PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3143</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
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Effective Date: 01/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: 01/11/2024
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/11/2023</td></tr>
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I. RELATED POLICIES:

A. MCCP2032 – CalAIM Enhanced Care Management (ECM)
B. MCUP3142 – CalAIM Community Supports (CS)
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions
E. CGA024 – Medi-Cal Member Grievance System
F. CMP36 – Delegation Oversight and Monitoring
G. MCUG3011 – Criteria for Home Health Services

II. IMPACTED DEPTS:

A. Health Services
B. Care Coordination
C. Claims
D. Finance
E. Member Services
F. Provider Relations
G. Administration

III. DEFINITIONS:

A. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
B. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
C. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.

IV. ATTACHMENTS:

A. Community Supports Criteria Matrix and Community Supports HCPCS Code Chart
B. Enhanced Care Management (ECM) Release of Information (ROI) Form
C. Enhance Care Management HCPCS Code Chart

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V. PURPOSE:

To describe Partnership HealthPlan of California's (PHC's) process for reviewing and authorizing requests for the Enhanced Care Management (ECM) benefit and optional Community Supports (CS).

VI. POLICY / PROCEDURE: /

A. ENHANCED CARE MANAGEMENT (ECM)

1. A Treatment Authorization Request (TAR) is required for all members receiving the ECM Benefit.
2. Providers shall submit a TAR to request ECM services electronically or via fax to PHC's Health Services Department for review. Instructions on how to submit a TAR and PHC's TAR processing timelines are described in PHC policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
3. ECM Eligibility Criteria:
    a. Member meets eligibility criteria as outlined in section VI.A. of policy MCCP2032 CalAIM Enhanced Care Management (ECM).
4. ECM TAR Requirements

    TARs submitted to PHC for ECM services shall contain:
    a. Documentation of the ECM Population(s) of Focus that the member meets criteria for
    b. Proposed ECM date(s) of services
        1) Dates should include the initial date of outreach and engagement, as well as the length of service anticipated, up to a maximum of 6 months
        2) If additional time or service is necessary, a new TAR shall be submitted
        3) Renewal TARs shall be submitted at least 10 days prior to the end of the prior approval to avoid gaps in care.
    c. Copy of the member's valid Enhanced Care Management (ECM) Release of Information (ROI) form.
    d. Copy of the member's Individualized Care Plan with the minimum elements below:
        1) Physical Health
            a) List of current active problems
            b) List of chronic health conditions
            c) Medication reconciliation documented
            d) Durable medical equipment needs noted or marked NA
            e) Number of Inpatient and Emergency Department visits in last 6 months
            f) Referral to medical provider if no recent (60 days) primary care visit noted
        2) Mental health assessment
            a) Screening noted with referral if needed
        3) Substance use screening
            a) Screening noted with referral if needed
        4) Social Determinants of Health assessment
            a) Housing stability documented with referral if needed
            b) Other referrals if needed
        5) Long Term Support Services (LTSS) screening
            a) Advanced care plan status addressed
            b) In-Home Support Services (IHSS) assessment
            c) Community Based Adult Services (CBAS)assessment
            d) Other assessments as needed
        6) Oral Health
            a) Dental care addressed
        7) ECM Provider attestation that the member has a valid Release of Information (ROI) form on file for ECM.

e. Service codes for ECM as outlined in Attachment C, ECM HCPCS Code Chart.

5. ECM providers are responsible for notifying PHC if a member discontinues ECM services. See PHC Policy MCCP2032 CalAIM Enhanced Care Management (ECM), section VI.F. Discontinuation of ECM.
6. For information on the process for a member, member's authorized representative, or a provider on behalf of a member, to appeal PHC UM decisions, see PHC policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

B. COMMUNITY SUPPORTS (CS)

1. A Treatment Authorization Request (TAR) is required for all members receiving a CS service.
2. Providers shall submit a TAR to request a CS service electronically or via fax to PHC's Health Services Department for review. Instructions on how to submit a TAR and PHC's TAR processing timelines are described in PHC policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
3. PHC is not required to offer CS services to all members in all of its service areas. To see a list of CS services that PHC currently offers, see section VI.A. of policy MCUP3142 CalAIM Community Supports.
4. CS Eligibility Criteria:
   a. To be eligible for a CS service, members must meet the medical necessity criteria outlined for the CS in Attachment A - Community Supports Criteria Matrix and Community Supports HCPCS Code Chart.
   b. PHC shall review all CS TARs on an individual basis to ensure the services requested are appropriate and cost-effective as outlined in DHCS APL 21-017 Community Supports Requirements.
5. CS TAR Requirements:
   TARs submitted to PHC for a CS service shall contain:
   a. Documentation of the medical necessity criteria as outlined in Attachment A.
   b. Proposed date(s) of service
   c. Service codes for the CS service as outlined in Attachment A.
6. Electronic Visit Verification (EVV) Requirements:
   Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   a. Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator no later than October 19, 2022.
   b. Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.
7. For information on the process for a member, member's authorized representative, or a provider on behalf of a member, to appeal PHC UM decisions, see PHC policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

C. WHOLE PERSON CARE TRANSITION TO ECM OR CS

1. Beginning January 1, 2022, PHC shall automatically authorize ECM and/or CS services for member who are identified by the Whole Person Care Lead Entity as eligible and transitioning from a Whole Person Care Pilot.
2. ECM and CS provider are not required to submit a TAR to PHC for transitioning members. For these members, PHC shall enter a presumptive TAR for six (6) months on the provider's behalf.
3. ECM and CS providers shall submit to PHC a renewal TAR ten (10) days prior to the expiration of the presumptive TAR to avoid gaps in care for the member.

a. All TARs submitted after the presumptive TAR must contain the documents required for services above.
b. All members continuing ECM and/or CS services must meet the benefit criteria as outlined in MCCP2032 CalAIM Enhanced Care Management (ECM) and/or MCUP3142 CalAIM Community Supports (CS).

D. QUALITY MONITORING
1. PHC shall review all ECM and CS TARs in an equitable and non-discriminatory manner.
2. During the review process, PHC shall screen members for ECM and/or CS services and make referrals for additional services when appropriate.
3. PHC shall actively monitor and track utilization and quality of the ECM benefit and approved CS services. For details on PHC's activities for oversight and quality monitoring, see PHC policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3142 CalAIM Community Supports (CS).

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) 438.3(e)(2)
B. DHCS CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract
C. DHCS Contract Exhibit A, Attachment 5 Utilization Management and Attachment 6, Provision 13, Ethnic and Cultural Composition
D. DHCS Contract Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals
E. DHCS APL 21-012 Enhanced Care Management Requirements (09/15/2021)
F. DHCS APL 21-017 Community Supports Requirements (11/05/2021)
G. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services; Associate Director of Utilization Management Strategies

X. REVISION DATES: 01/11/23

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

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PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.