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Section I: Care Management Programs and Community Support Services

I1: Utilization Management

Our Utilization Management Program is overseen by the Chief Medical Officer, Medical Directors responsible for the utilization review process and qualified health services staff. Our Utilization Management Program helps members to get the best quality healthcare by assuring that medically necessary healthcare services are provided at the right time and at the most appropriate service level or care setting covered under their benefit package. We work with our providers to evaluate services for medical appropriateness and timeliness.

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

I2: Enhanced Care Management

Effective July 1, 2022, CenCal Health offers Enhanced Care Management (ECM) a new statewide Medi-Cal benefit available to selected "Populations of Focus" as part of CalAim's

multi year initiatives. ECM is designed to address the clinical and non-clinical needs of the highest-need Members through intensive whole person care coordination. ECM has a phased implementation approach based on Department of Health Care Services defined Populations of Focus (POF).

Phase 1: 7/1/2022

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

Phase 2: 1/1/2023

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

Phase 3: 7/1/2023

- Individuals Transitioning from Incarceration (POF 4)
- Children & Youth Populations of Focus (POF 7)

Phase 4: 1/1/2024

- Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes (POF 8)

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

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

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

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

Referring Members to Enhanced Care Management

Providers are welcome to refer members who may benefit from ECM. ECM Referrals can also be submitted by but not limited to members or their Authorized Representatives, Community and Government agencies. To submit a referral request for ECM, Click here, or call our Member Services Department at 1-877-814-1861. We ask that you please allow ten (10) business days to determine eligibility and assign an ECM provider for Member Outreach.

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

I3: Care Management (Complex and Care Coordination)

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

CenCal Health has five variations of care management services:

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

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

To learn more about ECM please see the CalAIM section of our website cencalhealth.org/providers/calaim/

To refer a member to any of our Care Management Programs, providers can complete and submit a Case Management Referral Form located at cencalhealth.org/providers/calaim/.

The completed referral form may be faxed to (805) 681-8260 or the provider can call the Health Services Central Line at (805) 562-1082, option # 2 to obtain assistance with referring a member.

The Case Management Department will acknowledge referral and providers will be informed of the member's appropriateness for CM services. Once CM determines a member is appropriate for case management services and the member or authorized

representative agrees to the service, CM will begin to work collaboratively with the member, the member's family, physician(s), and other healthcare professional(s).

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

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

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

- Have complex or chronic medical conditions, including those affecting multiple organ systems or complicated therapy that warrant closer monitoring (e.g. CHF, uncontrolled diabetes, transplants, cancer, exacerbating asthma, ESRD or COPD),
- Have suffered a traumatic/ catastrophic injury or illness.
- Is non-adherent to medical or treatment regimen (e.g., two or more missed appointments, misuse of medications, poor dietary adherence).
- Are high utilizers of EDs (e.g., two visits in three months).
- Over/under utilize medical services that are available to them.
- Have frequent hospital admissions (same or different diagnosis) and readmissions. (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year).
- Need coordination of care for medically necessary services outside of the provider network.
- Require assistance following a particular medical regimen (e.g., pre-surgical). Have self-care deficits requiring one-to-one or group health education to promote well- being.
- Have high psychosocial risk factors that have or can result in significant negative health outcomes.
- Assistance with coordination to community resources (e.g. Food Bank, Meals on Wheels, Family resource Centers, and/or Unity Shop)
- Members with fragile conditions, including cognitive changes needing assistance with care coordination or care transitions.
- Require care coordination with specialized programs, such as Local Education Agency, Regional Centers and County Mental Health.

- Members who need transition from one care setting to another (e.g. from acute care facility to skilled nursing facility (SNF), SNF to home or other alternative living situations, home to SNF, and non-contracted to Contracted SNF)

CenCal Health's Care Management (CM) services are provided by Care Managers that consist of registered nurses, social workers, and clinical support associates via telephone. Care Management services are offered available to all members, both adult and pediatric members. Care management programs vary depending on the needs of the member. Please reference Section I2 Enhanced Care Management of the Provider Manual for more information.
CenCal Health's Case Management program includes:

- Conducting Member Assessments to identify and close any gaps in care and address the Member's physical, mental health, SUD, developmental, oral health, dementia, palliative care, chronic disease and LTSS needs as well as needs to SDOH.
- Complete a person centered care management plan for all members in consultation with the member to include addressing the members health and social needs including needs due to SDOH.
- Support and ensure access to all needed services and resources across physical and behavioral health systems.
- Provide referrals to community based social services and other resources outside of Member's MediCal benefits.
- Ensure continuous information sharing and communication with the Member and treating providers.
- Ensure Members receive all Medically Necessary services, including Community Supports to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH.
- Provide Closed Loop Referrals to Community Health Workers, peer counselors, and other community based social services.
- Facilitate and encourage the Member's adherence to recommended interventions and treatment.
- Ensure timely authorization of services to meet the Member's needs in accordance with the Members Case Management Plan.

A Care Manager will work with the Provider, the member and the member's family in an effort to help Member's gain or regain optimum health or improved functional capability in the right setting. The Care Manager will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury.

I4: Care Transitions

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

program is to improve transitions of care for our members by improving quality of care and avoid preventable readmissions.

The Care Transition team will collaborate with the facility staff and/or Member family/caregiver to facilitate the transition of care and ensure member is receiving care at the right setting and receives the necessary services upon discharge.

The Member's assigned Care Manager (e.g., Complex or Enhanced Care Management) will;

- Review the member's current condition and needs
- Assist the facility with preparing and educating the member about the care transition process, coordinating discharge plans, monitoring discharge planning activities, and determining the necessity of:
    - Alternative short and/or long-term living arrangements or placement efforts
    - Home care needs such as home health visits, DMEs, or medical supplies
    - Linkages to alternative financial and community resources available to the member such as adult day care, IHSS, MSSP, Recuperative Care, senior centers, meal delivery, waiver programs, etc.
    - Follow up visits with primary care providers and as appropriate, specialty care providers

- Contact community-based organizations and housing agencies as necessary
- Ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge.
- Follow up with the member post-transition from the SNF, ICF or CLHF stay for a minimum of two months or longer depending on the members need.

I5: Pediatric Whole Child Model

The Pediatric Whole Child Program has dedicated nurses and nonclinical professionals who assist providers with timely processing of necessary specialty referrals and service requests, as well as provide care coordination and care transition services to members. The Pediatric Program is designed as a "one-stop shop" for providers to obtain covered services for children and youth under the age of 21. The Pediatric team is comprised of a group of specialized staff who perform both utilization review and case management activities. Similar to CenCal Health's Adult Case Management Program, pediatric care coordination and care transition services are dependent on active family and/or caregiver participation.

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

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

Providers can refer a child or youth under the age of 21 to the Pediatric Whole Child Program case management the same way they would refer an adult to case management

or care transitions. Complete a CM Referral Form found at www.cencalhealth.org, under the Provider tab. Authorization requests (50-1, 18-1, 20-1) and referrals (RAF) are also submitted the same way as for adults, via the Provider Portal.

I6: Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations, and CenCal Health has elected to offer some Community Support services.

Community Supports are optional services for CenCal Health to offer and are optional for members to receive. As of January 1, 2023, CenCal Health offers the following

Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals
- Sobering Center
- Recuperative Care

Care Management Services

Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers, if they have appropriate experience.

Members Eligible to Receive Community Supports

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

Making a Referral for Community Supports

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

Community Supports Authorizations

Authorization through CenCal Health is required for members to obtain Community Supports. CenCal Health staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, the required Information and Referral form associated to that specific Community Supports service,

completion of a Member Care Plan by the ECM Provider (if receiving ECM services), and decision-making by CenCal Health. If approved after CenCal Health's assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime.

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

I7: Community Health Worker

Community Health Worker (CHW) services became a Medi-Cal benefit on July 1, 2022. CHW services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Importantly, CHW services provide a mechanism for the delivery of equitable and culturally competent care for CenCal Health members which align with CenCal Health's Population Health Management program. CenCal Health covers CHW services for members that meet criteria in accordance with CenCal Health Policy and DHCS requirements.

CenCal Health will use data-driven approaches to determine and understand populations who should be prioritized for CHW services using social determinant of health data, population health management risk stratification data, utilization data, and input from local providers. Generally, CenCal Health Members are eligible for CHW services if the following criteria are met:

- The presence or risk of one or more chronic conditions or environmental health exposure;
- Exposure to violence or trauma;
- The presence of barriers in meeting health needs; or
- The presence of a need which will benefit from the provision of those preventive care services provided by CHWs.

Additional detail regarding member eligibility for CHW services can be found in DHCS All Plan Letter 22-016:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf

Those individuals wishing to provide CHW services must meet certain qualification requirements. Those requirements include:

- Lived experience that aligns with the Member or population being served
- Professional certification **or** work experience of at least 2,000 hours in the past 3 years

Formal CHW certification, if not present, is required within 18 months of becoming a contracted CHW. Additionally, an annual 6 hours of ongoing training is required for all CHWs. All CHWs must be supervised by an organization or provider who holds responsibility for ensuring that CHWs meet all training and ongoing education requirements. It is this supervising provider or organization who will contract with CenCal Health and bill for CHW services, and will submit to CenCal Health a roster of all CHWs providing services to CenCal Health Members. CenCal Health will verify that all applicable requirements are met during the Contracting and Credentialing process.

CHW services require a Treatment Authorization Request (TAR) from a licensed practitioner. Services are recognized in 30-minute units, and the first 12 units (6 hours) are auto-approved through the initial TAR. For requests in excess of the initial 12 units, a written Care Plan is required and must be submitted to CenCal Health. The Care Plan must be:

- Written by one or more individual licensed providers (does not need to be the Supervising Provider);
- Clear regarding the objectives of continued CHW services to address the Member's condition, including the services required; and
- Reviewed every six months.

Required Care Plan components include:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Other health care professionals providing treatment for the condition or barrier;
- Written objectives that specifically address the recipient's condition or barrier affecting their health;
- The specific services required for meeting the written objectives; and
- The frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

Additional information regarding the provision of CHW services can be found in CenCal Health's Community Health Worker policy, available to providers upon request.