee, Utilization Management Committee, Provider Credentials and Peer Review Committee, Pharmacy & Therapeutics Committee, Member Support Committee, Claims Quality Committee, Network Management Committee, and Benefits Committee which in turn, provide the authority, direction, guidance, and resources to enable CenCal Health staff to carry out the QIHETP.

A. Quality Committee Organization Chart

The following image displays CenCal Health's quality committees reporting relationships and organizational bodies that represent the QIHETP structure, with ultimate oversight provided by the Board of Directors.



B. Benefits Committee

Benefits Committee Purpose

To provide the best possible services to CenCal Health's member population, the Plan has established a Benefits Committee which makes determinations and recommendations on whether non-benefits including experimental/investigational procedures, devices, or services should be added or removed from the Plan's benefits package. The Committee's process includes but is not limited to evaluating the effectiveness of benefits, and the cost of possible changes to the Plan's benefits. The Committee will evaluate suggested changes from its contracted provider network, its members, plan staff, and outside community-based partners as appropriate.

Benefits Committee Objectives

- Ensure CenCal Health's members and providers have an avenue to express their desire for new services to be added to the plan benefit packages.
- Ensure that other parties including internal staff/committees and the community are able to express their desires for new services to be added to the benefit packages.
- Ensure that the services that may be added to the benefit packages are safe for the members, cost effective for CenCal Health, and produce comparable or superior results over the services currently in place.
- Ensure issues that are brought to the committee's attention are discussed in an unbiased, open forum.
- Ensure complete and accurate evaluation of all suggested benefit changes to determine both the advantages and/or disadvantages of changes to the benefits.

Benefits Committee Responsibilities

- Ensure a scope of benefits that contributes to the achievement of CenCal Health's Mission.
- Review the scope of benefits to identify needed areas of improvement in care rendered by CenCal Health's providers.
- Review provider, member, staff, committee, and community input through Treatment Authorization Requests, claims, complaints and grievances (both provider and member), Fair Hearings, and Special Requests to ensure all involved have an adequate forum to voice their suggestions.
- Review of legislation and/or regulatory requirements regarding the change to the benefits.
- Review and make recommendations/determinations on Operational Instructional Letters (OILs) from the Department of Health Care Services.
- Evaluate overall effectiveness and costs of benefits added, including operational issues, as a result of this Committee's recommendations.
- Review and discuss with medical professionals as needed, appropriate clinical information and documentation when determining changes to benefits.
- Oversee the appropriate development and administration of relevant policies and procedures.
- Evaluate new technology and the new application of existing technology for possible inclusion in CenCal Health's benefit plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. This may include medical procedures, behavioral healthcare procedures, pharmaceuticals and/or devices.
- Ensure the dissemination of benefit information to providers, members, staff, and the community.
- Interface with appropriate CenCal Health committees to recognize the need for any benefit review and to implement benefit changes.

- Report recommendations sequentially as appropriate to obtain approval from CenCal Health's leadership, the Quality Improvement and Health Equity Committee (QIHEC), and the Board of Directors.
- The following indicators will be reviewed on an as needed basis:
    - Effectiveness, cost, impact of benefit changes on CenCal Health operations and membership.
    - Utilization and cost impacts of newly added procedure codes

Benefits Committee Membership

1. Chief Operating Officer (Chair)
2. Health Services Officer
3. Chief Medical Officer or designee
4. Chief Customer Experience Officer, Chief Health Equity Officer
5. Chief Financial Officer or designee
6. Medical Director, Behavioral Health
7. Director of Medical Management
8. Director of Member Services
9. Director of Provider Services
10. Director of Provider Relations
11. Deputy Chief Information Officer
12. Director of Claims
13. Director of Pharmacy
14. Director of Quality

Benefits Committee Meeting Frequency

The Benefits Committee meets quarterly as needed.

Benefits Committee Reporting Structure

The Benefits Committee reports to the Customer Experience Committee (CEC), and to the QIHEC.

C. Claims Quality Committee

CQC Purpose

The CQC oversees those processes that affect the accuracy and regulatory compliance of claims that are processed. This committee will provide oversight of service indicators as defined by the monitoring process, analysis, action, and measurement. The CQC through monitoring of appropriate indicators will identify areas of opportunity to improve processes, implement interventions, educate providers, and improve the quality of co-operation, coordination, and communication between departments within the agency.

CQC Objectives

- Identify and track quality indicators to identify areas of improvement for processing
- claims for CenCal Health providers.
- Assign responsibility for resolution of inter- and intra-departmental operational issues that may be adversely affecting claims processing.

CQC Responsibilities

- Review operational results to identify areas of potential improvement in claims processing quality for CenCal Health plans.
- Ensure CenCal Health providers' claims disputes are processed efficiently and in accordance with applicable regulatory and contractual guidelines.
- Interface with Network Management Committee (NMC) and Member Support Committee (MSC) for identification of trends, patterns, and development and implementation of corrective actions; assign responsibility for resolution of inter- and intra-departmental operational issues that may be adversely affecting claims processing.
- Provide support to reach CenCal Health's strategic objectives and mission relevant to the Quality Improvement and Health Equity Transformation Program (QIHETP).

CQC Membership

1. Director of Claims
2. Associate Claims Director (Chair)
3. Claims Operations Manager
4. Claims Administrative Analyst
5. Claims Configuration Analyst/Auditor
6. Encounter Data Quality Analyst
7. Claims Compliance Coordinator
8. Financial Analyst
9. Jr. Financial Analyst
10. Healthcare Data Analyst
11. Provider Services Healthcare Business Analyst
12. Manager, Grievance & Appeals/Quality Improvement
13. Sr. Quality Measurement Specialist

CQC Meeting Frequency

The CQC meets quarterly.

CQC Reporting Structure

The CQC reports directly to the Customer Experience Committee (CEC) on a quarterly basis. Additional task forces are formed on an as needed basis and may develop into official subcommittees as determined upon evaluation of need

D. Customer Experience Committee (CEC)

CEC Purpose

The CEC is a multidisciplinary committee designed to develop, implement, and monitor key operational policies and procedures related to the member, provider and health equity customer experience. The purpose of this committee includes but is not limited to: policy development, discussion of identified operational issues, monitoring of key operational quality indicators as reported up through sub-committees to identify opportunities to improve quality improvement and health equity metrics in operational processes, oversee interventions, and achieve regulatory and/or contractual compliance.

The CEC will advance and/or achieve our purpose through the following:

- Maximizing our customer experience through operational policy and operational excellence.
- Delineate roles and responsibilities for plan staff or sub-committee action(s) when determining areas of focused improvement.
- Holding rich discussion on identified improvement opportunities.
- Collectively add value as committee members and have minutes that provide action-oriented review of the customer experience topics discussed.
- Provide feedback into program development for reporting to the QIHEC in meaningful ways.
- Continuous monitoring and improvement of non-clinical components of quality performance indicators.
- Meet all DHCS contractual requirements that are applicable.
- Population Health Management (PHM) and Quality Improvement and Health Equity Transformation Program (QIHETP) inclusion into our oversight responsibilities.

CEC Objectives

- Ensure quality improvement committees, via QIHETP work plans, have adequate and available resources to accomplish committee goals and objectives in line with the mission and strategic goals of CenCal Health, including addressing disparities with a focus on health equity for our members, and improving the customer experience for our provider network. Resources evaluated should include, but are not limited to, availability of staff, data and information, analytical tools and expertise to meet our community needs.
- Ensure the development of plan policy and procedures incorporates contractual obligations, while being considerate of member feedback/voice when applicable as solicited from sources such as our Community Advisory Board, family engagement outreach, call center, member portal feedback and other sources.

- Utilize data to identify member needs beyond clinical gaps in care (SDOH). Develop action plans to address those needs, stratified to focus on the greatest needs, or those needs with the greatest impact on member health and well-being.
- Annual evaluation of the CEC Work Plan to identify barriers to continued improvement and appropriate interventions to address those barriers.

CEC Responsibilities

- Ensuring the availability and synergy of data to inform improvement opportunities for member access to quality and timely care.
- Identify indicators to be monitored by its sub-committees and select and prioritize opportunities for improvement.
- Refer trends and/or potentially problematic patterns of care, service or patient safety to appropriate QI sub-committees for further review, evaluation, and implementation of quality improvement interventions.
- Assure that appropriate analysis is reported to the QIHEC for monitoring of quality improvement.

CEC Membership

1. Director of Member Services (CEC Chair, Member Support Committee Chair)
2. Chief Operating Officer (Operations Division)
3. Chief Medical Officer (Health Services)
4. Chief Customer Experience & Health Equity Officer (Customer Experience Division)
5. Quality & Population Health Officer (Quality)
6. Director of Provider Relations (Provider Services)
7. Director of Provider Services (Network Management Committee Chair)
8. Director of Claims Operations (Claims Quality Committee Chair)
9. Associate Director of Claims (Claims)
10. Provider Services Quality and Credentialing Manager (Provider Services)
11. Director of Quality (Quality)
12. Deputy Chief Information Officer and HIPAA Security Officer (Information Technology)
13. Compliance Director and HIPAA Privacy Officer (Compliance)
14. Director of Behavioral Health (Health Services)
15. Director of Audits & Monitoring (Compliance)

CEC Frequency of Meetings

The CEC meets quarterly.

E. Member Support Committee (MSC)

MSC Purpose

The MSC oversees those processes that assist CenCal Health's members in navigating CenCal Health's system to ensure that members are confident that they will receive the appropriate care from providers and excellent service from the health plan. This committee provides oversight of access, service, and quality indicators, impacting membership and their ability to receive healthcare appropriately and timely. Through monitoring of appropriate indicators, MSC will identify areas of opportunity to improve processes and implement interventions. The MSC is also responsible for initiating review and providing recommendations for CenCal Health's performance on the Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey annually. MSC also reviews and provides input as needed, on state-mandated Performance Improvement Projects (PIPs) as appropriate to this committee's Charter and any quality improvement activities within the scope of this committee and its Member Materials/Cultural & Language Access Program.

MSC Objectives

- Ensure CenCal Health members have an understanding of their health care system and know how to obtain care and services when they need them.
- Ensures members understand their rights and responsibilities.
- Ensure CenCal Health members will have their concerns resolved quickly and effectively and have the right to voice grievances without fear of discrimination.
- Ensure CenCal Health members will have the right to appeal any denials of service, authorizations or referrals and receive a timely review by a Medical Director or their physician designee.
- Ensure CenCal Health members can trust that the confidentiality of their information will be respected and maintained.
- Ensure CenCal Health member's eligibility will be immediately recognized by participating providers and the Plan to ensure prompt medical care.
- Ensure CenCal Health Limited English Proficient (LEP) members have access to "preferred language" providers for Primary Care Physician selection.
- Ensure CenCal Health members have access to "preferred" language interpreter services at no charge when receiving medical care and may file a grievance if their language needs are not met.
- Ensure CenCal Health members can have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Ensure CenCal Health members can reach the Member Services Department quickly and be confident in the information they receive.

MSC Responsibilities

- Ensure achievement of the Member Services Department goals and objectives.
- Determine and establish a reporting calendar that delineates the reports to be submitted, the reporting frequency, and months reports are due to MSC and other quality committees as agreed upon and approved by the CEC and the QIHEC as appropriate.

- Review access, service and quality improvement indicators to identify areas for improving the CenCal Health member experience.
- Ensure compliance with applicable regulatory, accreditation, contractual and public reporting standards.
- Oversee the appropriate development and administration of relevant policies and procedures.
- Develop, maintain and disseminate CenCal Health's Member Rights and Responsibilities policy to members and providers.
- Develop, maintain and disseminate CenCal Health's member materials to ensure compliance with applicable regulations, cultural and language appropriate standards, and alignment with CenCal Health's strategic goals for member education and satisfaction.
- Oversee the solicitation of member input on quality improvement activities and policy development through the Community Advisory Board and member/family engagement feedback.
- Oversee the resulting data from member satisfaction surveys, like CAHPS, identifying areas of opportunity for improvement in services to CenCal Health members, their implementation and the monitoring of such activities.
- Interfaces with Network Management, Claims Quality and Customer Experience Committees for trends to investigate, QI opportunities or corrective action needed.
- Provide support to reach CenCal Health's strategic goals and Mission relevant to the QIHETP Description.
- Evaluation of CenCal Health's Health Promotion Program activities, providing input and support into action plans and member education materials.
- Development of appropriate indicators, analyzing results, developing necessary interventions and remeasuring results for the following subprocesses:
    - *Health Plan Responsiveness:* Responsiveness to member inquiries to ensure timely and appropriate resolution.
    - *Enrollment:* Communicating eligibility to providers and members.

  MSC, with the oversight of the CEC and approval from the QIHEC, has determined that the following processes directly impact member satisfaction and various regulatory and contractual obligations. These processes and their indicators will be monitored, evaluated by this committee, and reported to the CEC with any recommended corrective action plans.
    - Oversee timely resolution of all member-to-health plan interactions, including timely resolution of member grievances and appeals.
    - Oversee appropriateness of resolution of member inquiries/requests for assistance, through monitoring aggregate call tracking outcomes.
    - Oversee timely resolution of member inquiries/requests of website and member portal contacts to CenCal Health.
    - Oversee scheduling and access to interpreting, translation and alternative format services as requested by members.
    - Oversee the timeliness and accuracy of member eligibility related changes, including additions, terminations, and corrections within the health plan's current ability for control of eligibility and demographic data.
    - Oversee the timely communication of eligibility status to members.

- Oversee the timely communication of member eligibility to providers.

MSC Membership

1. Director of Member Services (Member Services) (Chair)
2. Associate Director of Member Services (Member Services)
3. Provider Services Regulatory Liaison (Provider Services)
4. Grievance & Appeals, Quality Improvement Manager (Member Services)
5. Call Center Manager (Member Services)
6. Business Data Analyst (Member Services)
7. Health Promotion Supervisor (Quality)
8. Health Promotion Educator (Quality)
9. Population Health Specialist (Quality)
10. Cultural & Linguistic Services Manager (Member Services)
11. Junior Financial Analyst (Finance)
12. Director of Claims or Designee (Claims)
13. Health Plan Nurse Coordinator or designee (Medical Management) (ad hoc)
14. Compliance Specialist or designee (Administration) (ad hoc)
15. Director of Communications & Community Relations (ad hoc)
16. Community Advisory Board Member (ad hoc)

MSC Frequency of Meetings

The MSC meets quarterly.

F. Network Management Committee (NMC)

NMC Purpose

The NMC oversees those processes that assist CenCal Health in maintaining access to an adequate network of providers for the provision of quality health care benefits to members and to ensure that providers are confident that they will receive excellent service from the health plan. This committee will provide oversight of service indicators as defined by the monitoring process, analysis, action and measurement. Through monitoring of appropriate indicators, NMC will identify areas of opportunity to improve processes and implement interventions, and any quality improvement activities within the scope of the committee.

NMC Objectives

- Ensure CenCal Health providers receive training, tools and support to enable them to provide high quality care to plan members while working effectively with the plan and as a Medi-Cal provider.
- Facilitate collaboration between CenCal Health, providers, community-based organizations and partners.
- Ensure CenCal Health providers will have their concerns resolved quickly and effectively and have the right to voice complaints or concerns without fear of termination.
- Ensure CenCal Health providers have access to accurate and timely eligibility information to ensure prompt medical care to members.

- Ensure CenCal Health providers have access to appropriate language assistance, including interpreter services, to ensure prompt medical care for their patients.
- Ensure CenCal Health providers can have a candid discussion of appropriate, cost-effective and medically necessary treatment options for their patients' conditions, per current Medi-Cal regulations.
- Ensure CenCal Health providers can reach our Provider Services, Provider Relations, Health Services, Member Services, and Claims departments quickly and be confident in the information they receive.
- Ensure a robust network of providers that is adequate to deliver high quality medical care that meets the ethnic, cultural and linguistic needs of our members through the ongoing monitoring of access and capacity.
- Ensure that network development efforts address new technologies, services and benefits, including collaborative opportunities with provider partners such as telemedicine, to augment availability of services within the service area.
- Ensure continuous quality improvement by developing appropriate indicators, analyzing results, implementing necessary interventions, and remeasuring results for the following subprocesses: Access Monitoring, Service Indicators, & Quality Improvement Activities.

<u>NMC Responsibilities</u>

- Ensure achievement of service to meet providers' goals and objectives.
- Maintain a reporting calendar that delineates reports to be submitted for the committee's review, the reporting frequency, and the months that reports are due.
- Review service indicators to identify areas of improvement for services rendered to CenCal Health providers.
- Ensure compliance with applicable regulatory, accreditation, contractual, and public reporting standards.
- Evaluate overall effectiveness of applicable service, quality, and improvement activities.
- Develop, maintain, and disseminate CenCal Health's provider materials as per regulatory requirements and in alignment with the health plan's strategic goals for provider education and satisfaction.
- Oversee the solicitation of provider input on quality improvement activities through outreach and surveys.
- Oversee the resulting data from provider satisfaction surveys, inquiries, complaints, appeals, PCP requests for member reassignment, and terminations to identify areas of opportunity for improvement in services to CenCal Health providers, including the implementation and monitoring of such activities.
- Interface with MSC, CQC and other committees and workgroups as appropriate for trends, patterns, corrective actions, and outcomes of reviews.
- Provide support to CenCal Health's management and staff on goals relevant to the Quality Improvement and Health Equity Transformation Program.

<u>NMC Membership</u>

1. Director of Provider Services (Provider Services) (Chair)

2. Provider Quality and Credentialing Manager (Provider Services)
3. Provider Contracts Manager (Provider Services)
4. Provider Relations Manager (Provider Relations)
5. Provider Operations Manager (Provider Services)
6. Quality Liaison (Provider Services)
7. Healthcare Business Analyst (Provider Services)
8. Senior Provider Services Trainer (Provider Relations)
9. Administrative Assistant (Provider Services)
10. Lead, Provider Services Representative (Provider Relations)
11. Chief Medical Officer/Medical Director (Health Services)
12. Health Services Officer (or designee) (Health Services)
13. Director of Member Services (Member Services)
14. Senior Community Relations Specialist (Communications & Community Relations)
15. Claims Operations Manager (Claims)
16. Supervisor, Claims Services (Claims)
17. Director of Finance (Finance)
18. Compliance Officer (Compliance)
19. Population Health Manager (Quality)

Network Management Committee Frequency of Meetings
The NMC meets quarterly.

G. Pharmacy & Therapeutics Committee (P&T)

P&T Purpose
The P&T Committee serves as the advisory committee to CenCal Health for the development and implementation of a plan-wide medication management program. The P&T Committee is responsible to provide guidance on development of a medical-pharmacy benefit comprised of a physician-administered-drug (PAD) list to ensure optimal efficacy, safety, and cost-effectiveness of drug therapy. Additionally, the P&T Committee will serve as the plan's Drug Utilization Review (DUR) board and oversee the plans activities to ensure quality medication management that meets the contractual requirements related to Medi-Cal DUR program.

P&T Objective
The P&T Committee serves as the advisory committee to CenCal Health for the development and implementation of a plan-wide medication management program for all matters pertaining to the use of medications, including development of prescribing guidelines, protocols and procedures to promote high quality and cost-effective drug therapy to the medications the plan has responsibility for contractually. The P&T Committee serves as CenCal Health's Drug Utilization Review (DUR) Board and oversees all plan DUR activities.

P&T Responsibilities

- Maintenance of a medical-pharmacy, physician-administered-drug (PAD) list based on an objective evaluation of efficacy, safety and cost-effectiveness of medications.
- Service in an advisory capacity to CenCal Health for all matters pertaining to the use of pharmacy-quality and utilization.
- The P&T Committee will ensure that the minutes of all P&T Committee meetings are accurate and reflect relevant discussion points.

The P&T Committee will review and evaluate summary analyses and results of activities that may include but not be limited to:

- Utilization indicator trend reports, both provider-specific and plan-wide.
- Population demographics, morbidities, health risks, and patterns
- As the health plan's DUR Board, review: Drug Utilization Review (DUR) elements consistent with the DHCS requirements and CenCal Health policy PHARM-05-DUR to include retrospective drug review and educational program notifications.
- Other issues related to the quality of drug usage, adverse drug events.

P&T Membership

The membership of the P&T Committee represents CenCal Health's practitioner network of physicians and pharmacists. P&T Committee members include but are not limited to:

- CenCal Health Chief Medical Officer or physician designee
- CenCal Health Pharmacy Director or designee (Chairperson)
- Two to four Network or CenCal Health physicians
    - At minimum, one practicing physician who is independent and free of conflict of interest from pharmaceutical manufacturers
    - At minimum, one practicing physician who is an expert regarding care of elderly or disabled members
- Two to four Network or CenCal Health pharmacists

To recruit members, current committee members, staff, and interested parties are asked for recommendations. Providers are advised of this opportunity through provider newsletters, bulletins, and CenCal Health's website.

All network physicians and pharmacists on the committee must be currently providing direct patient services to CenCal Health's members in Santa Barbara County. Staff makes recommendations for committee appointment based on factors including, but not limited to, attendance, contribution, regional and professional representation, relevant expertise, and knowledge of the pharmaceutical management process.

The P&T Frequency of Meetings

The P&T meets quarterly.

H. Provider Credentials & Peer Review Committee (PCC)

PCC Purpose
The PCC provides guidance and peer input into CenCal Health's provider peer review and credentialing processes.

PCC Responsibilities
- The PCC is responsible for providing guidance and peer input into CenCal Health's provider credentialing process.
- To review member and provider clinical complaints, grievances, and issues involving clinical quality of care concerns, as deemed appropriate by the CenCal Health Chief Medical Officer and/or Medical Director designee(s).
- To determine corrective action when necessary.
- To periodically review different areas of care provided to members as deemed appropriate by the CenCal Health Chief Medical Officer and/or Medical Director designee(s)
- Review and processing of requests of potential providers/practitioners for initial credentialing and reappointment for participation in CenCal Health's provider network.
- Approval of providers'/practitioners' initial credentialing and reappointment based on clinical competency and/or professional conduct.
- Review the provider credentialing policy annually and make recommendations for changes, if any, to the Board of Directors.
- Review of provider research related to clinical performance.

PCC Membership
The PCC consists of licensed practicing practitioners in CenCal Health's provider network, and CenCal Health's Chief Medical Officer and/or Medical Director designee(s). The CenCal Health Chief Medical Officer, Medical Director designee(s), and practicing practitioner members are the only voting members. The practicing practitioner members shall represent various specialties of the contracted provider network.
- To assure due process in the performance of peer review investigations, the CenCal Health Chief Medical Officer shall appoint other practitioner consultants as necessary to obtain relevant clinical expertise and representation by an appropriate mix of practitioner types and specialties.
- In addition to the practicing practitioner members, the PCC is assisted by the following non-voting CenCal Health staff members: Director of Provider Services, General Counsel, Provider Quality and Credentialing Manager, Credentialing Supervisor and Credentialing Specialist(s).
- The CenCal Health Chief Medical Officer or designee may act as Chairperson, or a Chairperson and a Co-Chairperson may be elected from among the voting members, by the voting members.
- The practicing practitioner members are recruited from the contracted provider network and are approved by the current members. The membership term is two years, with the potential to serve subsequent term(s). A quorum is a majority of

the voting members. The voting members shall be Officers of CenCal Health when acting within the scope of their duties as members of the PCC.

- To select committee members, PCC members or CenCal Health staff make recommendations for committee appointment based on factors including, but not limited to: attendance, contribution, regional and professional representation, relevant expertise, and knowledge of the credentialing process. Prospective committee members may be identified through interactions with network providers, including through collaborative meetings such as the Provider Advisory Board and Joint Operating Committees. As part of the recruitment process, credentialing staff will ensure all credentials are current and clear of adverse actions, and there are no quality-of-care concerns or member complaints.
- Each committee member will be required to sign CenCal Health's Oath of Confidentiality, which includes a statement regarding conflict of interest, wherein the member agrees to maintain the confidentiality of credentialing and peer review activities and to refrain from participating in activities that may represent a conflict of interest.
- As chair, the CenCal Health Chief Medical Officer or designee has the ultimate discretion regarding committee membership by assessing professionalism, impartiality, expertise, and contribution. The Chair reserves the right to approve, decline or dismiss committee members with or without cause. Reasons to dismiss a member may include, but are not limited to: lack of engagement, attendance at less than a minimum of 75% of meetings annually, failure to exhibit objectivity, conflicts of interest, violations of the Oath of Confidentiality, and voluntary or involuntary termination from CenCal Health's network.

PCC Minutes

The PCC minutes, as maintained by the Provider Services staff, will record the following:

- The members in attendance.
- Providers/practitioners approved for participation or denied for participation and those not acted upon, due to need for additional information or incomplete applications.
- For each provider/practitioner discussed, the minutes will identify the specialty and office location, any discussion regarding that provider/practitioner, the PCC's final decision, and the rationale for it's decision.

PCC Meeting Frequency

The PCC will meet quarterly or more frequently if necessary.

I. Pediatric Clinical Advisory Committee (PCAC)

PCAC Purpose

The PCAC is to advise on clinical issues in regard to CenCal Health's Whole Child Model Program (WCMP) as it relates to California Children Services (CCS) conditions including treatment authorization guidelines and to serve as clinical advisers on other clinical issues relating to CCS conditions (SB 586, Section 14094.17(a)). This Committee shall be

separate and distinct from CenCal Health's Quality Improvement and Health Equity Committee (QIHEC).

PCAC Function

- Advise CenCal Health on clinical issues related to CCS conditions, including treatment authorization guidelines.
- Serve as clinical advisers on other clinical issues relating to CCS conditions.
- Provide advice and consultation to the Plan with respect to the administration of WCMP.
- Promote collaboration among community and CCS providers to execute State requirements of the WCM Program.
- Increase provider awareness of WCM Program operational processes.
- Identify and make recommendations on process improvement opportunities related to WCM Program.
- Advise the Plan of emerging trends in the care of children with CCS-eligible conditions.
- Provide input into clinical quality of care issues as it relates to the WCM Program administration and refer to CenCal Quality Improvement Committee when appropriate.
- Provide feedback on clinical practice guidelines developed by regulatory agencies for CCS conditions.
- Provide guidance regarding clinical standards for CCS clinical conditions.

PCAC Membership

1. CenCal Health Chief Medical Officer or designee
2. CenCal Health Senior Medical Director
3. Santa Barbara County CCS Medical Director
4. San Luis Obispo County CCS Medical Director
5. At least four (4) CCS paneled providers
6. Clinical Manager, CenCal Health Pediatrics (as approved by CenCal Health CMO)
7. Director of CenCal Health Provider Services or designee (as approved by CenCal Health CMO)
8. Other members as approved by CenCal Health CMO

PCAC Meeting Frequency

The committee meets quarterly.

PCAC Reporting Structure

The PCAC reports directly to the QIHEC on a quarterly basis and ultimately to the Board of Directors.

J. Utilization Management Committee (UMC)

UMC Purpose

CenCal Health's Utilization Management (UM) Program is designed to promote the delivery of high quality, medically necessary, and cost-efficient health care for our members. The scope of UM activities covers all clinical aspects of preventive, diagnostic and treatment services in both the inpatient and outpatient settings, which includes behavioral health, physical health, pharmacy, case management, and grievances and appeals. The UMC is responsible for oversight of these UM activities and reports its progress to the QIHEC. The UMC reviews and approves program descriptions and plans on an annual basis. The purpose of this committee is to provide a venue for all UM related areas to present their progress on the annual plan and receive feedback, suggestions, and recommendations from the committee members. The committee upon receiving the reports shall assess the progress, related programs, identify any needs for process improvement, new utilization or care management programs, data reporting requirements, and make recommendations accordingly within the scope and responsibilities of this charter.

UMC Objectives

- Evaluate the effectiveness of the UM and case management (CM) programs by defining outcome parameters and assessing progress toward them.
- Annually adopt and oversee implementation of UM guidelines and criteria.
- Annually review and adopt evidence-based practice guidelines.
- Ensure appropriate access to medically necessary services and appropriate use of public funds under responsibility of CenCal Health.
- Review the programs' adherence to regulations related to utilization management and care management.
- Review and ensure the consistency of decision-making among UM licensed clinicians.
- Ensuring that utilization decisions are based on medical necessity criteria adopted by the committee and are not influence by financial considerations.
- Review and identify utilization trends and outlier cases identified and recommend action plans.

UMC Responsibilities

- Review and recommend annual approval of UM / CM / BH Program Descriptions.
- Based on the review of specified reports, identify trends, and determine actionable items to address and implement. These actions will be prioritized based on their significance and evaluated for effectiveness.
- Review and plan for implementation of regulatory updates related to UM and CM processes.
- Review and recommend actions to address trends in grievances and appeals

and state fair hearings.
- Identify entities or individuals who can respond to concerns or assist in developing improvement initiatives.
- Recommend process changes that enhance interdepartmental collaboration and processes.
- Approve or deny proposed UM guidelines or criteria used in decision-making.
- Approve or deny operational UM and CM policies proposed for implementation for BH or population health.
- Review reports received from UM delegated entities and address identified deficiencies in a timely manner.
- Approve or deny internal utilization, care management, pharmacy, and grievance and appeals reports. Address identified issues, and provide recommendations.
- Review and approve Inter-Rater Reliability (IRR) reports, training, and auditing of UM and CM staff.

Utilization Management Committee Membership and Quorum

The UMCs voting membership includes CenCal Health's CMO, Health Services Officer, Senior Medical Director, Medical Directors, and Department Directors. A quorum is a minimum of 5 UMC members or greater than 50% of the prevailing membership.

UMC Voting Members

- Chief Medical Officer (co-chair)
- Health Services Officer (co-chair)
- Senior Medical Director
- Quality and Population Health Officer
- Director of Medical Management
- Medical Directors
- Director of Pharmacy or designee
- Director of Behavioral Health
- Director of Quality or designee
- Director of Provider Services or designee
- Director of Member Services or designee
- Director of Claims or designee

UMC Non-Voting Members

- Medical Management Clinical Manager – Pediatric Utilization & Care Management
- Medical Management Clinical Manager – Adult Utilization Management
- Medical Management Clinical Manager – Adult Care Management
- Behavioral Health Clinical Manager
- Health Services Operations Analyst
- Director of Compliance or designee (optional attendee)

UMC Meeting Frequency
The UMC meets at least quarterly and may meet more frequently if deemed necessary by the committee chair.

UMC Reporting Structure
The UMC reports to the QIHEC on a quarterly basis.

VII. PROGRAM FUNCTIONAL AREAS AND RESPONSIBILITIES

CenCal Health's Behavioral Health, Case Management, Disease Management, Population Health Management (PHM), Utilization Management, Wellness and Prevention programs are systematically integrated with CenCal Health's QIHETP to promote the continuous monitoring and evaluation of clinical care and services provided to members.

Below are details surrounding these program functional areas and responsibilities:

A. Behavioral Health Program

CenCal Health's Behavioral Health Program is a system integrated with CenCal Health's QIHETP to promote the continuous monitoring and evaluation of behavioral health care and services provided to members. The program is designed to identify patterns of utilization, ensure efficient use of resources, and ensure the continuous improvement in the delivery of behavioral health care services. The Utilization Management Committee (UMC) approves the Behavioral Health Program Description annually and the QIHEC evaluates the key performance indicators at minimum quarterly.

- For additional details, please refer to *Appendix A – Behavioral Health Program Description*.

B. Care Management (CM) and Disease Management Program

CenCal Health's CM Program is a comprehensive, member-centered program that consists of Complex Care Management (CCM), Basic Care Management, Transitional Care Services (TCS), and other Care Coordination activities. Various CM Programs are available to all CenCal Health members who meet or trigger CM guidelines. CM services include general CM, which primarily works with the adult population, Pediatric-Whole Child Model (PWCM), Disease Management (DM), and Enhanced Care Management (ECM). These programs work collaboratively to support members through the continuum of CM services.

CenCal Health's CM activities are defined in CenCal Health's Care Management Program Description which also includes Complex Case Management and Disease Management Program functions.

- For additional details, please refer to *Appendix B - Care Management Program Description*.

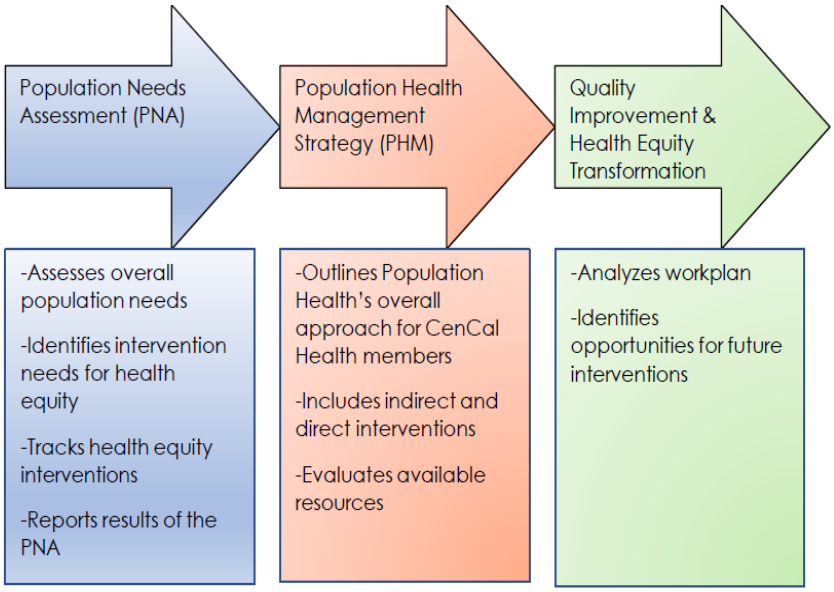
C. Population Health Management (PHM) Program

CenCal Health's Population Health Management (PHM) Program identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and enhanced quality of life. The PHM strategy is an action plan that describes population health activities, designed to directly impact member health and the communities in which they live. The PHM strategy defines a roadmap to ensure the PHM program aligns with CenCal Health's organizational strategic priorities with the functions being integrated into CenCal Health's QIHETP.

CenCal Health's PHM framework supports collaboration and synchronization of PHM efforts across the organization to allow flexibility in response to member needs. Although the execution of CenCal Health's QIHETP and PHM functions are spread amongst all departments across the organization, CenCal Health's Quality Department is the centralized department responsible for operational oversight and coordination. Data and information flow between functional areas to achieve program objectives, with dedicated support from teams and committees.

CenCal Health quality committee structure leverages the multidisciplinary expertise of staff and practitioners that serve on distinct quality committees. This approach enhances communication throughout CenCal Health and integrates patient-centered care and processes, thereby increasing the quality and efficacy of CenCal Health's QIHETP and PHM programs.

PHM programs and services delivered by CenCal Health to members and providers are planned, monitored, and evaluated through the QIHETP and reported quarterly to the QIHEC. Overall, CenCal Health's PHM program maintains a strong focus on health equity in all programs and services.



- For additional details, please refer to *Appendix C - Population Health Management Strategy and Program Description.*

D. Utilization Management (UM) Program

CenCal Health's UM Program is designed to promote the delivery of high quality, medically necessary, and cost-efficient health care for our members. The UM Program has quality operations that integrate UM Program operation with QIHETP operations through a systematic and coordinated system of reporting to the UMC and QIHEC. The program is designed to identify patterns of utilization and ensure efficient use of resources.

UM activities covers all clinical aspects of preventive, diagnostic and treatment services in both the inpatient and outpatient settings, which includes behavioral health, pharmacy, and medical case management.

Reporting of UM activities includes but is not limited to the number and types of service requests, denials, deferrals, modifications, appeals, and grievances. All reporting to the UMC, is overseen by CenCal Health's CMO or designee, and other CenCal Health leadership that participate on the UM Committee and/or QIHEC

- For additional details, please refer to *Appendix D – Utilization Management Program Description.*

E. Wellness and Prevention Program and Health Education System

CenCal Health maintains a Wellness and Prevention Program that ensures all members have equitable access to necessary wellness and prevention services. CenCal Health's

Wellness and Prevention Program is integrated within its PHM Program, which further ensures care coordination, and care management. It is designed to prevent illness and injury to CenCal Health's members, with a focus on health equity and the elimination of health disparities. This is achieved through the implementation and maintenance of both evidence-based and innovative wellness and prevention initiatives that meet DHCS and NCQA requirements, and CenCal Health priorities.

CenCal Health implements and 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. Administrative oversight of the health education system is overseen by a certified full-time health educator. Health education materials are provided to members in accordance with regulatory requirements, including ensuring that they are culturally and linguistically appropriate, and that they meet all readability and suitability requirements.

The activities and interventions within CenCal Health's Wellness and Prevention Program and Health Education System align with CenCal Health's QIHETP to support quality improvement, health equity, and PHM priorities.

- For additional details, please refer to *Appendix E – Wellness and Prevention Program Description*

F. Whole Child Model Program

CenCal Health's Pediatric Whole Child Program (PWCP) is a comprehensive member-centered program which aims at addressing all the aspects of health care for members aged 0-21 years old, including comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS eligible conditions. The PWCP will help families and health care providers obtain integrated and coordinated necessary health care services for children and youth under 21.

The PWCP's key features include streamlined processes, delivery of coordinated and organized services, decrease fragmentation of care, and promotion of quality care to children and youth. The facilitation and/or coordination of the right care at the right time and right place are key factors.

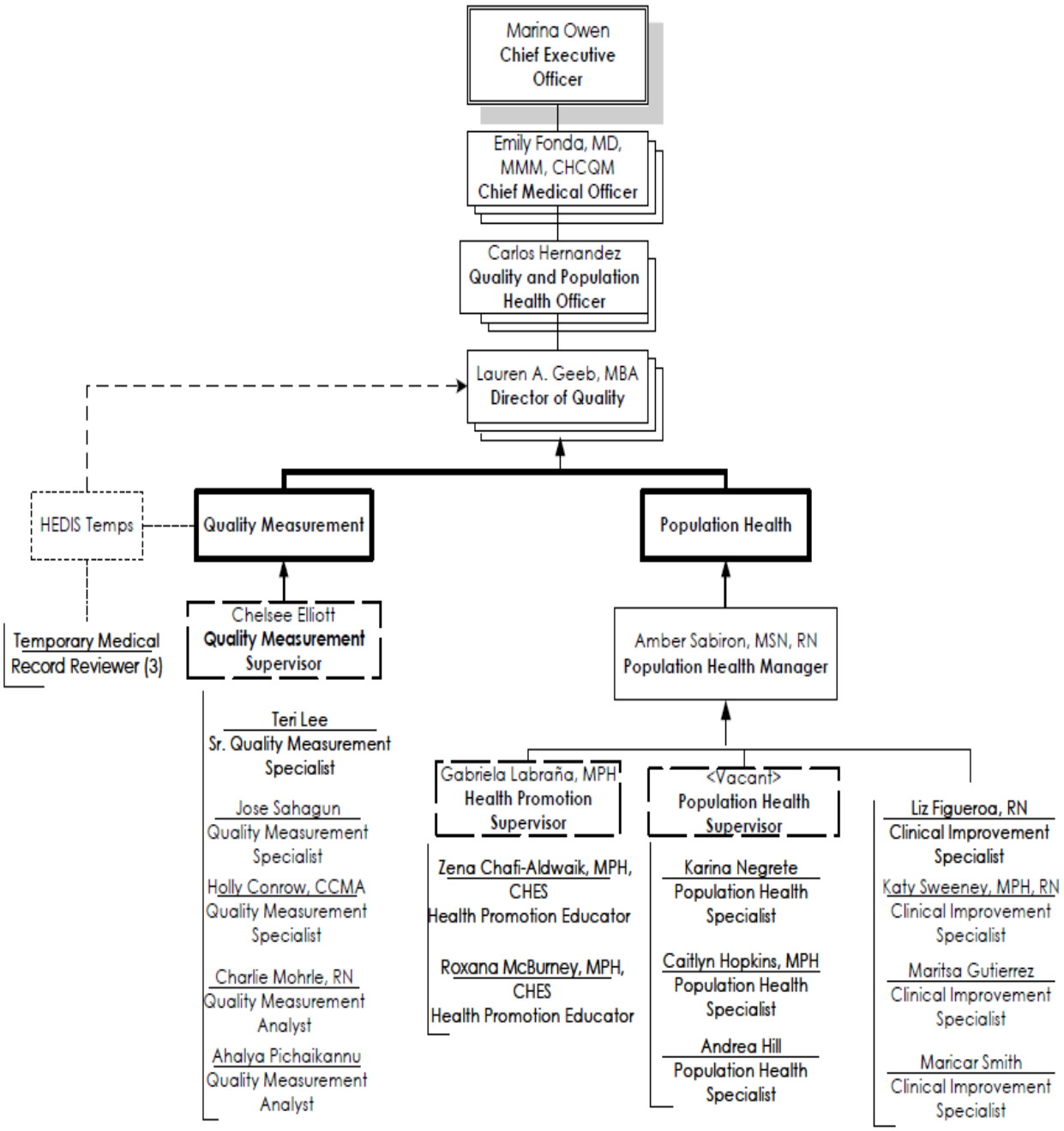
- For additional details, please refer to *Appendix F - Whole Child Model Program Description*

VIII. PROGRAM RESOURCES AND ANALYTICAL SUPPORT

Resources dedicated to CenCal Health's QIHETP are broad and include cross-departmental staff (clinical and non-clinical), data sources, and analytical expertise. Evaluation of the QIHETP resources is determined through evidence that the organization is successfully completing its quality improvement and health equity activities and meeting or exceeding identified goals in a timely and consistent manner

per the QIHETP work plan. An assessment of CenCal Health's QIHETP occurs annually by CenCal Health and its quality committees, and subsequently evaluated and approved by the Board of Directors. Throughout the year, performance and progress are monitored based on identified activities and key performance indicators.

Although the execution of QIHETP functions is spread among all departments across he organization, CenCal Health's Quality Department is responsible for operational oversight. Below are the resources and analytical support within the Quality Department dedicated to QIHETP:



Chief Medical Officer
As noted in *Section V. Authority and Responsibility*, the Chief Medical Officer (CMO) provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on Quality Improvement and Health Equity Annual Work Plan. The assigned activities for this position include but are not limited to:

- Assuring that the QIHETP program fulfills its purpose, works towards measurable goals, and remains in compliance with regulatory requirements.
- In collaboration with the Chief Health Equity Officer, oversees QIHETP operations and assists in the development and coordination of QIHETP policies and procedures.
- Serves as the Chair of QIHEC.
- Guides and assists in the development and revision of QIHETP policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for QIHEC review

Quality and Population Health Officer
The Quality and Population Health Officer leads the development and evolution of a systematic, organization-wide quality and population health strategy to improve member health outcomes through facilitation of CenCal Health's QIHETP.

Director of Quality
The Director of Quality is responsible for strategy development, planning, organizing, and leading the functions and activities of the Quality Department including population health management, quality measurement, clinical transformation, and health promotion. The Director of Quality develops, implements, leads, and directs the department in support of the QIHETP and population health programs and initiatives for CenCal Health.

Population Health Manager
The Population Health Manager is responsible for the daily operations, direct oversight, and functions of the population health, clinical quality, and health promotion teams. In coordination and collaboration with the Director of Quality, the Population Health Manager supports the execution and implementation of a Population Health and Quality Strategy to achieve health equity.

Population Health Specialists
Population Health Specialists support the year-round design, implementation, and maintenance of innovative improvement interventions and population health programs to maximize the quality of identified clinical priorities and address membership needs to advance health equity. This role supports health status improvement through access to services, education, wellness support, and reinforcing the importance of preventive health.

Health Promotion Supervisor
The Health Promotion Supervisor is responsible for leading the Health Promotion team by guiding development, design, implementation, maintenance, and evaluation of the health education functions essential to maintain compliance with the DHCS contract and to advance the general health status of CenCal Health's members. A masters-prepared professional, as defined by DHCS APL 18-016, responsible for preparation and implementation of the PNA and Action Plan.

Health Promotion Educator(s)
Health Promotion Educators design, implement, and maintain the health education functions essential to advance the general health status of CenCal Health's members and reduce health disparities. They support the integration of health promotion and education within PHM and contribute to the advancement of CenCal Health's Health Promotion Program to improve population health and achieve health equity.

Quality Measurement Supervisor
The Quality Measurement Supervisor is responsible for the Quality Measurement team providing leadership, mentorship, and supervision of daily operations and functions. The unit executes CenCal Health's regulatory and NCQA reporting of industry-standard quality of care measurements. They support the maximization of data accuracy, completeness and integration of measurements, CenCal Health's plan wide regulatory audit readiness, and the day-to-day management and oversight of initiatives to assure successful demonstration of CenCal Health's value to external stakeholders.

Quality Measurement Specialists
Quality Measurement Specialists are responsible for the year-round design, implementation, and maintenance of innovative quality measurement interventions to maximize the efficiency and effectiveness of identified quality measurement priorities by measuring key performance indicators. They assist with the creation and maintenance of administrative databases to continually increase the operational efficiency of measurement processes and analyses to achieve ongoing quality improvement priorities.

Quality Measurement Analysts
Quality Measurement Analysts are responsible for providing analytical support to the Quality Department's strategic objectives. They perform surveillance of innovative quality improvement interventions, provide ongoing clinical measurement and improvement processes, such as year-round Gaps in Care reporting, and function as a primary systems configuration analyst, programmer/analyst, and technical liaison to IT Department programmers in support of quality measurement initiatives.

Clinical Improvement Specialists
The Clinical Improvement Specialist are licensed Registered Nurses who support year-round design, implementation, and maintenance of population health and quality

improvement interventions to maximize the quality of identified clinical priorities, reduce inequities, and maximize NCQA Accreditation readiness and clinical performance. They work to improve clinical quality of identified clinical priorities to achieve health equity. They execute processes to identify, document, and investigate potential clinical grievance/appeals and clinical quality concerns; assure effective coordination with, and the systematic involvement of, CenCal Health physician designee to process clinical investigations.

Additional Resources
The following individuals and departments provide additional expertise and oversee key components of the QIHETP outside of Quality Department staff to carry out required QIHETP functions:

- Behavioral Health
    - Medical Director, Behavioral Health
    - Director, Behavioral Health
- Claims
    - Director, Claims Operations
    - Associate Director, Claims
    - Senior Claims Configuration Quality Assurance Analyst
- Compliance
    - Chief Compliance Officer
    - Compliance Director and Privacy Officer
    - Compliance Manager
- Finance
    - Chief Financial Officer
- Information Technology
    - Deputy Chief Information Officer
    - Associate Director, Data Analytics
    - Programmer/ Data Analyst
- Legal
    - General Counsel
- Medical Management
    - Senior Medical Director
    - Health Services Officer
    - Director, Medical Management
    - Associate Director, Utilization Management
    - Associate Director, Case Management
- Member Services
    - Director, Member Services
    - Grievance and Appeals Quality Manager
- Operational Excellence
    - Chief Performance Officer
    - Director, Operational Excellence

- Pharmacy
    - Director, Pharmacy Services
    - Associate Director, Pharmacy Services
- Provider Services
    - Director, Provider Services
    - Director, Provider Relations
    - Provider Quality & Credentialing Manager
    - Provider Services Contracts Manager

IX. DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

CenCal Health does not delegate quality management functions. If quality management functions were to be delegated in the future, CenCal Health will oversee and have final responsibility for all delegated quality management functions. At minimum, the delegated entity would be evaluated annually to ensure functions are conducted in compliance with CenCal Health's expectations to meet regulatory and/or NCQA Accreditation requirements.

X. COLLABORATIVE QUALITY IMPROVEMENT ACTIVITIES

CenCal Health works on collaborative quality improvement activities with other stakeholders including but not limited to primary care physicians (PCPs), clinic systems, local health departments, community-based organizations, the Department of Health Care Services, and other health plans.

CenCal Health's work with its PCPs and clinic systems include collaboration to support practice transformation to sustainably achieve clinical guideline compliance and reduce health care disparities to improve health outcomes for CenCal Health's membership. CenCal Health also collaborates with its PCPs and clinic systems to promote success with its pay-for-performance value-based Quality Care Incentive Program through Quality Collaborative and educational engagements.

To deepen understanding of membership needs and strengthen CenCal Health's relationship with the communities served, CenCal Health established a collaboration with LHDs in Santa Barbara and San Luis Obispo counties. CenCal Health is participating meaningfully in their Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs). Through this effort, shared goals and objectives were co-developed in alignment with DHCS' Bold Goals initiative to achieve significant improvements in clinical and health equity outcomes by 2025 for pediatric preventive care, behavioral health, and maternity outcomes (birth equity). The shared goals were specifically defined to improve:

- Pediatric preventive care (Santa Barbara Public Health Department)
- Adolescent depression screening (San Luis Obispo Public Health Department)

This collaboration will enhance CenCal Health's ability to identify the needs within member communities so that together, we can more effectively improve members' lives with a coordinated approach to population health management.

In addition to engaging with providers, CenCal Health collaborates with community based organizations and other health plans in the designing and development of interventions for Performance Improvement Projects (PIPs) and other quality/health equity-based quality projects.

CenCal Health routinely works with DHCS and NCQA as participants in advisory committees for different initiatives.

XI. EVALUATION

The overall effectiveness of CenCal Health's QIHETP is evaluated annually by CenCal Health's Quality sub-committees and reviewed by the QIHEC, with subsequent reporting to and approval made by the Board of Directors. Preparation for the annual Evaluation involves participation by all QIHETP leadership including but not limited to CenCal Health's CMO, CHEO, Behavioral Health Medical Director, Quality and Population Health Officer, and Quality Director.

At minimum the annual Evaluation includes:

- A description of completed and ongoing quality improvement activities that address quality and safety of clinical care, quality of service, and member experience.
- Trending of measures of performance in the quality and safety of clinical care and quality of service.
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices.
- A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions.
- A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies.
- An analysis of actions taken to address any CenCal Health-specific recommendations in the annual External Quality Review technical report and CenCal Health's specific evaluation reports.
- An analysis of the delivery of services and quality of care of CenCal Health and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of consumer satisfaction surveys.
- Equity-focused identified patterns of over- or under-utilization of physical and behavioral health care services, with corresponding planned interventions described in the Annual Work Plan to address identified utilization patterns.

- A description of CenCal Health's commitment to member and/or family-focused care through member and community engagement such as review of Community Advisory Board findings, member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how CenCal Health utilizes the information from this engagement to inform CenCal Health policies and decision-making.
- PHM activities and findings.
- Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.
- To the extent that CenCal Health delegates its quality improvement and health equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, CenCal Health's quality improvement and health equity annual plan includes evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance.

XII. WORK PLAN

The QIHETP was developed in alignment with CenCal Health's organizational strategic priorities and tactics to ensure the annual Work Plan is in support of achieving CenCal Health's mission and vision. To assure successful performance, CenCal Health's leadership is responsible for setting appropriate goals and objectives for staff and those involved in the QIHETP. CenCal Health's Quality Department leads the annual development of the QIHETP Work Plan, in coordination with all QIHETP participants (Quality Committees) plan wide, including but not limited to CenCal Health's CMO, CHEO, Behavioral Health Medical Director, Quality and Population Health Officer, and Quality Director.

At minimum the annual Work Plan includes:

- Yearly planned quality improvement activities and objectives, that address quality of clinical care, safety of clinical care, quality of service, and member's experience.
- Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services.
- The specific time frame for each activity's completion, including date.
- Staff members responsible for each activity, listed by role or title of lead staff-person.
- Monitoring of previously identified issues that require additional follow-up.
- Evaluation of the QIHETP, listed as a specific activity within the Work Plan, with a stated time frame and the role or title of lead staff person responsible for the evaluation.

The Work Plan is reviewed at least annually by QIHEC and approved by the Board of Directors. Progress on completion of planned activities and objectives is reported to the QIHEC quarterly, and subsequently the Board of Directors. To ensure compliance with regulatory requirements and evolving membership and community needs, updates

may be made throughout the year. Additional updates made to the work plan will be presented to the QIHEC and Board of Directors for approval on an ongoing basis.

XIII. AVAILABILITY OF PROGRAM TO PRACTITIONERS AND MEMBERS

CenCal Health's QIHETP including Description, Work Plan, and Evaluation is available on CenCal Health's website at www.cencalhealth.org on an annual basis. Additionally, printed copies are also available upon request.

XIV. NONDISCRIMINATION STATEMENT

Discrimination is against the law. CenCal Health follows state and federal civil rights laws. CenCal Health does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. CenCal Health provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CenCal Health between 8:00 a.m. – 5:00 p.m., Monday - Friday by calling 1-877-814-1861. Or, if you cannot hear or speak well, call TTY/TDD 1-833-556-2560 or 711 to use the California Relay Service.

How to file a grievance

If you believe that CenCal Health has failed to provide these services or unlawfully discriminated in another way based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with CenCal Health's Civil Rights Coordinator. You can file a grievance in writing, in person, or electronically:

- **By phone**: Contact CenCal Health's Civil Rights Coordinator between 8:00 a.m. – 5:00 p.m., Monday - Friday by calling 1-877-814-1861. Or, if you cannot hear or speak well, call TTY/TDD 1-833-556-2560 or 711 to use the California Relay Service.

- **In writing:** Fill out a complaint form or write a letter and send it to:
  Civil Rights Coordinator – Compliance Department
  4050 Calle Real, Santa Barbara, CA 93110

- **In person:** Visit your doctor's office or CenCal Health and say you want to file a grievance.

- **Electronically:** Visit CenCal Health's website at www.cencalhealth.org.

Office of Civil Rights – California Department of Health Care Services

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- **By phone:** Call 1-916-440-7370. If you cannot speak or hear well, call 711 (Telecommunications Relay Service).

- **In writing:** Fill out a complaint form or send a letter to:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

- Complaint forms are available at:
  https://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- **Electronically:** Send an email to CivilRights@dhcs.ca.gov.

Office of Civil Rights – U.S. Department of Health and Human Services

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing or electronically:

- **By phone:** Call 1-800-368-1019. If you cannot speak or hear well, call TTY 1-800-537-7697 or 711 to use the California Relay Service.

- **In writing:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

- Complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html.

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at .

XV. CONFIDENTIALITY AND CONFLICT OF INTEREST

Confidentiality

All employees, paid or unpaid interns, volunteers, contractors and employees from temporary help services, will be thoroughly briefed about confidentiality rules and procedures and must read and sign the Oath of Confidentiality required by CenCal Health's contract with the State of California, and CenCal Health. Employees who violate this policy are subject to disciplinary action up to and including discharge and legal action.

CenCal Health currently has and will continue to develop and own certain proprietary data and other confidential information that is not generally known outside of the organization and either has value in CenCal Health's operations or is private. This proprietary data and confidential information (referred to as "Confidential Information") includes, but is not limited to, the following: (a) patient names and medical information; (b) unique protocols and procedures developed and/or used by CenCal Health; (c) curricula, scripts and other program materials developed and/or used by CenCal Health in its training and educational programs; (e) information concerning compensation paid to employees and other terms of employment disclosed in confidence to an employee by CenCal Health in conjunction with the employee's performance of job duties; (f) software or other intellectual property developed by CenCal Health's staff or consultants; and (g) any other confidential information of, about, or concerning CenCal Health, its manner of operation, or other confidential data of any kind, nature or description.

All CenCal Health employees agree that at all times during and after their employment with CenCal Health they will hold in trust, keep confidential, and not disclose to any third party or make any use of Confidential Information except for the benefit of CenCal Health in the course and scope of their employment with CenCal Health, unless CenCal Health otherwise consents to it in writing. Upon the conclusion of employment, all employees shall promptly and without request return all CenCal Health Confidential Information, data or documents.

Conflict of Interest

Employees are expected to avoid, and not engage in, situations or business practices that conflict with the interests of the company. If under any circumstance, Employees' interests conflict with those of CenCal Health's, in all such cases the Employee must seek advice from the Chief Compliance Officer and his or her supervisor or senior management. The offering, giving, soliciting, or accepting any form of bribe or other

improper payment is expressly prohibited. CenCal Health business must be executed in a manner designed to further the interests of CenCal Health, rather than the interests of an individual.

Employees shall not accept or solicit personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or organization unless specifically permitted by CenCal Health. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department are not subject to any specific limitation. Business meetings at which a meal is served are not prohibited from being provided by CenCal Health to a partner, or by a partner to CenCal Health. CenCal Health and its employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose and are approved by the Legal Department.

XVI. APPENDIX

- Appendix A - Behavioral Health Program Description 2024
- Appendix B – Care Management Program Description 2024
- Appendix C – Population Health Management Strategy and Program Description 2024
- Appendix D – Utilization Management Program Description 2024
- Appendix E – Wellness and Prevention Program Description 2024
- Appendix F – Whole Child Model Program Description 2024

CenCal HEALTH®
Local. Quality. Healthcare.

2024 Behavioral Health Program Description

Review
Utilization Management Committee: 2/12/2024

Quality Improvement and Health Equity Committee: 2/29/2024

Board of Directors: 3/20/2024

TABLE OF CONTENTS

I. MISSION STATEMENT

CenCal Health's Mission Statement is *"to improve the health and well-being of the communities we serve by providing access to high quality health services, along with education and outreach, for our members."*

CenCal Health is committed to excellence through the operations of the Behavioral Health Department.

II. AUTHORITY

The Chief Medical Officer (CMO) oversees all clinical aspects of the Behavioral Health Program. For all lines of business, the Primary Care Physician is responsible for managing aspects of the member's health care needs, including basic case management services. To this end, all members select a PCP at the time of enrollment and are encouraged to establish a relationship with the physician as soon as possible. The member is instructed to contact his or her PCP whenever medical health care is needed. Thus, the PCP is informed about the member's needs and can make informed decisions regarding treatment.

III. PURPOSE

CenCal Health's Behavioral Health Program is designed to promote the delivery of high quality, medically necessary, and cost-efficient health care for our members. CenCal Health develops, implements, and improves its UM Program as needed or at minimum annually to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered services for its Members.

CenCal Health's Behavioral Health Program is a system integrated with CenCal Health's Quality Improvement and Health Equity Transformation Program (QIHETP) to promote the continuous monitoring and evaluation of care and services provided to members. The program is designed to identify patterns of utilization and ensure efficient use of resources. The Utilization Management Committee (UMC) approves the Behavioral Health Program Description annually and the Quality Improvement and Health Equity Committee (QIHEC) evaluates the key performance indicators at minimum quarterly and as needed.

IV. SCOPE OF THE PROGRAM

The scope of the Behavioral Health Department utilization management activities covers psychological testing, neuropsychological testing and Behavioral Health Treatment services. Outpatient Non-Specialty Mental Health Services do not require a referral nor authorization. Specialty Mental Health Services (SMHS) are a carve out to the County Department of Behavioral Health for Members who are severe in level of impairment of functioning. The CenCal Health Behavioral Health Department is the liaison between the County Departments of Behavioral Health and Drug Medi-Cal

Organized Delivery Systems and ensures, through collaboration, member's timely access to care. Additional, activities within the scope of the Behavioral Health Department are provided within the Operational Description section of this document.

V. GOALS AND OBJECTIVES

Behavioral Health Utilization Management is performed to promote an effective and efficient health care delivery system. The Behavioral Health program is designed to evaluate the medical appropriateness of services provided by participating physicians and other practitioners as well as facility providers and other ancillary providers. The goals of the Behavioral Health Program are to promote appropriate utilization, which includes evaluation of both potential over- utilization and under-utilization and care coordination as it pertains to supporting access to care.

The purpose of the Behavioral Health program is to achieve the following objectives for all members:

- Support the provision of effective, efficient and appropriate utilization of services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization and ensure the efficient use of resources.
- Promote fair and consistent Utilization Management decision-making.
- Focus resources on a timely resolution of identified problems.
- Promote and sustain optimal quality of care.
- Educate providers and other health care professionals about appropriate and cost- effective use of health care resources.
- Provide feedback as part of Medical Management to establish, update, and approve criteria for medical necessity at least annually.
- Promote consistency in authorization processing through application of defined criteria for clinical decision-making.
- Educate medical practitioners, providers, and other health care professionals about appropriate and cost-effective use of health care resources.
- Work cooperatively with practitioners and providers to promote appropriate management of all aspects of members' health care.
- Provide a system to monitor the delivery of services in a timely, effective and efficient manner consistent with the delivery of quality care.
- Continually monitor, evaluate and optimize health care resource utilization.
- Monitor utilization practice patterns of the physicians and specialty providers.
- Provide appropriate and timely feedback to members and practitioners to communicate reasons for treatment denial, the minimum clinical criteria required for authorization, and methods for appeal.
- Safeguard medical records, treatment authorization, and all other confidential information through appropriate operational protocols and use of physical mechanisms to protect member-specific information used in Utilization Management.
- Coordinate Utilization Management with quality management activities to support the ongoing monitoring of compliance with quality standards for the delivery of health services to members.
- Routine review of out-of-network seldom used specialty services.
- Conduct regular interrater reliability testing of physicians and non-physician, clinical behavioral health staff.

- Educate members regarding Federal, State, and local government and community resources as it pertains to Behavioral Health needs.
- Improve Member and provider satisfaction.
- Collaborate, provide support and advocacy to members and providers throughout the continuum of care.

VI. PROGRAM STRUCTURE

A. Organizational Structure

The CMO is responsible for all clinical aspects of the UM Program and ensures adherence to all regulatory requirements. CenCal Health's Health Services Division has operational, administrative, and fiscal responsibility for the UM Program. To effectively achieve program goals and objectives, the UM Department is comprised of licensed and non-licensed healthcare professionals, which may include registered nurses (RNs), licensed nurses or therapists, physicians, health educators, and other professionals to support UM operations.

CenCal Health members come from low-income families, but also include members that are seniors or persons with disabilities. To provide quality care to these members, the UM Program structure relies on a multidisciplinary approach to ensure efficient delivery of health care services in the best setting suited to meet the medical and psychosocial needs of the members.

B. Authority and Accountability

The Behavioral Health Program clinical functions are under the direction of the CMO, and operational administrative functions are under the direction of the Health Services Officer (HSO). The CMO retains responsibility for the utilization review process in accordance with H&S Code section 1367.01. Qualified licensed and non-licensed healthcare professionals, including health services specialists, nurses, physicians, and other clinically educated professionals have authority to function within the UM Program within the scope of their job descriptions.

The CMO is clinically focused and responsible for CenCal Health's Quality Program, Pharmacy Services, Behavioral Health, and all clinically related aspects of Utilization Management, Case Management, and Disease Management. Responsibilities include program development, implementation, and evaluation; participation in quality of care and clinical appeal and grievance review processes; physician review and oversight and quality monitoring; medical leadership for the health plan; and physician case reviews.

Reporting to the CMO, the Senior Medical Directors and Medical Directors are also responsible for the UM program. They have appropriate experience that include education, training, and professional experience in medical or clinical practice. Additionally, they must have a current license to practice without restrictions in California.

The Behavioral Health Director and Behavioral Health Manager are responsible for the day-to-day operations of the Behavioral Health Department. The Behavioral Health Director reports to the HSO. These leaders have appropriate health care experience and are responsible for overseeing the day-to-day UM activities, which

includes adhering to regulatory standards, performing clinical review, and applying appropriate decision-making guidelines.

The HSO is operationally focused and responsible for Pharmacy, Utilization Management, Care Management, Disease Management, and Behavioral Health. Responsibilities include operational administrative oversight of program development, implementation, evaluation, execution, and day to day operations, for example Turn-Around-Times and Staffing.

If required, CenCal Health utilizes board-certified physician consultants or accesses our external review organization's board-certified physicians to assist in making medical necessity determinations. UM dedicated physicians and physician consultants assure day-to-day utilization management and other specialty UM program decisions are based on medical necessity, medical appropriateness, within contractual provisions, and benefit coverage, while considering the need of individual members and characteristics of the local delivery system. UM determinations also consider the unique, including cultural, needs of the member and capacity and capabilities of the medical delivery system.

Clinical determinations based on medical necessity are made by appropriate licensed professionals. Decisions to deny a request for medical necessity may only be made by a physician or pharmacist. A pharmacist may deny requests for coverage of physician-administered-drugs requiring authorization through the medical benefit via procedure code.

To ensure that the first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, CenCal Health has adopted standards for personnel making review decisions. The following types of personnel can perform the functions listed:

1. Clinical Support Associates complete eligibility determinations, review referral forms for completeness, and interface with providers to obtain necessary, supporting clinical documentation for clinical review.

2. Licensed Professionals and Board-Certified Practitioners, which include Registered and UM Specialists, such as Licensed Nurses, Board-Certified Behavior Analysts, and Licensed Therapists, perform initial review or basic assessment of medical information, initial determination of benefit coverage, obtain additional supporting medical information from providers, and approve medically necessary referrals and services based on established guidelines. Under the supervision of a Licensed Professional, a UM Specialist can gather clinical notes and apply established clinical guidelines to perform basic review for service requests,

3. A designated licensed physician is responsible for all denials/modifications that are based on medical necessity and can directly obtain additional medical information from the treating physician as needed.

C. Committee Structure

CenCal Health's QIHEC is charged with responsibility for oversight for all the UM Program's activities and processes. The CMO or designee in collaboration with the

Chief Health Equity Officer (CHEO) chairs the QIHEC. A written summary of the QIHEC's proceedings are reported to CenCal Health's Governing Board (Board of Directors) at least quarterly, and more frequently if needed.

The QIHEC is also CenCal Health's medical advisory body charged with evaluating clinical policies and reviewing and approving all significant clinical initiatives and programs to assure appropriate clinical input from contracted provider network practitioners prior to and/or during implementation. The oversight of the UM Program is reported to the UMC quarterly, which is a subcommittee of the QIHETP. The UMC includes the participation and oversight by the Chief Medical Officer or Medical Director designee, the Behavioral Health Medical Director, Health Services Officer, the Quality Officer (QO) and other CenCal Health leadership to include at a minimum the Member Services Director supporting the appeals and grievances report related to UM.

The QIHETP continually strives for excellence and quality in health care delivery and service to CenCal Health's members, providers, internal customers, and the community by pursuing meaningful and measurable activities to improve processes, outcomes, and satisfaction.

VII. BEHAVIORAL HEALTH ACTIVITIES

To meet the purpose, scope, and goals of the Behavioral Health Program approved by CenCal Health's Board of Directors, Behavioral Health activities are focused in the following areas:

1. Annual evaluation, update and approval of the Behavioral Health Program Description.
2. Feedback on the annual update and adoption of clinical UM criteria, and the process for applying those criteria.
3. Quarterly reporting to the UMC on Key Performance Indicators (KPIs) including but not limited to; measurements of the number and percentage of denials, deferrals, modifications, each by type of authorization service request. The KPIs also include the number and percentage of appeals and grievances related to UM.
4. Consistent application of written UM criteria to support UM decisions by qualified licensed and board-certified health professionals, and the ongoing measurement of consistency in UM decisions as demonstrated through inter-rater reliability reviews.
5. Timely UM decisions and communication of such decisions to practitioners and, as indicated, to members.
6. Participation in the evaluation of investigative, experimental, or new medical technologies.
7. Evaluation of member, practitioner, and provider satisfaction with the UM and Care Coordination process.
8. Monitor and evaluation of the appropriate utilization of services; and decrease duplication of services.
9. Review and update of the physician-administered drug formulary and procedures for pharmaceutical management to promote the clinically appropriate use of pharmaceuticals.
10. Facilitation and access to medically necessary, covered services and

appropriate, cost-effective care to members.

11. Evaluate non-benefit exceptions.
12. Review out-of-network, seldom used specialty services.
13. Complete care coordination to Non-Specialty Mental Health Services and for Behavioral Health Treatment Services.
14. As appropriate, make referrals to Case, Disease Management, Substance Use Disorder Programs, Specialty Mental Health Services, Community Supports (CS), and Enhanced Care Management (ECM) for care coordination and/or disease-specific education.

VIII. BEHAVIORAL HEALTH PROCESS

CenCal Health's Health Services Department maintains departmental policies and procedures. These policies and procedures are reviewed annually and updated on an as-needed basis.

Behavioral Health UM decisions are based only upon appropriateness of care and service, medical necessity and existence of coverage. Behavioral Health staff (physician and non-physician staff) are not financially or otherwise compensated to encourage underutilization and/or denials. Compensation of individuals or entities that conduct UM activities are not structured to provide incentives to deny, limit, or discontinue Medically Necessary services. An attestation is signed by all clinical reviewers upon hire and annually thereafter, that UM determinations will not be unduly influenced by fiscal and administrative management considerations.

The Chief Medical Officer, Senior Medical Director, Medical Directors, Pharmacists, and contracted Physician Reviewers, as appropriate, are the only representatives with the authority to deny coverage for a service based on medical necessity or medical appropriateness.

The Primary Care Physician (PCP) is responsible for coordinating most aspects of the member's health care. However, members may access Emergency Services, Minor Consent Services, family planning services, basic prenatal care, sexually transmitted disease services, HIV testing, outpatient psychotherapy services, outpatient medication management services, and Limited Services without PCP referral or prior authorization. Regardless of the referral requirement, members are encouraged to seek their PCP's advice before seeking specialist consultation and treatment.

IX. BEHAVIORAL HEALTH CRITERIA AND MEDICAL NECESSITY

CenCal Health uses written objective criteria based on sound clinical evidence in making utilization decisions based on medical necessity. CenCal Health's policy on the adoption and development of clinical utilization management criteria defines eligible criteria sources, and the process for development, adoption, and review of clinical criteria.
CenCal Health ensures that its Utilization Management authorization decisions for Members' care is based on Medical Necessity of a requested service consistent with Member's Handbook and Covered benefits and in accordance with California State Criteria and California Children's Services.

CenCal Health ensures that policies and procedures for authorization decisions are based on the medical necessity of a requested health care service and are consistent with criteria or guidelines supported by sound clinical principles and evidence based.

- The criteria and/or guidelines used by CenCal Health to determine whether to authorize, modify, or deny healthcare services are developed from actively practicing healthcare providers, are consistent with sound clinical principles and processes. The criteria and guidelines are evaluated and updated, if necessary, at least annually.
- At least annually, network providers and members are notified that CenCal Health approved UM Criteria and/or guidelines are available upon request by contacting CenCal Health. If used as the basis of a decision to modify, delay, or deny services in a specific case, the UM Criteria/Guidelines are disclosed to the provider and the member upon request.

Clinical criteria used by CenCal Health or any Subcontractor or Downstream Subcontractor of CenCal Health when assessing medical necessity of covered services are also available on CenCal Health's website and upon request. These policies provide how CenCal Health authorizes, modifies, delays, or denies coverage of health care services through authorization requests which include prior, concurrent, and retrospective reviews.

- CenCal Health considers the available services in our local delivery system and our ability to meet the Member's specific heath care needs when applying UM Criteria which includes:
- Availability of inpatient, outpatient and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as surgi-centers vs inpatient services
- Availability of highly specialized services, such as transplants facilities or cancer centers
- Availability of skilled nursing facilities, subacute facilities, or home care in service area to support Members need after hospital discharge
- CenCal Health ensures that policies, processes, strategies, evidentiary standards, and other factors used for UM or Utilization Review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- CenCal Health notifies network providers, as well as members and potential members upon request, of all services that require prior authorization, concurrent authorization, or retrospective authorization, and ensures that all network providers are aware of the procedures and timeframes necessary to obtain authorization for these services.
- All UM activities are performed in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

The following factors that relate to the individual may be considered when applying clinical UM criteria:

- Age
- Co-morbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

CenCal Health shall utilize written UM decision-making criteria that are objective and based on sound medical evidence. Please refer to policy #HS-UM22, Clinical Criteria for Utilization Management Decisions for detailed information and to view the list of clinical guidelines adopted by CenCal Health. Some of the approved criteria include:

1. **Department of Health Care Services (DHCS)**
   - Medi-Cal Provider Bulletins and Manuals
   - Medi-Cal Managed Care All Plan Letters
   - California Children's Services (CCS) Guidelines and Numbered Letters

   Includes information on Medi-Cal and CCS services, programs, and claim reimbursement. Medi-Cal bulletins and manuals are available in its entirety free of charge on the Internet at www.medi-cal.ca.gov. CCS Numbered Letters are available at www.dhcs.ca.gov/services/ccs
2. **CenCal Health Policies**
3. **MCG® Guidelines** – Evidence-based clinical guidelines used for decision-making that are based on medical literature, textbooks and nationally recognized guidelines published in all fields of medicine, practice observations and database analyses, and review by expert consultants. Licensed guidelines are applied when Medi-Cal or the Centers for Medicare and Medicaid Services (CMS) guidelines are outdated, nonspecific, or nonexistent.
4. **Magellan Rx Management Library of Medical Necessity Criteria** – Evidence-based clinical guidelines used for decision-making on physician-administered-drugs based on medical literature, nationally recognized guidelines published in all fields of medicine, practice observations, and database analyses. Criteria is vetted through Magellan's Medical Necessity Criteria (MNC) committee and CenCal Health's Pharmacy & Therapeutics Committee
5. **Other Nationally Recognized Guidelines** - Nationally recognized health care and professional organizations, which includes evidence-based guidelines published by national entities, such as the National Guideline Clearinghouse, National Institute for Health, American College of Obstetricians and Gynecologists (ACOG), and other professional medical associations.

The intent of utilizing established screening and decision criteria is to promote consistency of reviews. The licensed staff, board certified staff, physician reviewers, and other associates who work in a capacity that allows him/her to apply screening and decision criteria is audited periodically but no less than yearly, for interrater reliability (IRR). The clinical management team compiles and analyzes the IRR results and review findings in the Utilization Management Committee and then up to the QIHEC. When an opportunity for improvement is identified, the Chief Medical Officer, Senior Medical Director, and Health Medical Director initiates an action plan to improve the consistency of applying UM criteria.

X. BEHAVIORAL HEALTH OPERATIONAL DESCRIPTION

A. Scope of Program Activities

The Behavioral Health Program's scope is comprehensive, systematic, and continuously refined to meet changing regulatory requirements. Behavioral Health processes support confidentiality of member-specific information obtained during utilization and care coordination activities. Any member-specific information obtained is kept confidential and in accordance with applicable laws and organizational policies. Clinical information submitted or obtained is used solely for the purposes of utilization management, quality management, care coordination, and discharge/transition planning activities. Clinical information is only shared with those entities who have authority to receive such information and only with those individuals who need access to such information to conduct utilization management and related processes.

CenCal Health is responsible for the provision of Non-Specialty Mental Health Services:

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

Primary Care Providers (PCPs) are responsible for performing routine mental health screenings of their patients and to provide mental health services within their scope of practice. PCPs do not need authorization to perform these services. If a PCP is unable to provide these services, they must refer a member to an in network Mental Health Practitioner.

Outpatient Mental Health Services may be accessed by Members by: searching the provider search tool and scheduling directly with a contracted CenCal Mental Health Practitioner, calling the Behavioral Health Call Center for assistance to identify an available in-network provider, or the PCP may submit a care coordination request directly to the Behavioral Health Department.

Members do not require a pre-authorization or a referral from a PCP for an initial assessment to determine medical necessity for mental health services, although a Behavioral Health Care Coordination Request is one mechanism to ensure access particularly when a Member has completed a mental health or substance use screening and the PCP/Member agrees on a referral to Mental Health services. Pre-authorization is required for Behavioral Health Treatment (ABA), Psychological and Neuropsychological testing. To the extent possible and permissible by current privacy and confidentiality regulations, mental health and general medical management is integrated for optimal health outcomes through care coordination activities.

The Behavioral Health Department coordinates referrals to the County Mental Health Plan for members who are screened to meet the County's level of care on the DHCS Screening for Mental Health Services or for whom a Mental Health Practitioner has assessed and completed a Transition of Care for. County Mental Health Programs cover Specialty Mental Health Services such as crisis services, inpatient, and residential

rehabilitation services to CenCal members.

CenCal Health requires that primary care providers (PCPs) within their scope of practice provide screening, assessments, behavioral counseling interventions and referrals to treatment (SABIRT) to Members 11 years of age and older, including pregnant women, for unhealthy alcohol use, unhealthy drug use, and tobacco use. Alcohol screening and behavioral counseling interventions do not require pre-authorization. Members who, upon screening and evaluation at the primary care level, meet criteria for an alcohol use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM V) or whose diagnosis is uncertain, must be referred to the County Department for Alcohol and Substance Use Disorder Treatment Services, Prior Authorization is not required.

CenCal Health ensures the provision of all Medically Necessary EPSDT services, including BHT services for eligible beneficiaries under 21 years of age when they are covered under Medicaid, regardless of whether California's Medicaid State Plan covers such services for adults. This includes children with autism spectrum disorder (ASD) for whom a licensed physician, surgeon, or psychologist determines that BHT services for the treatment of ASD are Medically Necessary, regardless of diagnosis. CenCal Health has primary responsibility for ensuring that all of a Member's needs for Medically Necessary BHT services are met across environments, including on-site at school or during virtual sessions.

The Behavioral Health Care Manager team completes utilization management reviews for all requests for BHT services and completes care coordination, including identifying members who may benefit from case management services and referring to the Case Management Department.

The Behavioral Health Program provides access to practitioners and members to communicate with the department that includes:

1. Availability of Behavioral Health staff for at least 8 hours a day during normal business days (Monday-Friday, excluding holidays) for inbound calls regarding UM and care coordination issues. Communications received after normal business hours are returned on the next business day, and communications received after midnight on Monday–Friday are responded to on the same business day.
2. Ability of Behavioral Health staff to receive inbound communication after normal business hours regarding Behavioral Health UM issues via fax, the Provider Portal, secure link and/or confidential voice mail.
3. Outbound communication from UM staff regarding inquiries about UM issues during normal business hours (Monday-Friday, excluding holidays), unless otherwise agreed upon.
4. Behavioral Health staff identifies themselves by name, title, and organization name when initiating or returning calls regarding Behavioral Health issues.
5. Behavioral Health staff, upon request from the caller, provides information regarding utilization management and care coordination requirements and procedures.
6. A toll-free number to contact appropriate staff at CenCal Health.
7. CenCal Health provides a separate phone number for receiving TDD/TTY messages or will use the States/711 Relay Services.

8. For all members who request language services, CenCal Health provides services, free of charge, in the requested language through bilingual staff or an interpreter. This factor does not apply to after-hours communications. Use of contracted translation services is not considered delegation.

B. Care Coordination Referrals

Upon Member request, Practitioner referral or internal CenCal Health referral, the Behavioral Health Staff will perform care coordination activities that include obtaining appointments with mental health Practitioners for an initial health assessment or primary care providers for referral evaluation for Behavioral Health Treatment Services. Coordination of care is achieved through communication with the member or member's representative and the health care team (PCP, specialists, and other health care providers actively involved in the Member's care).

The Behavioral Health Department completes mental health care coordination to ensure the Members are referred to the appropriate level of care and an initial mental health assessment appointment is obtained with a contracted providers in network as indicated.
The Behavioral Health Department identifies members who may benefit for case management/care coordination and completes referrals to the Case Management Department for medical case management, Community Supports and/or Enhanced Care Management services.

Care Coordination activities as it relates to Behavioral Health (including mental health services):

- Identifying member needs and referring them to the appropriate services, such as case management, community supports, and enhanced care management.
- Completing the DHCS required screening for mental health services.
- Obtaining medically necessary covered services through CenCal Health
- Providing care coordination to services that are not covered by CenCal Health and providing an explanation as to why services are not covered by CenCal Health
- Assisting members to identify contracted mental health Practitioner that fit their needs and preferences and obtaining an appointment with a mental health Practitioner.
- Assisting with transportation assistance to/from appointments with MH or BHT Practitioners
- Educating members on compliance related behaviors and supporting a positive member-provider relationship
- Performing outreach to members who no longer qualify for Specialty Mental Health Services and care coordinating their care to an in-network provider to continue mental health services through the scheduling of an initial mental health assessment appointment.
- Educating members to improve health literacy as it relates to the Mental Health benefit and the Behavioral Health Treatment benefit.
- Identifying Federal, State, local programs and community resources that members may benefit from and care coordinating to those programs with appropriate consents.
- Coordinating medically necessary care with in-network and out-of-network providers.

- Assisting members with navigating through the health care delivery systems by providing education and identifying members that would benefit from case management services including Community Supports and Enhanced Care Management services.

PCP's, providers, and outside agencies may submit a request directly to the Behavioral Health Department for Member Care Coordination for Mental Health or Substance Use Treatment.

C. Behavioral Health Utilization Management Review Processes

The Behavioral Health Program includes utilization management operations that are conducted by Behavioral Health staff with the appropriate experience and expertise. Behavioral Health utilization management clinical review is performed by health care professionals who possess an active professional license or certificate. Pre- established decision criteria are used to assist in UM decisions regarding requests for healthcare or other covered benefits. CenCal Health ensures compliance with mental health parity requirements when providing BHT services.

When making a determination of medical necessity, the designated Behavioral Health reviewer obtains relevant clinical information and consults with the treating physician, as necessary. Authorization and notification of decision for proposed services or referrals at the practitioner level involves utilizing information such as medical records, test reports, specialists' consults, and verbal communication with the requesting practitioner in the review determination. As necessary, the Behavioral Health reviewer will contact the requesting provider for additional supporting information. Additionally, CenCal may discuss or consult with a board-certified specialist in the area of the requested service(s) to assist with decision-making.

Part of this review process is to determine if the service, whether seldom used or an unusual specialty service, is available in network. If the service is not available in network, arrangements must be made for the member to obtain the service from a non-network provider for this episode of care. The Chief Medical Officer, Deputy Chief Medical Officer or Behavioral Health Medical Director may be involved when specialty services from specialists outside the network are to be arranged.

When non-clinical staff are utilized to pre-screen requests for service, a licensed health care professional oversees this process. The non-clinical staff may review requests for completeness, collect clinical and non-clinical data; however, they do not evaluate or interpret clinical information.

If the designated Behavioral Health reviewer agrees that the request is clearly medically necessary and is a covered benefit, an appropriate authorization is provided. However, when the reviewer questions the appropriateness of the request or the request does not meet established clinical guidelines, decision-making is deferred to the Behavioral Health Medical Director or to a designated CenCal Health physician reviewer in absences of the Behavioral Health Medical Director. Behavioral Health reviewers also have access to board-certified physicians for consultation. At no time are decisions made by any staff member, clinical reviewer, or physician that is based on financial incentives or involve a conflict of interest. All decisions to not authorize or deny a request based on medical necessity are made only by a UM physician or for

pharmaceutical request, by a pharmacist.

The following is a brief description of the various processes that are UM Program components when reviewing approvals, modifications, denials, and delays as in CFR Section 438.900:

1. Pre-service (Prospective) Review

A process of review in which clinical information and requests are reviewed to determine medical necessity prior to rendering services. Review determinations are based on the medical information available and obtained at the time of the review. CenCal Health informs providers about the procedures and services that require prior authorization, including the timeframes necessary to obtain prior authorization, through the Provider Portal, Provider Manual, Provider trainings and Provider Bulletin. Requests that require pre-service review are psychological testing, neuropsychological testing, and Behavioral Health Treatment services (ABA). As appropriate, the Health Plan may require consultation with a specialist before authorization the requested service.

- Requests that require pre-service review may include but are not limited to:
    - BHT Services
    - Psychological Testing
    - Neuropsychological Testing
- Prior authorization requirements shall NOT apply to:
    - Emergency services
    - Initial mental health and SUD assessments
    - Other as prescribed by contractual or regulatory requirements

2. Concurrent Review

A process of initial and ongoing review of hospitalizations, which includes but not limited to acute care facilities, skilled nursing facilities, and acute rehabilitation facilities. Concurrent review is performed through communication with hospital or facility case managers, discharge planners, physicians, and other member-assigned healthcare professionals, as well as communication with the member/authorized representative, as appropriate.

This communication process generally performed by telephone review, through restricted access to electronic health data system.. The process incorporates use of pre-established decision criteria in order to approve appropriate medically necessary care and assigns the most appropriate level of care for continued medical treatment. Review determinations are based on the medical information available at the time of the review.

3. Post-service (Retrospective) Review

A process to obtain medical information and to determine medical necessity as it relates to services that have been provided/rendered when there has been no notification or request for review during the pre-service or concurrent process or when clinical information was not available at the time services were being rendered. Clinical notes are required for the post- service review process. Review determinations are based on the medical information available for review, medical necessity, availability and medical appropriateness of rendered services, as well as the application of guidelines and coverage limits.

4. Discharge Planning

A process that facilitates coordination of ongoing care, whether at a lower level of outpatient mental health care or behavioral health treatment services. Discharge planning supports continuity of care and efficient use of resources and incorporates the involvement and decision- making process with the member and significant other(s). The process begins at the time of admission and is coordinated by the facility's discharge planner. CenCal Behavioral Health staff collaborate with hospital discharge planners to support the facility's discharge planning arrangements.

5. Second Medical Opinion

CenCal Health allows for a second medical opinion upon request of a patient or a participating health professional treating a patient. The Health Plan also reserves the right to obtain a second opinion for the initiation or continuation of services. The second medical opinion must be provided by an appropriately qualified health care professional at no cost to the member.
A request for a second opinion shall be granted if the requested service(s) is a covered benefit and:

a. The member questions the reasonableness or necessity of the recommended surgical procedures.
b. The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
c. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.
d. The treatment plan in progress in not improving the medical condition of the enrollee within an appropriate period given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.
e. The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

6. Out of Network (Out of Plan)

When required, requests for out of network services are reviewed by CenCal Health on a case- by-case basis. Determinations are made based on the member's medical needs, the availability of services within CenCal Health's practitioner and provider network to meet these needs and coverage limits.

7. Tertiary Care Services

The member's medical needs and the availability of the requested services from CenCal Health's in-network tertiary care centers and in-network non-tertiary care providers are taken into consideration. If a tertiary care request is considered for denial, the Chief Medical Officer, Deputy Chief Medical Officer, or Medical Director considers the network specialist's recommendations prior to making a coverage determination. It is important that the member's PCP agrees with a request to use a tertiary care center.

8. Transitional Care Services (TCS)

Care transition is when a member transfers from one setting or level of care to another, including but not limited to, discharges from hospitals, institutions, other acute care facilities and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long- term care settings. Members are identified through a risk stratification process. CenCal Health has a TCS team of Clinical Support Associates and Nurse Care Managers to coordinate discharge planning with hospitals and facilities to ensure that members are supported during their care transition. High-risk members will receive a member outreach within seven days post discharge to follow-up on doctor's appointments, medication reconciliation and assessment of further needs for Enhanced Care Management (ECM), Comprehensive Care Management (CCM) and Community Supports (CS). TCS services will extend at least thirty days post discharge.

XI. PROMOTING APPROPRIATE UTILIZATION - MONITORING UNDER and OVER UTILIZATION

CenCal Health's Behavioral Health UM decision-making is based only on appropriateness of care and service and existence of coverage. As part of CenCal Health's QIHETP, CenCal Health has a systematic process that outlines how staff conduct routine monitoring and analysis of program indicators for monitoring and detecting under and over-utilization services, including, but not limited to, outpatient drugs. CenCal Health identifies any significant variance from the standard of care, either as a sentinel event if an unjustifiable adverse outcome warrants immediate action or based on a pattern of practice that falls significantly outside of the established program and community standard. Research and analysis of such variances may include comparison of practice standards with other Medi-Cal or managed care organizations to validate over or under-utilization activities. Detailed analyses may be conducted to investigate and resolve identified problems.

Performance comparisons are made against benchmarks or goals and historical norms. Established methodologies are used for measurement purposes to every extent possible. When UM concerns are identified, an action plan is required to correct patterns of potential or actual inappropriate under or over-utilization. The QIHEC input is sought to further inform CenCal Health's analysis of monitored data and development of effective interventions.

Performance comparisons are made against adopted external sources (or internal sources when applicable) and historical norms. Established methodologies are used for measurement purposes to every extent possible. When UM concerns are identified, an action plan is required to correct patterns of potential or actual inappropriate under or over-utilization. The QIHEC input is sought to further inform CenCal Health's analysis of monitored data and development of effective interventions.

Such action plans may include, but are not limited to, provider education, member education, staff development, administrative changes, provider contract changes and/or alteration of provider privileges. The scope of each action plan is determined based on the circumstances and identified causes that relate to each unique adverse outcome or variance from standard. The scope of each action plan is approved by

an appropriate, CenCal Health Quality Committee, which assures that interventions are timely and meaningful; and reported to the QIHEC. Re-measurement is performed at appropriate intervals to determine the effectiveness of interventions.

XII. CONTINUITY AND COORDINATION BETWEEN MEDICAL CARE AND BEHAVIORAL HEALTHCARE

CenCal Heatlh collects data bout opportunities for collaboration between medical care and behavioral health care in the following areas:

1. Exchange of Information
2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care.
3. Approrpriuate use of psychotropic medications.
4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders.
5. Primary or secondary preventive behavioral healthcare program implementation.
6. Special needs of members with serious mental illness or serious emotional disturbance.

CenCal Health supports the exchange of bidirectional information between its behavioral healthcare practitioners and specialists, organizational providers, and or other non-behavioral health practitioners. Members who provide appropriate consent are referred to the Behavioral Health Department for care coordination. The Behavioral Health Department works closely with Primary Care Providers, referring providers, and mental health providers/ practitioners to share information on the outcome of the referral including appointments obtained with mental health specialists and the members attendance to those initial mental health assessment appointments to establish care. Primary care providers are required to ensure that members have timely access to care when screened and/or referred to mental health services Through Site Facility Review and Medical Record Review process, CenCal Health ensures the exchange of information between medical and mental health practitioners, when appropriate consents have been obtained. CenCal Health supports the model of care with the PCP directing care and mental health specialists coordinating care directly with the PCP. Information exchange is a reflection of a
shared model of care that supports accurate and timely coordination through signed releases of information and ad hoc care coordination to support whole person care.

XIII. DELEGATED UTILIZATION MANAGEMENT

When Behavioral Health Utilization Management is delegated to another entity, the utilization management operations and activities are conducted by qualified UM staff who must meet job description requirements that include education, training, or professional experience in medical or clinical practice and must have an appropriate and current California license to practice without restrictions. An initial determination that any potential Subcontractor or Downstream Subcontractor has the administration capacity, experience, and budgetary resources to fulfill their contractual obligations will be performed. Pre-contractual audits occur to assess whether these key components are in place to ensure that the entity will adhere to CenCal Health requirements. Each delegated organization must have a Utilization Management Program that is approved annually by CenCal Health's Delegation Oversight Committee, as well as a signed Delegation Agreement in place. Each delegation

agreement details the key components, processes, and reporting requirements of the delegate.

XIV. PHARMACY SERVICES

A. Prescription Drug Utilization Management

Effective January 1, 2022, the entire pharmacy benefit (traditional retail pharmacy medications and medical-benefit medications will no longer be the sole responsibility of CenCal Health. The pharmacy benefit will be split and administered as 1) the retail pharmacy benefit will be carved out of the responsibility of CenCal and administered under the DHCS program known as, Medi- Cal Rx and 2) The medications adjudicated under the medical-benefit such as physician- administered drugs (PADs) will continue to be administered and considered by CenCal Health . Pre-service, Concurrent, and Post-Service (Retrospective) physician-administered-drug (PAD) utilization reviews of medical necessity using established prior authorization criteria requirements set forth by CenCal Health Pharmacy & Therapeutics (P&T) Committee. Timeliness standards mirror those for UM Program Timeliness.

DHCS will determine the retail benefit formulary (contracted drug list – CDL) as well as any quantity limits and prior authorizations placed on certain drugs. The retail medication utilization management process is subject to the rules determined under the Medi-Cal Rx program. As such, Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of medical services are under the scope of Medi-Cal Rx. All CenCal Health stakeholders (Utilization Management staff, Care Management staff, Member Services staff, Network Providers, etc.) may coordinate with the CenCal Health Pharmacists and Pharmacy Technicians to work through the Medi-Cal Rx Clinical Liaisons to assist with care coordination and clinical issues for medications covered under the retail, Medi-Cal Rx benefit.

The medications adjudicated under the medical-benefit will continue to be subject to the CenCal Health medical-pharmacy benefit and coverage criteria. The CenCal Health Pharmacy staff will collect all pertinent medical information and has the authority to approve coverage if criteria are met. All determinations are made by a CenCal Health Physician or Pharmacist. All UM processes, including verbal and written notification of the decision to the practitioner and member are followed when a determination is made.

Medical Pharmacy, Physician Administered Drug (PAD) List

CenCal Health has an established process by which members and practitioners may request non benefit PAD drugs. Likewise, a process exits by which members and practitioners may appeal denied requests for PAD benefit drugs. CenCal Health follows established procedures regarding PAD list. CenCal Health's policies and procedures specify that the PAD benefit be:

- Based on sound clinical evidence from appropriate external organizations
- Clearly documented, and that the application of pharmaceutical management procedures is based on identified member needs
- Developed with input from appropriate actively practicing practitioners
- Reviewed at least annually and updated based on established criteria that governs pharmaceutical management decisions for therapeutic classes, and medications within classes

- Made available to its practitioners annually, including all pharmaceutical management procedures

CenCal Health has an established process by which members and practitioners may request non-benefit PAD drugs. Likewise, a process exists by which member and practitioners may appeal denied requests for PAD benefit drugs.

XVII. CARVED-OUT AND LINKED SERVICES FOR MEDI-CAL MEMBERS

Some services for the Medi-Cal members are carved out as described in Evidence of Coverage (EOC). Members may also be linked to other services such as the local educational agencies, waiver programs, and Regional Centers by the Behavioral Health Department or other Departments involved in the Member's care. Members are referred to their PCP to conduct Initial Health Appointments and coordinate necessary care and referrals to specialists, ancillary services, and linked services as needed. CenCal Health Behavioral Health Department, Utilization Management and Case Management staff may assist the provider in making referrals to and in locating necessary linked and carved-out services. CenCal Health ensures that all Medi-Cal members have access to appropriate covered services. Members in need of services not covered or carved-out of CenCal Health's benefit package are referred to providers or vendors who may be able to assists the member with their needs.

XVIII. DEPARTMENTAL STAFFING

The Behavioral Health Program Description is evaluated and revised at least annually by the Utilization Management Committee staff including at least the Chief Medical Officer, Senior Medical Director, Medical Director, Behavioral Medical Director, Physician Reviewer, Director of Behavioral Health Services, Director of Medical Management, and the Director of Pharmacy Services.

The BH Program is reviewed and approved by the Utilization Management Committee, then by Quality Improvement Health & Equity Committee (QIHEC). This approved UM Program Description is submitted to the CenCal Health Board.

The Health Services Division roles include the positions described below:

Health Services Officer

The Health Services Officer (HSO) is responsible for the day-to-operations for Pharmacy, Utilization Management, Care Management, Disease Management and Behavioral Health. Responsibilities include operational and administrative oversight of program development, implementation, evaluation, execution, and day to day operations.

Chief Medical Officer

The Chief Medical Officer's is accountable for overseeing the clinical strategy, development or revision and implementation of the UM Program. The Chief Medical Officer is responsible for providing clinical support, exercising professional judgment on issues of medical necessity, and overseeing staff's application of appropriate treatment protocols to utilization management decision-making.

Senior Medical Director

Reporting to the CMO, the Deputy CMO will provide medical leadership and assist the

CMO in ensuring medical quality and adherence to professional and ethical medical standards by the plan and its network of providers.
Provide oversight and management of all clinical activities for CenCal members. Emphasis will be on clinical quality, operational efficiency, and strategic planning for quality, utilization, and care management programs. Provide Physician/Clinical leadership for Utilization Management and Quality; Case Management leadership and consultation; external provider relations including education and outreach and program development. Additionally, the position will provide senior clinical leadership to the appeals, grievances, and quality of care concerns processes. The Deputy CMO will be a voting member of QI Committee.

The Senior Medical Director's responsibilities may include but is not limited to conducting monthly UM Inter-departmental workgroup meetings, conducing case rounds and UM reviews, conducting/attending Hospital and Medical group JOC's and acting as a chair at various meetings such as the Quality Improvement and Health Equity Committee, Peer Review Credentialing Committee, Provider Advisory Board Meeting, and is a voting member of the QIHEC and Utilization Management Committee.

Medical Director -Behavioral Health

The Behavioral Health Medical Director reports to the CMO. S/he oversees the processes within the BH Program. The Medical Director assures the effectiveness of decision making in all areas of preauthorization, concurrent, and retrospective reviews; and as necessary develops and applies consistent, medical appropriateness standards to selected procedures.

The Director of Behavioral Health is a licensed mental health practitioner who is a medical doctor or has a clinical PhD or PsyD, who is responsible for the operational units of the Behavioral Health Department and Behavioral Health Program. The Director of Behavioral Health is responsible for program adherence to regulatory requirements, program, and process improvements. The Director of Behavioral Health is accountable for managing the non-physician staff of program departments. The Director chairs/advises/participates in the Behavioral Health subcommittee that reports to QIHEC. The Director provides ongoing, effective, and efficient assessment of all clinical operations to help support the delivery of high-quality care in accordance with established regulatory requirements, and NCQA accreditation standards.

Medical Director

Medical Directors report to the CMO. S/he oversees the processes within the UM Program. The Medical Director is a California licensed physician and assures the effectiveness of decision making in all areas of preauthorization, concurrent, and retrospective reviews; and as necessary develops and applies consistent, medical appropriateness standards to selected procedures.
In the absence of the Chief Medical Officer, the Deputy Chief Medical Officer functions as the Chief Medical Officer designee, as assigned by the Chief Executive Officer.

Physician Reviewer

The physician reviewer reports to the Deputy CMO. Responsibilities may include clinical review of service request, appeals, grievances, and other clinical-related duties as

assigned.

Director of Medical Management

The Director of Medical Management is a licensed Registered Nurse and accountable for managing the non-physician staff of the case management, utilization management, and pediatric program departments. The Director provides ongoing, effective, and efficient assessment of all clinical operations to help support the delivery of high-quality care in accordance with established regulatory requirements, and National Committee for Quality Assurance (NCQA) Accreditation Standards when feasible. This position also oversees the UM department to ensure inter-rater reliability and compliance with timeliness standards.

Director of Pharmacy Services

The Director of Pharmacy Services is a California licensed pharmacist. The Director of Pharmacy is accountable for managing the Pharmacy Department operations and administration of the pharmacy benefits, which promotes efficacy, safety, and cost-effectiveness of drug therapy for all CenCal Health members.

Associate Director of Pharmacy Services

The Clinical Manager of Pharmacy Services is a California licensed pharmacist who is responsible for providing daily management of the overall Pharmacy UM process. This position also supervises the pharmacy technician staff and the delegated UM functions to ensuring inter- rater reliability and compliance with timeliness standards.

Clinical Pharmacist(s)

The Clinical Pharmacist(s) is a California licensed pharmacist is responsible for clinical determinations of physician-administered prior authorizations on the medical benefit, assisting in maintaining the plan's formulary management software, and support of plan wide clinical initiatives.

Director of Behavioral Health

The Director of Behavioral Health is a licensed mental health practitioner who is responsible for the operational units of the Behavioral Health Department and Behavioral Health Program. The Director of Behavioral Health is responsible for program adherence to regulatory requirements, program, and process improvements. The Director of Behavioral Health is accountable for managing the non-physician staff of program departments. The Director provides ongoing, effective, and efficient assessment of all clinical operations to help support the delivery of high-quality care in accordance with established regulatory requirements, and NCQA accreditation standards when feasible.

Behavioral Health Operations Manager

The Behavioral Health Operations Manager is a licensed practitioner who is, as assigned, responsible for the daily management of the Behavioral Health utilization management program and care coordination functions. This position supervises the department staff, which may include nurses, social workers, Board Certified Behavioral Analysts and nonclinical staff.
Responsibilities include but are not limited to staff training and education, adherence to

regulatory timelines, and interrater reliability. The Behavioral Health Clinical Manager is also the point person for all questions from network providers and out of plan providers about the utilization management, processes, including necessary documentation required to request service and referrals for case management services.

Behavioral Health Call Center Manager

Under the direct supervision of the Director of Behavioral Health, the Behavioral Health Call Center Manager manages the Behavioral Health (BH) Call Center operations. The Behavioral Health Call Center Manager is responsible for ensuring accurate and efficient handling of all member and provider calls, continuity of care requests, County referrals, escalated calls, and call center operational performance and regulatory compliance.

Behavioral Health Care Manager

Behavioral Health Care Managers include LMFT (or license eligible), LPCC (or license eligible), Registered Nurses, LCSW (or license eligible) and Board-Certified Behavioral Analysts (BCBA). The Behavioral Health Care Manager reviews authorization requests. The Behavioral Health Care Manager performs review or basic assessment using approved criteria and guidelines in the decision-making process. The Behavioral Health Care Managers are responsible for review and assessment of the request for the appropriateness of covered services within CenCal Health's benefit package. The Behavioral Health Care Manager completes reviews for BHT (ABA), psychological testing, and neuropsychological testing (as it relates to determining medical necessity for BHT (ABA).

Behavioral Health Community Integration Specialist

The Behavioral Health Community Integration Specialist is a mental health practitioner (licensed or registered) who is the the designated County MHP and DMC-ODS point of contact. The Behavioral Health Community Integration Specialist is responsible to support the relationship between CenCal Health and the County Department of Behavioral Health and Drug Medi-Cal Organized Delivery System, by ensuring coordination of care between entities and services-. The Behavioral Health County Liaison facilitates the Multi-Disciplinary meetings between agencies, supports member referrals to/from CenCal Health, and engages regularly with external/internal stake holders as the CenCal Health Behavioral Health representative.

UM Manager

The UM Manager is a licensed Registered Nurse who is responsible for assisting with daily management of the UM program. The UM, CM and Pediatric programs have independent Medical Management Managers, who work collaboratively with the Medical Management Director and each other to support the programs and requirements. These positions supervise the department staff, which may include nurses, social workers, and nonclinical staff. Responsibilities include but are not limited to staff training and education, adherence to regulatory timelines, and interrater reliability. The respective Medical Management Managers are also the point persons for all questions from network providers and out of plan providers about the UM, CM or Pediatric processes, including necessary documentation required to request service and referrals for case management services.

UM Supervisor

The UM Supervisor may be assigned to utilization management, case management-adult or case management-pediatric health operational unit. The Clinical Supervisor reports to the Health Services Clinical Manager in the related operational unit. This activity-oriented position requires the ability to coordinate day-to-day activities of their assigned unit and as appropriate, prepare timely reports of those activities to the department Manager and Director. This position is expected to provide training to staff, identify areas for improvement, resolve any staff issues, provide new hire orientation and supervise staff as needed.

Please refer to Case Management Program Description for the CM Nurse Coordinator for further detail.

Health Plan Nurse Coordinator (HPNC)

Clinical review staff include HPNC, UM Nurses and CM Nurse Coordinators who are Registered Nurses; and UM Specialist who are licensed professionals that hold a certification in one of the following: vocational nursing, physical, occupational or speech therapy. UM nurses, HNPC, CM Nurses, and UM specialists review preauthorization, concurrent, and retrospective requests. HPNC UM Nurses, CM Nurses, and Specialists perform review or basic assessment using approved criteria and guidelines in the decision-making process. HPNC UM Nurses, CM Nurses, and UM Specialists are responsible for review and assessment of the request for the appropriateness of covered services within CenCal Health's benefit package. HPNCUM Nurses and CM Nurses review all types of non-pharmacy covered services, including preadmission, concurrent and retrospective inpatient admissions, home health care, medical supply, durable medical equipment (DME, orthotics, prosthetics, and ambulatory care. HPNC can not deny requests for services.

UM Specialists have a limited scope of practice and are responsible for basic assessment and review of services that are within their scope of expertise and typically limited to assessment of skilled nursing facility stays or medical supply and durable medical equipment requests. The UM Specialist review all clinical documents with a RN or MD prior to making a decision for a requested service.

The UM Nurses, HPNC, CM Nurses, and UM Specialists also identify and refer in circumstances when a Member's Quality of Care (QOC) Concern (QOC) is suspected as clinically substandard. CenCal Health maintains a mechanism to identify, analyze, and resolve Potential Quality Issues (PQIs) to ensure that services provided to CenCal Health Members meet established QOC and service standards.

All QOC concerns are formally routed to CenCal Health's Quality Department Clinical Quality Team for review. PQI referrals may be done by email utilizing the PQI referral form. Specific information regarding the concern and whom the concern is regarding

must be submitted with sufficient medical information to clarify the reason for the concern.

members for potential Case Management intervention and collaborate with the Quality Management unit by making referrals regarding suspected quality of care issues to the Quality Improvement Supervisor. The UM Nurses, HNPC, CM Nurses, and Specialists act as interdepartmental liaisons to support prompt resolution of acute care, long-term care, and ambulatory care issues and questions. They also assist providers with claims issues and basic questions regarding treatment and referral requests.

Case Manager

Please refer to Case Management Program description for further detail.

Case Managers are Registered Nurses or Master-prepared Social Workers who coordinate services for specific members receiving services from in and out of network providers. They collaborate with the member to identify care coordination needs and to develop self- managing skills and person-centered goals. Case Managers also collaborates with members of the healthcare delivery team. Pediatric CM Nurse Coordinators have a dual-role function. They perform utilization review and case management activities. Refer to the Case Management Program Description, Pediatric Whole-Child Model Program Description, and Case Management job descriptions for detailed information.

Non-Clinical Support

UM Non-Clinical Supervisor

The UM Non-Clinical Supervisor is responsible for overseeing the daily tasks and duties of the UM CSA teams for both the Adult and Pediatric units. The UM Non-Clinical Supervisor reports to the UM Associate Director. The role requires the ability to coordinate the daily activities of the UM CSA teams and as appropriate, prepare timely reports to monitor UM CSA tasks. This position is expected to provide training to staff, identify areas of improvement, resolve employee performance issues and supervise the CSA staff.

Case Management (CM) Clinical Support Associate

Assist Case Managers and Social Workers as needed with appointment reminders and follow-up, provide health educational materials and information on community resources to members, perform telephonic health surveys, and facilitate necessary, non-medical or medical van transportation.

UM Clinical Support Associate

Clinical Support Associates are the first line of contact in the UM Department. CSA

answer incoming calls, assist UM Nurse and Specialist with obtaining necessary clinical information from providers, entry authorization requests and supporting documents into the system, as directed, send notices to providers and members.

Pharmacy Technician

Pharmacy technicians are the first line of contact in the PAD Pharmacy Department. Pharmacy technicians answer incoming calls, assist Pharmacists with obtaining necessary clinical information from providers, entry authorization requests and supporting documents into the system, as directed, send notices to providers and members.

Behavioral Health Navigators

Behavioral Health Navigators are non-clinical para professionals who coordinate Care for Members to Non-Specialty Mental Health Services. This includes obtaining an appointment date and time, providing health educational materials and ensuring a closed loop referrals mental health services . The Behavioral Health Navigator completes the DHCS required screening for mental health services, and appointment follow ups for Non Specialty Mental Health Services.

Clinical Support Associate

Clinical Support Associates are the first line of contact in the Utilization Management department. The Clinical Support Associate follows up with providers on authorization status, assist the BHCM-BHT with obtaining necessary clinical information from providers, enters authorization requests and supporting documents into the system and as directed, will send notices to providers and members.

Clinical Support Associates have a limited scope of practice as it relates to Utilization Management support and are typically limited to only assigning a provider for authorization requests for psychotherapy and medication management that do not require a clinical review and simply need to be assigned a rendering provider.

Behavioral Health Representatives

The Behavioral Health Representative will work under the direct supervision of the Behavioral Health Call Center Manager under clinical guidance from and the Director of Behavioral Health. Expectations of this position are to provide robust customer service for CenCal Health's membership and its provider network that is aligned with the Plan's strategic goals and Mission Statement. In this role, the Behavioral Health Representative assists Plan membership with the following needs: screening and referral coordination to the appropriate level of care based on screening outcome. Behavioral Health Representatives will provide three available providers to members who meet CenCal Health's level of care based on the DHCS Required screening for mental health services

XIX. COMMUNICATION SERVICES/TIMELINESS OF UM DECISIONS

CenCal Health follows the following decision and notification timeframes for all utilization management determinations.

Decision Timeframes	Medi-Cal Contract 08-85212	Non-Medi-Cal H&S Code 1367.01
Emergency Care	CenCal Health must not require Prior Authorization for emergency care for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.	Yes
Post-stabilization	CenCal Health must respond to a Provider's request for authorization for post-stabilization services within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855(a). Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.	Yes
Concurrent Review of authorization for treatment regimen already in place	Authorization for a Treatment Regimen Already in Place: CenCal Health must respond to a concurrent authorization request within five Working Days or less, consistent with the urgency of the Member's medical condition and in accordance with H&S Code section 1367.01(h)(1)	Yes
Retrospective Review	Authorization Request for Treatment Received: CenCal Health must accept requests for retrospective authorization requests within a reasonably established time limit, not to exceed 365 calendar days from the date of service. CenCal Health must communicate decisions to the Provider and to the Member who received the services or to the Member's designee within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S Code section 1367.01(h)(1).	Yes
Therapeutic Enteral Formula for Medical Conditions in	CenCal Health must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies	Yes

Infants and Children:	necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.	

Decision Timeframes	Medi-Cal Contract 08-85212	Non-Medi-Cal H&S Code 1367.01
Routine Authorizations	CenCal Health must respond to routine requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by CenCal Health to render a decision, and no longer than 14 calendar days from the receipt of the request, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. CenCal Health may extend this deadline up to an additional 14 calendar days only if the Member or the Member's provider requests an extension or if CenCal Health justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. CenCal Health must notify Member's provider and the Member in writing of any authorization request delayed beyond the five Working Day time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01	Yes
Expedited Authorizations	For requests in which a provider indicates, or UM determines that, following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, UM must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for services. UM may extend the 72 hour time period by up to 14 calendar days if the Member requests an extension, or if CenCal Health justifies, to the DHCS upon request, a need for additional information and how the extension is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	Yes

Decision Timeframes	Medi-Cal Contract 08-85212	Non-Medi-Cal H&S Code 1367.01
Expedited Authorizations, continued.	CenCal Health must make expedited authorization decisions for service requests where a Member's provider indicates; or CenCal Health, CenCal Health's Subcontractor, Downstream Subcontractor, or Network Provider; determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. CenCal Health must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after receipt of the request for services. CenCal Health may extend this deadline up to an additional 14 calendar days only if the Member or the Member's provider requests an extension or if CenCal Health justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. CenCal Health must notify Member's provider and the Member in writing of any authorization request delayed beyond the 72-hour time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01.	Yes

Decision Timeframes	2024 DCHS Medi-Cal Managed Care Contract	Non-Medi-Cal H&S Code 1367.01
Major Organ Transplant	Applicable for Major Organ Transplant (MOT). The referral authorization occurs within 72 hours of a PCP or specialist identifying the member as a potential candidate for the MOT and receiving all of the necessary information to make a referral authorization (APL 21-015)	Yes
Hospice	CenCal Health may only require Prior Authorization for inpatient hospice care. CenCal Health must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and all applicable DHCS APLs.	Yes
Physician Administered Drugs	For medical authorizations of Medically Necessary Physician administered drugs billed on a medical or institutional claim, CenCal Health must comply with the same timeframes as other medical services, set out at this subsection.	Yes

Communication of Review Decisions

CenCal Health's UM staff notifies the requesting provider of any decision to approve, deny, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Approvals will be communicated verbally and in writing to the provider. CenCal Health will issue a Notice of Action to the member and provider when the decision is made to approve, deny or modify a service request.

XX. DENIALS, APPEALS AND GRIEVANCES

Denials and modifications are typically based on benefit limitations, or the lack of medical necessity or sufficient supporting clinical information provided by the physician, practitioner, or facility. Only CenCal Health physicians can issue a denial or modification decision that is based on medical necessity. Attempts to reach the treating or requesting physician are often made prior to issuing denials and CenCal Health physicians are always available to discuss the denial with the practitioner. Denial decisions are communicated verbally and in writing as required by contract.

Physician reviewers are involved when service requests are denied or modified based on medical necessity. CenCal Health physicians who are responsible for decision-making of service requests must demonstrate analytical skills and have the education, training, and professional experience in the medical or clinical setting prior to employment by CenCal Health. When none of CenCal Health's qualified physician reviewers has applicable expertise to assess the medical necessity of a requested service, the CMO and/or Senior Medical Director has the authority to seek assistances from a board-certified specialist or external review agency to assists with decision-making.

Denial and modification Notice of Actions are mailed to the member within 2 working days of the decision and include:
A clear, concise, and specific explanation of the reasons for the plan's decision

- A reference to the criteria or guidelines used as a basis for the plan's decision, and notice that upon request the member and/or provider can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion upon which the denial decision was based
- Other clinical reasons used as a basis for a decision regarding medical necessity that are easily understood and do not contain abbreviations
- The name and telephone number and extension to reach the physician or pharmacist responsible for the decision (for written or electronic communications to providers only)
- Information on how the member and/or provider may file an appeal with CenCal, and as applicable, request an administrative hearing

Determinations of a denial or modification providers information the member and the provider that they a copy of the criterion (guideline, UM policy, etc.) used to make the decision is available upon request and provided.

Appeals

CenCal Health's Behavioral Health Department participates in thorough clinical review and timely resolution of service appeals.

CenCal Health has procedures in place for timely response to pre-service routine and expedited appeals. These procedures are detailed in Member Services Policy and Procedure MS-23 Member Appeals, MS-24 Communication and Education of Grievance and Appeals Process and MS-25 Monitoring and Oversight of Grievance and Appeals System.

To review an appeal, CenCal Health will appoint a physician not involved in the original decision to review the case. The appointed physician reviewer shall not have a conflict of interest with the case or parties involved in the appeal.

XXI. EVALUATION OF NEW TECHNOLOGY, EXPERIMENTAL AND INVESTIGATIVE

To keep pace with technological change and to ensure that members have equitable access to safe and effective care, CenCal Health has a process to evaluate and address new developments in medical technology as well as their application to

CenCal Health's member populations.

To decide whether to include new technologies (e.g., medical, pharmaceutical, devices and behavioral health procedures), CenCal Health reviews appropriate information from scientific literature and research and regulatory bodies as part of its decision-making process. CenCal Health may research, review, and adopt evidence-based clinical guidelines developed by nationally recognized health care organizations or plans clinical guidelines and/or use licensed clinical professionals in the evaluation of each new technology. Additionally, and in the absence of established and relevant UM criteria, CenCal Health, in consultation with practitioners of appropriate specialties and technological expertise may develop clinical criteria to use in the decision-making of newly adopted technologies.

XXII. INTERRATER RELIABILITY

CenCal Health shall perform interrater reliability (IRR) surveys at least annually to evaluate the consistency with which physicians and clinicians involved in the UM process apply approved clinical criteria. IRR surveys are uniformed in structure and administration. They are tailored to address specific areas for Adult UM, Pediatric UM and Behavioral Health UM. IRR surveys utilize our clinical guideline's vendor MCG IRR Criteria/ Guidelines for the IRR surveys.

Pharmacist surveys are administered through physician- administered drug clinical guideline Magellan Rx.

Reports are generated for evaluation and the respective Manager reviews the results and works with the Master Clinical Trainer to determine ongoing areas needed for staff education and training. The Director of Behavioral Health, Director of Medical Management and Chief Medical Officer reviews the final report and any areas for improvement. On an annual basis, the QIHEC shall receive an aggregate report noting the summary of IRR findings. IRR surveys are administered, and results interpreted by the Health Services Management Team. In turn, the Director of Behavioral Health and Chief Medical Officer reviews and analyzes the results for areas in need of improvement. On an annual basis, the UMC and the QIHEC shall receive an aggregate report noting the summary of IRR findings.

XXIII. INTEGRATION WITH QUALITY MANAGEMENT

The Behavioral Health Program has quality operations that integrate UM Program operations with QIHETP operations through a systematic and coordinated system of reporting to the Utilization Management Committee (UMC)and QIHEC. Reporting of utilization management activities incudes but is not limited to the number and types of service requests, denials, modifications, appeal and grievances. All reporting to UMC, is overseen by CenCal Health's CMO or designee, and other CenCal Health leadership that participates on the UMC and/or QIHEC.

The integration of CenCal Health's Behavioral Health Program and QAIP is assured by CenCal Health's QIHETP quality committee structure, as defined by the committee

table of organization, roles and responsibilities detailed written CenCal Health's QIHETP Description. As further detailed below, this Behavioral Health Program Description and an annual evaluation are reported to CenCal Health's QIHEC, which is appointed by CenCal Health's Board of Directors as its accountable entity to oversee CenCal Health's QIHETP, and the QIHEC's proceedings are reported to CenCal Health's Board of Directors.
The Behavioral Health Program has a variety of quality operations processes in place to ensure quality of care and service-oriented interventions are initiated and conducted. UM integration with quality operations supports activities to measure utilization trends or patterns compared with nationally recognized thresholds. Additionally, under- and over-utilization and Potential Quality Issues (PQIs) reporting to the QIHETP assures integration of additional UM Program and QIHEC activities, with appropriate leadership oversight and reporting within the QIHETP quality structure. All PQIs are referred to CenCal Health's Quality Department and are thoroughly investigated by RN-licensed clinical staff, and CenCal Health's CMO or physician designee.

XXIV. SATISFACTION WITH THE UM PROCESS, BH SERVICES, AND BH DEPARTMENT

Practitioner, member and other provider surveys are conducted annually or when a need is identified to assess satisfaction with CenCal Health's UM processes, and member surveys are conducted periodically to assess UM satisfaction. Through CenCal Health's member and provider complaint and appeal process, CenCal Health continually evaluates all programs to ensure that difficulties are not encountered when members are seeking care and when practitioners are requesting care. The QIHEC reviews data at least annually to identify opportunities and develop interventions for improvement.

Additionally, CenCal Health surveys members periodically to evaluate consumer satisfaction with several aspects of plan operations, including utilization management. This evaluation quantitatively measures member satisfaction with CenCal Health's utilization management program, which enables CenCal Health to identify and act upon opportunities to improve quality of service and/or care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provides a rich source of information that complements that which CenCal Health obtains from practitioners and providers. When available, together these data enable staff to perform a robust assessment of UM satisfaction.

The (CAHPS) member survey is, generally, performed every other year and is subject to a schedule determined by the California Department of Health Care Services.

XXV. EVALUATION OF THE UTILIZATION MANAGEMENT PROCESS

As part of CenCal Health's annual assessment of the Quality Assessment & Improvement Program, CenCal Health has a process for continuously reviewing the quality of care, performance of medical personnel, and utilization of services. The evaluation process includes ongoing assessment of the consistency with which UM criteria are applied by UM staff, evaluation of complaints and assessment of complaint

trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to appropriate CenCal Health staff and contracting providers, and the evaluation and verification of corrective actions.

The Behavioral Health Program evaluation is approved annually. After review and approval of the annual Behavioral Health Program Evaluation, the results are reported to CenCal Health's QIHEC, which is appointed by CenCal Health's Board of Directors as its designated entity to oversee CenCal Health's Quality Program. The QIHEC's proceedings are reported to CenCal Health's Board of Directors.

The evaluation of the Behavioral Health Program includes but is not limited to, an evaluation of effectiveness in:

- Resolving utilization and benefit issues, including but not limited to denials and appeals related to utilization decisions
- Creating and reviewing policies and procedures related to utilization management
- Monitoring trends and patterns of key utilization management indicators for over-and under-utilization and appropriateness of care
- Requesting studies, if applicable, on areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns
- Making referrals to the Health Services Quality Improvement Supervisor for investigation of potential quality of care issues discovered during processing of coverage requests
- Selecting and applying clinical criteria used for UM decisions

XXVI. CONFIDENTIALITY

Individuals engaged in Behavioral Health Program activities shall maintain confidentiality of all member information and any other information developed or presented as part of the Program. CenCal Health protects the confidentiality of member information and divulges and collects only enough information from the member, subscriber, or appropriate healthcare provider, as is necessary to conduct business activities. Activities and documents that are part of the UM Program are maintained in compliance with legal requirements.

XXVII. NONDISCRIMINATION

All medically necessary covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. Furthermore, all covered services are provided in a culturally and linguistically appropriate manner.

CenCal Health staff must immediately report any instance of discrimination, or services identified rendered in a culturally or linguistically inappropriate manner, to CenCal Health's Chief Medical Officer or Quality Officer to initiate a timely and thorough investigation. Each investigation and outcome are promptly processed through CenCal Health's mechanism for investigation of Potential Quality of Care (PQOC) events, including review by licensed clinical staff to determine whether alleged

discrimination plausibly had any impact on clinical quality of care. Each case, including appropriate follow-up to mitigate reoccurrences, is documented according to policy and procedure to execute PQOC investigations.

ACKNOWLEDGMENT AND APPROVAL

This Behavioral Health Program Description may be amended by the Chief Medical Officer or other appropriate Behavioral Health leadership as needed on a periodic basis to reflect improvements in BH Program operations.

The QIHEC reviewed, approved, and adopted this document with revisions at its meeting.

Approvals:

Print Name: Christopher Hill, RN, MBA
Health Services Officer

Signature: _____ Date:_____

Print Name: Emily Fonda, M.D
Chief Medical Officer

Signature: _____ Date_____

CenCal HEALTH®
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2024 Care Management Program Description

Review
Utilization Management Committee: 2/12/2024

Quality Improvement and Health Equity Committee: 2/29/2024

Board of Directors: 3/20/2024

I. OVERVIEW

CenCal Health's Care Management (CM) Program is a comprehensive, Member-centered program that consists of Complex Care Management (CCM), Basic Care Management, Transitional Care Services (TCS), and other Care Coordination activities. There are various CM Programs available to all CenCal Health Members who meet or trigger CM guidelines. CM services include general CM, which primarily works with the adult population, Pediatric-Whole Child Model (PWCM), Disease Management (DM), and Enhanced Care Management (ECM). These programs work collaboratively to support Members through the continuum of CM services.

The CM Program was developed to help CenCal Health's Members appropriately use health care services and/or gain access to State programs, community-based resources, and long-term services and supports. Facilitating access to such services allows Members to maintain independence at home, live in the least restrictive environment, and maximize their well-being. The goal of the CM Program is to support Members who need individualized guidance, education, and/or extensive coordination of their health care needs while optimizing value, and to achieve desirable outcomes for all stakeholders. The CM Program consists of various care levels from basic, which is primarily the responsibilities of the Primary Care Provider (PCP), to complex, which is a collaborative effort between CenCal Health, the Member, their PCP, and other involved Providers or organizations.

CenCal Health's CM services are available to all Members with various levels of needs. Eligible Members may include, but are not limited to, those with complex medical conditions or psychosocial needs, those with specific diagnosis that be at high risk due to over/under utilization of services, and those that may need Care Coordination or care transition assistance. For more information regarding eligibility, please refer to policy and procedure MM-CM114 Care Management Program, Planning and Coordination.

The Chief Medical Officer is responsible for all clinical programs, including CM services. As a component of the overall Health Services operations, these various CM Programs work collaboratively with CenCal Health's Utilization Management Program. Please refer to the Utilization Management Program Description, Section VI. Program Structure and subsection Authority and Accountability for authority designation.

CenCal Health has an opt-out approach wherein Members meeting criteria for CM have the right to decline to participate. During the outreach and engagement process, Members are informed that they may decline or terminate care management services at any time by notifying the assigned care manager or contacting CenCal Health's Member Services Department.

II. TYPES OF CARE MANAGEMENT AND ACUITY LEVELS

Complex Care Management

CCM is available to CenCal Health Members who need extra support to avoid adverse outcomes. CCM services may include, but are not limited to, coordination of timely, medically necessary services, conducting a comprehensive assessment of the Member's needs, determining available benefits and resources, and developing and implementing a patient-centered CM plan with goals, monitoring, and follow-up.

Basic Care Management

Basic CM is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs. As the "medical home," the Primary Care Physician (PCP), PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife provides this category of CM services. Coordination of carved-out and linked services are considered Basic CM services, but may be complex due to concurrent medical or social issues and problems.

Transitional Care Services

TCS are available to CenCal Health's Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings. TCS provides comprehensive transition of care support to Members by an assigned Care Manager/Discharge Planner with the goal of reducing gaps in care and preventable readmissions. Refer to policy and procedure HS-MM44 Transitional Care Services for more information.

Pediatric Whole Child Model

CM services are available to Members of all ages, including Members under the age of 21. The PWCM Program has a CM program tailored to Members under the age of 21 including those who are eligible for California Children's Services (CCS) and Children with Special Health Care Needs (CSHCN). Please refer to the Pediatric Whole Child Model (PWCM) Program policies and procedures for additional information.

Disease Management Programs

In addition to adult and pediatric CM services, CenCal Health has evidence-based Disease Management Programs (DMPs) and services in line with NCQA requirements that work in conjunction with the CM Program. These DMPs incorporate health education interventions, identify Members for engagement, and seek to close care gaps for Members participating in the interventions to improve health equity and reduce health disparities. The programs and services address the conditions including, but not limited to diabetes, cardiovascular disease, asthma, depression, Maternal Mental Health and obesity.

DMPs have components that are similar to CM services including the general goal of improving long-term medical treatment. Through tailored interventions that empower

behavior change and actions, including self-management support and health education, CenCal Health's DMPs and services aim to help Members:

- Improve self-management support skills for their chronic condition;
- Improve adherence to treatment plans;
- Minimize symptoms associated with a chronic condition; and
- Prevent future complications or the development of accompanying conditions related to chronic disease.

CenCal Health offers a comprehensive library of health education content through an NCQA-certified vendor to Members and Providers for use with their patients. The library includes self-management tools to help Members:

- Determine risk factors;
- Provide guidance on health issues;
- Recommend ways to improve health; and
- Reduce risk or maintain low risk.

With a focus on better management and prevention of future complications related to chronic conditions, CenCal Health's Members' quality of life will improve. Refer to the Disease Management Programs Process Flow document for additional information.

Enhanced Care Management

ECM is a Medi-Cal benefit that provides a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria, through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch, and person centered. Members enrolled in ECM must be assigned a Lead Care Manager who serves as the primary contact for the Member and who will support Members transition to a lower level of CM services. CenCal Health contracts with community-based Providers for the provision of ECM services. Please refer to policy and procedure MM-CM121 Enhanced Care Management for additional information.

Acuity Levels

There are four service and acuity levels within CM to support Members with different needs based on their risk level. CenCal Health's CM Program includes a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations, including long-term chronic care coordination and interventions for episodic, temporary needs. Service Level 3 is the most intense service, while Service Level 0 is the least intense. These levels are determined by the complexity of the case, level of

expertise needed (e.g., Care Manager Nurse, Care Management Social Worker, or CSA), and the type of necessary interventions or services.

Acuity Level	Acuity	Description
Level 3	Complex-High Risk	Members are "high-touch" individuals who have complex medical conditions, need care transitions, and require intense coordination of care. These Members may have experienced a critical event or new diagnosis that requires the extensive use of resources. These Members may need help navigating the health care system to facilitate appropriate delivery of care and services.
Level 2	Monitored-Moderate Risk	Members have at least two chronic conditions or more that collectively have an adverse effect on their health status, functioning or quality of life. They require advocacy and assistance navigating the health care system and connecting to community resources. Members under this service level require periodic contacts to assist with management of comorbidities to prevent further complications or individuals who are transitioning out of complex care to a lower service level in CM.
Level 1	Lifestyle-Low Risk	Members have health care conditions or social issues that are managed. The primary goal in this level is to maintain the Member's current health condition and to assist Members with follow up care. These Members receive routine informational mailings or calls about their condition. The intent for mailing these materials to the Member is to keep the Member's self-management skills up-to-date.
Level 0	Intermittent	Members (1) have completed CM and/or DM services and a portion of the post-program follow-up protocol where periodic outbound "check-ins" are performed; (2) are eligible for the CCS-WCM program that only want interventions when they initiate the contact to the CM department; or (3) are receiving Skilled Nursing Transitional Care Services, where outreach efforts have been unsuccessful.

III. GOALS AND OBJECTIVES

The primary goal of CM services is to help Members gain, regain, and/or maintain their optimum health status and/or improve or maintain functional capability, in the right setting and in a cost-effective manner. CM involves a comprehensive assessment of the Member's condition, determination of available benefits and resources, and may include the development and implementation of an Individualized Care Plan (ICP) with performance goals, monitoring, and follow-up, as applicable. Documentation in ICPs should include mutually agreed upon realistic plans, goals, interventions, barriers, progress, and outcomes.

The primary focuses of CM include, but are not limited to, the following:

- Enhancing the quality of life of the Member;
- Promoting healthy lifestyles and choices;
- Collaborating with and providing support and advocacy to Members and Providers throughout the continuum of care;
- Educating and assisting the member with navigating through the health care delivery system;
- Coordinating and facilitating timely access to in-network and out-of-network healthcare services, and as appropriate;
- Coordinating medically necessary services with other coverages or insurers;
- Providing assistances with navigating through the transitions of care;
- Improving Member safety;
- Promoting self-empowerment and self-managing skills;
- Maximizing access to self-management tools and techniques;
- Educating Members regarding available federal, State and local government and community resources;
- Coordinating with and obtaining services available from federal, State and local government agencies and community-based organizations;
- Decreasing fragmentation of care and avoiding duplication of services;
- Promoting cost-effective services in the right setting and in the least restrictive environment;
- Improving Member and Provider satisfaction;
- Reducing inappropriate service utilization;

- Monitoring and educating high-utilizers of services;
- Adhering to regulatory and HIPAA/confidentiality requirements;
- Applying Whole Person concepts to care management and care coordination activities; and
- Gaining or regaining optimum health or improved functional capability in the right setting.

IV. SCOPE OF SERVICES AND RESPONSIBILITIES

The primary clinicians responsible for providing CM and Care Coordination services are Health Plan Nurse Coordinators (HPNCs) and Care Management Social Workers (CMSWs). In this CM Program Description, these individuals are referred to as "Care Managers." Clinical Support Associates (CSAs) are non-clinical staff who assist the clinicians and perform clearly defined tasks, such as assisting Members with appointment reminders, transportation scheduling, providing resource materials, and performing follow up checks and health surveys. CenCal Health's Medical Directors provide clinical support and oversight to the CM department as it relates to care consultation, assessment, and care plan development. As a team, these clinicians and non-clinicians are responsible for the goals and objectives noted in the above section, and to provide the responsibilities noted below and in policy and procedure MM-CMXX Assignment of Care Manager and Care Manager Responsibilities.

CM teams work collaboratively to facilitate and/or coordinate covered services with network and out-of-network Providers, State agency programs, and community-based organizations to obtain appropriate and timely care for CenCal Health Members. CenCal Health assigns a Lead Care Manager to every Member enrolled in CM. Refer to policy and procedure MM-CMXX Assignment of Care Manager and Care Manager Responsibilities for scope of Care Manager responsibilities.

Similar to the general CM services, additional CM and Care Coordination services are available to Members under the age of 21 who are CCS-eligible and under the PWCM Program. Refer to MM-CMXX Assignment of Care Manager and Care Manager Responsibilities and the PWCM Program Description and its policies and procedures for additional information.

V. IDENTIFICATION OF MEMBERS AND ELIGIBILITY

Referral Sources

CenCal Health utilizes referrals to identify Members who may benefit from CM services. CenCal Health identifies these Members through referral sources, including but not limited to:

- PCPs;
- Consulting Specialist(s);
- Ancillary Care Providers (e.g., Durable Medical Equipment (DME) vendors);
- Community Based Organizations;
- CenCal Health's Quality Department;
- CenCal Health's Disease Management Department;
- CenCal Health's Utilization Management Department;
- CenCal Health's Behavioral Health Department;
- CenCal Health's Pharmacy Department;
- CenCal Health's Claims Department;
- CenCal Health's Nurse Advice Line;
- CenCal Health's Member Services Department;
- Enhanced Care Management and/or Community Supports Provider(s);
- Hospital Discharge Planners;
- Home Health Agency Staff;
- Health Educators;
- Public Health Departments;
- Employment and Human Services;
- Community Hospital Emergency Department or Discharge Planning Care Managers;
- Member Self-Referral or Caregiver Referral;
- Recuperative Care Centers;

- Homeless Shelters;
- CCS Offices and Medical Therapy Units; and
- Other, as approved by the CM Department Manager.

Data Sources

CenCal Health uses internal and external data as part of Risk Stratification and Segmentation (RSS) process to proactively identify Members who may benefit from Care Management services. Data sources may include, but are not limited to, the following:

- Screenings and/or Assessments (e.g., IHA, HRA, HST);
- Managed Care and Fee-for-Service Medical and Dental Claims and Encounters;
- Electronic Health Records (EHR);
- Referrals;
- Authorizations;
- Screenings Assessment, Brief Interventions, and Referral to Treatment (SABIRT);
- Medications for Addiction Treatment (MTOUD, also known as Medication for Opioid Use Disorder) and other SUD;
- Other Non-Specialty Mental Health Services Information;
- County Behavioral Health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System DMC-ODS, and Specialty Mental Health Services (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) Claims System;
- CenCal Health Pharmacy Claims and Encounters;
- Disengaged Member Reports (e.g., assigned Members who have not utilized any services);
- Laboratory Test Results;
- Admissions, Discharge, and Transfer (ADT) Data;
- Race, ethnicity, and language information;
- Sexual orientation and gender identity (SOGI) information;
- Disability Status;

- Housing Reports (e.g., through the Homeless Data Integration System (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data);

- For Members under 21, information on development and adverse childhood experiences (ACEs) screenings; and

- Analysis of Member-specific information including historical fee-for-service utilization data, when available and provided electronically by DHCS at the time of enrollment.

Screenings

CenCal Health proactively screens all eligible Members to identify those Members who have an increased risk of adverse health outcomes or worsening of their health status, and who may benefit from services or interventions that can improve or maintain their well-being. Please refer to policy MM-CM117 Risk Stratification and Health Survey.

VI. ASSESSMENT

Members enrolled in CM services are assigned a service level. Once contact has been made with a Member, attempts are made to perform a comprehensive assessment, or as appropriate, with their authorized representative, parent/guardian or their caregiver.

If CM services discontinue while a Member is admitted to a facility and the stay is longer than 30 calendar days, a re-assessment will be performed after discharge to determine if the member is still eligible for CM services.

The following may be included in the initial comprehensive assessment:

- Member's health status, including self-reported health status and condition-specific issues;

- Clinical history, including medication history;

- Limitations to activities of daily living (e.g., bathing, dressing, going to the toilet, transferring, feeding, and continence);

- Behavioral and mental health status, including cognitive functions and SUD;

- Life-planning activities;

- Social Drivers of Health (SDOH);

- Cultural and linguistic needs, preferences, or limitations;

- Visual and hearing needs, preferences, or limitations;

- Caregiver resources and involvement;
- Potential barriers;
- Availability of covered benefits and linkages to community resources and organization; and
- Member's need for services such as Community Supports services, community health worker (CHW) services, doula, and/or other services within or outside of CenCal Health's network, if medically appropriate and cost effective.

Ongoing management of these Members may include, but is not limited to, the following:

- Periodic review and revision of ICPs, which may include additions removal, or re-prioritization of interventions and goals that are whole person-centered;
- Identification of new barriers that prohibit progress toward planned interventions and goals;
- Facilitation and monitoring status of applications and referrals to federal, State or local agencies and/or community-based organizations;
- Collaborative development and communication of Member self-management plans; and
- Assessment of Member's progress as compared to their ICP.

VII. PROCEDURE

Enrollment and Care Manager Assignment

Upon a Member's enrollment to CM or Care Coordination services, the Care Manager will collaborate with the Member, family and/or Providers to accomplish the below activities. The Care Manager/care coordinator will:

- Work with the Member to identify Care Coordination needs and goals that are realistic and perceived as achievable by the Member;
- Determine whether the goals are within the scope of CM and Care Coordination services;
- Assign a service level based on the anticipated contact frequency and intensity of services necessary to achieve goals; and
- Identify, implement, coordinate, and/or plan interventions that lead towards the accomplishment of goals.

Care Manager assignments are based on the complexity of the Member's needs and their primary problems or concerns. Problems or concerns may be medical or psychosocial in nature and assigned accordingly. Considerations are also made for primary language spoken by the Member, acuity service levels, and the caseload of the Care Manager. Refer to policy and procedure MM-CM114 Care Management Program, Planning and Coordination and policy and procedure MM-CMXX Assignment of Care Manager Responsibilities.

Individualized Care Plan

CM services include the development of ICPs that are Member-centered and realistic to the Member. ICPs are developed based on assessment/survey findings and/or historical data. ICPs address problems and concerns of the Member as well as their Providers and other involved parties.

Care Managers may develop ICPs consistent with their scope of professional licensure, education, and practice. They are responsible for engaging the Member in the planning process and allowing the Member to be the primary decision-maker and goal setter. During the planning process, the Care Manager should communicate directly with the Member to prioritize planned interventions and to educate the Member on their conditions, provide alternatives, facilitate services, etc., as well as enable the Member to make informed and appropriate decisions.

Member input and participation in care planning is desirable in order to optimize the Member's acceptance of the ICP and thus maximize the potential of achieving the specified goals. With the permission of the Member, family members, physician(s), and other health care Providers should be engaged in the planning process. The Care Manager recognizes the importance of collaborating with the Member's physician(s) regarding input toward the development of an ICP as a key component of effective ICP development and care planning.

The ICP is used as a tool to help with timely coordination of services, thus increasing the effectiveness and efficiency of care/services provided to the Member. Member-centered ICPs help Care Managers document and track identified problems, issues, or barriers, goals, interventions, actions and timelines to achieve the goals.

Refer to policy and procedure MM-CM114 Care Management Program, Planning and Coordination for ICP development requirements.

Coordination

The Care Manager coordinates interventions specified in the ICP to promote:

- Quality, cost-effective outcomes;
- Optimization of health care benefits across the continuum of care;
- Timely access to medically necessary care; and

- Continuity of care, transition of care, and integration of services across a range of care settings.

Coordination of care is achieved through communication with the Member or Member's authorized representative and the health care team (PCP, specialist and other health care Providers actively involved in the Member's care). The Care Manager's communication throughout the coordination process will convey that the Care Manager does not provide or direct the provision of medical care to the Member.

As part of the coordination process, the Care Manager will communicate with the physician directing the Member's care and notify the physician that the Member is engaged in the CM program or when CM is closed. This initial communication should occur within one month of accepting the Member into CM and may take the form of a verbal phone call to the physician directly or the physician's office or a written letter. The method of communication (e.g., phone call or letter) should be documented in the notes.

Care Coordination is a separate process from the utilization review and authorization processes. The Care Manager clarifies these different processes with the Member and their Providers by explaining that Care Coordination facilitates the movement through the care continuum and the access to services whereas the authorization process evaluates the medical need for requested services.

Refer to policy and procedure MM-CM114 Care Management Program, Planning and Coordination for additional information pertaining to coordination activities.

Monitoring and Measuring

Monitoring within CM Program is the ongoing review of the Member's experience during their participation in CM services. Monitoring also consists of evaluating the Member's overall condition and progress toward achieving identified goals and outcomes of CM services. Measuring within the CM Program involves the review of the program design and its processes, the Member's perception of their outcome, and data analyses, with the latter being the most challenging measurement.

While a Member is receiving CM services, the Care Manager monitors and considers the following:

- Is the Member expressing their willingness to continue participation with CM services?

- Did the Member initially contribute in the ICP development and does the Member continue to be involved?

- Does the Member understand the importance and benefits of follow through with identified goals?

- Are there continuous knowledge deficits, barriers, and challenges that may limit the ability to attain goals?

- Is there a change in the physical, mental, and social status that prohibits or limits full participation in planned interventions and goals?

- Is there a need to delay or modify plans and goals due to unexpected circumstances?

- Is the Member engaged/motivated to adopt lifestyle changes to improve or maintain current health?

- Is the CM receiving adequate and appropriate feedback from the Member?

- Are the goals and timelines Member-centered and reasonable?

Outcome measurements for CM services are multifaceted. Measuring a service that is "Member-centered" comes from the Member's perspective, their satisfaction with the services, and their view of accomplishment, rather than from utilization patterns or cost effectiveness although these concepts are interrelated.

A basic way to measure Member-centered outcomes is by obtaining feedback from the Member about their experience with CM services. The CM department sends out a post-CM service satisfaction survey to Members who have completed their CM services. For those who do not return the survey, a CSA performs outreach. Management analyzes and reports the results to the Health Services Operations Workgroup and to the Healthcare Operations Committee. Member satisfaction is also measured by tracking complaints and grievances that are related to CM activities. As appropriate, areas identified as needing improvement will be addressed.

Data is also a useful tool to measure the overall effectiveness of the program as well as measure care specific outcomes. Use of claim and encounter data allows the CMP to measure resource utilization (pre, post, and concurrent), such as ED visits, admissions, and ancillary services.

Narrative care studies may also demonstrate program effectiveness. For example, the analysis and comparison of a Member's status before and after CM services may help management determine the program's value and effectiveness with other Members. Care study findings may include factors such as, ED visits decreased to three visits during the 6 months while under CM services and the number of hospital stays for a diabetic-related condition also decreased by one during the same period.

Tools used to measure and evaluate program effectiveness are reviewed bi-annually and may be updated or replaced as the CM Program Member demographics changes.

Each tool used to measure program effectiveness contains the following elements:

- Identify a relevant process or outcome to measure;

- Use valid methods that provide quantitative results;

- Set a performance goal, as appropriate;

- Clearly identify measure specifications;
- Collect data and analyze results; and
- Identify opportunities for improvement, if applicable.

Closure of Care Management Services

This part of the CM process focuses on discontinuing services when the Member transitions to their highest level of function, the best possible outcome has been attained, or the needs/desires of the Member have changed, or the Member is no longer eligible.

Refer to policy and procedure HS-CM105 Closure of Care Management Services for detailed information.

VIII. DEFINITIONS

Basic Population Health Management: means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

California Children Services (CCS): program through California's Department of Health Care Services for children with certain diseases or health problems. Through this program, children up to 21 years old can receive health care and services with specialized care centers. As of July 1, 2018, CenCal Health is responsible for authorization and payment of CCS covered services but not for CCS eligibility, which is performed by County CCS. Refer to the Pediatric Whole Child Program for additional information.

Care Coordination: Contractor's coordination of services for a Member between settings of care that includes: (A) Appropriate Discharge Planning for short-term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; (B) Services the Member receives from any other managed care health plan; (C) Services the Member receives in Fee-For-Service (FFS); (D) Services the Member receives from Out-of-Network Providers; and (E) Services the Member receives from community and social support Providers.

Care Management (CM): A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health, behavioral, and social needs.

Care Management Plan: a written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for

clinical and non-clinical service needs. CenCal Health uses the term "Individualized Care Plan (ICP)" in lieu of "CMP."

Care Management (CM) Program: means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. The Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home provide this category of Care Management services. Coordination of transition and linked services are considered Basic PHM services but may be complex due to concurrent medical, social issues and transitional care needs.

Care Manager: a registered nurse or an individual with a master's degree in Social Work or Clinical Psychology, who helps Members navigate through the continuum of care. A Care Manager can assess, plan, facilitate, coordinate care, evaluate, and advocate for options and services to meet a Member's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Clinical Support Associate (CSA): under the direction of a licensed staff, a CSA is a non- clinical individual who assists and works with Members to obtain necessary resources. This individual may provide information on community resources to Members, assist Members with appointments and transportation, and provide reminder calls.

Community Supports: substitute services or settings to those required under the California Medicaid State Plan that the Plan may select and offer to their Members pursuant to 42 C.F.R. § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Complex Care Management (CCM): an approach to Care Management that meets differing needs of high and rising-risk Members, including both ongoing chronic care coordination for chronic conditions and interventions for episodic, temporary needs. Plans must provide CCM in accordance with all NCQA CCM requirements.

Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria, through systematic coordination of services and CCM that is community-based, interdisciplinary, high-touch, and person-centered.

Individualized Care Plan: an ICP is a comprehensive document that identify individualized and member-centered problems, goals, planned inventions, barriers, and outcomes. Problems are identified based appropriate assessment or case source report. Interventions are targeted to address the associated goal and are either a short or long-term is goal is triggered. The ICP is the same as the Care Management Plan, as defined above.

Member: a Medi-Cal recipient who resides in CenCal Health's Service Area and who has enrolled with CenCal Health.

Primary Care Provider: means a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.

Provider: any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Risk Stratification and Segmentation (RSS): the process of separating Member populations into different risk groups and/or meaningful subsets, using information collected through population assessments and other data sources. RSS must result in the categorization of Members with care needs at all levels and intensities.

Service Area: the county or counties that the Plan is approved to operate in under the terms of its contract with DHCS. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Social Drivers of Health (SDOH): means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

IX. REFERENCES

- Disease Management Programs Process Flow
- CenCal Health Pediatric Whole Child Model Program Description
- Utilization Management Program Description
- MM-CM114 – Care Management Program, Planning and Coordination
- MM-CM51 – Assignment of Care Manager and Care Manager Responsibilities
- MM-CM121 – Enhanced Care Management
- MM-CM44 – Transitional Care Services
- MM-CM117 – Risk Stratification and Health Survey Tool
- HS-CM105 – Closure of Care Management Services
- NCQA Complex Care Management Standards 2023
- Population Health Management Program Guide

- Commission for Care Manager Certification (CCMC), Definition and Philosophy of Care Management at https://ccmcertification.org/about-ccmc/about-case-management/definition-and- philosophy-case-management

- Department of Health Care Services All Plan Letter (APL) 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities

- Department of Health Care Services APL 18-023: California Children's Services Whole Child Model Program

- Johns Hopkins HealthCare LLC, Care Management

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2023

Population Health Management (PHM) Strategy and Program Description

QIHEC Approval: August 2023
Updates: December 2023

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Table of Contents

Table of Contents (continued)

I. Program Purpose

To identify the strategy and organizational structure CenCal Health utilizes to implement a Population Health Management (PHM) program that ensures members have access to a comprehensive set of services based on membership needs and preferences across the continuum of care.

By implementing a PHM strategy, CenCal Health aims to:

- Promote wellness and prevention, including early intervention for healthier lifestyles.
- Improve care coordination and communication to ensure members receive timely and appropriate services, reducing fragmentation, and improving the overall patient experience.
- Optimize healthcare utilization by guiding members to the most appropriate care.
- Manage healthcare expenditures by focusing on preventive care, reducing unnecessary healthcare utilization, and proactively managing chronic conditions to prevent complications and hospitalizations.
- Identify and support high risk and vulnerable populations for tailored interventions.
- Focus on evidence-based practices.
- Recognize and address social drivers of health that impact a member's health and wellbeing.
- Utilize data analytics to assess health outcomes, identify high-risk populations, and inform program development and resource allocation.
- Align healthcare delivery with value-based care principles that emphasize quality outcomes and patient-centeredness.
- Engage members through health promotion, wellness programs, and personalized care management, empowering them to take an active role in managing their health.

The goal of PHM is to achieve better health outcomes and health equity through a holistic person-centered approach so that members can live longer, healthier, and happier lives.

I.A. Introduction

CenCal Health's mission is "*to improve the health and well-being of the communities we serve by providing access to high-quality health services, along with education and outreach, for our members.*" To this end, CenCal Health maintains a comprehensive strategy for population health management that is reviewed and updated annually to ensure program goals are being met and compliance with the Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA).

CenCal Health's PHM program was created to guarantee that all members have access to inclusive, equitable health services across the continuum of care, including the community setting, based on individual needs and preferences through participation, engagement, and focused interventions for a defined population. CenCal Health integrates PHM across the organization through the coordination of multiple program and service offerings into one seamless system. In doing so this creates efficiencies to improve health outcomes. To ensure a successful PHM strategy, the following critical components are incorporated, including population identification, data integration, stratification, measurement, care delivery systems, and community resources.

CenCal Health is committed to promoting and advancing health equity through CenCal Health's mission, vision, and values. As defined by the Center for Disease Control and Prevention (CDC), health equity is "the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to address historical and contemporary injustices, overcome economic, social, and other obstacles to health and health care, and eliminate preventable health disparities."

II. PHM Strategy and Population Needs Assessment

PHM Strategy

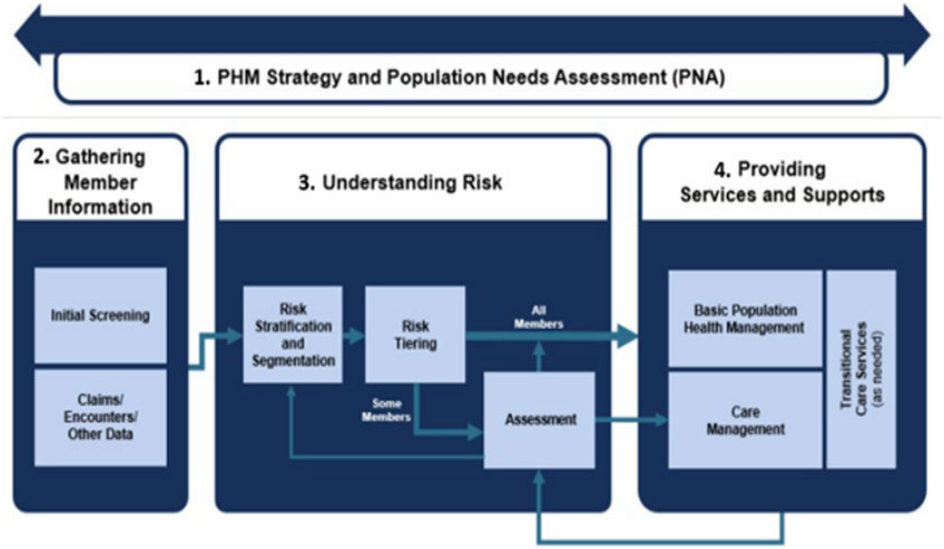
CenCal Health's PHM strategy defines how program services are delivered or offered. It provides a framework for a comprehensive plan to assess and meet the needs of the Plan's entire membership and throughout the member's lifespan. Additionally, the PHM strategy provides a structure for establishing activities that meet PHM goals. CenCal Health programs and services are designed to address the needs of the member population.

CenCal Health is committed to assessing and understanding the cause of health disparities for its members and working with internal and external stakeholders to overcome any inequalities. CenCal Health uses its Population Needs Assessment (PNA) to identify issues which can contribute to health disparities; the PNA Action Plan delineates the strategies CenCal Health will implement to address and mitigate those disparities. The PHM strategy relies on the data and information from the PNA.

The PHM Framework, including its four domains, serves as the foundation for CenCal Health's PHM program. It helps demonstrate how activities across the organization work cohesively to create a comprehensive strategy that addresses the needs, preferences, and values of a population. This allows CenCal Health to be flexible in determining where to focus interventions and tailor programs and services offered based on the results.

The sequential integration of the following operational domains comprises CenCal Health's PHM program:

1. PHM Strategy and Population Needs Assessment,
2. Gathering Member Information,
3. Understanding Risk, and
4. Providing Services and Supports



CenCal Health's comprehensive PHM strategy addresses NCQA's four areas of focus with specific goals for identified populations, the timeframe, type of intervention (program or service), and data source. The four areas of focus are:

1. Keeping members healthy.
2. Managing members with emerging risks.
3. Patient safety or outcomes across settings.
4. Managing members with multiple chronic illnesses.

Support for PHM programs include staff from various departments and team units.

- Preventive outreach to members to promote *Keeping Members Healthy* is provided by the following departments: Quality (Population Health, Health Promotion, and Quality Measurement team units), Member Services, and Communications.
- The Quality Department (Population Health, Health Promotion, and Quality Measurement team units), and Care Management staff within the Medical Management Department collaborate to identify and support *Managing Members with Emerging Risk*.
- Quality Department, Provider Services, Provider Relations, Member Services, and Medical Management, and Pharmacy Departments collaborate to ensure *Patient Safety or Outcomes Across Settings*.
- Within the Medical Management Department, Care Management's clinical and social work teams support *Managing Members with Multiple Chronic Illnesses.*

<table>
<tr><th colspan="3">Programs within NCQA Areas of Focus
NCQA PHM 1, Element A, Factors 1 & 2</th></tr>
<tr><td rowspan="3">Keeping members healthy</td><td colspan="2">Programs or services: Implement a Plan Do Study Act (PDSA) with a high-volume low-performing network contracted provider; Implement a Performance Improvement Project (PIP) from 2023-2026 focused on disparity reduction (goal identified below) that includes engagement with local entities to address deficiencies; Implement a wellness and prevention initiative called the “Staying Healthy: Kids” program to educate parents of pediatric members on the importance and schedule of preventive care in a culturally and linguistically appropriate manner (as described in section VI.A);

Data Source: NCQA HEDIS® Measure - Well Child Visits in the First 15 Months of Life (W30-6+)[1]

Overall Goal: 67.56% (2023 NCQA Quality Compass Medicaid 90th percentile) of pediatric members receive six (6) or more well-child visits in the first 15 months of life (aggregate baseline: 54.59%, HEDIS MY2022).

Disparity Goal: Reduce the racial/ethnic disparity among pediatric Hispanic/Latino subgroup (aggregate baseline: 54.59%, HEDIS MY 2022) compared to White subgroup (aggregate baseline: 57.21%, HEDIS MY 2022) that receive six (6) or more well-child visits in the first 15 months of life.

Population: Pediatric members due for preventive visits, with focus on Hispanic/Latino subgroup.

Timeframe: Begin 7/1/2023; End 12/31/2026</td></tr>
<tr><td>Strategies</td><td>Activities</td></tr>
<tr><td>Implement a PIP to reduce the disparity between Hispanic and White members for Well-Child Visits in collaboration with pediatric network providers and local entities (community-based organizations) that serve this demographic.</td><td>• Assemble a cross functional, multidisciplinary team
• Complete a barrier analysis, per PIP standards
• Implement identified intervention(s)
• Evaluate for sustainability and spread</td></tr>
<tr><td>Managing members with emerging risk</td><td colspan="2">Goal 1: 36.78% (Quality Compass 2022 Medicaid HEDIS 90th percentile) of pregnant members that were screened for clinical depression (with a standard assessment instrument like the PHQ-9) while pregnant.

Goal 2: 27.77% (Quality Compass 2022 Medicaid HEDIS 90th percentile) of postpartum members that were screened for clinical depression (with a standard assessment instrument like the PHQ-9) after delivery.

Goal 3: 69.01% (Quality Compass 2022 Medicaid HEDIS 90th percentile) of pregnant members that were screened for clinical depression (with a standard assessment instrument like the PHQ-9) during pregnancy, and if screened positive, received timely follow-up care.</td></tr>
</table>

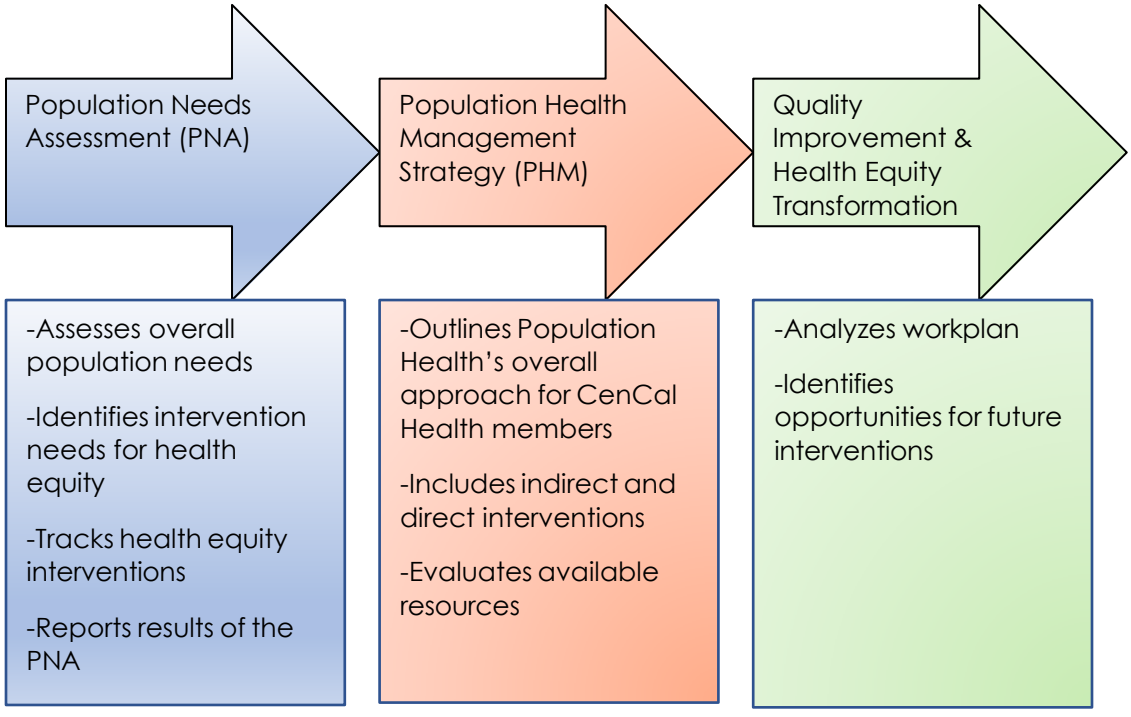
1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

	Goal 4: 82.78% (2023 NCQA Quality Compass Medicaid HEDIS 90th percentile) of postpartum members that were screened for clinical depression (with a standard assessment instrument like the PHQ-9) after delivery, and if screened positive, received timely follow-up care. **Population:** Pregnant members and postpartum members. **Timeframe:** Begin 7/1/2023; End 12/31/2024 **Programs or services:** CenCal Health's cross-functional Disease Management Maternal Mental Health program, including distribution of member health education literature. **Data Sources:** HEDIS Electronic Clinical Data Set Measures – 1) Prenatal Depression Screening and Follow-Up (PND-E) and 2) Postpartum Depression Screening and Follow-Up (PDS-E)
Patient Safety	**Goal:** 10% reduction of hospitalizations from Skilled Nursing Facility (SNF) due to infection and hospitalizations within partnering locations. **Population:** Members receiving care at any one (1) of six (6) pilot site nursing homes in Santa Barbara and San Luis Obispo counties. **Timeframe:** Begin 7/1/2023; End 6/30/2024 **Programs or services:** Support identified SNF sites with purchasing new materials and implementing evidence-based bathing protocols; Educate partnering SNF sites on new materials and process in collaboration with Project SHIELD. **Data Source:** Claims data of inpatient admissions from SNFs due to infection
Managing multiple chronic illnesses	**Goal 1:** 46.76% (2023 NCQA Quality Compass Medicaid 90th percentile) of diabetic members received an annual kidney health evaluation, including a blood test for kidney function and a urine test for kidney damage. **Goal 2:** 90% of diabetic members with one or more chronic conditions eligible for Care Management had an assessment initiated for at least one (1) factor within 30 calendar days following enrollment. **Goal 3:** 90% of diabetic members with one or more chronic conditions eligible for Complex Care Management have completed at least one or more self-management goals to manage diabetes within 60 days of enrollment. **Population:** Subpopulation of the general Diabetes Disease Management program population: members 18 and over with a diagnosis of diabetes who have one or more additional chronic conditions. **Timeframe:** Begin 7/1/2023; End 6/30/2024 **Programs or services:** Care management, health education

	Data Source: HEDIS Measure – Kidney Health Evaluation for Patients with Diabetes; CenCal Health's Care Management tracking software

PHM program activities are integrated into CenCal Health's Quality Improvement and Health Equity Transformation Program (QIHETP). The QIHETP defines the process of continuous improvement in the quality of clinical care and services, health equity, patient safety, and member experience provided by CenCal Health and its contracted provider network. The QIHETP supports CenCal Health's organizational goals, established state-wide priorities, and identified community needs. To ensure appropriate resource allocation, annually an organization-wide work plan is developed based on an evaluation of the prior year's work plan. The work plan reflects ongoing activities throughout the year and addresses:

- Yearly planned population health and health equity activities and objectives.
- Time frame for each activity's completion.
- Staff members responsible for each activity.
- Monitoring of previously identified issues.
- Evaluation of the program.



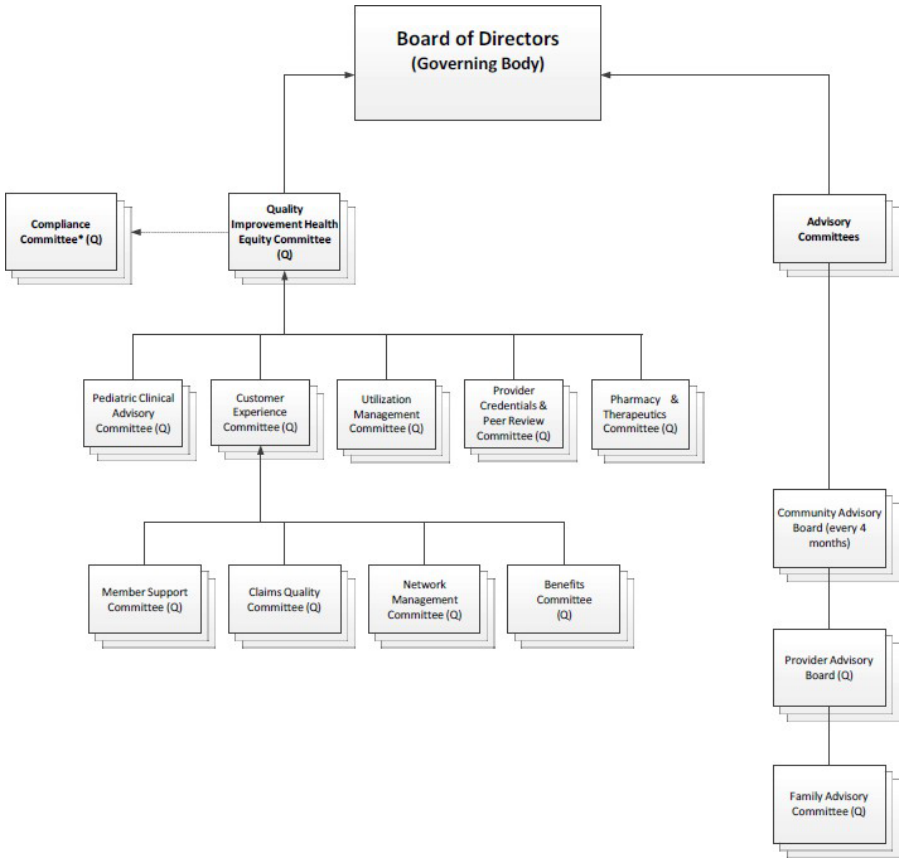
Although the execution of quality and population health functions is spread amongst all departments across the organization, CenCal Health's Quality Department leads the annual development of the QIHETP and the PHM strategy, in coordination with all QIHETP participants

plan wide. This includes but is not limited to CenCal Health's Chief Medical Officer (CMO), Chief Health Equity Officer, and Quality & Population Health Officer.

CenCal Health utilizes a quality committee structure that leverages the multidisciplinary expertise of staff and practitioners that serve on distinct quality committees. This approach enhances communication throughout CenCal Health and integrates patient-centered care and processes, thereby increasing the quality and efficacy of CenCal Health's QIHETP and PHM programs.

The Quality Improvement Health Equity Committee (QIHEC) is the Board of Directors appointed entity responsible for monitoring and evaluating quality, health equity, and PHM activities. The QIHEC activities are supervised by CenCal Health's CMO or the CMO's designee, in collaboration with CenCal Health's Chief Health Equity Officer. The committee meets at minimum quarterly.

The following organizational chart illustrates the relationship between the quality committees that advise the Board of Directors.



Population Needs Assessment

CenCal Health recognizes the importance of offering health education, cultural and linguistic (C&L), and quality improvement services that aim to achieve health equity within its membership. CenCal Health annually assesses its population to identify health disparities or gaps in services. The annual Population Needs Assessment (PNA) evaluates data sources to determine needs of child and adolescent members, members with disabilities, members of different racial or ethnic groups, members with limited English proficiency, and needs related to social drivers of health.

The PNA focuses on identifying health disparities and developing plans of action to address them. Populations experiencing health disparities are identified through a systematic process that analyzes service utilization patterns, disease burden, and gaps in care. It also considers the membership's risk level, geographic location, and age. The PNA action plan describes objectives and strategies to overcome health disparities throughout the community served in collaboration with community partners.

To deepen CenCal Health's understanding of its members and strengthen its relationship with the communities served, CenCal Health has established a collaboration with local health departments (LHDs). This collaboration allows for meaningful participation in their Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs) and to co-develop at least one shared goal/SMART objective with each LHD that aligns with DHCS' Bold Goals initiative as described in DHCS' Comprehensive Quality Strategy. CenCal Health will participate meaningfully by providing funding, staffing, and/or data. The collaboration with the LHDs will enhance CenCal Health's ability to identify the needs and strengths holistically to improve members' lives more effectively and sustainably.

The shared SMART objectives with LHDs in CenCal Health's service region are as follows:

Santa Barbara	San Luis Obispo
By December 31st, 2025, CenCal Health and the Santa Barbara Public Health Department will increase the Santa Barbara Health Care Center's aggregate rate of "Well Child Visits in the First 30 months of life – 6 or more visits" from a baseline of 64.05% (period ending 10/31/23) to 68.09% (2023 Quality Compass Medicaid 90th Percentile) by implementing equity focused interventions (that address identified barriers in most need), informed by a robust barrier analysis.	By December 31, 2025, CenCal Health and San Luis Obispo County will improve the CenCal Health adolescent depression screening rate by 50%, from a HEDIS MY2022 baseline of 30.56% to 45.84%, by conducting an analysis (a comprehensive report to identify the sub-populations in most need of focus, including stratification by race, age, region, and sex) and using the analysis to inform initiatives such as the creation of communication tools and provider trainings.

III. Gathering Member Information

CenCal Health's PHM strategy relies on correct and inclusive member information to gain an accurate picture of each member's social and health needs. This information includes but is not limited to each member's health related goals, preferences, and specific needs. CenCal Health

gathers this information using a variety of different tools including but not limited to an initial health survey, claims, encounter, member portal information, and other data.

III.A. Initial Screening Process

CenCal Health utilizes the Health Risk Assessment (HRA) Survey to satisfy initial screening requirements of all new members in lieu of the Health Information Form (HIF)/Member Evaluation Tool (MET). The HRA survey is included within the new member welcome packet and then mailed annually to all adults and California Children's Services (CCS) members. The HRA is also offered to members within the member portal. While completion of HRAs is not delegated to the primary care practitioners (PCP), to determine appropriate interventions, screenings, and preventive services, members are asked to provide their completed HRA to their PCP for review during their Initial Health Appointments (IHA) or annual preventive medicine evaluation.

CenCal Health requires PCPs to conduct comprehensive IHAs within 120 days for new members, and annual preventive medicine evaluations for established members. Exams must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. IHAs must be completed in accordance with:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule for members under age 21, including but not limited to provision of all immunizations necessary to ensure that members are up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.
- United States Preventive Services Taskforce (USPSTF) Grade A and B recommendations for adults and children, however not all components must be completed during the initial appointment, so long as members receive all required screenings in a timely manner.
- American College of Obstetricians and Gynecologists (ACOG) standards and guidelines for pregnant or postpartum members.
- For pregnant, breastfeeding, or postpartum members, or a parent/guardian of a child under the age of five (5), documentation of a referral to the Women, Infants, and Children Program (WIC) program is mandated by Title 42 CFR 431.635(c).

As soon as possible and no later than 60 calendar days following the IHA or other visit that identified a need for follow-up, PCPs must make arrangements for necessary follow-up, diagnostic, and/or treatment services for risk factors or disease conditions discovered. This includes the provision of immunizations in accordance with the recommendations published by the Advisory Committee on Immunization Practices (ACIP).

III.B. Claims/Encounters/Other Data

CenCal Health systematically collects, integrates, and assesses member data to inform its PHM programs. CenCal Health's IT Department maintains an Enterprise Data Warehouse (EDW) that is updated daily, weekly, and monthly, depending on the type of data source. CenCal Health receives data from multiple sources; medical and behavioral claims, pharmacy claims, laboratory results, hospital appraisals, electronic health records, and advanced data sources, such as but not limited to California Immunization Registry and Department of Health Care Services (DHCS). CenCal Health utilizes this extensive data and the PNA to identify and understand member needs and to prepare data-informed strategies for how to meet them.

III.C. Social Drivers and Community Needs

Social Drivers of Health (SDOH) are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. CenCal Health assesses these drivers through active collection of data through different data sources. CenCal Health regularly communicates with its provider network to promote reporting of SDOH diagnosis codes via CenCal Health's website, the Provider Manual, publishing articles in the Provider Bulletin, and provider trainings.

CenCal Health's HRA survey also contains specific questions related to SDOH. If the member is enrolled in Care Management, a Comprehensive Health Assessment (CHA) is additionally completed which also contains questions related to SDOH. Collection of SDOH and community needs information helps identify member needs beyond clinical gaps in care. This information will help CenCal Health develop tailored action plans using stratified data to focus on the member's greatest needs, or those needs with the greatest impact on members' health and well-being.

To achieve health equity, CenCal Health staff review HEDIS quality measure results from its health equity dashboard that includes stratification using key factors of race, ethnicity, language, geography, gender, and age. Additional SDOH factors that may negatively influence access to care and/or exacerbate inequities are also included. CenCal Health also maintains a separate PHM Dashboard based on claims and supplemental data sources to monitor utilization of key services that incorporates stratified SDOH information; the dashboard allows staff to segment utilization differences by race, ethnicity, age, sex, etc. to then address health inequities via planned interventions.

IV. Understanding Risk

CenCal Health aims to help members with their health before they require intensive treatment and care. Therefore, understanding member risk is important as it helps to identify potential interventions that are at the earliest possible point of intervention based on member risk level. CenCal Health utilizes Risk Stratification and Segmentation (RSS) and Risk Tiering to understand members' risk.

IV.A. Population Risk Stratification & Segmentation

At least annually, CenCal Health segments and stratifies its entire population into subsets for tailored interventions. Stratification is completed through a Risk Stratification System. Member needs are incorporated into the RSS Algorithm by considering members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks. SDOH factors are integrated by incorporating, at minimum, the RSS measures and data sources. Prior to the availability of the DHCS PHM Service, CenCal Health uses an internally developed RSS algorithm to meet the requirements defined by the DHCS 2024 Medi-Cal Managed Care Contract and Population Health Policy Guide.

The HRA is a data source for risk stratification, as it evaluates a member's health status, determines risk level and need for care management, care coordination, and/or access to community resources using a whole-person care approach. It consists of questions that identify member risk, such as multiple ED visits, inpatient stays, falls, LTSS needs, and mental health or substance use disorder needs. Following the evaluation of HRA responses, members are scored

and assigned to an initial level of support with the goal of reducing avoidable readmissions and regaining optimum health and improved functional capability in the right setting, cost-effectively. CenCal Health maintains a data-driven RSS process which complements CenCal Health's HRA risk scoring to identify members by level of risk. The intensity of intervention with members is determined by risk level, highest to lowest. Members identified are contacted to further evaluate needs and determine the appropriate level of support and resources needed.

Health equity is one of CenCal Health's principal strategic objectives. To reduce biases and not exacerbate inequities, CenCal Health's RSS algorithm incorporates relevant and available data from non-utilization sources to complement utilization-dependent data sources. CenCal Health's non-utilization sources include, but are not limited to:

- HRAs, which are distributed to and requested of all new Members and annually for adult and California Children Services (CCS) members.
- Race, ethnicity, language, gender, geography, age, and disability data, which provides valuable insight to member risk not influenced by utilization-dependent data collection barriers.
- Disengaged member queries since the probability of risk is high for members that have not previously utilized any CenCal Health benefits and/or are not engaged with care.

CenCal Health utilizes several integrated data sources as defined in the Population Risk Stratification/Segmentation and Risk Tiering Policy, including but not limited to screenings and assessments, claims data, social needs data, electronic health records, as well as information from community partners.

On an annual basis, Quality and Medical Management departments collaboratively analyze CenCal Health's RSS Algorithm results to ensure that the RSS Algorithm avoids and reduces biases in its RSS approach.

IV.B. Risk Tiering

CenCal Health additionally utilizes risk tiering to determine eligibility for care management (CM) programs or other services. Risk Tiers include Low, Medium-rising, or High and are defined based on the sum of risk scores for 76 CenCal Health-identified RSS measures based on a member's individual social and medical circumstances. Risk Tiers are separately defined for pediatric and adult members because the RSS measures identify conditions, events, and characteristics that often correlate with age. Members from each of the pediatric and adult Risk Tiers are sampled, and their medical and social characteristics, at minimum, are reviewed to validate the appropriateness of the Risk Tier thresholds considering the sampled member's Risk Tier placement.

Risk Tiers and RSS measure risk point assignments are reevaluated based on the Medical Management clinical evaluation to ensure the appropriateness of the thresholds. Thresholds are revised as warranted to assure appropriate member assignment by Risk Tier.

IV.C. Assessment and Reassessment to Understand Member Needs

In addition to the initial screening, all adult and California Children Services (CCS) members are requested to complete an HRA annually to determine if a significant change to their health or risk level has occurred. A significant change to a member's health status or level of care is defined by an event that may include but is not limited to sentinel medical events, new diagnoses, unplanned hospitalizations, or significant changes to independence with Activities of Daily Living (ADLs). Members are assessed and tracked programmatically using claims and other supplemental administrative data to identify any significant change in health status or risk. Following each annual reassessment, and as needed upon significant changes in health status, the member's individualized Care Plan is realigned in response to any evolving changes in health status, risk level, or medical needs.

CenCal Health uses the RSS and the PHM Service Risk Tiers to:

1. Connect all members, including those with rising risk, to appropriate CenCal Health services, including but not limited to CM programs, wellness and prevention services, and Transitional Care Services.
2. Assess all members within a PHM Service High Risk Tier upon enrollment into CenCal Health CM, to identify members' health and individual needs and preferences to meaningfully engage them with the most appropriate services and supports.
   a) Assessments are performed for the following, at minimum:
      i. Members with Long-Term Services & Supports (LTSS) needs
      ii. Members entering Complex Care Management (CCM)
      iii. Members entering Enhanced Care Management (ECM)
      iv. Children with Special Health Care Needs (CSHCN)
      v. Pregnant individuals (assessments for prenatal and postpartum that are comparable to the ACOG and CPSP standards).
      vi. Seniors and Persons with Disabilities (SPD) who meet the definition of "high risk"
   b) Annual reassessments are performed for CSHCN, CCM and members with LTSS needs.
   c) Through the assessment/reassessment process, Medical Management staff work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available.

Assessments and referrals are conducted in line with the DHCS PHM Policy Guide requirements.

V. Providing PHM Services and Supports

The following sections describe PHM programs and services administered by CenCal Health in alignment with DHCS and NCQA PHM requirements. PHM programs and services delivered by CenCal Health to members and providers are planned, monitored, and evaluated through the QIHETP and reported quarterly to the QIHEC. CenCal Health's PHM program maintains a strong focus on health equity in all programs and services.

V.A. Basic Population Health Management (BPHM)

As defined by DHCS, Basic Population Health (BPHM) is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier, at the right time and in the right setting. CenCal Health maintains a BPHM system and ensures it promotes health equity and provides all members services delivered in a culturally and linguistically competent manner that are responsive to member needs, beliefs, and preferences. All Basic PHM services are aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

The BPHM system includes:

1. Access, Utilization, and Engagement with Primary Care
2. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports
3. Information Sharing and Referral Support Infrastructure
4. Integration of Community Health Workers (CHWs) in PHM
5. Wellness and Prevention Programs
6. Programs Addressing Chronic Disease
7. Programs to Address Maternal Health Outcomes
8. PHM for Children

V.A.i. Access, Utilization, and Engagement with Primary Care

CenCal Health delegates the primary CM and care coordination role to PCPs. CenCal Health's approach to ensure that all members are engaged with their assigned provider is to distribute monthly care management reports to PCPs that identify members in need of IHAs, as well as to distribute monthly quality-of-care reports to PCPs through CenCal Health's pay-for-performance program, Quality Care Incentive Program (QCIP).

As part of the QIHETP, CenCal Health ensures members have access to an adequate network of providers for the provision of quality health care benefits through the ongoing monitoring of access and capacity. Additionally, CenCal Health ensures that recruitment efforts address new technologies, services, and benefits, including collaborative opportunities with provider partners such as telemedicine, to augment availability of services within the service area CenCal Health routinely monitors network adequacy indicators and implements interventions as necessary if gaps are identified.

CenCal Health staff regularly communicate with PCPs through Provider Bulletin articles and expectations are communicated through the Provider Manual. Members are educated on the importance of engaging with primary care through routine member newsletter articles, the member portal, targeted health education outreach interventions, and on CenCal Health's website. The Preventive Health Guidelines are promoted annually and through various distribution channels.

V.A.ii. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports

CenCal Health ensures members have access to needed services that address all their health and health-related needs, including navigation and referrals to services that address members' developmental, physical, mental health, substance use disorder (SUD), dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

CenCal Health organizes care coordination and continuity of care for members who may need or are receiving services and/or programs from out-of-network providers. This coordination can include health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs, 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, to address members' needs and to mitigate impacts of SDOH.

CenCal Health has established relationships and processes to meet Closed Loop Referral requirements, and by January 2025, will ensure coordination of warm hand-offs to other public benefits programs, including but not limited to CalWORKs, CalFresh, WIC Supplemental Nutrition Program, Early Intervention Services, Supplemental Security Income, and others. Additionally, assistance is provided to members, members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons with navigating health delivery systems, including CenCal Health's Subcontractor and Downstream Subcontractor Networks, to access covered and uncovered services.

CenCal Health has Memorandums of Understanding (MOUs) with County Mental Health Plans and Drug Medi-Cal Organized Delivery Systems Plans to formalize roles to ensure care coordination, care navigation, and referral needs of all members are addressed.

V.A.iii. Information Sharing and Referral Support Infrastructure

Information Sharing

CenCal Health ensures that providers maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law. CenCal Health communicates all necessary care coordination to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons and facilitates the exchange of necessary information in accordance with all state and federal privacy laws.

Referral Support Infrastructure

CenCal Health maintains a Closed Loop Referral system that allows tracking of referrals and their outcomes with the goal of decreasing duplication of services and improving timely linkage to resources for members in accordance with the No Wrong Door Policy. CenCal Health is committed to addressing member health related needs such as physical, mental health, SUD, LTSS, oral, vision and developmental through comprehensive care coordination including coordination of Closed Loop Referrals. Referrals are made to all appropriate support services, including but not limited to Community Supports, Community Health Workers, LTSS services, NSMHS, and SMHS, from the appropriate delivery system. Comprehensive care coordination requires bilateral communication with those involved in the members care and/or other service providers. CenCal Health ensures members receive Closed Loop Referrals as quickly as possible not to exceed regulatory timelines.

CenCal Health has a timely, centralized process to track referrals in accordance with access timeliness standards and utilizes encounter data and claims reports to ensure members are receiving services. CenCal Health's has developed additional MOUs with third party entities and county programs as a method to ensure clear understanding of the various agencies specific service eligibility, assessments, Closed Loop Referral coordination and data sharing processes.

V.A.iv. Integration of Community Health Workers in PHM

Community Health Workers (CHWs) are uniquely skilled to support the C&L needs of members to optimize their engagement and improve health equity. CHWs provide benefit and support to improve health outcomes through person-centered, team-based care, and their ability to promote patient engagement and address SDOH conditions.

Members who may benefit from CHW services including those in priority populations are identified using data from CenCal Health's RSS process and based on data from the DHCS PHM

Service. Additionally, CenCal Health identifies members by reviewing those currently in CenCal Health clinical programs that may benefit from CHW support. All members identified are assessed for need and CenCal Health coordinates linkage to CHW services through the member's PCP and contracted CHW providers. CenCal Health has implemented a robust member/provider communication plan on how to access services, including promotion in the new member welcome packet, through member newsletters, and alerts on CenCal Health's member portal. CenCal Health also conducts outreach to relevant providers via Provider Bulletins, routine meetings, trainings, and the CenCal Health website in order to inform providers of the CHW benefit and what it consists of.

CenCal Health promotes the CHW benefit as part of BPHM to address primary care underutilization, children's preventive care, maternity and birth equity, and integrated behavioral health. For BPHM programs, CenCal Health identifies sub-populations in need of certain types of outreach or education and identifies CHWs within the provider network that would best address those sub-populations, to create collaborative programs and interventions to reach target members. Because CHWs are a unique type of service provider to support provider-patient relationship building, engaging them on BPHM programs increases member engagement in programs, improves the efficiency with which members navigate the health system, and results in improved quality of care and health equity.

V.A.v. Wellness and Prevention Programs

CenCal Health provides comprehensive wellness and prevention programs to all members. These programs aim to improve physical and mental health for members through initiatives that implement evidence-based best practices directed at helping members set and achieve wellness goals.

CenCal Health ensures organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health. At a minimum, the programs and services address appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions, within the following areas of focus:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

The wellness and prevention outreach is conducted via direct U.S. Postal Service outreach, with the opportunity for follow-up via member portal or inbound member phone call. CenCal Health understands the importance of not contradicting the telephonic outreach conducted by providers. CenCal Health supports this separate provider telephonic outreach by providing them with monthly gaps in care data, described in section VII.

Wellness and prevention programs are coordinated by CenCal Health's Health Promotion team, within the Quality Department. For each program's member outreach, CenCal Health's Care Management team within the Medical Management Department is provided with a list of members who received wellness and prevention outreach. Sample program materials are included in this notification. Additionally, the Care Management and Health Promotion teams

participate in monthly collaborative meetings with the larger Quality Department to ensure teams are aligned and coordinated with member outreach.

Providers are also notified of their assigned members who received wellness and prevention program outreach via lists and information on the provider portal each time an outreach is conducted. Sample program materials are also included in this notification, for providers' reference. Providers are then able to conduct reinforcing outreach should they choose to. A reminder of the availability of these resources on the provider portal is included in the quarterly Quality Care Incentive Program communications.

CenCal Health wellness and prevention programs include the following:

Wellness and Prevention Programs
Program: Stay Healthy: Adults **Population:** Adult members due for key preventive services **NCQA Area of Focus:** Keeping members healthy **DHCS Health Education Focus:** Appropriate use of health care services; Risk-reduction and healthy lifestyles **Description:** The Stay Healthy: Adults program is offered to all adult members who are due for important aspects of preventive care and includes targeted mailings that provide: • Health education about the preventive service that the member is due for, including why the service is important for health, and where and how to access the preventive service • The ability for members to follow up with a Certified Health Educator for more support and information • Access to CenCal Health's online health education service with information, tools, and resources for preventive care and healthy lifestyles
Program: Stay Healthy: Kids **Population:** Pediatric members due for preventive services, including EPSDT **NCQA Area of Focus:** Keeping members healthy **DHCS Health Education Focus:** Appropriate use of health care services; Risk-reduction and healthy lifestyles **Description:** The Stay Healthy: Kids program is offered to the parents of all pediatric members who are due for certain aspects of preventive care, including developmental screening, lead screening, and other EPSDT services and includes targeted mailings that provide: • Health education about the preventive service that the member is due for, including why the service is important for health, and where and how to access the preventive service • The ability for members to follow up with a Certified Health Educator for more support and information • Access to CenCal Health's online health education service with information, tools, and resources for preventive care and healthy lifestyles

Program: Breathing Better

Population: Members diagnosed with asthma

NCQA Area of Focus: Managing members with emerging risk

DHCS Health Education Focus: Self-care and management of health conditions

Description: The Breathing Better program includes a health education mailing that provides members with:

- Health education about asthma self-management as well as information about the correct use of controller and rescue medications.
- An Asthma Action Plan and reminder that members should complete this annually with their provider
- The ability for members to follow up with a Certified Health Educator for more support and information
- Access to CenCal Health's online health education service with information, tools, and resources for asthma self-management

Program: Healthy Pregnancy

Population: Members who are pregnant

NCQA Area of Focus: Managing members with emerging risk

DHCS Health Education Focus: Risk-reduction and healthy lifestyles

Description: The Healthy Pregnancy program is offered to all members who are newly pregnant. This health education program includes a targeted mailing that provides:

- Health education about the importance of timely prenatal visits and information on a healthy pregnancy, including nutrition, dental care, immunizations, mental wellness, physical activity, and more.
- The ability for members to follow up with a Certified Health Educator for more support and information.
- Access to CenCal Health's online health education service with information, tools, and resources for healthy pregnancy

Program: Healthy Postpartum

Population: Members who are up to 12 months postpartum

NCQA Area of Focus: Managing members with emerging risk

DHCS Health Education Focus: Risk-reduction and healthy lifestyles

Description: The Healthy Postpartum program is offered to all members who are newly postpartum, through 12 months postpartum. This health education program includes a targeted mailing provides:

- Health education information on the importance of timely postpartum visits and on postpartum wellness, nourishment, and returning to exercise.

- The ability for members to follow up with a Certified Health Educator for more support and information.
- Access to CenCal Health's online health education service with information, tools, and resources for a healthy postpartum season

Program: Safe Care

Population: All members

NCQA Area of Focus: Patient safety

DHCS Health Education Focus: Appropriate use of health care services; Risk-reduction and healthy lifestyles

Description: The Safe Care program is open to any member seeking education about best practices for patient safety advice for hospital care as well as transitional support across health care settings. This dynamic health education program utilizes multiple methods of messaging and engagement to meet members' education needs, including:

- Distribution via the CenCal Health's website and member portal
- Member portal bi-directional engagement
- Information about patient safety and patient self-advocacy
- The ability for members to contact a Certified Health Educator for more support and information
- Access to CenCal Health's online health education library with information, tools, and resources for preparing for hospital care

Program: Know More

Population: Varied based on each "Know More" program goal

NCQA Area of Focus: Keeping members healthy

DHCS Health Education Focus: Risk-reduction and healthy lifestyles

Description: The "Know More" educational series provides health information to members using digital platforms. Each "Know More" program focuses on a different aspect of care, engaging members with health content aimed at preventing illness and reducing risk. Offering digital video and interactive health education content provides an alternative way of engaging members with health information at point of service. Current programs within the "Know More" series include:

- Know More: HPV (nationally recognized)
- Know More: STIs
- Know More: Vaping

Additional "Know More" topics are planned for development, as they provide an alternative way to engage members with health education information at point of service.

In addition to these programs, the identification of specific, proactive wellness initiatives and programs that address member needs are identified in the PNA.

Self-Management Tools
CenCal Health offers a comprehensive library of health education content to both members and providers. This library is licensed from an NCQA-certified vendor (Healthwise) and includes self-management tools to help members determine risk factors, provide guidance on health issues, and recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. Self-management tools are offered on at least the following topics:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

Members can access these tools directly from CenCal Health's website, member portal or through printed mail by request.

V.A.vi. Programs Addressing Chronic Disease
CenCal Health offers evidence-based Disease Management programs (DMPs) in line with NCQA requirements and DHCS Wellness and Prevention requirements that target chronic illnesses and mental health, including maternal mental health. Members with any of these conditions, listed below, receive CM services and support from CenCal Health that is appropriate for their medical circumstances, and compliant with NCQA's standards for PHM Complex Care Management.

Disease Management Program Description
CenCal Health's Disease Management programs and services align with NCQA Accreditation standards. Using a proactive, multidisciplinary, and systematic approach, CenCal Health's DMPs include the primary care practitioner as the primary manager of the member's care supported by plan staff and specialists. Additionally, these DMPs incorporate health education interventions, identify members for engagement, and seek to close care gaps for members participating in the interventions to improve health equity and reduce health disparities. All programs provide a comprehensive, ongoing, and coordinated approach to achieve desired health outcomes.

At minimum, the programs and services address the following health conditions:

- Asthma
- Cardiovascular disease
- Diabetes
- Depression
- Maternal mental health

CenCal Health's DMPs have components that are like CM services including the general goal of improving long-term medical treatment. Through tailored interventions specific to the needs of each member that empower behavior change and actions, DMPs and services connect with CenCal Health's PNA and PHM strategy, and other community programs to help members:

- Improve self-management support skills.

- Improve adherence to treatment plans.
- Minimize symptoms associated with chronic conditions.
- Prevent future complications or the development of accompanying conditions related to chronic disease.

CenCal Health members who qualify for DMP support are enrolled in these programs and may opt-out of the program at any time. Members and providers have access to the comprehensive library of health education content that includes self-management tools to help reduce risk and improve health.

With a focus on better management and prevention of future complications related to chronic conditions, CenCal Health's members' quality of life will improve.

V.A.vii. Programs to Address Maternal Health Outcomes

CenCal Health ensures the provision of all medically necessary services for pregnant women, including but not limited to comprehensive risk assessments and individualized care plans that include obstetrical, nutrition, psychosocial, health education interventions, and appropriate follow-up to address clinical and health-related social needs. Risk assessments for pregnant members are performed with a comprehensive risk assessment tool comparable to the ACOG and Comprehensive Perinatal Services Program (CPSP) standards.

Maternal mental health is one of CenCal Health's Disease Management program topics, as described in section V.A.vi. Additionally, prenatal and postpartum health are topics included in CenCal Health's Wellness and Prevention program, as described in section V.A.v.

V.A.viii. PHM for Children

CenCal Health's approach to ensure all children under the age 21 receive preventive and primary health services in line with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is to actively promote preventive visits to providers and members. EPSDT services are promoted to providers via Provider Bulletins, the Provider Manual, during provider meetings, and through CenCal Health's new Quality Care Incentive Program (QCIP) that offers significant financial incentives for completion of key EPSDT services.

CenCal Health promotes EPSDT services to its members through the new member welcome packet, the member handbook, member newsletters, and personalized alerts in a member portal. Preventive Guidelines member handouts promoting the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule are also sent to all member households annually through the member newsletter.

CenCal Health coordinates health and social services for children between settings of care and across delivery systems and ensures that children and their families can access medically necessary physical, behavioral, and dental health services, as well as social and educational services. CenCal Health monitors rates of children's preventive care service utilization using a claims-based dashboard. For any variances identified, staff intervenes with providers through routine outreach and one-on-one meetings.

V.B. Care Management Programs

CenCal Health's Care Management (CM) program is a comprehensive, member-centered program that consists of Complex Care Management (CCM), Basic Care Management, Transitional Care Services (TCS), and other care coordination activities. CM was developed to help members appropriately use health care services and/or gain access to state programs, community-based resources, and long-term services and support. Facilitating access to such services allows members to maintain independence at home, live in the least restrictive environment, and maximize their well-being.

The CM program's goal is to support members who need individualized guidance, education, and/or extensive coordination of their health care needs while optimizing value, and to achieve desirable outcomes for all stakeholders. The CM program consists of various care levels from basic, which is primarily the responsibilities of the PCP, to complex, which is a collaborative effort between CenCal Health, the member, their PCP, and other involved providers or organizations.

CM services are available to members with various levels of needs. Eligible members may include, but are not limited to, those with complex medical conditions or psychosocial needs, those with specific diagnosis that be at high risk due to over/under utilization of services, and those that may need care coordination or care transition assistance.

The CMO is responsible for all clinical programs, including CM services. As a component of the overall Health Services operations, these various CM programs work collaboratively with CenCal Health's Utilization Management program.

CenCal Health ensures that members have access to CenCal Health's Cultural and Language Access Services. Health information is presented in the members' native language during appointments and staff are responsible for advocating for and ensuring each member is aware of their rights and responsibilities in accessing services across delivery systems and by addressing any immediate barriers to care due to social drivers of health.

The care team involved in managing members in CM services are nurses, Social Workers, Clinical Support Associates, and Medical Directors in collaboration/consultation with Behavioral Health and Medical Management departments. Health Plan Nurse Coordinators and Care Management Social Workers are the primary clinicians who provide CM and care coordination services. Clinical Support Associates are non-clinical staff who assist clinicians and perform tasks, such as assisting members with appointments and transportation, providing resource materials, and performing follow up checks and health surveys. The Care Managers will coordinate care based on the interventions identified in the care plan.

V.B.i. Complex Care Management

Complex Care Management (CCM) is available to CenCal Health members who need extra support to avoid adverse outcomes. Members are proactively identified for Care Management services via the Risk Stratification and Segmentation (RSS) process and via various referral sources which may include member self-referrals and/or referral from an authorized representative, community-based organizations, hospitals, and non-contracted providers. CCM services may include, but are not limited to, coordination of timely, medically necessary services, conducting a comprehensive assessment of the member's needs within 60 days of

enrollment, determining available benefits and resources, and developing and implementing a patient-centered CM plan with goals, monitoring, and follow-up. The comprehensive assessment components include but are not limited to;

- Member's health status, including self-reported health status and condition-specific issues
- Clinical history, including medication history
- Limitations to activities of daily living (e.g., bathing, dressing, going to the toilet, transferring, feeding, and continence)
- Behavioral and mental health status, including cognitive functions and substance use disorders (SUD)
- Life-planning activities
- Social drivers of health
- Availability of covered benefits and linkages to community resources and organizations
- Cultural and linguistic needs, preferences, or limitations
- Visual and hearing needs, preferences, or limitations
- Caregiver resources and involvement
- Potential barriers
- Member's need for services such as Community Supports services, CHW services, doula, and/or other services within or outside of CenCal Health's network, if medically appropriate and cost-effective

Individualized Care Plans (ICPs) are member-centered, with goals prioritized to include long-term and short-term focus, level of monitoring, identification of goals related to self-management, and follow up. ICPs also include identified problems, issues, or barriers, list of interventions (i.e. such as referrals needed and follow up), actions, and timelines to achieve the goals and improve health outcomes.

Members in care management are tracked in CenCal Health's Care Management system. The Care Management system consists of an assessment with automatic intervention and prompts for follow-up on care management plan goals. The Care Management system also documents times and dates of interactions that occur with members, practitioners, and providers.

V.B.ii. Enhanced Care Management

CenCal Health's Enhanced Care Management (ECM) program successfully launched in 2022 and has been implemented for the designated Populations of Focus (POFs). CenCal Health has built a diverse network of ECM providers that reflect member demographics and meet the cultural and linguistic needs of POFs.

CenCal Health is committed to the sustained growth of the ECM program and continues to build its capacity by increasing provider network size and adequacy, increasing provider engagement and recruitment outreach strategies, conducting member outreach and engagement training, and by continually scanning utilization-based and non-utilization-based data sources to identify members eligible for ECM enrollment. CenCal Health educates network providers and Community Support (CS) partners regarding the ECM benefit and how to refer potential members. Information about ECM is also shared via the CenCal Health website and Member and Provider Bulletins.

CenCal Health assures its method for assessing member ECM eligibility does not introduce or perpetuate biases. To appropriately identify members potentially eligible for ECM enrollment,

CenCal Health's robust, balanced, and data-driven method counters member underutilization bias by incorporating a variety of non-utilization data sources, including demographic information such as race, ethnicity, language, geography, gender, and age to not introduce or perpetuate biases often associated with underutilization by marginalized subpopulations.

V.C. Transitional Care Services

CenCal Health's Care Transition Program assists members who need care transition within and across all healthcare systems and settings. The goal of the program is to reduce avoidable readmissions and quality inequities and to improve member experience during the care transition process by reducing care fragmentation.

The PCP's responsibility is to serve a central role in coordination of member care, including transitions between systems and settings. CenCal Health's Utilization and Care Management teams work in conjunction with PCPs, other providers, and support systems and organizations, as part of a multidisciplinary team to deliver patient-centered transitional care. Referrals are made to CM to support members through the continuum of care while ensuring post-hospitalization care coordination and outpatient/follow up services are provided.

The Care Transition team assesses SDOH such as financial barriers, social supports, transportation, and housing. An important part of the Care Transition program is to ensure members understand the discharge plan, particularly for non-English-speaking members and those with low health literacy. Upon discharge, the assigned Care Transition team (RN, social worker and Clinical Support Specialist) conducts timely follow up with the member and their PCP to ensure they remain engaged in their transition plan and are receiving necessary services. Members receive closed loop referrals to wrap-around services to ensure they can continue to successfully reside in the community.

VI. Organizational Support for PHM

CenCal Health staff operate in coordinated effort across departments within the organization to implement PHM programs and processes. Health Promotion and Population Health teams within the Quality Department implement member and provider-facing interventions in response to PHM requirements and health plan quality scores. Medical Management (CM and Behavioral Health teams) Department staff implement care and disease management programs and care coordination processes. Member Services Department staff coordinate member eligibility and support for transitions and referrals. The table below describes Organizational Supports for PHM in relation to NCQA Areas of Focus and DHCS Risk Tiers.

NCQA's four (4) Areas of Focus include:

- Keeping Members Healthy
- Managing Members with Emerging Risk
- Patient Safety or Outcomes Across Settings
- Managing Members with Multiple Chronic Condition

DHCS' Risk Tiers include: *No/Low Risk*, *Moderate/Rising Risk*, and *High Risk.*

Note: CenCal Health included an additional level of risk to the table below, "Transitions of Care," to describe operational efforts to support members moving through different levels of care or care settings.

Organizational Supports include:

- Member Services interventions
- Health Education interventions
- Care Management interventions
- Population Health interventions
- Utilization Management interventions

Specific goal rates, target populations, timelines, and staff responsible for implementing the relevant organizational support are incorporated into CenCal Health's QIHETP Work Plan.

DHCS Risk Tier	NCQA Area of Focus	Organizational Support
No/Low Risk: Members with no identified disease diagnosis or utilization flag	Keeping Members Healthy	Member Services Interventions: Promote member benefits through the Member Handbook. Support member needs through the call center and portal. Health Education Interventions: Member newsletters with primary and preventive care information sent to member households. Implementation and promotion of an online health education library for use by all members. Population Health Interventions: Generate and provide "Care Management" reports on the provider portal; offer virtual and in-person trainings on preventive services topics.
Moderate/Rising Risk: Members at risk of disease or disease progression as identified through diagnosis or service code; members who are pregnant	Managing Members with Emerging Risk	Member Services Interventions: Ensuring access to specialty care to manage emerging or chronic conditions. Health Education Interventions: Educational programs to support healthy lifestyle choices, inform on self-management practices, and educate on medication and treatment compliance. (Better Breathing program, Stay Healthy: Adults and Kids programs, Healthy Pregnancy program, Healthy Postpartum program, Safe Care program, Know More program). Population Health Interventions: Generate and provide data on the provider portal to assist with PCP patient management.
Transitions of Care: members moving through different levels of care or care settings	Patient Safety or Outcomes Across Settings	Member Services Interventions: Assistance with eligibility and referrals across levels of care, such as from acute to Skilled Nursing Facility.

		Utilization Management Interventions: Review and approval of referrals and authorizations for transitions to different levels of care. Care Coordination Interventions: coordinate services; assess member needs for additional services and care management; review discharge plans; coordinate transportation as necessary; communicate with member's PCP to ensure coordination of care: assist with post discharge monitoring.
High Risk	Managing Members with Multiple Chronic Conditions	Member Services Interventions: Eligibility and referral coordination. Health Education Interventions: Educational materials on managing risk and chronic condition self-management. Care Coordination Interventions: Complex care management, complete assessments, individual member care plans, health education, disease management and coordination of services.

VI.A. Health Education

CenCal Health implements and 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. CenCal Health ensures administrative oversight of the health education system by a certified full-time health educator, as defined by DHCS All Plan Letter (APL) 18-016. The Health Education team is integrated into the Quality department and works closely with all CenCal Health departments.

The Health Education system is strategically integrated within the QIHETP to ensure health education and promotion activities and interventions support quality improvement, health equity, and PHM priorities. Member health education needs are also informed annually by the PNA, which describes member health status and seeks to identify gaps in services and health disparities.

Written Health Education Materials

CenCal Health provides members with health education materials designed to assist them to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes by including information on health conditions, management of health conditions, and self-care. Topics may include messages about preventive care, health promotion, screenings, disease management, and healthy living.

Health education materials are provided to members in accordance with the DHCS requirements, including ensuring that they are culturally and linguistically appropriate, and that they meet all readability and suitability requirements. Materials are provided at or below a 6th grade reading level, use 12-point font, and undergo all required clinical review and field testing.

Documentation of readability reviews are kept for written health education materials currently in use. In addition to written health education materials, CenCal Health offers self-management tools, derived from available evidence, as described in section V.A.v.

Member Incentives

CenCal Health utilizes member incentives to motivate individuals to adopt healthy behaviors, such as quitting smoking, losing weight, receiving timely post-partum care, or accessing timely immunizations, with the goal of improving health status, enhancing prevention and health outcomes, and reducing program costs. Additionally, CenCal Health uses incentives for focus groups and surveys to better understand the needs of members, and to use that information to develop materials and programs that may help members better navigate the health care system and improve their health status.

VI.B. Other Activities – Interventions that Indirectly Affect Members

CenCal Health collaborates with providers, community-based organizations (CBOs), and local public health departments, to create programs, policies, and/or processes to benefit CenCal Health's membership.

The following table describes such activities, as well as what aspect of member health, or which target population, they relate to.

Initiative Type	Initiative Description	Area of Focus
Provider Gaps in Care Reports (Quality Care Incentive Program)	Automated monthly list of members with missing clinically recommended services supplied to providers for direct outreach to close gaps in care. Clinically recommended services encompass aspects of care addressing Women's Health, Pediatric Care, Behavioral Health, Respiratory Care, Cardiac Care, and Diabetes Care.	Keeping members healthy; Managing members with emerging risk
Provider Bulletin	Monthly health awareness to all primary care practitioners that amplifies a specific health topic to increase engagement with their patients related to health screenings, immunizations, guidance, and other preventative care counseling.	Keeping members healthy
Community Newsletter	Sent to recipients quarterly, this newsletter keeps community stakeholders updated on CenCal Health initiatives, governance, and current issues, including those that affect both members and providers.	Keeping members healthy
Provider Education and Trainings	Monthly live and/or recorded training webinars to support provider staff on a variety of subjects designed to enhance the quality of care and services members receive. Continuing Medical Education credits are offered at most of CenCal Health's provider trainings, to encourage maximized attendance from network clinicians.	Keeping members healthy; managing members with emerging risk
Potential Quality Issue (PQI) Review System	Investigation is thoroughly performed after the identification of a PQI to reveal whether care was substandard or rendered in accordance with clinical standards. CenCal Health works to identify,	Patient safety or outcomes across settings

	investigate, and initiate corrective action in circumstances when a member's Quality of Care Concern (QOC) is verified as clinically below standard. This process aims to aid in the evaluation and improvement of the overall quality of care delivered to members.	
Social Media	Social media accounts (Facebook, Instagram, and LinkedIn) are used to promote key messaging on CenCal Health news and initiatives, as well as important health topics affecting members and the community.	Keeping members healthy
Community Collaboration	CenCal Health engages with community stakeholders on various levels. CenCal Health regularly participates in local community coalitions/initiatives that aim to improve the health of the community CenCal Health serves. CenCal Health has also established relationships with key state and national organizations to partner on awareness campaigns and interventions (e.g. American Cancer Society).	Keeping members healthy; Patient safety; Managing members with emerging risk
Provider E-Mail/Fax Blasts	CenCal Health routinely utilizes direct provider electronic communication to impart urgent or important topics. This is a more direct method than the Provider Bulletin, and often is clinical alerts, new resource announcements, or other key topics.	Keeping members healthy; patient safety or outcomes across settings
Targeted Health Campaigns with Providers and CBOs	CenCal Health regularly collaborates with community agencies and healthcare providers to develop and distribute health education messaging on important topics.	Keeping members healthy; managing members with emerging risk
Provider Portal	CenCal Health's provider portal allows providers to electronically submit claims to CenCal Health and check member eligibility, submit authorizations electronically, and view informative CenCal Health reports, such as Gaps in Care and Immunization recall.	Keeping Members Healthy; Managing members with Emerging Risk
Quality Care Incentive Program (QCIP)	This pay-for-performance program aligns financial incentives to healthcare providers with excellence in clinical care of health plan members. It emphasizes clinical priorities of significance to CenCal Health members and encourages increased utilization of evidence-based treatment, screening, and preventive health services.	Keeping Members Healthy; Managing Members with Emerging Risk
Health Equity Collaborative with ACAP	In collaboration with the national organization, Association Community Affiliated Plans (ACAP), CenCal Health joined a Health Equity Collaborative, focused on developing a health equity strategy for the organization. The goal is to improve and eliminate inequities of quality of care and service.	Keeping members healthy; Managing Members with Emerging Risk

VI.C. Informing Members About Available PHM Programs

PHM programs and services are accessible to all CenCal Health members. CenCal Health uses multiple methods for communicating information to members about available PHM programs and services. CenCal Health informs all members of the programs available through the member newsletter which directs members to the CenCal Health website. Additionally, depending on the program, CenCal Health uses direct member mailing and telephonic outreach through CenCal Health's Population Health, Care Management, and/or Member Services teams. With the development of a member portal in 2023, members are also informed of available PHM programs and services through their member portal account.

CenCal Health coordinates several concurrent programs, offered both directly from CenCal Health and through contracted providers and partner community-based organizations. To minimize confusion, CenCal Health works to minimize duplication of efforts, and also carefully develops outreach language to ensure members understand who is involved in the program. All significant programs being planned or offered to members are shared with both the Community Advisory Board and the QIHEC, to ensure that key community agency and healthcare provider stakeholders can provide input into program delivery and any potential duplication. All program materials are also branded as CenCal Health so that members know they are participating in education or activities coordinated by their health plan.

VI.D. Community Engagement and Coordination of PHM Programs

As a local County-Organized Health System, CenCal Health is an active member of its community, participating in many local coalitions, boards, and events. CenCal Health routinely solicits input and collaboration from network providers and local entities (community-based organizations) for its PHM program and activities. A CenCal Health's Community Advisory Board (CAB) is given an update and presentation at each quarterly meeting and has an opportunity to provide input on completed and planned health education and PHM programs and activities (refer to the Table of Programs in Section II). Additionally, CenCal Health utilizes the annual PNA to inform the types of collaborations we build with community partners and organizations.

As health equity is a central tenet to CenCal Health's PHM framework and services, CenCal Health is heavily invested in cultivating community partnerships. This is reflected in CenCal Health's 2023—2025 Strategic Plan as one of four strategic goals. The two key objectives of this Strategic Plan goal are to ensure that CenCal Health consistently, effectively, and respectfully engages the community within its plan operations: facilitating community collaboration to strengthen the health system and engaging on health equity locally.

Objective 1: Facilitate community collaboration to strengthen the health system

Strategies:

- Convene, educate and collaborate with community stakeholders on Medi-Cal reforms, changes and directions to enable coordinated action
- Align the CenCal Health Doorway to Health Foundation to advance quality and health equity for all and promote innovation
- Play a leading policy role as liaison, educator and advocate for local Medi-Cal and safety-net health care priorities at the local and statewide level

Objective 2: Engage locally on health equity

Strategies:

- Embrace the role of convener, facilitator, and humble partner with other health providers, social service leaders and government agencies to promote health equity
- Solicit member, provider and community partner voices through meaningful engagement to improve customer experience
- Collect, analyze and share data on health disparities and the social determinants of health to propel community action

VI.E. Informing Members on Interactive Content

CenCal Health notifies members who are eligible for various PHM programs through direct mailing, live telephonic outreach, robo-call outreach, or through their member portal account. Members are notified of their eligibility for the program and any actions they need to take to participate in it and/or use program services. All communications are in the appropriate threshold language and literacy level. All programs are voluntary. Members can choose to participate and can stop participating at any time.

VII. Program Evaluation

CenCal Health's PHM program impacts the health of its member population through programmatic strategy, execution, evaluation, and continuous improvement. CenCal Health is committed to ongoing program evaluation to continuously improve and evolve its PHM program. CenCal Health measures the effectiveness of its PHM strategy through a systematic process that evaluates whether it has achieved its goals and to gain insight into areas needing improvement. Continual assessment is necessary to inform the evolution of the overall program with health equity being a principal program goal prerequisite.

To assess effectiveness, CenCal Health annually conducts a comprehensive analysis that includes:

- Quantitative results for at least four relevant clinical, cost/utilization, and member experience metrics.
- Comparison of results with a benchmark or goal.
- Interpretation of results.

To regularly assess its PHM program, CenCal Health utilizes data received monthly from CenCal Health's NCQA certified HEDIS software vendor that enables ongoing programmatic measurement of valuable key performance indicators (KPIs). CenCal Health performs 128 distinct quality measurements monthly to evaluate program efficacy.

Throughout the year, CenCal Health also will routinely engage with DHCS regarding CenCal Health's PHM programs to ensure regular, bidirectional communication on implementation challenges and successes. The results inform PHM program refinements and current year goals.

Annually, the Quality department presents recommended priorities for improvement to the QIHEC who oversees the execution of meaningful activities to improve processes, outcomes, and satisfaction. Priorities for improvement are identified based on gaps relative to external

Medicaid benchmarks. QIHEC-approved priorities establish a minimum subset of goals for organizational improvement, including those for PHM program improvement.

VII.A. Quality Measures

CenCal Health monitors and reports clinical performance using the DHCS Managed Care Accountability Set (MCAS) quality measures for measurement year 2023/2024. All Medi-Cal Managed Care Plans (MCPs) are required to annually report these measures to DHCS through an NCQA HEDIS Compliance Audit. Measures within MCAS include but are not limited to measures from NCQA and the Centers for Medicare and Medicaid Services (CMS) adult and child core set.

Quality department staff provide updates on a quarterly basis to the QIHEC and the Board of Directors. Updates are shared via a Quality Dashboard which is a consolidation of the DHCS priority measures used for tracking and reporting as part of CenCal Health's QIHETP. The Quality Dashboard is utilized as a quick reference to monitor these priorities quarterly to identify areas where benchmarks are not being met.

VII.B. Key Performance Indicators

CenCal Health calculates all member-level KPIs monthly to monitor performance and obtain a real-time understanding of the operations and effectiveness of the PHM program. The KPIs monitored are aligned with requirements in the DHCS PHM Policy Guide. KPIs include data for the ECM Quarterly Implementation Monitoring Reporting (QIMR), the CalAIM Incentive Payment Program (IPP), and the newly added DHCS PHM monitoring KPIs.

VII.C. Identifying Opportunities for Improvement

CenCal Health reports QIHETP and PHM updates quarterly to the QIHEC and Board of Directors to obtain valuable input and feedback on processes and outcomes. With this quarterly monitoring and reporting of rates and program outcomes, CenCal Health can routinely assess needs and adapt work plan strategies to meet the emerging needs of plan members.
The annual QIHETP Work Plan evaluation process allows for reflection on key performance and programmatic metrics and requirements, with an opportunity to identify areas that have room for improvement. The QIHETP Work Plan includes space for identifying areas for improvement, which ensures CenCal Health is continuously focusing on quality improvement in relation to QIHETP and PHM.

Additionally, the annual PNA reviews key areas of health plan operations, member demographics and health status, and data sources to identify any gaps in services and areas for improvement. A Gap Analysis is included in the report as well as an Action Plan, which defines strategies that will be incorporated into PHM activities to address the findings from the assessment.

VIII. Delivery-System Supports

CenCal Health supports its network practitioners or providers to achieve PHM goals by:

- Sharing data (additional detail provided in section VIII.B).
- Offering evidence-based or certified shared decision-making aids.
- Providing practice transformation support to PCPs.

- Providing an annual training on health equity, cultural competency, bias, diversity, or inclusion.

Decision-Making Aids

CenCal Health promotes certified evidence-based shared decision-making aids to members, practitioners, and providers through routine communications and mailings. Shared decision-making aids provide information about treatment options and outcomes. Designed to complement practitioner counseling, these aids facilitate member and practitioner discussion on treatment decisions, and may also focus on preference-sensitive conditions, chronic case management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens. Certified evidence-based shared decision-making aids are available on CenCal Health's website.

Practice Transformation

CenCal Health offers practice transformation to network PCPs through financial incentives, learning collaboratives, and data sharing to improve health plan membership health outcomes. Examples of support provided include:

- Distribution of monthly member-level PCP Gaps in Care Performance Reports via its value-based, pay-for-performance, Quality Care Incentive Program (QCIP).
- Distribution of quarterly QCIP payments.
- Distribution of annual NCQA HEDIS Audit PCP Performance Reports.
- Monthly quality and population health-focused collaborative meetings with large provider practices.
- Monthly provider trainings on identified aspects of care with opportunities for improvement. Through its membership with the Santa Barbara County Consortium, CenCal Health offers its providers Continuing Medical Education credits for their participation in the trainings.
- Participation in CenCal Health's Quality Improvement/Population Health Initiatives.
- Promotion of best practices inclusive of clinical practice guidelines through provider bulletin articles, email blasts, and CenCal Health's website.
- Promotion of member health education materials and resources.
- Ad-hoc training (upon request) on how to utilize reports made available via CenCal Health's secure provider portal.

VIII.A. Pay for Performance Program

CenCal Health's Pay for Performance program, the Quality Care Incentive Program (QCIP), identifies members who are due for clinically recommended services to help PCPs provide high quality health care for members. CenCal Health includes quality measures in QCIP that meet certain criteria such as needed clinical improvement, alignment with state-wide quality priorities, and the ability to measure quality of care accurately with available data.

CenCal Health's QCIP quality measures encompass aspects of care that PCPs can influence either through direct care or through referral to specialists or other ancillary practitioners. Identified priority measures are consistent with accepted clinical guidelines and are clinically relevant to CenCal Health's membership. Measures are evaluated annually and as priorities regarding these criteria change, CenCal Health may update measures. Generally, measures

remain in the program for at least two (2) years and no less than one (1) year. Measures are separated into two (2) categories:

- Priority Measures – Identified priority aspects of care included in incentive payment calculations
- Informational Measures – Identified aspects of care not included in incentive payment calculations

QCIP performance reporting occurs monthly for all PCPs via the provider portal. A display of quality scoring for each PCP's membership includes:

- A PCP's trended overall quality performance
- A PCP's quality performance score by month
- A PCP's quality performance score by measure and measure categories
- A PCP's combined quality score for all measures
- Member's due for various aspects of care

QCIP incentive payments are distributed on a quarterly basis to reflect the prior twelve (12) months of performance, with each payment calculation period rolling forward by a quarter.

VIII.B. Sharing Data

CenCal Health provides comparative quality information to its network providers to help them make referral decisions for selected specialties and to meet PHM goals. CenCal Health uses the following tools to assist providers:

- Monthly provider Gaps in Care Performance Reports via QCIP. These reports include member-level data for specific evidence-based measures.
- Annual HEDIS audit provider performance reports for contracted PCPs which compare provider quality performance ratings to prior year's performance, NCQA benchmarks, and State Aggregates.
- Quality information, including organization-developed performance measures based on evidence-based guidelines:
    - Agency for Healthcare Research and Quality (AHRQ) patient safety indicators associated with a provider.
    - Risk adjusted measures of mortality, complications, and readmission.
    - CAHPS Clinician and Group Survey.
    - The American Medical Association's Physician Consortium for Performance Improvement measures.
- Cost information to demonstrate to providers the relative costs of episode of care, practitioner services, in-office procedures, and relative dollars per member per month, overall or by type of service or dollars per procedure.
- Care pattern reports that include quality and cost information such as external cost-comparison databases with information about the potential cost of members seeking care out-of-network.

VIII.B.i. Provider Portal

CenCal Health provides ongoing support to its contracted provider network by providing access to its portal for providers, administrators, and staff. Portal documents are updated and changed constantly to meet the needs of users, to improve functionality, and to meet nationally recognized standards and regulations in healthcare. The portal contains many interactive capabilities such as:

- Checking member eligibility
- Requesting pre-authorizations
- Reviewing:
    - Claims data and claims status
    - Pharmacy data
    - Emergency department usage
    - Patient profile report that shows all services performed for a particular member during a specified time period
- Quality Care Incentive Program (QCIP) reports for capitated PCPs enrolled in the program:
    - Performance reports and trend lines
    - Gaps in care member-level detail reports
    - Financial performance reports and trend lines

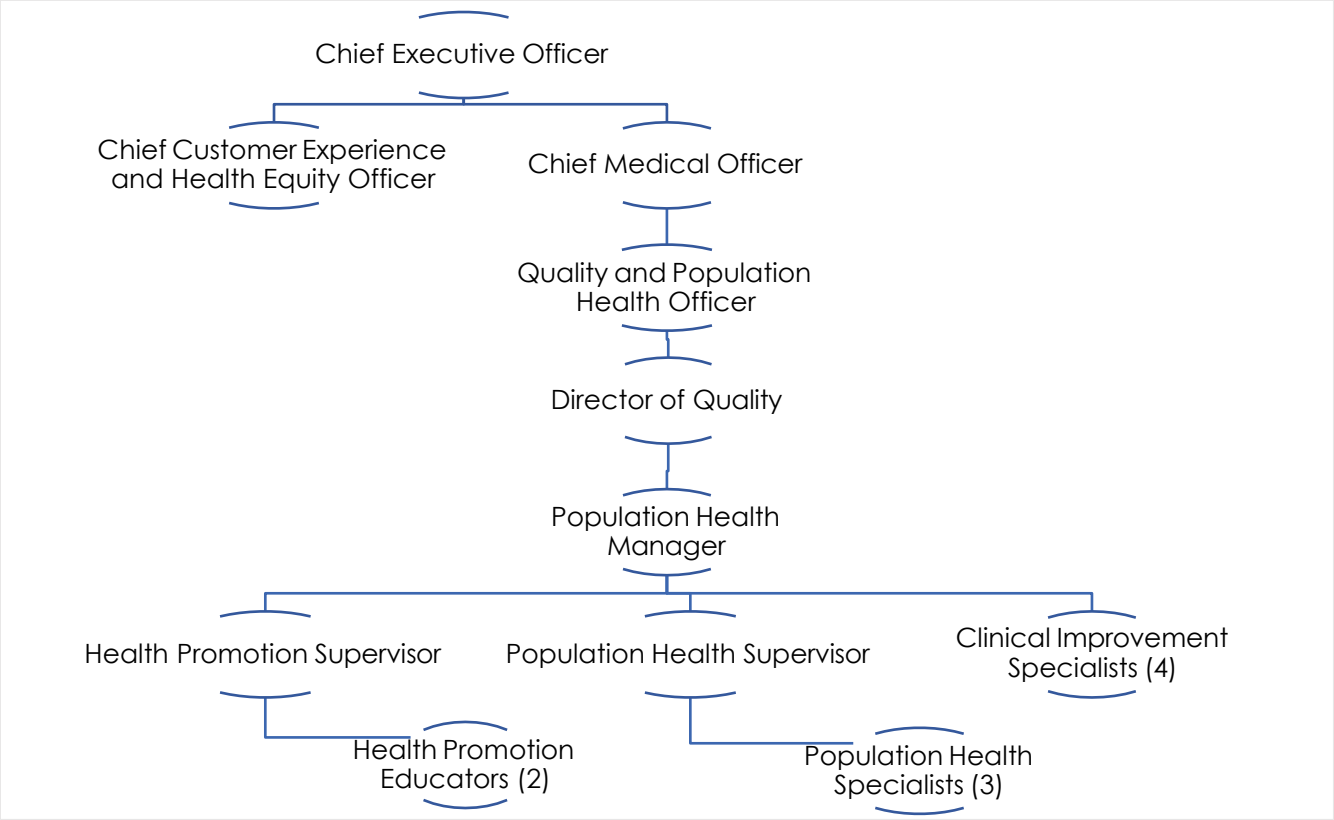
VIII.B.ii. Quality Dashboard

The Quality Dashboard is a consolidation of DHCS priority measures used for tracking and reporting as part of CenCal Health's QIHETP. For Measurement Year (MY) 2022, DHCS requires MCPs to meet thresholds for 15 quality measures. Quality dashboard metrics are reported quarterly to the QIHEC and the Board of Directors. CenCal Health staff utilize the Quality Dashboard as a quick reference to monitor these priorities quarterly and implement interventions and process improvements as needed. Metrics inform PHM activities, health education outreach, and provider training and support.

IX. Population Health Organizational Structure

The Quality department is responsible for developing, maintaining, and ensuring implementation of CenCal Health's PHM strategy, identifying health disparities and wellness and prevention member needs and aligning community efforts to meet members' needs based on DHCS and NCQA requirements. The Quality department is also responsible for oversight of QIHETP and ensures continuous and strategic alignment with PHM. To ensure PHM goals are met, Quality department staff engage with internal and external stakeholders including members.

CenCal Health's PHM program is provided cross-functionally by a multidisciplinary team across departments. The Quality and Population Health Officer and the Chief Medical Officer provide overall strategic oversight. The PHM program is led by the Quality Director and Population Health Manager within the Quality Department. The Population Health unit contains the Health Promotion team, Population Health team, and Clinical Quality team. Working cohesively, the teams within the Population Health unit implement PHM activities and processes.



IX.A. Team Roles and Responsibilities

Chief Medical Officer
The Chief Medical Officer (CMO) is a member of the executive team with strategic leadership responsibility for clinical oversight, physician partnership, and quality improvement in support of the organization's vision, mission, and values. Reporting directly to the Chief Executive Officer (CEO), the CMO provides clinical leadership to the organization and is accountable for effective medical decision-making, adherence to professional and ethical medical standards, application of state and health plan policy and overseeing clinical programs for CenCal Health members.

Chief Customer Experience and Health Equity Officer
The Chief Customer Experience and Health Equity Officer (CXO/CHEO) provides strategic vision and leadership for the management of key relationships with members, providers, and community partners. The CXO is responsible for understanding and championing diverse customer perspectives across CenCal Health's service area and sponsoring improvements in access to care, member engagement and satisfaction, provider and community partner retention and satisfaction, and quality of customer service and service outcomes.

Quality and Population Health Officer
The Quality and Population Health Officer leads the development and evolution of a systematic, organization-wide quality and population health strategy to improve member health outcomes through facilitation of CenCal Health's QIHETP.

Director of Quality
The Director of Quality is responsible for strategy development, planning, organizing, and leading the functions and activities of the Quality Department including population health management, quality measurement, clinical transformation, and health promotion. The Director of Quality develops, implements, leads, and directs the department in support of the quality and population health programs and initiatives for CenCal Health.

Population Health Manager
The Population Health Manager is responsible for the daily operations, direct oversight, and functions of the population health, clinical quality, and health promotion teams. In coordination and collaboration with the Director of Quality, the Population Health Manager supports the execution and implementation of a Population Health and Quality Strategy to achieve health equity.

Health Promotion Supervisor
The Health Promotion Supervisor is responsible for leading the Health Promotion team by guiding development, design, implementation, maintenance, and evaluation of the health education functions essential to maintain compliance with the DHCS contract and to advance the general health status of CenCal Health's members. A masters-prepared professional, as defined by DHCS APL 18-016, responsible for preparation and implementation of the PNA and Action Plan.

Population Health Supervisor
The Population Health Supervisor is responsible for leading the Population Health team by guiding development, implementation, and monitoring of population health programs and quality improvement activities performed by the Population Health team.

Population Health Specialist(s)
Population Health Specialists support the year-round design, implementation, and maintenance of innovative improvement interventions and population health programs to maximize the quality of identified clinical priorities and address membership needs to advance health equity. This role supports health status improvement through access to services, education, wellness support, and reinforcing the importance of preventive health.

Health Promotion Educator(s)
Health Promotion Educators design, implement, and maintain the health education functions essential to advance the general health status of CenCal Health's members and reduce health disparities. They support the integration of health promotion and education within PHM and contribute to the advancement of CenCal Health's Health Promotion Program to improve population health and achieve health equity.

X. References

- DHCS CalAIM: 2023 Population Health Management (PHM) Policy Guide
- DHCS Measurement Year 2023 Managed Care Accountability Set
- CenCal Health 2023 Care Management Program Description
- CenCal Health 2023 Disease Management Program Description
- CenCal Health 2023 QIHETP Program Description
- CenCal Health 2023 Wellness and Prevention Program Description

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2024 Utilization Management Program Description

Utilization Management Committee: 2/12/2024

Quality Improvement and Health Equity Committee: 2/29/2024

Board of Directors: 3/20/2024

UM Program Description

Table of Contents

UM Program Description

Table of Contents

UM Program Description

I. MISSION STATEMENT

CenCal Health's mission is *"to improve the health and well-being of the communities we serve by providing access to high quality health services, along with education and outreach, for our members."*

CenCal Health is committed to excellence through a value-added Utilization Management (UM) Program.

II. AUTHORITY

The program is under the clinical direction of the CMO, and the operational administrative direction is provided by the Health Services Officer (HSO). For all lines of business, the Primary Care Physician (PCP) is responsible for managing all aspects of the member's health care needs, including basic case management services. To this end, all members select a PCP at the time of enrollment and are encouraged to establish a relationship with the physician as soon as possible. The member is instructed to contact their PCP whenever medical health care is needed. Thus, the PCP is informed about his or her patient's needs and can make informed, appropriate decisions regarding treatment.

III. PURPOSE

CenCal Health's UM Program is designed to promote the delivery of high quality, medically necessary, and cost-efficient health care for our members. CenCal Health develops, implements, and improves its UM Program as needed or at minimum annually to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its members.

CenCal Health's UM Program is a system integrated with CenCal Health's Quality Improvement and Health Equity Transformation Program (QIHETP) to promote the continuous monitoring and evaluation of care and services provided to members. The program is designed to identify patterns of utilization and ensure efficient use of resources. The Utilization Management Committee (UMC) approves the UM Program Description and the Work Plan and Work Plan Evaluation, annually, and the Quality Improvement and Health Equity Committee (QIHEC) evaluates the UM Program key performance indicators at minimum quarterly and as needed.

IV. SCOPE

The scope of UM activities covers all clinical aspects of preventive, diagnostic and treatment services in both the inpatient and outpatient settings, which includes behavioral health, pharmacy, and medical case management. Additional scope of program activities is provided within the Operational Description section of this document.

V. GOALS AND OBJECTIVES

Utilization Management is performed to promote an effective and efficient medical health care delivery system. The UM program is designed to evaluate the medical appropriateness of medical services provided by participating physicians and other

UM Program Description

practitioners as well as facility providers and other ancillary providers. The goal is to promote appropriate utilization, which includes evaluation of both potential over-utilization and under-utilization.

The goals of the UM program are to:

- Support effective, efficient, and appropriate utilization of facilities and services through an ongoing monitoring and educational program.
- Promote fair and consistent UM decision-making.
- Focus resources on timely resolution of identified problems.
- Promote and sustain optimal quality of care.
- Educate medical practitioners, providers, and other health care professionals about appropriate and cost-effective use of health care resources.
- Establish, update, and approve criteria for medical necessity at least annually.
- Promote consistency in authorization processing through application of defined criteria for clinical decision-making.
- Work cooperatively with practitioners and providers to promote appropriate management of all aspects of members' health care.
- Provide a system to monitor the delivery of medical and related services in a timely, effective, and efficient manner consistent with the delivery of quality care.
- Continually monitor, evaluate, and optimize health care resource utilization.
- Monitor utilization practice patterns of the physicians, contracted hospitals and contracted ancillary service and specialty providers.
- Provide appropriate and timely feedback to members, practitioners, and hospitals to communicate reasons for treatment denial, the minimum clinical criteria required for authorization, and methods for appeal.
- Safeguard medical records, treatment authorization, and all other confidential information through appropriate operational protocols and use of physical mechanisms to protect member-specific information used in UM.
- Coordinate UM with quality management activities to support the ongoing monitoring of compliance with quality standards for the delivery of health services to members.
- Routine review of out-of-network seldom used specialty services.
- Conduct regular interrater reliability testing of physician and non-physician, clinical UM staff.

VI. PROGRAM STRUCTURE

A. Organizational Structure

The CMO is responsible for all clinical aspects of the UM Program and ensures adherence to all regulatory requirements. CenCal Health's Health Services Division has operational, administrative, and fiscal responsibility for the UM Program. To effectively achieve program goals and objectives, the UM Department is comprised of licensed and non-licensed healthcare professionals, which may include, registered nurses (RNs), licensed nurses or therapists, physicians-, health educators, and other professionals to support UM operations. CenCal Health members come from low-income families, but also include members that are seniors or persons with disabilities. To provide quality care to these members, the UM Program structure relies on a multidisciplinary approach to ensure efficient delivery of health care services in the best setting suited to meet the medical and psychosocial needs of the members.

B. Authority and Accountability

The UM Program clinical functions are under the direction of the CMO, and operational administrative functions are under the direction of the Health Services Officer (HSO). The CMO retains responsibility for the utilization review process in accordance with H&S Code section 1367.01. Qualified licensed and non-licensed healthcare professionals, including health services specialists, nurses, physicians, and other clinically educated professionals have authority to function within the UM Program within the scope of their job descriptions. The CMO is clinically focused and responsible for CenCal Health's Quality Program, Pharmacy Services, Behavioral Health, and all clinically related aspects of Utilization Management, Case Management, and Disease Management. Responsibilities include program development, implementation, and evaluation; participation in quality of care and clinical appeal and grievance review processes; physician review and oversight and quality monitoring; medical leadership for the health plan; and physician case reviews and medical decisions including service reductions, and denials that are made in whole or in part, based on medical necessity.

Reporting to the CMO, the Senior Medical Directors, Behavioral Health Medical Director and other Medical Directors are also responsible for the UM program. They have appropriate experience that include education, training, and professional experience in medical or clinical practice. Additionally, they must have a current license to practice without restrictions in California.

The Medical Management Director, UM Managers and Supervisors are responsible for the day-to-day operations of the UM Department. The Medical Management Director reports to the HSO. These nurse leaders have appropriate health care experience and are responsible for overseeing the day-to-day UM activities, which includes adhering to regulatory standards, performing clinical review, and applying appropriate decision-making guidelines. The HSO is operationally focused and responsible for Pharmacy, Utilization Management, Care Management, Disease Management, and Behavioral Health. Responsibilities include

operational administrative oversight of program development, implementation, evaluation, execution, and day to day operations, for example Turn-Around-Times and Staffing.

If required, CenCal Health utilizes board-certified physician consultants or accesses our external review organization's board-certified physicians to assist in making medical necessity recommendations. UM dedicated physicians and physician consultants assure day-to-day utilization management and other specialty UM program decisions are based on medical necessity, medical appropriateness, within contractual provisions, and benefit coverage, while considering the need of individual members and characteristics of the local delivery system. UM determinations also consider the unique, including cultural, needs of the member and capacity and capabilities of the medical delivery system.
Clinical determinations based on medical necessity are made by appropriate licensed professionals. Decisions to deny a request for medical necessity may only be made by a physician or pharmacist. A pharmacist may deny requests for coverage of physician-administered-drugs requiring authorization through the medical benefit via procedure code.

To ensure that the first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, CenCal Health has adopted standards for personnel making review decisions. The following types of personnel can perform the functions listed:

1. Clinical Support Associates complete eligibility determinations, review referral forms for completeness, and interface with providers to obtain necessary, supporting clinical documentation for clinical review.
2. Licensed Professionals, which include Registered / Vocational Nurses and Therapist perform initial review or basic assessment of medical information, initial determination of benefit coverage, obtain additional supporting medical information from providers, and approve medically necessary referrals and services based on established guidelines-
3. A designated licensed physician is responsible for all denials/modifications that are based on medical necessity and can directly obtain additional medical information from the treating physician as needed.

C. Committee Structure
CenCal Health's QIHEC is charged with responsibility for oversight for all the UM Program's activities and processes. The CMO or designee in collaboration with the Chief Health Equity Officer (CHEO) chairs the QIHEC. A written summary of the QIHEC's proceedings are reported to CenCal Health's Governing Board (Board of Directors) at least quarterly, and more frequently if needed.

The QIHEC is also CenCal Health's medical advisory body charged with evaluating clinical policies and reviewing and approving all significant clinical initiatives and programs to assure appropriate clinical input from contracted provider network practitioners prior to and/or

during implementation. The oversight of the UM Program is reported to the UMC quarterly, which is a subcommittee of the QIHEC. The UMC includes the participation and oversight by the CMO or Medical Director designee, and Behavioral Health Medical Director, the HSO, the Quality & Population Health Officer, and other CenCal Health leadership to include at a minimum the Member Services Director supporting the appeals and grievances report related to UM.

The QIHETP continually strives for excellence and quality in health care delivery and service to CenCal Health's members, providers, internal customers, and the community by pursuing meaningful and measurable activities to improve processes, outcomes, and satisfaction.

VII. UTILIZATION MANAGEMENT ACTIVITIES

To meet the purpose, scope, and goals approved by CenCal Health's Board of Directors, UM activities are focused in the following areas:

1. Annual evaluation, update, and approval of the UM Program Description.
2. Annual update and adoption of clinical UM criteria, and the process for applying those criteria.
3. Quarterly reporting to the UMC on Key Performance Indicators (KPIs) including but not limited to; measurements of the number and percentage of denials, deferrals, modifications, each by type of authorization service request. The KPIs also include the number and percentage of appeals and grievances related to UM.
4. Consistent application of written UM criteria to support UM decisions by qualified licensed health professionals, and the ongoing measurement of consistency in UM decisions as demonstrated through inter-rater reliability reviews.
5. Timely UM decisions and communication of such decisions to practitioners and, as indicated, to members.
6. Participation in the evaluation of investigative, experimental, or new medical technologies.
7. Evaluation of member, practitioner, and provider satisfaction with the UM process.
8. Review and update of the physician-administered drugs and procedures for pharmaceutical management to promote the clinically appropriate use of pharmaceuticals.
9. Monitor and evaluation of the appropriate utilization of services; and decrease duplication of services.
10. Facilitation and access to medically necessary, covered services and appropriate, cost-effective care to members.
11. Evaluate non-benefit exceptions.
12. Review out-of-network, seldom used specialty services.
13. As appropriate, make referrals to Case or Disease Management and Substance Use

Disorder (SUD) programs, Comprehensive Case Management (CCM), Community Supports (CS), and Enhanced Case Management (ECM) for care coordination and/or disease-specific education.

VIII. UTILIZATION MANAGEMENT PROCESS

CenCal Health's Health Services Department maintains departmental policies and procedures. These policies and procedures are reviewed annually and updated as needed. UM decisions are based only upon appropriateness of care and service and existence of coverage. CenCal Health prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities are not structured to provide incentives to deny, limit, or discontinue Medically Necessary services. An attestation is signed by all clinical reviewers upon hire and annually thereafter, that UM determinations will not be unduly influenced by fiscal and administrative management considerations.

The CMO, Senior Medical Director, Medical Directors, Pharmacists, and contracted Physician Reviewers, as appropriate, are the only representatives with the authority to deny or reduce coverage for a service based on medical necessity or medical appropriateness.
The Primary Care Physician (PCP) is responsible for coordinating most aspects of the member's health care. However, members may access emergency services, minor consent services, family planning services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Viruses (HIV) testing, and limited services without PCP referral or prior authorization. Regardless of the referral requirement, members are encouraged to seek their PCP's advice before seeking specialist consultation and treatment.

IX. UTILIZATION MANAGEMENT CRITERIA AND MEDICAL NECESSITY

CenCal Health uses written objective criteria based on sound clinical evidence in making utilization decisions based on medical necessity. CenCal Health's policy on the adoption and development of clinical utilization management criteria defines eligible criteria sources, and the process for development, adoption, and review of clinical criteria at CenCal Health's QIHEC.
CenCal Health ensures that its UM authorization decisions for its members' care is based on medical necessity of a requested service consistent with members handbook and covered benefits and in accordance with California State Criteria and California Children's Services (CCS).

CenCal Health ensures that its policies, processes, strategies, evidentiary standards, and other factors used for UM or Utilization Review are consistently applied to medical/surgical, mental health, and Substance Use Disorder (SUD) services and benefits. The criteria and/or guidelines used by CenCal Health to determine whether to authorize, modify, or deny health care services are developed with involvement from actively practicing health care providers, are consistent with sound clinical principles and processes, and are reviewed and updated if necessary, at least annually. *See MM-UM 22 Clinical Criteria for UM Decisions for*

additional information.

At least annually, network providers, practitioners, and members are notified that CenCal Health approved UM Criteria and/or guidelines are available upon request by contacting CenCal Health. If used as the basis of a decision to modify, delay, or deny services in a specific case, UM Criteria/Guidelines are disclosed to the member and provider (inclusive of network practitioners as well as out-of-network practitioners) and the Member in that specific case.

Relevant UM and Utilization Review policies and procedures are available on CenCal Health's website (www.cencalhealth.org/providers/forms-manuals-policies/policies-procedures/) and upon request by any provider or member. Clinical criteria used by CenCal Health or any Subcontractor or Downstream Subcontractor of CenCal Health when assessing medical necessity of covered services are also available on CenCal Health's website and upon request. These policies provide how CenCal Health authorizes, modifies, delays, or denies coverage of health care services through authorization requests which include prior, concurrent, and retrospective review.

- CenCal Health ensures that policies and procedures for authorization decisions are based on the medical necessity of a requested health care service and are consistent with criteria or guidelines supported by sound clinical principles and evidence based.
- CenCal Health considers the available services in our local delivery system and our ability to meet the Member's specific heath care needs when applying UM Criteria which includes:
    - Availability of inpatient, outpatient, and transitional facilities
    - Availability of outpatient services in lieu of inpatient services such as surgi-centers vs inpatient services
    - Availability of highly specialized services, such as transplants facilities or cancer centers
    - Availability of skilled nursing facilities, subacute facilities, or home care in service area to support Members need after hospital discharge
- CenCal Health ensures that policies, processes, strategies, evidentiary standards, and other factors used for UM or Utilization Review are consistently applied to medical/surgical, mental health, and SUD services and benefits.
- CenCal Health notifies network providers, as well as members and potential members upon request, of all services that require prior authorization, concurrent authorization, or retrospective authorization, and ensures that all network providers are aware of the procedures and timeframes necessary to obtain authorization for these services.
- All UM activities are performed in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

The following factors that relate to the individual are considered when applying clinical UM

criteria:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

Please refer to policy MM-UM22, Clinical Criteria for Utilization Management Authorization Decisions for detailed information and to view the list of clinical guidelines adopted by CenCal Health. Some approved criteria include:

1. **Department of Health Care Services (DHCS)**
   - Medi-Cal Provider Bulletins and Manuals
   - Medi-Cal Managed Care All Plan Letters
   - California Children's Services (CCS) Program criteria, guidelines, and Numbered Letters when applicable
   - Includes information on Medi-Cal and CCS services, programs, and claim reimbursement. Medi-Cal bulletins and manuals are available in its entirety free of charge at: *https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx*

2. **CenCal Health Medical Policies**

3. **MCG® Guidelines**
   Evidence-based clinical guidelines used for decision-making that are based on medical literature, textbooks and nationally recognized guidelines published in all fields of medicine, practice observations and database analyses, and review by expert consultants. Licensed guidelines are applied when Medi-Cal or the CMS guidelines are outdated, nonspecific, or nonexistent.

4. **Magellan Rx Management Library of Medical Necessity Criteria**
   Evidence-based clinical guidelines used for decision-making on physician-administered-drugs based on medical literature, nationally recognized guidelines published in all fields of medicine, practice observations, and database analyses. Criteria is vetted through Magellan's Medical Necessity Criteria Committee and CenCal Health's Pharmacy & Therapeutics Committee.
5. **Other Nationally Recognized Guidelines**
   Nationally recognized health care and professional organizations, which includes evidence-based clinical guidelines published by national entities, such as the National Guideline Clearinghouse, National Institute for Health, American College of Obstetricians and Gynecologists (ACOG), and other professional medical associations.

The intent of utilizing established screening and decision criteria is to promote consistency of reviews. The licensed staff, physician reviewers, and other associates who work in a capacity that allows him/her to apply screening and decision criteria is audited periodically but no less than annually, for Inter-Rater Reliability (IRR). The clinical management team compiles, analyzes, and reports the IRR results to the UMC. These findings are then reported to the QIHEC. When an opportunity for improvement is identified by the CMO, Medical Directors, and or the Director of Medical Management will initiate an action plan to improve the consistency of applying UM criteria.

X. UTILIZATION MANAGEMENT OPERATIONAL DESCRIPTION

A. Scope of Utilization Management Program Activities

The UM Program's scope is comprehensive, systematic, and continuously refined to meet changing regulatory requirements. UM processes support confidentiality of member-specific information obtained during UM activities. Any member-specific information obtained is kept confidential and in accordance with applicable laws. Clinical information submitted or obtained are used solely for the purposes of utilization management, quality management, case and disease management, discharge planning activities. Clinical information is only shared with entities who have authority to receive such information and only with those individuals who need access to such information to conduct utilization management and related processes.

The UM Program provides access to practitioners and members to communicate with the department that includes:

1. Staff are available at least 8 hours a day during normal business days for inbound collect or toll-free calls regarding UM issues.
2. Ability of UM staff to receive inbound communication after normal business hours regarding UM issues via fax and/or confidential voice mail. Communications received after normal business hours are returned on the next business day, and communications received after midnight on Monday–Friday are responded to on the same business day.
3. Outbound communication from UM staff regarding inquiries about UM issues during normal business hours (Monday-Friday, excluding holidays), unless otherwise agreed upon.
4. UM staff identifies themselves by name, title, and organization name when initiating or returning calls regarding UM issues.
5. UM staff, upon request from the caller, provides information regarding UM requirements and procedures.
6. A toll-free number to contact appropriate staff at CenCal Health.
7. CenCal Health provides a separate phone number for receiving TDD/TTY messages or will use the States/711 Relay Services. Services can be obtained by calling 1-833-556-2560 or 711.
8. For all members who request language services, such as questions regarding UM, CenCal

Health provides services, free of charge, in the requested language through bilingual staff or an interpreter. This factor does not apply to after-hours communications. Use of contracted translation services is not considered delegation.

B. Review Processes

The UM Program includes UM operations and activities that are conducted by qualified staff with the appropriate experience and expertise. UM clinical review is performed by licensed health care professionals who possess an active professional license or certificate. Pre-established decision criteria are used to assist in UM decisions regarding requests for healthcare or other covered benefits.

When making a determination of coverage based on medical necessity, the designated UM reviewer obtains relevant clinical information and consults with the treating physician, as necessary. Authorization and notification of decision for proposed services, referrals, or hospitalizations at the practitioner level involves utilizing information such as medical records, test reports, specialists' consults, and verbal communication with the requesting practitioner in the review determination. As necessary, the UM reviewer will contact the requesting provider for additional supporting information. Additionally, CenCal Health may discuss or consult with a board- certified specialist in the area of the requested service(s) to assist with decision-making.

Part of this review process is to determine if the service, whether seldom used or an unusual specialty service, is available in network. If the service is not available in network, arrangements must be made for the member to obtain the service from a non-network provider for this episode of care. The CMO, Senior Medical Director or Medical Director may be involved when specialty services from specialists outside the network are to be arranged.

When non-clinical staff pre-screen requests for service, a licensed health care professional oversees this process. The non-clinical staff may review requests for completeness and collect clinical and non-clinical data; however, they do not evaluate or interpret clinical information.

If the designated UM reviewer agrees that the request is clearly medically necessary and is a covered benefit, an appropriate authorization is provided. However, when the reviewer questions the appropriateness of the request or the request does not meet established clinical guidelines, decision-making is deferred to a Medical Director or to a designated CenCal Health physician reviewer in absences of the Medical Director. UM reviewers also have access to board-certified physicians for consultation. At no time are decisions made by any staff member, clinical reviewer, or physician that is based on financial incentives or involve a conflict of interest. All decisions to not authorize or deny a request based on medical necessity are made only by a UM physician or for physician-administered-drugs, a pharmacist.

CenCal Health provides training to Network Providers on procedures and services that require Prior Authorization for Medically Necessary services and ensures that all network

providers are aware of the procedures and timeframes necessary to obtain Prior Authorization. CenCal Health provides training within 30 calendar days of executing the contract and within 30 calendar days of contracting with a network provider.

The following is a brief description of the various processes that are UM Program components when reviewing approvals, modifications, denials, and delays as in CFR Section 438.900:

1. **Pre-service (Prospective) Review:**
   A process of review in which clinical information and requests are reviewed to determine medical necessity prior to rendering services. Review determinations are based on the medical information available and obtained at the time of the review. CenCal Health informs providers about the procedures and services that require prior authorization, including the timeframes necessary to obtain prior authorization, through the Provider Portal, Provider Manual, and Provider Bulletin. As appropriate, CenCal Health may require consultation with a specialist before authorizing the requested service.

   Requests that require pre-service review may include but are not limited to:
   - Elective inpatient hospitalization
   - Skilled nursing facility admission
   - Outpatient procedure
   - Diagnostic procedure
   - Therapy service
   - Home health
   - Home infusion
   - Durable medical equipment requests.

   Prior authorization requirements shall NOT apply to:
   - Emergency services
   - Family planning services
   - Preventive services
   - Basic prenatal care
   - Sexually transmitted disease services
   - HIV testing
   - Initial mental health and SUD assessments
   - Other as prescribed by contractual or regulatory requirements

2. **Concurrent Review**
   A process of initial and ongoing review of hospitalizations, which includes but not limited to acute care facilities, skilled nursing facilities, and acute rehabilitation facilities. Concurrent review is performed through communication with hospital or facility case managers, discharge planners, physicians, and other member-assigned healthcare professionals, as well as communication with the member/authorized representative, as appropriate. This communication process generally performed by telephone review, through restricted access to electronic health data system, The process incorporates use of pre-established decision criteria to approve appropriate medically necessary care and assigns the most appropriate level of care for continued medical

treatment. Review determinations are based on the medical information available at the time of the review.

3. **Post-service (Retrospective) Review**
   A process to obtain medical information and to determine medical necessity as it relates to services that have been provided/rendered when there has been no notification or request for review during the pre-service or concurrent process or when clinical information was not available at the time services were being rendered. Clinical notes are required for the post-service review process. Review determinations are based on the medical information available for review, medical necessity, availability, and medical appropriateness of rendered services, as well as the application of guidelines and coverage limits.

4. **Discharge Planning**
   A process that facilitates coordination of ongoing care, whether at a lower level of inpatient care or in the home with home care services. Discharge planning supports continuity of care and efficient use of resources and incorporates the involvement and decision-making process with the member and significant other(s). The process begins at the time of admission and is coordinated by the facility's discharge planner. CenCal UM nurses collaborate with hospital discharge planners to support the facility's discharge planning arrangements.

5. **Second Medical Opinion**
   CenCal Health allows for a second medical opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, CenCal Health will authorize an Out-of-Network Provider to provide the second opinion at no cost to the member in accordance with 42 CFR section 438.206. CenCal Health also reserves the right to obtain a second opinion for the initiation or continuation of services. A request for a second opinion shall be granted if the requested service(s) is a covered benefit and:

   a. The member questions the reasonableness or necessity of the recommended surgical procedures.
   b. The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
   c. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.
   d. The treatment plan in progress in not improving the medical condition of the enrollee within an appropriate period given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.
   e. The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

6. **Emergency Department Services**
   CenCal Health's provider agreements specify provisions for coverage of emergency services necessary to screen and stabilize members without preauthorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

   No referrals are required for treatment of an emergency condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in the following:

   - Placing the health of the member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
   - Serious impairment to bodily function
   - Serious dysfunction of any bodily organ or part
   - Death

   Emergency Department services are also covered if referred by an authorized CenCal Health representative, a network PCP or specialist. Notification to CenCal Health is not required for payment of Emergency Department services for an emergency medical condition.

7. **Out of Network (Out of Plan)**
   When required, requests for out of network services are reviewed by CenCal Health on a case- by-case basis. Determinations are made based on the member's medical needs, the availability of services within CenCal Health's practitioner and provider network to meet these needs and coverage limits. CenCal Health provides its clinical protocols and evidenced-based practice guidelines governing Prior Authorization, Utilization Management and Retrospective Review to all providers including Out-of-Network Providers providing services to its members.

   All providers including Out-of-Network Providers can request CenCal Health's clinical protocols and evidenced-based guidelines by calling the Health Services UM Department at (805) 562-1082. For members under the age of 21, callers select option 1; for members 21 and older, callers select option 2.

8. **Tertiary Care Services**
   The member's medical needs and the availability of the requested services from CenCal Health's in-network tertiary care centers and in-network non-tertiary care providers are taken into consideration. If a tertiary care request is considered for denial, the CMO, Senior Medical Director or Medical Director considers the network specialist's recommendations prior to making a coverage determination.

2. **Transitional Care Services (TCS)**
   Transitional Care Services is when a member transfers from one setting or level of care

to another, including but not limited to, discharges from hospitals, institutions, other acute care facilities and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long- term care settings. Members are identified through a risk stratification process. CenCal Health has a TCS team of Clinical Support Associates and Nurse Care Managers to coordinate discharge planning with hospitals and facilities to ensure that eligible members are supported during their care transition. Members identified as high-risk members will receive a member outreach within seven days post discharge to follow-up on doctor's appointments, medication reconciliation and assessment of further needs for Enhanced Care Management (ECM), Comprehensive Care Management (CCM) and Community Supports (CS). TCS services will extend at least thirty days post discharge.

3. Standing Referral

CenCal Health maintains a standing referral process that provides a determination within three working days from the date the request is made by the member or the member's PCP and all appropriate medical records and other items of information necessary are received to make a determination. Once a determination is made, the referral must be made within four working days of the date that the proposed treatment plan, if any, is received by CenCal Health's CMO or the CMO's designee, in accordance with H&S Code section 1374.16. For more detail, please reference CenCal Health's policy and procedure MM-UM Standing Referrals.

4. Specialty Standing Referrals

CenCal Health has a specialty referral system to track and monitor referrals requiring Prior Authorization by CenCal Health. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, CenCal Health must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request.

CenCal Health's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. CenCal Health's specialty referral systems must include information on requested out-of-network services. CenCal Health must ensure that all Network Providers are aware of the specialty referral processes and tracking procedures. For more detail, please reference CenCal Health's policy and procedure MM-UM Standing Referrals.

XI. PROMOTING APPROPRIATE UTILIZATION / MONITORING UNDER AND OVER-UTILIZATION

CenCal Health's UM decision-making is based only on appropriateness of care and service and existence of coverage. As part of CenCal Health's QIHETP, CenCal Health has a systematic process that outlines how staff conduct routine monitoring and analysis of program indicators for monitoring and detecting under and over-utilization of services, including, but not limited to, outpatient prescription drugs. CenCal Health identifies any

significant variance from the standard of care, either as a sentinel event if an unjustifiable adverse outcome warrants immediate action or based on a pattern of practice that falls significantly outside of the established program and community standard. Research and analysis of such variances may include comparison of practice standards with other Medi-Cal or managed care organizations to validate under or over-utilization activities. Detailed analyses may be conducted to investigate, and resolve identified problems.

Performance comparisons are made against adopted external sources (or internal sources when applicable) and historical norms. Established methodologies are used for measurement purposes to every extent possible. When UM concerns are identified, an action plan is required to correct patterns of potential or actual inappropriate under or over-utilization. The QIHEC input is sought to further inform CenCal Health's analysis of monitored data and development of effective interventions.

Such action plans may include, but are not limited to, provider education, member education, staff development, administrative changes, provider contract changes and/or alteration of provider privileges. The scope of each action plan is determined based on the circumstances and identified causes that relate to each unique adverse outcome or variance from standard. The scope of each action plan is approved by an appropriate, CenCal Health Quality Committee, which assures that interventions are timely and meaningful; and reported to the QIHEC. Re-measurement is performed at appropriate intervals to determine the effectiveness of interventions.

XII. DELEGATED UTILIZATION MANAGEMENT

When UM is delegated to another entity (Subcontractor or Downstream Subcontractor), the UM operations and activities are conducted by qualified UM staff who must meet job description requirements that include education, training, or professional experience in medical or clinical practice and must have an appropriate and current California license to practice without restrictions. An initial determination that any potential Subcontractor or Downstream Subcontractor has the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations will be performed. Pre-contractual audits occur to assess whether these key components are in place to ensure that the entity will adhere to CenCal Health requirements. Each delegated organization must have a UM Program that is approved annually by CenCal Health's Delegation Oversight Committee, as well as a signed Delegation Agreement in place. Each delegation agreement details the key components, processes, and reporting requirements of the delegate.

XIII. PHARMACY SERVICES

A. Pharmacy Program Scope

Effective January 1, 2022, the entire pharmacy benefit (traditional retail pharmacy medications and medical-benefit medications will no longer be the sole responsibility of CenCal Health. The pharmacy benefit will be split and administered as 1) the retail pharmacy benefit will be carved out of the responsibility of CenCal and administered under

the DHCS program known as, Medi-Cal Rx and 2) The medications adjudicated under the medical-benefit such as physician-administered drugs (PADs) will continue to be administered and considered by CenCal Health. Pre-service, Concurrent, and Post-Service (Retrospective) physician-administered-drug (PAD) utilization reviews of medical necessity using established prior authorization criteria requirements set forth by CenCal Health Pharmacy & Therapeutics (P&T) Committee. Timeliness standards mirror those for UM Program Timeliness.

DHCS will determine the retail benefit formulary (contracted drug list – CDL) as well as any quantity limits and prior authorizations placed on certain drugs. The retail medication utilization management process is subject to the rules determined under the Medi-Cal Rx program. As such, Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of medical service are under the scope of Medi-Cal Rx. All CenCal Health stakeholders (Utilization Management staff, Care Management staff, Member Services staff, Network Providers, etc.) may coordinate with the CenCal Health Pharmacists and Pharmacy Technicians to work through the Medi-Cal Rx Clinical Liaisons to assist with care coordination and clinical issues for medications covered under the retail, Medi-Cal Rx benefit.

The medications adjudicated under the medical-benefit will continue to be subject to the CenCal Health medical-pharmacy benefit and coverage criteria. The CenCal Health Pharmacy staff will collect all pertinent medical information and has the authority to approve coverage if criteria are met. All determinations are made by a CenCal Health Physician or Pharmacist. All UM processes, including verbal and written notification of the decision to the practitioner and member are followed when a determination is made.

B. Medical Pharmacy, Physician Administered Drug (PAD) List

CenCal Health has an established process by which members and practitioners may request non-benefit PAD drugs. Likewise, a process exists by which members and practitioners may appeal denied requests for PAD benefit drugs. CenCal Health follows established policies and procedures regarding PAD list. CenCal Health's policies and procedures specify that the PAD benefit be:

- Based on sound clinical evidence from appropriate external organizations
- Clearly documented, and that the application of pharmaceutical management procedures is based on identified member needs
- Developed with input from appropriate actively practicing practitioners
- Reviewed at least annually and updated based on established criteria that governs pharmaceutical management decisions for therapeutic classes, and medications within classes
- Made available to its practitioners annually, including all pharmaceutical management procedures

XIV. BEHAVIORAL AND MENTAL HEALTH SERVICES

Members suspected or diagnosed with a mental health condition, as defined by the current DSM, resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning and children under the age of 21 years who are not eligible for specialty mental health services are eligible for outpatient mental health services as a Medi-Cal benefit managed by CenCal Health. Primary Care Providers (PCPs) are responsible for performing routine mental health screenings of their patients and to provide mental health services within their scope of practice. PCPs do not need authorization to perform these services. PCP's can direct members to a contracted Mental Health practitioner at any time, a referral is not required. Members do not require a pre- authorization or a referral from a PCP for an initial assessment nor treatment with a contracted Mental Health Practitioners. County Mental Health Programs cover necessary crisis services, inpatient, and residential rehabilitation services to CenCal members.

XV. SUBSTANCE ABUSE SERVICES

CenCal Health requires that primary care providers (PCPs) within their scope of practice provide screening, assessments, behavioral counseling interventions and referrals to treatment (SABIRT) to Members 11 years of age and older, including pregnant women, for unhealthy alcohol use, unhealthy drug use, and tobacco use. Alcohol screening and behavioral counseling interventions do not require pre-authorization. Members who, upon screening and evaluation at the primary care level, meet criteria for an alcohol use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM V) or whose diagnosis is uncertain, must be referred to the County Department for Alcohol and Substance Use Disorder Treatment Services. Prior Authorization is not required.

XVI. BEHAVIORAL HEALTH TREATMENT SERVICES (BHT)

CenCal Health ensures the provision of all Medically Necessary EPSDT services, including BHT services for eligible beneficiaries under 21 years of age when they are covered by under Medicaid, regardless of whether California's Medicaid State Plan covers such services for adults. This includes children with autism spectrum disorder (ASD) for whom a licensed physician, surgeon, or psychologist determines that BHT services for the treatment of ASD are Medically Necessary, regardless of diagnosis. CenCal Health has primary responsibility for ensuring that all of a Member's needs for Medically Necessary BHT services are met across environments, including on-site at school or during virtual sessions.

XVII. CARVED-OUT AND LINKED SERVICES FOR MEDI-CAL MEMBERS

Some services for the Medi-Cal members are carved out as described in Evidence of Coverage (EOC). Members may also be linked to other services such as the local educational agencies, waiver programs, and Regional Centers. Members are referred to their PCP to conduct Initial Health Appointments and coordinate necessary care and referrals to specialists, ancillary services, and linked services as needed. CenCal Health Utilization Management and Case Management staff may assist the provider in making referrals to and in locating necessary linked and carved-out services. CenCal Health ensures that all Medi-Cal members have access to appropriate covered services. Members in need of services not covered or carved-out of CenCal Health's benefit package are referred to providers or vendors who may be able to assists the member with their needs.

XVIII. UM PROGRAM DEPARTMENTAL STAFFING RESOURCES

The UM Program Description is evaluated and revised at least annually by UMC staff including at least the Chief Medical Officer, Senior Medical Director, Medical Director, Behavioral Medical Director, Physician Reviewer, Director of Behavioral Health Services, Director of Medical Management, Director of Pharmacy Services,
The UM Program is reviewed and approved by the Utilization Management Committee, then by Quality Improvement Health & Equity Committee (QIHEC). This approved UM Program Description is ultimately submitted to CenCal Health Board.
The Health Services Division roles include the positions described below:

Health Services Officer
The Health Services Officer (HSO) is responsible for the day-to-operations of the UM Program. The HSO oversees staffing, workflow processes, turn-around-times and other administrative responsibilities of the UM program.

Chief Medical Officer
The CMO is accountable for overseeing the strategy, development or revision and implementation of the UM Program. The CMO is responsible for providing clinical support, exercising professional judgment on issues of medical necessity, and overseeing staff's application of appropriate treatment protocols to utilization management decision-making.

Senior Medical Director
Reporting to the CMO, the Senior Medical Director will provide medical leadership and assist the CMO in ensuring medical quality and adherence to professional and ethical medical standards by the plan and its network of providers. Provide oversight and management of all clinical activities for CenCal members. Emphasis will be on clinical quality, operational efficiency, and strategic planning for quality, utilization, and care management programs. Provide Physician/Clinical leadership for Utilization Management and Quality; Case Management leadership and consultation; external provider relations including education and outreach and program development. Additionally, the position will provide senior clinical leadership to the appeals, grievances, and quality of care concerns processes.

The Senior Medical Director's responsibilities may include but is not limited to conducting Monthly UM Inter-departmental workgroup meetings, conducting case rounds and UM reviews, conducting/attending Hospital and Medical Group JOC's, and acting as Chair at various meetings such as Quality Improvement and Health Equity Committee (QIHEC) Peer Review Credentialing Committee, attendance at P&T Committee, Provider Advisory Board Meeting and is a voting member of the QIHEC and Utilization Management Committee.

Medical Director - Behavioral Health
The Behavioral Health Medical Director report to the CMO. S/he oversees the processes within the BH Program. The Medical Director assures the effectiveness of decision making in all areas of preauthorization, concurrent, and retrospective reviews; and as necessary

develops and applies consistent, medical appropriateness standards to selected procedures. In the absence of the CMO, Senior Medical Officer functions as the CMO designee, as assigned by the Chief Executive Officer.

The Medical Director of Behavioral Health is a California licensed physician whose responsibilities may include but are not limited to attendance and Utilization Management Committee Meetings, and QIHEC meetings, attendance at Monthly UM Interdepartmental meetings and BeWell JOC's. The BH Medical Director is also setting UM BH Healthcare Policies and reviewing UM Behavioral Health Cases.

Medical Director
Medical Directors report to the CMO. They oversee the processes within the UM Program. The Medical Director is a California licensed physician and assures the effectiveness of decision making in all areas of preauthorization, concurrent, and retrospective reviews; and as necessary develops and applies consistent, medical appropriateness standards to selected procedures. In the absence of the CMO, the Senior Medical Director functions as the CMO designee, as assigned by the Chief Executive Officer.

Director of Behavioral Health
The Director of Behavioral Health is a licensed mental health practitioner who is responsible for the operational units of the Behavioral Health Department and Behavioral Health Program. The Director of Behavioral Health is responsible for program adherence to regulatory requirements, program, and process improvements. The Director of Behavioral Health is accountable for managing the non-physician staff of program departments. The Director provides ongoing, effective, and efficient assessment of all clinical operations to help support the delivery of high-quality care in accordance with established regulatory requirements, and NCQA accreditation standards when feasible.

Director of Medical Management
The Director of Medical Management is a licensed Registered Nurse and accountable for managing the non-physician staff of the case management, utilization management, and pediatric program departments. The Director provides ongoing, effective, and efficient assessment of all clinical operations to help support the delivery of high-quality care in accordance with established regulatory requirements, and National Committee for Quality Assurance (NCQA) Accreditation Standards when appropriate. This position also oversees the UM department to ensure inter-rater reliability and compliance with timeliness standards.

Director of Pharmacy Services
The Director of Pharmacy Services is a California licensed pharmacist. The Director of Pharmacy is accountable to manage the Pharmacy Department operations and administration of the pharmacy benefits which promotes optimal efficacy, safety, and cost-effectiveness of drug therapy for all CenCal Health members.

Associate Director of Pharmacy Services
The Associate Director of Pharmacy Services is a California licensed pharmacist who is

responsible for providing daily management of the overall Pharmacy UM process. This position also supervises the pharmacy technician staff and the delegated UM functions to ensuring inter-rater reliability and compliance with timeliness standards.

Clinical Pharmacist(s)
The Clinical Pharmacist(s) is a California licensed pharmacist is responsible for clinical determinations of physician-administered prior authorizations on the medical benefit, assisting in maintaining the plan's formulary management software, and support of plan wide clinical initiatives.

UM Manager
The UM Manager is a licensed Registered Nurse who is responsible for assisting with daily management of the UM program. The UM, CM and Pediatric programs have independent Medical Management Managers, who work collaboratively with the Medical Management Director and each other to support the programs and requirements. These positions supervise the department staff, which may include nurses, social workers, and nonclinical staff. Responsibilities include but are not limited to staff training and education, adherence to regulatory timelines, and interrater reliability. The respective Medical Management Managers are also the point persons for all questions from network providers and out of plan providers about the UM, CM or Pediatric processes, including necessary documentation required to request service and referrals for case management services.

UM Supervisor
The UM Supervisor may be assigned to utilization management, case management-adult or case management-pediatric health operational unit. The Clinical Supervisor reports to the Health Services Clinical Manager in the related operational unit. This activity-oriented position requires the ability to coordinate day-to-day activities of their assigned unit and as appropriate, prepare timely reports of those activities to the department Manager and Director. This position is expected to provide training to staff, identify areas for improvement, resolve any staff issues, provide new hire orientation, and supervise staff as needed.

Health Plan Nurse Coordinator (HPNC) Case Management (CM) Nurse Coordinator (*Please refer to Case Management Program Description for the CM Nurse Coordinator for further detail.)*
Clinical review staff include HPNC, and CM Nurse Coordinators who are Licensed Nurses; and who hold a California license in one of the following: vocational or registered . HNPC and CM Nurses, review preauthorization, concurrent, and retrospective requests. HPNC, CM Nurses, perform review or basic assessment using approved criteria and guidelines in the decision-making process. HPNC , CM Nurses, tare responsible for review and assessment of the request for the appropriateness of covered services within CenCal Health's benefit package. HPNC and CM Nurses review all types of non-pharmacy covered services, including preadmission, concurrent and retrospective inpatient admissions, home health care, medical supply, durable medical equipment (DME, orthotics, prosthetics, and ambulatory care. HPNC's cannot deny requests for services.

UM Program Description

The HPNC, CM Nurses, and UM Specialists also identify and refer in circumstances when a Member's Quality of Care (QOC) Concern (QOC) is suspected as clinically substandard. CenCal Health maintains a mechanism to identify, analyze, and resolve Potential Quality Issues (PQIs) to ensure that services provided to CenCal Health Members meet established QOC and service standards.

All QOC concerns are formally routed to CenCal Health's Quality Department Clinical Quality Team for review. PQI referrals may be done by email utilizing the PQI referral form. Specific information regarding the concern and whom the concern is regarding must be submitted with sufficient medical information to clarify the reason for the concern.
The HNPC, CM Nurses, and Specialists act as interdepartmental liaisons to support prompt resolution of acute care, long-term care, and ambulatory care issues and questions. They also assist providers with claims issues and basic questions regarding treatment and referral requests.

Case Manager
Please refer to Case Management Program description for further detail.
Case Managers are Registered Nurses or Master-prepared Social Workers who coordinate services for specific members receiving services from in and out of network providers. They collaborate with the member to identify care coordination needs and to develop self-managing skills and person-centered goals. Case Managers also collaborates with members of the healthcare delivery team. Pediatric CM Nurse Coordinators have a dual-role function. They perform utilization review and case management activities. Refer to the Case Management Program Description, Pediatric Whole-Child Model Program Description, and Case Management job descriptions for detailed information.

Non-Clinical Support

UM Non-Clinical Supervisor
The UM Non-Clinical Supervisor is responsible for overseeing the daily tasks and duties of the UM CSA teams for both the Adult and Pediatric units. The UM Non-Clinical Supervisor reports to the UM Associate Director. The role requires the ability to coordinate the daily activities of the UM CSA teams and as appropriate, prepare timely reports to monitor UM CSA tasks. This position is expected to provide training to staff, identify areas of improvement, resolve employee performance issues and supervise the CSA staff.

Case Management (CM) Clinical Support Associate
Assist Case Managers and Social Workers as needed with appointment reminders and follow-up, provide health educational materials and information on community resources to members, perform telephonic health surveys, and facilitate necessary, non-medical or medical van transportation.

UM Clinical Support Associate
Clinical Support Associates are the first line of contact in the UM Department. CSA answer

incoming calls, assist UM Nurse and Specialist with obtaining necessary clinical information from providers, entry authorization requests and supporting documents into the system, as directed, send notices to providers and members.

Pharmacy Technician
Pharmacy technicians are the first line of contact in the PAD Pharmacy Department. Pharmacy technicians answer incoming calls, assist Pharmacists with obtaining necessary clinical information from providers, entry authorization requests and supporting documents into the system, as directed, send notices to providers and members.

CM Social Worker
Responsibilities include but are not limited to communicating with members, providers, and community-based organizations; assisting pediatric members with special healthcare needs and their families to transition into adulthood, assisting with housing resources; referring to funding sources, identifying community resources to maintain members in the least restrictive environment and acting as a liaison on the Member's behalf.

XIX. COMMUNICATION SERVICES / TIMELINESS OF UM DECISIONS

Below are the decision and notification timeframes for all UM determinations.

Decision Timeframes	2024 DHCS Medi-Cal Managed Care Contract	Non-Medi-Cal H&S Code 1367.01
Emergency Care	CenCal Health must not require Prior Authorization for emergency care for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.	Yes
Post-Stabilization	CenCal Health must respond to a Provider's request for authorization for post-stabilization services within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855(a). Non-Urgent Care Following an Exam in an Emergency Room: Contractor must respond to a Provider's request for post-stabilization services within 30 minutes or the service is deemed approved.	Yes
Concurrent Review (of authorization for treatment regimen already in place	Authorization for a Treatment Regimen Already in Place: CenCal Health must respond to a concurrent authorization request within five Working Days or less, consistent with the urgency of the Member's medical condition and in accordance with H&S Code section 1367.01(h)(1)	Yes
Retrospective Review	Authorization Request for Treatment Received: CenCal Health must accept requests for retrospective authorization requests within a reasonably established time limit, not to exceed 365 calendar days from the date of service. CenCal Health must communicate decisions to the Provider and to the Member who received the services or to the Member's designee within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S Code section 1367.01(h)(1).	Yes
Therapeutic Enteral Formula for Medical Conditions in Infants and Children:	CenCal Health must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.	Yes

UM Program Description

COMMUNICATION SERVICES/TIMELINESS OF UM DECISIONS (cont.)

Decision Timeframes	2024 DHCS Medi-Cal Managed Care Contract	Non-Medi-Cal H&S Code 1367.01
Routine Authorizations	CenCal Health must respond to routine requests and concurrent requests as expeditiously as Member's condition requires but no longer than five working days from receipt of the information reasonably necessary and requested by CenCal Health to render a decision, and no longer than 14 calendar days from CenCal receipt of the request, in accordance with 42 CFR section 428.210 and H&S section 1367.01	Yes

Expedited Authorizations	CenCal Health must make expedited authorization decisions for service requests where a Member's provider indicates; or CenCal Health, CenCal Health's Subcontractor, Downstream Subcontractor, or Network Provider; determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. CenCal Health must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after receipt of the request for services. CenCal Health may extend this deadline up to an additional 14 calendar days only if the Member or the Member's provider requests an extension or if CenCal Health justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. CenCal Health must notify Member's provider and the Member in writing of any authorization request delayed beyond the 72-hour time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01.	Yes
Major Organ Transplant	Applicable for Major Organ Transplant (MOT). The referral authorization occurs within 72 hours of a PCP or specialist identifying the member as a potential candidate for the MOT and receiving all of the necessary information to make a referral authorization (APL 21-0015). (Contract Exhibit A, Attachment III Section 5.3.7 (F)	
Hospice	CenCal Health may only require Prior Authorization for inpatient hospice care. CenCal Health must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and all applicable DHCS APLs.	

Physician Administered Drugs	For medical authorization of Medically Necessary Physician administered drugs billed on a medical or institutional claim, CenCal Health must comply with the same timeframes as other medical services, at set out in this subsection.	

Communication of Review Decisions
CenCal Health's UM staff notifies the requesting provider of any decision to approve, deny, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Approvals may be communicated electronically, verbally, or in writing to the provider. CenCal Health will issue a Notice of Action to the member and provider when the decision is made to approve, delay, deny or modify a service request.

XX. DENIALS, APPEALS AND GRIEVANCES

Denials and modifications are typically based on benefit limitations, or the lack of medical necessity or sufficient supporting clinical information provided by the physician, practitioner, or facility. Only CenCal Health physicians can issue a denial or modification decision that is based on medical necessity. Attempts to reach the treating or requesting physician are often made prior to issuing denials and CenCal Health physicians are always available to discuss the denial with the practitioner. Denial decisions are communicated verbally and in writing as required by contract.
Physician reviewers are involved when service requests are denied or modified based on medical necessity. CenCal Health physicians who are responsible for decision-making of service requests must demonstrate analytical skills and have the education, training, and professional experience in the medical or clinical setting prior to employment by CenCal Health. When none of CenCal Health's qualified physician reviewers has applicable expertise to assess the medical necessity of a requested service, the CMO and/or Senior Medical Director has the authority to seek assistances from a board- certified specialist or external review agency to assists with decision-making.

Denial and modification Notice of Actions are mailed to the member within 2 business days of the decision and include:

- A clear, concise, and specific explanation of the reasons for the plan's decision
- A reference to the criteria or guidelines used as a basis for the plan's decision, and notice that upon request the member and/or provider can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion upon which the denial decision was based
- Other clinical reasons used as a basis for a decision regarding medical necessity that are easily understood and do not contain abbreviation

- The name and telephone number and extension to reach the physician or pharmacist responsible for the decision (for written or electronic communications to providers only)
- Information on how the member and/or provider may file an appeal with CenCal, and as applicable, request an administrative hearing
- Determinations of a denial or modification will inform the member and the provider that a copy of the criterion (guideline, UM policy, etc.) used to make the decision is available upon request and provided.

  For additional detail, on CenCal Health's Denial process please refer to CenCal Health's HS-MM49 UR – PA Concurrent Review and Retrospective Review and HS-UM07 Notification of UR Determinations and Timeliness.

Appeals

CenCal Health's Health Services Department participates in thorough clinical review and timely resolution of service appeals.

CenCal Health has procedures in place for timely response to pre-service, concurrent, and post- service routine and expedited appeals. These procedures are detailed in Member Services P&Ps MS-23_Member Appeals, MS-24_Communication and Education of Grievance and Appeals Process and MS-25_Monitoring and Oversight of Grievance and Appeals System.

To review an appeal, CenCal Health will appoint a physician not involved in the original decision to review the case. The appointed physician reviewer shall not have a conflict of interest with the case or parties involved in the appeal.

XXI. EVALUATION OF NEW TECHNOLOGY, EXPERIMENTAL AND INVESTIGATIVE

To keep pace with technological change and to ensure that members have equitable access to safe and effective care, CenCal Health has a process to evaluate and address new developments in medical technology as well as their application to CenCal Health's member populations.

To decide whether to include recent technologies including but not limited to medical procedures, behavioral healthcare procedures, pharmaceuticals and devices, CenCal Health's Benefits Committee reviews appropriate information from appropriate government regulatory bodies and reviews relevant scientific information that may include, but is not limited to:

- Articles in peer-reviewed literature.
- Recommendations from professional societies.
- Summaries from organizations that rely on the judgment of experts when determining the effectiveness of new technology.

CenCal Health will seek input from relevant specialists with the expertise and credentials

appropriate for the topic and other professionals with expertise in the relevant technology within the organization. If needed, the Benefits Committee will seek the guidance and contact external specialists, researchers or institutions who specialize in the condition involved.

CenCal Health's Behavioral healthcare professionals are involved in the decision-making process for behavioral healthcare services. CenCal Health may research, review, and adopt evidence-based clinical guidelines developed by nationally recognized health care organizations or the plan's clinical guidelines and/or use licensed clinical professionals in the evaluation of each recent technology.

Additionally, and in the absence of established and relevant UM criteria, CenCal Health, in consultation with practitioners of appropriate specialties and technological expertise may develop clinical criteria to use in the decision-making of newly adopted technologies.

XXII. INTERRATER RELIABILITY

CenCal Health shall perform interrater reliability (IRR) surveys at least annually to evaluate the consistency with which physicians and clinicians involved in the UM process apply approved clinical criteria. IRR surveys are uniformed in structure and administration and tailored to address specific areas for Adult UM, Pediatric UM, and Behavioral Health. IRR surveys utilize our clinical guideline's vendor MCG IRR criteria/guidelines for the IRR surveys. Pharmacist surveys are administered through physician-administered-drug clinical guideline vendor Magellan Rx. Reports are generated for evaluation and the respective MM Manager reviews the results and collaborates with the Master Clinical Trainer to determine ongoing areas needed for staff education and training. The Director of Medical Management and the CMO review the final report and any areas for improvement. On an annual basis, the UMC and the QIHEC shall receive an aggregate report noting the summary of IRR findings.

XXIII. INTEGRATION WITH QUALITY MANAGEMENT

The UM Program has quality operations that integrate UM Program operation with QIHETP operations through a systematic and coordinated system of reporting to the UMC and QIHEC. Reporting of UM activities includes but is not limited to the number and types of service requests, denials, deferrals, modifications, appeals, and grievances. All reporting to the UMC, is overseen by CenCal Health's CMO or designee, and other CenCal Health leadership that participate on the UM Committee and/or QIHEC.

The integration of CenCal Health's UM Program is assured by CenCal Health's QIHETP quality committee structure, as defined by the committee table of organization, roles and responsibilities detailed written CenCal Health's QIHETP Description. As further detailed below, this UM Program Description and an annual evaluation are reported to CenCal Health's QIHEC, which is appointed by CenCal Health's Board of Directors as its accountable entity to oversee CenCal Health's QIHETP, and the QIHEC's proceedings are reported to CenCal Health's Board of Directors.

The UM Program has a variety of quality operations processes in place to ensure quality of

care and service-oriented interventions are initiated and conducted. UM integration with quality operations supports activities to measure utilization trends or patterns compared with nationally recognized thresholds. Additionally, under- and over-utilization and Potential Quality Issues (PQIs) reporting to the QIHEC assures integration of additional UM Program and QIHETP activities, with appropriate leadership oversight and reporting within the QIHETP quality structure. All PQIs are referred to CenCal Health's Quality Department and are thoroughly investigated by RN-licensed clinical staff, and CenCal Health's CMO or physician designee.

XXIV. SATISFACTION WITH THE UM PROCESS

Practitioner and other provider survey are conducted annually or when a need is identified to assess satisfaction with CenCal Health's UM processes, and member surveys are conducted periodically to assess UM satisfaction. Through CenCal Health's member and provider complaint and appeal process, CenCal Health continually evaluates the UM program to ensure that difficulties are not encountered when members are seeking care and when practitioners are requesting care. The QIHEC reviews data at least annually to identify opportunities and develop interventions for improvement.

Additionally, CenCal Health surveys members periodically to evaluate consumer satisfaction with several aspects of plan operations, including utilization management. This evaluation quantitatively measures member satisfaction with CenCal Health's utilization management program, which enables CenCal Health to identify and act upon opportunities to improve quality of service and/or care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provides a rich source of information that complements that which CenCal Health obtains from practitioners and providers. When available, together these data enable staff to perform a robust assessment of UM satisfaction. The (CAHPS) member survey is performed every other year and is subject to a schedule determined by the California Department of Health Care Services.

XXV. EVALUATION OF THE UTILIZATION MANAGEMENT PROCESS

As part of CenCal Health's annual assessment of the QIHETP, CenCal Health has a process for continuously reviewing the quality of care, performance of medical personnel, and utilization of services. The evaluation process includes ongoing assessment of the consistency with which UM criteria are applied by UM staff, evaluation of complaints and assessment of complaint trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to appropriate CenCal Health staff and contracting providers, and the evaluation and verification of corrective actions.

The UM Program evaluation is approved annually. After review and approval of the annual UM Program Evaluation by the UM Committee, the results are reported to CenCal Health's QIHEC, which is appointed by CenCal Health's Board of Directors as its designated entity to oversee CenCal Health's Quality Program. The QIHEC's proceedings are reported to CenCal Health's Board of Directors.

The evaluation of the UM Program includes, but is not limited to, an evaluation of

effectiveness in:

- Resolving utilization and benefit issues, including, but not limited to denials and appeals related to utilization decisions
- Creating and reviewing policies and procedures related to utilization management
- Monitoring trends and patterns of key utilization management indicators for over-and under-utilization and appropriateness of care
- Requesting studies, if applicable, on areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns
- Making referrals to the Quality Department for investigation of potential quality of care issues discovered during processing of coverage requests
- Selecting and applying clinical criteria used for UM decisions

XXVI. CONFIDENTIALITY

Individuals engaged in UM Program activities shall maintain confidentiality of all member information and any other information developed or presented as part of the Program. CenCal Health protects the confidentiality of member information and divulges and collects only enough information from the member, subscriber, or appropriate healthcare provider, as is necessary to conduct business activities. Activities and documents that are part of the UM Program are maintained in compliance with legal requirements.

XXVII. NONDISCRIMINATION

All medically necessary covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. Furthermore, all covered services are provided in a culturally and linguistically appropriate manner.

CenCal Health staff must immediately report any instance of discrimination, or services identified rendered in a culturally or linguistically inappropriate manner, to CenCal Health's CMO or Quality Officer to initiate a timely and thorough investigation. Each investigation and outcome are promptly processed through CenCal Health's mechanism for investigation of Potential Quality of Care (PQOC) events, including review by licensed clinical staff to determine whether alleged discrimination had any impact on clinical quality of care. Each case, including appropriate follow-up to mitigate reoccurrences, is documented according to policy and procedure to execute PQOC investigations.

XXVIII. ACKNOWLEDGMENT AND APPROVAL

This UM Program Description may be amended by the HSO, the CMO, or other appropriate UM leadership as needed on a periodic basis to reflect improvements in UM Program operations.

The QIHEC reviewed, approved, and adopted this document with revisions at its meeting.

XXIX. REFERENCE

A. Behavioral Health Program Description
B. Care Management Program Description
C. Whole Child Model Program Description

UM Program Description

D. Diabetes Program Description
E. Heart Disease Management Program Description

UM Program Description

Approvals:

Name / Title: Christopher Hill, RN, MBA, Health Services Officer

Signature:_____ Date: _____

Name / Title: Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer

Signature:_____ Date: _____

2024 Wellness and Prevention Program Description

Quality Improvement and Health Equity Committee: 2/29/2024

Board of Directors: 3/20/2024

CenCal HEALTH®
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Table of Contents

Wellness and Prevention Program Description

I. Purpose

CenCal Health provides a comprehensive Wellness and Prevention Program, including the provision of evidence-based self-management tools, to all its members.

The purpose of the program is to:

- Offer services focused on preventing illness and injury
- Promote healthy behaviors
- Help members identify and manage their health risks
- Reduce risk factors

The activities and interventions within CenCal Health's Wellness and Prevention Program align with CenCal Health's Quality Improvement and Health Equity Transformation Program (QIHETP) to support quality improvement, health equity, and Population Health Management (PHM) priorities.

II. Program Requirements

CenCal Health provides wellness and prevention programs that meet applicable federal and state requirements, and National Committee for Quality Assurance (NCQA) PHM standards, including for the provision of evidence-based self-management tools.

CenCal ensures that the wellness and prevention programs align with the California Department of Health Care Services (DHCS) Comprehensive Quality Strategy.

CenCal Health provides wellness and prevention programs in a manner specified by DHCS, and in collaboration with Local Government Agencies (LGAs) as appropriate.

CenCal Health ensures that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

CenCal Health ensures that all requirements for PHM and coordination of care, including the development of the annual Population Needs Assessment (PNA), are inclusive for all members.

III. Goal and Activities

The goal of CenCal Health's Wellness and Prevention Program is to prevent illness and injury to CenCal Health's members, with a focus on health equity and the elimination of health disparities. This is achieved through the implementation and maintenance of both evidence-based and innovative wellness and prevention programs that meet DHCS and NCQA requirements, and CenCal Health priorities.

In collaboration with LGAs, the following activities support achievement of the program goal:

- Identification of specific, proactive wellness initiatives and programs that address member needs as identified in CenCal Health's Population Needs Assessment (PNA)
- Provision of evidence-based disease management programs including, but not limited to, programs for diabetes, asthma, and obesity that incorporate health education interventions, target members for engagement, and seek to close care gaps for members participating in these programs.
- Initiatives, programs, and evidence-based approaches to improve access to preventive health visits, developmental screenings, and services for members less than 21 years of age.
- Initiatives, programs, and evidence-based approaches to improve pregnancy outcomes for women, including through 12 months post-partum.
- Initiatives, programs, and evidence-based approaches to ensure adults have access to preventive care in compliance with all applicable state and federal laws.
- A process to monitor provision of wellness and preventive services by Primary Care Physicians (PCPs) as part of CenCal Health's Site Review process.
- Provision of health education materials that meet members' health education, cultural, and linguistic needs.
- Initiatives and programs that implement evidence-based best practices to help members set and achieve wellness goals.

IV. Program Components and Priorities

CenCal Health maintains a Wellness and Prevention Program that ensures all members have equitable access to necessary wellness and prevention services. CenCal Health's Wellness and Prevention Program is integrated within its PHM Program, which further ensures care coordination, and care management.

To ensure all members have equitable access to necessary wellness and prevention services, CenCal Health assesses each member's needs across the continuum of care based on member preferences, performs data-driven risk stratification, identifies gaps in care and executes standardized assessment processes.

Overall, CenCal Health's PHM Program, including its Wellness and Prevention Program, seeks to improve the health outcomes of all members consistent with DHCS requirements and guidance.

CenCal Health's Wellness and Prevention Program priorities include the following major components.

A. Services for Members less than 21 Years of Age

CenCal Health's PHM Strategy contains a specific section focused on how CenCal Health provides PHM services to members less than 21 years of age, including but not limited to, Basic PHM, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, Care Coordination services, Early Intervention Services and a Wellness and Prevention Program.

CenCal Health's robust Wellness and Prevention Program ensures the provision of all physical, behavioral, and oral health services to members less than 21 years of age. This includes compliance with the following provisions as indicated in CenCal Health's contract with DHCS:

i. Initial Health Appointment (IHA)
ii. Children's Preventive Services
iii. Immunizations
iv. Blood Lead Screens
v. EPSDT Services
vi. Behavioral Health Treatment (BHT) Services
vii. Local Education Agency (LEA) Services

CenCal Health's approach to ensuring services for members less than 21 years of age are further delineated in CenCal Health's policy and procedure titled *"Ensuring EPSDT Screening, AAP Bright Futures Preventive Services, and Medically Necessary Diagnostic and Treatment Services, for Members Under Age 21."*

i. <u>Initial Health Appointment (IHA)</u>

For members less than 18 months of age, CenCal Health ensures the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

For members ages 18 months and older, CenCal Health ensures an IHA is performed within 120 calendar days of enrollment.

The IHA provides or arranges the provision of, all immunizations necessary to ensure that the member is up-to-date for their age, Adverse Childhood

Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.

If the provisions of an IHA are not met, then CenCal Health's Case Management and Care Coordination teams will work directly with the member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

ii. Children's Preventive Services

CenCal Health provides preventive health visits for all members less than 21 years of age at times specified by the most recent AAP Bright Futures periodicity schedule and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. CenCal Health also provides, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

Where a request is made for children's preventive services by the member, the member's parent(s) or guardian, or through a referral from the local Child Health and Disability Prevention (CHDP) program, an appointment will be made for the member to have a visit within ten working days of the request, unless the member declines a visit within ten working days of the request and another appointment date is chosen by the member.

At each non-emergency primary care visit with a member less than 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, will be advised of the children's preventive services due and available from CenCal Health. Documentation will be entered in the member's medical record which indicates the receipt of children's preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation is entered in the member's medical record which indicates the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of these services.

All children's preventive services will be reported as part of CenCal Health's encounter data submittal required by CenCal Health's contract with DHCS. CenCal Health ensures appropriate acquisition for missed reporting of children's preventive services.

iii. Immunizations

CenCal Health covers vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensures the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). CenCal Health documents attempts that

demonstrate unsuccessful efforts to provide the vaccination. When practical, reasons for failed attempts are medically coded.

At each non-emergency primary care visit with members less than 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, is advised of the vaccinations due and available from CenCal Health immediately, if the member has not received vaccinations in accordance with ACIP standards. Documentation is entered in the member's medical record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation is entered in the member's medical record which indicates the vaccinations were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then the member's medical record will demonstrate that the member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

CenCal Health ensures that member-specific vaccination information is reported to immunization registries established in CenCal Health's service area(s) as part of the Statewide Immunization Information System. Reports are made following the member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting is in accordance with all applicable State and federal laws.

Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, CenCal Health develops policies and procedures for the provision and administration of the vaccine. CenCal Health covers and ensures the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures will be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

CenCal Health provides information to all network providers regarding the VFC Program and is encouraged to promote and support enrollment of applicable network providers in the VFC program as seen appropriate.

iv. Blood Lead Screens

CenCal Health covers and ensures the provision of a blood lead screening test to members at ages one and two in accordance with 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. CenCal Health ensures its network providers follow the Childhood Lead Poisoning

Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department. CenCal Health identifies, at least quarterly, all members less than six years of age with no record of receiving a required lead test, and remind the responsible provider of the requirement to test children.

If a member refuses the blood lead screen test, CenCal Health requires a signed statement of voluntary refusal by the member (if an emancipated minor) or the parent(s) or guardian of the member is documented in the member's medical record. If the member (if an emancipated minor) or the parent(s) or guardian of the member refuses to sign the statement, the refusal is documented in the member's medical record. All unsuccessful attempts to provide the lead screen test are documented.

v. Early and Periodic Screening, Diagnosis and Treatment EPSDT Services

CenCal Health covers and ensures the provision of all screening, preventive and medically necessary diagnostic and treatment services for members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r) and W&I Code section 14132(v). The EPSDT benefit includes all medically necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the State Plan. All EPSDT services are covered services unless expressly excluded under CenCal Health's contract with DHCS.

For members less than 21 years of age, CenCal Health complies with all requirements identified in APL 19-010. CenCal Health provides, or arranges and pays for, all medically necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the State Plan, unless expressly excluded in CenCal Health's contract with DHCS. Covered services include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, care coordination, case management, and Targeted Case Management (TCM) services. If members less than 21 years of age are not eligible or accepted for medically necessary TCM services by a Regional Center or local government health program, CenCal Health arranges for comparable services for the member under the EPSDT benefit in accordance with APL 19-010.

CenCal Health arranges for all medically necessary services identified at a preventive screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C). CenCal Health ensures that all medically necessary services are provided in a

timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for treatment, whether or not the services are covered services.

Without limitation, CenCal Health identifies available providers, including if necessary out-of-network providers and providers eligible to enroll in the Medi-Cal program, to ensure the timely provision of medically necessary services. CenCal Health provides appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for medically necessary services, including all services available through the Medi-Cal program, whether or not they are covered services.

Covered services do not include California Children's Services (CCS), or Specialty Mental Health Services (SMHS). CenCal Health ensures that the case management for medically necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans is equivalent to that provided by CenCal Health for covered services for members less than 21 years of age and, if indicated or upon the member's request, provide additional care coordination and case management services as necessary to meet the member's medical and behavioral health needs.

vi. Behavioral Health Treatment (BHT) Services

For members less than 21 years of age, CenCal Health covers medically necessary BHT services regardless of diagnosis in compliance with APL 22-006.

CenCal Health provides medically necessary BHT services in accordance with a recommendation from a licensed Physician, surgeon, or a licensed psychologist and provides continuation of BHT services under continuity of care.

The member's treatment plan is reviewed, revised, and/or modified no less than every six months by a BHT service provider. The member's behavioral treatment plan is modified or discontinued only if it is determined that the services are no longer medically necessary under the EPSDT medical necessity standard.

CenCal Health has primary responsibility for the provision of medically necessary BHT services and coordinates with Local Education Agency, Regional Centers, and other entities that provide BHT services to ensure that members timely receive all medically necessary BHT services, consistent with the EPSDT benefit. CenCal Health provides medically necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity.

CenCal Health makes good faith attempts to enter into MOUs with Regional Centers and LEAs, and CenCal Health enters MOUs with County Mental Health Plans to facilitate the coordination of services for members with developmental disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 18-009, APL 22-005, and APL 22-006. If CenCal Health is unable to enter into a MOU or a one-time case agreement with a Regional Center, as required by APL 18-009, CenCal Health will inform DHCS why it could not reach an agreement with the Regional Center and will demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the Regional Center.

vii. Local Education Agency (LEA) Services

CenCal Health reimburses LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT.

B. Services for Adult Members

CenCal Health's PHM Strategy ensures the provision of PHM services to adult members, including but not limited to, Basic PHM, preventive Services, Care Coordination services, and Wellness and Prevention Programs.

CenCal Health's robust Wellness and Prevention Program ensures the provision of all physical, behavioral, and oral health services to adult members. This includes compliance with the following provisions as indicated in CenCal Health's contract with DHCS:

i. Initial Health Appointment (IHA) for Adults Ages 21 and over

CenCal Health covers and ensures that IHAs for adult members are performed within 120 calendar days of enrollment.

CenCal Health ensures that the IHA for adult members includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) grade A and B recommendations.

ii. Adult Preventive Services

CenCal Health covers and ensures the provision of all preventive services and medically necessary diagnostic and treatment services for adult members as follows.

CenCal Health ensures the provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

CenCal Health covers and ensures the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. CenCal Health ensures that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

iii. Immunizations

CenCal Health covers vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate CenCal Health's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement.

In addition, CenCal Health covers and ensures the provision of age and risk appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

At each non-emergency primary care encounter the member must be advised of the vaccinations due and available from CenCal Health, if the member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the member's medical record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the member's medical record which indicates the vaccinations were advised, and the member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the medical record must demonstrate that the member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

CenCal Health ensures that member-specific vaccination information is reported to immunization registries established in CenCal Health's Service Area(s) as part of the Statewide Immunization Information System. Reports will be made following the member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting will be in accordance with all applicable state and federal laws.

C. Services for Pregnant and Postpartum Members

CenCal Health covers and ensures the provision of all medically necessary services for members who are pregnant and postpartum. CenCal Health utilizes the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure members receive quality perinatal and postpartum services.

i. Risk Assessment
CenCal Health implements a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. CenCal Health maintains the results of this assessment as part of the member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then CenCal Health must ensure case management and care coordination are working directly with the member to accomplish the assessment. CenCal Health follows up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the member's medical record. The risk assessment may be completed virtually through a telehealth visit with the member's consent.

ii. Referral to Specialists
CenCal Health ensures that pregnant members referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, Licensed Midwives, and ensure access to genetic screening with appropriate referrals. CenCal Health ensures that pregnant and postpartum members are referred to Doulas as required under W&I Code section 14132.24. Doula services are a preventive benefit for Medi-Cal members, and services include but are not limited to personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the network to provide necessary high-risk pregnancy services.

D. Wellness and Prevention Campaigns

Under the larger Wellness and Prevention program, CenCal Health provides specific, focused wellness and prevention programs to all members. These programs aim to improve physical and mental health for members through

initiatives that implement evidence-based best practices directed at helping members set and achieve wellness goals.

CenCal Health ensures organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health. At a minimum, the programs and services address appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions, within the following areas of focus:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

The wellness and prevention outreach is conducted via direct U.S. Postal Service outreach, with the opportunity for follow-up via Member Portal or inbound member phone call. Wellness and prevention programs are coordinated by CenCal Health's Health Promotion team, within the Quality Department.

For each program's member outreach, CenCal Health's Care Management team within the Medical Management Department is provided with a list of members who received wellness and prevention outreach. Sample program materials are included in this notification. Providers are also notified of their assigned members who received wellness and prevention program outreach via lists and information on the Provider Portal each time an outreach is conducted. Sample program materials are also included in this notification, for providers' reference. Providers are then able to conduct reinforcing outreach should they choose to. A reminder of the availability of these resources on the Provider Portal is included in the quarterly Quality Care Incentive Program communications.

Wellness and Prevention Campaigns
Program: Stay Healthy: Adults
Population: Adult members due for key preventive services **NCQA Area of Focus:** Keeping members healthy **DHCS Health Education Focus:** Appropriate use of health care services; Risk-reduction and healthy lifestyles

Description: The Stay Healthy: Adults program is offered to all adult members who are due for important aspects of preventive care and includes targeted mailings that provide: • Health education about the preventive service that the member is due for, including why the service is important for health, and where and how to access the preventive service • The ability for members to follow up with a Certified Health Educator for more support and information • Access to CenCal Health's online health education service with information, tools, and resources for preventive care and healthy lifestyles
Program: Stay Healthy: Kids
Population: Pediatric members due for preventive services, including EPSDT **NCQA Area of Focus**: Keeping members healthy **DHCS Health Education Focus**: Appropriate use of health care services; Risk-reduction and healthy lifestyles **Description:** The Stay Healthy: Kids program is offered to the parents of all pediatric members who are due for certain aspects of preventive care, including developmental screening, lead screening, and other EPSDT services and includes targeted mailings that provide: • Health education about the preventive service that the member is due for, including why the service is important for health, and where and how to access the preventive service • The ability for members to follow up with a Certified Health Educator for more support and information • Access to CenCal Health's online health education service with information, tools, and resources for preventive care and healthy lifestyles
Program: Breathing Better
Population: Members diagnosed with asthma **NCQA Area of Focus:** Managing members with emerging risk **DHCS Health Education Focus:** Self-care and management of health conditions

Description: The Breathing Better program includes a health education mailing that provides members with: • Health education about asthma self-management as well as information about the correct use of controller and rescue medications. • An Asthma Action Plan and reminder that members should complete this annually with their provider • The ability for members to follow up with a Certified Health Educator for more support and information • Access to CenCal Health's online health education service with information, tools, and resources for asthma self-management
Program: Healthy Pregnancy
Population: Members who are pregnant **NCQA Area of Focus:** Managing members with emerging risk **DHCS Health Education Focus:** Risk-reduction and healthy lifestyles **Description:** The Healthy Pregnancy program is offered to all members who are newly pregnant. This health education program includes a targeted mailing that provides: • Health education about the importance of timely prenatal visits and information on a healthy pregnancy, including nutrition, dental care, immunizations, mental wellness, physical activity, and more. • The ability for members to follow up with a Certified Health Educator for more support and information. • Access to CenCal Health's online health education service with information, tools, and resources for healthy pregnancy
Program: Healthy Postpartum
Population: Members who are up to 12 months postpartum **NCQA Area of Focus:** Managing members with emerging risk **DHCS Health Education Focus**: Risk-reduction and healthy lifestyles **Description:** The Healthy Postpartum program is offered to all members who are newly postpartum, through 12 months postpartum. This health education program includes a targeted mailing provides:

• Health education information on the importance of timely postpartum visits and on postpartum wellness, nourishment, and returning to exercise. • The ability for members to follow up with a Certified Health Educator for more support and information. • Access to CenCal Health's online health education service with information, tools, and resources for a healthy postpartum season
Program: Safe Care
Population: All members **NCQA Area of Focus:** Patient safety **DHCS Health Education Focus:** Appropriate use of health care services; Risk-reduction and healthy lifestyles **Description:** The Safe Care program is open to any member seeking education about best practices for patient safety advice for hospital care as well as transitional support across health care settings. This dynamic health education program utilizes multiple methods of messaging and engagement to meet members' education needs, including: • Distribution via the Health Plan website and Member Portal • Member portal bi-directional engagement • Information about patient safety and patient self-advocacy • The ability for members to contact a Certified Health Educator for more support and information • Access to CenCal Health's online health education library with information, tools, and resources for preparing for hospital care
Program: Know More series
Population: Varied based on each "Know More" program goal **NCQA Area of Focus:** Keeping members healthy **DHCS Health Education Focus:** Risk-reduction and healthy lifestyles **Description:** The "Know More" educational series provides health information to members using digital platforms. Each "Know More" program focuses on a different aspect of care, engaging members with health content aimed at preventing illness and reducing risk. Offering digital video and interactive health education content provides an alternative way of engaging members

with health information at point of service. Current programs within the "Know More" series include:

- Know More: HPV (nationally recognized)
- Know More: STIs
- Know More: Vaping

Additional "Know More" topics are planned for development, as they provide an alternative way to engage members with health education information at point of service.

In addition to these campaigns, the identification of specific, proactive wellness initiatives and programs that address member needs are identified in the PNA and implemented by the Health Promotion team.

E. Self-Management Tools

CenCal Health offers a comprehensive library of health education content to both members and providers for use with their patients. CenCal Health's self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information.

Members can access directly from CenCal Health's website, Member Portal or through printed materials. CenCal Health's health education library includes a multitude of self-management tools supplied by Healthwise, Inc. (an NCQA certified vendor).

Topics covered include but are not limited to:

- Health weight (Body Mass Index) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying depressive symptoms

Tools include but are not limited to:

- Personalized worksheets
- Physical activity logs

- Caloric intake log
- Mood log

To view the library of self-management tools, visit the CenCal Health's public website www.cencalhealth.org/health-and-wellness/self-management-tools

F. Population Needs Assessment (PNA)

CenCal Health recognizes the importance of offering health education, cultural and linguistic (C&L), and quality improvement services that aim to achieve health equity within its membership. CenCal Health annually assesses its population to identify health disparities or gaps in services. The annual Population Needs Assessment (PNA) evaluates data sources to determine needs of child and adolescent members, members with disabilities, members of different racial or ethnic groups, members with limited English proficiency, and needs related to social drivers of health.

PNA findings inform CenCal Health's Wellness and Prevention program activities, including campaigns offered, and health education initiatives created.

G. Health Appraisals

CenCal Health administers health appraisals annually for adults and children, called the Adult and Pediatric Health Survey Tools (HST). The HSTs are distributed monthly to all new members, and in advance of the twelfth month after completion of a member's prior HST, or before their enrollment date if no prior HST was completed by the member.

Results from the HSTs initiate Case Management and Disease Management outreach, and trigger specific member outreach follow-up.

V. Health Education

CenCal Health implements and 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. CenCal Health ensures administrative oversight of the health education system by a certified full-time health educator, as defined by DHCS APL 18-016. The Health Education team is integrated into the Quality department and works closely with all CenCal Health departments, including, but not limited to, Case Management, Disease Management, Member Services.

The Health Education system is strategically integrated within the QIHETP to ensure

health education and promotion activities and interventions support quality improvement, health equity, and PHM priorities. Member health education needs are also informed annually by the PNA, which describes member health status and seeks to identify gaps in services and health disparities.

CenCal Health monitors the health education system including accessibility for Limited English Proficient (LEP) members and the performance of providers that are contracted to deliver health education services. CenCal Health ensures appropriate allocation of health education resources and conducts appropriate levels of program evaluation.

A. Written Health Education Materials

CenCal Health provides members with health education materials designed to assist them to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes by including information on health conditions, management of health conditions, and self-care. Topics may include messages about preventive care, health promotion, screenings, disease management, and healthy living.

Health education materials are provided to members in accordance with DHCS requirements, including ensuring that they are culturally and linguistically appropriate, and that they meet all readability and suitability requirements. Materials are provided at or below a 6th grade reading level, use 12-point font, and undergo all required clinical review and field testing. Documentation of readability reviews are kept for written health education materials currently in use.

B. Member Incentives

CenCal Health utilizes member incentives to motivate individuals to adopt healthy behaviors, such as quitting smoking, losing weight, receiving timely post-partum care, or accessing timely immunizations, with the goal of improving health status, enhancing prevention and health outcomes, and reducing program costs. Additionally, CenCal Health uses incentives for focus groups and surveys to better understand the needs of members, and to use that information to develop materials and programs that may help members better navigate the health care system and improve their health status.

C. Member Outreach

CenCal Health utilizes a variety of member outreach methods for education, behavioral change, and disease management purposes.

i. Website

The "Health and Wellness" section of CenCal Health's website includes a comprehensive interactive library of health education topics. Members can view and print this information at no cost.

ii. Social Media

CenCal Health's social media outlets are used periodically for health promotion messaging that address quality improvement priorities, seasonal health topics, as well as other useful or targeted health information. This includes creating educational videos for YouTube.

iii. Direct Mail
Targeted mailings provide information for specific member groups and are used as components of health promotion interventions, quality improvement efforts, community activities, and disease management programs.

iv. Voicemail
Members can choose to call the Health Education Request Line to request health education materials be sent to their home on specific topics they are interested in learning about.

v. Member Newsletter
Four times per year, all households receive the member newsletter, *Health Matters/Temas de Salud*, which contains Plan information, health topics, and promotion of services and resources.

vi. Member Portal
The Member Portal is a secure avenue to for members to access their health information online. Members can request health education Materials, classes near them, or help over the phone

vii. Health Fairs
CenCal Health provides members with health information and answers questions related to health behaviors and Plan benefits and services.

viii. Community
Creative partnerships with network healthcare providers and/or local community organizations to disseminate Plan-developed educational materials and programs. Collaboration with CHWs to educate members on health needs, as well as connect members with community resources.

ix. Case Management and Disease Management
Members are provided health education materials and resources through the Plan's Case Management and Disease Management programs

D. Provider Outreach
CenCal Health assists Providers with developing and delivering health education interventions.

i. Trainings

Training is provided on various topics, including techniques to enhance effectiveness of provider/patient interaction, health plan and community health education resources available, priority improvement areas, and Population Needs Assessment findings.

ii. Collaborations

CenCal Health partners with Providers on various quality improvement and health education programs.

iii. Resources

Providers are offered health education resources to aid in their communication with members. All resources are culturally and linguistically appropriate.

VI. Team Roles and Responsibilities

Chief Medical Officer
The Chief Medical Officer (CMO) is a member of the executive team with strategic leadership responsibility for clinical oversight, physician partnership, and quality improvement in support of the organization's vision, mission, and values. Reporting directly to the Chief Executive Officer (CEO), the CMO provides clinical leadership to the organization and is accountable for effective medical decision-making, adherence to professional and ethical medical standards, application of state and health plan policy, and overseeing clinical programs for CenCal Health members.

Chief Customer Experience and Health Equity Officer
The Chief Customer Experience and Health Equity Officer (CXO/CHEO) provides strategic vision and leadership for the management of key relationships with members, providers, and community partners. The CXO is responsible for understanding and championing diverse customer perspectives across CenCal Health's service area and sponsoring improvements in access to care, member engagement and satisfaction, provider and community partner retention and satisfaction, and quality of customer service and service outcomes.

Quality and Population Health Officer
The Quality Officer leads the development and evolution of a systematic, organization-wide quality and population health strategy to improve member health outcomes through facilitation of CenCal Health's QIHETP.

Director of Quality
The Director of Quality is responsible for strategy development, planning, organizing, and leading the functions and activities of the Quality Department including population health management, quality measurement, clinical transformation, and health promotion. The Director of Quality develops, implements, leads, and directs the department in support of the quality and population health programs and initiatives for CenCal Health.

Population Health Manager
The Population Health Manager is responsible for the daily operations, direct oversight, and functions of the population health, clinical quality, and health promotion teams. In coordination and collaboration with the Director of Quality, the Population Health Manager supports the execution and implementation of a Population Health and Quality Strategy to achieve health equity.

Health Promotion Supervisor
The Health Promotion Supervisor is responsible for leading the Health Promotion team by guiding development, design, implementation, maintenance, and evaluation of the health education functions essential to maintain compliance with the DHCS contract and to advance the general health status of CenCal Health's members. A masters-prepared professional, as defined by DHCS APL 18-016, responsible for preparation and implementation of the PNA.

Health Promotion Educator(s)
Health Promotion Educators design, implement, and maintain the health education functions essential to advance the general health status of CenCal Health's members and reduce health disparities. They support the integration of health promotion and education within PHM and contribute to the advancement of CenCal Health's Wellness and Prevention Program to improve population health and achieve health equity.

VII. Reporting

Progress on the initiatives within the Wellness and Prevention Program are reported to quality committees for oversight, monitoring, and input.

A. Community Advisory Board
CenCal Health's Community Advisory Board (CAB) provides input and advice on key Wellness and Prevention Program components. Specifically, the CAB reviews PNA findings and discusses improvement opportunities with an emphasis on Health Equity and Social Drivers of Health.

Additionally, the CAB provides input and advice, including, but not limited to, the following areas related to wellness and prevention:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;
iii. Findings of the PNA;
iv. Community resources and information;
v. Population Health Management;
vi. Quality;
vii. Health Equity

Health Promotion staff present an update at each quarterly CAB meeting.

B. Member Support Committee

In accordance with the Member Support Committee charter within the QIHETP, the Member Support Committee evaluates Wellness and Prevention Program activities, providing input and support to initiatives and member education materials.

Health Promotion staff present an update at each quarterly meeting.

VIII. Program Evaluation

Consistent with CenCal Health's QIHETP, CenCal Health staff perform an annual evaluation of the Wellness and Prevention Program. The annual evaluation includes achievements and identified opportunities for improvement to inform the development of a comprehensive work plan for the next year. The annual evaluation prioritizes member needs to continually advance the effectiveness of CenCal Health's Wellness and Prevention Program to prevent illness and injury to CenCal Health's members and eliminate health inequities.

2024 Pediatric Whole Child Program Description

Utilization Management Committee: 2/12/2024

Quality Improvement and Health Equity Committee: 2/29/2024

Board of Directors: 3/20/2024

TABLE OF CONTENTS

OVERVIEW

CenCal Health's Pediatric Whole Child Program (PWCP) is a comprehensive member-centered program which aims at addressing all the aspects of health care for members aged 0-21 years old including comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS eligible conditions. The PWCP will assist families and health care providers to obtain integrated and coordinated necessary heath care services for children and youth under the age of 21. The Program is an integral component of the Medical Management Department.

Key features of the PWCP are streamlined processes, delivery of coordinated and organized services, decrease fragmentation of care, and promotion of quality care to children and youth. The facilitation and/or coordination of the right care at the right time and right place are key factors. Children and youth who have a California Children's Services eligible (CCS) conditions, at high-risk, and are identified as needing individualized (or family) guidance, education and extensive coordination of their health care needs meet program eligibility. Like the Adult Case Management Program, the PWCP consists of various care levels; from basic, which is primarily the responsibility of the primary care provider (PCP), to complex, which is a collaborative effort between the PCP, CenCal Health, specialists, CCS specialty care centers and community-based organizations.

AUTHORITY

The Pediatric Whole-Child Program (WCM) is an integrated model that combines utilization review and case management activities into one program. Therefore, please refer to the Utilization Management Program Description for details on authority designation.

GOALS AND OBJECTIVES

The Pediatric Whole-Child Program is designed to assist members under the age of 21 and their families navigate through the healthcare delivery system. Improving or maintaining the child's health status and their functional capabilities, in the right care setting and in a cost-effective manner are the primary program goals. Components of the program are identification of members who meet eligible conditions, comprehensive assessments of the member's condition, coordination of primary, specialty, and subspecialty services, determination of available benefits and resources, coordination with other agencies, risk stratification of members and the development and implementation of an individualized care plan (ICP) with realistic performance goals, monitoring timelines, and follow-up.

Primary child/person-centered goals are:

- Enhance the care and quality of life of the child/youth
- Improve coordination and integration of primary and preventive services with specialty care services, such as Early and Periodic Screening Diagnosis, and

Treatment (EPSDT), long-term services and supports (LTSS), regional center services, and community-based services
- Utilize a child and youth and family-centered approach and promote active participation by the child/youth's parents and families
- Provide support and advocacy to the child, youth, their family, and provider
- Improve access and navigation of care through the health care delivery system
- Maintain or exceed CCS program standards and specialty care access, including access to appropriate subspecialties
- Provide continuity of care for at least 12 months for children and youths to their specialist upon PWCP enrollment
- Provide provider referrals, and service authorizations
- Facilitate care across a continuum through effective resource coordination and navigation through the transitions of care
- Improve the transition from youth to adult systems of care through better coordination of medical and nonmedical services and supports and improved access to appropriate adult providers for youth who age out of CCS
- Improve member (and their family) and provider satisfaction
- Maximize member and family access to educational materials, tools and techniques

Program objectives are:

- Early identification and management of children and youth with CCS conditions, at high-risk, or high cost
- Coordination with specialized programs or community-based organization
- Decrease or minimize fragmentation and/or duplication of care
- Promote quality, cost-effective care at the right time and in the right setting
- Incorporate adherence guidelines and other standardized practice tools to develop achievable goals
- Adhere to regulatory requirements and as appropriate, accreditation requirements
- Meet pediatric plan performance standards and measurements imposed by State regulations and guidelines
- Measure outcome using practice-based guidelines
- Positive and improved child/youth and family experience

SCOPE OF SERVICE

The PWCP is child-centered but dependent on active family and/or caregiver participation. PWCP focuses on delivering coordinated and integrated cost-effective, healthcare services to members under the age of 21. Children and youth who have a CCS condition, high-risk condition, have a complex and chronic care need or in need of assistance with navigating through the health care delivery system are the target population.

CenCal Health had executed a Memorandum of Understanding (MOU) with Santa Barbara and San Luis Obispo Counties CCS programs that outlines the respective responsibilities and obligations under the WCM as well as coordination of the delivery of

services to CCS members. Advisory committees that meet quarterly for families and CCS clinicians have been established.

Children, youth, and families receive an array of care coordination and case management services, which may include but not limited to:

- Collaborating with primary care provider (PCP) and the medical home
- Facilitating preventive care with PCP, alcohol and substance abuse services, or behavioral health services
- Coordinating in-network and out-of-network specialty care services and referrals
- Assisting families with obtaining continuity of care with current specialists
- Arranging non-emergency medical and non-medical transportation as necessary to obtain covered services and treatments
- Communicating with providers and interdisciplinary care team members
- Identifying supportive and collaborative partnerships with the family to facilitate care
- Processing provider referrals and service authorizations in a timely manner, including referrals to pediatric specialists
- Ensuring timely referrals to medically necessary specialty providers, including Special Care Centers and pediatric tertiary care hospitals
- Educating families about community-based organizations and resources; and how to access those services
- Referring to or coordinating care with specialized programs, such as Local Educational Agency, Regional Center, Early Start, CCS Specialty Services and Medical Therapy Program, Targeted Case Management Programs (Maternal, Child and Adolescent Health), Foster Care Program, Mental Health, Substance Abuse, In-Home Support Services, Private-Duty Nursing, long-term services and supports, etc.
- Coordinating care transitions between levels of care
- Ensuring care is delivered in the least restrictive setting
- Assisting families with navigating through the healthcare system
- Ensuring families have access to ongoing information, education, and support so that they understand the care plan for their child/youth and their role in the individual care process
- Providing information on community resources
- Empowering families to manage their child/youth's condition
- Transitioning youth to the adult case management program when aging out of CCS services

RESPONSIBILITIES

To facilitate the access of appropriate and timely care, the PWCP team will coordinate services for members under the age of 21 who receive services from network and non-network providers. The assigned Care Coordination Team consisting of a Pediatric Health Plan Nurse Coordinator, Social Worker and Pediatric Clinical Support Associate will work collaboratively with the member, family and healthcare team, which may include but are not limited to, discharge planners at contracted and out-of-plan hospitals, pediatric specialists and providers.

Responsibilities of the PWCP team include but are not limited to:

1. Identify children or youth that have a CCS condition, medically complex condition, identified as high risk or high utilizers.
2. Perform a risk stratification process to determine high and low risk members.
3. Perform Pediatric Health Risk Assessment Surveys (PHRA) for high-risk members.
4. Reassess at least annually or when utilization data, claims data, or changes in the child/youth's health status increase their risk status.
5. Facilitate timely processing of medically appropriate referrals and service requests.
6. Based on the risk stratification results, health survey and assessment findings, assign a CM service level; as appropriate, develop an individualized care plan (ICP) that include the anticipated number of contacts and necessary goals, tasks and interventions.
    a) In collaboration with the child/youth's family and as appropriate to CM service level, will develop an individualized care plan that is person-centered, time specific and measurable with a particular focus on CCS specialty care, identification of behavioral health needs and coordination of services.
    b) Develop tasks and goals that are attainable, address identified or potential health risks, or can help the child/youth achieve goals related to the improvement of health or functional status.
    c) Identify community resources and other agencies including mental health and substance use disorder services. Inform members of these resources by sending them informational materials and/or directly linking them to these resources.
    d) If necessary, adjust the CM service level to correlate with the intensity of services being provided.
7. Advocate for medically necessary services that meet the comprehensive health care need of the child/youth.
8. Facilitate continued care services for children or youths who have or will need assistance transitioning as they "age out" of CCS services.
9. Coordinate care with network and non-network providers, specialty, and subspecialty care centers.
10. In collaboration with hospital discharge planners, facilitate post-hospitalization care, which may include:
    a) Assess pre and post hospital living arrangements, which may include the physical and mental function and cognition, social and family support, needs for durable medical equipment (DME) and other services.
    b) Address pre-discharge factors, including the understanding of the medical condition by child/youth and their family.
    c) Identify a representative for the child/youth.
    d) Identify available community and financial resources.
    e) Identify services needed upon discharge, e.g., home care, community-based organizations, medical supplies and equipment, specialist follow up, mental or behavioral health services, etc.
    f) Anticipate potential problems or barriers to post-discharge plan.
11. Facilitate collaboration among all parties to achieve goals and to help with informed decision making.

12. Advocate for the child by linking them with services that may help promote and maintain a better quality of life.

CASE IDENTIFICATION

A. REFERRAL SOURCES

- Primary Care Providers
- Consulting Specialist(s)
- CenCal Health employees
- Ancillary Care Providers, e.g., DME vendor
- Community Based Organizations
- Quality Management Department
- Disease Management Department
- Pharmacy Department
- Claims Department
- Advice Nurse Unit
- Parent or Caregiver
- Hospital Discharge Planners or Emergency Departments
- Home Health Agency Staff
- Health Educators
- Public Health Department
- Employment and Human Services
- CCS Medical Therapy Units
- Recuperative Care Centers and Homeless Shelters
- Other, as accepted by the Department Manager

B. DATA SOURCES

- Claim or encounter data
- Hospital discharge data
- Pharmacy data
- UM management statistical data
- Data supplied by families/caregivers
- Indicators identified on Risk Stratification Tool, Health Survey Tool or Initial Health Assessment data
- Internal operational data
- HIPAA compliant, shared Electronic Medical Record (EMR)
- Analysis of child-specific information including historical fee-for-service utilization data, when available, provided by DHCS electronically at the time of enrollment.

CCS IDENTIFICATION AND REFERRALS

Upon receiving a referral for a possible CCS condition of a member under the age of 21, the PWCP team will refer the member to the local County CCS for medical, residential and financial eligibility determination. Upon the determination of CCS eligibility by the county, member is enrolled to the PWCP. The Health Plan Nurse Coordinator will issue

appropriate treatment authorizations related to the CCS conditions using CCS guidelines. To track CCS referrals, CenCal Health coordinates with the County CCS office through an as needed follow-up of members who are on "Pending CCS Review".

CenCal Health will refer and authorize pediatric members who are eligible for a major organ transplant to CCS approved transplant special care centers for an evaluation within 72 hours of receiving a referral from the member's PCP or a specialist. CenCal Health's CCS Medical Director will review for medical eligibility using CCS guidelines. CenCal Health will authorize transplant services upon determination of medical eligibility.

If an established PWCP member with an existing CCS eligible condition is suspected of having a new potential CCS diagnosis (multiple CCS conditions) as assessed by the Health Plan Nurse Coordinator, referral to the CCS County office will be done. Treatment authorizations will be issued upon determination of medical eligibility.

Should CenCal Health disagree with the County's medical eligibility determination, a dispute resolution process may be initiated. CenCal Health shall designate appropriate staff to participate in a dispute resolution. CenCal Health will notify, in email or other written communication, of its disagreement with the County. The communication notice will include a copy to CenCal Health Chief Medical Officer (CMO) or designee and the County CCS Medical Director or designee.

Within five business days, the receiver of the written disagreement shall respond by similar email or other written form; also copying the clinical leadership of the other party.

Upon receipt, the original party shall either concur with the other party's response or, within five business days, request a formal meeting of each party's appropriate staff, appropriate executive leadership (such as COO or CMO, deputy director or department director) and clinical staff.

UTILIZATION MANAGEMENT

The PWCP team's Pediatric Clinical Support Associate (CSA) and Health Plan Nurse Coordinators (HPNC) ensure timely authorization of services. The HPNC will review requests for authorizations using CCS guidelines and criteria (CCS medical regulations, provider paneling requirements and Numbered Letters). The HPNC will review for Neonatal Intensive Care Unit (NICU) and High- Risk Infant Follow-Up Program (HRIF) acuity. CenCal Health shall notify the county CCS program in writing of all CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services. Notification shall occur as soon as CenCal Health is made aware, but no later than 15 calendar days of being made aware, of a member no longer having Medi-Cal eligibility. The Pediatric Medical Director will provide guidance and direction on CCS related issues. Medi-Cal and health plan criteria will be applied if member does not meet CCS criteria.

CenCal Health promotes the Medical Home concept of care. CCS pediatric specialist and providers are advised to go through the member's PCP for referrals.

The PWCP team will meet regularly with local County CCS for care coordination. Discussions will focus on complex cases, MTP members and transition planning.

CCS eligibility redeterminations (Annual Medical Reviews) are done by the County CCS program. To aid in medical eligibility review, CenCal Health has developed a comprehensive Annual Medical Review process to provide necessary documentation to the County CCS team. CenCal Health will issue authorizations for services to CCS paneled providers if a member is determined to have continued eligibility for CCS.

CASE MANAGEMENT REFERRALS

CenCal Health will accept case management referrals from any referral sources such as but not limited to members, parents, local education agencies, CCS county offices, community agencies, regional centers, etc.

A Pediatric Case Management team member will acknowledge the receipt of a Case Management referral to the referral source within 72 hours. Member outreach will occur within 5 business days for routine referrals and within 72 hours for urgent referrals. Initial feedback (i.e., referral status) will be provided to the referral source no later than 30 calendar days of the referral receipt date. Additional and continuous feedback to referral source and/or PCP in 30 - 90 day intervals, or sooner if deemed medically necessary will be provided while the case is open.

The referral source and/or PCP shall be notified, and communication will be documented in the notes when the child/youth and their family declines PWCP Case Management services or is inappropriate for program interventions.

RISK STRATIFICATION PROCCESS (RSP)

CenCal Health developed a Risk Stratification process to assess the CCS member's risk level through utilization and claims data. The data thresholds include number of ED visits, number of hospital admissions, total inpatient days, inpatient cost, outpatient cost, pharmacy cost and total patient cost. The RSP report will be used to classify CCS members into higher and lower risk groupings, allowing the PWCP team to identify those members who have more complex health care needs.

The RSP report will be run monthly for established members. The high-risk members will have a PHRA done within 90 days of identification and an ICP within 90 days after the PHRA. Low risk members will be monitored to see if they hit any high-risk triggers or if there is a change in their condition. The high-risk members will have a PHRA and ICP performed within 45 days of implementation date. Low risk members will have a PHRA done within 1 year of implementation date.

PEDIATRIC HEALTH RISK ASSESSMENT (PHRA)

Members who are high risk based on the risk stratification process will receive a Pediatric Health Risk Assessment (PHRA) survey within 90 days of enrollment. The PHRA may be done by mail (mailed upon enrollment) telephonically or in-person. New members and Newly CCS-eligible members will receive a PHRA by mail within 90 days of enrollment. New members who are at high risk will have an ICP developed within 90 days of PHRA. Low risk members will have their needs assessed annually at the time of their CCS annual medical eligibility redetermination.

The PHRA will ensure that each CCS member receives case management, care coordination, provider referral, and/or service authorization from a CCS paneled provider who has clinical experience with the CCS population or clinical experience with pediatric patients with complex CCS conditions. The PHRA will establish a starting point for the ICP, which will be developed for each member that demonstrates a need for an ICP.

Some key assessment features of the PHRA include:

- General Health
- Diagnosis: CCS conditions and other health conditions
- Level of care
- CCS specialists
- List of prescribed medications
- Specialized or customized durable medical equipment
- Activity limitations
- Assistance required
- Evaluation of home situation, including family and caregiver participation and involvement, community support, etc.
- Evaluation of available benefits within the organization and from community resources

Other questions include:

- Medical History: hospitalizations, ED visits
- Social and linguistic history
- Age-appropriate questions about mental health, substance use, family planning, eating disorders, etc.

Ongoing management of these children and youth includes:

- For complex service levels, the development or revision of existing individualized care plan (ICP), which includes prioritized goals that are child/youth-centered
- Identification of barriers to meeting goals or complying with the plan
- Facilitation of initial referrals or follow-up visits to CCS specialty care providers
- Communication with the family or caregiver regarding necessary primary, preventive, and specialty care services
- Communication of child/youth-centered, family and caregiver dependent plans
- Assessment of child/youth's progress as compared to their individualized care plan

- Development of a child/youth contact schedule (e.g., frequency of follow-up and communication). Schedule is based on acuity and intensity levels (refer to section "PWCP Service Levels" for detailed information) and monthly review of progress toward identified goals
- If PWCP services terminate while a child/youth is admitted to a facility and the stay is longer than 30 calendar days, a re-assessment will be performed after discharge to determine if the child is still eligible for PWCP services

INDIVIDUALIZED CARE PLAN (ICP)

An ICP is a comprehensive member-specific plan that is developed from the results of a PHRA to plan, and address identified risk conditions, prioritize needs and propose interventions, including methods, timeframe, outcome goals, referrals, and collaborative team responsibilities. ICPs incorporate identified family goals and objectives, healthcare preferences, description of services customized to the child/youth's needs, and outcome of identified goals and objectives.

An ICP will be developed within 90 days of a completed PHRA and RST report (claims and utilization data) for new members and newly CCS-eligible members) who are classified as high risk. New members and newly CCS-eligible members determined as low risk will be contacted telephonically or in person by a Pediatric team member within 120 calendar days of their enrollment. For WCM transitioning members who are low risk will be contacted by phone or in person by a member of the Pediatric team within 1 year of WCM transition date.

In collaboration with the family and physician providers, the case manager shall develop an ICP for the child/youth in the Complex service level. When applicable, the PWCP team will collaborate with other agencies, e.g., Regional Center, Local Educational Agency, CCS Medical Therapy, etc. to develop a comprehensive ICP. Only Case Managers (RN and SW), consistent with the scope of their clinical practice, may develop an ICP with the child/youth's family and involved providers.

The case manager should engage the child/youth's family in the planning process since their active participation is essential and they act as the primary decision-maker and goal setter. During the planning process, the case manager should communicate the role that the family will play in order to understand and incorporate their priorities, and to educate and prepare them with making informed and appropriate decisions.

Family input and participation in care planning is desirable in order to optimize the family's acceptance of the plan and thus maximize the potential of achieving the specified goals. The child/youth's family, physician(s), and other health care providers should be engaged in the planning process. The case manager recognizes the importance of collaboration with the child/youth's physician in developing the ICP as a key component of effective case management.

A Health Plan Nurse Coordinator and/or a Social Worker will develop an ICP, focusing on an active family participation, coordination of CCS specialty care and behavioral health services, if appropriate. An integral part of the ICP development is the identification of appropriate community resources such as family empowerment/advocacy centers and

other agencies. The system for ICP development has a mechanism to directly identify and obtain specific printed materials and resources based on problems and goals that were individually identified through care planning. The PWCP team will be responsible to inform members of these resources by sending them informational materials and/or directly linking them to these agencies and resources.

An ICP will also have these additional key components:

- Have questions that address member's goals and preferences
- Have measurable objectives and timetables
- Identifies medical, behavioral health, mild to moderate mental health, EPSDT services, substance use disorder (SUD) needs, and other medically necessary services within network and, when necessary, treatment by an out-of-network provider
- Is completed in collaboration with the member, member's family, and/or their designated caregiver

The ICP serves to provide a common method for case managers to document and plan their involvement in a case. The ICP may be used as a tool to help assure timely coordination of services that increase the effectiveness and efficiency of care/services provided to the child/youth.

The case manager recognizes that ICPs are dynamic and may require ongoing evaluation of progress. When appropriate, the case manager should initiate and implement appropriate modifications in the ICP. When developing an ICP, the CM shall consider the benefits available through the child/youth's health plan. The case manager must clearly understand and as necessary, advocate for the benefits that are necessary and available through the health plan. Additionally, the CM should consider incorporating available community resources and/or government agencies to the ICP.

The ICP should appropriately identify all of the following elements: long & short-term goals; timeframes for follow-up; resources to be utilized (both the plan's resources and community-based resources); and collaborative approaches to accomplishing goals. Therefore, ICPs shall be:

a) **Outcome-Specific**: ICPs will identify short-term and long-terms goals. Goals shall include target dates and timeframes for reassessment of progress toward and accomplishment of desired outcomes. Short-term goals usually address the immediate health status of the child/youth. A long-term goal aims to achieve sustaining health improvement or optimal health status.
b) **Individualized:** ICPs will specify child/youth-centered and active family participation goals, identify necessary resources, and identify approaches to use to achieve specified tasks and/or goals.
c) **Time-Specific**: Developed goals have estimated timelines for achievement. Timelines may be adjusted. Timelines allow the CM to evaluate the progress toward achieving goals and to determine whether identified goals can be accomplished.
d) **Collaborative:** The CM involves the child/youth's family and the health care team in the ongoing plan of care. Progress toward and/or accomplishment

(or failures) of desired goals/outcomes identified in the ICP are communicated to the primary care provider and involved multidisciplinary health care team members.

e) **Evidence-Based:** As appropriate, ICPs should incorporate evidence-based interventions and goals when evidence-based guidelines are available, such as licensed clinical practice guidelines.

COORDINATION OF ICP

The CM coordinates the interventions specified in the ICP to:

- Promote quality, cost-effective outcomes, and optimize health care benefits across the continuum of care; and
- Promote continuity of care and integration of services for the child/youth across a range of settings.

Coordination of care is achieved through communication with the child/youth's family and the multidisciplinary health care team (e.g., physician, other health care providers, and specialized programs actively involved in the care). The care management team (CM) shall make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the MCP must follow up with the member to assist in planning next steps in care coordination understand barriers and make adjustments to the referrals if warranted. The CM team shall also attempt to connect with the provider to whom the member was referred to and facilitate a warm hand off to necessary treatment.

As part of the coordination process, the HPNC is expected to periodically communicate with the child/youth's primary care provider (PCP). The HPNC shall inform the PCP about the family's engagement in the PWCP, progression or barriers toward identified goals, and case closure. The initial communication should occur within one month of establishing an ICP and may take the form of a verbal phone call directly with the physician or the physician's office or a written notice, the latter being the preferred method of communication. The mode of communication (phone call or notice) is documented in the case file.

The coordination of care function may include:

- Obtaining coverage for the services provided under the child/youth's health benefit plan
- Identifying resources that are most appropriate to meet the needs
- Processing provider referrals or service authorization requests
- When available, linking the child/youth with services needed but not covered under the health benefit package, with an explanation of what services are not covered
- Providing educational information to the child/youth's family so that the family can better manage their child/youth needs
- As appropriate, coordinating benefits with other health coverage
- Coordinating continuum of care with specialized programs such as CCS Medical Therapy Program, Regional Center, Mental Health, Alcohol and Substance Use

Program, Local Educational Agency, Special Education, Public Health Department and Foster Care Program

The PWCP is designed to provide a single point of care coordination, integrating the functions of care coordination with processing provider referrals and service authorizations. Consolidating these functions to one care team provides consistency to families. Each care team consists of at least one nurse, one social worker, and a clinical support associate. Depending on the complexity of the case, one of the above disciplines will be the designated contact person for the family. As necessary, the care team can seek support from other Health Services team members, which may include a physician and/or utilization management nurse.

TRANSITION PLANNING/AGING OUT

An integral part of care coordination is Transition Planning of CCS members to prepare them to adulthood and aging out of CCS. CenCal Health will follow CCS guidelines for members in preparation for their transition into adulthood. Forms, member letters and checklists will be used in accordance with CCS Guidelines. Transition preparation will commence as early as the member turns 14 years old with focus on:

- Assisting members and families in identifying adult CCS primary care providers and specialists
- Ensuring that equipment (DME) and supplies needs are addressed
- Linking members and families to community agencies and resources that would assist the member with future adult career goals and education if applicable

CenCal Health's Health Plan Nurse Coordinators and Social Workers will coordinate with the County Medical Therapy Program staff (Physical/Occupational Therapists, MTP Physician, Orthopedic Specialist) and Community Agencies (Regional Center, Special Education – SELPA) to address transition planning needs. Social Workers will address needs of transitional aged youth during the Medical Therapy Clinic post conferences.

The PWCP Health Plan Nurse Coordinators will work with CenCal Health's Adult Case Management Team when the member turns 18 to prepare for aging out of CCS. Coordination would include active planning for referrals, resources, and review of ICP goals and interventions. Coordination will conclude with a warm hand-off on the member's 21st birthday.

Care coordination may also include identifying children and facilitating referrals to external agencies and organizations such as Regional Centers (Early Start Program), Local Education Agency (LEA), Foster Care Program, California Children's Services (CCS), County Behavioral Wellness (Mental Health) for medical, psychological, cultural, special care, or social needs using available resource information regarding available community-based programs and services. The case manager will identify and inform the family which referred services are not eligible for coverage under the child/youth's health benefit plan.

When coordinating with specialized programs, such as County Mental Health or the Regional Center, the roles and responsibilities of CenCal Health's Case Manager are

established in individual Memorandums of Understanding (MOU). Each MOU outlines responsibilities of both parties.

At all times during PWCP services, including planning and coordination, the Case Manager maintains the confidentiality of the child/youth's information in accordance with applicable laws and regulations.

TERMINATION AND CASE CLOSURE

This part of the PWCP process is similar to the adult Case Management Program. PWCP services are discontinued when the child/youth transitions to their highest level of function, ages out of the program and/or transitions to adult case management services, attains the best possible outcome, or the needs/desires of the child/youth and their family changes. Refer to policy *HS-CM105 Closure of Case Management Services* for detailed information.

Case closure requires communication to the child/youth's family, referring provider, and primary care provider. The preferred mode of communication is in writing and includes, as appropriate, the following:

a) Date of services (start and end dates)
b) Goals accomplished and as appropriate, include dates
c) Barriers, challenges and/or limitation to achieving goals
d) Outstanding issues that should or need to be address
e) Reason of case closure

Case Managers may close a case for the following reasons:

a) Loss of health plan eligibility
b) Member moves out of county/health plan
c) Achievement of targeted ICP goals and documented outcomes
d) Family opts out of continuation of PWCP services
e) Unable to locate child/youth and their family after 3 documented attempts
f) The case manager determines that s/he is no longer able to provide appropriate PWCP services due unsafe (hostile, threatening, verbally abusive) situation, non-compliance, non-adherence to plan of care. This closure reason requires approval by the Pediatric Health Services Manager.

PWCP SERVICE LEVELS

Like the adult Case Management Program, the PWCP has the following service levels:

Basic Case Management is a component of comprehensive medical case management. The Primary Care Physician (PCP) generally provide these services. Therefore, enrollment into case management services is unnecessary. However, collaboration with the Health Plan may be necessary to facilitate services and achieve outcomes. Basic Case Management means a collaborative process of assessment,

planning, facilitation and advocacy for options and services to meet an individual's health needs. Basic Case Management includes:

- Initial health assessment of a child or youth by their primary care provider
- Identification of appropriate providers and facilities
- Direct communication between the provider and the child/youth's family
- Education on healthy lifestyles
- Coordination of specialty care services, carved-out services, and linkages to available resources

Comprehensive/Complex Medical Case Management includes the involvement of the PWCP team with care coordination for the child/youth and their family in collaboration with the PCP, specialist(s), and other health care or community-based providers to achieve outcomes. The PWCP team collaborates with these providers to:

- Coordinate medically necessary health care services
- Facilitate timely access to and/or continuity of care to specialty care and/or CCS providers
- Improve provisions of preventive services are met, in accordance with established standards and periodicity schedules, and coordinated with specialty care services

Comprehensive PWCP services may include health risk assessment, care planning, coordination, transition of care, referral, follow-up, and monitoring the appropriateness of services and resources required to meet the child/youth's health care needs are available.

PWCP ACUITY AND INTENSITY

The PWCP has three service levels. Children and youths in the PWCP are assigned one of three case management service (risk) levels: low risk (Lifestyle/Maintenance), moderate-risk (Monitored), or high-risk (Complex). Services under these levels are provided, facilitated, and/or coordinated by the PWCP team in collaboration with the child/youth's family and with participation from the PCP and other members of multidisciplinary team.

ACUITY AND INTENSITY LEVELS

Acuity and intensity levels are used to determine appropriate caseloads, case assignments, and staffing allocation. Acuity and intensity levels can fluctuate. As the child/youth's acuity or intensity of service changes, the PWCP service level may also change.

Please note that children or youth with a CCS condition(s) receive at least the minimal level (Level 1-Lifestyle/Maintenance) of case management services during the annual medical review period.

Acuity Levels are assigned based on the complexity of the case. The complexity of the case is determined by the risk of the child/youth's condition to deteriorate, the number of identified problems, concerns, or issues that need to be addressed and interventions that need to be completed to accomplish established goals. Goals for identified

problems, concerns, or issues should be realistic, agreed upon, attainable, and measurable. The intensity of service, such as the number of contacts and tasks necessary to address individual problems, concerns, or issues or accomplish interventions are currently not contributing factors in determining acuity level.

Level 1 (Lifestyle): One identified problem, concerns, issues, goals, interventions, or intensity level of 0-1

Level 2 (Monitored): Two identified problems, concerns, issues, goals, interventions, or intensity level of 2-3

Level 3 (Complex): Three or more identified problems, concerns, issues, goals, interventions, or intensity level of 4-5

Intensity Levels are assigned based on the number of anticipated contacts or tasks that are needed to accomplish interventions and goals. Contacts can occur with the child/youth and their family, the primary care provider, members of the multidisciplinary providers, etc. Tasks are specific pieces of work that are clearly defined, short in duration, and expected by an individual. The anticipated number of contacts and/or tasks during a specific time period determines the intensity level. Contacts are verbal or written communications. Telephonic or in-person. With the child/youth, their family, a member of the multidisciplinary team, specialized program, or community-based organization, local educational agency, mental health, etc. Intensity levels are noted below:

Level 0 = no more than 0-1 contacts/tasks per month

Level 1 = up to 4 contacts/tasks in a 2-month period

Level 2 = contacts/tasks are greater than 2 x month, not to exceed 4 x month

Level 3 = contacts/tasks average 1 x week in a 30-day period

Level 4 = contacts/tasks average 2 to 3 x week

Level 5 = contacts/tasks exceeds 3 x week

Mass (bulk) mailing of health-related materials is not considered a "contact" or "task" for a specific case.

LEVEL 1: Lifestyle (Maintenance) Case Management

Some children and youths have CCS or PWCP eligible conditions that are easily controlled, currently non-symptomatic, and/or effectively managed by the family and only need minimal assistance from the Plan to coordinate care. These children/youth are considered low-risk and in Level 1-Lifestyle/Maintenance case management services.

Services provided by the Lifestyle/Maintenance level include but are not limited to:

- Periodic mailings of health educational materials
- Infrequent communication with the child/youth's family and health care provider about medical and pharmacy claims
- Periodic assistance with non-emergency or non-medical transportation to covered services
- Help with getting PCP appointment or specialty follow up care
- Post-hospitalization outreach to the child/youth's family to ensure the correct follow-up care are scheduled and needed medical equipment are delivered

Children or youth assigned to this level have one identified problems, concerns, or issues that require interventions from the PWCP team. Generally, the family of these children and youths need limited assistances with navigating through the health care delivery system and/or obtaining necessary discharge, follow up, or transitional care services. Limited interactions with the family are needed. The child or youth is at low risk for complications. The child/youth's family may benefit from periodic health education materials.

The mode of communication in this level is telephonic or written.

Typical Level of Case Assignment:

- Acuity Level = 1. One identified problem, concern, issue, or intervention.
- Intensity Level = 0-1. No more than 4 contacts/tasks every two months. *Mass mailing or auto generated voice message distribution of educational materials are not used to determine an Intensity Level for an individual case*.

LEVEL 2: Monitored Case Management

Children or youths who have less complicated conditions, such as less severe and reasonably controlled asthma or diabetes but have a risk for developing other conditions or complications as their condition progresses, may benefit from ongoing monitoring and help with staying healthy. Case managers or care coordinators will track these children and youth's health status and their needs over a specific period of time. Encourage progress toward their health goals and periodically give their family health information about maintaining a healthy lifestyle.

Children and youths in Level 2 have chronic conditions that are at-risk for developing other conditions or complications. Services provided in Level 2 include all services in Level 1 and include at least one of the following:

- Routine monitoring of the child/youth's health status
- Re-assessment of the family's ability to manage the child/youth's condition
- Timely communication with providers and specialists about necessary preventive and specialty care services
- Review of medications and discussion with our clinical pharmacists
- Assistance with obtaining mental or behavioral health services

- Assistance with identifying and contacting community agencies and specialized programs

The mode of communication in this level is telephonic or written.

Typical Level of Case Assignment:

- Acuity Level = 2. Two identified problems, concerns, issues, or interventions
- Intensity Level = 1 through 3
  - 1 = up to 4 contacts in a 2-month period
  - 2 = contacts are greater than 2 x month, not to exceed 4 x month
  - 3 = contacts average 1 x week in a 30-day period

LEVEL 3: Complex Case Management

Level 3 is Complex Case Management. Level 3 include services provided in Level 1 and 2 and support Basic Case Management activities that are generally the responsibilities of the child/youth's PCP. These children/youths may have a newly diagnosed chronic condition, a worsening condition, or experienced a critical event that requires the extensive use of resources, and their families need help navigating the system to facilitate appropriate delivery of care and services.

In general, children and youths in Level 3 need:

- care transition from one care setting to another
- extensive care coordination
- timely and coordinated access to services that if delayed, increases the risk or worsens the child/youth's condition
- physical and mental health concerns concurrently addressed
- evaluation of suboptimal living arrangements or support systems

Level 3 services include but are not limited to:

1. Level 1 and 2 services
2. Support of the acute or chronic illness, including emotional and social support, and issues identified by the multidisciplinary team
3. Intense coordination of resources to ensure child/youth maintains or regains optimal health or improved functionality
4. The development of a collaborative child/youth-centered care plan that includes input from the child/youth's family and PCP. And is updated no less than annually
5. Assessment and facilitation of transitional care needs into and out of one level of care to another. Including, help with discharge planning, care coordination, and child/youth and family education when moving from a hospital to a lower level of care or to home

The mode of communication in this level is telephonic and written, and on a case-by-case basis, face-to-face, in-person.

Typical Level of Care Assignment:

- Acuity Level = 3. Three or more identified problems, concerns, issues, or interventions.
- Intensity Level = 1 through 5

    1 = up to 4 contacts in a 2-month period
    2 = contacts are greater than 2 x month, not to exceed 4 x month
    3 = contacts average 1 x week in a 30-day period
    4 = contacts average 2 to 3 x week
    5 = contacts exceed 3 x week

Conditions eligible for Complex (Level 3) Case Management include but are not limited to:

- Medical non-adherence (e.g., child/youth has missed two or more appointments, medication misuse or abuse, poor dietary adherence)
- High utilization of ED visits (e.g., two visits in three months)
- Children or youths who over/under utilize medical services that are available to them
- Frequent hospital admissions (same or different diagnosis) or readmissions (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes or asthma (e.g., four hospital admissions in one year)
- Psychosocial high-risk factors resulting in significant negative health outcomes
- Acute or escalating behavioral or substance abuse issues
- Extensive care coordination needs of a child/youth receiving medically necessary services in and out of the provider network, requiring benefit coordination, or receiving services with community-based organizations
- Unstable medical conditions that warrant close monitoring, such as uncontrolled diabetes, exacerbating asthma, recent traumatic brain injury or motor vehicle accident
- Complex or chronic medical condition, including those which affect multiple organ systems and/or which require ongoing complicated therapy (e.g., transplants, cancer, organ failure)
- Family with an enrolled child/youth who need assistances understanding and/or adhering to a particular medical regime (e.g., post-operative care, chemotherapy, dialysis)
- Children or youth requiring care coordination with specialized programs, such as Local Education Agency, Special Education, Regional Centers, County Mental Health, Substance Abuse, CCS Medical Therapy Program, etc.

DEPARTMENT STAFFING

The PWCP incorporate functions of care coordination and utilization management. The program consists of the following job classifications. Refer to the Human Resources Department's job descriptions for detailed descriptions of roles and responsibilities, knowledge, and education requirements.

1. Chief Medical Officer
2. Pediatric Medical Director
3. Director of Health Services
4. Pediatric Health Services Manager
5. Pediatric Health Plan Nurse Coordinator
6. Care Management Social Worker - Pediatric
7. Clinical Support Associate

DEFINITIONS

Pediatric Clinical Support Associate (aka: CSA) - Under the direction of a licensed staff, a CCS is a non-clinical individual who assists and works with child/youth's family to obtain necessary resources. This individual enters service and referral requests into the electronic database, provides information on community resources to family, assist the family with appointments and transportation, and provide reminder calls.

Pediatric Health Plan Nurse Coordinator (aka: case manager (CM)) - A registered nurse who help members navigate through the continuum of care. They assess, plan, facilitate, coordinate care, perform prospective, concurrent, and retrospective review, process service and referral requests, evaluate and advocate for options and services to meet a child/youth's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Individualized Care Plan- ICP is a comprehensive document that identify individualized and child-centered problems, planned inventions/tasks, and goals. Problems are identified based on the health survey findings, concerns of the child/youth and their involved caregivers and families. Interventions are targeted to address the associated problem and either a short or long-term goal is triggered.

Intervention- The act of intervening. For the purposes of determining intensity levels, an intervention is an action that needs to occur between an identified problem, issue, or concern and the goal. For example, form a collaborative care team to discuss expectations and goals, secure IHSS assistance for member, coordinate follow up appointment to non-contracted specialist, etc. These actions are not tasks, such as call dial-a-ride, make a PCP follow-up appointment.

Transition of Care (Care Transition)- The movement of a child/youth from one setting of care (hospital, ambulatory, primary care practice, ambulatory care practice, long-term care, home health, rehabilitation facility) to another, e.g., from home to group home or skilled nursing facility (SNF) or acute care to SNF.

REFERENCES

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3) American Case Management Association (ACMA) National Hospital Case Management Survey (2009)

4) California Legislative Information. Senate Bill 586. Retrieved on 11/9/16 from http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586

5) Case Management Society of America. What is Case Management? Retrieved on July 6, 2016 from http://solutions.cmsa.org/acton/fs/blocks/showLandingPage/a/10442/p/p-0003/t/page/fm/1

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8) Family Voices of California, SB 586 Redesign/Whole Child Model Key Points. Retrieved on 11/9/16 from http://www.familyvoicesofca.org/wp-content/uploads/2016/08/key-points.pdf