Quality Improvement Health Equity Committee (QIHEC) Report

Date: January 17, 2024

From: Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, Quality Improvement & Health Equity Committee (QIHEC) Chairperson

Through: Marina Owen, Chief Executive Officer

Contributors: Carlos Hernandez, Quality & Population Health Officer
Van Do-Reynoso, PhD, Chief Customer Experience Officer & Chief Health Equity Officer

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Executive Summary

This is CenCal Health's QIHEC report to your Board, including information about the committee's proceedings for its 4th quarterly meeting of 2023, completed on December 14th, 2023.

This report summarizes key topics reviewed by the QIHEC as your Board's appointed entity accountable to oversee the effectiveness of CenCal Health's Quality Improvement & Health Equity Transformation Program (QIHETP).

The QIHEC's recent proceedings included the following actions:

- Approval of August 24, 2023, QIHEC minutes.
- Approval or acceptance of reports from the Pediatric Clinical Advisory Committee, Pharmacy & Therapeutics Committee, Customer Experience Committee, Utilization Management Committee, and Credentialing Committee.
- Approval of:
    - Follow-up items including a CCS/TCRC performance analysis age group stratification, an analysis of possible causes of low inpatient average length of stay (ALOS), and tonsillectomy utilization; and confirmation of the closed or open status of additional follow-up requests.
    - 2023 Risk Scoring & Stratification Analysis of Racial, Ethnic, and other Potential Algorithmic Biases.
    - QIHETP Work Plan Update, with focus on Well Child Visit Performance Improvement Project – 15 Months of Age.
    - Quality Dashboard of key performance indicator results.

- Key Performance Metrics, which demonstrate cross-functional QIHETP integration of Utilization Management, Access and Availability, and Member Grievance operations.

- Approval of fourteen QIHETP & Related Program Policies (Attachment 1: provided for your Board's consideration and recommended approval).

The QIHEC's approval of the action items listed above included consideration by contracted network physicians and other representatives that are required members of the QIHEC.

Background

Your Board, as CenCal Health's governing body, is required to participate in CenCal Health's Quality Improvement System as follows:

1. *Appointment of an accountable entity within CenCal Health to oversee the effectiveness of the Quality Improvement and Health Equity Transformation Program (QIHETP).*

   This responsibility was completed with your Board's March 2023 approval of CenCal Health's QIHETP Program Description. Your approval affirmed your Board's appointment of the QIHEC as its accountable entity to oversee quality improvement and health equity activities. The QIHEC, chaired by the Chief Medical Officer in collaboration with the Chief Health Equity Officer, is accountable for overseeing the QIHETP's effectiveness and organization-wide quality improvement.

2. *Annual approval of the overall QIHETP, annual Work Plan, and Work Plan Evaluation.*

   This responsibility was completed with your Board's March 2023 approval of CenCal Health's QIHETP Program Description, Quality Program Work Plan Evaluation of performance for the prior year, and the current year's QIHETP Work Plan. These documents detail CenCal Health's achievements and goals for continued improvement during the coming year. They define the structure of CenCal Health's QIHETP and responsibilities of entities and individuals within CenCal Health that support improvement in quality of care, patient experience, and safety. They also demonstrate CenCal Health's investment of resources to ensure continuous improvement. The QIHEC oversees quarterly updates to ensure the effectiveness of the current QIHETP Work Plan.

3. *Review of written progress reports from the QIHEC describing actions taken, progress in meeting QIHETP objectives, improvements made, and directing*

necessary modifications to QIHETP policies and procedures to ensure compliance with quality improvement and health equity standards.

This memorandum represents your Board's report on the quality committee's recent proceedings for its 4th quarterly meeting of 2023, and includes QIHETP and related policies for your consideration, direction, and approval. This report fulfills your Board's responsibility to review written progress reports from the QIHEC.

After each quarterly meeting of the QIHEC, staff present your Board with approved minutes of the QIHEC's proceedings to assure the full scope of QIHEC activities is available for your Board's awareness. Additionally, each quarterly report will include policies reviewed and approved by the QIHEC, for your Board's further consideration, direction, and approval.

In total, this report includes the summary of recent QIHEC proceedings detailed above, and the following three attachments:

1. QIHETP & related program policies reviewed and approved by the QIHEC.
2. The meeting agenda for the recent QIHEC meeting.
3. The meeting minutes of the former QIHEC, which were approved at the recent meeting of the QIHEC.

The policies reviewed by the QIHEC provide details about CenCal Health's QIHETP program structure and related processes to ensure the effectiveness of the QIHETP. The QIHEC's engagement in this policy review enabled valuable feedback and direction from the QIHEC to meaningfully direct the effective administration of CenCal Health's QIHETP.

CenCal Health staff and DHCS have confirmed that the policies reviewed by the QIHEC comply with all DHCS quality improvement and health equity standards. The QIHEC's approval of the attached policies serves as the QIHEC's recommendation for your Board's approval, as the entity appointed by and accountable to your Board.

Next Steps

The proceedings of future quarterly QIHEC meetings will be reported to your Board after each meeting of the QIHEC, to fulfill the progress reporting responsibilities described above. Subject to your Board's approval, staff will complete implementation of the attached QIHETP policies.

Recommendation

Staff recommends your Board accept this progress report, and provide additional direction if warranted, based on the attached policies and other content that was evaluated and approved by the QIHEC.

Acceptance of this report includes approval of the QIHETP and related policies provided for reference as Attachment 1.

Attachments:

- Attachment 1 – QIHETP & Related Policies (qty. 14)
- Attachment 2 - QIHEC Meeting Agenda, December 14, 2023
- Attachment 3 - QIHEC Approved Minutes, August 24, 2023

Attachment 1: QIHETP & Related Policies

QIHETP & Related Policies and Procedures for QIHEC Approval & Adoption	Effective Date	Contract Reference
1. Translation of Written Materials	February 2017	R.0056
2. Access to Linguistic and Interpreter Services	May 2018	R.0158
3. Cultural and Language Access	June 2018	R.0056
4. Alternative Format Selection Process	July 2022	R.0158
5. Provider Directory Creation and Maintenance	January 2023	R.0166
6. Ensuring EPSDT Screening, AAP Bright Futures Under 21	January 2023	R.0061
7. Community Advisory Board	January 2024	R.0195
8. Provider Credentialing and Recredentialing	January 2024	R.0045
9. Vaccines for Children Program	January 2024	R.0058
10. Identification, Referral, and Care Coordination for NSMHS, SMHS, SUD	January 2024	R.0061
11. Early and Periodic Screening, Diagnostic and Treatment Services EPSDT	January 2024	R.0061
12. Provider to Member Ratios	January 2024	R.0178
13. External Quality Review Organization Requirements	January 2024	R.0043
14. Credentialing Systems Control and Oversight	February 2024	NCQA CR1

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Translation of Written Member Materials	**Policy No. :** MS-30
Department: Member Services	
Cross Functional Departments: N/A	
Effective Date: 02/2017	**Last Revised Date:** 03/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Eric Buben Director of Member Services	**Officer Signature and Date:** Van Do-Reynoso, MPH, PhD Chief Customer Experience & Health Equity

I. Purpose:

To define appropriate protocols and procedures for translation of vital documents and other Member materials for identified threshold language(s) for Limited English Proficiency (LEP) Members that are consistent with the mandated requirements. These are but not limited to, Executive Order 13166, the Language Assistance Guidelines, Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) 1300.67 and, (Title 28) of the California Code and Federal Health and Human Services guidelines. CenCal also provides Alternative Format Selections as outlined in All-Plan Letter (APL 22-002).

II. Policy:

A. CenCal Health has established an internal document translation process and a "translation team" of staff members, who are certified in Spanish written translation to translate CenCal Health Member materials into the threshold language which has been identified as Spanish.

B. CenCal Health accommodates Alternative Format Selections (AFS) for Members and Authorized Representatives (ARs). For AFS and the process for how CenCal Health ensures AFS are completed and distributed, please refer to CenCal Health's policy and procedure: MS-33 – Alternative Format Selection Process.

C. The above processes and services are offered to support all LEP Members in the delivery of Covered Services, including without limitation, Members less than 21 years of age.

III. Procedure:

A. All of CenCal Health's Member materials are translated into Spanish which is CenCal Health's only threshold language in our two counties of service, Santa Barbara and San Luis Obispo. Translation of documents are coordinated by the Translation Coordinator who is responsible for

the coordination of all translated documents, the accuracy and cultural appropriateness of the document.

B. The translation team consists of team members that have their writing competency evaluated by an outside qualified State of California certified evaluator who has attested to the competency of the translation team's written skills.

C. Translated documents are evaluated for:
   1. accuracy of translation (evaluates whether the Spanish translation accurately reflects the original English message); contains appropriate grammar, syntax;
   2. cultural and linguistic appropriateness (transposition of thoughts expressed by one language and by one social group into the appropriate expression of another social group);
   3. culturally transposition of translated document (cultural decoding, recoding and encoding to ensure credibility for the reader);
   4. readability (ability of targeted audience to be able to comprehend intended message using idioms and slang, vernacular); and
   5. clarity and conciseness of translation, and literacy to assess whether the translated material is at the appropriate literacy level of the target audience (recommended 6th grade.)

D. The Translation Team members must receive a score of 80% or higher on their Language Assessments to provide written or verbal translation in Spanish for CenCal Health. See more information about staff language assessments in CenCal Health policy & procedure: MS-31_Cultural and Language Access Program.

E. CenCal Health translates all informing materials, which are vital documents that provide Members with essential information about access to and usage of Plan services. These are documents such as Evidence of Cover/Member Handbooks, Member rights and grievance information, new Member packets, and provider directories (for a full list of vital documents see APL 18-016 and APL 21-004). All such informing materials and vital documents must be current and approved by DHCS prior to distribution to Members.

F. CenCal Health translates all health education materials into its threshold languages automatically (currently, only Spanish), which are designed to modify personal behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including updates on current health conditions, self-care, and management of health conditions.
   1. Examples of these documents include messages about preventive care, health promotion, screenings, disease management, healthy living and healthy communications.

2. These documents can be approved by CenCal Health after going through the internal review process overseen by the Plan's Health Educator.
3. CenCal Health complies with APL 18-016, which sets forth the requirements for Health Education Materials.
4. For its non-threshold languages which are infrequently used, CenCal Health offers oral translation of the information requested through our voice-only or our VRI interpreter services through Certified Languages International (CLI) when requested by Member, or coordinates with a vendor of written translation services for our non- threshold languages when the written documentation is preferred.

G. All translated documents are logged in a Translation Log and acted upon fully and immediately for translation. The log contains the following data fields: date of translation request, name of person and/or department requesting translation, name of document, name of translator, name of reviewers, name of editor, number of words, and cost (cost is tracked only as a method to determine cost savings.)

H. All procedures above are maintained to ensure that verbal and written translations are monitored and evaluated for propriety and support the delivery of Covered Services to LEP Members, including without limitation, those under 21 years of age. Feedback relating to translation services is obtained by the Community Advisory Board (CAB) and through the Plan's Member and family engagement. Such feedback is utilized to update cultural and linguistic policy and procedure and improve the services that support the delivery of Covered Services to Members, including those less than 21 years of age. The processes describing how feedback is obtained and how it is incorporated into policy and decision-making are further described in CenCal Health policies MS-XXX - Community Advisory Board, and MS – XXX – Member and Family Engagement.

IV. Definitions:

All Plan Letter (APL) or **Policy Letter (PL):** a binding document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Covered Services: Health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*., 22 CCR section 51301 *et*

seq., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, CenCal Health's contract with DHCS, and APLs that are made the responsibility of the CenCal Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Health Educator: an individual on staff at CenCal Health to assess and approve written health education materials. The Health Educator must have one of the following qualifications: (i) Master of Public Health (MPH) degree with a specialization in health education or health promotion, from a program of study accredited by the Council on Education for Public Health, sanctioned by the American Public Health Association; or (ii) MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc. Individuals who do not meet either requirement may not approve of written health education materials for the Plan, unless approved by DHCS in accordance with APL 18-016.

Health Literacy: The ability to read, understand, and act on health care information. CenCal Health is required to provide Member information in a low literacy format.

Limited English Proficiency (LEP): an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor's employees.

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Potential Member or Potential Enrollee: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

Threshold Language: threshold Languages in each county are designated by the Department of Health Care Services. These are primary languages spoken by Limited English Proficiency (LEP) population groups meeting a numeric threshold of 3,000 or 5% of the eligible beneficiaries residing in a county, whichever is lower. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county whose main concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes are also considered threshold languages for a county.

V. References:

A. DHCS 2024 Contract: Exhibit A Attachment III Section 5.2.10 Access Rights and 5.2.11 Cultural & Linguistics Program and Committees
B. NCQA: National Committee for Quality Assurance (NCQA) "Surveyor Guidelines for the Accreditation of Managed Care Organizations," Standard Members' Rights and Responsibilities
C. Department of Health Care Services Contract: 08-85212
D. DHCS All-Plan Letter 22-002: Alternative Format Selection for Members With Visual Impairments
E. DHCS All-Plan Letter 21-004 (REVISED): Standards for Determining Threshold Languages, Non-Discrimination Requirements, and Language Assistance Services
F. DHCS All-Plan Letter 18-016: Readability and Suitability of Written Health Education Materials
G. DHCS All-Plan Letter 21-004: Standards for Determining Threshold Languages, Non-Discrimination requirements, and Language Assistance Services
H. Senate Bill 223: Atkins. Health care language assistance services
I. Senate Bill 1423: Hernandez. Medi-Cal: oral interpretation services
J. Americans with Disabilities Act (ADA)
K. Section 504 of the Rehabilitation Act GOV 11135
L. Title 28: California Code of Regulations, 1300.67.04 Language Assistance Guidelines
M. Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) 1300.67
N. Executive Order 13166
O. HIPAA Notice of Privacy Practices 164.520(b)

VI. Cross Reference:

A. Policy and Procedures (P&P):
   1. MS-31 – Cultural and Language Access
   2. MS-32 – Delivery of Interpreter Services
   3. MS-33 – Alternative Format Selection Process

B. Standard Operating Procedure (SOP):
   1. MSSOP-012 – Translation Request Process

C. Program Documents:
   1. N/A

VII. Attachments:

A. N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
10/2023		Checked-Out for 2024 Integration		
02/2023	Van Do-Reynoso, Eric Buben	Policy revised to align with 2024 DHCS Contract Amendment requirements for R.0056, and moved to new P&P Template.	1/1/2024	TBD
09/2022	Eric Buben, Chris Morris	Policy revised to align with 2024 DHCS Contract Amendment requirements for Deliverables R.0157, R.0188 and R.0189.	1/1/2024	10/30/2022
09/2021	Eric Buben	Policy updated per APL 21-004 requirements.	Immediately	2021
10/2020	Eric Buben	Reviewed per Annual Review Instructions.		
01/2020	Eric Buben	Revised paragraph discussing vital documents to be more inclusive of example of vital documents and the need to have these approved by DHCS. Also added a section about Health Education Materials and		

		examples of these and that these can be approved internally when the Plan's Health Educator has reviewed. Referenced APL 11-018_Readability and Suitability of Written Health Education Materials for requirements for developing, translating and approving both vital documents and Member education materials. DHCS Contract Manager requested P&P update to include the Plan's adherence to contract language of providing a TTY Machine for the hard of hearing/deaf membership. Language inserted into P&P including CenCal Health's TTY number.		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Access to Linguistic and Interpreter Services	**Policy No. :** MS-32
Department: Member Services	
Cross Functional Departments: Health Services, Behavioral Health	
Effective Date: 05/2018	**Last Revised Date:** 03/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Eric Buben Director of Member Services	**Officer Signature and Date:** Van Do-Reynoso, MPH, PhD Chief Customer Experience & Health Equity Officer

I. Purpose:
To ensure communication access to Members in alternative formats or through other methods that provide effective communication, including: assistive listening systems, American Sign Language interpreters, captioning, written communication, electronic format, plain language or written translations, and oral interpreters.

II. Policy:

A. CenCal Health ensures equal access to the provision of high-quality interpreter and linguistic services for Limited English Proficient (LEP) Members and Potential Members, and for Members and Potential Members with disabilities.

B. CenCal Health ensures that Deaf or Hard of Hearing, monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact. Key points of contact include medical care settings, such as telephone, advice and urgent care transactions, and outpatient encounters with providers; and non-medical care settings, such as Member Services, orientations and appointment scheduling.

C. CenCal Health ensures that any lack of interpreter services does not impede or delay a Member's timely access to care.

D. In relation to the provision of Covered Services, CenCal Health offers the following linguistic services to Members at no cost:

1. Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD) services for Members with hearing impairments;

2. Oral interpreters, sign language interpreters, or bilingual providers;
3. Full and immediate translation of written material;
4. Referrals to culturally and linguistically appropriate community service program; and
5. Auxiliary Aids.

E. The services described above are offered to all Members who require communication access or assistance in the support and delivery of Covered Services, including without limitation, Members less than 21 years of age.

III. Procedure:

A. CenCal Health's demographic population analysis indicates that the Plan's only Threshold Language is Spanish, following Threshold Language guidance provided by DHCS. Accordingly, CenCal Health call center staff are bilingual in English and Spanish. There are also providers in-network who offer bilingual services through office staff personnel. For LEP Members who speak languages other than English and Spanish, CenCal Health offers the interpreter services described below.

B. Interpreter Services.
   1. Interpreter Network.
      a. CenCal Health has developed an interpreter network of "face to face" interpreters for American Sign Language and Spanish to meet the established criteria for the Plan's Member population. CenCal Health interpreters are independent contractors working directly with the Cultural and Linguistic Services Manager to coordinate and schedule face- to-face interpreter services for Spanish and ASL requests. All independent contractors have a signed Business Associate Agreement (BAA) with the Plan. Additionally:
         1. Scheduling is required for all face-to-face interpreting services;
         2. A minimum of 5 days is required for all standard (non-urgent) Spanish and American Sign Language (ASL) requests;
         3. Urgent requests can be submitted at any time, however, in the event a face-to- face interpreter is not available, CenCal Health recommends the use of a telephonic interpreter.

      b. CenCal Health contracted interpreters are evaluated by the Plan's Cultural & Linguistic Services Manager who received certification for Spanish interpretation from the National Board of Certification of Medical Interpreters. Contractors are evaluated for their proficiency in

both English and Spanish, knowledge in both languages of healthcare terminology, and concepts relevant to healthcare delivery systems. They must have training and education in interpreting ethics, professional conduct, and confidentiality.

c. CenCal Health also contracts with a telephonic vendor, Certified Language International (CLI), that offers over 230 languages for oral interpretation to CenCal Health's network providers as well as its LEP population. CLI provides the following services:
   1. Telephonic access to interpreter services to CenCal Health staff and its provider network for LEP Members 24/7. Examples include Members needing assistance with CenCal Health call center services such as benefit questions, transportation, pharmacy, PCP selection and reselection, and grievance and appeals.
   2. Video Remote Interpreting (VRI) services to LEP Members in 22 languages for face-to-face interpreting via video remote access in the physician's office (by connecting a live interpreter on camera from CLI's network with the provider and Member in the physician's office), inclusive of sign language VRI services.

2. Member Access. Members needing language assistance services (including ASL), can access these services by calling the toll free Member Services telephone number that is listed in the Member's Evidence of Coverage/Member Handbook, newsletters, flyers, informational brochures, new Member welcome letters and on CenCal Health's website at www.cencalhealth.org. Hard of Hearing and Deaf Members needing interpretation services can coordinate the service through the Plan's Cultural and Linguistic Services Manager (additional information on Section 4, below).

3. Provider Access. Physician(s) needing interpreter services can request the service by (i) contacting the Plan's Member Services Cultural and Linguistic Services Manager, who arranges an interpreter for the Member/physician for those instances requiring face-to-face interpretation; or (ii) calling CLI's toll-free telephone number for assistance in the language needed for the Member by providing the CenCal Health client code or via CLI's website portal 24-hours a day, 7days a week. This contact information is found in the Provider Manual (available on CenCal Health's website), newsletters, flyers, informational brochures, and also discussed at the Health Plan sponsored training sessions for the Plan's provider network. At the provider's request an instruction sheet will be provided with a step-by-step process.

4. ASL; Auxiliary Aids; Alternative Formats. Members and Potential Members will be offered, at no cost, Auxiliary Aids such as TTY/ TDD, qualified American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats.
    a. CenCal Health provides Deaf and Hard of Hearing Members the CA Relay information in the Member Evidence of Coverage/Member Handbook, the language assistance taglines document (inserted in all Notice of Action (NOA) and Notice of Appeal Resolution (NAR) letters), and the CenCal Health website.
    b. CenCal Health offers TDD/TTY that is housed in the Member Services Department. The call center manager and two supervisors are assigned to provide responses/communication with any Members using this service for interpreter or translation requests, or any other assistance sought. CenCal Health's TTY number is 1-833-556-2560.
5. Captioning; Translations. CenCal Health provides captioning in Threshold Languages (Spanish), or an alternative format if requested, for video materials. or provides for fully translated videos in Spanish for website use and on social media.

C. Feedback relating to the linguistic and interpreter services addressed in this policy is obtained by the Community Advisory Board (CAB) and through the Plan's Member and family engagement. Such feedback is utilized to update cultural and linguistic policy and procedure and improve the services that support the delivery of Covered Services to Members, including those less than 21 years of age. The processes describing how feedback is obtained and how it is incorporated into policy and decision-making are further described in CenCal Health policies MS-40 - Community Advisory Board, and MS–41 – Member and Family Engagement.

IV. Definitions:

All Plan Letter (APL) or Policy Letter (PL): a binding document issued by DHCS that provides clarification on CenCal Health's contractual obligations, implementation instructions due to changes in State or federal law or regulation or judicial decisions. Guidance pursuant to an APL or PL requires Plan's compliance and maintains regulatory force and effect.

Covered Services: Health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*., 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, CenCal Health's contract with DHCS, and APLs that are made the responsibility of the CenCal Health pursuant to the California

Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Deaf: having a hearing loss of such severity that communication and learning is primarily by visual methods (i.e., manual communication, writing, speech reading (lip-reading), and gestures).
Hard of Hearing: having some degree of hearing loss ranging from mild to profound.

Limited English Proficient: an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor's employees.

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Potential Member or Potential Enrollee: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

Threshold Language: Threshold Languages in each county are designated by the Department of Health Care Services. These are primary languages spoken by Limited English Proficiency (LEP) population groups meeting a numeric threshold of 3,000 or 5% of the eligible beneficiaries residing in a county, whichever is lower. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county whose main concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes are also considered threshold languages for a county.

V. References:

A. DHCS 2024 Contract: Exhibit A, Attachment III, Section 5.2.10 Access Rights
B. Civil Rights Act, 1964 – Title VI, Executive Order 13166
C. Language Assistance Guidelines, Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) 1300.67 and (Title 28) California Code of Regulations, 1300.67.04 Language Assistance Guidelines of California Code and Federal Health and Human Services
D. Department of Health Care Services Contract: 08-85212
E. DHCS All-Plan Letter 21-004: Standards for Determining Threshold Languages, Non-Discrimination requirements, and Language Assistance Services
F. Senate Bill 223: Atkins. Health care language assistance services
G. Senate Bill 1423: Hernandez. Medi-Cal: oral interpretation services

H. American with Disabilities Act (ADA)
I. Section 504 of the Rehabilitation Act
J. GOV 11135
K. HIPAA Notice of Privacy Practices 164.520(b)
L. Welfare & Institutions Code Section Section 14029.91

VI. Cross Reference:

A. Policy and Procedures (P&P):
   1. MS-31 – Cultural & Language Access
   2. MS-40 – Community Advisory Board
   3. MS-41 – Member & Family Engagement

B. Standard Operating Procedure (SOP):
   1. MSSOP-013 – Interpreter Request Process
   2. MSSOP-014 – Auditing of CLI and Interpreter Invoicing
   3. MSSOP-015 – ASL and Spanish Interpreter On-Boarding Process
   4. MSSOP-049 – Certified Languages

C. Program Documents:
   1. N/A

VII. Attachments:

A. N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
02/2023	Van Do-Reynoso, Eric Buben	Policy revised to align with 2024 DHCS Contract Amendment requirements for R.0056, and moved to new P&P Template.	1/1/2024	TBD
Revision 2023				
09/2022		Policy revised to align with 2024		

		DHCS Contract Amendment requirements.		
09/2021		Policy updated per APL 21-004 requirements.		
10/2020		Updated to reflect new, face-to-face, Video Remote interpreting availability through Certified Languages International for LEP Members in 22 languages. Also minor typos corrected for annual review process.		
01/2020		DHCS Contract Manager requested P&P update to include the Plan's adherence to contract language of providing a TTY Machine for the hard of hearing/deaf membership. Language inserted into P&P including CenCal Health's TTY number.		
06/2019		Moved to new P&P Template only.		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Cultural and Language Access to Services Program	**Policy No. :** MS-31
Department: Member Services	
Cross Functional Departments: Provider Services, Quality	
Effective Date: 06/2018	**Last Revised Date:** 03/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Eric Buben Director of Member Services	**Officer Signature and Date:** Van Do-Reynoso, MPH, PhD Chief Customer Experience & Health Equity Officer

I. Purpose:

To ensure CenCal Health's compliance and commitment to its Limited English Proficient (LEP) membership with their language needs for improved health care services. This policy also provides for the cultural sensitivity awareness of all CenCal Health staff and specific training and in-service for staff interacting directly with Members who may be LEP, low literacy, have diverse cultural and ethnic backgrounds, or disabilities, including Members identified as Seniors and Persons with Disability (SPD), regardless of gender, sexual orientation or gender identity.

II. Policy:

A. CenCal Health supports the delivery of covered services to Members by maintaining and continually monitoring, improving, and evaluating cultural and linguistic services to all Members. In keeping with its mission of "providing access to high quality medical services," and to fulfill its obligations, CenCal Health provides access to language services for its LEP Members, including those less than 21 year of age and to parents/caregivers of minor Members, with 24-hour interpreter services at all key points of contact with staffing and by interpreters, and telephone language services as follows:

1. Staffing the Member Services Department Call Center and other direct Member contact positions with bilingual/bicultural staff in the threshold language(s).

2. Providing access to independent contractors in Santa Barbara and San Luis Obispo counties to interpret for CenCal Health LEP Members at monolingual provider's offices.

3. Reviewing and updating (when applicable) the cultural and linguistic programs offered by CenCal Health to align with CenCal Health's Population Needs Assessment.

4. Ensuring the cultural and Health Equity linguistic programs offered by CenCal Health's contractors and sub-contractors align with CenCal Health's Population Needs Assessment.

5. Creating a formal process of evaluating and tracking the linguistic capability of bilingual staff, contracted staff (clinical and non-clinical) and contracted interpreters.

6. Contracting with a telephonic interpreter vendor to provide interpreter services 24/7 to CenCal Health Members that speak languages other than English.

7. Ensuring that LEP Members are notified in their materials that interpreter services are available at no cost to the Member.

8. Establishing formal procedures for accessing Interpreter Services and translation of Member materials in the threshold language.

9. Use of National standards for Culturally and Linguistically Appropriate Services (CLAS) for reference.

10. No cost access to the following linguistic services:

    a. Oral interpreters, sign language interpreters, or bilingual providers
    b. Full and immediate translation of written material
    c. Referrals to culturally and linguistically appropriate community service program
    d. Auxiliary Aids

11. CenCal Health does not discriminate on the basis of any characteristic protected by federal or state non-discrimination law as outlined in All Plan Letter (APL) 21-004. This includes, without limitation, sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. CenCal Health is subject to federal requirements contained in the Americans with Disabilities Act

(ADA), including standards for communicating effectively with people with disabilities to ensure they benefit equally from government programs. CenCal Health ensures compliance with the ADA through the procedures noted in this policy, as well as the policies and procedures of MS-30 - Translation of Written Member Materials, MS-32 - Delivery of Interpreter Services, MS-33 - Alternative Format Selection Process, and MS-22 – Member Grievances.

12. CenCal Health ensures non-discrimination and equal access to the provision of high-quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities in accordance with APL 21-004, federal and State law.

III. Procedure:

A. CenCal Health's Cultural and Language Access Services Program:

1. Meets the needs of its LEP Members by following the U.S. Department of Health and Human Services (DHHS) guidelines, Title VI of the Civil Rights Act (Executive Order 13166), Title 28, Section 1300.67.04, the American Disabilities Act (ADA) of 1990 and its contracts with the Department of Health Care Services (DHCS).

2. Utilizing the recommended four (4) factor analysis (demographics, competency of interpreter and bilingual staff and monitoring of the program) is used to ensure language access.

3. Alternative Format Selections (AFS) are made available following CenCal Health's policy and procedure, MS-33 – Alternative Format Selection Process.

4. CenCal Health also ensures equal access and compliance with all applicable civil rights laws for Members with disabilities and ensure accessible web and electronic content, and building accessibility providing ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5. CenCal Health posts (i) DHCS-approved nondiscrimination notice, and (ii) language taglines, in a conspicuously visible font size in English, the Threshold Languages, the top 15 non-English languages in the State (at minimum), and any other languages determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request

auxiliary aids and services, including materials in alternative formats. Additional information on these services can be found in Plan policies MS-30 - Translation of Written Member Materials, MS-32 - Delivery of Interpreter Services, and MS-33 - Alternative Format Selection Process. The nondiscrimination notice and taglines must include CenCal Health's toll-free and TTY/TDD telephone number for obtaining these services, and must be posted as follows:

a. In all conspicuous physical locations where CenCal Health interacts with the public;
b. In a location on CenCal Health's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
c. In the Member Handbook/Evidence of Coverage, all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and members of the public, in accordance with APL 21-004, 42 CFR Section 438.10(d)(2)-(3) and Welfare & Institutions (W&I) Code Section 14029.91(a)(3) and (f).

6. CenCal Health's nondiscrimination notice must include all information required by W&I Code section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:
   a. Both CenCal Health and the DHCS Office of Civil Rights (OCR), if there is a concern of discrimination 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, or identification with any other persons or groups defined in Penal Code 422.56; and
   b. The DHHS Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (W&I Code § 14029.91(e)). Additional information on Member grievances is available in Plan policy MS-22 – Member Grievances.

7. CenCal Health collects demographic data of its Member population, including those less than 21 years of age, to determine the language needs of its Members, including AFS needs. The data is then collected and analyzed which allows CenCal Health to identify the threshold languages and "points of contact" that Members would need to access appropriate cultural and linguistic services.

8. CenCal Health validates the proficiency of the bilingual staff and the contracted interpreters in the source and target language in order to establish competency and to ensure that health care information is communicated accurately.

9. CenCal Health has an established "Translation Team" of certified Spanish written translators who are responsible for translating all Member materials vital, and Member informing materials into Spanish. This process ensures that the information is disseminated to the Member in an appropriate threshold language (Spanish is CenCal Health's only threshold language) and is at the literacy level as recommended by the DHHS guidelines.

10. CenCal Health must ensure that the Community Advisory Board (CAB) is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. Further details regarding the CAB roles and responsibilities can be referenced in P&P, MS-40_Community Advisory Board. CenCal Health also obtains feedback from Members for further incorporation in policy and decision-making through Member and family engagement as further described in P&P MS-41 – Member and Family Engagement.

11. The above are performed to ensure monitoring and evaluation of CenCal Health's Cultural and Linguistic services offered for improvement opportunities in the delivery of covered services to our membership, including those Members less than 21 years of age.

12. The monitoring and evaluation process will ensure any lack of interpreter services does not impede or delay a Member's timely access to care.

13. Immediate actions will be taken to improve delivery of Cultural & Linguistic (C&L) appropriate services when deficiencies are noted.

B. Staffing and Auxiliary Aid Assistance:

1. CenCal Health has staffed its Member Services Department and Call Center with bilingual/bicultural staff to meet the needs of its membership as defined by the demographic report data.

2. Members can get assistance in accessing services, navigating the health care system and accessing interpreter services by calling the toll-free Member Services telephone number.

3. CenCal Health provides the deaf and hard of hearing Members the CA Relay information, in the Member EOC/Member Handbook, in the Language Assistance taglines document that is inserted in all Notice of Action (NOA) and Notice of Appeal Resolution (NAR) letters and on the Member side of the CenCal Health website.

4. CenCal Health has a Telecommunications Device for the Deaf (TDD) also known as a Teletypewriter (TTY) that is housed in the Member Services Department and the Call Center Manager and two Call Center Supervisors are assigned to provide responses/communication with any Members using this service for interpreter or translation requests, or any other assistance sought. CenCal Health's TTY number is 1-833-556-2560.

C. Evaluation of Proficiency of Bilingual Staff:

1. CenCal Health has developed a formal evaluation process and tool to test and evaluate the capacity of the bilingual staff, including employees, contracted staff and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services.

2. The evaluation consists of assessing oral fluency and expression, listening, comprehension, and health care vocabulary of the bilingual staff member by an independent outside evaluator.

3. Staff must score 80% or higher on their certified Language Assessment for verbal and written Spanish Translation to translate for CenCal Health.

D. Recruitment and Retainment of Culturally & Linguistically competent Providers:

1. CenCal Health actively recruits and retains providers that reflect the cultural and linguistic needs of its Medi-Cal population in our service areas.

2. Providers are educated in the contracting and onboarding process for expectations around C&L, availability of interpreting and translation services offered by CenCal Health for their use, and asked to provide

linguistic capabilities in their practice to assist CenCal Health in assignment of Members to meet C&L needs.

E. Non-Threshold Languages:
   1. For other Members who speak a language other than the identified threshold language(s), CenCal Health provides 24-hour over the telephone language line services.

   2. This process allows 24/7 coverage through "over the phone" interpreter services to Health Plan Members in over 230 languages at all key points of contact.

   3. All Member Services staff are trained to assist LEP Members access to an interpreter via the telephone per the training outlined in policy MS-02 Member Services Staff Training.

   4. Additional information on interpreter services and availability of alternative formats can be found in Plan policies MS-32 - Delivery of Interpreter Services and MS-33 - Alternative Format Selection Process.

F. Notification to Members of the Availability of Free Language Access Services:

   1. Members are notified of the availability of free language services and how to access these services through numerous Member materials such as the Member Handbook/Evidence of Coverage, the Member Newsletter, the Language Card, which is included in the New Member Packet, postings of language access availability in provider offices and training of contracted providers of medical services regarding the use of telephone language assistance.

G. Member Assignment to Primary Care:

   1. CenCal Health Members can select the Primary Care Provider (PCP) of their choice.

   2. Members can request an assignment to a PCP that speaks their language.

   3. Member Services Representatives are available to assist Members in the selection of language appropriate providers.

   4. Members that do not pick a provider are auto assigned a PCP based upon age, sex and language capability within 30 days of enrolling with CenCal Health.

H. Member and Provider Grievance Process:
   1. CenCal Health has an established grievance process where all LEP Members (including those less than 21 years of age) can file a grievance, or have a grievance filed on their behalf if their language access needs are not met.

   2. The Grievance System allows for the investigation of the complaint and provides the appropriate resolution to the Member.

   3. All discrimination grievances are immediately forwarded to CenCal Health's Compliance Investigator, who is known as CenCal Health's Discrimination Grievance & Appeals Coordinator. These grievances are investigated separately from the Grievance & Appeals Process and not entered into CenCal Health's on-line grievance tracking system and must follow the requirements for reporting discrimination grievances to the Office of Civil Rights (OCR), as outlined by APL 21-004. Reference CenCal Health's grievance system policy and procedure titled, "MS-22 – Member Grievances.

I. Interpreter Services:
   1. CenCal Health has developed a network of independent contractors in Santa Barbara and San Luis Obispo counties whose competency is established by an independent outside evaluator, for Spanish and American Sign Language needs.

   2. Medical providers can schedule interpretation services by calling the Member Services Coordinator directly.

   3. Members can call the toll-free Member Services line and request interpreter services for a scheduled appointment.

   4. CenCal Health also offers 24/7 interpreter services for voice and video remote interpreters via Certified Languages International (CLI) for over 230 languages.

J. Translation of Vital Documents/Member Informing Materials:

   1. CenCal Health has an established policy for translation of written Member materials (P&P MS-30_Translation of Written Member Materials).

   2. All Vital documents /Member Informing Materials are translated immediately into CenCal Health's only threshold language, Spanish.

3. The CenCal Health Translation Team comprised of certified Spanish written translators, are the designated individuals who are responsible for managing the translation process.

4. For AFS identified, CenCal Health works to secure the Member needs through internal creation and development of the materials or vendor services to accomplish the AFS translation requested.

K. Monitoring and Evaluation:
   1. The monitoring and evaluation process will ensure that cultural and linguistic services support the delivery of covered services to Members, including those less than 21 years of age. It will further work to ensure that there is no lack of interpreter services resulting in any impediment or delay to a Member's timely access to care.

   2. Immediate actions will be taken to improve delivery of C&L appropriate services when deficiencies are noted.

   3. Provider Contracting and Resources:

      a. CenCal Health assesses the availability of PCP specific linguistic services in the contracting process.
      b. Cultural and Linguistic Competency is a component of the Provider Workshops.
      c. Access to interpreter services for LEP Members and training materials for cultural sensitivity are provided through CenCal Health's Provider Manual.

   4. The Member Grievance System and PCP Reselection Reason Tracking

      a. Provides for the monitoring of dissatisfaction based upon cultural and language barriers. Refer to CenCal Health P&P, MS-20 – Grievance & Appeals Process.

   5. Quality Improvement and Health Equity Transformation Program (QIHETP/ Quality Improvement and Health Equity Committee QIHEC):

      a. Overall trends in Member and provider issues regarding gaps in cultural and linguistic needs are tracked and monitored through CenCal Health's Quality Improvement and Health Equity Committee structure under the QIHETP to identify the systematic and continuous activities to monitor, evaluate, and

improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care Agreement.

b. The QIHEC meets quarterly to direct all QIHETP findings and required actions and is facilitated by CenCal Health's Chief Medical Officer (CMO), or the CMO's designee, in collaboration with the Chief Health Equity Officer.

6. Linguistic Capability of Employees and Contracted Staff:
   a. CenCal Health assesses and tracks the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical).
   b. CenCal Health maintains a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members to systematically resolve any identified gaps in CenCal Health's ability to address cultural and linguistic needs. The training includes instruction on:
      i. CenCal Health's policies and procedures for language assistance;
      ii. How to work effectively with LEP Members and Potential Members;
      iii. How to work effectively with interpreters in person and through video, telephone, and other media; and,
      iv. Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services.

7. CenCal Health Staff Training for Diversity, Equity and Inclusion (DEI):
   a. All new CenCal Health staff receives Cultural Sensitivity, Diversity, Competency and Health Equity Training as noted in CenCal Health's Cultural Competency and DEI Training policy and procedure. Thereafter, all staff continue to receive Cultural Sensitivity, Diversity, Competency and Health Equity Training on an annual basis.

IV. Definitions:

All Plan Letter (APL) or Policy Letter (PL): a binding document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual

obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Alternative Format Selections (AFS): four modalities for receiving Member informing materials as alternatives to standard English and Spanish materials designed for CenCal Health membership at large.

1. **Large Print:** At minimum, 20 point, Times New Roman font or equivalent, or larger depending upon need and reasonable requests by members or ARs.
2. **Audio CD:** A voice recording onto a CD of health plan member materials requested in the audio CD format. May or may not be encrypted if disclaimer was presented to member at time of request.
3. **Data CD:** Electronic formats of Member materials added to a CD in their electronic format (.pdf, Word, etc.). May or may not be encrypted if disclaimer was presented to member at time of request.
4. **Braille:** A form of written language for blind people, in which characters are represented by patterns of raised dots that are felt with the fingertips.

Health Literacy: refers to the ability to read, understand, and act on health care information. CenCal Health is required to provide member information in a low literacy format): Threshold languages in each county are designated by the Department of Health services. These are primary languages spoken by Limited English Proficiency (LEP) population groups meeting a numeric threshold of 3,000 eligible beneficiaries residing in a county. Languages spoken by a population of eligible LEP beneficiaries residing in a county whose main concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes are also considered threshold languages for a county.

Interpreter: an individual who facilitates communication between two parties who do not speak the same language.

Limited English Proficient (LEP): an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor's employees.

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Population Needs Assessment (PNA): a process for:
A. Identifying Member health needs and Health Disparities;
B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and
C. Implementing targeted strategies for health education, C&L, and QI programs and services.

Potential Member or Potential Enrollee: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

Subcontractor: an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement

Threshold Language: Threshold Languages in each county are designated by the Department of Health Care Services. These are primary languages spoken by Limited English Proficiency (LEP) population groups meeting a numeric threshold of 3,000 or 5% of the eligible beneficiaries residing in a county, whichever is lower. Additionally, languages spoken by a population of eligible LEP beneficiaries residing in a county whose main concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes are also considered threshold languages for a county.

V. References:

A. DHCS 2024 Contract: Exhibit A, Attachment III, Subsection 2.2.10.D.3 Network and Access to Care, Section 5.2.10 Access Rights, and 5.2.11 Cultural & Linguistics Program and Committees
B. DHCS All-Plan Letter 21-004 (REVISED): Standards for Determining Threshold Languages, Non-Discrimination Requirements, and Language Assistance Services
C. DHCS All-Plan Letter 22-002: Alternative Format Selection for Members With Visual Impairments
D. Senate Bill 223: Atkins. Health care language assistance services
E. Senate Bill 1423: Hernandez. Medi-Cal: oral interpretation services
F. Americans with Disabilities Act (ADA)
G. Section 504 of the Rehabilitation Act
H. GOV 11135
I. Medi-Cal Managed Care Division, Policy Letter 99-03, Linguistic Services, Title 42, Code of Federal Regulations (CFR) Section 440.262
J. Title 28 California Code of Regulations (CCR), 1300.67.04 Language Assistance Guidelines
K. HIPAA Notice of Privacy Practices 164.520(b)
L. Title VI of the Civil Rights Act (Executive Order 13166)
M. Section 1557 of the Affordable Care Act of 2010
N. 42 CFR Sections 438.10 and 438.206(c)(2)
O. 22 CCR Sections 53876, 51202.5 and 51309.5(a)

VI. Cross Reference:

A. Policy and Procedures (P&P):
   1. MS-22 – Member Grievances
   2. MS-23 – Member Appeals
   3. MS-24 – Communication and Education (G&A Process)
   4. MS-25 Monitoring and Oversight (G&A Process)
   5. MS-30 – Translation of Written Member Materials
   6. MS-31 – Cultural and Language Access
   7. MS-32 – Delivery of Interpreter Services
   8. MS-33 – Alternative Format Selection Process
   9. MS-40 – Community Advisory Board
   10. MS-41 – Member/Family Engagement
   11. PS-XXX – Cultural Competency and Diversity, Equity, and Inclusion (DEI) Training
   12. MS-02 – Member Services Staff Training

B. Standard Operating Procedure (SOP):
   1. MSSOP-012 – Translation Request Process
   2. MSSOP-013 – Interpreter Request Process
   3. MSSOP-014 – Auditing of CLI and Interpreter Invoicing
   4. MSSOP-015 – ASL and Spanish Interpreter On-Boarding Process
   5. MSSOP-016 – Bilingual Assessment Process for Internal Staff
   6. MSSOP-049 – Certified Languages
   7. MSSOP-064 – Alternative Format Selection (AFS)

C. Program Documents:
   1. N/A

VII. Attachments:
A. N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
10/2023		Checked out for 2024 Integration		

02/2023	Van Do-Reynoso, Eric Buben	Policy revised to align with 2024 DHCS Contract Amendment requirements for R.0056 and R.0158, and moved to new P&P Template.	1/1/2024	TBD
01/2023	Eric Buben	Policy revised to align with 2024 DHCS Contract Amendment requirements for R.0192.	1/1/2024	TBD
09/2022	Eric Buben, Chris Morris	Policy revised to align with 2024 DHCS Contract Amendment requirements.	1/1/2024	10/30/2022
06/2022	Eric Buben	Revised to align with APL 22-002, Alternative Format Selection for Members.	ASAP	7/1/2022
09/2021	Eric Buben	Policy updated per APL 21-004 requirements.		
10/2020		Reviewed per Annual Review Instructions.		
01/2020		DHCS Contract Manager requested P&P update to include the Plan's adherence to contract language of providing a TTY Machine for the hard of hearing/deaf membership. Language inserted into P&P including CenCal Health's TTY number. Reference to old version of Translation of Written Materials P&P corrected to reflect new name of this P&P (MS-30_Translation of Written Member Materials)		
06/2019		Moved to new P&P Template only.		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Alternative Format Selection Process	**Policy No. :** MS-33
Department: Member Services	
Cross Functional Departments: All Departments sending member materials (Behavioral Health, Health Services, Quality)	
Effective Date: 07/2022	**Last Revised Date:** 03/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Eric Buben Director of Member Services	**Officer Signature and Date:** Van Do-Reynoso, MPH, PhD Chief Customer Experience & Health Equity Officer

I. Purpose:

To ensure CenCal Health's compliance with the Department of Health Care Services (DHCS) All-Plan Letter (APL) 22-002 and the commitment to its membership with visual impairments or other disabilities requiring the provision of written materials in alternative formats, by tracking Members' alternative format selections (AFS). The Americans with Disabilities Act (ADA) requires that services, programs, and activities provided by public entities must be accessible to individuals with disabilities, including visual impairment. (See 42 United States Code (U.S.C.) 12131). CenCal Health is subject to the standards of Title II of the ADA, including standards for communicating effectively with individuals with disabilities to ensure they benefit equally from government programs.

II. Policy:

A. CenCal Health must provide appropriate auxiliary aids and services to individuals in CenCal Health's population with disabilities, including those under 21 years of age and Seniors and Persons with Disabilities (SPD), to maintain and support the delivery of Covered Services to Members.

B. In determining what types of auxiliary aids and services to provide, CenCal Health must give "primary consideration" to the individual's request of a particular auxiliary aid or service.

C. CenCal Health offers an alternative format accessibility tool for members on its website and on its electronic Member Portal. This tool provides for alternative viewing options for all information on the website and within the secure Member Portal. The tool provides accessibility features such as: large print-various sizing, text spacing, line height adjustment, saturation modifications, paused animations, hide imaging, alternate contracts,

highlight tools, underline tools, pointer features and dyslexia friendly assistance.

D. Compliance with APL 22-002 indicates CenCal Health must:

1. Provide auxiliary aids and services to a family member, friend, or associate of a Member if required by the ADA, including if said individual is identified as the Member's authorized representative (AR), or is someone with whom it is appropriate for CenCal Health to communicate (e.g., a disabled spouse of a Member).
2. Accommodate the communication needs of all qualified Members with disabilities, including ARs, and be prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate.

3. Provide appropriate auxiliary aids and services to Members with disabilities, including alternative formats, upon request.

4. Inform Members who state that they have difficulty reading print communications on account of a disability of their right to receive auxiliary aids and services, including alternative formats.

5. If a Member selects an electronic format, such as an audio or data CD, the information may be provided unencrypted (i.e., not password protected), but only with the Member's informed consent. CenCal Health must inform a Member who contacts the Plan regarding an electronic alternative format, that unless the Member requests a password protected format, the Member will receive notices and information in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. CenCal Health must make clear that Members may request an encrypted (i.e., password protected) electronic format. If the Member requests notices and information in a password protected electronic format, CenCal Health must provide a password protected electronic format with unencrypted instructions on how the Member is to access the encrypted information.

III. **Procedure**:

A. Collection of AFS Data by CenCal Health. CenCal Health must collect and store AFS information for Members and ARs, (including, for example, individuals who have power of attorney for health-related matters), and

share Member AFS data with DHCS as specified in the "Alternative Format Data Process Guide" provided by DHCS.

1. AF Data Process Guide Requirements:
   CenCal Health and our sub-contractors and network providers will be required to enter any new Member AFS that they receive at the time of request through the AFS online screens or by calling the AFS Helpline.

   a. To enter the Member's selection into the AFS online screens use the following web link and follow the prompts: https://afs.dhcs.ca.gov/
   b. To utilize the AFS Helpline, call 1-833-284-0040 and provide the Member's selection.

2. CenCal Health will provide Members with their AFS when that selection is known whether that information is provided directly by the Member or is received through DHCS Alternative Format weekly database update. DHCS requires CenCal Health to ensure Members receive their most current AFS, as their selection can change over time.

3. DHCS will send an AFS file to CenCal Health from the DHCS Alternative Format database weekly. All files will be uploaded through CenCal Health's SFTP folders.

4. CenCal Health must update Member records using the weekly AFS file sent by DHCS and use this file to deploy the alternative format requested by the Member.

5. CenCal Health will share AFS data with our sub-contractors and network providers as appropriate.

6. CenCal Health is not required to submit AFS data to DHCS for ARs, but must track AR AFS data and provide alternative formats to ARs as required by law.

B. Intake & Processing of AFS Requests – Staff Roles. All alternative format selection requests received in Member Services or via another department, will be forwarded to the Member Services Department to document the request formally into our Call Tracking System and/or for direct entry, into CenCal Health's Health Information System (HIS).

   1. Role of the Member Services Representative for AFS:
      a. Member Service Representatives (MSRs) will categorize all phone requests under specific AFS coding classification and will follow the

attached call scripting approved by DHCS as submitted and approved by CenCal Health's DHCS Contract Manager.

b. The MSR will determine the specific needs by asking the Member or AR if this is a one-time document request, or if the Member or AR prefers all Member materials in the AFS selected.

c. If the Member or Authorized Representative (AR) states that another format is acceptable to help in translating the document into the requested AFS (such as read over the phone, interpreted into their preferred language through our language interpreter service Certified Languages International (CLI)), or another AFS instead (audio CD vs. Braille as an example) the MSR will assist by reading/explaining the information in question, secure an interpreter, or provide/coordinate the alternate format the Member approves.

d. If the Member or AR indicates the AFS selection is for "all" documents, the MSR will add the entry into the AFS section of CenCal Health's HIS and then notify CenCal Health's Health Navigator Team to initiate the AFS into the DHCS Alternative Format Database, as outlined earlier in this policy and procedure under Section III.A.1, *AF Data Process Guide Requirements.*

e. If the Member or AR indicates the request is a one-time need, the MSR will document this is a one-time request into their call tracking documentation and will forward the request for AFS to CenCal Health's Cultural & Linguistics Manager and the Director of Member Services to initiate the translation process. These entries should not be forwarded to a Health Navigator for entry into the DHCS Alternative Format Database, as there is no identified on-going need as verified by the Member and documented.

2. Role of the Cultural & Linguistics Manager for AFS:
   a. The C&L Manager, in receipt of an AFS request from the Member Services team, will coordinate with the Director of Member Services and the Communications Department to meet the AFS request for the Member.

   b. The AFS request will be assessed, and a decision will be made to accommodate the Member's request; internal (mainly for large print, audio or data CD selections), or if a vendor will be needed and used to create the document into the selected AFS (examples: Large print of large/complex documents or Braille).

c. Coordination of this process is managed by the C&L Manager and will be performed as soon as possible dependent upon vendor turnaround times, internal turnaround capacity and size of documents in question.

d. The C&L Manager will secure the distribution of the document(s) out to the Member when the translations are complete and will notify Members and ARs of progress periodically during the process.

3. Role of the Health Navigator for AFS:
   a. Any AFS sent to a Health Navigator to enter into the DHCS Alternative Format Database, will be promptly entered within the same business day, or within 24 hours.

   b. The Health Navigator will record the date and time of entry in the Alternative Format Database for any requests received into the Member Services AFS Log.

C. Notification of AFS Policy and Procedures to Sub-Contractors/ Network Providers
   1. CenCal Health is responsible for ensuring that sub-contractors and our provider network comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters regarding AFS. CenCal Health communicates the requirements to all sub-contractors and network providers.

   2. CenCal Health will assist sub-contractors and network providers in meeting this obligation by offering information or training on the effective communication requirements of Title II of the ADA, and technical assistance on such topics as local alternative format vendors, and how to provide accessible documents and websites.

   3. CenCal Health will be able to report efforts to ensure that Members are aware of their right to receive effective communication, what requests for auxiliary aids and services have been made by Members, and we responded to those requests, and our response to any complaints regarding the receipt of effective communication.

   4. Failure to demonstrate compliance with the law for AFS may result in enforcement action, including but not limited to, sanctions.

D. Due Process Requirements

1. Constitutional due process requires that a Member's benefits must not be reduced or terminated without timely and adequate notice explaining the reasons for the proposed action and the opportunity for a hearing. (Goldberg v. Kelly (1970) 397 U.S. 254, 267–268).

2. In the case of a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, DHCS has determined that adequate notice means notice in the Member's selected alternative format, or notice that is otherwise in compliance with the ADA, Section 504 of the Rehabilitation Act of 1973, and Government Code Section 11135.

3. CenCal Health may not deny, reduce, suspend, or terminate services or treatments without providing adequate notice within applicable legal timeframes outlined in 42 CFR 438.404; 42 CFR 431.211. CenCal Health must calculate the deadline for a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, to act from the date of adequate notice, including all deadlines for appeals and aid paid pending.

4. Ordinarily, Members must exhaust CenCal Health's internal appeal process (CenCal Health appeal process outlined in P&P: MS-23), and receive notice that an adverse benefit determination has been upheld, prior to proceeding to a state hearing. However, if CenCal Health fails to provide adequate notice to a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, the Member is deemed to have exhausted CenCal Health's internal appeal process and may immediately request a state hearing.

5. CenCal Health is prohibited from requesting dismissal of a state hearing based on failure to exhaust CenCal Health's internal appeal process in such cases.

E. Monitoring and Compliance
   1. CenCal Health's Cultural and Language Access Services Program meets the needs of its Limited English Proficient (LEP) Members by following Health and Human Services (HHS) guidelines, Title VI of the Civil Rights Act (Executive Order 13166), Title 28, Section 1300.67.04, the American Disabilities Act (ADA) of 1990 and its contracts with the Department of Health Care Services. This would include utilizing the recommended four (4) factor analysis (demographics, competency of interpreter and bilingual staff, monitoring of program) is used to ensure language access

and ensures that the AFS Database information is referenced before sending Member informing materials. CenCal Health Policy and Procedures, MS-30, MS-31 and MS-32 provide further details for CenCal Health's C&L Access Services Program, translation of written materials procedures and interpreter service options for LEP membership.

2. CenCal Health collects demographic data in the Health Information System (HIS) for Members to determine alternative language needs, including AFS. All staff responsible for sending Member-informing materials will check for Member AFS selections before mailing. CenCal Health staff will ensure that Members selecting an AFS, are provided their materials in the selected format unless the Member advises otherwise.

3. AFS data for CenCal Health is monitored for compliance by Member Services and reported, as necessary, to applicable internal committees to evaluate and determine whether improvements are necessary and ensure the delivery of Covered Services to all Members, including those less than 21 years of age.

IV. Definitions:

Audio CD: a voice recording onto a CD of health plan Member materials requested in the audio CD format. May or may not be encrypted if disclaimer was presented to Member at time of request.

Braille: a form of written language for blind people, in which characters are represented by patterns of raised dots that are felt with the fingertips.

Covered Services: health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*., 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, CenCal Health's contract with DHCS, and APLs that are made the responsibility of the CenCal Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Data CD: electronic formats of Member materials added to a CD in their electronic format (.pdf, Word, etc.). May or may not be encrypted if disclaimer was presented to Member at time of request.

Large Print: at minimum, 20-point Times New Roman or equivalent font or larger depending upon need and reasonable requests by Members or ARs.

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Potential Member or Potential Enrollee: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

V. References:

A. DHCS 2024 Contract: Exhibit A Attachment III Section 5.2.10 Access Rights
B. All-Plan Letter 22-002: Alternative Format Selection for Members With Visual Impairments
C. All-Plan Letter 21-004 (REVISED): Standards for Determining Threshold Languages, Non-Discrimination Requirements, and Language Assistance Services
D. Title II – American Disabilities Act (ADA)
E. 28 Code of Federal Regulations (CFR) 35.160 (b)
F. 42 United States Code (U.S.C.) 12131)
G. 45 Code of Federal Regulations (CFR) 92.102 (b)
H. Department of Health Care Services Contract: 08-85212

VI. Cross Reference:

A. Policy and Procedures (P&P):
   1. MS 23 – Member Appeals
   2. MS-30 – Translation of Written Member Materials
   3. MS-31 – Cultural and Language Access
   4. MS-32 – Delivery of Interpreter Services

B. Standard Operating Procedure (SOP):
   1. MSSOP-064 – Alternative Format Selections (AFS)

C. Program Documents:
   1. N/A

VII. Attachments:

A. N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
03/2023	Van Do-Reynoso, Eric Buben	Policy revised to align with 2024 DHCS Contract Amendment requirements for R.0056, and moved to new P&P Template.	1/1/2024	TBD
09/2022		Policy revised to comply with 2024 DHCS Contract.		
07/2022		New policy created to comply with APL 22-002: Alternative Format Selection.		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Provider Directory Creation and Maintenance	**Policy No. :** PS-PS101
Department: Provider Services	
Cross Functional Departments:	
Effective Date: 05/2015	**Last Revised Date:** 11/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Luis Somoza Director of Provider Services	**Officer Signature and Date:** Jordan Turetsky, MPH Chief Operating Officer

I. Purpose:
To describe the process by which CenCal Health ensures an updated and compliant provider directory which is made available by print and online.

II. Policy:

A. CenCal Health publishes and maintains a provider directory with information on Network Providers that deliver health care services to Members. The provider directory complies with all applicable laws, regulations, and the contract requirements between CenCal Health and the Department of Health Care Services (DHCS). This includes, without limitation, inclusion of all required data elements, accessibility, and compliance with uniform provider directory standards.

B. CenCal Health's provider directory is available to all Members, non-Members, Providers, members of the public, and to DHCS for distribution, as required by applicable law and DHCS contract requirements.

C. CenCal Health's provider directory must be available in both paper and electronic formats. Provider directory information shall be included with CenCal Health's written Member information for new Members, and thereafter available upon request.

D. Electronic provider directories are posted on CenCal Health's website in a machine readable and accessible file and format, and made accessible to Members, non-Members, and Providers.

E. CenCal Health updates its online provider directory every 24 hours. The online provider directory is searchable by, at minimum, Network Provider

name, practice address, city, ZIP Code, California license number, National Provider Identifier (NPI) number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

F. CenCal Health audits and monitors the accuracy of the information contained in the provider directory, including an annual review and update of the entire directory for each product offered.

G. CenCal Health is required to submit its complete provider directory to DHCS for review and approval prior to initial operations. CenCal Health's provider directory submission must include complete, accurate and updated provider directory and provider network information and data, and be submitted as required by Title 42 of the Code of Federal Regulations (CFR) section 438.10(h)(3).

H. CenCal Health's provider directory must comply with all requirements in Policy Letter (PL) 11-009.

I. CenCal Health submits a copy of its printed provider directory to DHCS on a monthly basis. DHCS is authorized to require changes or corrections to CenCal Health's provider directory at any time.

J. Information on how new Members receive and/or access the CenCal Health provider directory is outlined in MS-01 – New Member Enrollment Process.

III. **Procedure**:

A. Provider Directory Required Data Elements
   a. CenCal Health's Provider Directory must comply with 42 CFR section 438.10(h) and Health & Safety Code (H&S) Section 1367.27, and shall include the following information for in-network Primary Care Providers, specialists, hospitals, Enhanced Care Management and Community Support Providers, pharmacies, behavioral health providers, long-term services and supports (LTSS) providers, and any other providers (e.g. community health workers) contracted for Medi-Cal Covered Services, as appropriate:
      a. The Provider or site's location name as well as any group affiliation(s), NPI number(s), address(es), telephone number(s), office email address (if available), and if applicable, website URL, for each service location;
      b. Provider's specialty type (including board certification, if any) and paneling status that allows them to treat specific populations,

including but not limited to, whether they are a California Children's Services (CCS) paneled Provider;

c. Whether the Provider is accepting new patients;
d. Information on the Provider's affiliated medical group or independent practice association (IPA), NPI number, address, telephone number, and, if applicable, website URL for each physician provider of affiliated group or IPA;
e. Admitting privileges, if any, at hospitals contracted with the Plan;
f. The hours and days when each service location is open, including the availability of evening or weekend hours;
g. The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities as required by PL 11-009;
h. The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility, and whether the Provider has completed cultural competence training;
i. Whether the provider is accepting new patients;
j. The telephone number to call after normal business hours;
k. Identification of Network Providers or sites that are not available to all or new Members; and
l. The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.

b. The provider directory shall also inform Members that they are entitled to:
   a. Language interpreter services, at no cost to the Member, including how to obtain interpretation services; and
   b. Full and equal access to covered services, including Members with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

B. Ongoing Provider Directory Updates
   1. CenCal Health must update and submit its paper and electronic provider directories to DHCS in accordance with 42 CFR section 438.10(h)(3)(i)(A)-(B). CenCal Health must submit under the following timelines:

      a. A paper provider directory must be updated at least monthly, if CenCal Health does not have a mobile-enabled, electronic directory; or
      b. Quarterly, if CenCal Health has a mobile-enabled, electronic provider directory; or

   c. An electronic provider directory must be updated no later than 30 calendar days after CenCal Health receives updated Provider information.
2. CenCal Health meets or exceeds the DHCS required timelines noted above by updating the hardcopy print provider directory on a monthly basis, and the electronic directory on a nightly basis. CenCal Health updates the online provider directory when informed of and upon confirmation of any of the following:
   a. A Network Provider is no longer accepting new patients for that product, or an individual Provider within a Provider group is no longer accepting new patients.
   b. A Provider is no longer under contract for a particular plan product.
   c. A Provider's practice location or other information required to be included on the directory has changed.
   d. It is discovered that a Provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.
   e. Any other information that affects the content or accuracy of the provider directory.
3. CenCal Health shall delete a Provider from the directory upon confirmation of any of the following:
   a. A Provider has retired or otherwise has ceased to practice.
   b. A Provider or provider group is no longer under contract with CenCal Health for any reason.
   c. The contracting provider group has informed CenCal Health that the Provider is no longer associated with the provider group and is no longer under contract with the Plan.
4. Providers are able to log onto the CenCal Health Provider Portal to verify or submit changes electronically to the information required to be in the directory. All newly contracted Network Providers are trained during New Provider Orientation on how to view and navigate the directory on the Plan's website.
5. Members, potential Members, Providers, and members of the public also maintain the ability to notify CenCal Health if the provider directory appears to contain any inaccurate, incomplete, or misleading information. The provider directory includes both a dedicated email address and a telephone number to report such inaccuracies or potential inaccuracies, as well as a hyperlink on the Plan's online provider directory linking to a form where the information can be reported directly to the Plan through its website. This information shall be disclosed prominently in the directory as well as the Plan's website.
   a. Upon receipt of a notice informing CenCal Health of a possible inaccuracy in the provider directory, CenCal Health shall promptly

investigate, and if necessary, undertake corrective action within thirty (30) business days to ensure the accuracy of the provider directory.

b. CenCal Health's investigation regarding its provider directory shall comply with the requirements of Health & Safety Code Section 1367.27 subsection (o)(2).

6. On an annual basis, CenCal Health reviews and updates the entire provider directory for each product offered. This process includes notifying all Network Providers and requiring affirmative responses acknowledging and confirming that the information is current and accurate, or updating the information required to be in the directory. CenCal Health complies with all applicable steps noted in Health & Safety Code Section 1367.27, subsection (l), for its annual review and update.

C. Bi-Annual and Annual Provider Directory Updates

1. CenCal Health shall take appropriate steps to ensure the accuracy of the information concerning each Network Provider listed in CenCal Health's provider directory in accordance with applicable law, and shall, at least annually, review and update the entire provider directory for each product offered. Each calendar year, CenCal Health shall notify all Network Providers listed in its provider directory as follows:
   a. For individual Providers who are not affiliated with a provider group (including physicians, surgeons, nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists, as applicable), CenCal Health shall notify each Network Provider at least once every six months.
   b. For all other Network Providers, including Federally Qualified Health Centers or primary care clinics; facilities, including, but not limited to, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities; pharmacies, clinical laboratories, imaging centers, and other facilities who have a Network Provider Agreement with CenCal Health, CenCal Health shall notify its Network Providers to ensure that they are contacted at least once annually.
2. The notification shall include all of the following:
   a. The information that CenCal Health has in its directory regarding the Network Provider, including a list of networks and plan products that include the Network Provider.
   b. A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to Health and Safety Code Section 1367.27 (p).

c. Instructions on how the Network Provider can update the information in the provider directory using CenCal Health's online interface.

3. CenCal Health shall require an affirmative response from the Network Provider acknowledging that the notification was received. The Network Provider shall confirm that the information in the provider directory is current and accurate or update the information required to be in the directory, including whether or not the Network Provider is accepting new patients for each CenCal Health product.
4. If CenCal Health does not receive an affirmative response and confirmation from the Network Provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory, within 30 business days, CenCal Health shall take no more than 15 business days to verify whether the Network Provider's information is correct or requires updates.
5. CenCal Health shall document the receipt and outcome of each attempt to verify the information. If CenCal Health is unable to verify whether the Network Provider's information is correct or requires updates, CenCal Health shall notify the Network Provider 10 business days in advance of removal that the Network Provider may be removed from the provider directory.
6. The Network Provider may be removed from the provider directory at the next required update of the provider directory after the 10-business-day notice period. A Network Provider may not be removed from the provider directory if he or she responds before the end of the 10-business-day notice period.
7. General acute care hospitals shall be exempt from the annual review requirements noted above.

D. Auditing and Monitoring; Data Verification

CenCal Health performs ongoing auditing and monitoring of provider directory data via a variety of methods.

1. CenCal Health verifies initial provider directory data through the credentialing process. Primary source verification, performed during credentialing, is through the Medical Board of California, the American Board of Specialties, Department of Consumer Affairs Licensing Agency, Osteopathic Medical Board of California, the AMA Physician Master File, National Plan and Provider Enumeration System (NPPESP, the Office of the Inspector General, and other sources.
2. When discrepancies are noted, Provider Services staff perform outreach to confirm the discrepancy and obtain accurate data. In addition, Provider Services performs monthly data audits to ensure data integrity.
3. CenCal Health monitors DHCS' Suspended and Ineligible ("S&I") List to ensure any Network Provider listed on the S&I List is removed from the

online and print directories upon identification. This is reviewed by CenCal Health:
   a. At the time of initial credentialing; and
   b. On a monthly basis thereafter.
4. CenCal Health informs Members, within each publication of its Member newsletter, to check the Plan's online provider directory or to call the Member Services department concerning changes to the Plan's contracted network, as Members who refer to hardcopy directory information may not have the most current up-to-date information.
5. At least annually, CenCal Health performs usability testing of the hospital and physician directory, using internal staff who are not involved in the development of the directory. This testing is also conducted whenever there are significant changes to member demographics and when there are changes to the layout or design of the directory.

IV. Definitions:

Community Supports: Substitute services or setting to those required under California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 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.

Covered Services: those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*., 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, CenCal Health's contract with DHCS, and APLs that are made the responsibility of the CenCal Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Enhanced Care Management: 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 comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Network Provider: any provider or entity that has a Network Provider Agreement with CenCal Health, CenCal Health's subcontractor, or CenCal Health's downstream subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the contract between CenCal

Health and DHCS. A Network Provider is not a subcontractor or downstream subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement: a written agreement between a Network Provider and CenCal Health, subcontractor, or downstream subcontractor.

Primary Care Provider (PCP): 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.

Potential Member or Potential Enrollee: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

V. References:

A. DHCS Agreement, Exhibit A, Attachment III Section 5.1.3.H
B. Health & Safety Code Section 1367.27
C. 42 CFR Section 438.10
D. NCQA HP Standards and Guidelines
E. Policy Letter (PL) 11-009
F. APL 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX

VI. Cross Reference:

A. Policy and Procedures (P&P):
   1. MS-01 New Member Enrollment Process

B. Standard Operating Procedure (SOP):
   1. N/A

C. Program Documents:
   1. N/A

VII. Attachments:

A. Attachment A: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
11/2023		Checked Out for NCQA Edits		
11/2023		2024 Template Migration	01/2024	
04/2023	Jordan Turetsky, Robert Janeway	Policy revised to align with DHCS Contract Wave 3 requirements	01/01/2024	TBD
05/2015		P&P Established		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Ensuring EPSDT Screening, AAP Bright Futures Preventive Services, and Medically Necessary Diagnostic and Treatment Services, for Members Under Age 21	**Policy No.:** TBD
Department: Quality	
Cross Functional Departments: Medical Management, Provider Services	
Effective Date: January 1, 2023	**Last Revised Date:** N/A
P&P Require DHCS Approval? Y ☒ N ☐	**Annual Review Date:** August 1, 2023
Director Signature and Date: Lauren Geeb, MBA Director of Quality Improvement	**Officer Signature and Date:** Carlos Hernandez Quality Officer

I. Purpose:

To describe CenCal Health's processes to maintain a robust Quality Improvement Health Equity Transformation Program (QIHETP) to ensure the provision of all physical, behavioral and oral health services to Members less than 21 years of age, and to actively promote EPSDT screening and AAP Bright Futures Preventive Services to Members and their families.

II. Policy:

A. CenCal Health maintains a QIHETP and Basic PHM system to identify and address Members in need of all EPSDT screening, and AAP Bright Futures preventive and Medically Necessary diagnostic and treatment services for members less than 21 years of age.

B. 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).

C. 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.

D. All EPSDT services are Covered Services unless expressly excluded under the DHCS 2024 Medi-Cal Managed Care Agreement.

III. Procedure:

A. CenCal Health promotes and ensures the provision of all EPSDT screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age, and requires Primary Care Providers (PCPs) to identify and address Member's Covered Services needs, including underutilization of preventive services, as follows:
    1. Initial Health Appointment for Members less than 21 Years of Age
        i. For Members less than 18 months of age, CenCal Health promotes and ensures the provision of an initial health appointment 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.
        ii. For Members ages 18 months and older, CenCal Health promotes and ensures an initial health appointment is performed within 120 calendar days of Enrollment.
        iii. At the initial health appointment the PCP must provide, or arrange for 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.
        iv. If the provisions of the initial health appointment are not met, then CenCal Health ensures case management and Care Coordination are working directly with the Member to receive appropriate services that include but are not limited to health screenings, immunizations, and risk assessments.

B. Children's Preventive Services
    1. For all Members less than 21 years of age, CenCal Health promotes and its PCPs are required to provide preventive health visits and anticipatory guidance at times specified and as outlined in the most recent AAP Bright Futures Periodicity Schedule. CenCal Health promotes and its PCPs provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.
    2. When 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 must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.
    3. 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, is advised of the Children's preventive services due and available from CenCal Health.

i. Documentation is entered in the Member's Medical Record which indicates the receipt of Children's preventive services in accordance with the AAP Bright Futures standards.

ii. 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 those services.

4. CenCal Health promotes and ensures complete reporting and appropriate collection of all children's preventive services rendered and required as part of the DHCS Encounter Data submittal.

C. Immunizations

1. CenCal Health covers and promotes 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).

i. If vaccination services are refused, documentation is entered in the Member's Medical Record to indicate 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 those services.

ii. Providers documented attempts that demonstrate unsuccessful efforts to provide the vaccination are considered sufficient to meet vaccination requirements. Reasons for failed attempts to vaccinate must be medically coded.

2. 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, must be advised of the vaccinations due and available from CenCal Health immediately, if the Member has not received vaccinations in accordance with ACIP standards.

i. 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.

ii. 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.

iii. If vaccinations cannot be given at the time of the visit, then documentation in the Medical Record must demonstrate that the Member was informed how to obtain necessary

vaccinations or that the Member was scheduled for a future appointment for vaccinations.

3. CenCal Health requires and 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.
    i. Reports must be made following the Member's initial health appointment and all other health care visits that result in an administered vaccine within 14 calendar days.
    ii. Registry reporting must be in accordance with all applicable State and federal laws.
4. Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, CenCal Health covers and requires the provision and administration of the vaccine.
    i. CenCal Health covers, requires and ensures the provision of the vaccine from the date of its approval regardless of whether the vaccine has been incorporated into the Vaccines for Children (VFC) Program.
    ii. CenCal Health's coverage of the provision and administration of the FDA-approved vaccine is in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.
5. CenCal Health provides information to all Network Providers regarding the VFC Program and promotes and supports enrollment of applicable Network Providers in the VFC program as appropriate.

D. Blood Lead Screens
1. CenCal Health covers, promotes 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 DHCS APL 20-016.
    i. CenCal Health promotes and 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.
    ii. CenCal Health identifies, at least quarterly, all Members less than six years of age with no record of receiving a required lead test, and reminds responsible Providers of the requirement to test Children.
2. If the Member refuses the blood lead screen test, CenCal Health requires Network Providers to ensure 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.

i. If the Member (if an emancipated minor) or the parent(s) or guardian of the Member refuses to sign the statement, the refusal must be noted in the Member's Medical Record.

ii. Documented unsuccessful attempts to provide the lead screen test are considered sufficient evidence to meet the lead testing requirement.

E. EPSDT Services

1. CenCal Health promotes and its PCPs are required to provide EPSDT screenings and AAP Bright Futures preventive services to Members and their families;
2. CenCal Health's Quality Department identifies Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services and ensures outreach to these Members in a culturally and linguistically appropriate manner;
   i. For Members less than 21 years of age, CenCal Health complies with all requirements identified in APL 19-010.
      a) CenCal Health's Network Providers provide, or CenCal Health 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 by the DHCS 2024 Medi-Cal Managed Care Agreement.
      b) Covered Services includes, 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.
      c) 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, per requirements in Exhibit A, Attachment III, Section 5.6 (MOUs with Third Parties), CenCal Health arranges for comparable services for the Member under the EPSDT benefit in accordance with APL 19-010.
   ii. CenCal Health promotes and ensures its Network Providers arrange 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).
      a) CenCal Health ensures 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.

b) All Medically Necessary services are provided timely, whether or not the services are Covered Services under the DHCS 2024 Medi-Cal Managed Care Agreement.

iii. 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.

a) 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 under the DHCS 2024 Medi-Cal Managed Care Agreement.

iv. Covered Services do not include Specialty Mental Health Services (SMHS).

a) For these non-Covered Services, CenCal Health ensures that:

- The case management for Medically Necessary services authorized by 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;
- If indicated or upon the Member's request, CenCal Health provides additional Care Coordination and case management services as necessary to meet the Member's medical and behavioral health needs.

F. Local Education Agency (LEA) Services

1. CenCal Health reimburses LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT as specified in DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Subsection 4.3.17 (School-Based Services).]

G. To ensure Members' EPSDT screenings and AAP Bright Futures Preventive Services are completed and addressed appropriately, CenCal Health's Basic PHM system supports Primary Care case management, through CenCal Health's integration of cross-functional processes. Policy and procedure _____ Basic Population Health Management: Identifying Members Needing Preventive Services & Increasing Appropriate Preventive Services Utilization, defines CenCal Health's system to assure appropriate utilization of services,

including but not limited to EPSDT and AAP Bright Futures preventive services, for Members less than 21 years of age.

IV. Definitions:

Basic PHM: 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.

Bright Futures Periodicity Schedule: the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and guidelines published by the American Academy of Pediatrics and Bright Futures, in accordance with which all Members under 21 years of age must receive well child assessments, screenings, and services.

Care Coordination: CenCal Health's coordination of services for a Member between settings of care that includes: appropriate Discharge Planning for short term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; services the Member receives from any other managed care health plan; services the Member receives in Fee-For-Service (FFS); services the Member receives from out-of-network providers; and services the Member receives from community and social support providers.

Discharge Planning: planning that begins at the time of admission to a hospital or facility to ensure that necessary care, services, and supports are in place in the community before a Member leaves the hospital or facility in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Downstream Subcontractor: an individual or an entity that has a Downstream Subcontractor agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider agreement.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.

Fee-For-Service (FFS): the Medi-Cal delivery system in which providers submit claims to and receive payments from DHCS for Medi-Cal covered services rendered to Medi-Cal recipients.

Local Educational Agency (LEA): a school district, county office of education, charter school, community college district, California State University or University of California campus.

Medically Necessary or **Medical Necessity:** reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under Cal. W&I Code § 14059.5(a) and 22 C.C.R. § 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 U.S.C. § 1396d(r)(5), as required by Cal. W&I Code §§ 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. The Plan must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Medical Records: the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.

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

Network Provider: any provider or entity that has a Network Provider agreement with CenCal Health, CenCal Health's Subcontractors, or CenCal Health's Downstream Subcontractors, and receives Medi-Cal funding directly or indirectly to order, refer, or render covered services. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider agreement.

Primary Care: health care usually rendered in ambulatory settings by PCPs, and mid-level practitioners, and emphasizes the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Provider (PCP): 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, or non-physician medical practitioner. For SPD Members, a PCP may also be a Specialist or clinic.

Quality Improvement and Health Equity Transformation Program (QIHETP): the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care Agreement.

Service Area: the county or counties that CenCal Health is approved to operate in under the terms of the DHCS 2024 Medi-Cal Managed Care Agreement. A Service Area may be limited to designated zip Codes (under the U.S. Postal Service) within a county.

Specialty Mental Health Service (SMHS): a Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary specialty mental health services.

Subcontractor: an individual or entity that has a Subcontractor agreement with CenCal Health that relates directly or indirectly to the performance of CenCal Health's obligations under the DHCS Medi-Cal Managed Care Agreement. A Network Provider is not a Subcontractor solely because it enters into a Network Provider agreement.

Targeted Case Management (TCM): services which assist Members within specified target groups to gain access to needed medical, social, educational and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Vaccines for Children (VFC) Program: the federally funded program that provides free vaccines for eligible children age 18 or younger (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating Providers.

Working Day(s): Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays web page (www.calhr.ca.gov/employees/pages/state-holidays.aspx).

V. References:

A. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III,

- 2.2.10 – Quality Care for Children
- 5.3.4 – Services for Children less than 21 Years of Age

VI. Cross Reference:

A. Policy document:

1. Basic Population Health Management: Identifying Members Needing Preventive Services & Increasing Appropriate Preventive Services Utilization

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Community Advisory Board	**Policy No. :** MS-40
Department: Member Services	
Cross Functional Departments: Quality	
Effective Date: 01/2024	**Last Revised Date:** 05/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Eric Buben, Director of Member Services	**Officer Signature and Date:** Van Do-Reynoso, Chief Customer Experience Officer and Chief Health Equity Officer

I. Purpose:

To set forth the requirements of CenCal Health's Community Advisory Committee (CAC), known as CenCal Health's Community Advisory Board (CAB). To describe the representation, recruitment, and participation requirements of Medi-Cal Members on CenCal Health's CAB.

II. Policy:

A. CenCal Heath established and maintains a CAB and meets periodically with the CAB concerning the development and implementation of its cultural and linguistic accessibility standards and procedures. [22 CCR § 53876(c)]

B. CenCal Health shall ensure Member and family engagement through maintaining a CAB whose composition reflects CenCal Health's Member population and whose input is actively utilized in policies and decision-making by CenCal Health.

C. CenCal Health ensures that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members (including, without limitation, LEP Members under 21 years of age), and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public policy within CenCal Health's CAB.

D. CenCal Health must engage in a Member and family-oriented engagement strategy to Quality Improvement (QI) and Health Equity, including children

and caregiver representation on the CAB, and using CAB findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity Interventions for Members, including without limitation, those under 21 years of age.

E. CenCal Health has and must continue to maintain a diverse CAB pursuant to 22 CCR section 53876(c), comprised primarily of CenCal Health's Members, as part of the CenCal Health's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

III. Procedure:

A. CAB Membership and Selection Committee

1. CenCal Health shall convene a CAB selection committee tasked with selecting the members of the CAB.

2. CenCal Health must demonstrate a good faith effort to ensure that the CAB selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAB:

   a. Persons who sit on CenCal Health's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, behavioral health, regional centers, local education authorities, dental Providers, Indian Health Services (IHS) Facilities, and home and community-based service Providers; and
   b. Persons and community-based organizations who are representatives of each county within CenCal Health's Service Area adjusting for changes in membership diversity.

3. The CAB Selection Committee ensures the CAB membership reflects the general Medi-Cal Member population in CenCal Health's Service Area, including representatives from IHS Providers, LEP Members (including, without limitation, those under 21 years of age), adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and will be modified as the population changes to ensure that CenCal Health's community is represented and engaged. The CAB selection committee must also make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAB, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

4. CenCal Health's CAB selection committee must select all of its CAB members promptly, no later than 180 calendar days from the effective date of CenCal Health's Medi-Cal Managed Care Contract with the California Department of Health Care Services (DHCS).

B. CAB Member Resignation

1. Should a CAB member resign, is asked to resign, or is otherwise unable to serve on the CAB, CenCal Health must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAB vacancy.

C. CAB Coordinator

1. CenCal Health must designate a CAB coordinator and maintain a written job description detailing the CAB coordinator's responsibilities.
2. The CAB coordinator may be an employee of CenCal Health, CenCal Health's Subcontractor, or CenCal Health's Downstream Subcontractor. CenCal Health's CAB coordinator must not be a member of the CAB or a Member enrolled with CenCal Health.
3. The CAB coordinator 's responsibilities must include managing the operations of the CAB in compliance with all statutory, rule, and contract requirements, including, but not limited to:

    a. Ensuring CAB meetings are scheduled, and CAB agendas are developed with the input of CAB members;
    b. Maintaining CAB membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAB;
    c. Actively facilitating communications and connections between the CAB and CenCal Health leadership, including ensuring CAB members are informed of CenCal Health decisions relevant to the work of the CAB;
    d. Ensuring that CAB meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAB meetings; and
    e. Ensuring compliance with all CAB reporting and public posting requirements.

D. CAB Communications with CenCal Health's Board of Directors (BOD)
1. In order to ensure active communication between the CAB and CenCal Health's BOD, CenCal Health maintains a CAB liaison assigned by CenCal Health's BOD who sits on both the CAB and the BOD.

2. To keep the BOD apprised on current information from the CAB, the Member Services department assembles the CAB meeting minutes, agenda, and additional information through a CAB memorandum to include in the BOD packet for review and consideration following each CAB meeting.
3. CenCal Health also ensures that any regular changes to the duties of CAB are shared by a report from CenCal Health to the BOD.

E. DHCS Statewide Consumer Advisory Committee

1. CenCal Health must appoint one member of the CAB, selected by the CAB, or another CenCal Health Member designated by the CAB, to serve as CenCal Health's representative to DHCS' Statewide Consumer Advisory Committee, consistent with Exhibit A, Attachment III, Section 5.2.11.D (Community Engagement) of the contract between CenCal Health and DHCS. CenCal Health is responsible to compensate the CAB member representative for their time and participation on DHCS' Statewide Consumer Advisory Committee, including transportation expenses to appear in person.

F. CAB Meetings

1. CenCal Health must hold its first regular CAB meeting promptly after all initial CAB members have been selected by the CAB selection committee and quarterly thereafter.

2. CenCal Health must make the regularly scheduled CAB meetings open to the public, posting meeting information publicly on CenCal Health's website in a centralized location, 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

3. CenCal Health must provide a location for CAB meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.

4. CAB must draft written minutes of each of its meetings and the associated discussions.
    a. All minutes must be posted on CenCal Health's website and submitted to DHCS no later than 45 calendar days after each meeting.
    b. CenCal Health must retain the minutes for no less than 10 years and provided to DHCS, upon request.

5. CenCal Health must ensure that CAB members are supported in their roles on the CAB, including but not limited to providing resources to educate CAB members to ensure they are able to effectively participate in CAB meetings, providing transportation to CAB meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAB member participation possible.

6. CenCal Health must demonstrate that CAB input is considered in annual reviews and updates to relevant policies and procedures, including CAB input pursuant to Exhibit A, Attachment III, Section 5.2.11.E (Community Advisory Committee) of the contract between CenCal Health and DHCS, that is relevant to policies and procedures affecting cultural and linguistic services, quality, and Health Equity. CenCal Health must provide a feedback loop to inform CAB members how their input has been incorporated.

G. Duties of the CAB

1. The CAB shall carry out the duties as set forth in CenCal Health's Managed Care Contract with the DHCS. Such duties include, but are not limited to:

   a. Identifying and advocating for preventive care practices to be utilized by CenCal Health;
   b. CenCal Health must ensure that the CAB is included and involved in developing and updating cultural and linguistic policy and procedure decisions, with the objective to evaluate and improve (where necessary) such services that support the delivery of Covered Services to Members, including those less than 21 years of age. Such cultural and linguistic policy and procedure decisions, shall include, without limitation, those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAB may also advise on necessary Member or Provider targeted services, programs, and trainings;
   c. The CAB must provide and make recommendations to CenCal Health regarding the cultural appropriateness of communications, partnerships, and services;
   d. The CAB must review Population Needs Assessment (PNA) findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health. CenCal Health must allow its CAB to provide input on selecting targeted health education, cultural and linguistic, and QI strategies;
   e. CenCal Health must provide sufficient resources for the CAB to support the required CAB activities outlined above, including supporting the CAB in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f. The CAB must provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;
ii. Priorities for health education and outreach program;
iii. Member satisfaction survey results;
iv. Findings of the Population Needs Assessment (PNA);
v. Plan marketing materials and campaigns.
vi. Communication of needs for Network development and assessment;
vii. Community resources and information;
viii. Population Health Management;
ix. Quality;
x. Health Delivery Systems Reforms to improve health outcomes;
xi. Carved Out Services;
xii. Coordination of Care;
xiii. Health Equity; and
xiv. Accessibility of Services

H. CAB Demographic Report

1. To ensure CenCal Health's CAB membership is representative of the Communities in the Plans' Service Area, CenCal Health must complete and submit to DHCS annually an Annual CAB Member Demographic Report by April 1 of each year.

2. The Annual CAB Member Demographic Report must include descriptions of all of the following:

a. The demographic composition of CAB membership;
b. How CenCal Health defines the demographics and diversity of its Members and Potential Members within the Plan's Service Area;
c. The data sources relied upon by CenCal Health to validate that its CAB membership aligns with the Plan's Member demographics;
d. Barriers to and challenges in meeting or increasing alignment between CAB's membership with the demographics of the Members within the Plan's Service Area;
e. Ongoing, updated, and new efforts and strategies undertaken in CAB membership recruitment to address the barriers and challenges to achieving alignment between CAB membership with the demographics of the Members within the Plan's Service Area; and
f. A description of the CAB's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAB input impacted and shaped CenCal Health initiatives and/or policies.

IV. Definitions:

Covered Services: those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*., 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, CenCal Health's contract with DHCS, and APLs that are made the responsibility of the CenCal Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Health Disparity: differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

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

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

Member or Enrollee: a Potential Member who has enrolled with CenCal Health.

Population Needs Assessment (PNA): a process for:
A. Identifying Member health needs and Health Disparities;
B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and
C. Implementing targeted strategies for health education, C&L, and QI programs and services.

Potential Member or Potential Enrollee: a Medi-Cal recipient who resides in CenCal Health's service area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes specified by DHCS.

V. References:

A. 22 CCR section 53876(c)

B. CenCal Health's Medi-Cal Managed Care Contract with DHCS, Exhibit A Attachment III Section 1.1.10 Member Representation

C. CenCal Health's Medi-Cal Managed Care Contract with DHCS, Exhibit A Attachment III Section 2.2.10.E.7 Quality and Health Equity

D. CenCal Health's Medi-Cal Managed Care Contract with DHCS, Exhibit A Attachment III Section 5.2.11.D.8 Community Engagement

E. CenCal Health's Medi-Cal Managed Care Contract with DHCS, Exhibit A Attachment III Section 5.2.11.E Community Advisory Committee

F. PL 99-001 Community Advisory Committee

VI. Cross Reference: N/A

VII. Attachments: N/A

Revision History:

Revision Date	Leaders who Reviewed and Approved	Reason for Change	Effective Date	DHCS Approval Date
2/2023		Policy revised to align with 2024 DHCS Contract Amendment requirements for R.0056 and R.0059.	1/1/2024	TBD

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Provider Credentialing and Recredentialing	**Policy No.:** PS-CR03
Department: Provider Services	
Cross-Functional Departments: Quality	
Effective Date: 01/2024	**Last Revision Date:** N/A
P&P Require DHCS Approval? Y ☒ N ☐	
Director or Officer Signature and Date: Luis Somoza Provider Services Director	**Officer Signature and Date:** Jordan Turetsky Chief Operating Officer Emily Fonda, MD Chief Medical Officer

I. Purpose

To ensure that CenCal Health's Network Providers and practitioners meet, and will continue to meet, all professional licensing and performance credentialing requirements necessary in order to provide CenCal Health members at all times with the highest level of medical, hospital and behavioral health care possible. Also, to ensure that participating providers, practitioners and physician executives meet basic qualifications before providing services to members of CenCal Health programs.

II. Policy:

A. CenCal Health and its fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors shall maintain written policies and procedures for the initial credentialing, recredentialing, recertification and reappointment of all Network Providers and practitioners that render acute, primary, and/or behavioral health services to assigned members, in accordance with 42 CFR section 438.214 and Part 2 of the Department of Health Care Services (DHCS) APL 22-013, dated July 19, 2022 (supersedes APL 19-004, dated June 12, 2019)

B. CenCal Health ensures Network Providers and practitioners who deliver covered services to Members are qualified in accordance with applicable standards and are licensed, certified or registered, as appropriate. This policy also defines the credentialing of physicians and physician executives who serve in an administrative capacity for CenCal Health, and who make decisions regarding Utilization Management, Case Management, Quality Improvement, Member Satisfaction, Peer Review, Pharmacy & Therapeutics, or other decisions affecting clinical care or services for members of CenCal Health programs. Providers and practitioners are informed of the credentialing policy and procedure through their Provider contract agreements and amendments, CenCal Health's Provider Manuals, CenCal Health's website, Provider Bulletin articles, and other materials issued by CenCal Health.

III. Procedure:

A. The CenCal Health credentialing and recredentialing functions are a component of the Quality Improvement and Health Equity Transformation Program which is overseen by the Quality Improvement and Health Equity Committee (QIHEC). The Provider Credentials Committee (PCC) is a subcommittee of the QIHEC, chaired by the CenCal Health Chief Medical Officer or designee, and comprised of at least six credentialed Network Providers or practitioners. The PCC's functions include:

   a. Reviewing provider's and practitioner's requests for participation in CenCal Health's provider network; and

   b. Providing final decisions regarding initial or subsequent credentialing based on clinical competency and professional conduct.

B. Providers To Be Credentialed

   1. The scope of the Network Providers and practitioners to be credentialed and recredentialed by CenCal Health under this policy include all licensed and contracted Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Podiatric Medicine (DPMs), Doctors of Chiropractic (DCs), doctoral level behavioral health practitioners (PhDs, PsyDs), any dentists who provide services under medical benefits (e.g., oral surgeons, DDSs); non-physician behavioral health practitioners such as licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), professional clinical counselors, (PCCs), board certified behavior analysts (BCBAs); non-physician medical practitioners such as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNMs) and certified nurse anesthetists

(CRNAs); and non-physician non-licensed independent practitioners such as registered dieticians (RDs) and physical therapists (PTs). CenCal Health will credential and recredential the following practitioners:

a. All Network Providers and practitioners who have a contracted, independent relationship with CenCal Health

b. All Network Providers and practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.

c. All physician executives who serve in an administrative capacity for CenCal Health or contracted groups.

d. All Network Providers and practitioners who are hospital-based but see CenCal Health's members as a result of their independent relationship with CenCal Health. An example of this type of practitioner would be an anesthesiologist with a pain management practice.

2. CenCal Health will *not* credential or recredential the following practitioners:

a. Providers or practitioners who practice exclusively within the inpatient setting and who provide care for CenCal Health's members only as a result of the members obtaining care at the hospital or inpatient setting

b. Providers or practitioners who practice exclusively within freestanding facilities and who provide care for CenCal Health's members only as a result of the members obtaining care at the facility.

C. Non-Discrimination Policy for Network Providers and Practitioners

1. No provider or practitioners shall be denied an agreement with CenCal Health, have any corrective actions imposed, or have his/her agreement suspended or terminated solely on the basis of race, color, age, gender, marital status, sexual orientation, religious creed, ancestry, national origin, physical or mental disability, or the types of procedures or the patients in which the provider or practitioner specializes.
2. CenCal Health will track and trend reasons for denial and/or termination from the network to protect against discrimination occurring in the credentialing or recredentialing process. A monitoring report will be reviewed by the PCC at least annually.
3. PCC members shall sign a "Statement of Confidentiality" that includes a non-discrimination statement.
4. Documents and information submitted to the PCC for a decision to participate in CenCal Health's provider network shall not designate a practitioner's race, ethnic or national identity, gender, age, sexual orientation or types of procedures performed except where needed for verification of

information as part of the credentialing process, such as with the NPDB or AMA.

D. Credentialing Application and Letter

1. A credentialing application, attestation, and contract agreement must be completed, signed, and returned to CenCal Health by each provider and practitioner interested in participation.
2. The application for Network Provider and practitioner credentialing requires a signed and dated attestation, which includes, but is not limited to, the following statements by the applicant regarding the following:
    a. Any limitations or inabilities that affect the practitioner's ability to perform any of the position's essential functions, with or without accommodation.
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. Any history of loss or limitation of privileges or disciplinary activity
    e. Current adequate malpractice insurance coverage as per the Physician Service Agreement
    f. The application's accuracy and completeness.
3. The application requests a copy of the current DEA certificate (if applicable), malpractice insurance policy face sheet indicating term and liability limits, and written documentation of:
    a. All work history activities since completion of postgraduate training, either on the application or a Curriculum Vitae, with a written or verbal explanation of any gaps of six months or more in the work history (gaps in work history exceeding one year must be explained in writing)
    b. An explanation of all positive answers to attestation questions on the application.
4. The application also requests information regarding board certification, professional training, Educational Commission of Foreign Medical Graduates (ECFMG) (if applicable), clinical privileges, felony convictions, malpractice history, Medicare and Medi-Cal certificate numbers, and pertinent information regarding office features.

E. Initial Credentialing

1. All Network Providers must have executed Network Provider agreements with CenCal Health and must be qualified in accordance with current applicable legal, professional, and technical standards, including

appropriate licensure, certification, or registration as required by state and federal law.

2. All Network Providers and practitioners must have a valid National Provider Identifier (NPI) number.

3. All contracted Laboratory Testing Sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

4. CenCal Health shall conduct onsite reviews of its Network Provider sites but may accept evidence of National Committee on Quality Assurance (NCQA) Provider Organization Certification (POC) in lieu of a monitoring visit at the Network Provider's site. Conversely, CenCal Health may choose to seek POC from the NCQA which would allow CenCal Health to be exempt from DHCS' medical review audit of credentialing practices, while retaining overall responsibility for ensuring that credentialing requirements are met.

5. All verifications, attestations, and information releases will be less than 180 days old (or for some, 365 days) at the time of the credentialing decision as per NCQA standards.

F. Initial Primary Source Verification

1. At time of credentialing, at least the following information is verified from the primary source or an NCQA approved verification source:

   a. A current valid license to practice in the State of California, verified with the Medical Board of California, Dental Board of California, the California Board of Chiropractic Examiners, or Board of Registered Nurses. Alternate means of verification include entry in the AOA or AMA Physician Master Files. CenCal Health retains the right to decline to accept an initial credentialing application from a practitioner whose license is on probation or otherwise not free and unencumbered.

   b. The status of clinical privileges at any contracted inpatient facility within CenCal Health's service area listed by the practitioner on the application, if applicable, by contacting the facility's medical staff office. If an applicant does not have adequate clinical privileges, as determined by the practitioner's agreement with CenCal Health, the practitioner must supply the name(s) of any practitioner(s) who will admit members to a contracted inpatient facility on their behalf, (known as a "covering practitioner"). Covering practitioners must be

participating practitioners in CenCal Health's network and must have a specialty that is comparable to that of the practitioner he is covering. A practitioner may also designate the hospitalist program at a contracted inpatient facility as his inpatient coverage.

c. A valid DEA certificate, as applicable, by obtaining a photocopy of the original certificate. Alternate means of verification include: documented visual inspection of the original certificate, or entry in the AMA or AOA Physician Master Files. If a practitioner does not have all schedules on their DEA certificate, CenCal Health will contact the practitioner for an explanation of the missing schedules and the practitioner's plan for continuity of care.

2. Education and training of Network Providers: If the practitioner is not board certified, CenCal Health verifies the practitioner's highest level of education and training, by contacting the school or residency program. Practitioner's specialties will be listed in CenCal Health's Provider Directory according to their highest level of education and training: i.e. board certification or completed residency in their indicated specialty and subspecialty areas of concentration. Any practitioner not meeting the above criteria will be listed as a General Practitioner in the Provider Directory. A practitioner wishing to contract as a Primary Care Provider (PCP) must have completed a residency in a field that qualifies them to act as a PCP. CenCal Health has determined that residency programs meeting these criteria include: Internal Medicine, Family Practice, and Pediatrics.

3. If the Network Provider or practitioner has been identified as an HIV/AIDS Specialist, the following additional criteria is verified prior to indicating this sub-specialty in provider listings:

   a. Provider or practitioner is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; OR

   b. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; OR

   c. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

i. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND
ii. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; OR
iii. Meets the following qualifications:
    I. In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; AND
    II. Has completed any of the following:
        1) In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; OR
        2) In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; OR
        3) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
iv. Board certification. If the Network Provider or practitioner states that he/she is board certified on the application, certification is verified through the specific board, the ABMS, or entry in the AMA or AOA Physician Master Files.
v. History of professional liability claims by querying the NPDB. Sanction information by querying the NPDB, HIPDB, CIN-BAD, the appropriate state medical boards, and/or the AMA/AOA Physician Master Files.

vi. Medicare/ Medicaid sanctions by querying the NPDB, CIN-BAD, or OIG. Also monitored via Suspended & Ineligible Provider List & Excluded Parties List System.
vii. All Network Providers and practitioners must have good standing in the Medicare and Medicaid/Medi-Cal programs. Providers and practitioners that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in CenCal Health's provider network,

4. Initial Credentialing Site Visits: For all PCPs, a Facility Site Review of the provider's primary care office location(s), including an audit of patients' medical records, is performed by a CenCal Health nurse reviewer who is certified by DHCS to perform these site and medical record reviews. The facility review evaluates the office or clinic as compared to CenCal Health's and the Department of Health Care Services' standards. The medical record review evaluates the documentation of appropriate care to ensure conformity with CenCal Health's and the Department of Health Care Services' standards.

G. Recredentialing

1. The Recredentialing process is repeated at least every three years but may be repeated more frequently when required by a change in relevant information or at the direction of the PCC. Network Providers, practitioners and physician executives are recredentialed within three years of their last credentialing date, which is the date the PCC rendered their decision regarding the provider's or practitioner's participation.

2. Recredentialing Primary Source Verification: During recredentialing, at least the following information is verified from the same primary sources as those used for initial credentialing:
   a. A valid California state license to practice
   b. A valid DEA certificate (if applicable). If a practitioner does not have all schedules on his DEA Certificate, CenCal Health will request an explanation of the missing schedules and the practitioner's plan for continuity of care
   c. Malpractice insurance is current and adequate
   d. The status of clinical privileges at all contracted hospitals within CenCal Health's service area that the practitioner lists on the application (as applicable)
   e. Board certification, if the practitioner states that he/she is board certified
   f. If the practitioner has been identified as an HIV/AIDS Specialist, the criteria described in the "Initial Primary Source Verification" section of

this policy is re-verified in order to continue indicating this sub-specialty in provider listings.

3. History of professional liability claims.

4. Sanctions Information. The Medical Board of California, the NPDB, and CIN-BAD (as applicable) are queried for any reported sanctions or actions against the practitioner's license since last review. Sanction information may also be identified through querying the HIPDB or entry in the AMA/AOA Physician Master Files. If the practitioner has been licensed in another state within the past five years, that state's medical board will be contacted for status and sanction history.

5. For PCPs and specialty care providers, the Provider Credentials Committee incorporates the following minimum quality data in its recredentialing review:
    a. Member grievance data as reported by Member Services Department. All member complaints in the previous credentialing cycle will be documented in the practitioner's file, but only those complaints that meet or exceed the following criteria are brought to the PCC for review:
        i. *Pattern:* 3 or more complaints of the same type in the previous credentialing cycle
        ii. *Severity:* 3 or more "with merit" in the previous credentialing cycle

6. Provider complaint data as reported by Provider Services Department

7. Information from quality improvement activities, which may include routine medical record audits as appropriate and any quality of care concerns known to CenCal Health that may be useful to the Committee in making an informed recommendation regarding clinical competency and/or professional conduct. Quality of care concerns include those reviewed by the Chief Medical Officer, Health Services Department, and by other committees of CenCal Health, including but not limited to peer review. Peer review activities are overseen by CenCal Health's Chief Medical Officer or medical director designee, in coordination with all credentialing considerations.

8. Recredentialing Site Visits: An office visit and assessment of medical record keeping practices is conducted for all PCP practice sites within the three-year period before a recredentialing decision. PCPs must attain a passing score on facility and chart audit, or submit a corrective action plan if required within the specified time frame.

9. Continuous Monitoring of credentials: In order to verify that all providers' and practitioner's licenses, DEA certificates, and liability coverage have not lapsed during the three-year recredentialing cycle, CenCal Health will routinely request current documentation either via the internet or by contacting the provider or practitioner.

10. Continuous Monitoring of quality and performance: The Health Services staff and Chief Medical Officer also routinely monitor quality issues that may impact the credentialing process, including member/provider complaints and other quality of care concerns.

11. Continuous Monitoring of sanctions: CenCal Health routinely monitors for medical board actions by obtaining real-time reports via e-mail subscription.

H. Provider/Practitioner Application Recommendations and Actions

1. No Issues files may be approved via Medical Director signature. NCQA recognizes the Medical Director sign-off date as the approval date.

2. If it is established that the applicant has verification or clinical issues for discussion, the PCC must review the file and render a decision with or without restrictions, including but not limited to full approval, approval for a shortened timeframe, or request for additional information.

3. The PCC decision is final. The PCC may still credential a provider or practitioner despite documentation of unfavorable information (e.g., malpractice claims, deficient site audits, sanctions).

4. The decisions of the PCC are based on a risk of harm to CenCal Health's members. Such a risk may be based on (but is not limited to) one or all of the following:
    a. Clinical incompetence
    b. Improper professional conduct
    c. Malpractice claims history
    d. Past or current disciplinary actions and sanctions
    e. Lack of work history or unexplained gaps in work history
    f. A history of restrictions and/or revocations of licensure, DEA certification, clinical privileges, and/or participation in other medical organizations
    g. Felony convictions and/or illegal drug use
    h. Member complaints and/or unsatisfactory member surveys
    i. Fraudulent credentials or misrepresentation of credentials

j. Noncompliance/nonresolution with CenCal Health's quality improvement plan and quality of care issues

5. CenCal Health notifies applicants of initial credentialing decisions and recredentailing denials within 60 days of the decision date.

I. Disciplinary Actions Against Network Providers and Network Providers Appeal of Corrective Actions

1. The PCC may impose corrective actions, after a governmental agency takes action against a provider or practitioner that affects the provider's/practitioner's license or credentials to practice or authorization to prescribe controlled substances.

J. Provider Right to Appeal

1. If the PCC denies participation of an applicant or terminates participation of a contracted provider or practitioner, the provider/practitioner has the right to appeal this decision as stated in CenCal Health's policy titled Provider Complaints and Grievances

2. A provider or practitioner must exhaust the remedies afforded by CenCal Health's Provider Complaints and Grievances policy before resorting to formal legal action which
   - Challenges any decision made pursuant to this credentialing policy or the procedures used to arrive at such a decision
   - Asserts any claim against CenCal Health or any participants in the decision process.

3. If the PCC terminates a provider's or practitioner's participation in CenCal Health's provider network and the provider/practitioner does not request a hearing or appeal and the decision of the PCC is upheld, Provider Services shall immediately proceed, pursuant to the terms of the provider's agreement with CenCal Health, to terminate the agreement.

K. Medical Board of California and National Practitioner Data Bank (NPDB) Reporting

1. Pursuant to Business and Professions Code, Section 805, CenCal Health shall report any reportable actions related to a "medical disciplinary cause or reason" to the Medical Board of California and/or the National Practitioner Data Bank following relevant reporting guidelines.

2. A provider or practitioner who is the subject of a proposed adverse action reportable to the Medical Board of California or the NPDB may request an informal meeting with the Director of Provider Services to dispute the text of the report filed regarding verification issues, and/or with the Chief Medical Officer or appointed Medical Director regarding any Quality of Care dispute. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report to be filed is consistent with the final action.

L. Delegation of Credentialing and Recredentialing

CenCal Health has the discretion to delegate credentialing and recredentialing activities to subcontractors and downstream subcontractors such as to a professional credentialing verification organization or to entities such as medical groups or independent physician organizations. CenCal Health shall enter into a formal and detailed written agreement with the delegated entity. Such agreement shall be revised when the parties change the agreement's terms and conditions. CenCal Health shall remain ultimately responsible for the completeness and accuracy of the delegated activities.

M. CenCal Health shall establish a delegation system that performs the following functions:

1. Evaluates the delegated entity's ability to perform delegated activities that includes an initial review to assure that the delegated entity has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

2. Assures its members that the same standards of participation as required by DHCS and CenCal Health are maintained throughout its provider network;

3. Retains the right to approve, suspend, or terminate all providers, practitioners and sites of care;

4. Continuously monitors, evaluates, and approves the delegated functions through the receipt and review of reports no less than semiannually;

5. Ensures that a consistent and equitable process is used throughout its network by requiring:
   a. The delegated entity adheres to at least the same criteria outlined in this policy. CenCal Health will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation.

   b. A mutually agreed upon document, which may be a contract, letter, memorandum of understanding, or other document, which clearly

defines the performance expectations for CenCal Health and the delegated entity. This document will define CenCal Health's and the delegate's specific duties, responsibilities, activities, reporting requirements, and identifies how CenCal Health will monitor and evaluate the delegate's performance. This mutually agreed upon document will also specify the remedies available to CenCal Health, including (but not limited to) revocation of the delegation if the delegate does not fulfill its obligations.

c. CenCal Health's staff to audit the delegate's policies and procedures and a sample of credentialing files on an annual basis to evaluate whether the delegated entity's activities are being conducted in accordance with CenCal Health's expectations and NCQA standards. The only exception to the oversight requirements is when CenCal Health delegates to an entity that is NCQA Certified for Credentialing or accredited by NCQA. CenCal Health may waive the annual audit and may assume that the delegate is carrying out responsibilities in accordance with NCQA standards.

d. At least annually, CenCal Health's staff monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.

e. At least annually, CenCal Health acts on all findings that result from each delegate's monitoring of its credentialing system security controls. CenCal Health implements a quarterly monitoring process until each delegate demonstrates improvement for a finding over three consecutive quarters.

f. If monitoring reveals deficiencies in the delegate's credentialing and recredentialing processes, CenCal Health will work with the delegate to set priorities and correct the problems. If serious problems cannot be corrected, CenCal Health will revoke the delegation arrangement that CenCal Health retains the right, based on quality issues, to approve, suspend or terminate providers and practitioners.

g. Functions performed by vendors that do not involve decision-making (i.e. data collection as may be performed by a CVO) are not delegated functions, as defined in this section.

IV. Definitions:

American Board of Medical Specialties (ABMS): An NCQA-approved source for verification of board certification.

American Medical Association (AMA) Physician Master File: An NCQA-approved source for verification of various MD credentials, including, but not limited to: medical license, DEA certificate, education and training, board certification, sanction activity.

American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report/Physician Master File: An NCQA-approved source for verification of various DO credentials, including, but not limited to: medical license, DEA certificate, education and training, board certification, sanction activity.

Chiropractic Information Network-Board Action Databank (CIN-BAD): Official Actions Database which is a comprehensive repository of information on actions taken by official bodies with regard to individual chiropractors. It is maintained by the Federation of Chiropractic Licensing Boards as a service to its member boards, to the health care community, and to the general public.

Complete Application: An application with 1) All blanks filled in and necessary additional explanations provided; 2) all requested attachments submitted; 3) verification of the information is complete; and 4) all information necessary to properly evaluate the applicant's qualifications received and is consistent with the information provided in the application.

Council for Affordable Quality Healthcare (CAQH): CAQH is a non-profit alliance of health plans and related associations working together to achieve the shared goal of streamlining the business of healthcare. CAQH is an NCQA-certified Credentials Verification Organization (CVO) and serves as a central repository for credentialing applications that member organizations can access.

Credentialing: means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership in order to ensure that Network Providers are properly licensed and certified as required by state and federal law. A part of CenCal Health's Quality Assessment and Improvement Program which verifies credentials with the issuer of the credential or other recognized monitoring organization, in order to evaluate a provider's qualifications, affiliations, competency, and to monitor the quality of medical services provided.

Credentials Verification Organization (CVO): An organization that provides primary source verification services to health care organizations to improve and expedite the credentialing process.

Educational Commission for Foreign Medical Graduates (ECFMG): An organization that certifies providers who have graduated from a medical school

in another country. ECFMG verifies each provider's diploma with the medical school prior to issuing certification.

Facility-based Provider: A provider who sees CenCal Health's members only as a result of the member being directed to a hospital, freestanding facility, or other inpatient setting. Examples of this type of provider are hospitalists, pathologists, radiologists, anesthesiologists, neonatologists, and emergency room physicians. The facility is responsible for credentialing these providers.

Freestanding Facilities*:* A health care facility that is physically, organizationally, and financially separate from a hospital and whose primary purpose is to provide immediate or short-term medical care on an outpatient basis. Examples of this type of facility include, but are not limited to, mammography centers, urgent care centers, surgical centers, and ambulatory behavioral health care facilities. CenCal Health assesses these facilities as Organizational Providers.

Healthcare Integrity and Protection Data Bank (HIPDB)*:* A nationwide flagging system established by the Health Insurance Portability and Accountability Act of 1996, Section 221(a), Public Law 104 191, to create a databank of healthcare related adverse actions, including civil judgments, criminal convictions, and actions taken by federal and state agencies responsible for licensing and certification of healthcare practitioners, providers, and suppliers.

Independent Relationship*:* An independent relationship exists between CenCal Health and a provider when CenCal Health directs its members to see a specific provider or group of providers. An independent relationship is not synonymous with an independent contract.

Medical Disciplinary Cause or Reason*:* Refers to an aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Member*:* a Medi-Cal recipient who resides in the Plan's Service Area and who has enrolled with the Plan.

National Practitioners Data Bank (NPDB): An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists, and other health care providers. The U.S. Government established the Data Bank to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

Network Provider: any provider or entity that has a network provider agreement with CenCal Health, CenCal Health's subcontractor, or CenCal Health's downstream subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render covered services. A Network Provider is not a

subcontractor or downstream subcontractor by virtue of the network provider agreement.

Office of Inspector General (OIG): In response to legislation preventing certain individuals and businesses from participating in federally-funded health care programs (e.g. Medicare), the OIG developed a program to exclude these individuals and entities, and maintains a list of all currently excluded parties. Querying the OIG identifies parties excluded due to sanctions imposed by federally-funded health care programs.

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.

Provider Credentials Committee: A committee of credentialed Network Providers who are made responsible by the QIHEC to review and render decisions regarding provider credentialing and recredentialing.

Primary Source Verification: Refers to contacting the entity, agency, or institution that issues a provider's credential for verification of the document's authenticity. Also refers to an entity, such as a state licensing agency with legal responsibility for originating a document and ensuring the accuracy of the document's information. For some credentials, the primary source does not need to be contacted directly if they make verification available through another source. For the purposes of this policy, primary source verification means contacting either the actual issuer or another recognized monitoring source approved for verification by the National Committee for Quality Assurance (NCQA). For example, board certification may be verified by contacting the appropriate specialty board (the issuer) or the NCQA approved source of the American Board of Medical Specialties (ABMS) directory.

Quality Improvement and Health Equity Committee (QIHEC): the committee facilitated by CenCal Health's Chief Medical Officer (CMO), or the CMO's designee, in collaboration with the Chief Health Equity Officer, to meet at least quarterly to direct all QIHETP findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP): the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care Agreement.

Subcontractor: means an individual or entity that has a contract with an Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM) entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A

Network Provider is not a subcontractor by virtue of the Network Provider agreement with the MCO, PIHP, or PAHP

Verification File: A provider's complete credentialing application with all verifications and documentation gathered during the credentialing verification process, including quality improvement data furnished by the Health Services Department and member complaint data furnished by the Member Services Department.

180-Day Timeframe: To ensure that the PCC does not consider an applicant whose credentials may have changed since verification, CenCal Health and its staff will adhere to strict timeframes for the credentialing process. All verifications, attestations, and information releases will be less than 180 days old at the time of the credentialing decision as per NCQA standards, with the exception of those designated by NCQA as 365 (360) day time limited. For written verifications, the 180-day time limit begins with the date on the written verification from the entity that verified that particular credential. Unless otherwise stated, all verification timeframes in this policy are 180 days prior to the decision.

V. References:

A. 42 CFR section 438.2
B. 42 CFR section 438.214
C. DHCS 2024 Medi-Cal Managed Care Contract, Exhibit A, Attachment III, section 2.2.12
D. DHCS APL 22-013, dated July 19, 2022, supersedes APL 19-004
E. DHCS APL 19-004, dated June 12, 2019, supersedes APL 17-019

VI. Cross Reference:

A. Policy and Procedures (P&Ps):

1. PS-CR01 Provider Enrollment and Screening
2. PS-CR21 Facility Site Review and Medical Record Review Overview
3. PS-CR22 Facility Site Review and Medical Record Review Process
4. PS-CR23 Medical Record Standards

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date	DHCS P&P Approval Date
2023-11		2024 Template Migration		
2023-09		NCQA Revision		
2022-12		2024 Contract Amendment Update		
2022-08		2024 Contract Amendment Update		
2021-01		Removed references to obsolete policy, update staff titles and committee names		
2019-05		Added NPMPs, CAQH, Medical Director sign off of all clean files. Changed reference of policy number from 500-2010-J to PS-CR03		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Vaccines for Children Program	**Policy No. :** PS-CR35
Department: Provider Services	
Cross Functional Departments: Quality	
Effective Date: 01/2024	**Last Revised Date:** 11/2023
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Luis Somoza Provider Services Director	**Officer Signature and Date:** Jordan Turetsky, MPH Chief Operating Officer

I. **Purpose**: To specify how CenCal Health will inform its Network Providers about the Vaccines for Children (VFC) Program, including promoting and supporting enrollment of appropriate Network Providers in the Program.

II. **Policy**:

A. CenCal Health shall provide information to all Network Providers regarding the VFC Program. CenCal Health shall promote and support enrollment of applicable Network Providers in the VFC program to improve access to immunizations.

B. CenCal Health shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the VFC Program. CenCal Health coverage shall be in accordance with Medi-Cal guidelines issued prior to final Advisory Committee of Immunization Practices (ACIP) recommendations.

C. CenCal Health shall cover vaccinations, except for vaccinations expressly excluded in Department of Health Care Services (DHCS) 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 childhood immunization schedule and recommendations published by ACIP.

1. CenCal Health's Network Providers are required to document attempts that demonstrate unsuccessful efforts to provide the vaccination, which will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

D. CenCal Health shall ensure 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 must be made following the Member's initial health appointment and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

III. Procedure:

A. CenCal Health shall disseminate information to Network Providers about the VFC Program, which include, but shall not be limited to, the following means:
   1. Including VFC Program information in the Provider Manual, explaining the scope and purpose of the VFC Program, and encouraging Network Providers to register as a VFC Program provider.
   2. Providing updated VFC Program information in the CenCal Health Provider Bulletin not less than annually.
   3. Providing VFC Program information and encouraging enrollment in the Program in new Network Provider orientation for pediatric primary care providers.

B. CenCal Health shall promote and support enrollment of applicable Network Providers in the VFC Program to improve access to immunizations through a variety of methods, including but not limited to:
   1. The methods described in section III.A above; and
   2. Addressing enrollment in the VFC Program during the initial contracting of new pediatric primary care Network Providers.

IV. Definitions:

A. Advisory Committee on Immunization Practices (ACIP): a group of medical and public health experts that develop recommendations on how to use vaccines to control diseases in the United States.

B. Covered Services: those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*., 22 CCR section 51301 *et seq*., 17 CCR section 6800 *et seq*., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the Plan's contract with DHCS, and APLs that are made the responsibility of the Plan pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

C. Department of Health Care Services (DHCS) or **Department:** the single state department responsible for the administration of the Medi-Cal Program, CCS, Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

D. Food and Drug Administration: a government agency for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices.

E. **Medical Records** means the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.
F. **Network Provider:** any Provider or entity that has a Network Provider Agreement with CenCal Health or CenCal Health's Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
G. **Network Provider Agreement:** a written agreement between a Network Provider and CenCal Health or CenCal Health's Subcontractor.
H. **Service Area:** the county or counties that CenCal Health is approved to operate in under the terms of its contract with DHCS.
I. **Subcontractor:** an individual or entity that has a Subcontractor Agreement with CenCal Health that relates directly or indirectly to the performance of CenCal Health's obligations under its Medi-Cal managed care contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
J. **Vaccines for Children (VFC) Program**: the federally funded program that provides free vaccines for eligible children age 18 or younger (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating Providers.

V. References:

A. Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14131 *et seq*.
B. 17 CCR section 6800 *et seq.*
C. 22 CCR section 51301 *et seq*.
D. Medi-Cal Provider Manual
E. CenCal Health 2024 DHCS Contract, Exhibit A, Attachment III, sections 2.2.10.D.2..

VI. Cross Reference:

A. Policy and Procedures (P&P):
   1. *QU-XXX* Ensuring Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screening, American Academy of Pediatrics (AAP) Bright Futures Preventive Services, and Medically Necessary Diagnostic and Treatment Services, for Members Under Age 21

B. Standard Operating Procedure (SOP): N/A

VII. Attachments: N/A

Revision History:

Revision Date	Leaders who Reviewed and Approved	Reason for Change	Effective Date	DHCS Approval Date
11/2023	Jordan Turetsky, Chief Operating Officer	2024 Template Migration	01/2024	
09/2023	Jordan Turetsky, Chief Operating Officer	P&P Established	01/2024	TBD

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Identification, Referral, and Care Coordination for Members in Need of Non-Specialty Mental Health Services, Specialty Mental Health Services, and/or Substance Use Disorder Treatment Services	**Policy No. :** MM-BH301
Department: Medical Management	
Cross Functional Departments: Behavioral Health	
Effective Date: January 1, 2024	**Last Revised Date:** N/A
P&P Require DHCS Approval? Y ☒ N ☐	**Annual Review Date:**
Director/Officer Signature and Date: Christopher Hill, MBA, BS, RN Health Services Officer	**Officer Signature and Date:** Emily Fonda, MD, MMM, CHCQM Chief Medical Officer

I. Purpose

CenCal Health ensures the provision of all Medically Necessary services and identifies, refers, and coordinates care for Members requiring Non-specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS), and Substance Use Disorder (SUD) treatment services.

II. Policy:

A. Identification

1. CenCal Health identifies its Members seeking and/or requiring NSMHS or SMHS by ensuring they receive DHCS-approved standardized screenings as necessary and appropriate to receive Closed Loop Referrals to the appropriate delivery system for mental health services either in CenCal Health's provider network or the Mental Health Plan (MHP) network in accordance with the No Wrong Door policies set forth in Cal. W&I Code § 14184.402(h). For the purposes of this policy, the MHP is County Behavioral Health.

2. CenCal Health identifies, refers, and coordinates care for Members requiring SUD treatment services in accordance with policy MM-BH304 *Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Treatment Services*.

B. Service Coverage

1. CenCal Health shall cover specified outpatient services to adult Members

experiencing mild-to-moderate distress or impairment of mental, emotional, or behavioral functioning.

2. In accordance with Cal. W&I Code section 14184.402(b)(2), CenCal Health shall also provide Medically Necessary NSMHS to Members under the age of 21.

3. CenCal Health shall cover Medically Necessary covered SUD services for Members under the age of 21.

4. Consistent with federal guidance from the Centers for Medicare & Medicaid Services (CMS), behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, maintain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered under the EPSDT mandate.

5. Clinically appropriate and covered SUD services delivered by CenCal Health providers (e.g., drug and alcohol SABIRT services, tobacco cessation counseling, and medications for addiction treatment [also known as medication-assisted treatment or MAT)] are covered by CenCal Health whether or not the Member has a co-occurring mental health condition.

    a. Such services delivered by CenCal Health providers in the primary care office setting, emergency department setting, inpatient hospital setting, and other contracted medical settings are covered by CenCal Health whether or not the Member has a co-occurring mental health condition.

6. When clinically appropriate and a covered benefit, CenCal Health provides timely NSMHS for Members consistent with the No Wrong Door policies even when:

    a. NSMHS are provided during the assessment process;

    b. NSMHS are provided prior to the determination of a diagnosis;

    c. NSMHS are provided prior to a determination of whether NSMHS criteria set forth in Cal. W&I Code section 14184.402(b)(2) are met;

    d. NSMHS are not included in a Member's individual treatment plan;

    e. Member has a co-occurring mental health condition and SUD; and/or

    f. NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between CenCal Health and County Behavioral Health.

7. Likewise, clinically appropriate and covered SMHS are covered by County Behavioral Health whether or not the Member has a co-occurring SUD.

Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the Member has a co-occurring mental health condition. Refer to MM-BH304 Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Services and HS-QI402 Alcohol, Tobacco, and Drug Screening Assessment, Behavioral Counseling Interventions and Referral Treatment in Primary Care.

8. Concurrent NSMHS and SMHS

   a. Members may concurrently receive NSMHS from a CenCal Health provider and SMHS via a County Behavioral Health provider when the services are clinically appropriate, coordinated and not duplicative.

   b. When a Member meets criteria for both NSMHS and SMHS, the Member should receive services based on the individual clinical need and established therapeutic relationships.

   c. Likewise, County Behavioral Health must not deny or disallow reimbursement for SMHS provided to a Member on the basis of the Member also meeting NSMHS criteria and/or receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

   d. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between CenCal Health and County Behavioral Health to ensure Member choice. CenCal Health must coordinate with County Behavioral Health to facilitate care transitions and guide referrals for Members receiving NSMHS to transition to a SMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the Member. Such decisions should be made via a patient-centered shared decision-making process.

C. Care Delivery Coordination

1. CenCal Health shall refer to and coordinate with County Behavioral Health for the delivery of NSMHS and SMHS, in accordance with the care coordination and data sharing requirements set forth in the Memorandum of Understanding (MOU) between CenCal Health and County Behavioral Health.

2. In accordance with SMHS access criteria set forth in Behavioral Health Information Notice No. 21-073, County Behavioral Health is contractually required to provide or arrange for the provision of SMHS for Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder.

3. CenCal Health coordinates care for Members requiring SUD treatment

services in accordance with the process outlined in MM-BH304 *Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Treatment Services*.

4. CenCal Health is required to use the transition of care tool to facilitate transitions of care to County Behavioral Health for all Members, including adults age 21 and older and youth under age 21, when their service needs change.

D. Dispute Resolution

1. CenCal Health shall follow the dispute resolution process outlined in *MM-BH302 Mental Health Services – Dispute Resolution* to resolve disputes between CenCal Health and County Behavioral Health.

E. As applicable, for all applicable county and State MHPs, CenCal Health has executed DHCS-compliant MOUs with County Behavioral Health to ensure that the services for CenCal Health Members are properly coordinated and provided in a timely and non-duplicative manner.

F. CenCal Health complies with all mental health parity requirements in 42 CFR section 438.900 *et seq*. CenCal Health ensures it does not apply any financial or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

III. Procedure:

A. Identifying Members in Need of NSMHS, SMHS, and/or SUD Treatment Services

1. CenCal Health primary care providers (PCPs) are responsible for performing mental health screenings. CenCal Health Providers identify Members requiring NSMHS or SMHS treatment through various required mental health screenings, including Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), adverse childhood experiences (ACE), and Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in CenCal Health's provider network or the County Behavioral Health network, in accordance with the No Wrong Door policies set forth in Cal. W&I Code §14184.402(h).

a. CenCal Health covers mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and

other screening services.

i For Members under age 21, refer to policy [insert P&P no.] Ensuring EPSDT Screening, AAP Bright Futures Preventive Services, and Medically Necessary Diagnostic and Treatment Services, for Members Under Age 21 and policy HS-MMXX Early and Periodic Screening, Diagnostic, and Treatment Services.

b. CenCal Health identifies Members requiring SUD treatment services in accordance with the process outlined in MM-BH304 *Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Treatment Services.*

2. In accordance with APL 22-028, CenCal Health utilizes the DHCS-approved standardized Adult and Youth Screening Tools, as appropriate, to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact CenCal Health or County Behavioral Health seeking mental health services.

B. Service Coverage

1. CenCal Health is responsible for providing the following outpatient mental health services when Medically Necessary:

a. Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services.

b. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

c. Outpatient services for the purposes of monitoring drug therapy.

d. Outpatient laboratory, drugs (excluding CenCal Health carved-out medications), supplies, and supplements prescribed by mental health providers in CenCal Health's network and PCPs, including physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions. Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medication or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders.

e. Psychiatric consultation.

f. Hypnotherapy.

g. Health behavior assessments and interventions.

h. Psychiatric collaborative care.

i. Other NSMHS as described in the Medi-Cal Provider Manual.

2. In addition to the above, CenCal Heath provides psychotherapy to Members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder.

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

4. For Members who are 21 years of age and older who meet the criteria for NSMHS set forth in Cal. W&I Code section 14184.402(b)(2), CenCal Health covers Medically Necessary NSMHS in accordance with Cal. W&I Code section 14059.5). CenCal Health also covers Medically Necessary covered SUD services in accordance with Cal. W&I Code section 14059.5 for Members who are 21 years of age and older. CenCal Health's coverage of NSMHS and SUD services complies with Cal. W&I Code section 14184.402(f).

5. For Members who are under 21 years of age, CenCal Health covers Medically Necessary covered NSMHS in accordance with Cal. W&I Code section 14184.402(b)(2). CenCal Health also covers Medically Necessary covered SUD services for Members who are under 21 years of age.

   a. NSMHS and covered SUD services for this population are Medically Necessary if they are necessary to correct or ameliorate a mental health condition or substance use condition discovered by an EPSDT screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and CenCal Health covers such services.

6. CenCal Health must cover and pay for all Medically Necessary covered mental health and SUD services for the Member, including the following:

   a. All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.

   b. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 17-010 and CenCal Health's contract with DHCS. These services include, but are not limited to, SMHS, DMC services, and DMC-ODS services.

   c. NMT services and, for Members less than 21 years of age, NEMT

services, to and from DMC services, DMC-ODS services, and SMHS, in compliance with APL 17-010 and CenCal Health's contract with DHCS.

d. Medically Necessary Covered Services after CenCal Health has been notified by a DMC, a DMC-ODS, County Behavioral Health, or a mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 C.C.R §1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

   i The initial health history and physical examination required upon admission, consultations, and any Medically Necessary covered services; Skilled Nursing Facility (SNF) room and board when IMD services are provided to Members less than 21 years of age and age 65 and over. CenCal Health will not cover other inpatient psychiatric facility/IMD room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/IMD per diem rate.

e. All Medically Necessary Medi-Cal-covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under CenCal Health's contract with DHCS. This includes reimbursement for Medically Necessary Medi-Cal-covered psychotherapeutic drugs administered by out-of-network providers for Members not otherwise excluded under CenCal Health's contract with DHCS. Reimbursement to pharmacies for psychotherapeutic drugs shall be provided through the Medi-Cal Fee for Service (FFS) program. To qualify for reimbursement, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

7. Mental health services, including an initial mental health assessment, covered by CenCal Health shall be provided by licensed or licensed-eligible mental health professionals as specified in the Psychological Services Medi-Cal Provider Manual or by PCPs within the scope of their practice.

   i An initial mental health assessment will be covered by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and geographical access requirements. Refer to policy MM-UMXX *Notification of UR Determinations*.

   ii Authorization for services after the initial mental health assessment will be based on the medical necessity for the requested service in a manner that is consistent with current evidence-based clinical practice guidelines an in accordance with MM-UMXX *Notification of UR Determinations*.

8. Covered NSMHS and SUD treatment services may be delivered in person or via telehealth/telephone as specified in Exhibit A, Attachment III,

Subsection 5.3.1(Covered Services) of the 2024 DHCS Medi-Cal Managed Care Agreement.

9. For the provision of psychiatric emergencies during non-business hours, CenCal Health acts in accordance with MM-XX *After-Hours Availability of Plan or Contract Physician*.

10. CenCal Health will adhere to utilization management requirements as described in Utilization Management Program Description and MM-UMXX *Notification of UR Determinations*.

C. Referring Members for NSMHS, SMHS, and/or SUD Treatment Services

   a. Members who are seeking mental health services who are not currently receiving NSMHS or SMHS with positive initial mental health screening results may be further assessed either by the Member's PCP or by referral to a network mental health provider.

      i When the Member's condition is beyond the PCP's scope of practice, the PCP must refer the Member to a mental health provider. The first attempt to refer the Member shall be made within CenCal Health's provider network.

      ii If the Member's PCP cannot perform the mental health assessment, the PCP shall refer the Member to the appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, either in CenCal Health's provider network or County Behavioral Health's network, is made.

      iii To ensure a Closed Loop Referral is completed, the Member's PCP shall follow up to ensure services were rendered. Should the Member's PCP require assistance wherein CenCal Health coordinates the referral, CenCal Health shall conduct follow-up with the Member to ensure services were rendered, as described in MM-BH303 *Access to Non-Specialty Mental Health Services & Substance Use Disorder Covered Services, & Referral Completion and Tracking for Specialty Mental Health & Substance Use Disorder Services.*

   b. CenCal Health shall refer Members in need of SUD treatment services in accordance with MM-BH304 *Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Treatment Services*.

   c. CenCal Health shall ensure that contracted providers are educated on the referral process of adult Members with significant impairment resulting from a covered mental health diagnosis to County Behavioral Health such that referrals made are Closed Loop Referrals. CenCal Health Providers are required to use the standardized DHCS transition of care tool and submit requests to CenCal Health's Behavioral Health Department. CenCal Health's Behavioral Health Department shall

coordinate the Member's referral directly with County Behavioral Health.

D. Care Delivery Coordination and Transition of Care

a. CenCal Health shall provide case management and care coordination for all Medically Necessary services.

b. CenCal Health has executed DHCS-compliant MOUs with County Behavioral Health to ensure services for CenCal Health Members are properly coordinated and provided in a timely and non-duplicative manner.

c. CenCal Health shall refer to and coordinate with County Behavioral Health services for the delivery of SMHS.

d. CenCal Health shall coordinate care for SUD treatment services in accordance with MM-BH304 *Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Treatment Services*.

e. When not duplicative and coordinated between CenCal Health and County Behavioral Health, CenCal Health Providers shall continue to provide NSMHS to Members concurrently receiving SMHS.

f. If a Member becomes eligible for SMHS during the course of receiving covered NSMHS, CenCal Health shall continue the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.

i When a Member meets criteria for both NSMHS and SMHS, the Member will receive services based on the individual clinical need and established therapeutic relationships. CenCal Health shall not deny or disallow reimbursement for NSMHS provided to a Member based on the basis of the Member also meeting SMHS criteria and/or also receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated, and not duplicative.

ii If it is determined that a Member receiving NSMHS meets the criteria for SMHS due to a change in the Member's condition, CenCal Health Providers are required to use the standardized DHCS-approved transition of care tool to ensure proper transition of care. Members meeting criteria for SMHS shall be referred to County Behavioral Health.

g. If it is determined that a Member receiving SMHS meets the criteria for NSMHS due to a change in the Member's condition, CenCal Health Providers are required to use the standardized DHCS transition of care tool to ensure proper transition of care. Members meeting criteria for NSMHS as indicated by a DHCS-approved standardized transition tool

shall be referred by County Behavioral Health to CenCal Health.

i CenCal Health shall not deny or disallow reimbursement for SMHS provided to a Member based on the basis of the Member also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated, and not duplicative.

h. New CenCal Members and existing CenCal Health Members whose mental health condition has stabilized such that the Member no longer qualifies to receive SMHS but instead becomes eligible to receive NSMHS from CenCal Health have the right to request continuity of care for up to twelve (12) months. CenCal Health shall follow the continuity of care procedures described in policy *MM-UM08 Continuity of Care*.

IV. Definitions:

Closed Loop Referral: coordinating and referring the Member to available community resources and following up to ensure services were rendered.

County Behavioral Health: MHP with whom CenCal Health contracts.

Covered Services: those health care services, set forth in Cal. W&I Code §§ 14000 et seq. and 14131 et seq., 22 C.C.R. §§ 51301 et seq., 17 C.C.R. §§ 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California § 1115 Medicaid Demonstration Project, the Plan's contract with DHCS, and APLs that are made the responsibility of the Plan pursuant to the California § 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Medically Necessary or **Medical Necessity**: reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under Cal. W&I Code § 14059.5(a) and 22 C.C.R. § 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 U.S.C. § 1396d(r)(5), as required by Cal. W&I Code §§ 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. The Plan must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

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

No Wrong Door: Members receive timely behavioral health services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent provision, whereby CenCal Health covers Medically Necessary NSMHS for a Member concurrently receiving SMHS covered by , and ensure those services are coordinated and not duplicative. *See* Cal. W&I Code § 14184.402.

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.

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.

V. References:

A. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 4.3.13 Mental Health Services

B. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 5.5 Mental Health and Substance Use Disorder Benefits

C. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.5.2 Non-Specialty Mental Health Services and Substance Use Disorder Services

D. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 5.6 MOUs with Third Parties

E. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.6.1 MOUs with Third-Party Entities and County Programs

F. DHCS APL 22-028: Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

G. DHCS APL 22-005: No Wrong Door for Mental Health Services Policy

H. DHCS APL 21-013: Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans

I. DHCS APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services

J. Behavioral Health Identification Notice No. 21-073: Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements

VI. Cross-References:

A. Policy and Procedures (P&P):

1. MM-BH304 – Identification, Referral, and Care Coordination for Members Requiring Alcohol or Substance Use Disorder Treatment Services
2. HS-QI402 – Alcohol, Tobacco, and Drug Screening Assessment, Behavioral Counseling Interventions and Referral Treatment in Primary Care
3. MM-BH403 – Mental Health Services – Dispute Resolution
4. MM-UMXX Notification of UR Determinations
5. MM-BH303 – Access to Non-Specialty Mental Health Services & Substance Use Disorder Covered Services, & Referral Completion and Tracking for Specialty Mental Health & Substance Use Disorder Services
6. MM-CM114 – Program Planning and Coordination
7. MM-UM08 – Continuity of Care
8. MM-XX – After-Hours Availability of Plan or Contract Physician
9. QI-XX – Ensuring EPSDT Screening, AAP Bright Futures Preventive Services, and Medically Necessary Diagnostic and Treatment Services, for Members Under Age 21
10. HS-MMXX Early and Periodic Screening, Diagnostic, and Treatment Services

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
02/13/2023	Chris Hill, Health Services Officer	Revised to comply with 2024 DHCS Operational Readiness requirements.	01/01/2024	TBD
06/2022	Seleste Bowers, Director	Revised to comply with		

	Behavioral Health	APL 22-006 requirements. Additional changes made due to an AIR issued by DHCS.		
06/2022	Seleste Bowers, Director Behavioral Health	Revised to comply with APL 22-005 and APL 22-006 requirements.		
03/2022	Seleste Bowers, Director Behavioral Health	Revised to comply with APL 21-013 requirements.		
01/2022		Department changed from "Health Services" to "Behavioral Health Department."		
2021		Updated language regarding Mild to Moderate Covered Services. Changed language to refer to providers in gender neutral "they" vs. "he/she." Included Level of Care Screening Tool to be utilized. Updated APL references.		
2021		Added circumstances when a referral would be required.		

2021		Annual review of HS-BH301 completed. Naming logic revised to Medical Managed (MM) and added "family" to the covered mental health services.		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Early and Periodic Screening, Diagnostic, and Treatment Services	**Policy No.:** HS-MMXX
Department: Medical Management	
Cross Functional Departments: Behavioral Health, Provider Services, Quality	
Effective Date: January 1, 2024	**Last Revised Date:** N/A
P&P Require DHCS Approval? Y ☒ N ☐	**Annual Review Date:** TBD
Officer Signature and Date: Christopher Hill, RN, BS, MBA Health Services Officer	**Officer Signature and Date:** Emily Fonda, MD, MMM, CHCQM Chief Medical Officer

I. Purpose:

CenCal Health ensures eligible Members under the age of twenty-one (21) receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) case management services.

II. Policy:

A. The EPSDT benefit includes the specific services listed in 42 U.S.C. § 1396(d) as well as Behavioral Health Treatment (BHT), comprehensive case management and Care Coordination, and transportation services.

B. The EPSDT benefit is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. The goal is to address any identified issues by maintaining or improving the health condition – they need not cure a condition.

C. CenCal Health has established protocols for identifying, referring, and providing EPSDT case management services for Members less than twenty-one (21) years of age.

D. CenCal Health has established EPSDT case management protocols to assist Members less than twenty-one (21) years of age in gaining access to all Medically Necessary Covered Services and non-covered services – including medical, behavioral health, dental, social, educational, and other services – in compliance with timely access standards.

E. CenCal Health has established data exchange protocols to support the provision of EPSDT services as well as the coordination of non-covered services (such as social support services).

F. Where EPSDT services are delivered by a CenCal Health Network Provider or Subcontractor, the Plan ensures compliance with EPSDT requirements, as identified in this policy.

III. Procedure:

A. Identification, Referral, and Provision of EPSDT Services

1. EPSDT services are Medically Necessary medical, behavioral health, dental, social, educational, and other services, and include identification of a diagnosis, effective treatment, and appropriate care.
2. CenCal Health's Network Providers perform and provide appropriate EPSDT services, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures guidance, within the scope of their practice.
3. Network Providers are adequately informed and trained about EPSDT services through onboarding and annual trainings as well as through the CenCal Health Provider Manual.
4. When outside the scope of the Network Provider's practice, CenCal Health refers the Member to a third-party entity to provide the service in accordance with the AAP/Bright Futures guidance, as appropriate, as follows:
    a. The Member's Network Provider submits a referral to CenCal Health for services outside the scope of their practice;
    b. CenCal Health evaluates for Medical Necessity in accordance with the Plan's UM review policy, ensuring adherence to AAP/Bright Futures guidance;
    c. If not adequately identified by the referring Network Provider, CenCal Health identifies an appropriate Network Provider or third-party entity to provide the EPSDT service, as appropriate;
    d. CenCal Health approves the authorization, notifies the Member and referring Provider of the Member's ability to obtain the Medically Necessary EPSDT services from the identified Network Provider or third-party entity, and ensures the Member receives the approved services.

B. Ensuring Access to All Medically Necessary EPSDT Services

1. No Additional Service Limitations: CenCal Health makes Medical Necessity decisions on an individual basis, and does not impose service limitations other than Medical Necessity; there are no flat or hard limits based on a monetary cap or budgetary constraint.
2. Timely Access: CenCal Health ensures that all Medically Necessary Covered Services and non-covered services for Members less than twenty-one (21) years of age are initiated within timely access standards no later than sixty (60) calendar days following either a preventative

screening or other visit that identifies a need for a follow-up. The Plan 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.

3. Compliance with Americans with Disabilities Act (ADA): CenCal Health complies with the ADA mandate to provide services in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws.
4. California Children's Services (CCS): An exception to the statewide CCS carve-out approach (as detailed in APL 19-010), CCS is carved-in for CenCal Health Members, and as such, the Plan ensures the provision of CCS benefits in coordination with the local county CCS office.
5. CenCal Health covers and ensures Members less than 21 years of age are provided appropriate case management to assist them in gaining access to all Medically Necessary medical, behavioral health, dental, social, educational, and other services. In addition to those specific services listed in 42 U.S.C. § 1396(d), CenCal Health ensures the following, in accordance with DHCS APL 19-010 and 20-012:
   a. Provision of Medically Necessary Behavioral Health Treatment (BHT) services, as outlined in CenCal Health Policies MM-BH301 ("Mental Health Services") and HS-QI402 ("Alcohol, Tobacco, and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment in Primary Care").
   b. Provision of comprehensive case management services, including coordination of all Medically Necessary EPSDT services delivered both within and outside CenCal Health's Provider network as well as coordination of carved-out and linked EPSDT services and referral to appropriate community resources and agencies.
   c. Provision of in-home nursing, as provided by home health agencies or individual nurse Providers, in accordance with APL 20-012 and the Plan's private duty nursing policy.
   d. Identification, referral, and/or coordination of Targeted Case Management (TCM) services, as appropriate and outlined in CenCal Health Policy MM-CMXX ("Targeted Case Management"). If the Plan determines an EPSDT Member is not eligible or accepted for Medically Necessary TCM services, CenCal Health ensures the Member's access to services is comparable to EPSDT TCM services.
   e. Assistance with scheduling appointments and coordination of necessary transportation to and from medical appointments for Medically Necessary EPSDT services, as outlined in CenCal Health Policy HS-UMXX ("Emergency Medical Transportation (EMT), Non-

Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT)").

f. Educating and informing EPSDT Members or their families/primary caregivers about benefits, availability, and how to access EPSDT services through the evidence of coverage (EOC) and again annually if the eligible EPSDT Member has not yet accessed EPSDT services.

6. Carved-Out EPSDT services

   a. Covered EPSDT Services do not include Specialty Mental Health Services (SMHS), Substance Use Disorder (SUD) services, or dental services. For these non-covered services, CenCal Health ensures:

      i. That case management for Medically Necessary services authorized by county mental health plans, Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans is equivalent to that provided by the Plan for Covered Services for Members less than 21 years of age; and
      ii. Provision of additional Care Coordination and case management services as necessary to meet the Member's medical and behavioral health needs, if indicated or upon the Member's request.

   b. For dental services not covered by the Denti-Cal Program, CenCal Health ensures the following:

      i. Dental screenings/oral health assessments are included as part of the initial health assessment and as part of every periodic assessment, and are consistent with the AAP/Bright Futures periodicity schedule and anticipatory guidance;

      ii. Referrals to appropriate Medi-Cal dental Providers;

      iii. Annual dental referrals are made no later than twelve (12) months of age or when a referral is indicated based on assessment; and

      iv. Provision of medical Covered Services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.

7. Shared Responsibility for EPSDT services – where another entity (such as a Local Education Agency (LEA), Regional Center (RC), or local governmental health program) has overlapping responsibility for providing EPSDT services, CenCal Health does the following:

   a. Assesses the level of Medically Necessary EPSDT services the child requires;

b. Determines what level of service (if any) is being provided by other entities; and

c. Coordinates the provision of services with the other entities to ensure both that the services provided are not duplicative as well as that the child is receiving all Medically Necessary EPSDT services in a timely manner.

C. Data Exchange Protocols in Support of EPSDT Services

1. CenCal Health implements secured data exchange mechanisms to provide and coordinate EPSDT services with both Network Providers as well as third-party entities providing EPSDT services to its Members.

2. On a regular and ad hoc basis, the Plan shares necessary data to facilitate the provision of EPSDT services, including authorizations, clinic visit notes, screening results, laboratory values, and progress notes.

IV. Definitions:

Behavioral Health Treatment (BHT): services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than 21 years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.

California Children's Services (CCS)-Eligible Condition: a medical condition that qualifies a child to receive medical services under the CCS Program, as specified in 22 C.C.R. §§ 41515.1, et seq.

Care Coordination: coordination of services for a Member between settings of care that includes: appropriate discharge planning for short- and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; services a Member receives from any other managed care health plan; services a Member receives via fee-for-service (FFS); services a Member receives from out-of-network Providers; and services a Member receives from community and social support Providers.

CCS Program: a State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.

Covered Services: those health care services, set forth in W&I Code §§ 14000 et seq. and 14131 et seq., 22 C.C.R. §§ 51301 et seq., 17 C.C.R. §§ 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the Plan's contract with DHCS, and APLs that are made the responsibility of the Plan pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care

program or other federally approved managed care authorities maintained by DHCS.

Drug Medi-Cal (DMC): the State system wherein Members receive Covered Services from DMC-certified SUD treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS): a program for the organized delivery of SUD services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), and (r), as well as 42 C.F.R. §§ 441.50 et seq., as required by Cal. W&I Code §§ 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.

Local Educational Agency (LEA): a school district, county office of education, charter school, community college district, California State University, or University of California campus.

Medically Necessary or **Medical Necessity**: reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under Cal. W&I Code § 14059.5(a) and 22 C.C.R. § 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 U.S.C. § 1396d(r)(5), as required by Cal. W&I Code §§ 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. The Plan must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

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

Network Provider: any Provider or entity that has a Network Provider Agreement with CenCal Health, CenCal Health's Subcontractor, or CenCal Health's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

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.

Regional Center (RC): a non-profit, community-based entity that is contracted by the California Department of Developmental Services that develops, purchases and manages services for Members with developmental disabilities and their families.

Specialty Mental Health Service (SMHS): a Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary specialty mental health services.

Subcontractor: an individual or entity that has a Subcontractor Agreement with CenCal Health that relates directly or indirectly to the performance of CenCal Health's obligations under its Medi-Cal managed care contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Substance Use Disorder (SUD): those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Targeted Case Management (TCM): services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 U.S.C. § 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and CenCal Health.

V. References:

A. 42 U.S.C. §§ 1396d(a), 1396d(r), 1396n(g)(2)

B. Cal. W&I Code §§ 14059.5(b), 14132(v)

C. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 4.3.9 Other Population Health Requirements for Children

D. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III Section 5.3.4 Services for Members less than 21 Years of Age

E. DHCS APL 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

F. DHCS APL 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21

G. American Academy of Pediatrics (AAP)/Bright Futures Initiative

VI. Cross References:

A. Policy and Procedures (P&Ps):

1. HS-CMXX – Early Start Program
2. HS-QIXX – Care Management Services for Children with Special Health Care Needs
3. HS-QI402 – Alcohol, Tobacco, and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment in Primary Care
4. HS-UMXX – Emergency Medical Transportation (EMT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT)
5. MM-BH300 – Behavioral Health Treatment
6. MM-BH301 – Mental Health Services
7. MM-CMXX – Targeted Case Management
8. MM-PE201 – Care Management for Private Duty Nursing Services

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
[insert date P&P] is internally finalized	Christopher Hill, MBA, BS, RN	Updated to comply with 2024 Medi-Cal Managed Care Agreement		

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Provider to Member Ratios	**Policy No. :** PS-CR28
Department: Provider Services	
Cross Functional Departments: Member Services and Quality	
Effective Date: 01/2024	**Last Revised Date:**
P&P Require DHCS Approval? Y ☒ N ☐	
Director/Officer Signature and Date: Luis Somoza, Director of Provider Services	**Officer Signature and Date:** Jordan Turetsky, MPH Chief Operating Officer

I. Purpose: To ensure that CenCal Health Members have sufficient and adequate accessibility to Network Providers by ensuring that required Provider to Member ratios are met.

II. Policy:

A. CenCal Health shall retain sufficient professional medical staff, including an adequate number of Physicians, Physician extenders, Specialists and sub-Specialists, to provide access to preventive and managed health care services.

B. Primary Care Physician (PCP) to Member Ratio: CenCal Health shall ensure that its Provider network satisfies a ratio of at least one full-time equivalent Primary Care Physician (PCP) for every 2,000 CenCal Health Members in accordance with 22 CCR section 53853(a) (1).

C. High-volume Specialist to Member Ratio: CenCal Health shall ensure that its Provider network satisfies a ratio of at least one full-time equivalent High-volume Specialist for every 2,000 Members to demonstrate National Committee for Quality Assurance (NCQA) Network Management standards for accreditation are met in regard to Availability of Practitioners Providing Specialty Care. Based on encounter and member demographic data, CenCal Health has identified OB/GYN as a High-volume Specialty.

D. Physician to Member Ratio: CenCal Health shall ensure that its Provider network satisfies a ratio of at least one full-time equivalent Physician for every 1,200 Members in accordance with 22 CCR section 22 CCR section 53953(a) (2).

E. Non-Physician Medical Practitioner Member Caseload Ratio: Full time equivalent NPMP Member caseload shall not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

F. Physician to member ratios are reported through the Quality Improvement and Health Equity Transformation Program (QIHETP), ensuring cross-functional oversight of Provider Network and Access to Care operations.

III. **Procedure**:

A. Provider Network Analysis
   1. CenCal Health performs no less than quarterly analysis to support monitoring of compliance with applicable Provider to Member ratios.
   2. CenCal Health performs Physician to member ratio adequacy analysis by generating PCP to Member, High-volume Specialist to Member and Physician to Member ratios based on enrolled Members and Physician Network Providers.
   3. To ensure that CenCal Health maintains sufficient Specialists and sub-Specialists, Primary Care Providers, and Physician extenders in their Provider Network, quarterly CenCal Health:

      a. Performs monthly geo-mapping to assess distribution of Providers by type and specialty.
      b. Conducts quarterly analysis of appointment availability survey results to identify trends and outliers.
      c. Conducts analysis of Member Grievances coded upon as access to care issues.

B. Monitoring and Oversight of Provider Ratios
   1. The regular provider network analyses described above are produced and reviewed by Provider Services leadership.
   2. Provider ratios are presented to and overseen by the Quality Improvement and Health Equity Committee (QIHEC) and reported quarterly to the QIHEC via the quality dashboard.

C. Addressing Provider to Member Ratio Risk
   1. In the event that quarterly or ad hoc analysis and monitoring through the above activities or through Annual Network Certification identifies potential or actual risk of CenCal Health's Provider Network not meeting required Provider ratios, CenCal Health will:.
      a. Perform further analysis to determine the specific provider type or geographic area which is most contributing to inadequate ratios.
      b. CenCal Health's analysis will leverage all available data sources including, but not limited to, California Department of Health Care

Services (DHCS) Provider data, information collected through CenCal Health's Annual Network Certification, and collaboration with other health plans' to understand their Provider Networks, to identify non-contracted Providers who may be recruited into the CenCal Health Provider network.

c. Under the oversight of the QIHEC, the output of these additional analysis will be leveraged to develop and launch targeted interventions to remedy the deficiency, including but not limited to recruitment of additional physicians to the CenCal Health provider network.
d. The output of such activities will be monitored by the QIEHC no less than quarterly.
e. Should ratios continue to trend toward potential or actual risk after interventions are in place, CenCal Health will implement a Corrective Action Plan (CAP) specific to meeting required ratios, will notify DHCS of the potential for a deficiency, and will engage the QIEHC monthly to monitor progress until ratios are met. Interventions to increase ratios will include provider recruitment of in-area and out of area physicians. CAP closure will occur when ratios are trending in a positive direction for 3 consecutive months, and CenCal Health shall notify DHCS of such closure.

IV. Definitions:

High-volume Specialist: specialty types identified as in high demand geographically and/or by specialty based on encounter data; those specialty types most likely to provide services to the largest segment of members.

Member: a Potential Member who has enrolled with CenCal Health**.**

Network Provider: any Provider or entity that has a Network Provider Agreement with CenCal Health, CenCal Health's Subcontractor, or CenCal Health's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Physician: any person holding a valid and unrevoked physician's and surgeon's certificate or certificate to practice medicine and surgery, issued by the Medical Board of California or the Osteopathic Medical Board of California.

Potential Member: a Medi-Cal recipient who resides in Contractor's Service Area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of

the aid codes enumerated under this definition in the DHCS Medi-Cal Managed Care Contract, Exhibit A, Attachment I, Section 1.0 (Definitions).

Primary Care Physician (PCP): a Physician 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.

Quality Improvement and Health Equity Committee (QIHEC): the committee facilitated by CenCal Health's Chief Medical Officer (CMO), or the CMO's designee, in collaboration with the Chief Health Equity Officer, to meet at least quarterly to direct all QIHETP findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP): the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.

Specialist: a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in Welfare and Institutions Code section 14197.

V. References:

A. 22 CCR section 53853 (a)(1) and (2)
B. NCQA HP Standards and Guidelines

VI. Cross Reference:

A. Policy and Procedures (P&P):
    1. PS-CRXXX Supervision of Non-Physician Medical Practitioners

VII. Attachments: N/A

Revision History:

Revision Date	Leaders who Reviewed and Approved	Reason for Change	Effective Date	DHCS Approval Date
11/2023		Checked out for NCQA Revisions		
12/2022	Jordan Turetsky, Carlos Hernandez, Eric Buben, Robert Janeway	New P&P	1/2024	

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: External Quality Review Requirements	**Policy No.:** AMO-EXT-XX
Department: Audits & Monitoring	
Cross-Functional Departments: Claims, Medical Management, Member Services, Provider Contracts, Quality	
Effective Date: 01/2024	**Last Revision Date:** N/A
P&P Require DHCS Approval? Y ☒ N ☐	
Director or Officer Signature and Date: Puja Shah, Esq. Director of Audits & Monitoring	**Officer Signature and Date:** Karen S. Kim, JD, MPH Chief Compliance & Fraud Prevention Officer

I. Purpose

The purpose of this policy is to describe how CenCal Health will meet External Quality Review Organization (EQRO) requirements and cooperate with and assist the EQRO designated by the California Department of Health Care Services (DHCS) in conducting its EQR reviews of CenCal Health.

II. Policy:

A. At least annually or more frequently as requested by DHCS, CenCal Health must cooperate with and assist the EQRO designated by DHCS in conducting its EQR reviews of CenCal Health and its Delegated Entities in accordance with 42 USC §1396u-2(c)(2) and 42 CFR §§438.310 et seq.

B. CenCal Health must comply with all requirements set forth in 42 CFR §§438.310 et seq., APL 19-017: Quality and Performance Improvement Requirements, and CMS EQR protocols, which provide detailed instructions on how to complete the EQR activities.

C. CenCal Health shall participate in Performance Improvement Projects (PIPs), as required by DHCS.

D. CenCal Health and its Delegated Entities shall comply with Corrective Action Plans (CAPs), as required by DHCS.

E. CenCal Health shall comply with consumer satisfaction survey (CSS) requirements as well as the EQRO's validation of network adequacy data and encounter data.

F. At the direction of DHCS, CenCal Health shall participate in DHCS focused studies of quality outcomes and access to services.

G. CenCal Health shall implement the EQRO's technical guidance provided to CenCal Health in conducting mandatory and optional activities.

III. Procedure:

A. Quality Performance Measures

1. On an annual basis, CenCal Health's Quality Department shall track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:

   a. CenCal Health shall work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures;

   b. CenCal Health shall calculate and report all required Quality Performance Measures and Health Equity measures at the reporting unit level as directed by DHCS.

      i. CenCal Health shall calculate performance measure rates, to be verified by the EQRO;

      ii. CenCal Health shall report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS.

      iii. CenCal Health shall initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of the Medi-Cal Managed Care contract operation;

   c. CenCal Health shall exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS.

   d. CenCal Health shall meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.

2. Delegated Entities

   a. CenCal Health shall separately report to DHCS all required performance measure results at the reporting unit level for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors (hereafter collectively referred to as "Fully Delegated Entities").

   b. CenCal Health shall ensure that its Fully Delegated Entities whose rates CenCal Health separately reports to DHCS also exceed the DHCS-established MPL for each required Quality Performance Measure and

Health Equity measure selected by DHCS.

3. DHCS corrective action options

   a. In accordance with 42 CFR §§438.700 et seq., WIC §14197.7, and Exhibit E of the Medi-Cal Managed Care contract between CenCal Health and DHCS (hereafter referred to as "the DHCS Contract"), CenCal Health shall comply with DHCS-imposed financial sanctions, administrative sanctions, and/or Corrective Actions on CenCal Health for failure to meet required MPLs.

      i. DHCS may require CenCal Health to make changes to its executive personnel if CenCal Health has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years.

      ii. DHCS may also limit CenCal Health's Service Area expansion or suspend Member enrollment based on CenCal Health's persistent and pervasive poor performance on Quality Performance Measures.

      iii. In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider CenCal Health's performance on specified quality and equity benchmarks, as determined by DHCS and communicated in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

   b. If CenCal Health's Fully Delegated Entities fails to exceed the DHCS-established MPL, CenCal Health shall subject its Fully Delegated Entities to appropriate Corrective Actions in accordance with CenCal Health's Escalation and Sanctions policy (AMO-31). The Corrective Actions may include, but are not limited to, financial sanctions, CAPs, and a requirement to change its executive personnel.

B. Performance Improvement Projects

   1. CenCal Health's Quality Department shall conduct or participate in Performance Improvement Projects (PIPs), including any PIP required by CMS, in accordance with 42 CFR §438.330. CenCal Health shall conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require CenCal Health to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require CenCal Health to participate in statewide collaborative PIP workgroups.

2. CenCal Health shall have policies and procedures in place to ensure that its Fully Delegated Entities also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.
3. CenCal Health's Quality Department shall comply with the PIP requirements outlined in DHCS APL 19-017: Quality and Performance Improvement Requirements and shall use the PIP reporting format as designated therein to request DHCS's approval of proposed PIPs.
4. Each PIP shall include the following:
    a. Measurement of performance using objective quality indicators;
    b. Implementation of equity-focused interventions to achieve improvement in the access to and quality of care;
    c. Evaluation of the effectiveness of the interventions based on the performance measures; and
    d. Planning and initiation of activities for increasing or sustaining improvement.
5. CenCal Health's Quality Department shall report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1. On an annual basis until January 1, 2026, CenCal Health's Quality Department shall timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey (CSS).
2. Beginning January 1, 2026, concurrent with the requirement for Health Plan Accreditation (HPA) by the National Committee for Quality Assurance (NCQA), CenCal Health's Member Services Department shall publicly post the annual results of its – and its Fully Delegated Entities' – Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on CenCal Health's website, including results of any supplemental questions as directed by DHCS.
3. If CenCal Health has HPA prior to January 1, 2026 and reports its CAHPS data to the NCQA, CenCal Health's Member Services Department shall publicly post the annual results of its – and its Fully Delegated Entities' –CAHPS survey on CenCal Health's website, including results of any supplemental questions as directed by DHCS.
4. CenCal Health's Quality Department shall incorporate results from the CAHPS survey in the design of quality improvement and Health Equity activities.

D. Network Adequacy Validation. CenCal Health's Provider Services Department

shall participate in the EQRO's validation of CenCal Health's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR §§438.14(b), 438.68, and 438.358.

E. Encounter Data Validation. As directed by DHCS, CenCal Health's Claims Department shall participate in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR § §438.242(d) and 438.818.

F. Focused Studies. As directed by DHCS, CenCal Health's Health Services Department shall participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by CenCal Health.

G. Technical Assistance. In accordance with 42 CFR §438.358(d) and at the direction of DHCS, CenCal Health's IT Department shall implement EQRO's technical guidance provided to CenCal Health in conducting mandatory and optional activities described in 42 CFR §438.358 and the DHCS Contract.

IV. Definitions:

Capitation Payment: a regularly scheduled payment made by DHCS to CenCal Health on behalf of each Member for each month the Member is enrolled with CenCal Health that is based on the actuarially sound capitation rate for the provision of Covered Services, and paid regardless of whether a Member receives services during the period covered by the payment.

Corrective Actions: specific identifiable activities or undertakings of CenCal Health which address deficiencies or noncompliance with CenCal Health's Medi-Cal Managed Care contract with DHCS.

Corrective Action Plan (CAP): corrective measures that address deficiencies detected as a result of ongoing monitoring and auditing.

Delegated Entity: a subcontracted entity who enters into a risk-based written agreement with CenCal Health to perform functions on behalf of CenCal Health.

Department of Health Care Services (DHCS): the single State Department responsible for the administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, and other health-related programs.

DHCS All Plan Letter (APL): a binding document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Downstream Fully Delegated Subcontractor: a Downstream Subcontractor that contractually assumes all duties and obligations of CenCal Health under the Medi-

Cal Managed Care contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

External Quality Review (EQR): the analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that CenCal Health, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.

External Quality Review Organization (EQRO): an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354 and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.

Fully Delegated Subcontractor: a Subcontractor that contractually assumes all duties and obligations of CenCal Health under the Medi-Cal Managed Care contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

Health Disparity: differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

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

Member or Enrollee: a potential member who has enrolled with CenCal Health.

Minimum Performance Level (MPL): refers to CenCal Health's minimum performance requirements for select Quality Performance Measures.

National Committee for Quality Assurance (NCQA): is an organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the quality of care and services that Members receive.

Network: PCPs, Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom CenCal Health enters into a Network Provider Agreement.

Network Provider Agreement: a written agreement between a Network Provider and CenCal Health, Subcontractor, or Downstream Subcontractor.

Quality Performance Measures: tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that

are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Rating Period: a period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR §438.7(a).

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

V. References:

A. 42 USC §1396u-2(c)(2)

B. 42 CFR §§ 438.14(b), 438.68, 438.242(d), 438.310 et seq., 438.330, 438.354, 438.358, 438.700 et seq., 438.818

C. WIC §14197.7

D. DHCS 2024 Contract, Exhibit E

E. DHCS APL 19-017: Quality and Performance Improvement Requirements

F. CMS EQR protocols

VI. Cross-References: N/A

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date	DHCS P&P Approval Date
12/2023	Karen S. Kim, JD, MPH, Chief Compliance Officer; Puja Shah, Esq., Director of Audits & Monitoring	2024 DHCS Contract OR Deliverable R.0043.	12/2023	TBD

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Credentialing Systems Control and Oversight	**Policy No.:** PS-CRXXX
Department: Provider Services	
Cross-Functional Departments: Medical Management, Quality	
Effective Date: 02/2024	**Last Revision Date:** N/A
P&P Require DHCS Approval? Y ☐ N ☒	
Director or Officer Signature and Date: Luis Somoza Provider Services Director	**Officer Signature and Date:** Jordan Turetsky, MPH Chief Operating Officer Emily Fonda, MD Chief Medical Officer

I. Purpose

To describe the credentialing system controls in place to ensure the security and accuracy of provider information.

II. Policy:

CenCal Health will employ system controls to address: how primary source information is received, dated, and stored; how modified information is tracked and dated from its initial verification; the titles and roles of staff who are authorized to review, modify and delete information, and the circumstances when modification or deletion is appropriate; the security measures in place to protect the information from unauthorized modification; and how CenCal Health monitors compliance with credentialing system controls described in this policy and takes appropriate action when necessary.

III. Procedure:

A. Receipt and Handling of Primary Source Verification Information
   1. Credentialing and recredentialing applications and supporting documents are received by email, fax or mail. Applications and documents received by mail are scanned as pdf working documents.

2. The Credentialing Specialist reviews applications for any missing information, or items that require further explanation, and makes requests to providers/practitioners as needed.
3. Applications and supporting documents are tracked throughout the credentialing process via a shared onboarding tracker.
4. Applications and supporting documents are saved in folders with access limited to credentialing staff and CenCal Health medical directors responsible for the credentialing process.
5. Credentialing data from the applications and supporting documents is entered and stored electronically on CenCal Health's secured credentialing database "Symplr". Access to the database is set to user functions, with "write" functionality authorized only for credentialing staff.
6. Processed applications, supporting documents and primary source verifications (PSVs)are stamped via manual date stamp or electronic date stamp in the electronic file.
7. Completed electronic files are saved to subfolders within the access-limited credentialing folder designated for the credentialing manager/supervisor for review, then for the medical directors for review and recommendation.
8. "Clean" files are approved via medical director signature and saved to a corresponding access-limited subfolder. Files requiring review by the CenCal Health Provider Credentials and Peer Review Committee (PCC)are held in the access-limited review subfolder pending the PCC's decision.

B. Tracking Modifications
1. As part of the credentialing process, the applicant is notified of his/her right to obtain the status of his/her application, and to correct erroneous information.
2. Upon receipt of corrections, the credentialing specialist will re-verify the primary source information. If there is still a discrepancy, the applicant will be notified within seven (7) business days. If all information necessary to process the application is not received within thirty (30) business days from the date the applicant was given notice regarding the required information, the application will be deemed incomplete. The application will be in an inactive status and not forwarded for further review or recommendation until all information has been obtained and verified.
3. PSVs received between recredentialing cycles are date stamped by the credentialing specialists (manually or electronically) and filed in the provider's/practitioner's credentials file.

4. Provider/practitioner data entered into the credentialing database is tracked via the audit trail function. Only the credentialing specialists, supervisor and manager are authorized to update, modify or delete provider/practitioner data.
5. If a modification needs to be made to credentialing information, the credentialing specialist will document the date the modification was made, the reason the modification was made and who made the modification. For updates to PSVs, the credentialing specialist will document the change, who they spoke with, and initial and date the PSV. A note will also be entered in the corresponding section of the credentialing database.

C. Authorization to Modify Information
1. The credentialing specialists, credentialing supervisor, and credentialing manager are granted authorization to create, edit and delete documentation into a provider file or electronic record as determined by user scope of practice.
2. PSV information may be modified by credentialing specialists, the credentialing supervisor or credentialing manager when verification information changes. If PSV information changes, the credentialing staff will obtain new verifications, initialed and dated by credentialing staff, and stored in the applicant's electronic file.
3. Examples of appropriate modifications to credentialing information include but are not limited to:
   a. Updates to expired licensure or other documents
   b. Changes/updates to education, training, or privileges
   c. To correct data entry errors
   d. Duplicate profiles
   e. Documents appended to incorrect provider profile
4. Examples of *inappropriate* modifications to credentialing information include but are not limited to:
   a. Altering credentialing approval dates
   b. Altering dates on verifications
   c. Whited out dates or signatures on hard copy documents
   d. Unauthorized deletion of provider/practitioner files or documentation

D. Securing Information
1. Physical access to provider/practitioner files is limited to the credentialing staff and medical directors who are responsible for the credentialing process.
2. Remote workstations are in physically secure areas. Computer screens are positioned to prevent viewing by unauthorized individuals. All password-

based systems on workstations mask, suppress or otherwise obscure passwords so that unauthorized persons are not able to observe them. Authorized users are prohibited from allowing others to access computer systems with their account, password, badge, or unique ID information.

3. Password protections include:
    a. Using strong passwords
    b. Discouraging users from writing down passwords.
    c. Using IDs and passwords unique to each user.
    d. Changing passwords when requested by staff or if passwords are compromised.
    e. Disabling passwords of employees who transition to a non-credentialing role within the organization or who leave the organization.
    f. CenCal Health follows the National Institute of Standards and Technology guidelines.
4. Examples of when credentialing information may be released:
    a. Upon request from CenCal Health's Compliance or Legal departments
    b. Regulatory or accreditation agencies: access requires direct supervision by the credentialing manager or supervisor to ensure no data is accessed without authorization.

E. Credentialing Process Audits
1. At least annually, CenCal Health credentialing staff will monitor compliance with the processes and controls described in this policy and procedure.
    a. The Symplr system administrator will run a report of all files with modifications and pull a random sample of those files.
    b. The random sample will include 5% or 50 files of each type (initial and recredentialing), or at least 10 of each.

F. Credentialing System Controls Oversight
1. In the random sample audited, the designated credentialing specialist will identify all modifications that did not meet the guidelines established in this policy and procedure. These may include but are not limited to:
    a. Modifications made by unauthorized persons
    b. Inappropriate or inaccurate modifications
2. Any modifications to provider/practitioner credentialing data that do not meet the guidelines established in this policy and procedure will be analyzed and appropriate action taken, as needed.
    a. An analysis report will include the number or percentage of noncompliant modifications, and the types of noncompliant modifications

b. Any unauthorized or inaccurate data modifications will be corrected
c. Any system controls that were inadequate or were circumvented to allow unauthorized data modifications will be reviewed and updated as needed.
d. These actions may be taken by any authorized credentialing staff under supervision by the credentialing supervisor or manager.
e. CenCal Health will implement a quarterly monitoring process to assess the effectiveness of its actions on all findings until improvement is demonstrated for at least one finding over three consecutive quarters.

IV. Definitions:

Credentialing: means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership in order to ensure that Network Providers are properly licensed and certified as required by state and federal law. A part of CenCal Health's Quality Assessment and Improvement Program which verifies credentials with the issuer of the credential or other recognized monitoring organization, in order to evaluate a provider's qualifications, affiliations, competency, and to monitor the quality of medical services provided.

Network Provider: any provider or entity that has a network provider agreement with CenCal Health, CenCal Health's subcontractor, or CenCal Health's downstream subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render covered services. A Network Provider is not a subcontractor or downstream subcontractor by virtue of the network provider agreement.

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.

Provider Credentials Committee: A committee of credentialed Network Providers who are made responsible by the QIHEC to review and render decisions regarding provider credentialing and recredentialing.

Primary Source Verification: Refers to contacting the entity, agency, or institution that issues a provider's credential for verification of the document's authenticity. Also refers to an entity, such as a state licensing agency with legal responsibility for originating a document and ensuring the accuracy of the document's information. For some credentials, the primary source does not need to be contacted directly if they make verification available through another source. For the purposes of this policy, primary source verification means contacting either the actual issuer or another recognized monitoring source approved for

verification by the National Committee for Quality Assurance (NCQA). For example, board certification may be verified by contacting the appropriate specialty board (the issuer) or the NCQA approved source of the American Board of Medical Specialties (ABMS) directory.

V. References:

A. NCQA Standards describing Credentialing System Controls and Oversight

VI. Cross Reference:

A. Policy and Procedures (P&P):

a. PS-CR03 Provider Credentialing and Recredentialing

b. PS-CR11 Credentialing of Organizational Providers

B. Program Documents:

1. Sample Annual Credentialing Data Modification Report

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date	DHCS P&P Approval Date
MM/YYYY	[Insert Name, Insert Title]	[Insert sentence outlining the driver of P&P revision, see style guide for more details.]	MM/YYYY	TBD

Attachment 2

Quality Improvement & Health Equity Committee (QIHEC)
Meeting Agenda

Meeting Date: **December 14, 2023**

Meeting Time: **4:00 to 5:30 p.m.**

Chairperson: **Emily Fonda, MD, MMM, CHCQM** – Chief Medical Officer, Internal Medicine, CenCal Health
Co-Chairperson: **Michael Collins, DO, MPH, MS** – Sr. Medical Director, Preventive Medicine, CenCal Health

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QIHEC Voting Members:

***Network Provider**

Marina Owen - Chief Executive Officer, CenCal Health
Edward Bentley, MD* – Gastroenterologist – Santa Barbara, CA – ***Board Liaison***
Neal Adams, MD, MPH – Medical Director, Psychiatrist, CenCal Health
Polly Baldwin, MD* – Family Practitioner – Santa Barbara, CA
Bethany Blacketer, MD* - Family Practitioner – Santa Maria, CA
Jeffrey Kaplan, MD* - Pediatrician – Santa Maria, CA
Van Do-Reynoso, MPH, PhD – Chief Customer Experience Officer/Chief Health Equity Officer, CenCal Health
Joseph Freeman, MD, FACEP* - Emergency Medicine, Cottage Health System – Santa Barbara, CA
Carlos Hernandez - Quality & Population Health Officer, CenCal Health
Sara Macdonald – Community Member and CenCal Health Member – Santa Barbara County, CA
Douglas Major, OD* - Optometrist – San Luis Obispo, CA
Mazharullah Shaik, MD* – Director of Quality, Community Health Centers of the Central Coast, Santa Maria, CA
Elizabeth Snyder, MHA* - Senior Director - Administrative Services, Dignity Health Central Coast Division, Santa Maria, CA

Staff:

Eric Buben, Director, Member Services
Sheila Hill, MSPH, MBA, CPHQ; NCQA Project Leader
Cathy Slaughter, Director, Provider Relations
Lauren Geeb, MBA, Director, Quality
Stephanie Lem, PharmD, Clinical Manager, Pharmacy
Sheila Thompson, RN, CPHQ, Provider Quality & Credentialing Manager
Chris Hill, RN, MBA, Health Services Officer

Secretary: Mimi Hall, Executive Assistant

Location: Via Virtual Microsoft Teams

Agenda Item	Minutes	Vote Required
1. Introductions & Announcements Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer	5	No
Approval of Minutes		
2. August 24, 2023, QIHEC Meeting Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer	5	Yes
New Business		
Consent Agenda These items are considered routine and are normally approved by a single vote of the Committee without separate discussion to conserve time and permit focus on other matters on this agenda. Individual consent items may be removed and considered separately at the request of a committee member. ***Dr. Emily Fonda, Chief Medical Officer***	5	Yes
3. Approval of Pediatric Clinical Advisory Committee Report Rea Goumas, MD, Medical Director, Whole Child Model		
4. Acceptance of Pharmacy & Therapeutics Report for Q4 2023 Stephanie Lem, PharmD, Associate Director, Pharmacy		
5. Approval of Customer Experience Committee Report Eric Buben, Director, Member Services		
6. Approval of Utilization Management Committee Report Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer Chris Hill, RN, MBA, Health Services Officer		
7. Approval of Credentialing Committee Report Sheila Thompson, RN, CPHQ, Provider Quality & Credentialing Manager		

Follow-Up		
8. CCS/TCRC Age Breakout Analysis Chelsee Elliott, Quality Measurement Supervisor	5	Yes
9. Under/Over-utilization ALOS & Tonsillectomies Analysis Chelsee Elliott, Quality Measurement Supervisor	5	Yes
10. Verbal Updates – Refer to Follow-up Tabular Summary Lauren Geeb, MBA, Director, Quality	5	Yes
Quality Improvement & Health Equity Transformation Program (QIHETP) Activities		
11. Risk Scoring & Stratification Bias Analysis & Adjustments Chelsee Elliott, Quality Measurement Supervisor	10	Yes
12. QIHETP Work Plan Update, with focus on Well Child Visit Performance Improvement Project – 15 Months of Age (W30) Lauren Geeb, MBA, Director, Quality	5	Yes
13. Approval of Quality Dashboard Lauren Geeb, MBA, Director, Quality	5	Yes
14. QIHETP Systems Integration – Key Performance Metrics Reporting **a.** Access and Availability – Cathy Slaughter, Director, Provider Relations **b.** Grievances & Appeals – Eric Buben, Director, Member Services **c.** Utilization Management – Chris Hill, RN, MBA, Health Services Officer	15	Yes
Policy Review & Feedback		
15. QIHETP & Related Program Policies Carlos Hernandez, Quality & Population Health Officer	5	Yes
Open Forum & Future Agenda Items	5	No
Adjourn		

Attachment 3

Quality Improvement & Health Equity Committee (QIHEC) Meeting Minutes

Date: August 24, 2023

Time: 4:00 to 5:30 p.m.

Chairperson: Emily Fonda, MD, CHCQM, MMM, Chief Medical Officer
Co-Chairperson Michael Collins, DO, MPH, MS, Senior Medical Director

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QIHEC Voting Members: ***Network Provider**

Marina Owen - Chief Executive Officer, CenCal Health
Edward Bentley, MD* – Gastroenterologist – Santa Barbara, CA – ***Board Liaison***
Neal Adams, MD, MPH – Medical Director, Psychiatrist, CenCal Health
Polly Baldwin, MD* – Family Practitioner – Santa Barbara, CA
Bethany Blacketer, MD* - Family Practitioner – Santa Maria, CA
Jeffrey Kaplan, MD* - Pediatrician – Santa Maria, CA
Van Do-Reynoso, MPH, PhD – Chief Customer Experience Officer/Chief Health Equity Officer, CenCal Health
Noemi Doohan, MD, PhD, MPH* – Medical Director, Family Medicine, Santa Barbara County Public Health
Joseph Freeman, MD, FACEP* - Emergency Medicine, Cottage Health System – Santa Barbara, CA
Carlos Hernandez - Quality & Population Health Officer, CenCal Health
Sara Macdonald – Community Member and CenCal Health Member – Santa Barbara County, CA
Douglas Major, OD* - Optometrist – San Luis Obispo, CA
Mazharullah Shaik, MD* – Director of Quality, Community Health Centers of the Central Coast, Santa Maria, CA
Elizabeth Snyder, MHA* - Sr. Director - Administrative Services, Dignity Health Central Coast Division, Santa Maria, CA

Staff:

Eric Buben, Director, Member Services
Chris Hill, RN, MBA; Health Services Officer
Gabriela Labraña, MPH, Supervisor, Health Promotion
Amber Sabiron, MSN, RN, Manager, Population Health
Lauren Geeb, MBA; Director, Quality
Sheila Hill, MSPH, MBA, CPHQ; NCQA Project Leader
Stephanie Lem, PharmD; Clinical Manager, Pharmacy
Sheila Thompson, RN, CPHQ; Provider Quality & Credentialing Manager

Committee Members Absent: **Dr. Blacketer (Excused), Dr. Doohan (Excused), Dr. Shaik**

Secretary: Mimi Hall, Executive Assistant

Location: Via Virtual Microsoft Teams

Topic	*Discussion*
1a. Introductions and Announcements *Michael Collins, DO, MPH, MS, Senior Medical Director* **1b. Department of Justice & CenCal Health Settlement** *Marina Owen, Chief Executive Officer*	In Dr. Fonda's absence, Dr. Michael Collins, Co-chair, called the meeting to order at 4:02 p.m. It was determined that a quorum had been met, and the Committee was ready to proceed with business at hand. Ms. Owen spoke to the Committee about the Department of Justice and CenCal Health's recent settlement. That concluded *Introductions and Announcements* of the agenda.
2. Approval of Minutes of May 25, 2023, QIHEC Meeting	***Motion made*** by Ms. Macdonald to approve the minutes of the May 25, 2023, QIHEC Meeting; seconded by Dr. Bentley. Motion passed.
3. Consent Agenda (items #3-5)	***Motion made*** by Ms. Snyder to approve the Consent Agenda; seconded by Dr. Bentley. Motion passed.
6. Infection Prevention Nursing Home Pilot Program Update *Emily Fonda, MD, CHCQM, MMM, Chief Medical Officer*	In Dr. Fonda's absence, Ms. Sabiron, MSN, RN, Manager, Population Health, gave an update to the Committee regarding the *Infection Prevention Nursing Home Pilot Program*. Ms. Sabiron indicated that Phase One, which was the information training sessions as well as training session with our community partners, has been completed. Memorandums of Understanding (MOUs) have been sent out to each identified community partner and are awaiting responses from them. That concluded Ms. Sabiron's update of the *Infection Prevention Nursing Home Pilot Program Update*. This agenda item is for informational purposes only.
7. Annual Adoption of Clinical Practice Guidelines *Amber Sabiron, MSN, RN, Manager, Population Health*	Ms. Sabiron spoke to the Committee about the annual adoption of *Clinical Practice Guidelines* and accompanied her oral update with a PowerPoint Presentation. **Executive Summary:** CenCal Health uses clinical practice guidelines to help practitioners make decisions about appropriate health care for specific clinical circumstances and behavioral healthcare services. CenCal Health makes decisions for Member education that are consistent with its practice guidelines. CenCal Health adopts, disseminates, and monitors the use of clinical practice guidelines at least every two years, or more frequently if national guidelines change within the two-year period. **Background:** Clinical practice guidelines supported by CenCal Health are selected based on contractual requirements and identified membership needs using data compiled from reliable sources (e.g., claims, utilization, pharmacy, epidemiological, HEDIS, or demographic data). CenCal Health's clinical practice guidelines address the provision of acute or chronic medical and behavioral health conditions. A subset of the clinical guidelines is used as the basis for CenCal Health's Disease Management programs and Quality Improvement Projects. For those aspects of care which DHCS has not specified approved practice guidelines, CenCal Health adopts nationally recognized standards, best practices guidelines and/or

	recommendations from appropriate professional organizations for proven methods that are evidence based, or time-tested, research supported and accepted by peer professionals as reasonable practice. **Next Steps:** Subsequent to the QIHEC adoption, the clinical practice guidelines are disseminated by CenCal Health's Quality Department to contracted Network Providers electronically via CenCal Health's provider portal, on CenCal Health's website, and by notice in CenCal Health's provider bulletin. CenCal Health distributes practice guidelines to Network Providers and Members and potential Members, upon request. Monitoring of compliance with adopted clinical practice guidelines is performed by CenCal Health's Quality Department at least annually. The comprehensive list of practice guidelines is available on our website, which is noted on the cover memo in your meeting packet. Specifically, for COVID-19 treatment guidelines, we utilize the National Institutes of Health for these practice guidelines, which outline clinical management of adults as well as non-hospitalizations for general management of COVID and then therapeutic management, as well. And again, for more information you can visit their website for COVID-19 treatment guidelines specifically for the National Institute of Health. For the next steps regarding the clinical practice guidelines, they are disseminated and distributed to our practicing providers. They're available on our provider portal as well as our website. Additionally, they are available to our members and potential members upon request, in addition to the Member Bulletin. The Quality Department does look at these practice guidelines annually and monitor them. **Discussion:** Dr. Bentley mentioned that the guidelines are quite diverse, and, in some instances, there may be conflicting guidelines. Therefore, in those instances, who within CenCal Health is the arbitrators of those complexities? Ms. Sabiron confirmed that she understood Dr. Bentley's question; when there are several practice guidelines referring to the same matter, what is the hierarchy of that circumstance? Dr. Bentley affirmed and gave an example: for colorectal cancer screening, many of the specialists recommend that screening begin at the age of forty-five, and the American College of Physicians have just come out with a recommendation beginning at age 50; that is one example. Therefore, when there is a difference of recommendations, how do we reconcile the differences? Is there an individual or group within CenCal Health who will be the arbitrator of that? Mr. Hernandez responded and explained that one of the determining factors is what the guideline sources, and there are three specific guideline sources that are required by DHCS by contract and those are the US Preventive Services Task Force, the American College of Obstetrics and Gynecologists and the American Academy of Pediatricians for the pediatric population. If there is a conflict between those guideline sources and the supplemental sources that are adopted by QIHEC, it would be those that are contractually required that would prevail. Otherwise, if there are two competing sources that are not required by contract, then that determination would be made by our medical director staff in coordination with Dr. Fonda, our Chief Medical Director. Dr. Major asked to confirm what a physician's role would be in these instances. For example, in San Luis Obispo County, for eye screening, Dr. Major indicated that he performs all of the school vision screening for kindergarteners and there are a number of children that haven't been checked for eye care, and that doesn't meet the Bright Start standards, therefore, can we go ahead as a group and agree to connect those pediatricians to realize that they're not meeting those standards? Is this our role to keep it nudging it forward when we see these public health issues?

	Mr. Hernandez agreed that it is within our role. And, for guideline adoption, this is another rule in the QIHEC guideline development. If there is a local need that might go beyond the professional recommendation of a given organization, then it could be brought to the QIHEC for guideline development and adoption, and then that guideline could be used as a priority, going forward. Dr. Major agreed and indicated that these issues might be easily solved by just locating the guidelines, as this is the whole goal of this committee, as he believes. Mr. Hernandez thanked Dr. Major for his input. At the end of discussion, Dr. Major ***made a motion*** to approve the guidelines as specified with the various medical associations; seconded by Dr. Baldwin. Motion passed.

8. 2023 Population Needs Assessment *Gabriela Labraña, MPH, Supervisor, Health Promotion*	Ms. Labraña spoke to the Committee about the 2023 Population Needs Assessment and accompanied her discussion with a Power Point Presentation. Ms. Labraña started by indicating that PNA is an assessment that the Quality Department performs every year for our membership. The main purpose is to identify member health needs and health disparities to evaluate our activities and implement strategies to improve in areas where we have found gaps, therefore, the 2023 PNA is reflective of data from calendar year 2022 and it was just recently finalized. Ms. Labraña reviewed a high-level overview of what is contained in the report, and indicated to the Committee that the full PNA report is available in the meeting packet. **Purpose:** CenCal Health recognizes the importance of offering services that address health equity within health education, Cultural & Linguistic (C&L), and quality improvement (QI) services. The goal of the annual Population Needs Assessment (PNA) is to identify gaps in care, health disparities, and service areas with room for improvement. The annual PNA is a fundamental component of CenCal Health's overall Population Health Management (PHM) Strategy. CenCal Health incorporates PNA findings into PHM activities and implements targeted strategies to address member needs and improve health outcomes throughout the community served in collaboration with community partners. CenCal Heath completes the annual PNA in accordance with the Department of Health Care Services (DHCS) and the national Committee for Quality Assurance (NCQA) accreditation requirements. **Key Findings:** <u>Health Status and Disease Prevalence</u> • Over 75% of adult members reported their overall health in 2022 as being good, very good, or great. • About 94% of parents/guardians reported their children's overall health was good or very good in 2022. • The disease prevalence of four chronic conditions were assessed: asthma, chronic obstructive pulmonary disease, diabetes, and hypertension. The rate of hypertension has decreased 5.81% since 2020. The rate of asthma, chronic obstructive pulmonary disease, and diabetes has remained stable since 2020. <u>Access to Care</u> Consumer Assessment of Healthcare Providers and Systems (CAHPS) data indicates the majority of adult and pediatric members report the ability to access primary and urgent care timely and when necessary. The required PCP-to-member ratio of 1:2000 and the required physician-to member

	ratio of 1:1200 were both met for 100% of members in 2022. The Plan will focus on increasing utilization of both the Adult and Pediatric Health Survey Tools to comprehensively assess members' health and social needs. <u>Health Disparities</u> Health education and QI activities will focus on closing the following identified disparities regarding race, language spoken, sex, and/or region related to Chlamydia Screening, Asthma Medication Ratio, Breast and Cervical Cancer Screening, Developmental Screening, Controlling High Blood Pressure, Immunization for Adolescents, Timely Postpartum Care, and Child and Adolescent Well-Care Visits. **Action Plan** Based on the findings, CenCal Health has developed an Action Plan that will address identified gaps. In alignment with CenCal Health's Quality Improvement and Health Equity Transformation Program, topics included in the Action Plan are those priorities which fell below the DHCS quality benchmarks and/or those that may have decreased significantly. More in-depth information on the Action Plan can be found in your meeting packet, in addition to the complete Population Needs Assessment. **Discussion:** Dr. Major commended Ms. Labraña for her presentation and indicated that there is some new legislation that was coming through that will look at provider access. If the legislation is passed, if CenCal Health would be within the guidelines? Ms. Labraña responded that she is not familiar with the legislation that Dr. Major was referring to, and if no other staff is able to comment, then The Quality Department can certainly take a look at the legislation and report back. Dr. Major responded that the new legislation will be forthcoming in 2024 and that he is aware of no ACEs scores associated, although, there will be the social determinants, however, he asked if that also something that you put in here now? Ms. Labraña thanked Dr. Major for bringing this topic up and responded that it is not included, however, that can be considered for future meetings. She continued that it is not clear the type of data that is available as far as ACE score results, however, she is aware that there is utilization of a screening in general, yet it is unclear if we receive comprehensive data on results. That is something that can be investigated. Dr. Major indicated that San Luis Obispo County will be losing its only pediatric ophthalmologist, therefore, just wanted to give a heads up about that. Mr. Hernandez commented that CenCal Health does receive score results, and that they are reported by the procedure code that is reported by the practitioner that performs the screening to indicate whether the score is normal or not. That information is used for utilization trending or at least it soon will. Currently, Quality is working on a process to collect that data and is also a participant in a local community collaborative that is funded by an ACE Grant. CenCal Health is working in that collaborative to improve a score screening network guide, which will be monitored on a dashboard. It was agreed that the legislative question and discussion above will be followed-up on at a future meeting. Next, Ms. Hill asked when will the more detailed objectives to those goals be developed or is that something for the beginning of the year? Ms. Labraña stated that the objectives that are in the PNA report will be the working objectives. Ms. Hill responded that it is like PIP development. In other words, are we going to understand what the PIP (Program Improvement Project) is with the more detailed version of exactly what we are doing? And will there be member outreach? Ms. Labraña responded affirmatively, and that typically after the report is approved, that is when the process begins with some internal work groups to begin work on the actual objectives and implementing

	strategies. We then really flesh out the steps that will be taken to achieve those goals. Ms. Hill thanked Ms. Labraña for her response. Ms. Owen indicated that she recalled that Quality had action plans developed last year for the PNA and they are different this year. She asked if Ms. Labraña would highlight a success. For instance, there was pediatric developmental screening on the list and was wondering where you think were the major achievements. We see that some are still on the list and so we know on which ones we are still working on. Ms. Labraña thanked Ms. Owen for her question and continued that updates to last year's action plan were occurring quarterly at CAB (Community Advisory Board) and MSC (Member Services Committee). However, Ms. Labraña indicated that one highlight was an objective from last year's PNA and was related to breast cancer screening, Ms. Zena Chafi-Aldwaik and Ms. Geeb coordinated a mobile mammography event to bring access to breast cancer screening to an area that does not have a lab nearby, and is in an underserved area, and that it was a success. Ms. Labraña asked Ms. Geeb if she wanted to chime-in on that event, which was some great work. Ms. Geeb agreed and stated that was one that focused on a particular population where we have seen a disparity, therefore, we are hoping to use that later in the year. We have been doing the work, however, what we have learned is that some of our strategies are taking a little bit more time to move the needle, so to speak. However, we have also seen some great achievements in improving pediatric visits as well. Ms. Geeb continued that they identified some new disparities, but she agreed with Ms. Labraña about pediatric achievements. Ms. Geeb indicated that she would be talking a bit more later in the meeting about breast cancer screening. She continued that CenCal Health rates are among the top 10% of health plans. And we also want to sustain some performance. Dr. Baldwin asked how the Quality team produces the action items that it will implement to improve these measures. Ms. Labraña responded that typically the Population Health team will convene to look at the findings and the HEDIS results from the year and look at the health disparities identified and then determine what is feasible, where our impact will be greatest. We want our objectives to be smart. There are so many things that we could tackle, but we really try to choose things that are organizational priorities that will close a health disparity or meet an unmet need. And we always get input from our Community Advisory Board and from an internal committee to make sure that what we have identified as objectives really do speak to what is needed in the Community. Ms. Geeb added that in addition to a very much data-driven approach and really looking at healthcare disparities, Quality is building an internal dashboard to identify disparities between different populations, but also the state has new requirements for the population needs assessment. After discussion concluded, Dr. Collins asked for a motion to approve. Dr. Bentley ***made a motion*** to approve the *2023 Population Needs Assessment* as presented; seconded by Ms. Macdonald. Motion passed.

9. 2023 Population Health Management (PHM) Program and Strategy *Amber Sabiron, MSN, RN, Manager, Population Health*	Ms. Sabiron spoke to the Committee about the *2023 Population Health Management (PHM) Program and Strategy*. **EXECUTIVE SUMMARY** CenCal Health's Population Health Management (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 inequities. The PHM Framework, including its four (4) domains, serves as the foundation for CenCal Health's PHM program. It helps demonstrate how activities across the organization are integrated 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 the Plan's PHM program: 1. PHM Strategy and Population Needs Assessment, 2. Gathering Member Information, 3. Understanding Risk, and 4. Providing Services and Supports In addition to utilizing the above framework CenCal Health incorporates the National Committee for Quality Assurance's (NCQA) four areas of focus which cover the entire care continuum. Using the four areas of focus below CenCal Health determines targeted populations and sets goals for each area of the following: 1. Keeping members healthy 2. Managing people with emerging risks 3. Patient safety or outcomes across settings 4. Managing multiple chronic illnesses **BACKGROUND** CenCal Health maintains a comprehensive strategy for PHM that is reviewed and updated annually to ensure program goals are being met and in compliance with the Department of Health Care Services (DHCS) and 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's PHM Strategy deliverable to DHCS aims to prepare managed care plans for a more robust collaboration with Local Health Departments (LHDs) that is to begin in 2024, when CenCal Health will be required to meaningfully participate in LHDs'

	community health assessments (CHAs) and community health improvement plans (CHIPs) in the service area(s) where CenCal Health operates. DHCS requires MCPs to set up a meeting with LHDs in their service area prior to the deliverable due date to discuss a) early planning around how MCPs may meaningfully participate and b) co-development of at least one shared goal/SMART objective. **NEXT STEPS** Subsequent to the QIHEC adoption: • Meet with our Local Health Departments to meaningfully collaboration with the Community Health Assessment (CHA) • Create a SMART goal related to the CHA • Submit PHM Strategy and Program Description to DHCS by 10/31/2023 **RECOMMENDED ACTION** Acceptance and approval of the PHM Strategy and Program Description. Dr. Major ***made a motion*** to approve the *2023 Population Health Management (PHM) Program and Strategy,* as presented; seconded by Ms. Snyder. Motion passed.
10. 2022 PHM Impact Analysis and Priorities for Improvement *Lauren Geeb, MBA; Director, Quality*	Ms. Geeb spoke to the Committee about the *2022 PHM Impact Analysis and Priorities for Improvement* and accompanied her oral update with a PowerPoint Presentation. **Executive Summary** Annually, the Department of Health Care Services (DHCS) adopts the NCQA 50th and 90th Medicaid percentiles as its Minimum Performance Level (MPL) and High-Performance Level (HPL) to sanction and reward Medi-Cal plans for performance. Likewise, CenCal Health adopts these percentiles to identify priorities for improvement. To identify CenCal Health's priorities for improvement, staff evaluated CenCal Health's most recent quality of care performance results completed in June 2023 for Measurement Year **(MY)** 2022 against the following immediate and long-term organizational priorities. DHCS' Managed Care Accountability Set (MCAS) priorities in relation to the gap in performance to the HPL in anticipation of DHCS MY 2023 requirements (Priority 1), and aspects of care required for NCQA Health Plan Accreditation (Priority 2). The proposed immediate priorities (level 1) for improvement are: • Well-child visits, including lead and developmental screening, and childhood immunizations. • Child and adolescent well-care visits, including adolescent immunizations. • Follow-up after emergency department visits for substance use and/or mental illness. • Chronic disease management (asthma, hypertension). • Women's reproductive health (maternal care, cancer screening). **<u>MY 2022 FINDINGS</u>** Based on the minimum performance thresholds that must be met across all reporting units the following results were reported to DHCS and NCQA: • Exceptional performance was achieved for six aspects of care: breast cancer screening, a low rate of diabetes blood glucose poor control, pediatric preventive health exams (15 months – 30 months), adolescent immunizations, postpartum care timeliness, and timely follow-up after emergency department visit for substance use.

	• MPL not met for three aspects of care: pediatric lead screening, hypertension control, and timely follow-up after emergency department (ED) visit for mental illness. **PROPOSED PRIORITIES FOR IMPROVEMENT** As CenCal Health seeks out NCQA Accreditation in 2024 and the goal to ensure all DHCS required measurement surpass the Medicaid 50th Percentile for MY 2023, the following are priorities for improvement. Red checkmarks indicate a rate is currently projecting below the MPL based on claims data through June 30th, 2023. Black checkmarks indicate a significant gap (5 points or greater) between current performance and the HPL. **Next Steps** Subsequent to the QIHEC's approval of the attached priorities will be submitted to CenCal Health Board of Directors for feedback and to ensure compliance with the Quality Improvement and Health Equity standards. Subsequent to CenCal Health's Board of Directors' feedback, CenCal Health will complete implementation of the policies. Priorities that support the QIHETP and PHM programs, and health plan accreditation activities, will be presented to the QIHEC at least annually. Dr. Collins asked the Committee if there were any questions for Ms. Geeb. There being none, Ms. Macdonald ***made a motion*** to approve the *2022 PHM Impact Analysis and Priorities for Improvement*; seconded by Dr. Freeman. Motion passed.

11. 2022 CCS/TCRC Quality Results
Chelsee Elliott, Quality Measurement Supervisor
	Ms. Elliott spoke to the Committee about the *2022 CCS/TCRC Quality Results* and accompanied her presentation with a PowerPoint Presentation.
	
	EXECUTIVE SUMMARY
	A quality-of-care evaluation of priority measures selected by the Department of Health Care Services (DHCS) was completed to compare performance between the California Children's Services (CCS) and Tri-Counties Regional Center (TCRC) subpopulation to CenCal Health's general membership. This annual evaluation, which includes a comparison to DHCS minimum performance levels (MPLs) for a select set of measures, is to identify differences in quality of care and utilization, as well as potential underlying reasons for variations in the provision of care.
	
	Notable Findings for CCS/TCRC members:
	• Most quality indicators assessed rated higher than the general population.
	• In Santa Barbara, minimum performance thresholds were met for three out of 4 measures assessed.
	• Completion of well-care exams was higher for most age cohorts evaluated (ages 0-21) compared to the general population.
	• In Santa Barbara, the following measure rated significantly higher than the general population:
	  o Asthma Medication Ratio (8-points higher)
	  o Follow-Up for Children Prescribed ADHD Medication (14-points higher)
	• In San Luis Obispo, the following measure rated significantly higher than the general population:
	  o Immunizations for Children (12-points higher)
	  o Immunizations for Adolescents (14-points higher)
	
	Opportunities for Improvement: The following measures rated below the MPL or had an identified disparity:

- Chlamydia Screening (16-20 years) – Santa Barbara
- Well-Child Visits in the First 15 Months of Life – San Luis Obispo
- Chlamydia Screening (16-20 years) – San Luis Obispo
- Lead Screening
- Pediatric developmental screenings (Age 1)

Emergency Department (ED) utilization was higher for the CCS/TCRC population in both counties. However, higher ED utilization is historically customary for this population due to the greater prevalence of serious medical conditions and/or disability among members.

NEXT STEPS

CCS/TCRC eligible members will continue to be included by responsible committees or departments in interventions that are applicable to the CCS/TCRC membership in CenCal Health's ongoing quality improvement activities for all aspects of care where improvement is needed in the plan's general membership. Special attention must be taken to ensure provider interventions include residential facilities that specialize in care for disabled youth, when applicable.

Subsequent to this meeting, CenCal Health's Quality team will:

- Systematically evaluate the areas of concern to confirm priorities for improvement and identify strategies to address relevant barriers (i.e., social drivers of health, access issues) to improved performance;
- Lead the design and implementation of timely interventions to resolve identified disparities.

Dr. Collins asked the Committee if there were any questions for Ms. Elliott regarding her report.

Discussion:

Dr. Baldwin asked if it is possible to get the chlamydia data broken-out by age as she is wondering if it is the younger members in that age range rather than, say, members over the age of twenty, that we need to target more, through the pediatric providers? Ms. Elliott confirmed that there is and continued that this is definitely an area on which there can be focus. Mr. Hernandez offered that this topic will be brought back to a future QIHEC meeting to demonstrate the break-out for chlamydia screening.

Dr. Kaplan indicated that he sees on CenCal Health's Provider Portal the need for chlamydia screening of young women, and inquired if it is all 16- to 20-year-old women that need screening? What are the criteria that includes them to be screened for chlamydia? Mr. Hernandez responded that it is those that are sexually active, and as determined through administrative data, meaning, claims data. There is a nationally recognized set of codes, either diagnostic or procedure codes, which are indicative of sexual activity, and those are the ones that are included. Dr. Kaplan responded that in his experience as a pediatrician, it is rare that this age-group of women will divulge that information. They will answer on the surveys that they are not sexually active, however, when looking at the data that CenCal Health provides that indicates the quality measures of the age-group, and when I check their medical records, none of them have admitted sexual activity, in my office. Therefore, it makes it a little more difficult to know how to go about procuring this information short of screening every 16-year-old girl. Mr. Hernandez agreed and stated that when Quality performs this measurement, we are collecting claims data from all sources. Moreover, of practitioners, providers that have submitted claims to CenCal Health and that indication may be coming from a practitioner outside of your office. Dr. Kaplan agreed that is the case. For instance, one of the criteria done routinely for an ED or urgent care visit for a stomachache is a pregnancy test which qualifies them for a screening test for chlamydia. Perhaps Quality could communicate out to the relevant providers that if they are testing for pregnancy

	to also screen for chlamydia. That would take care of the issue right at the source. Mr. Hernandez responded that he appreciated the suggestion and that his team will follow up to check the value set for this measurement to see whether a pregnancy test might be driving that. Next, Ms. Elliott indicated that she was able to quickly bring-up the data that indicated that pregnancy tests are included as well as just a code submitted for pregnancy as well as sexual activity, which could include contraceptives being submitted as a claim. Dr. Kaplan thanked Ms. Elliott and offered that it is mostly coming from urgent care and ED data on pregnancy testing; overwhelming majority of it. Ms. Hill asked Ms. Elliott whether there is a workgroup that looks at the data and could perform a deeper dive to develop some initiatives that can determine some theories as to why the numbers are what they are and develop some solutions. Ms. Elliott responded that the information was shared with Medical Management as well as Case Management, and it was determined that there was a certain age group member that was frequenting the ED. They were able to speak with the member, however, the member declined assistance. Ms. Elliott confirmed that there is outreach in these instances. There being no further discussion, Dr. Collins asked for a motion to approve the *2022 CCS/TCRC Quality Results.* A ***motion was made*** by Dr. Freeman; seconded by Dr. Bentley. Motion passed.
12. QIHETP Work Plan Update *Lauren Geeb, MBA; Director, Quality*	Ms. Geeb spoke to the Committee about the *QIHETP Work Plan Update* and accompanied her presentation with a PowerPoint Presentation. **Executive Summary** CenCal Health implemented a Board approved *Quality Improvement & Health Equity Transformation Program (QIHETP)* in March 2023 as part of the Department of Health Care Services (DHCS) CalAIM initiative to advance and innovate Medi-Cal. The Quality Improvement and Health Equity Committee (QIHEC) is CenCal Health's Board-appointed entity to oversee CenCal Health's QIHETP performance outcomes. Monitoring is completed through quarterly and annual review of the QIHETP Work Plan to ensure effective oversight by the QIHEC and CenCal Health's Board of Directors. The 2023 QIHETP Work Plan was developed in congruence with CenCal Health's strategic plan and objectives. Relevant updates are presented for review, feedback, and approval. The Quality department leads the annual development of a QIHETP Work Plan inclusive of population health management (PHM) activities, in coordination with all QIHETP participants plan wide, including but not limited to CenCal Health's Chief Medical Officer, Chief Health Equity Officer/Chief Customer Experience Officer, and Quality & Population Health Officer. Updated quarterly, this Work Plan is a living document that is amended throughout the year to reflect emerging regulatory and organizational priorities. It includes at minimum the following: • Yearly planned quality improvement and health equity activities and objectives, which address quality of clinical care, safety of clinical care, quality of service, and member's experience. • Planned inclusive, equity-focused interventions to address identified patterns of over- or under-utilization. • Evaluation of the program, listed as a specific activity within the work plan. • Time frame for each activity's completion. • Staff members responsible for each activity. • Monitoring of previously identified issues that require additional follow-up.

	Updates QIHETP progress is underway demonstrating active interventions throughout Q3 2023 with some goals being achieved or partially met as outlined in the attached Work Plan. The following updates of significance were made to ensure ongoing compliance with emerging regulatory requirements or identified opportunities for improvement: • New tasks that support the Grievance System oversight of key performance indicators, and Network Access and Availability standards to achieve program integration QIHETP Systems. • CenCal Health's ongoing efforts to promote initial health appointments (IHA) with tasks that reflect an IHA monitoring system that including annual evaluation and dissemination of performance results to support continuous improvement and compliance with standards. • Development of an annual PHM Strategy and Program Description consistent with DHCS and NCQA requirements. • KPI monitoring of PHM Dashboard and Health Equity Dashboard to inform outreach to members and feedback to PCPs. **Next Steps** • Subsequent to the QIHEC's approval of the quarterly Work Plan updates, the Work Plans will be submitted to the CenCal Health Board of Directors for feedback and to ensure regulatory compliance. • Subsequent to CenCal Health's Board feedback, QIHETP participants will incorporate feedback into existing interventions as appropriate. CenCal Health staff will continue to monitor progress across tasks and objectives and report updates through the various QIHETP committee systems to ensure continuous improvement to advance health equity. **Discussion:** Dr. Major asked about coverage for the County jail population of San Luis Obispo and Santa Barbara counties. Ms. Geeb deferred to Ms. Cathy Slaughter, Director of Provider Relations, on Dr. Major's question. Ms. Slaughter asked Dr. Major if he was referring to enhanced care management through CalAIM. Dr. Major confirmed that he was. Ms. Slaughter indicated that program will officially kick-off January 1, 2024, and her department has already been having productive and collaborative discussions with both counties to learn of their partners that are providing support so that CenCal Health can be prepared to assist with the transition, in addition to the two counties' Behavioral Health departments. Although this part of the CalAIM program commences on January 1, 2024, there is a timeframe by which each county can independently start with the pre-release services. Each county may have different time frames, and there will be more information forthcoming on that. Dr. Major indicated that he would like to connect with Ms. Slaughter on this topic, and he stated that he is glad that Ms. Slaughter is on top of this topic. Ms. Slaughter responded that she would follow up with Dr. Major. There being no further discussion, Dr. Major ***made a motion*** to approve *the QIHETP Work Plan Update,* as presented; seconded by Dr. Freeman. Motion passed.

13. Approval of Quality Dashboard *Lauren Geeb, MBA; Director, Quality*	Ms. Geeb spoke to the Committee about the Quality Dashboard and accompanied her oral update with a PowerPoint Presentation. **Executive Summary** The Department of Health Care Services (DHCS) requires managed care plans to meet minimum performance levels (MPL) for a select set of quality measures known as the Managed Care Accountability Set (MCAS). Failure to meet required benchmarks annually, in any reporting unit, may lead to consequences including but not limited to corrective actions and/or financial sanctions. CenCal Health staff utilize a Quality Dashboard as a reference to monitor DHCS priorities quarterly to identify areas where benchmarks are not being met. For the period ending June 30, 2023, 15 measures were evaluated across both counties. *When evaluating results from the most recent quarter, claims lag may artificially suggest a decrease in performance.* Key highlights are: • Like the previous quarter, four measures continue to rate in the top 10% of Medicaid plans for timely postpartum care, adolescent immunizations, breast cancer screenings, and well-child exams (for ages 15-30 months). • Well-Child Visits in the First 15 Months of Life surpassed the minimum threshold for this period assessed. Improvement is attributed to ongoing population health initiatives including the development of a gaps in care report to identify children at risk of falling behind the American Academy of Pediatrics Periodicity Schedule. • Five measures rated below minimum thresholds (previously 6). Improvement is needed for lead testing, cervical cancer screening, controlling high blood pressure, and follow-up visits after emergency department visit for substance use/mental illness. Actions to motivate and improve compliance with clinically recommended services include but are not limited to: • Continuous promotion of CenCal Health's Quality Care Incentive Program (QCIP) ❖ Most recently an in-person provider training workshop was held on August 17th which included sharing of best practices and promotion of Initial Health Appointment completion rates. • Member-level gaps in care detail reports to prioritize member outreach. ❖ Recent developments include a new Well Baby Report and Lead Testing Opportunity List. • Recurring meetings with high volume primary care practices • Member health educational campaigns **NEXT STEPS** QIHEC members have discussion to yield diverse input and exchange ideas to identify the most effective interventions for improvement. Towards this goal, staff ask for input from the QIHEC consistent with their respective roles to monitor and enhance organization-wide quality improvement to advance health equity. Quality department staff will: • Complete submission of two PIP Designs by the DHCS deadline of September 8, 2023. • Continue monthly monitoring to track outcomes of focused improvement interventions and assess performance against emerging regulatory requirements. • Continue providing practice transformation support to guide delivery system clinical improvement. • Provide quarterly update of Quarter 4, 2023 based on MY 2023 requirements.

	After the QIHEC's approval of the attached Quality Dashboard report, the Quality Dashboard will be submitted to CenCal Health Board of Directors for feedback and to ensure compliance with the Quality Improvement and Health Equity Transformation Program standards of the DHCS Contract and DHCS Comprehensive Quality Strategy. Ms. Geeb stated that her department will continue their monitoring. It is important to note that what is improving the most is our engagement with our providers to support practice transformation with one-on-one training to go through their Gaps-in-Care lists and share best practices, as well. The Quality Department recently had their first in-person workshop, and it was very well received. The Quality Department plans to conduct many more next year. **Discussion:** Dr. Kaplan commented that it appears that providers that are hitting less than the expected compliance of quality measures are incentivized at the same level as those that are closer to or achieving the quality measures. Mr. Hernandez responded that is the way that the program is designed, and that those providers are being awarded based on their position within each quintile. It is anticipated that CenCal Health will reduce the incentive award for those providers that are in the lesser quintiles and increase the incentive award for those that are in the higher quintiles. Another possibility is dividing the continuum or the stratification of providers into different groups. The current QCIP model is flexible and is designed so that we can change those thresholds if needed and change the amounts that are paid per threshold. Dr. Kaplan responded that it takes a lot of effort to get those percentages higher, so to incentivize based on compliance makes better sense, instead of the current program where if all providers perform very poorly, everybody can still get greatly rewarded. Mr. Hernandez indicated that that is something that CenCal Health are aware of in the design and development process and for the future evolution of the program. Next, Dr. Kaplan ***made a motion*** to approve the Quality Dashboard, as presented; seconded by Dr. Major. Motion passed.
14. QIHETP Systems Integration – Key Performance Metrics Reporting *Cathy Slaughter, Director, Provider Relations* *Eric Buben, Director, Member Services* *Chris Hill, RN, MBA, Health Services Officer*	Ms. Slaughter introduced to the Committee the Provider Relations part of the *QIHETP Systems Integration – Key Performance Metrics Reporting* and accompanied her presentation with a PowerPoint Presentation. **Executive Summary** This report summarizes the ongoing assessment and monitoring of CenCal Health's compliance with network access and availability standards as required by contractual and regulatory requirements and described in APL 23-001. **Background** APL 23-001 is the latest iteration of DHCS' guidance to the managed care plans regarding access and availability standards and outlines the annual assessment and reporting requirements referred to as Annual Network Certification (ANC). Beginning in 2018, Medi-Cal Managed Care Plans (MCPs) submit their network assessment each year in the format dictated by DHCS in the APL, which is then reviewed by DHCS who either approves and certifies the MCP's network or issues a Corrective Action Plan. Components of the assessment include provider to member ratios, the inclusion of mandatory providers in the MCP's network (i.e., Federally Qualified Health Centers, Rural Health Clinics, Freestanding Birth Centers, Indian Health Facilities, Certified Nurse Midwives and Licensed Midwives), and the MCP's compliance with time or distance (T/D) standards by zip code for various provider types. T/D standards are based on population density of each county in the MCP's service area

	with greater parameters afforded to counties with geographic considerations such as national forests and bodies of water, and areas that are less dense in population. San Luis Obispo and Santa Barbara Counties are both categorized as "small" counties with those corresponding standards. CenCal Health uses geomapping technology as per DHCS specifications as the basis for the assessment of compliance with T/D standards as part of the ANC filing, and conducts ongoing monitoring of the network by performing the geomapping and analysis quarterly. Findings of those activities are reported through the Network Management Committee quarterly. **Q2 2023 Findings** CenCal Health has a robust network of primary care and specialty physicians throughout the service area, thus the ratios of physicians to members and PCPs to members are well within the requirements as reported in the accompanying slide. There are known gaps in compliance with T/D standards in outlying rural areas of certain zip codes. *Detailed findings are on this agenda item cover memo.* *in your meeting packet*. When a MCP identifies a gap in compliance, it must submit an Alternate Access Standard (AAS) request to DHCS for the nearest known provider, contracted or not. If not contracted, the MCP must demonstrate efforts to enter into a contract with that provider. CenCal Health has approved AAS for each of these known gaps, and in each of these cases, is already contracted with the nearest provider. For some of these gaps, it may be a small portion of a zip code that is beyond T/D standards, for example four members who live in Ragged Point in the northwest corner of 93452. Beginning in 2021, DHCS allowed telehealth as an option to supplement access, however, in 2022, limited the telehealth allowance to 15% of each zip code. **Next Steps** The ongoing monitoring of access and availability is one factor that drives provider recruitment activities. The Provider Relations team seeks to engage any new providers that become established in our service area and partners with existing providers on possible solutions. As an example, collaboration with ChildNet and Valley Childrens Hospital in Madera led to some pediatric subspecialists offering appointments at a site in San Luis Obispo County. Some gaps cannot be mitigated by CenCal Health, where services simply do not exist, such as the lack of a hospital between city centers in Santa Barbara and San Luis Obispo, and Bakersfield in Kern County. CenCal Health also ensures the availability of telehealth appointments and transportation services where needed. This concluded Ms. Slaughter's part of the presentation. There being no questions, Dr. Collins asked for a motion to approve. ***Motion made by*** Ms. Macdonald to approve the Provider Relations portion of the *QIHETP Systems Integration – Key Performance Metrics Reporting*, as presented; seconded by Ms. Snyder. Motion passed. Next, Mr. Buben spoke to the Committee about the Member Services portion of *QIHETP Systems Integration – Key Performance Metrics Reporting*. Mr. Buben accompanied his presentation with a PowerPoint Presentation. **<u>Executive Summary</u>** Consistent with the Quality Department's to be numbered Policy and Procedure entitled; *<u>Integration of Utilization Management into QIHETP Systems</u>*, this memo and accompanying slides will support the Grievance System oversight KPI reporting

	requirement. This memo highlights the grievance volume filed by CenCal Health's members from September 1, 2022, through June 30, 2023. This memo also highlights the outcomes and severity levels of grievances filed. **Key findings related to Severity Outcomes:** • Clinical Grievances o 52% with no findings (0) points assigned for each. o 38% with an administrative or interpersonal issue found (1) point assigned for each. o 9% with a Mild/Minor Quality of Care concern (2) points assigned for each. o 2% with a Major/Severe Quality of Care concern (4) points assigned for each. • Non-Clinical Grievances o 59% with no findings (0) points assigned for each. o 36% with an administrative or interpersonal issue found (1) point assigned for each. o Minor, Moderate or Major/Severe Quality of Care do not apply to "non-clinical" grievances. Quality of care concerns are always considered "clinical." Mr. Buben commented that the meeting packet has a full memo and charts and breakouts of those charts for the Committee's review. **Next Steps** Every grievance filed is investigated directly with the provider/ provider's staff for awareness and to investigate all aspects of the member's concerns. Trend reports are monitored regularly by the internal grievance team and monitored through many quality sub-committees to report on key findings. As potential quality improvements (PQIs) are identified from grievance review findings, any related to the quality or delivery of medical care provided are referred for Peer Review discussion as determined necessary by CenCal Health's physician reviewers. Follow-up actions for administrative and interpersonal findings are provided to the Grievance Team, Quality Nurses, Case Management, Provider Services, or other CenCal Health departments to complete requested follow-up with providers or internal plan staff to ensure full resolution of member concerns and to assist in mitigation of future grievances. Dr. Collins asked for a motion to approve this agenda item. ***Motion made*** by Dr. Bentley to approve the Member Services portion of *QIHETP Systems Integration – Key Performance Metrics Reporting*, as presented; seconded by Ms. Snyder. Motion passed. Lastly, Mr. Chris Hill spoke to the Committee on the Medical Management portion of the *QIHETP Systems Integration – Key Performance Metrics Reporting*. Mr. Hill accompanied his presentation with a PowerPoint Presentation.

Executive Summary
Consistent with the Quality Department's yet to be numbered Policy and Procedure entitled; *Integration of Utilization Management into QIHETP Systems*, this presentation and accompanying slides will support the Utilization Management team's KPI metric reporting requirement. CenCal Health completes an annual assessment and monitoring of our compliance with network access and availability standards.

The goal is to ensure that ***all*** CenCal Health members have access to Primary Care, Hospitals, and Core Specialties. CenCal Health utilizes geomapping technology per DHCS specifications to ensure compliance with Time and Distance standards as part of the plan's Annual Network Certification.

Q2 2023 Utilization Management KPI Metric Summary

- The aggregate number of service authorizations across the 4-departments under the Health Services Division and stratified by the 4-authorzation service types.
    - Long Term Care (LTC)
    - Inpatient
    - Medical
    - Referral

  ** OF NOTE: not all authorization types are applicable to each Department **

- The aggregate service determinations are stratified by the 3-regulatory options; approved, denied, or modified.

Mr. Hill commented that 8,323 requests were approved and ten were denied, 233 were modified, which means that it is partially approved and partially denied overall with a 94% approval rate, 3% denial rate and 3% modified. Some folks may have seen the latest report from the OIG, which recently came out and talked about having an average 12.5% denial rate across the country for Medicaid plans. Medicare being 5.7% and the range for some plans are anywhere from 7% denial rate up to 41%. Not only in California, but in the country. This gives you an idea of the variation in the denial rate. CenCal Health's Utilization Management approves most things, and our volume stays rather consistent quarter over quarter.

There being no questions, Dr. Collins next asked for a motion to approve.

Motion made by Dr. Major to approve the Medical Management (Utilization Management) portion of the *QIHETP Systems Integration – Key Performance Metrics Reporting***;** seconded by Dr. Freeman. Motion passed.

15. Over & Underutilization Monitoring Report *Chelsee Elliott, Supervisor, Quality Measurement*	Ms. Elliott spoke to the Committee about the *Over & Underutilizing Monitoring Report and* accompanied her presentation with a PowerPoint Presentation. **Executive Summary** As part of CenCal Health's Quality Improvement and Health Equity Transformation Program (QIHETP), CenCal Health conducts routine monitoring and analysis of program indicators for monitoring and detecting underutilization and over-utilization of services, including, but not limited to, outpatient prescription drugs. Annually, CenCal Health staff perform a quantitative data analysis against established thresholds (Medicaid 10th and 90th percentiles) for services and procedures deemed at risk for extreme utilization in Medicaid populations, according to the National Committee for Quality Assurance (NCQA). Inpatient utilization oversight is a high priority and an ongoing focus for the medical management department. Historically, the trend for average length of stay has been consistent, but days per one-thousand-member months and discharges have slightly increased from the prior year. In 2022, there was an increase in hospital allegations during the summer and in late fall early winter, which was likely related to COVID-19. With that being said, all rates remained within threshold except average length of stay in Santa Barbara County, which rated below the 10th percentile. We cannot rule out concern about the low average length of stay and consequently we have identified it as a potential concern that requires further investigation. Outpatient utilization rates for both counties remained within thresholds and showed a slight increase from previous years. This indicates that as we continue to emerge from the pandemic, members are utilizing primary care services more appropriately. Although showing a steady increase, emergency department utilization rates for both counties remained within thresholds and remained below the pre-pandemic peak from 2019. Recently, DHCS has selected asthma medication ratio as an indicator to monitor outpatient prescription drugs. This measure indicated appropriate utilization and rated among the top 10% of Medicaid plans. This significant increase in rate could be due to our internal pay for performance program, which includes this measure. **Background** In June 2023, CenCal Health reported 21 quality indicators to the Department of Health Care Services (DHCS) and monitored 15 additional indicators for the period ending December 31st, 2022, using the NCQA Healthcare Effectiveness Data & Information Set (HEDIS) and the Centers for Medicare & Medicaid Services (CMS) Core Measure Set. CenCal Health's utilization for a standard set of measures is evaluated against Medicaid benchmarks (10th and 90th percentiles) or historical trends/Medi-Cal averages when benchmarks are unavailable to monitor performance for DHCS priority measures and CenCal Health priority measures. Utilization trends are evaluated by CenCal Health's Chief Executive Officer and Health Services and Quality Division leadership including the Chief Medical Officer, Senior Medical Director, Behavioral Health Medical Director, Quality and Population Health Officer, Medical Management Director, Behavioral Health Director, Pharmacy Director, and Quality Director. Staff annually review and present metrics to detect possible over and under-utilization and discuss significant trends with the QIHEC. Staff research areas of concern, provide data for the implementation of interventions that address concerns, and monitor improvement. Domains monitored include: • *Inpatient Acute Care:* Bed Days, Discharges, and Average Length of Stay • *Ambulatory Care:* Emergency Department and Outpatient visits • *Outpatient prescription drugs* • *Frequency of Selected Procedures*

- *Behavioral Health, including Non-specialty Mental Health Services for adult and pediatric members. CenCal Health stratified several Behavioral Health measures, in alignment with NCQA guidelines, by race and ethnicity to support the identification and reduction of disparities.*

CenCal Health is responsible for providing specified services to adults diagnosed with a mental health disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in mild to moderate impairment of mental, emotional, or behavioral functioning. As a part of CenCal Health's Quality Program, CenCal Health conducts routine monitoring and analysis of program indicators for monitoring and detecting under-utilization and over-utilization of services, including, but not limited to, outpatient prescription drugs.

Data Limitations

The division of mental health coverage of services between the Managed Care Plan and Specialty Mental Health is a barrier to the completeness of data necessary for some measurements. CenCal Health does not receive some of the County's Mental Health data, which reflects in measures that require a specific mental health diagnosis. If a PCP does not include this diagnosis in encounter documentation, it will result in a given member not being included in the measure's eligible population.

NEXT STEPS
Subsequent to this meeting, CenCal Health's Quality Team will act to correct patterns of potential or actual inappropriate underutilization or overutilization by:

- Systematically evaluating the potential concerns and possible priorities for improvement as listed below,
- Confirming priorities for improvement and identify relevant barriers to improved performance,
- Leading the design and implementation of timely interventions to resolve the identified barriers.

Potential areas of concern and possible priorities for improvement are:

- Average Length of Stay in SB County rated below the 10th percentile, which could indicate a lower rate of members being hospitalized. CenCal Health will continue to monitor this aspect of care to ensure members are receiving appropriate care.

- Follow-Up After ED Visit for Mental Illness (7-Day Follow-Up & 30-Day Follow-Up) across both counties.

This concluded Ms. Elliott's presentation to the Committee. Dr. Collins thanked Ms. Elliott for her presentation and opened the floor to comments and questions. There being none, Dr. Collins asked for a motion to approve.

Motion made by Dr. Bentley to approve the *Over & Underutilization Monitoring Report*, as presented; seconded by Ms. Macdonald. Motion passed.

Policy Review & Feedback	
16. QIHETP & Population Health Management (PHM) Program Policies *Carlos Hernandez, Quality & Population Health Officer*	Mr. Hernandez spoke to the Committee about the *QIHETP & Population Health Management Program Policies* and accompanied his oral update with a PowerPoint Presentation. Mr. Hernandez indicated that this presentation provides an overview of five of CenCal Health policies and procedures that support our part in the CalAIM Medical Managed Care program transformation. Mr. Hernandez indicated to the Committee that at the last QIHEC meeting, he reviewed his department's responsibilities. Although he stated that he won't go into that in detail again, however, he wanted to reiterate that one of the responsibilities with the transformation from a quality improvement committee to a quality improvement health equity committee is to review policies and procedures to ensure that they are compliant with DHCS requirements and DHCP's comprehensive quality strategy, and that includes this committee's approval of those policies and procedures. He next reviewed the slides that accompanied his presentation. Highlights include: ❖ The program is required to be NCQA compliant with programs that support diabetes, cardiovascular disease, asthma, and depression management, and must align with DHCS' comprehensive quality strategy, which means that CenCal Health must collaborate with local government agencies that align with the PNA that Ms. Labraña presented on earlier this evening. ❖ Address adult and pediatric preventive care priorities, and maternity care outcomes. ❖ Supportive of a patient-centered medical home model. ❖ Provide these services in a culturally and linguistically appropriate manner. Next, Mr. Hernandez reviewed the five policies with the Committee. He indicated that the first three policies are currently implemented, and the last two will be implemented effective January 1, 2024. Subject to this Committee's approval of the policies, they will then be brought to the CenCal Health Board of Directors for their review and feedback, and subsequent approval. Mr. Hernandez reminded the Committee that any QIHETP policies or those that are supportive of NCQA accreditation will be presented to this Committee (QIHEC)at least on an annual basis. However, these will be brought to this Committee on a quarterly basis so that they are distributed throughout the year. Mr. Hernandez opened the floor to questions or comments. There being none, Dr. Collins thanked Mr. Hernandez for his presentation and asked for a motion to approve the agenda item. ***Motion made*** by Ms. Snyder to approve the *QIHETP & Population Health Management Program Policies*, as presented; seconded by Dr. Major. Motion passed.

***If needed*, return to any Consent items designated for discussion**	There were none to discuss.

Open Forum & Future Agenda Items	Dr. Collins invited topics for future agenda items and any discussion topics that the Committee would like to pursue. Dr. Major shared that his office and all the San Luis Obispo school nurses will be meeting with Jack O'Connell, who is the new lobbyist for the California School Association (CSA), and anyone is welcome to attend. The meeting will be held at the Madonna Inn in San Luis Obispo on September 18, 2023. There were no additional topics for discussion nor future agenda items brought forward. Dr. Collins expressed his appreciation for the Committee's patience, participation, collaboration, engagement, and endurance for this evening's meeting, and that he looks forward to seeing the Committee members at the next meeting.
Adjournment	There being no further business, Dr. Collins adjourned the meeting at 6:06 p.m.

Respectfully submitted,
Mimi M. Hall
Executive Assistant

Approved,
Michael Collins, DO, MPH
_____
Michael Collins, MD, MPH, MS
Sr. Medical Director
Co-Chair, Quality Improvement & Health Equity Committee