Technical Assistance Guide for Medical Audits

Category 2: Population Health Management and Coordination of Care

June 2026

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal Managed Care Plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. The Contract and Enrollment Review Division (CERD) of DHCS' Audits and Investigations (A&I) is responsible for performing the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Population Health Management and Coordination of Care
- Category 3 – Network and Access to Care
- Category 4 – Grievances, Appeals, and Member's Rights
- Category 5 – Quality Improvement and Health Equity Transformation Program
- Category 6 – Plan Organization and Administration

USING THE TECHNICAL ASSISTANCE GUIDE (TAG)

The TAGs are designed to identify key elements commonly evaluated by A&I's audit process to promote transparency. The TAG is grouped by subcategories and includes the following components, as applicable:

Requirement: This column identifies "key" statutory, regulatory, and contractual requirements related to core managed care organization systems and processes that may be included in scope and additional areas identified based on risk. While this narrows the audit scope, the audit team may investigate the MCP's compliance with other requirements.

- MCPs are ultimately responsible for ensuring compliance with all provisions of the DHCS contract as well as any applicable All Plan Letters (APLs), Plan Letters (PLs) and Dual Policy Letters.
- The contract requirements can be supplemented with applicable laws, regulations, APLs, etc.
- This TAG cites language from the DHCS Boilerplate Contract and related Federal and State laws and regulations.
- "Contractor" means "MCP" or "Plan" in this document.

Documentation Reviewed: The items in this column reflect a hierarchy of documents.

- Initially listed items (√) indicated will most likely confirm contractual compliance or not.
- Lower listed alternate/optional documents (△) may contain information that will help determine the status of the MCP's compliance with a particular requirement.
- Documents are not only reviewed for individual compliance, but as reference in the review of all other evidence and interviews to determine actual implementation in practice, effectiveness and MCP actions taken.
- The Documents include, but are not limited to:
  - Policies and Procedures
  - Organizational Charts
  - Committee Meeting Minutes
  - Monitoring Reports
  - Data Logs
- Verification Studies are listed in this section where applicable.

Examples of Best Practices: This column details strategies implemented by some MCPs to either demonstrate compliance with a contract requirement or correct an identified deficiency. MCPs and individual audits can present distinct characteristics, and best

practices may not transfer seamlessly. The audit team does not audit to best practices but may use them to evaluate compliance. It remains the responsibility of the MCP to demonstrate that it is meeting its contractual obligations.

CATEGORY 2: POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE OVERVIEW

Introduction/Overview

Population Health Management (PHM) is a broad approach that aims to improve the health of a population by identifying and addressing health disparities and promoting wellness. It involves data analysis, risk stratification, and targeted interventions. Population health care management and care coordination are strategies for improving the health outcomes of a specific group of individuals by managing their care and engaging them in their own healthcare. Care management focuses on individualized care plans, while care coordination emphasizes seamless, integrated care across different settings, ensuring a patient-centered approach across various health services.

The Category 2 Audit Program includes the following subcategories:

- 2.1: Population Health Management Program Requirements
- 2.2: Population Needs Assessment
- 2.3: Data Integration and Exchange
- 2.4: Population Health Management Service
- 2.5: Population Risk Stratification and Segmentation, and Risk Tiering
- 2.6: Screening and Assessments
- 2.7: Care Management Programs
- 2.8: Basic Population Health Management
- 2.9: Other Population Health Requirements for Children
- 2.10: Transitional Care Services
- 2.11: Targeted Case Management Services
- 2.12: Mental Health Services
- 2.13: Alcohol and Substance Use Disorder Treatment Services
- 2.14: California Children's Services

- 2.15: Services for Persons with Developmental Disabilities
- 2.16: School-Based Services
- 2.17: Dental
- 2.18: Direct Observed Therapy for Treatment of Tuberculosis
- 2.19: Women, Infants, and Children Supplemental Nutrition Program
- 2.20: Home and Community-Based Services Programs
- 2.21: In-Home Supportive Services
- 2.22: Indian Health Care Providers
- 2.23: Justice-Involved Reentry Coordination
- 2.24: Managed Care Liaisons
- 2.25: Enhanced Care Management *(Contract Section 4.4)*
- 2.26: Community Supports *(Contract Section 4.5)*
- 2.27: Community Based Adult Services *(Contract Section 5.4)*
- 2.28: Services for Members Less Than 21 Years of Age: EPSDT, Preventive Services, BHT *(Contract Section 5.3)*
- 2.29: Initial Health Appointment: Adults and Children *(Contract Section 5.3)*
- 2.30: Continuity of Care for Seniors and Persons with Disabilities *(Contract Section 5.2)*
- 2.31: Pregnant and Postpartum Members *(Contract Section 5.3)*

CATEGORY 2.1: POPULATION HEALTH MANAGEMENT PROGRAM REQUIREMENTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.1 **Equitable Access to Services and Care Coordination** A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assess Member's needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes at both the individual Member level, and at the community level. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance. Contractor must report on PHM program operations, effectiveness, and outcomes based on DHCS guidance specified in the PHM Policy Guide, as noted in All Plan Letter (APL) 22-024. *Note: Starting in 2023, MCPs are no longer required to submit an annual PNA action plan and instead are required to meaningfully*	» Policies & Procedures (P&Ps): o PHM Program » Information Dissemination: o Provider Manual o Newsletters/Education o Member Handbook and Newsletters o Plan Website » Oversight Documents: o QIHET Description o QIHETP Work Plan o QIHETP Annual Evaluation o Evidence of participation in LHJ-led CHA/CHIP processes » PHM Care Management (CM) Org Chart o Qualified Staff and Supervisors	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's PHM program meets Contract requirements. Oversight of the Plan's PHM program is evident. Relevant entities (Providers, Members, etc.) are informed about the Plan's PHM program and the process to access PHM-related services.

Requirement	Documentation to Review	Examples of Best Practices
participate in the Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) process of their local health jurisdiction.		

Contract Exhibit A, Attachment III, Section 4.3.1
 	
NCQA PHM Standards and PNA Requirements
 	
B. Contractor must ensure its PHM program meets, at a minimum, all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and State requirements as set forth in APL 22-024. As described in Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment) and in accordance with APL 23-021, Contractor must fulfill its Population Needs Assessment (PNA) requirement by meaningfully participating in the local health jurisdiction (LHJ) Community Health Assessment (CHA)/ Community Health Implementation Plan (CHIP) process in the Service Area county(ies) in which it operates, and submit a PHM Strategy, informed by PNA findings, to DHCS. PHM Strategy submission documentation will include an NCQA-approved PHM strategy for accredited Plans. Contractor that has not yet obtained NCQA accreditation is still responsible for submitting PHM Strategy documentation prepared for near-future NCQA submission
	» Policies & Procedures (P&Ps):
	  ○ PHM Program
	  ○ NCQA Accreditation
	» Oversight Documents:
	  ○ QIHET Description
	  ○ QIHETP Work Plan
	  ○ QIHETP Annual Evaluation
	  ○ Evidence of participation in LHJ's CHA/CHIP process
	» NCQA Accreditation
		P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.
		
		All documents reviewed demonstrate the Plan's PHM program meets Contract requirements.
		
		Note: Beginning in 2028, all LHJs will be on the same CHA / CHIP timing cycle. Until then, MCPs must report their involvement in the CHA/CHIP process to Program as part of the PHM Strategy.

Requirement	Documentation to Review	Examples of Best Practices
in line with NCQA Health Plan Accreditation standards, inclusive of population assessment documentation informing PHM Strategy and accreditation application process if Contractor is without current accreditation, upon DHCS request. *Note: Between 2024 and 2027, MCPs will be required to support LHJs on current CHA/CHIP processes occurring during this time frame. These CHAs/CHIPs will be on different cycles during this time period, but will all be on the same cycle starting 2028.*		

CATEGORY 2.2: POPULATION NEEDS ASSESSMENT

Requirement	Documentation to Review	Examples of Best Practices

Contract Exhibit A, Attachment III, Section 4.3.2
 	
Populations Needs Assessment
 	
A. Contractor must conduct a PNA by participating in the CHA/ CHIP processes led by Local Health Departments (LHDs) in the Service Area county(ies) where Contractor operates, as defined further in APL 23-021 and the PHM Policy Guide.
B. Contractor operating in multiple LHD jurisdictions must participate in the CHA/CHIP process for each jurisdiction in which it operates.
C. Contractor must submit an annual PHM Strategy that demonstrates that Contractor is responding to community needs and provides PHM updates as specified and, in the format prescribed by the Department.
D. Contractor must ensure that any populations covered by a Fully Delegated Subcontractor, Partially Delegated Subcontractor, or Downstream Subcontractor are included in the PNA and PHM Strategy process.
E. Contractor must publish on its website all LHD CHAs/CHIPs in the Service Area along with a brief description of how Contractor participated in the CHA/CHIP process. Contractor must also share findings from the
	» Policies & Procedures (P&Ps) Information Dissemination:
	  ○ Provider Manual
	  ○ Newsletters/Education
	  ○ Member Handbook and Newsletters
	  ○ Plan Website (Published PNA)
	
	» List of the Plan's covered LHD jurisdictions
	
	» MOUs with LHDs:
	  ○ Includes process for CHA/CHIP participation
	
	» Oversight Documents:
	  ○ Meeting Minutes
	  ▪ QIHEC
	  ▪ Governing Board
	  ▪ CAC, includes evidence of sharing of CHA/CHIP findings
	  ▪ Evidence of participation in LHJ's CHA / CHIP process
		P&Ps, that reflect Contract requirements, are established, maintained, reviewed, updated, and implemented.
		
		All documents reviewed demonstrate the Plan's PNA process meets Contract requirements.
		
		Relevant entities (Providers, Members, etc.) are informed about the Plan's PNA process.
		
		Oversight of the Plan's PNA process is evident.
		
		Note: Beginning in 2023, MCPs are no longer required to submit an annual PNA and PNA action plan, and are instead required to meaningfully participate in the CHA / CHIP process of their LHJ.

Requirement	Documentation to Review	Examples of Best Practices
CHA/CHIPs in Service Area with their Community Advisory Committees (CACs). *See Note Above Regarding MCP support of LHJs for CHA/CHIP processes*	» Includes evidence of Plan's response to community needs	
Contract Exhibit A, Attachment III, Section 4.3.2 **Populations Needs Assessment** F. Based on participation in the CHA/CHIP process in the Service Area, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy: 1. Targeted health education materials for Members, including Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services; 2. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and 3. Wellness and prevention programs. G. Contractor's MOU with an LHD must include a requirement that Contractor coordinate with the LHD to develop a process to implement DHCS guidance regarding the PNA and PHM Strategy requirements. H. The PNA and PHM Strategy requirements, as outlined in this Subsection, and other PHM	» Policies & Procedures (P&Ps) » Evidence of Annual Review/Update of the: ○ Targeted Health Education Materials ○ Member-facing Outreach Materials ○ NSMHS Outreach Materials ○ Cultural and Linguistic and QI Strategies ○ Wellness and Prevention Programs ○ Contractor's MOU with LHD ○ PHM Strategy Requirements	P&Ps that reflect Contract requirements are established, maintained (reviewed/updated), and implemented. All documents reviewed demonstrate the Plan's PNA & PNA process meet Contract requirements, e.g., there is evidence of timely updates of required documents.

Requirement	Documentation to Review	Examples of Best Practices
deliverables, as described in this Contract, remain consistent with 22 CCR, sections 53876, 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), 28 CCR, section 1300.67.04; 42 CFR sections 438.206(c)(2), 438.330(b)(4) and 438.242(b)(2); and APL 23-021. I. Additional operational details on the PNA and PHM Strategy are located in the PHM Policy Guide. Any future updates will also be communicated to Contractor via the PHM Policy Guide.		

CATEGORY 2.3: DATA INTEGRATION AND EXCHANGE

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.3 **Data Integration and Exchange** In accordance with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and State data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment III, Section 2.1 (Management Information System), as follows: A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members; B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the DHCS; C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems; D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and	» Policies & Procedures (P&Ps): ○ MIS and MIS Capabilities (data exchange) » Evidence of the Plan's PHM MIS Capacity ○ Meets DHCS data integration and exchange requirements as outlined in Contract Section 4.3.3 Exhibit A, Attachment III » MIS/Data Audits ○ No less frequently than once every 3 years and shared with DHCS	P&Ps, that reflect Contract requirements, are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's MIS meets Contract requirements.

Requirement	Documentation to Review	Examples of Best Practices
E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety Code (H&S) section 130290. F. Comply with the CMS Interoperability and Patient Access Final Rule set forth at CMS-9115-F.		

CATEGORY 2.4: POPULATION HEALTH MANAGEMENT SERVICE

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.4 **Population Health Management Service** Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS. Contractor must use the PHM Service, at a minimum, to: A. Perform Risk Stratification and Segmentation (RSS) activities and Risk Tiering functions as described in this Subsection; B. Identify and assess Member-level risks and needs through use of the PHM Service's Risk Tiering functionality, which places Members into high, medium-rising, or low Risk Tiers, and use the RSS and Risk Tiering functionality to identify and assess Member-level risks and needs as specified in the PHM Policy Guide; C. Inform and enable Member screening and assessment activities, including pre-populating screening and assessment tools; and D. Support Member engagement and education activities. *Note: PHM Policy Guide Excerpt on Next Page*	» Policies & Procedures (P&Ps): ○ RSS and Risk Tiering (RSST) Functions ○ Evidence of the Plan's use of the PHM Service to: ○ Perform RSST ○ Identify and Assess Member-Level Risks (low, medium-rising, high) and needs ○ Inform/Enable Member Screening and Assessment Activities ○ Support Member Engagement and Education Activities » Information Dissemination: ○ Provider Manual ○ Newsletters/Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures, etc.	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers) are informed about the requirement to use the PHM service. Of note, as of March 2026, only MCPs (and soon BHPs) have access to Medi-Cal Connect. Beginning Fall 2026, Member direct access will be removed. Oversight of the Plan's use of the PHM Service is evident. *Note: See Program update below regarding MCP risk tiering requirements*

Requirement	Documentation to Review	Examples of Best Practices
	○ Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ Governing Board	
PHM Policy Guide – Updated January 2026 Update March 2026: The Medi-Cal Connect PHM Service is centrally designed at DHCS, and the expectation of MCPs is to use its capabilities to improve population health management and quality. At this time, Medi-Cal Connect has been implemented / launched for all MCPs.	See Above	*Note: as of March 2026: MCPs must implement one of the following:* 1. *RSS program that meets NCQA requirements for RSS* 2. *DHCS RSST risk tiers* 3. *A combination of (1) and (2), which may include a pilot of part of DHCS risk tiers.* *DHCS has indicated that all MCPs will be required to use RSST risk tiers no earlier than January 2027.*

CATEGORY 2.5: POPULATION RISK STRATIFICATION AND SEGMENTATION, AND RISK TIERING

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.5 **Stratification and Segmentation, Risk Tiering** Contractor must use RSS and Risk Tiering to identify and assess Member-level risks and needs and, as needed, connect Members to services in a manner specified in the PHM Policy Guide and detailed below: 1. Consider findings from the PNA and all Members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH; 2. Comply with NCQA PHM standards 3. Risk stratify and/or segment all Members at least annually and during each of the following timeframes: a) Upon each Member's Enrollment; b) Annually after each Member's Enrollment c) Upon a significant change in the health status or level of care of the member; and d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM),	» Policies & Procedures (P&Ps) » RSST approach and processes and how they are used to connect Members to services » Procedures to adhere to NCQA PHM Standards » Evidence of the Plan's use of RSST to: ○ Identify and assess Member-level risks and needs (considering results from Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), risks, SDOH) and connect Members to services » Other Evidence » Evidence of Timely Re-stratification	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's RSS/Risk Tiering process meets Contract requirements.

Requirement	Documentation to Review	Examples of Best Practices
Enhanced Care Management (ECM), and Transitional Care Services. 4. Submit its processes to DHCS upon request regarding how it identifies Significant Changes in Members' health status or level of care and how it is monitoring appropriate re-stratification; 5. Incorporate a minimum list of data sources, as specified in the PHM Policy Guide; 6. Avoid and reduce biases in its RSS approach, such as only using utilization data, by using evidence-based methods to prevent further exacerbation of Health Disparities; and 7. Continuously reassess the effectiveness of the RSS methodologies and tools.	» NCQA Accreditation » Policies & Procedures (P&Ps) » Appropriate re-stratification » Continuous reassessment of effectiveness of RSST methodologies and tools » Information Dissemination o Provider Manual o Newsletters, Education o Member Handbook and Newsletters o Plan Website » Oversight Documents o Meeting Minutes ▪ QIHEC ▪ Governing Board o Evidence/List of Data Used in the RSST Approach. For Each Type of Data Listed o Include a description of the data and its origin	

Requirement	Documentation to Review	Examples of Best Practices
	○ How the data will be incorporated into the RSST process ○ Evidence of Methods of Bias Analysis Used to: ▪ Analyze Contractor's RSST approach ▪ Analyze whether any biases were identified and corrected	
Contract Exhibit A, Attachment III, Section 4.3.5 **Population Risk Stratification and Segmentation, Risk Tiering** B. Once the PHM Service RSS and Risk Tiering functionality is available for use by Contractor, Contractor must use RSS and PHM Service Risk Tiers to: 1. Connect all Members, including those with rising risk, to an appropriate and available Contractor-identified level of service, including but not limited to, care management programs, Basic PHM, and Transitional Care Services; and 2. Contractor may supplement the PHM Service outputs with local data sources and methodologies. C. Upon request, Contractor must ensure that its RSS and Risk Tiering approach is	» Policies & Procedures (P&Ps) ○ RSST functions to connect Members to services ○ Tracking/monitoring for timely annual RSS and appropriate re-stratification (based on significant health status/level of care changes) ○ Provider Manual, Newsletters, and Education ○ Other Evidence » If applicable, evidence of:	Providers are informed about the Plan's PHM Service Risk Tiers to connect Members to appropriate services based on Member needs or risks. Verification Study results show compliance with Contract requirements for Population RSS and Risk Tiering. Universe sampled shows evidence of the Plan's RSS and Risk Tiering of all Members during the following: 1. Upon enrollment; 2. Annually after enrollment; 3. Upon significant health status and level of care change; 4. Upon occurrence of events / new information of potential changing Member's needs (CCM/ECM/TCM referrals)

Requirement	Documentation to Review	Examples of Best Practices
submitted to DHCS for review and approval in a form and method prescribed by DHCS.	○ Utilization of supplemental service outputs with local data sources and methodologies ○ RSST approach is reported to DHCS ○ Verification Study ○ Determine compliance with RSST requirements by reviewing ○ Potential samples from the universe of: ▪ Newly enrolled Members with RSS completion and risk level data and ▪ Members tracked/monitored with timely annual RSS ▪ CCM, ECM, and TCM Referrals » Medical Records and Case Notes for CCM, ECM, and TCM	

CATEGORY 2.6: SCREENING AND ASSESSMENTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.6 **Screening and Assessments** A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening or assessment of each Member's needs within 90 days of Enrollment and share that information with DHCS, and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three attempts to contact a Member to conduct the initial screening or assessment using available modalities. B. Contractor must conduct necessary screening and assessments to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards. C. Contractor must abide by DHCS guidance for Member screening and assessment, including guidance for how to use the PHM Service for the screening and assessment process. D. Contractor must monitor what percentage of required assessments are completed per the specifications above.	» Policies & Procedures (P&Ps) » Information Dissemination ○ Plan Website ○ Meeting Minutes ▪ QIHEC ○ Screening and Assessments Tracking / Monitoring Reports ○ HIF/MET for All Members ○ 90-day timeframe ○ IHA for All Members ○ 120-day timeframe ○ For Duals, documentation of PC visit in the last 12 months, or connection to a PCP ○ HRA for SPD Members (up to a) 90-day timeframe (complete the HRA within 60 days of the RSS date) ○ Blood Lead Screening Test	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members, etc.) are informed about the timeframes for required screenings and assessments. Oversight of the Plan's screening and assessment process is evident. Timely screenings and assessments: Initiate the HRA within 30 days of identifying the member through RSS, referral, or other means, and completing the assessment within 60 days of identification date. Update March 2026 for Blood Lead Screenings: BLS is less critical for basic PHM because it is already covered in MCAS.

Note: IHA, Immunizations, and Blood Lead Level Screenings are covered more extensively in this Audit Program in Section 2.29 PHM Policy Guide (Streamlining Screenings) PHM Policy Guide (January 2026)	○ Members ages 12 to 72 months ○ Tracking/Monitoring Records ○ Timely completion of HIF/METs, IHAs, HRAs, Blood Lead Screening Tests	

CATEGORY 2.7: CARE MANAGEMENT PROGRAMS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.7 **Care Management Programs (General Overview)** Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic PHM*). Members receiving the care management services described in this Subsection must have an assigned CCM Care Manager and a Care Management Plan (CMP). **Enhanced Care Management** Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members. ECM provides systematic coordination of services	» Policies & Procedures (P&Ps): ○ PHM Care Management Programs ○ Assigning Care Managers (CM) ○ Documenting and Maintaining Care Management Plans » Information Dissemination: ○ Plan Website » Oversight Documents: ○ Meeting Minutes ○ QIHEC ○ Governing Board ○ CAC ○ PHM CM Org Chart ○ Qualified Staff / Chain of Command » CCM CM Job Description » Policies & Procedures (P&Ps): ○ CCM ○ ECM	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's care management programs meet Contract requirements. Relevant entities (Providers, Members, etc.) are informed about the Plan's care management programs and the process to access these services. Oversight of the Plan's PHM care management programs is evident through meeting minutes in QIHEC, Governing Board, and CAC. Specific areas of focus include identification of and recommendations to address performance gaps and member experience. P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's care management programs meet Contract requirements, including the implementation of ECM and CCM. Relevant entities (Providers, Members, etc.) are informed about the Plan's care management programs (CCM and ECM) and the process to access these services.

Requirement	Documentation to Review	Examples of Best Practices
and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. **<u>Complex Care Management</u>** Complex Care Management (CCM) (which equates to "Complex Case Management" as defined by NCQA) is an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members through both ongoing, chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. Contractor must consider CCM to be an opt-out program, i.e. Members have the right to participate or to decline to participate. Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members, at minimum. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach. A. Care Management Programs Contractor must operate and administer the following care management programs:	○ Basic PHM ○ CCM and ECM are inclusive of Basic PHM ○ ECM » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures, etc. » Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC ○ PHM CM Org Chart ▪ Qualified Staff/Chain of Command » Medical Records » Case Notes – CCM and ECM	Oversight of the Plan's use of the PHM Service is evident, including CCM and ECM programs through meeting minutes in QIHEC, Governing Board, and CAC. Specific areas of focus include identification of and recommendations to address performance gaps and member experience. P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Basic PHM by the Member's Primary Care Physician (PCP) is evident in CCM and ECM medical records and case notes. Relevant entities (Providers, Members, etc.) are informed about the Plan's care management programs (CCM and ECM) and the process to access these services. Oversight of the Plan's use of the PHM Service is evident, including CCM and ECM programs.

Requirement	Documentation to Review	Examples of Best Practices
1. ECM as described in Exhibit A, Attachment III, Section 4.4 (Enhanced Care Management). 2. CCM *Note: ECM is covered more extensively in Section 2.25 of this Audit Program*		
Contract Exhibit A, Attachment III, Section 4.3.7 **CCM: NCQA Standards, Program Design, Comprehensive Assessments, Member Opt-Out Option, and Interventions** a. Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program: i. Contractor's CCM program must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting; ii. Contractor's CM program must include comprehensive assessment of the Member's condition; determination of	» Policies & Procedures (P&Ps): ○ Comprehensive Assessment of Members ○ Documenting and maintaining Care Management Plans (CMP) and ensuring all CMP requirements are met ○ CCM is an opt-out program ○ Various interventions depending on Member needs and population needs ○ Long-term and chronic care coordination ○ CCM program must meet NCQA standards » NCQA Accreditation » Oversight Documents of CCM:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Evidence that the Plan's CCM program meets NCQA CCM standards. Implemented CMPs are: Individualized according to Member's needs, including a variety of appropriate interventions Measurable goals Reviewed periodically and updated. Verification Study: Results show compliance with CCM Contract requirements, including evidence of CMs fulfilling their roles and responsibilities for CCM Members.

Requirement	Documentation to Review	Examples of Best Practices
available benefits and resources; and development and implementation of a CMP with performance goals, monitoring and follow-up; iii. Contractor's CCM program must have an opt-out method under which Members meeting criteria for CCM have the right to decline to participate; iv. Contractor's CCM program must include a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic Care Coordination and interventions for episodic, temporary needs.	○ Meeting Minutes ○ QIHEC ○ PHM Care Management Committee » Medical Records » CCM Case Notes » Verification Study ○ ECM: See Section 2.25 » CCM: Determine compliance with CCM requirements by reviewing: ○ Universe of the Plan's CCM Members ○ Medical Records and CCM Case Notes	
Contract Exhibit A, Attachment III, Section 4.3.7 **CCM: Disease Management Programs, EPSDT, Community Supports, and Program Description** v. Contractor's CCM program must incorporate disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.	» Policies & Procedures (P&Ps): ○ CCM Program ○ Incorporates disease-specific management programs (e.g., asthma and diabetes and associated self-management support and health education ○ Includes the provision of EPSDT services	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical Records and CCM Case Notes show evidence of: » Disease management programs and health education The provision of EPSDT services, as applicable Assessment of Community Supports needs.

Requirement	Documentation to Review	Examples of Best Practices
vi. For Members under age 21, Contractor's CCM program must include Early Periodic Screening, Diagnosis and Testing (EPSDT); all Medically Necessary services, including those that are not necessarily covered for adult Members, must be provided as long as they could be Medi-Cal services. b. Contractor must assess Members for the need for Community Supports as part of its CCM program to eligible Members. c. A description of the CCM program must be included, in a manner to be prescribed by DHCS, in Contractor's annual PHMS for DHCS review and approval, outlining all the components of its CCM program, including all those listed in this Subsection.	○ Includes the assessment of Community Support needs » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures, etc. » Oversight Documents: ○ Meeting Minutes ○ QIHEC ○ Governing Board ○ CAC » Medical Records » CCM Case Notes	
Contract Exhibit A, Attachment III, Section 4.3.7 **B. CCM Care Manager Role** 1. Assignment of CCM Care Manager a. Contractor must identify and assign a CCM Care Manager for every Member receiving CCM. Following NCQA requirements, Contractor may delegate CCM to Network Providers or other	» Policies & Procedures (P&Ps): ○ Assigning CCM CMs ○ Delegation of CCM program, as applicable, to NCQA certified network providers, including delegation responsibilities ○ PCPs can be CCM CMs	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. If applicable, there are Delegation Agreements (Das) with NCQA-certified network providers if CCM is delegated by the Plan. PHM CM Org Chart lists PCP CMs, if applicable.

Requirement	Documentation to Review	Examples of Best Practices
entities that are NCQA-certified. PCPs may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this Subsection. b. When a CCM Care Manager other than the Member's PCP is assigned, Contractor must provide the Member's PCP with the identity of the Member's assigned CCM Care Manager, and a copy of the Member's CMP. c. When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must: i. Identify a lead CCM Care Manager and communicate the identity of the Care Manager to all treating Providers and the Member; and ii. Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services and delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.	○ When CCM utilizes a non-PCP CM, Plans will: ▪ Notify the Member's PCP with the identity of the non-PCP CM ▪ Provide the PCP with a copy of the CMP ▪ Ensure there is no duplication of services	As applicable, the Basic PHM medical records contain the Plan's communication to notify the PCP of the Member's non-PCP CM. When, in the provision of CCM there are multiple providers performing separate aspects of care coordination, the Plan will: » Identify a lead CCM CM and communicate the identity of the lead CM to all treating providers » Ensure there is no duplication of services

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.7 **B. CCM Care Manager Role: Member Assessments** 2. CCM Care Manager Responsibilities a. Contractor is responsible for ensuring CCM Care Managers comply with all of the Basic PHM requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and all NCQA CCM standards. b. Contractor must ensure that the CCM Care Manager performs the following duties: i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, Substance Use Disorder (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH.	» Policies & Procedures (P&Ps): ○ Ensuing CCM CMs comply with Basic PHM and NCQA requirements ○ Description of CCM CM job duties » NCQA Accreditation » CCM CM Job Description » Medical Records » CCM Case Notes	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical Records and CCM Case Notes show that the Plan: ○ Conducts Member assessments to identify and close any gaps in care and address the Member's physical and mental health, SUD, developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH.
Contract Exhibit A, Attachment III, Section 4.3.7 **B. CCM Care Manager Role: CMP and Information Sharing** 2. CCM Care Manager Responsibilities ii. Complete a CMP for all Members receiving CCM, consistent with the	» Policies & Procedures (P&Ps): ○ Description of CCM CM job duties ○ Documenting and maintaining CMPs and ensuring all CMP requirements are met:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical records and CCM case notes show that the Plan's CCM CM performs all required duties. CCM CMP meets all requirements, including updating CMP annually and upon changes in the

Requirement	Documentation to Review	Examples of Best Practices
Member's goals in consultation with the Member. The CMP must: a. Address a Member's health and social needs, including needs due to SDOH; b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member; c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers; d. Be developed using a person-centered planning process that includes identifying, educating, and training the Member's parents, family members, legal guardians, Authorized Representatives (ARs), caregivers, or authorized support persons, as needed; and e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract. iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and iv. Specify the responsibility of each Provider that provides services to the Member.	▪ Updating CMP ▪ CMP kept in electronic format (medical record) ▪ CMP is individualized and developed with inputs from relevant persons ○ CMP includes: ▪ All services and treating providers ▪ Referrals to community-based social services ○ Continuous information sharing and communication with the Member and treating providers ○ Responsibilities of each provider that provides services to members » Medical Records » CCM Case Notes and CMP	Member's health status/level of care or upon the Member's request. CCM CMP includes identifying, educating, and training relevant persons (caregivers and authorized reps).

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.7 **B. CCM Care Manager Role: Member Follow-Up** 2. CCM Care Manager Responsibilities c. Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH; d. Support and assist the Member in accessing all needed services and resources, including across the physical and Behavioral Health delivery systems e. Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate; f. Provide referrals to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports and local community organizations and other programs or services offered by other agencies and third-party entities with which Contractor has or will have a MOU.	» Policies & Procedures (P&Ps): ○ Description of CCM CM job duties, including: ▪ Ensuring provision of all medically necessary services, including Community Supports ▪ Support and assistance of the Member in accessing needed services ▪ Communication to relevant persons (caregivers and authorized reps) ▪ Referrals to Community Health Workers (CHWs), peer counselors, and other community-based social services ▪ Assessing understanding of referral instructions and provides further referral-related assistance as needed » Medical Records » CCM Case Notes and CMP	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical records and CCM case notes show that the Plan's CCM CM performs all required duties. If applicable, provision of Community Supports services. Evidence of support and assistance of Member to access resources across he physical and BH delivery systems. CMPs are reviewed and/or modified to address unmet service needs.

Requirement	Documentation to Review	Examples of Best Practices
g. Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs further assistance to access the services, and if so, provide such assistance; h. Review and/or modification of Member's CMP, when applicable, to address unmet service needs;		
Contract Exhibit A, Attachment III, Section 4.3.7 **B. CCM Care Manager Role: Service Authorizations** 2. CCM Care Manager Responsibilities i. Facilitate and encourage the Member's adherence to recommended interventions and treatment. j. Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.	» Policies & Procedures (P&Ps): ○ Methods to facilitate and encourage Member adherence to CMP ○ Ensuring timely authorization of services » Grievance Logs (CCM-related grievances) » Medical Records » CCM Case Notes » Verification Study ○ Determine compliance with CCM requirements and fulfillment of CCM	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. No grievances related to delayed authorization of CCM-related services; For CCM-related grievances that are identified, timely resolution is performed by the Plan. Verification Study results show that medical records, CCM case notes, and the CCM CMP demonstrate compliance with CCM requirements and fulfillment of CCM CM roles.

Requirement	Documentation to Review	Examples of Best Practices
	CM roles by evaluating/testing: ○ CCM Universe ○ Grievance Logs (CCM-related) ○ Medical Records ○ CCM Case Notes ○ CCM CMP	

CATEGORY 2.8: BASIC POPULATION HEALTH MANAGEMENT

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.8 **Basic PHM P&Ps: Access to Services and Care Coordination** A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: 1. Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs; 2. Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs; 3. Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with Contractor; 4. Ensure each Member receives all needed preventive services in partnership with the Member's assigned PCP.	» Policies & Procedures (P&Ps): ○ Basic PHM is for all Members ○ Ongoing source of care ○ Access to needed services, including care coordination ○ Basic PHM through engagement and partnership between the Member and PCP (preventive services) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures, etc. » Screenings: ○ HIF/MET and IHA (all members) ○ HRA (SPDs)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate that the Plan's Basic PHM Program meets requirements, with an emphasis on timely access and care coordination and engagement with primary care. Relevant entities (Providers, Members) are informed about the Plan's Basic PHM Program, including Provider and Member responsibilities (screenings and assessments). The MCP demonstrates evidence that members are appropriately referred when screened positive for a condition that requires follow-up care. Oversight of the Plan's BPHM Program is evident through meeting minutes in QIHEC, Governing Board, and CAC. Specific areas of focus include identification of and recommendations to address performance gaps and member experience. MCP reviews utilization trends and population health data from QIHEC on PCP utilization/engagement and preventive services, if available. Of note: As of March 2026, Program does not recommend this area as an audit focus, given the ability to track MCP's analysis of population health data in Medi-Cal Connect.

Requirement	Documentation to Review	Examples of Best Practices
	» Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	
Contract Exhibit A, Attachment III, Section 4.3.8 **Basic PHM P&Ps: Continuity of Care** **A.** Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: 5. Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from out-of-Network Providers. *Note: Continuity of Care is covered more extensively in this Audit Program in Section 2.30*	» Policies & Procedures (P&Ps): ○ Continuity of Care benefits are inclusive of Basic PHM ○ Continuity of Care Benefits: Eligibility, Access, Adjudication Process	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.8 **Basic PHM P&Ps: Member Resources and Education** A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: 6. Ensure Members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom Contractor has or will have an executed MOU. **Basic PHM P&Ps: Member Utilization Reports and Primary Care Services** 7. Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization.	» Policies & Procedures (P&Ps): ○ Provision of resources and education, MOUs with entities that offer various programs and services to Members ○ Review utilization report, identify non-use of primary care, develop strategies for identified health disparities » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ UM (PCP utilization) ○ IHA Monitoring Reports ○ Meeting Minutes ▪ QIHEC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about how to access services offered by agencies/third parties for accessing these services). P&Ps include provisions on the generation of Member utilization reports in subsection 7, including stratifications noted to identify disparities and how to address any disparities identified. QI Initiatives address health disparities. MCPs measure results of QI initiatives and report on these results to appropriate governing committees.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.8 **Basic PHM P&Ps: Facilitating Care - Appointments, Transportation, Education** A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: 8. Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age. **Basic PHM P&Ps: Culturally and Linguistically Competent Service Delivery** 9. Ensure all services are delivered in a culturally and linguistically competent manner that promotes Health Equity for all Members. **Basic PHM P&Ps: Coordination of Health and Social Services** 10. Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans,	» Policies & Procedures (P&Ps): ○ Access to care facilitation: setting appointments, transportation, health education, PCP contact and visits, especially for members <21 years ○ Provision of Basic PHM in a culturally and linguistically appropriate manner ○ Coordination of health and social services between settings of care » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Meeting Minutes ▪ QIHEC ○ Referral Tracking / Monitoring Reports ▪ TCM	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed of the provision of assistance for coordination of care, including culturally appropriate linguistic services. Chart note includes documentation of language interpreter's ID number if a member's spoken language is not English or if the provider speaks the same language as the member. Referral Tracking / Monitoring Reports demonstrate compliance with care coordination requirements and Members receive needed services through referrals (TCM, SMHS, Community Supports, ECM, CLR) to mitigate SDOH factors.

Requirement	Documentation to Review	Examples of Best Practices
delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH.	▪ SMHS ▪ Community Supports ▪ ECM ▪ Closed Loop Referral ▪ Etc.	
Contract Exhibit A, Attachment III, Section 4.3.8 **Basic PHM P&Ps: Coordination of Referrals** A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: 11. Coordinate referrals to ensure Care Coordination with public benefits programs, including without limitation, as required by this Contract under the requirements set forth for Memorandums of Understanding (MOUs) in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). **Basic PHM P&Ps: Assisting Members with Navigating Health Delivery Systems**	» Policies & Procedures (P&Ps): ○ Referral coordination to public benefits programs; MOUs with these entities ○ Assistance to Members and relevant caregivers and authorized reps to navigate health delivery systems, including access to services not covered in this Contract ○ Provision of resources to address disease progression / disability and improve behavioral, developmental, physical, and oral health outcomes ○ Communication to Members, caregivers, and authorized reps of all care	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed of the provision of referral coordination to public benefits programs, navigation of health delivery systems. Submission of evidence that the Plan provides resources to address disease / disability progression to improve overall health outcomes. Of note, generally this information comes from the provider. Submission of communication documentation regarding all care coordination given to Members. Note: Care coordination of referrals and communication of care coordination to members is most critical; resources on disease progression would most likely and often come from the provider rather than the MCP and therefore is less critical.

Requirement	Documentation to Review	Examples of Best Practices
12. Assist Members, Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and Downstream Subcontractor Networks, to access Covered Services as well as services not covered under this Contract. **Basic PHM P&Ps: Addressing Disease Progression** 13. Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. **Basic PHM P&Ps: Communication of Care Coordination to Members** 14. Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate.	coordination provided to Members » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Meeting Minutes ▪ QIHEC	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.8 **Basic PHM P&Ps: Sharing and Maintaining Member Information** A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum: 15. Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and State and federal law. 16. Facilitate exchange of necessary Member Information in accordance with any and all State and federal privacy laws and regulations, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable. **Basic PHM P&Ps: Duplication of Services** 17. Maintain processes to ensure no duplication of services occurs.	» Policies & Procedures (P&Ps): ○ Ensure provision of Basic PHM is documented in the medical records ○ Facilitate data exchange in accordance with State and federal laws » Medical Records	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical records demonstrate the provision of Basic PHM that includes assessment and identification of needs and addressing such needs.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.8 **B. Wellness and Prevention Programs** 1. Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools; 2. Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy.	» Policies & Procedures (P&Ps): ○ Provision of comprehensive wellness and prevention programs that align with DHCS Comprehensive Quality Strategy and NCQA standards » NCQA Accreditation » Oversight Documents: ○ Meeting Minutes ▪ QIHEC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.
Contract Exhibit A, Attachment III, Section 4.3.8 **B. Wellness and Prevention Programs** 3. Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum; a. Identification of specific, proactive wellness initiatives and programs that address Member needs; b. Evidence-based disease management programs including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education	» Policies & Procedures (P&Ps): ○ Provision of comprehensive wellness and prevention programs in collaboration with LGAs ○ Implementation of evidence-based disease management programs ○ Initiatives, programs, and evidence-based approaches to improve: ▪ Access to preventive health visits, developmental screening (especially	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's PHM program meets Contract requirements. Documentation of oversight process demonstrates Plan efforts to initiate programs and evidence-based approaches in the provision of its wellness and prevention programs. Tracking/monitoring reports show improvement in pregnancy / postpartum outcomes. Note: Program considers this is a critical area that aligns with bold goals outlined in the CQS; this work also complements Transitional Care Services birthing policies.

Requirement	Documentation to Review	Examples of Best Practices
interventions, target Members for engagement, and seek to close care gaps for Members participating in these programs; c. Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (Services for Members Less Than 21 Years of Age); d. Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum; e. Initiatives, programs, and evidence-based approaches on ensuring adults have access to Preventive Care, as described in Exhibit A, Attachment III, Subsection 5.3.5 (Services for Adults) and in compliance with all applicable State and federal laws; f. A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment III, Subsection 5.2.14 (*Site Review*);	for Members <21 years), and pregnancy outcomes ▪ Assurance of Adult Preventive Care ○ Monitor wellness and prevention programs through the Facility Site Review (FSR) process » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ▪ QIHETP Work Plan » FSR/MRR Report	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.8 **B. Wellness and Prevention Programs** g. Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); and h. Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals. 4. Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS. 5. Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.	» Policies & Procedures (P&Ps): ○ Provision of health education materials given in a manner that meets the Member's cultural and linguistic needs ○ Approaches that implement evidence-based practices aimed at helping Members set and achieve wellness goals » Contracts with Vendor Providing Wellness and Prevention Education » Verification Study ○ Determine compliance with Basic PHM requirements: ○ Select 5 – 10 cases from the IHA universe; in selecting cases, review grievance logs – may consider members with Basic PHM-related grievances. ○ Review medical records for HIF/METs, HRAs (for SPDs), and PCP visits (IHA visits) and determine	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented If applicable, the Plan maintains contracts with vendors providing health education resources Verification Study results show that medical records demonstrate compliance with Basic PHM requirements: » Comprehensive Assessment » Care Coordination » Preventive Care » Improved Health Outcomes » Etc.

Requirement	Documentation to Review	Examples of Best Practices
	whether there is BPHM-related access to care and care coordination for medical needs identified.	

CATEGORY 2.9: OTHER POPULATION HEALTH REQUIREMENTS FOR CHILDREN

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.9 **EPSDT** For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children: **A.** Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Case Management Responsibilities Contractor must provide case management to assist Members less than 21 years of age in gaining access to all Medical Necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 United States Code (USC) sections 1396d(a), 1396d(r), and 1396n(g)(2), and Welfare and Institutions Code (W&I) section 14059.5(b). Case management services for Members less than 21 years of age also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, Contractor must provide EPSDT case management services as Medically Necessary services for Members less than 21 years of age, as required in Exhibit A, Attachment III,	» Policies & Procedures (P&Ps): ○ For Members <21 years, provide Basic PHM and EPSDT case management to: ○ Assist Members in accessing medically necessary care (medical, behavioral health, dental, social, educations, and other services) ○ Enable data exchange for care coordination ○ Ensure timely initiation of services within timely access standards, regardless if services are covered in the Contract » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's Basic PHM that includes the provision of case management for EPSDT services Relevant Gain access to medically necessary care that: » Enables data exchange for care coordination » Ensures timely initiation of services within timely access standards, regardless if the services are covered in the Contract P&Ps and medical records reflect American Academy of Pediatrics' Bright Futures periodicity schedule and anticipatory guidance. See DHCS EPSDT document shared by Program.

Requirement	Documentation to Review	Examples of Best Practices
Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*), and must ensure that all Medically Necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract. *Note: EPSDT is covered more extensively in Section 2.28 of this Audit Program.*	» Oversight Documents: ○ Utilization and Monitoring Reports of EPSDT Services » Medical Records	
Contract Exhibit A, Attachment III, Section 4.3.9 **Children Special Health Care Needs** For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children: Children with Special Health Care Needs Contractor must develop and implement policies and procedures to provide services for CSHCN. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation: 1. Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation, and Durable Medical Equipment (DME) and supplies. These may include assignment to a Specialist as PCP, Standing Referrals, or other methods.	» Policies & Procedures (P&Ps): Includes methods for: ○ Monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, transportation, DME, and supplies ○ Monitoring and improving quality, health equity and appropriate care ○ Ensuring care coordination » Information Dissemination: ○ Provider Manual ○ Member Handbook ○ Plan Website » Oversight Documents:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about the Plan's provision of CSHCN case management and the process to access this service. Oversight of the Plan's CSHCN case management program is evident. Medical records show care coordination with DDS, Regional Centers, LHDs, the local CCS, execution of MOUs, and designation of a regional center liaison.

Requirement	Documentation to Review	Examples of Best Practices
2. Methods for monitoring and improving the quality, Health Equity and appropriateness of care for CSHCN. 3. Methods for ensuring Care Coordination with Department of Developmental Services (DDS), local health departments and local California Children's Services (CCS) Programs, as appropriate and as required under any applicable MOUs between Contractor and local health departments and DDS for the CCS Program.	○ Meeting Minutes: ▪ QIHEC ▪ Um Reports of CSHCN services ▪ QI Reports of CH/QI initiatives for CSHCN » Medical Records	
Contract Exhibit A, Attachment III, Section 4.3.9 **Early Intervention Services** For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children: C. Early Intervention Services Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local RC or local Early Start	» Policies & Procedures (P&Ps): ○ Methods to identify eligible members for EIS ○ Collaboration with the local RC/Early Start Program ○ Provision of care management to provide services identified in the IFSP ○ (IFSP is developed with PCP participation) » Information Dissemination: ○ Provider Manual ○ Member Handbook ○ Plan Website	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan has methods to identify, track and refer eligible Members to the Early Start Program. The Plan has an MOU with the RC and medical records and EIS case management notes show collaboration in determining the medically necessary diagnostic and preventive services and treatment plans for Members. IFSP records indicate the IFSP was developed with PCP participation.

Requirement	Documentation to Review	Examples of Best Practices
program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members. Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.	» Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ▪ Plan and RC Quarterly Meeting Minutes ○ Universe of EIS-identified Members for referral to RC » MOU with RC; RC Liaison » Medical Records and EIS Case Management Notes	

CATEGORY 2.10: TRANSITIONAL CARE SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.10 **Transitional Care Services (General Overview)** Contractor must provide Transitional Care Services (TCS) to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, APL 22-024, and the PHM Policy Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings. Contractor must identify every Member undergoing a transition as high-risk or lower-risk according to the criteria in the PHM Policy Guide. For all identified high-risk Members, Contractor must ensure a Member has a single point of contact for the duration of the transition. If a Member identified as high risk is not receiving CCM or ECM, Contractor must identify a care manager who is a single point of contact responsible for ensuring the completion of all	» Policies & Procedures (P&Ps): ○ Provision of TCS for all Members transferring from one setting / level of care to another ○ Identification of transitioning Members as high to lower-risk ○ Need for a single point-of-contact for high risk Members (for duration of transition) and dedicated care management team for lower-risk Members ○ Care Manager assignment for high risk Members not receiving CCM or ECM ○ Include a process in place to meet TCS A-C requirements below » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate compliance with TCS requirements, including ensuring the completion of all TCS by facilitating referrals and ensuring no gaps in care, and appropriate staffing of TCS care managers. Relevant entities (Members, Providers) are informed about the Plan's TCS benefits and the process to access these services for all Members. Oversight of the Plan's TCS is evident.

Requirement	Documentation to Review	Examples of Best Practices
Transitional Care Services, including making referrals and ensuring no gaps in care. For Members identified as lower risk, a single point of contact is not required, but there must be a dedicated care management team available as described further in the PHM Policy Guide. Contractor must ensure that TCS processes meet the requirements of A-C below, for both high and lower risk Members. The PHM Policy Guide describes in further detail how the requirements below apply to high and lower risk Members.	○ Plan Website » Oversight Documents: ○ Org Chart – TCS Staffing, including TCS care managers ○ Tracking Reports of Members accessing TCS ○ Referral Tracking Reports ○ Meeting Minutes: ▪ QIHEC	
Contract Exhibit A, Attachment III, Section 4.3.10 **Member Evaluation, Consent and Referrals to IHSS/HCBS** A. General Requirements for Transitional Care Applicable to All Members in Transition, including High- and Lower-Risk Members Contractor must implement transitional care processes that meet the following further requirements as specified in the PHM Policy Guide, at minimum: 1. Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs.	» Policies & Procedures (P&Ps): ○ Ensure each Member is evaluated for all care settings appropriate to their condition ○ Permission is needed for data information sharing to facilitate transitions ○ If eligible, Members need to be referred to ECM, Community Supports and/or County social service agencies for IHSS/HCBS » Information Dissemination: ○ Provider Manual,	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate compliance with TCS requirements, including: discharge of Members to settings that meet their medical and/or LTSS needs; permission was obtained as appropriate to share information with Providers; referrals to Community Supports and other services were made. TCS Tracking Reports show appropriate dispositions at discharge. If case notes and evaluations are part of the medical records and reviewed during the audit, they should be reviewed to ensure appropriate evaluations were made and documented.

Requirement	Documentation to Review	Examples of Best Practices
2. Ensure that permission is obtained from Members, Members' parents, legal guardians, or ARs, as appropriate to share information with Providers to facilitate transitions, in accordance with federal and State privacy laws and regulations. 3. Ensure referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS) for Members who may be eligible for such services, and in accordance with any MOU executed between Contractor and such agencies;	○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ TCS Tracking Reports of Members disposition at discharge » Case Notes and Evaluations » Referral Tracking Reports » Consent Forms for Information Sharing	
Contract Exhibit A, Attachment III, Section 4.3.10 **Member Referral to ECM and Community Supports, Prior Authorizations, and Discharge Planning** A. Contractor must implement transitional care processes that meet the following further requirements as specified in the PHM Policy Guide, at minimum: 4. Ensure referrals to ECM and Community Supports for Members identified as having unstable housing, experiencing homelessness, or needing nursing facility care, for whom transition to home/assisted living facility or short	» Policies & Procedures (P&Ps): ○ Provision of housing assistance referral for eligible Members in need of short-term post-hospitalization/recuperative care ○ Prior authorization timeframes for services needed before discharge ○ Discharge planning/prior authorization training » Information Dissemination:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate compliance with TCS requirements, including referrals, if applicable, to ECM and Community Supports for housing/transition. Timely service authorizations prior to discharge. Training materials submitted to ensure provider network facility's discharge planning staff are educated on services and supplies medications needed prior authorization.

Requirement	Documentation to Review	Examples of Best Practices
term post hospitalization/recuperative care are alternatives. 5. Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (Timeframes for Medical Authorization). Prior Authorizations should be complete prior to discharge. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S section 1367.01, and Exhibit A, Attachment III, Section 2.3 (Utilization Management Program) of this Contract. 6. Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization	○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Prior Authorization Tracking Reports ○ Monitoring Reports for Referrals to ECM and Community Supports ○ Meeting Minutes: ▪ QIHEC	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.10 **Coordination and Information Sharing for Discharge Planning** A. Contractor must implement transitional care processes that meet the following further requirements as specified in the PHM Policy Guide, at minimum: 7. Ensure that mutually agreed-upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and out-of-Network Provider hospitals within its Service Area. 8. Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur. 9. Require all of its contracted hospitals, and all SNFs with electronic health records, to send Admission, Discharge, and Transfer (ADT) notifications to Contractor for each of its assigned Members in accordance with Interoperability and Patient Access Final Rule set forth at CMS-9115-F, and in accordance with the California Health and Human Services Data Exchange	» Policies & Procedures (P&Ps): ○ The need for mutually agreed-upon P&Ps for discharge planning and TCS between the Plan and discharging facilities ○ QI process to analyze root causes of delayed discharges and addressing them for timely discharge outcomes ○ Requirement for the Plan's contracted facilities to send ADT notifications to the Plan for each assigned Member ○ Requirement for the Plan to use ADT notifications for discharge planning, providing timely TCS and ensuring all discharging Members have a PCP who can provide follow-up care » Oversight Documents: ○ Grievance Logs ○ TCS Reporting, including ADT feed data and data	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented (e.g., mutually agreed-upon P&Ps for discharge planning and TCS between the Plan and its network and out-of-network facility providers). P&Ps describe how the Plan uses ADT notifications from its contracted hospitals and SNFs for discharge planning and to provide timely TCS for transitioning Members. All documents reviewed demonstrate the Plan's compliance, including ensuring transitioning Members have a PCP and that discharging facilities have contract information of PCPs. There are no grievances related to delayed discharges.

Requirement	Documentation to Review	Examples of Best Practices
Framework set forth in H&S section 130290, and as further specified in the PHM Policy Guide. 10. Ensure all Members being discharged from discharging facilities, including SNFs, have a PCP who can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs.	on timely and/or delayed discharges ○ Meeting Minutes: ▪ QIHEC » Medical Records	
Contract Exhibit A, Attachment III, Section 4.3.10 **Completion of Facility's Discharge Planning Process** B. Responsibility to Ensure Completion of Facility's Discharge Planning Process, Including Member Engagement Contractor must ensure the discharging facility completes a Discharge Planning process that engages Members, Members' parents, legal guardians, or Authorized Representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor must ensure that the facility's process is consistent with CMS Conditions of Participation, State regulations, and Joint Commission Requirements, as applicable, including as follows: 1. Contractor must ensure the discharging facility focuses on the Member's goals	» Policies & Procedures (P&Ps): ○ Completion of the discharging facility discharge planning includes: ▪ Focusing on Member goals and treatment preferences ▪ Ensuring use of a consistent assessment and/or assessment tools to identify Members likely to suffer adverse health consequences upon discharge if lacking adequate discharge planning ○ Referral of high-risk Members to ECM or Community Supports;	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's compliance by ensuring the completion of the Plan's discharge process and engaging with the Member (e.g., focus on Member goals and treatment preferences as documented in the medical record). Discharging facility's assessment process and/or assessment tools are consistent for all Members. Discharging facilities have processes to identify high-risk and lower-risk Members and refer them to appropriate services. Referrals to ECM and Community Supports for eligible Members.

Requirement	Documentation to Review	Examples of Best Practices
and treatment preferences during the discharge process, and that they are documented in the Medical Record. Contractor must ensure the discharging facility uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. a. For high-risk Members, Contractor must ensure the facility shares this information with the care manager. Contractor must also ensure the discharging facility has processes and procedures in place to refer Members to ECM or Community Supports as needed. b. For lower risk Members, Contractor must ensure the hospital has processes and procedures to leverage this assessment to identify Members who may benefit from services and refer Members to Contractor for high risk TCS, ECM, or Community Supports.	Discharging facility must inform the Plan's case manager of the Member's high-risk level of care » Oversight Documents: ○ Discharge Facility's Assessment Tools ○ Referral Tracking Reports: ECM and Community Services Referrals	
Contract Exhibit A, Attachment III, Section 4.3.10 **Completion of Facility's Discharge Planning Process** B. Responsibility to Ensure Completion of Facility's Discharge Planning Process, Including Member Engagement	» Policies & Procedures (P&Ps): ○ Inform Member and designated caregiver of continued health care requirements following discharge	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan complies with discharge planning requirements (e.g., completion of a discharge checklist,

Requirement	Documentation to Review	Examples of Best Practices
2. For discharge instructions, Contractor must ensure that the Member and their designated caregiver are informed of the continuing health care requirements following discharge from the facility. This information must include, but is not limited to, education and counseling about the Member's medications, including dosing and proper use of medication delivery devices, when applicable. The information must be provided in a culturally and linguistically appropriate format to the Member and caregiver, and must include the opportunity for the caregiver to ask questions about the post-hospital needs of the Member per H & S section 1262.5. 3. For discharge coordination, Contractor must ensure discharging facility has process in place for coordinating care with the following: a. For Member's designated family caregiver, Contractor must ensure the discharging facility has processes to ensure Member's designated family caregiver is notified of the Member's discharge or transfer to another facility per H&S section 1262.5. b. For post-discharge Providers, Contractor must ensure discharging facility provides necessary clinical information to the appropriate post-discharge Providers,	○ Discharge instructions to be given in a culturally and linguistically appropriate format and allow opportunity for questions about post-hospital needs of the Member ○ Coordination of discharge with the: ▪ Member's designated caregiver – caregiver must be notified by discharging facility ▪ Post-discharge providers » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Medical Records » Case Notes » Discharge Checklist	educating the Member and caregiver about the Member's medications). Relevant entities (Provider, Members, caregiver) are informed about the responsibilities of the Plan, Member and post-discharge PCPs regarding continued health care requirements. Discharging facilities send discharge summaries to the post-discharge provider.

Requirement	Documentation to Review	Examples of Best Practices
including the discharge summary per 42 CFR section 482.43.		
Contract Exhibit A, Attachment III, Section 4.3.10 **C. High Risk Members** 1. Contractor must identify every Member undergoing a transition as high risk or lower-risk. For the criteria for high and lower-risk, and detailed requirements for each, refer to the PHM Policy Guide. 2. For Members identified as high risk, Contractor must ensure the Member has a single point of contact for the duration of the transition who is responsible for ensuring a successful transition…. The single point of contact is responsible for: a. Outreach to Member; b. Assessing Member's risk for adverse outcomes to inform needed TCS and identify Members that may require ECM, CCM (if not already enrolled), or Community Supports, using the discharging facility data and Member engagement; c. Reviewing facility discharge summary; d. Ensuring Member receives appropriate discharge instructions; e. Ensuring follow up Providers receive appropriate clinical information; f. Ensuring medication reconciliation is complete post discharge;	» Policies & Procedures (P&Ps): ○ TCS requirements for high-risk Members include a single point-of-contact responsible for various care coordination duties to ensure: ▪ Member outreach and assessment ▪ Provision of appropriate discharge instructions ▪ Medication reconciliation is completed post-discharge ▪ Follow-up providers receive appropriate clinical information ▪ Members with SUD and mental health needs receive treatment upon discharge	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, specifically the TCS requirements to identify every transitioning Member as high-risk or lower-risk, and carrying out TCS as required for high-risk Members. All documents reviewed, including medical records, demonstrate the Plan provides appropriate TCS for high-risk Members (e.g., outreach, use of discharge facility data/instructions and Member engagement to identify risks and referral needs; completion of medication reconciliation and follow-up services). There are no grievances related to TCS for high-risk Members. Oversight of TCS for high-risk Members is evident.

Requirement	Documentation to Review	Examples of Best Practices
g. Ensuring Members with SUD and mental health needs receive treatment for those conditions upon discharge h. Ensuring the completion of all recommended follow-up, including any needed specialty or primary care follow-up, any SUD or mental health treatment, or any needed community or home-based services.	▪ Completion of all recommended follow-up needs » Oversight Documents: ○ Grievance Logs ○ TCS Tracking/Monitoring Reports for high-risk Members » Referral Tracking Reports » Medical Records » Case Notes	
Contract Exhibit A, Attachment III, Section 4.3.10 **C. Lower Risk Members** 3. For Members identified as lower risk, Contractor must, in addition to meeting all general requirements in Paragraphs A and B above: a. Ensure Member has, at minimum, telephonic access to a dedicated TCS team for at least 30 days from the discharge. The team must: i. Be able to access the Member's discharge documents to be able to assist Member with questions, including but not limited to medication changes;	» Policies & Procedures (P&Ps): ○ TCS requirements for lower-risk Members include telephonic access to a dedicated TCS team for at least 30 days from the discharge date to engage in various care coordination duties: ▪ Access to Member's discharge documents ▪ Answering questions, such as medication changes	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, specifically the TCS requirements for lower-risk Members (e.g., dedicated TCS team and phone line). All documents reviewed, including medical records, demonstrate the Plan provides appropriate TCS for lower-risk Members (e.g., Member communication of TCS team and phone line; assistance with care coordination needs, referrals, and escalation assistance). There are no grievances related to TCS for lower-risk Members. Oversight of TCS for lower-risk Members is evident.

Requirement	Documentation to Review	Examples of Best Practices
ii. Assist Member with any TCS needs identified by Member, including but not limited to access to ambulatory care, appointment scheduling, referrals, arranging Non-Emergency Medical Transport (NEMT); iii. Provide escalation to meet any TCS needs as needed, including connecting Members with a licensed Provider, if necessary; and iv. Place and coordinate referrals to longer term care management programs such as ECM/CCM, and/or Community Supports for eligible Members at any point in the transition.	▪ Assistance for accessing services, referrals to CCM/ECM and Community Supports » Oversight Documents: ○ Grievance Logs ○ TCS Team Org Chart and Job Description of Staff ○ TCS Tracking/Monitoring Reports for lower-risk Members » Referral Tracking Reports » TCS Phone Line Log Records » Medical Records » Case Notes	Review of the TCS Phone Line Log Records confirms that the phone line is active and the volume of calls is consistent with the TCS Tracking/Monitoring Reports for lower-risk Member.
Contract Exhibit A, Attachment III, Section 4.3.10 **C. Added Requirements for Lower Risk Members** 3. For Members identified as lower risk, Contractor must, in addition to meeting all general requirements in Paragraphs A and B above: b. Ensure Member can access the TCS team through a dedicated phone number as follows:	» Policies & Procedures (P&Ps): ○ Phone communication requirements for TCS ○ Ensure medication reconciliation and follow-up care with PCP or other provider with prescribing authority (within 30 days if not seen by PCP for 12 months)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed, including medical records, demonstrate compliance with TCS requirements, including access to the TCS team through a phone system that meets TCS standards and completion of medication reconciliation.

Requirement	Documentation to Review	Examples of Best Practices
i. During business hours, Contractor must ensure Members can connect with live TCS team member within no more than one automated phone selection option. ii. Outside of business hours, Members must be able to be referred to Emergency Services as needed and be able to leave a message. TCS team must respond to Members within one Working Day of message. iii. Contractor must ensure the Member is notified of the TCS support team and phone line directly, and make best efforts to ensure Member is notified directly within 24 hours of discharge. c. Ensure Member completes follow-up with ambulatory PCP, Specialist, or advanced practice Provider that has prescribing authority within 30 calendar days to ensure medication reconciliation. For a Member who has not had a visit with their assigned PCP within the last 12 months, ensure the Member completes PCP follow-up in addition to any necessary non-primary care ambulatory visits within 30 calendar days. d. Use data from discharges to assess and identify Members that may newly qualify for ECM/CCM or Community Supports.	○ CCM/ECM Community Supports referrals, if applicable » Information Dissemination: ○ Includes TCS phone line information ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ PCP utilization reports ○ TCS Tracking/Monitoring Reports for lower-risk Members » Referral Tracking Reports » Case Notes » TCS Phone Line Log Records	Relevant entities (Providers, Members) are informed about the Plan's TCS support team and phone line. Utilization Reports show PCP visits by discharged Members. Referral tracking reports should reflect referrals made to ECM/CCM and Community Supports. A review of the TCS Phone Line Log Records confirm that the phone line is active and the volume of call is consistent with the TCS Tracking / Monitoring reports for lower-risk Members.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.10 **D. Nursing Facility Transitions** 1. For diversion from the need for a nursing facility with supports, Contractor must evaluate all Members who have been identified as requiring nursing facility care for Community Supports. This includes the following, as appropriate: short term post-hospitalization, recuperative care, and respite services; day habilitation services; Community Supports supporting transitions to home, or a Residential Care Facility for the Elderly/ Adult Residential Facility, and personal care/homemaker services; as well as for ECM, IHSS, and/or waiver programs that may allow the Member to live at home or in alternative settings with support, as aligned with the Member's goals. 2. When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum: a. Coordinate with facility discharge planners, care or Case Managers, or	» Policies & Procedures (P&Ps): ○ Implementation of TCS procedures for Nursing Facility (NF) discharges are incompliance with APL 23-004, including: ▪ Care coordination with facility discharge planners, case managers, or social workers to provide case management and TCS for all transitions ▪ Evaluation for Community Supports, ECM, IHSS, and/or waiver programs ▪ Assistance with evaluating medical needs and available care settings ○ Sharing of MDS Section Q data into transition assessments » Oversight Documents: ○ Grievance Logs ○ TCS Tracking and Monitoring Reports:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate compliance with TCS NF transition requirements (e.g., evaluation for Community Supports, ECM, IHSS, and/or waiver programs, evaluation of medical needs and available care settings, sharing of MDS Section Q data into transition assessments). There are no grievances related to TCS for NF discharges such as delays or discharge to inappropriate levels of care. Referral tracking reports show referrals to Community Supports, ECM, IHSS, and/or waiver programs. Oversight of TCS is evident for Members transitioning to or from SNFs.

Requirement	Documentation to Review	Examples of Best Practices
social workers to provide case management and Transitional Care Services during all transitions; b. Assist Members being discharged or Members' parents, legal guardians, or ARs by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS programs; c. Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;	▪ Nursing Facility Discharges ○ Meeting Minutes ▪ QIHEC » Referral Tracking Reports	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.10 **D. Nursing Facility Transitions** 2. When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum: d. Ensure all Members being discharged from nursing facilities, have a PCP that can provide follow-up care, as appropriate, and that the discharging facilities have contact information for PCPs. e. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge; f. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; g. Follow-up with Members, Members' parents, legal guardians, or ARs, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.	» Policies & Procedures (P&Ps): ○ Processes to ensure the provision of follow-up care and that the discharging facility has contact information of PCPs and that follow-up appointments are scheduled prior to discharge ○ Verification if Members arrived safely at the agreed upon case setting and that their medical needs are met; follow-up with Members and relevant caregivers or authorized reps to ensure the new care setting complies with TCS requirements » TCS Phone Log Records » Medical Records » Discharge Instructions » Case Notes	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented (e.g., all Members discharged from nursing facilities have a PCP and the discharging facility has the PCP's contact information). TCS Phone Log records document verification calls post-discharge to ensure compliance with TCS requirements. There is documentation that outpatient appointments and other immediate follow-ups are scheduled prior to discharge. There is documentation of follow-up communication with facilities or at-home settings confirming that the Member arrived safely and there is evidence of follow-up with the Members and relevant caregivers and authorized reps to ensure new care settings are appropriate.

CATEGORY 2.11: TARGETED CASE MANAGEMENT SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.11 **Identifying Target Populations for TCM and Coordination with LGAs** A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that Members are receiving TCM services Contractor is not already aware of, Contractor must reach out to LGAs to coordinate care, as appropriate. B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member. C. Because TCM can be a direct duplication of services such as, but not limited to, Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services. For specific guidance on	» Policies & Procedures (P&Ps): ○ Plans must identify target population for TCM programs and coordinate care with LGAs (e.g., providing covered services identified in Member care plans, including referrals and prior authorizations) ○ Establish process to ensure TCM received is not duplicative » Information Dissemination: ○ Includes TCS phone line information ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ○ Tracking and Monitoring Reports/Records of TCM	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about the Plan's TCM program and the process to access these services. The Plan identifies and tracks target populations for TCM within their service area to coordinate care with LGAs. Compliance with TCM requirements is evident (e.g., tracking/monitoring records show TCM services received are not duplicative).

Requirement	Documentation to Review	Examples of Best Practices
ECM overlap with county-based TCM, see the ECM Policy Guide.	population within the Plan's service area	
Contract Exhibit A, Attachment III, Section 4.3.11 **Designated TCM Coordinator Representatives and PCP Notification** D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues. E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information. F. For Members less than 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (Services for Members Less Than 21 Years of Age). Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM Providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described	» Policies & Procedures (P&Ps): ○ Designating a representative to coordinate TCM with LGAs (e.g., notifying PCPs when Members are receiving TCM services and providing appropriate LGA information) ○ The Plan is responsible to provide medically necessary EPSDT benefits » Information Dissemination: ○ Includes TCS phone line information ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Tracking / Monitoring Reports for EPSDT Services » Medical Record	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical records show that the Plan notifies PCP and/or case managers when Members are receiving services; PCPs receive appropriate LGA information. Evidence that the Plan's Designee is fulfilling its TCM responsibilities (e.g., sharing the Member's appropriate Provider information and PCP and/or case manager assignment with LGAs and resolving all related operational issues).

Requirement	Documentation to Review	Examples of Best Practices
in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).	» Plan TCM Designee and their Job Description » List of LGAs working with the Plan to provide TCM Services	

CATEGORY 2.12: MENTAL HEALTH SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.12 **Non-Specialty Mental Health Services** Contractor must use DHCS-approved standardized screening tools as identified in APL 22-028 to ensure Members seeking mental health services who are not currently receiving Non-specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(f) and specified in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*). A. Non-Specialty Mental Health Services Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies even when: 1. NSMHS were provided: a. During the assessment process; b. Prior to determination of a diagnosis; or c. Prior to determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met;	» Policies & Procedures (P&Ps): ○ No Wrong Door policies for the provision of timely NSMHS and SMHS. ○ Use of standardized screening tools in compliance with APL 22-028 ○ Concurrent provision of NSMHS and SMHS if not duplicative and when coordinated between the Plan and MCP » Workflow / Flowchart for MHS (NSMHS or SMHS) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters » Oversight Documents: ○ Grievance Logs ○ Meeting Minutes: ▪ QIHEC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's provision of MHS and the process to access these services There are no MHS-related grievances Oversight of the Plan's provision of MHS is evident (e.g., grievance logs, referral tracking) Verification Study results show compliance with NSMHS Contract requirements, including evidence of timely provision of NSMHS.

Requirement	Documentation to Review	Examples of Best Practices
2. NSMHS were not included in Member's individual treatment plan; 3. Member has a co-occurring mental health condition and SUD; or 4. NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the MHP.	○ Tracking and Monitoring Referral Reports ▪ MCP to MHP ▪ MHP to MCP ○ UM Tracking / Monitoring Reports (MHS) » Verification Study ○ Determine compliance with mental health service requirements by reviewing/sampling: ▪ MHS Universe for NSMHS ▪ Referral tracking for timely provision of NSMHS ▪ Grievance Logs (MHS-related) ▪ Medical Records	
Contract Exhibit A, Attachment III, Section 4.3.12 **B. Specialty Mental Health Services** 1. Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.	» Policies & Procedures (P&Ps): ○ No Wrong Door policies for the provision of timely NSMHS and SMHS. ○ MHP MOU Requirement ○ Use of Transition Tools	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented There are no MHS-related grievances Oversight of the Plan's provision of MHS is evident (e.g., grievance logs, referral tracking and correspondence)

Requirement	Documentation to Review	Examples of Best Practices
2. Contractor must also enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner. 3. If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2 (*Non-specialty Mental Health Services and Substance Use Disorder Services*), and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.	○ Concurrent provision of NSMHS and SMHS if not duplicative and when coordinated between the Plan and MCP » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » MOU with MHP » Verification Study ○ Determine compliance with mental health service requirements by evaluating: ▪ MHS Universe (NSMHS/SMHS) ▪ Grievance Logs (MHS-related) ▪ MHS Referral Logs and Correspondence ▪ Medical Records	Verification Study results show that medical records demonstrate compliance with mental health service requirements: 1. Appropriate use of screening tools 2. Timely provision of mental health services (NSMHS or SMHS) through referral and coordination of care

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.12 **C. Mental Health Services Disputes** 1. Disputes between Contractor and MHP must not delay the provision of Medically Necessary services by Contractor or MHP. 2. If Contractor and MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013, and as specified in Exhibit A, Attachment III, Subsection 5.5.5 (*Mental Health and Substance Use Disorder Services Disputes*). Specifically, as set forth in APL 21-013, Contractor and MHPs must complete the plan level dispute resolution process within 15 Working Days of identifying the dispute. 3. Contractor and MHP may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or MHP determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and MHP will have one Working Day after identification of a dispute to attempt to resolve the dispute at the	» Policies & Procedures (P&Ps): ○ The mental health dispute process includes timeframes for timely resolution of disputes to avoid delay in the provision of mental health services » Referral Workflow/Flowchart ○ Shows the sequence of steps in referring Members to NSMHS and SMHS » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ○ Grievance Logs ○ Tracking and Monitoring Reports for: ▪ Mental health disputes	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's provision of MHS and the process to access these services, including timely dispute resolution The Plan monitors MH disputes to ensure timely resolution and avoid delays in the provision of mental health services There are no MH-related grievances (e.g., delayed referral to MHP Network for SMHS)

Requirement	Documentation to Review	Examples of Best Practices
plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and MHP. *Note: Mental Health and SUD Benefits are also covered in Contract Section 5.5, Pages 400 - 409*	▪ Referral Reports from MCP to MHP ▪ Referral Reports from MHP to MCP ▪ UM Tracking / Monitoring Reports of mental health services	

CATEGORY 2.13: ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.13 **Identifying and Referring Members for Alcohol or SUD Services and MOUs with County Departments** A. Contractor must identify and refer Members requiring alcohol and/or SUD treatment services to the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient heroin and other opioid detoxification Providers available through the Medi-Cal Fee-For-Service (FFS), as appropriate. Contractor must assist Members in locating available treatment service sites. To the extent that alcohol and/or SUD treatment services are not available within Contractor's Service Area, Contractor must coordinate with the County Department responsible for SUD treatment to refer Members to available treatment outside of Contractor's Service Area. B. Contractor must have MOUs with each County Department responsible for alcohol and SUD treatment services within	» Policies & Procedures (P&Ps): ○ Plan must identify and refer Members requiring alcohol and/or SUD treatment services to the County, or other community resources (e.g., FFS sites or outside the Plan's service area) if services are unavailable in the County ○ MOU with MHP is required » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ Grievance Logs ○ Meeting Minutes: ▪ QIHEC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about the Plan's provision of alcohol and SUD treatment services and the process to access these services. There are no grievances related to alcohol and SUD treatment services. Oversight of alcohol and SUD treatment services is evident (e.g., quarterly meetings with the MHP to review MOU and coordinate care).

Requirement	Documentation to Review	Examples of Best Practices
Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities between Contractor and County Departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.	▪ MOU Quarterly Meeting Minutes	
Contract Exhibit A, Attachment III, Section 4.3.13 **Coverage for Medically Necessary Services, Coordination, Referrals, and Medications** C. For Members receiving alcohol and SUD treatment services through County Departments, Contractor must continue to provide all Medically Necessary Covered Services and coordination and referral of services between its Network Providers and other treatment programs for the Member. D. Prescribing and medication management of buprenorphine and other prescribed medications for SUD treatment (also known as medication-assisted treatment or MAT) are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals, or other contracted medical facilities.	» Policies & Procedures (P&Ps): ○ Ongoing provision of medically necessary services and care coordination between the Plan's network providers and other treatment programs ○ The Plan pays for MAT when provided in primary care offices, hospitals, or contracted medical facilities » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about the Plan's provision of alcohol and SUD treatment services, the process to access these services (e.g., MAT), and the ongoing coverage of medically necessary services provided by the Plan's network providers. There are no grievances related to MAT payment disputes and there is oversight of the Plan's alcohol and SUD treatment services.

Requirement	Documentation to Review	Examples of Best Practices
Data Sharing Agreements with County Departments E. Contractor must enter into a data sharing agreement with the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient opioid disorder treatment. Contractor's data sharing agreement with such County Departments must also require such County Departments, and all Part 2 programs contracting with such County Departments that provide services to Members, to use authorization forms that align with DHCS data sharing and authorization guidance for the disclosure of information that provide the following: 1. Comply with 42 CFR part 2; 2. Name both Contractor and DHCS as potential recipients of the data being disclosed; 3. Indicate that Contractor and DHCS are permitted to use such data for payment and health care operations purposes, as defined by HIPAA; and 4. If 42 CFR Part 2 is modified to permit such a practice, include a statement indicating that any information disclosed to a covered entity or business associate may be redisclosed to the extent permitted by the HIPAA privacy rule,	○ Plan Website ○ Brochures » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ○ Grievance Logs	

Requirement	Documentation to Review	Examples of Best Practices
except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.		

CATEGORY 2.14: CALIFORNIA CHILDREN'S SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.14 **Overview** A. Notwithstanding any other provisions in W&I section 14094.4 *et seq*. for Contractors operating in COHS counties, Contractor must maintain policies and procedures to identify and refer Members with California Children's Services (CCS)-Eligible Conditions to the local CCS Program for determination of CCS eligibility. These policies and procedures must include the following, at a minimum: 1. The requirement that Network Providers complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-Eligible Condition; 2. The requirement that Contractor supports CCS program referral pathways in the non-Whole Child Model counties including but not limited to identifying children who may be eligible for the CCS program through internal reports, Provider directed referrals, or direct referrals from Contractor;	» Policies & Procedures (P&Ps): ○ Identification / referral for CCS eligibility determination ○ Support of CCS referral pathways in non-WCM counties ○ Completion of baseline health assessments and diagnostic evaluations and same-day referrals » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Provider Instruction Materials on CCS Reimbursement Requirements » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about the provision of CCS services and how to access them. Completed baseline health assessments and diagnostic evaluations. Oversight of the CCS program is evident (e.g., CCS referral tracking, quarterly meetings between the Plan liaison and CCS liaison to review MOU and coordinate care. Verification Study results show compliance with CCS Contract requirements, including joint case management by the Plan and CCS Case Managers.

Requirement	Documentation to Review	Examples of Best Practices
3. Instruct Network Providers that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network, and that reimbursement is only from the date of referral; 4. The requirement that Network Providers complete the initial referrals of Members with suspected CCS-Eligible Conditions same day using modalities accepted by the local CCS Program. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program. *Note: APL 23-034 CCS Whole Child Model Program requirements are also included in this Audit Program*	▪ Quarterly Meeting Minutes (Plan and CCS) ○ CCS Referral Tracking/Monitoring Reports ○ CCS Case Managed Members » Medical Records » Verification Study ○ Determine compliance with CCS requirements by sampling and reviewing: ▪ The Plan's CCS Universe ▪ CCS Referral Tracking Documents ▪ Grievance Logs (CCS-related) ▪ Medical Records ▪ CCS Case Notes	
Contract Exhibit A, Attachment III, Section 4.3.14 **Provision of Covered Services** 5. Instruct Network Providers of their requirement to continue to provide all	» Policies & Procedures (P&Ps): ○ Plan is responsible for providing and reimbursing medically necessary care even if the local CCS program denies	Medical records and CCM case notes indicate ongoing joint case management after Member is deemed CCS-eligible. There is evidence of the timely provision of covered services, including the provision of private duty nursing services in accordance with APL 20-012.

Requirement	Documentation to Review	Examples of Best Practices
Covered Services to the Member until CCS Program eligibility is confirmed; 6. The requirement that once eligibility for the CCS Program is established for a Member, Contractor must continue to provide all Covered Services that are not authorized by CCS Program and must ensure the coordination of services and joint case management between the Member's PCP, CCS Providers, and the local CCS Program. Contractor must continue to provide case management services to ensure all Covered Services authorized through the CCS Program are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 *(Services for Members Less Than 21 Years of Age)*. Without limitation, Contractor must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS Program that a Member desires to utilize, as required by APL 20-012; and 7. The requirement that Contractor ensure all Medically Necessary Covered Services are provided to the Member if the local CCS Program does not approve CCS Program eligibility. If the local CCS Program denies authorization for any service, Contractor remains responsible for providing and reimbursing for the	authorization of the services (e.g., Member has been deemed non-eligible for CCS) ○ Continue provision of covered services » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ Grievance Logs ○ Meeting Minutes: ▪ QIHEC ▪ Quarterly Meeting Minutes (Plan and CCS) ○ UM Records of Members receiving PDN Services » Medical Records » CCS Case Management Notes (e.g., in WCM cases)	There are no CCS-related grievances involving the lack of CCS case management to coordinate and access PDN services. Provider instruction materials include directions to provide all covered services until CCS eligibility is confirmed.

Requirement	Documentation to Review	Examples of Best Practices
cost of the service if it is determined to be Medically Necessary.		
Contract Exhibit A, Attachment III, Section 4.3.14 **Authorization for Payment** B. Authorization for payment must be retroactive to the date the CCS Program was informed about the Member through an initial referral by Contractor or a Network Provider. In an emergency admission, Contractor or a Network Provider must be allowed until the next Working Day to inform the CCS Program about the Member. **Members Aging Out** C. Contractor must maintain policies and procedures for identifying CCS-eligible Members that are aging out of the CCS Program. Within 12 months of a CCS Member aging out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include the following, at a minimum: 1. Identifying the Member's CCS-Eligible Condition; 2. Planning for the needs of the Member to transition from the CCS Program; 3. A communication plan with the Member in advance of the transition;	» Policies & Procedures (P&Ps): ○ CCS payment authorization is retroactive to initial referral by the Plan; Next day CCS notification is allowed for emergency admissions ○ Establish CCS aging out transition 12 months before Member turns 21 years of age » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Grievance Logs ○ Meeting Minutes: ▪ QIHEC ▪ Quarterly Meeting Minutes (Plan and CCS)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Medical records show that 12 months before the Member turns 21 years of age, a care coordination plan is evident for aging-out CCS Members that also includes a communication plan; there is continued assessment of the Member through the first 12 months of transition There are no CCS-related grievances regarding CCS reimbursements or inadequate assistance with CCS aging-out transitions

Requirement	Documentation to Review	Examples of Best Practices
4. Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS-Eligible Condition(s); and 5. Continued assessment of the Member through first 12 months of the transition.	○ Tracking/Monitoring Reports of CCS Members with Age Data » Medical Records » CCS Case Management Notes (e.g., in WCM cases)	
Contract Exhibit A, Attachment III, Section 4.3.14 **MOUs** D. Contractor must have Memorandums of Understanding (MOUs) with each CCS Program within its Service Area that are in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.	» Policies & Procedures (P&Ps): ○ Execute an MOU with CCS; requires designation of a CCS liaison and Plan liaison for CCS Members » Oversight Documents: ○ Quarterly Meeting Minutes (Plan and CCS) » Verification Study ○ Evaluate the following to determine compliance with CCS requirements: ▪ CCS Universe ○ Include in the sample Members 20 years of age to verify compliance with aging-out care coordination ▪ Grievance Logs: CCS-Related	Execution of an MOU with CCS that specifies Plan and CCS responsibilities, including quarterly meetings for care coordination Verification Study results show evidence of compliance with CCS requirements: 1. Medical records document care coordination between CCS and the Plan for the provision of medically necessary services pending CCS eligibility determination. 2. Implementation of CCS aging out care coordination 3. Provision of join case management with the CCS case manager and Basic PHM provider.

Requirement	Documentation to Review	Examples of Best Practices
	▪ CCS Referral Logs/Correspondence ▪ Medical Records ▪ CCS Case Notes ▪ WCM CCS Case Notes, if applicable	
APL 23-034 (Pages 11 – 12) **CCS Whole Child Model Program** Risk Level and Needs Assessment Process Plans must assess each CCS Member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data. Plans must have a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible Member's risk level that will be used to classify Members into high and low risk categories, allowing Plans to identify Members who have more complex health care needs. Plans must have a process to assess a Member's current health, including CCS condition(s), to ensure that each CCS-eligible Member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below: 1. Members identified as high risk through the Pediatric Risk Stratification Process	» Policies & Procedures (P&Ps): ○ Plan must assess each CCS Member's risk level (e.g., through a pediatric risk stratification mechanism that classifies Members into high and low risk categories ○ For high-risk Members, further assessment is needed within 90 days of enrollment to assist in the development of the Member's Individual Care Plan (ICP) ○ Ensure case management for care coordination based on Member risk » Information Dissemination: ○ Provider Manual ○ Member Handbook	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, including a PRSP for CCS-eligible Members. For high-risk Members, medical records show additional assessment is completed within 90 days of enrollment to assist in the development of the Member's ICP. The Plan provides WCM case management to coordinate provision of CCS care coordination.

Requirement	Documentation to Review	Examples of Best Practices
(PRSP) must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the Member's Individual Care Plan (ICP)	○ Plan Website » Oversight Documents: ○ Grievance Logs » Medical Records » CCS WCM Case Management Notes	

CATEGORY 2.15: SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.15 **Policies and Procedures and Care Coordination** A. Contractor must maintain policies and procedures for identifying and tracking Members with Developmental Disabilities (DD), including all services they receive. B. Contractor must designate its own liaison to coordinate with each RC operating within Contractor's Service Area to assist Members with DD in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10). C. Contractor must refer Members with DD to a RC for evaluation and for access to non-medical services provided by the RC, including, but not limited to, respite, out-of-home placement, and supportive living. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (MOUs with Local Government Agencies, County Programs, and Third Parties) to coordinate services for the Member with RC staff to ensure the non-duplication services	» Policies & Procedures (P&Ps): ○ Identification and referral of DD Members to the RC and methods to track DD Members and monitor services they receive ○ Plan will execute an MOU with the RC and designate its liaison; the Plan's liaison will collaborate in developing the individual development service plan which includes identification of medical needs » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Tracking and monitoring reports of DD Members,	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, including referring DD Members to an RC for evaluation of non-medical services provided by the RC (e.g., respite care) Relevant entities (Providers, Members) are informed about the benefits for Members with DD, including information on the Plan's assistance in accessing these services (e.g., from the RC) Then Plan has tracking and monitoring reports of Members with DD, including all services they receive

Requirement	Documentation to Review	Examples of Best Practices
and to create the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT).	including services they receive	
Contract Exhibit A, Attachment III, Section 4.3.15 **Policies and Procedures and Care Coordination** D. Contractor must maintain policies and procedures to identify and refer eligible Members to the HCBS program administered by the Department of Developmental Services (DDS). E. Contractor must refer to Exhibit A, Attachment III, Subsection 4.3.20 (*Home and Community-Based Services Programs*) for further coordination of care requirements related to providing HCBS programs through the HCBS-DD Waiver.	» Policies & Procedures (P&Ps): ○ Plan will identify / refer eligible Members to the HCBS program administered by the DDS	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, including the process to refer Members to the HCBS DD Waiver Program

CATEGORY 2.16: SCHOOL-BASED SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.16 **General Requirements** A. Contractor must have an MOU in place with all LEAs in its Service Area in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) to ensure there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's Individualized Education Plan (IEP) or the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian, or AR, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation. B. Contractor must cover Medically Necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to a Member who is 25 years of age or younger. Contractor must cover these services in accordance with DHCS guidance related to the Children and Youth Behavioral Initiative (CYBHI) and at the DHCS established fee schedule. Contractor must execute	» Policies & Procedures (P&Ps): ○ Plan to cover medically necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to Members <21 years of age or younger in accordance with CYBHI » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ○ Meeting Minutes: UM (tracking reports for school-based services) » MOU with all LEAs in the Plan's Service Area	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented The Plan has MOUs in place with all LEAs IEP or IFSP is developed in collaboration with the Member's PCP Medical record and case noes document care management and coordination of care for school-based services Oversight of the Plan provision of mental health services is evident

Requirement	Documentation to Review	Examples of Best Practices
agreements in accordance with DHCS guidance and in accordance with H&S section 1374.722 and W&I section 5963.4(c).	» Medical Records » CM Case Notes	
Contract Exhibit A, Attachment III, Section 4.3.16 **General Requirements** C. By 2025, Contractor is required to provide Covered Services, including preventive services and adolescent health services provided in schools or by school-affiliated health providers. D. Contractor must implement interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers for Children in publicly funded childcare and preschool, and TK-12 Children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I section 5961.3(b).	» Policies & Procedures (P&Ps): ○ Plan will implement interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated BH providers for children in public funded schools » Work Plan for Access ○ Should detail how the Plan will increase access to preventive, early intervention, and BH services for children in public schools	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented

CATEGORY 2.17: DENTAL

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.17 **Screenings, Assessments, Referrals, and Covered Services** A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract. B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the Member's first tooth or at 12 months of age, whichever occurs first.	» Policies & Procedures (P&Ps): ○ Plan to cover and ensure that dental screenings and oral health assessments are included for all Members (e.g., FRADS) ○ For Members less than 21 years of age, the Plan ensures a dental screening and oral health assessment as part of every periodic assessment » Oversight Documents: ○ UM Tracking and Monitoring Reports of: ▪ Dental services (FRADS) ▪ Dental Records ○ UM Dental Referral Tracking and Monitoring Reports » Medical Records » Dental Records	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, including coverage of dental screenings, assessments, and dental referrals For Members <21 years of age, there is documentation of periodic health assessments (PHAs) that include dental screenings and assessments

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.17 **Other Covered Services and Prior Authorization** C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures. If Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in	» Policies & Procedures (P&Ps): ○ Plan will cover medically necessary dental-related covered services that are not exclusively provided by dentists or dental anesthetists » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website (includes published PA protocols) » Oversight Documents: ○ UM Tracking and Monitoring Reports of dental services ○ UM Reports of dental services ○ Meeting Minutes: ▪ QIHEC » Plan Org Chart: Dental Liaison » Dental Records	Relevant entities (Providers, Members) are informed of covered dental services and how to access these services UM Tracking/Monitoring Reports of dental services and dental records show provision of medically necessary dental-related covered services The Plan has a designated Dental Liaison to assist with referrals

Requirement	Documentation to Review	Examples of Best Practices
the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.		

CATEGORY 2.18: DIRECT OBSERVED THERAPY FOR TREATMENT OF TUBERCULOSIS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.18 **General Requirements** Contractor must assess the risk of treatment resistance or noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy. A. The following groups are at risk for treatment resistance or noncompliance for the treatment of Tuberculosis (TB): 1. Members with demonstrated resistance to Isoniazid and Rifampin; 2. Members whose treatment has failed or who have relapsed after completing a prior regimen; 3. Substance users; 4. Members with mental health conditions or SUD; 5. Elderly, Children and adolescent Members; 6. Members with unmet housing needs; 7. Members with language and/or cultural barriers; and 8. Members who have demonstrated noncompliance by failing to keep office appointments.	» Policies & Procedures (P&Ps): ○ Risk assessment of treatment resistance or non-compliance with drug therapy for each Member who requires placement on anti-TB drug therapy; Plan will continue provision of all medically necessary covered services to Members with TB on DOT » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Tracking / Monitoring TB Referrals to the LHD ○ Meeting Minutes: ▪ QIHEC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's risk assessment process and referrals related to the treatment of TB Medical records show evidence of appropriate TB screenings and referrals to the LHD, if applicable for DOT Oversight of the Plan's DOT for treatment is evident (e.g., TB referral tracking and monitoring reports)

Requirement	Documentation to Review	Examples of Best Practices
B. Contractor must refer Members with active TB and Members who have treatment resistance or non-compliance issue risks to the TB control officer of the LHD for Direct Observed Therapy (DOT). If a Provider finds that a Member is at risk for treatment resistance or noncompliance with treatment, Contractor must refer the Member to the LHD for DOT.	» Medical Records	
Contract Exhibit A, Attachment III, Section 4.3.18 **General Requirements** C. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (MOUs with Local Government Agencies, County Programs, and Third Parties) to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on DOT.	» Policies & Procedures (P&Ps): ○ Plans will have MOUs with the LHD to ensure joint case management and care coordination with the LHD TB Control Officer » MOU Document	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented The Plan has an MOU with the LHD

CATEGORY 2.19: WOMEN, INFANTS, AND CHILDREN SUPPLEMENTAL NUTRITION PROGRAM

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.19 **General Requirements** A. Women, Infants, and Children (WIC) services are not covered under this Contract. However, Contractor must maintain procedures to identify and refer eligible Members for WIC services. Contractor must also have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (MOUs with Local Government Agencies, County Programs, and Third Parties) to ensure referrals. As part of the referral process, Contractor must provide the WIC program with the Member's current hemoglobin or hematocrit laboratory value. Contractor must also document the laboratory values and the referral in the Member's Medical Record. B. Contractor must refer, and document the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and PL 98-010.	» Policies & Procedures (P&Ps): ○ Plan will identify WIC-eligible Members and refer them to the WIC program ○ Plan will share and document H&H lab results when referring to WIC ○ Plan will execute an MOU with the LHD » Training Materials ○ Outline requirements that staff to be knowledgeable of WIC eligibility criteria, workflow in referring Members to WIC, and documentation requirements during the referral process » Oversight Documents: ○ WIC-related Tracking and Monitoring Reports » Medical Records	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about how the Plan can assist and refer Members to access the WIC program benefits Plan has an MOU with the LHD Plan provides training of staff to identify WIC-eligible Members and refer them to the WIC program (e.g., providing WIC with the Hgb/Hct Lab value and to document this in Medical Records)

CATEGORY 2.20: HOME AND COMMUNITY-BASED SERVICES PROGRAM

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.20 **Covered Services and Third-Party Collaboration** B. Contractor must continue to provide all Covered Services to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive an HCBS program other than this Contract. Contractor must continuously collaborate and exchange Member health care and medical information with all third-party entities providing the Member with Medi-Cal HCBS…Such third-party entities include, but are not limited to: 1. DHCS; 2. State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health (CDPH), and the California Department of Aging; 3. Home and Community Based Alternatives Waiver agencies;	» Policies & Procedures (P&Ps): The Plan will ○ Continue to provide all covered services to a Member when that Member is enrolled in (or applying to enroll in), receiving (or applying to receive) an HCBS program other than in this Contract ○ Continuously collaborate and exchange Member health care and medical information with all third-party entities » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters » Medical Records	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's coordination of HCBS and the process to access this service Medical records show that the Plan continues to provide all covered services to a Member when that Member is enrolled in (or applying to enroll in), receiving (or applying to receive) a HCBS program other than in this Contract

Requirement	Documentation to Review	Examples of Best Practices
4. Assisted Living Waiver Care Coordination agencies; 5. RCs; 6. Multipurpose Senior Services Program sites; 7. Medi-Cal Waiver Program agencies; and 8. California Community Transitions lead organizations.		
Contract Exhibit A, Attachment III, Section 4.3.20 **Procedures to Identify Members for HCBS** C. Contractor must maintain procedures to identify Members who may benefit from Medi-Cal HCBS programs and refer Members to the third-party entity administrating the HCBS program. The HCBS programs include, but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally-funded Medi-Cal HCBS programs. If the Member is then authorized to receive Medi-Cal-funded HCBS program services, the Member must remain enrolled with Contractor and Contractor must continue to	» Policies & Procedures (P&Ps): The Plan will ○ Maintain procedures to identify Members who may benefit from the Medi-Cal HCBS programs and refer Members to the third-party entity administering the HCBS program ○ If the Member is then authorized to receive Medi-Cal- funded HCBS, the Member must remain enrolled with the Plan and the Plan must continue to provide all services and benefits covered under this Contract to the Member » Medical Records	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Medical records show that the Plan continues to provide all covered services

Requirement	Documentation to Review	Examples of Best Practices
provide all services and benefits covered under this Contract to the Member.		
Contract Exhibit A, Attachment III, Section 4.3.20 **Third Party Requirements** D. Contractor's collaboration with third-party entities providing the Member with HCBS program services must include, but is not limited to: 1. Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and Care Coordination concerns. 2. Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive services. Such coordination must include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for the provision of both Medi-Cal and non-Medi-Cal programs pursuant to DHCS guidance to Contractor and HCBS Providers.	» Policies & Procedures (P&Ps): ○ The Plan's collaboration with third-party entities providing the Member with HCBS must include but is not limited to: ▪ Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS and to act as a central point-of-contact for questions, access and care coordination concerns ▪ Timely exchange of information regarding the Member and their health care needs and services ▪ Efforts to obtain and arrange for the provision of both Medi-	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented

Requirement	Documentation to Review	Examples of Best Practices
3. As contracted delegates of the State, Contractor and such third-party entities administering HCBS programs and/or providing HCBS program services are authorized to share Member information with one another, including PHI/Personal Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, complying with the provisions within their respective Business Associate Agreements with the State, and sharing this information with each other as part of their contractual responsibilities pursuant to and in compliance with 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).	Cal and non-Medi-Cal programs » Plan Org Chart ○ Staff to act as a central point-of-contact for HCBS care coordination	

CATEGORY 2.21: IN-HOME SUPPORTIVE SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.21 **Policies and Procedures** Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum: A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services; B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member; C. Designate a person to serve, as the day-to-day IHSS liaison with county IHSS agency. 1. Contractor, in collaboration with county IHSS agency, must ensure Contractor's IHSS liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how Contractor and Primary Care Providers can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for	» Policies & Procedures (P&Ps): The Plan: ○ Identifies/refers eligible Members to the County IHSS program ○ Coordinates with the County to ensure non-duplication of services through ECM, Community Supports and other services » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Plan Org Chart ○ IHSS Liaison and Job Description ○ Training Records of Staff: Evidence of comprehensive training on IHSS assessment and	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's IHSS coordination and the process to access this service The Plan designated an IHSS Liaison is trained sufficiently to fulfill all IHSS liaison duties, including IHSS referrals for Members in inpatient or SNF settings as part of TCS requirements The Plan systematically tracks all Members receiving IHSS

Requirement	Documentation to Review	Examples of Best Practices
Members in inpatient and Skilled Nursing Facility settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.	referral processes (e.g., SNF referrals as part of TCS requirements) » Oversight Documents: ○ IHSS Tracking and Monitoring Reports	
Contract Exhibit A, Attachment III, Section 4.3.21 **Policies and Procedures** Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum: 2. The IHSS liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the county IHSS liaison. D. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS; E. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and	» Policies & Procedures (P&Ps): ○ IHSS Liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the County IHSS Liaison ○ The Plan must reach out and coordinate with the County IHSS agency for any Members identified by DHCS as receiving IHSS ○ The Plan conducts a reassessment of Member Risk Tier upon identifying Members referred to or receiving IHSS and continues the provision of Basic PHM while Members receive IHSS » Plan Org Chart	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented, including reassessment and risk tiering for Members newly receiving IHSS Relevant entities (Providers, Members) are informed about the Plan's IHSS coordination and the process to access this service Medical records show the care coordination through the provision of ongoing Basic PHM while the Member is receiving IHSS

Requirement	Documentation to Review	Examples of Best Practices
F. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.	○ IHSS and LTSS Liaison ○ LTSS Liaison training records for IHSS referrals and assessments » Medical Records	

CATEGORY 2.22: INDIAN HEALTH CARE PROVIDERS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.22 **Tribal Liaison and Coordination of Referrals and Payments** Contractor must have an identified tribal liaison dedicated to working with each Indian Health Care Provider (IHCP) in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider).*	» Policies & Procedures (P&Ps): ○ Includes designated Tribal Liaison for coordinating referrals and payment for services provided to Indian Members from an IHCP » Plan Org Chart ○ Tribal Liaison and Job Description	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan's org chart includes a designated Tribal Liaison responsible for coordinating referral and payment for services.

CATEGORY 2.23: JUSTICE INVOLVED RE-ENTRY COORDINATION

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.23 **Policies and Procedures: Coordination with Correctional Facilities** Contractor must maintain policies and procedures for coordinating with Correctional Facilities and pre-release care managers in order to support Members who are leaving a Correctional Facility and reentering the community. Such policies and procedures must include all requirements as detailed in the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Initiative, including: A. A designated Justice Involved liaison, as required in Exhibit A, Attachment III, Subsection 4.3.24 (*Managed Care Liaisons*); B. Assigning ECM Providers to serve as pre-release care managers and/or as post-release ECM Providers for Justice Involved Individuals; C. Coordinating the Member's transition from the pre-release to the post-release period, including any needed data sharing; and D. Ensuring the provision of any Medically Necessary Covered Services including ECM, physical and behavioral health services,	» Policies & Procedures (P&Ps): ○ The Plan will coordinate with correctional facilities and pre-release care managers to support Justice-Involved individuals » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Plan Org Chart ○ Justice-Involved Liaison and Job Description » ECM Provider List ○ List of the Plan's ECM providers providing care management for Justice-Involved Individuals » Medical Records » Case Notes (as applicable)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's provision of Justice-Involved Re-entry coordination and the process to access these services The Plan maintains subcontracts with ECM providers who serve as pre-release care managers and/or as post-release ECM providers for Justice-Involved Individuals Case Notes show evidence of care coordination

Requirement	Documentation to Review	Examples of Best Practices
Community Supports, NEMT, and Non-Medical Transportation (NMT).		

CATEGORY: 2.24 MANAGED CARE LIAISONS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.24 **Tribal and LTSS Liaisons** Contractor must designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with Member's other services and to ensure effective oversight and delivery of services. Liaisons must receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes. Contractor must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change. Pursuant to the obligations set forth in this section, Contractor must designate the following liaisons: A. Tribal liaison as required in Exhibit A, Attachment III, Subsection 4.3.22 (*Indian Health Care Providers*) B. Long-Term Services and Supports (LTSS) Liaison	» Policies & Procedures (P&Ps): ○ The Plan must designate day-to-day trained Tribal Liaisons and LTSS Liaisons ○ The Plan must notify the other party for which they are serving as a liaison of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within 5 days of the change ○ The Plan must retain qualified staff and supervisors » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Plan Org Chart ○ Tribal and LTSS Liaisons ○ Job Description	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented The Plan designated a Tribal Liaison and LTSS Liaison The LTSS Liaison's training records include: • Training on the rules and regulations pertaining to Medi-Cal covered LTC services • Payment and coverage policies • Prompt claims payment requirements

Requirement	Documentation to Review	Examples of Best Practices
LTSS Liaisons must receive training on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies; prompt claims payment requirements; Provider resolutions, policies and procedures; and care management, coordination and transition policies.	○ Training Records	
Contract Exhibit A, Attachment III, Section 4.3.24 **Transportation and CCS Liaisons** C. Transportation Liaison Contractor must have a direct line for Providers and Members to receive real-time assistance directly from Contractor with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. Contractor must also have a process to triage urgent transportation calls when the Member or Provider communicates that they have attempted to work with the broker but the issue remains unresolved and is time sensitive. D. California Children's Services Liaison CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care	» Policies & Procedures (P&Ps): ○ The Plan must designate day-to-day trained Transportation and CCS Liaisons ○ The Transportation Liaison's role cannot be delegated to a broker ○ The CCS Liaison must receive training on the full spectrum of rules and regulations pertaining to the CCS program, including referral requirements and processes, annual medical review processes with counties, care management and authorization process for CCS Members » Information Dissemination:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented The Plan designated a Transportation Liaison and LTSS Liaison The Transportation Liaison has a direct line for providers and Members to receive real-time assistance and has a process to triage urgent calls

Requirement	Documentation to Review	Examples of Best Practices
management and authorization processes for CCS Children.	○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Plan Org Chart ○ Transportation and CCS Liaisons ○ Job Description ○ Training Records	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.24 **County Child Welfare Liaisons** E. County Child Welfare Liaison 1. Contractor must designate at least one individual to serve as the county child welfare liaison who will serve as a leader within Contractor to be the point of contact for child welfare departments and be the advocate on behalf of Members involved in county child welfare. Additional county child liaisons must be designated as needed to ensure the needs of Members involved with county child welfare are met. 2. Contractor's county child welfare liaison(s) will follow DHCS-issued standards and expectations as set forth in APLs or other similar instructions. Contractor's county child welfare liaison must: a. Have expertise in Child welfare services, County Behavioral Health Services. b. Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensure Covered services are closely coordinated with other services, including social services	» Policies & Procedures (P&Ps): The County Child Welfare Liaison: ○ Serves as a leader to be the point-of-contact for child welfare departments and be the advocate on behalf of Members involved in county child welfare programs ○ Follows DHCS-issued standards and expectations as set forth in APLs or other instructions ○ Provides resources and support to Member's care manager about Medi-Cal managed care plan enrollment and disenrollment when they are made aware that the Member will move ○ Additional County Child Liaisons must be designated to ensure Member needs are met » Information Dissemination: ○ Provider Manual	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented The Plan designated a County Child Welfare Liaison The County Child Welfare Liaison has expertise in child welfare services and County behavioral health services. The Liaison acts as a resource to ECM providers providing services to children and youth Members receiving child welfare services and serves as a point of escalation for care managers

Requirement	Documentation to Review	Examples of Best Practices
and Specialty Mental Health Care Services. c. Act as a resource to ECM Providers providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners. d. Be sufficiently trained on County Care Coordination and assessment processes. e. Provide resources and support to Member's care manager about Medi-Cal managed care plan Enrollment and disenrollment when they are made aware that the Member will move to a different county.	○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Plan Org Chart ○ County Child Welfare Liaison ○ Job Description ○ Training Records	
Contract Exhibit A, Attachment III, Section 4.3.24 **Justice-Involved, Regional Center, Dental and IHSS Liaisons** F. Justice Involved Liaison 1. Contractor must have an assigned Justice Involved liaison for justice involved reentry coordination, which may be one individual or multiple identified individuals, and make available information related to the Justice	» Policies & Procedures (P&Ps): ○ The Plan must designate day-to-day trained Justice-Involved, Regional Center, Dental and IHSS Liaisons ○ The Justice-Involved Liaison must be available to support correctional facilities, pre-release care management providers, and/or ECM providers in	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented The Plan designated Justice-Involved, Regional Center, Dental and IHSS Liaisons

Requirement	Documentation to Review	Examples of Best Practices
Involved liaison's title, name, contact phone number and email address. 2. The Justice Involved liaison must be available to support Correctional Facilities, pre-release care management Providers, and/or ECM Providers in the reentry planning process as required in Exhibit A, Attachment III, Subsection 4.3.23 (*Justice Involved Reentry Coordination*) and further specified in the Policy and Operational Guide for Planning and Implementing CalAIM Justice Involved Initiative. G. RC Liaison as required in Exhibit A, Attachment III, Subsection 4.3.15 (*Services for Persons with Developmental Disabilities*) H. Dental Liaison as required in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*) I. IHSS Liaison as required in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Support Services*)	the re-entry planning process » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Plan Org Chart ○ Justice-Involved, Regional Center, Dental and IHSS Liaisons ○ Job Description ○ Training Records	

CATEGORY 2.25: ENHANCED CARE MANAGEMENT

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.3.7 **Care Management Programs Overview** The Plan must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*). Members receiving care management must have an assigned CCM Care Manager and a Care Management Plan (CMP). **Enhanced Care Management Overview** Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and consistently apply comprehensive care management that is	» Policies & Procedures (P&Ps): ○ PHM Care Management Programs ○ Assigning Care Managers ○ Documenting and maintaining Care Management Plans (CMPs) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Org Chart: ○ PHM Care Management » Oversight Documents: ○ Meeting Minutes: ▪ QIHEC ▪ Governing Board ▪ CAC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Documents reviewed demonstrate the Plan's Care Management programs meet Contract requirements Relevant entities (Providers, Members) are informed about the Plan's Care Management programs and the process to access these services (e.g., ECM) Oversight of the Plan's PHM Care Management programs is evident, including the ECM component

Requirement	Documentation to Review	Examples of Best Practices
community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).		
Contract Exhibit A, Attachment III, Section 4.4.1 **Administration of ECM** A. Contractor must follow all provisions in the Enhanced Care Management (ECM) Policy Guide, in addition to provisions outlined in this Contract. B. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, Exhibit A, Attachment III, Subsection 4.4.2 (Populations of Focus for Enhanced Care Management), through systematic coordination of services and comprehensive care management. C. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered. D. Contractor must ensure ECM is available throughout its Service Area. E. Contractor must ensure ECM is offered primarily through in-person interaction	» Policies & Procedures (P&Ps) » Information Dissemination: ○ Provider Manual ○ Member Handbook ○ Plan Website	The Plan's P&Ps and MOC describe an ECM program that: 1. Includes a whole-person care approach 2. Identifies and addresses Member's clinical needs 3. Is community-based, through its ECM provider network 4. Ensures ECM services encompass the 7 core components Through various ways (Provider Manual, Member Handbook, Plan website), the Plan informs ECM providers and Members about the availability of ECM and how to access services (e.g., how to request ECM services or a new or different ECM manager or provider) Meeting minutes and Plan Reports to the Governing Body/UM/QI Committees reveal Plan oversight, e.g., review and approval of policies or policy changes, grievance reports, ECM reports and updates, oversight, education and outreach efforts to inform providers and members of the ECM program.

Requirement	Documentation to Review	Examples of Best Practices
where Members and their family members, legal guardians, Authorized Representatives (ARs), caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and Telehealth, when appropriate and with the Member's consent. F. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor, specifically that all such services are community-based, interdisciplinary, high-touch and person-centered. All such situations require DHCS approval through the exemption process and plans must be also making demonstrable progress to moving these ECM functions to community-based providers. G. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract. H. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Exhibit A, Attachment III, Subsection 4.4.11 (Core		Grievance logs/files have minimal or no cases related to ECM services; The Plan follows protocols for appropriate and timely grievance resolution and takes follow-up action.to correct any deficiencies identified. Meeting minutes and Plan Reports to the Governing Body/UM/QI Committees reveal Plan oversight, e.g., review and approval of policies or policy changes, grievance reports, ECM reports and updates, oversight, education and outreach efforts to inform providers and members of the ECM program. Grievance logs/files have minimal or no cases related to ECM services; The Plan follows protocols for appropriate and timely grievance resolution and takes follow-up action.to correct any deficiencies identified.

Requirement	Documentation to Review	Examples of Best Practices
Service Components of Enhanced Care Management). I. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources, including but not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs). J. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members. K. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following, at a minimum: 1. Explain ECM and how a Member may request it; 2. Maintain a list of ECM Providers as part of its Provider Directory, adherent to requirements established in the ECM Policy Guide; 3. Explain that ECM participation is voluntary and can be discontinued at any time; 4. Explain that the Member must authorize ECM-related data sharing;		

Requirement	Documentation to Review	Examples of Best Practices
5. Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and 6. Meet standards for culturally and linguistically appropriate communication Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees) and in Exhibit A, Attachment III, Subsection 5.1.3 (Member Information).		
Contract Exhibit A, Attachment III, Section 4.4.2 **Populations of Focus for ECM** A. Subject to the phase-in and Member transition requirements described in Exhibit A, Attachment III, Subsection 4.4.6 (Member Identification for Enhanced Care Management). B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one of the following Populations of Focus, as described in the ECM Policy Guide 1. Members experiencing homelessness: a. Members without dependent Children/youth living with them experiencing homelessness; and b. Homeless families or unaccompanied Children/youth experiencing homelessness. 2. Members at risk for avoidable hospital or emergency department utilization;	» Policies & Procedures (P&Ps) » Information Dissemination: ○ Provider Manual ○ Provider Newsletters ○ Provider Education: ▪ Provision of ECM Services, Referrals, and Follow-Up ▪ Documentation of initial and ongoing training » Verification Study: ○ Conduct a verification study to determine compliance. Sample selection methodology: ▪ Select Members from 4 – 5 Populations of Focus	Plan P&Ps describe eligibility criteria for different populations of focus (POF), including a process for network providers to refer potential ECM members to the Plan. Plan P&Ps, referral documents/forms, and referral processes adequately collect information to determine POF eligibility based on the ECM Policy Guide. Plan P&Ps, referral documents/forms, and referral processes do not require additional information beyond what is allowable in DHCS' ECM Referral Standards and Templates. Plans are not required to use the specific forms given as examples within this document.

Requirement	Documentation to Review	Examples of Best Practices
3. Members with serious mental health and/or Substance Use Disorder (SUD) needs; 4. Members transitioning from incarceration; 5. Adult Members living in the community and at risk for Long-Term Care (LTC) institutionalization; 6. A Member residing in an adult nursing facility transitioning to the community; 7. Children enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition; 8. Children involved in Child welfare; and 9. Birth equity population of focus.	▪ Review grievance universe for potential POFs of higher risk	
Contract Exhibit A, Attachment III, Section 4.4.2 **Populations of Focus for ECM** C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full but may benefit from ECM. D. Contractor must follow all applicable DHCS policies and guidance, including All Plan Letters (APLs) and the ECM Policy Guide, that further define the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus, and the JI Policy and Operations guide, that further define the approach to ECM for the Justice Involved Population of Focus.	» Policies & Procedures (P&Ps) » Information Dissemination: ○ Provider Manual ○ Provider Newsletters ○ Provider Education: ▪ Provision of ECM Services, Referrals, and Follow-Up ▪ Documentation of initial and ongoing training	In addition to above: Written provider resources and trainings document referral process and eligibility requirements are shared with ECM providers. The Plan's description of POF eligibility criteria should align with the "Populations of Focus Eligibility Criteria" for each POF as described in the ECM Policy Guide. Verification Study: Results show compliance with contract requirements for the provision of ECM (e.g., documentation shows members met selected POF eligibility requirement).

Requirement	Documentation to Review	Examples of Best Practices
E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs: 1. 1915(c) waiver programs including: a. Multipurpose Senior Services Program (MSSP); b. Assisted Living Waiver (ALW); c. Home and Community-Based Alternatives (HCBA) Waiver; d. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver; e. HCBS programs for Individuals with Developmental Disabilities (DD); and f. Self-Determination Program for Individuals with intellectual and DD.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.4.2 **Populations of Focus for ECM** E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs: 2. Fully integrated programs for Members dually eligible for Medicare and Medicaid including: a. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); b. Program for All-Inclusive Care for the Elderly (PACE); c. Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs); and d. Non EAE D-SNPs. 3. California Community Transitions (CCT) Money Follows the Person (MFTP) 4. Complex Care Management (CCM) **CalAIM ECM Policy Guide, Page 27** For all ECM Populations of Focus, Plans must establish policies and procedures that allow network Providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met.	» Policies & Procedures (P&Ps) » Information Dissemination: ○ Provider Manual ○ Provider Newsletters ○ Provider Education: ▪ Provision of ECM Services, Referrals, and Follow-Up ▪ Documentation of initial and ongoing training	Written provider resources and trainings document referral process and eligibility requirements are shared with ECM providers.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.4.3 **ECM Providers** A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community. B. ECM Providers may include, but are not limited to: 1. Counties; 2. County Behavioral Health Providers; 3. Primary Care Provider (PCP) or Specialist or Physician groups; 4. Federally Qualified Health Centers (FQHCs); 5. Community health centers; 6. Community-based organizations; 7. Hospitals or hospital-based Physician groups or clinics (including public hospitals or district or municipal public hospitals); 8. Rural Health Clinics (RHCs) or Indian Health Care Providers (IHCP); 9. Local Health Departments (LHDs); 10. Behavioral Health entities; 11. Community mental health centers; 12. SUD treatment Providers; 13. Community Health Workers (CHW)	» Policies & Procedures (P&Ps) » Oversight Documents: ○ ECM Member Tracking Logs » Medical Records » ECM Case Notes	Plan P&Ps describe Plan processes to assign members to ECM providers within its network and disseminate assignment of eligible Members within the requirement timeframe. SMI, SUD, and SED POF members are assigned to an appropriate behavioral health ECM provider.

Requirement	Documentation to Review	Examples of Best Practices
14. Organizations serving individuals experiencing homelessness; 15. Organizations serving justice-involved individuals; 16. CCS Providers; and 17. Other qualified Providers or entities that are not listed above, as approved by DHCS.		
Contract Exhibit A, Attachment III, Section 4.4.3 **ECM Providers** C. For the Population of Focus for eligible individuals with Serious Mental Illness (SMI) or SUD and the Population of Focus for eligible individuals with Contractor must prioritize county Behavioral Health staff or Behavioral Health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their Behavioral Health Services. D. Contractor must attempt to contract with each IHCP as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment III, Subsection 3.3.7… E. Contractor must ensure ECM Providers meet the requirements set forth in APLs including but not limited to the requirements regarding the use of a care management documentation system.	» Policies & Procedures (P&Ps) » Oversight Documents: ○ ECM Member Tracking Logs » Medical Records » ECM Case Notes *Note: Subsections E and F are more fully addressed as part of Section 4.4.11 (Core Service Components of ECM) of this Audit Program.*	MCP provides resources and trainings for ECM providers to meet program integrity standards on documentation. These materials may include live or asynchronous trainings, documentation templates, and other supports. In these resources, the MCP may not require ECM providers to use specific care management portals or systems used by the MCP. Rather, ECM providers must be allowed alternative methods to provide this information to MCPs.

Requirement	Documentation to Review	Examples of Best Practices
F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can: 1. Document Member goals and goal attainment status; 2. Develop and assign care team tasks; 3. Define and support Member Care Coordination and Care Management needs; and 4. Gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, LTC facility, housing status). G. Contractor must also comply with requirements on data exchange pursuant to Exhibit A, Attachment III, Subsection 4.4.12 (Data System Requirements and Data Sharing to Support Enhanced Care Management). H. Contractor must ensure all ECM Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013 (Provider Credentialing/Recredentialing and Screening/Enrollment). If APL 22-013 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals		

Requirement	Documentation to Review	Examples of Best Practices
employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider. I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate. J. Contractor must ensure ECM Providers serving the Justice Involved Population of Focus meet not only the standard ECM Provider requirements, but requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative, including, but not limited to: 1. Meeting the following criteria pertaining to participation in pre-release care management services and warm handoffs: a. If the Correctional Facilities in the ECM Provider's county of operation leverage an in-reach care management model, Contractor must ensure that JI ECM Providers offer pre-release care management services as in-reach care management Providers and continue to serve the Member post-release as the Member's ECM Provider.		

Requirement	Documentation to Review	Examples of Best Practices
b. If the Correctional Facilities in the ECM Provider's county of operation leverage an embedded care management model, Contractor must ensure that the ECM Provider participates in a warm handoff with the pre-release embedded care manager and the Member. 2. ECM Providers must bill Fee-for-Service (FFS) for all pre-release care management services and warm handoffs by either enrolling through the Provider Application and Validation for Enrollment (PAVE) system or contracting with the Correctional Facility to provide services billed under the Correctional Facility National Provider Identifier (NPI).		
Contract Exhibit A, Attachment III, Section 4.4.4 **ECM Provider Capacity** A. Contractor must develop and manage a network of ECM Providers. B. Contractor must ensure sufficient ECM Provider capacity to meet the unique needs of all ECM Populations of Focus, including by contracting with providers with specific skills and experience serving specific Populations of Focus. C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general	» Deferred to Program until further notice; see highlighted note	*Note: As of March 2026, Program does not recommend A&I review ECM Provider Capacity, as Program regularly tracks and monitors ECM provider capacity compliance; this area is therefore considered lower risk.* *Regarding Section F, per Program, this provision for Plan-provided ECM is no longer allowed.*

Requirement	Documentation to Review	Examples of Best Practices
Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (Network and Access to Care). D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM Model of Care (MOC) Template as referenced in Exhibit A, Attachment III, Subsection 4.4.5 (*Enhanced Care Management Model of Care*) and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS. E. Contractor must report to DHCS any Significant Changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS. F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor or Network Provider Agreements, as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria: 1. There are insufficient ECM Providers, or a lack of ECM Providers with qualifications		

Requirement	Documentation to Review	Examples of Best Practices
and experience, to provide ECM for one or more of the Populations of Focus in one or more counties; 2. There is a justified Quality of Care concern with one or more of the otherwise qualified ECM Providers; 3. Contractor and the ECM Providers are unable to agree on rates; 4. ECM Providers are unwilling to contract; 5. ECM Providers are unresponsive to multiple attempts to contract; 6. ECM Providers who have a State-level pathway to Medi-Cal Enrollment but are unable to comply with the Medi-Cal Enrollment process or Contractor's verification requirements for ECM Providers; or 7. ECM Providers without a State-level pathway to Medi-Cal Enrollment that are unable to comply with Contractor's verification requirements for ECM Providers. G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis. H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based		

Requirement	Documentation to Review	Examples of Best Practices
manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Section 1.19 (Sanctions). I. Contractor must ensure Network overlap of the Justice Involved pre-release care management Provider network and the Justice Involved ECM Provider network across Contractor's Service Area. Contractor must submit to DHCS, for prior approval, any requests for exception from Network overlap requirements across Medi-Cal managed care plans in the same county for one of the permissible reasons as described in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative.		
Contract Exhibit A, Attachment III, Section 4.4.5 **ECM Model of Care** A. Contractor must develop an ECM MOC template in accordance with the DHCS-approved MOC Template. The MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM. B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all	» Deferred to Program until further notice; see highlighted note	*Note: As of March 2026, Program does not recommend A&I review ECM Models of Care, as Program previously reviewed and approved all MOCs to determine MCP operational readiness to meet ECM requirements ahead of new ECM POFs being implemented.* *Unlike Community Supports, there are no ongoing, regular updates to the MOCs.*

Requirement	Documentation to Review	Examples of Best Practices
requirements and policies and procedures described in its MOC, in addition to APLs. C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its MOC as applicable for Contractor's plan model. D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administering or delivering ECM services, approved policies and procedures, and Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.		
Contract Exhibit A, Attachment III, Section 4.4.6 **Member Identification for ECM** A. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Exhibit A, Attachment III, Subsection 4.4.2 *(Populations of Focus for Enhanced Care Management)*.	» Policies & Procedures (P&Ps) » Oversight Documents: ○ Tracking and monitoring reports to identify potential ECM Members Tracking and monitoring reports to monitor the source of ECM referrals (i.e., community-based or not)	At a minimum, MCPs should have active efforts to encourage community-based referrals. Plan P&Ps describe processes to drive community-based referrals for ECM. As noted in DHCS' ECM Policy Guide, Page 103, DHCS expects MCPs to source the majority of referrals for ECM from the community (i.e., from the MCP's network of providers – inclusive of PCPs and other clinical Providers, ECM, and Community Supports Providers – and other community-based sources). MCPs may use data-based approaches such as

Requirement	Documentation to Review	Examples of Best Practices
B. To identify such Members, Contractor must consider the following: 1. Members' health care utilization; 2. Needs across physical, behavioral, developmental, and oral health; 3. Health risks and needs due to Social Drivers of Health; and, 4. Long-Term Services and Supports needs. C. Contractor must identify Members for ECM through the following pathways: 1. Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to: a. Enrollment data; b. Encounter data; c. Utilization/claims data; d. Pharmacy data; e. Laboratory data; f. Screening or assessment data. g. Clinical information on physical and Behavioral Health; h. SMI/SED/SUD data, if available; i. Risk stratification information for Children in County Organized Health System (COHS) counties with WCM programs; j. Information about Social Drivers of Health, including standardized	» For subsection (c) and (d): ○ Provider Education – Provision of ECM services, referral, and follow-up documentation of initial and ongoing training	encounter, utilization, and claims data; however, these types of data-based approaches are less successful in engaging members than community-based approaches. MCP P&Ps, training materials, and/or tracking/monitoring reports track and promote community-based referrals. P&Ps, training materials, and tracking and monitoring reports track and promote community-based referrals. MCPs actively provide outreach to community-based service providers in health care and other sectors to increase community-based referrals by trusted messengers. P&Ps describe identification processes that consider available data to determine if a member meets ECM Policy Guide POF eligibility criteria. Data should consider: member health care utilization; needs across physical, behavioral, development, and oral health; health risks and needs due to social drivers of health; LTSS needs; enrollment, encounter, utilization, claims, and screening data, including external identification sources from providers and/or members. The Plan has training materials and has implemented trainings on accessing ECM to health care providers, social services providers, and other potential sources of community-based referrals.

Requirement	Documentation to Review	Examples of Best Practices
assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes; k. Results from any available Adverse Childhood Experience (ACE) screening; and l. Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system). 2. Receipt of requests from ECM Providers and other Providers or community-based entities. a. Contractor must accept requests for ECM on behalf of Members from: i. ECM Providers; ii. Social service or other Providers; and iii. Community-based entities, including those contracted to provide Community Supports, as described in Exhibit A, Attachment III, Subsection 4.5.3 (Community Supports Providers). b. Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.		

Requirement	Documentation to Review	Examples of Best Practices
c. Contractor must directly engage with and provide training to Network Providers, Subcontractors, Downstream Subcontractors, and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members, with the goal of having the majority of ECM eligible Member referrals coming from Providers and community sources, rather than Contractor identification. d. Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers. 3. Requests from Members a. Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, ARs, caregivers, and authorized support persons to request ECM on a Member's behalf. b. Contractor must provide information to Members regarding the Member initiated ECM request and approval process. 4. For pre-release services under the Justice Involved Reentry Initiative, Contractor must have processes that: a. Identify any Member who received pre-release services for presumptive eligibility		

Requirement	Documentation to Review	Examples of Best Practices
and enrollment in ECM, including using the JI aid code for enrolled Members. b. Receive notifications of pre-release services from Correctional Facilities or their contracted pre-release care managers through their JI liaison. c. Receive notifications from the ECM Provider who is acting as the pre-release care manager or who has received a warm handoff.		
Contract Exhibit A, Attachment III, Section 4.4.7 **Authorizing Members for ECM** A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*). If a Member meets ECM Population of Focus eligibility requirements, Contractor must authorize ECM without additional requirements. B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner. C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, AR, caregiver, or authorized support person:	» Policies & Procedures (P&Ps) ○ Must include a framework determining member eligibility on a timely basis. ○ Describes ECM Presumptive Authorization requirements » Oversight Documents: ○ Any available reports on the timeliness of authorizations, monitoring efforts to ensure ECM offered is equitable and non-discriminatory	At a minimum, P&Ps include guidelines for timely authorization of ECM and are aligned with authorization processing requirements as outlined in APL 21-011 (within 5 working days for routine and within 72 hours for expedited referrals). P&Ps include Presumptive Authorization for provider types for each ECM POF. These P&Ps should allow contracted ECM providers that are eligible for Presumptive Authorization to offer ECM services for 30 days and be paid for such services, as outline in the ECM Policy Guide. Any grievances or appeals regarding authorizations are resolved, including for Presumptive Authorizations. The MCP uses tracking and monitoring reports to ensure timely authorization of ECM within the above parameters and upon receipt of referral. The Plan uses tracking and monitoring reports to ensure eligible ECM providers are implementing Presumptive Authorization. The Plan also makes a

Requirement	Documentation to Review	Examples of Best Practices
1. Contractor must ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*) and APL 21-011; 2. If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to Appeal and the Appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011; and 3. Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (Member Grievance and Appeal System) and APL 21-011. D. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where		provider portal or other systems available to EMC providers, as these providers must validate Medi-Cal coverage and that the member is not already receiving ECM. *Note: DHCS has received feedback that some MCPs take months to authorize ECM. Timely authorization, assignment to an ECM provider, and receipt of ECM are foundational to implementation of this benefit. New CLR requirements mean that MCPs must collect and report these data on timely authorization.*

Requirement	Documentation to Review	Examples of Best Practices
select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM. E. Contractor must authorize ECM services for all Members who were found eligible for pre-release services under the CalAIM Justice Involved Reentry Initiative. ECM services are authorized for 12 months per the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative. F. To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment III, Subsection 5.1.5 (Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests) and APL 21-011.		
CalAIM ECM Policy Guide (Pages 109-115) **ECM Presumptive (Streamlined) Authorization Requirements** MCPs must implement streamlined authorization arrangements with select ECM Providers for a timeframe of 30 calendar days. MCPs are required to implement presumptive authorization arrangements with the specific ECM Providers in their networks serving the specific Populations of Focus listed in Figure 5 of the ECM Policy Guide (page 110).	» See Above	In addition to above: *Note: "Presumptive Authorization" will soon be renamed to "Streamlined Authorization." These requirements were created to decrease the time between member identification and initiation of ECM services.* *MCPs must implement presumptive authorization for any contracted providers within the provider types noted, by ECM POF, in the Policy Guide. MCPs may further expand presumptive authorization to any other types of ECM providers. Some MCPs have implemented presumptive authorization for all ECM referrals.*

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.4.8 **Assignment to an ECM Provider** A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Exhibit A, Attachment III, Subsection 4.4.4 (*ECM Provider Capacity*). B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis. C. Contractor must ensure communication of Member Assignment to the designated ECM Provider occurs within ten Working Days of authorization or on an agreed upon schedule. D. Pursuant to the Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, for Members eligible for pre-release services under the CalAIM Justice Involved Reentry 1115 Initiative, Contractor must, to the extent possible, assign an ECM Provider that was the pre-release care manager or the care manager who received a warm handoff from the Correctional Facility while the individual was incarcerated.	» Policies & Procedures (P&Ps) » Oversight Documents: ○ ECM Member Assignment Tracking Logs » Medical Records » ECM Case Notes » Verification Study: ○ Conduct verification study to determine compliance.	Plan P&Ps describe Plan processes to assign members to ECM providers within its network and disseminate assignment of eligible Members within the requirement timeframe. Plan P&Ps document a clear process through which members are assigned to an ECM provider that best meets their needs, identified via referral information and other available data. Additional parameters specific to ECM provider types are detailed in Subsections E – H within the Contract, as capacity allows. Of note, per Program, as of March 2026, these requirements only apply if a member is already receiving services from a provider that is also an ECM provider, and is concerned a lower priority for the Department's ECM Policy team. Plan P&Ps include guidelines for member assignment to specialty providers, as noted in Contract Subsections D – H and the ECM Policy Guide, as appropriate. Verification Study: Results show compliance with contract requirements for the provision of ECM (e.g., documentation shows Plan communication/assignment of members to an appropriate ECM provider. This assignment should consider the medical, behavioral, and social care needs for each member. Note for VS: California Children's Services POF – eligible members should be assigned to ECM

Requirement	Documentation to Review	Examples of Best Practices
E. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable. F. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions G. If a Member receives services from a MHP for SED, SUD, or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. H. If a Member is enrolled in CCS and the Member's CCS Case Manager is Affiliated with a contracted ECM Provider, Contractor must assign that Member to that CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or AR has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. I. Contractor must notify the Member's PCP, if different from the ECM Provider, of the		providers with experience caring for children with complex health conditions, such as specialty medical providers and PCPs. *Note: DHCS often receives feedback from stakeholders that community-based organizations are not adequately skilled or experienced in health care or health care delivery systems. For people with significant medical or behavioral health needs, ECM providers that are based in or integrated within delivery systems are more likely to provide experience or expertise to address health needs. See VS study above regarding CCS as an example.*

Requirement	Documentation to Review	Examples of Best Practices
assignment to the ECM Provider, within ten Working Days of the date of assignment. J. Contractor must document the Member's ECM Lead Care Manager in its system of record. K. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable.		
Contract Exhibit A, Attachment III, Section 4.4.9 **Initiating Delivery of ECM** A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law. B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to: 1. Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and 2. ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related	» Policies & Procedures (P&Ps) » Medical Records » ECM Case Notes	Plan P&Ps include: • How the ECM provider will assign to each member a Lead Care Manager with the expertise and skills that meet the unique needs of each member. • How the ECM provider will take member preferences into account. • The process by which members may change their Lead Care Manager. • The process the MCP will follow when a member requests to change their ECM provider, including how the MCP will respond to requests as soon as possible and within a maximum of 30 days.

Requirement	Documentation to Review	Examples of Best Practices
data sharing as required by federal law and to facilitate ongoing data sharing with Contractor. C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has an ECM Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, ARs, caregivers, and other authorized support persons, as appropriate. The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Drivers of Health, regardless of setting.		
Contract Exhibit A, Attachment III, Section 4.4.10 **Discontinuation of ECM** A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time. B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met: 1. The Member has met all care plan goals;	» Policies & Procedures (P&Ps) » Medical Records » ECM Case Notes	Plan P&Ps include: • "Graduation" criteria the MCP will apply when making the determination to transition the member to a lower level of care management or coordination. • How ECM providers will be expected to notify the MCP when discontinuation criteria are met. • How the MCP will work with ECM providers to transition members to lower levels of care management / coordination to meet their needs, when appropriate.

Requirement	Documentation to Review	Examples of Best Practices
2. The Member is ready to transition to a lower level of care; 3. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or 4. The ECM Provider has not been able to connect with the Member after multiple attempts. C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify the ECM Provider to initiate discontinuation of services in accordance with the NOA process described in Exhibit A, Attachment III, Subsection 5.1.5 (Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests); Exhibit A, Attachment III, Section 4.6 (Member Grievance and Appeal System); and APL 21-011. D. Contractor must develop processes for transitioning Members from ECM to other levels of care management to provide coordination of ongoing Member needs. E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor. F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to Appeal and the Appeals process by way of the NOA process as described in Exhibit A,		• How the MCP will notify the ECM provider when it discontinues ECM.

Requirement	Documentation to Review	Examples of Best Practices
Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.		
Contract Exhibit A, Attachment III, Section 4.4.11 **Core Service Components of ECM** Contractor must ensure all Members receive all of the following seven ECM core service components, as further defined in APLs: A. Outreach and engagement; B. Comprehensive assessment and Care Management Plan (CMP); C. Enhanced coordination of care; D. Health promotion; E. Comprehensive transitional care; F. Member and family supports; and G. Coordination of and referral to community and social support services. **APL 23-032 (Pages 2 – 6)** **Enhanced Care Management Requirements** Refer to APL 23-032 issued December 22, 2023 for descriptions of each of the components A – G above.	» Policies & Procedures (P&Ps) » Information Dissemination: ○ Provider Education: ▪ Provision of ECM Services, Referrals, and Follow-Up » Job Description: ○ ECM Care Lead » Oversight Documents: ○ Grievance Logs/Files » Medical Records » ECM Notes » ECM Care Plan » Verification Study: ○ Conduct a verification study to determine compliance on whether the Plan ensures ECM Members receive all seven	At a minimum, Plan P&Ps include provisions that every member receiving ECM has access to all ECM Core Service Components. Plan policies and procedures and Model of Care address requirements for ECM providers to complete and maintain a Comprehensive Assessment and Care Management Plan, including involvement of clinicians to address member medical and mental health needs. Plan P&Ps detail how the MCP and ECM providers will work together to ensure the provision of Core Service Components for ECM. P&Ps should set clear expectations that ECM providers directly provide or coordinate access to services to meet member needs, including in other delivery systems. For example, MCPs may assist in the provision of transitional care services by notifying ECM providers when members are admitted or discharged from the hospital. If a community-based ECM provider is not familiar with care coordination for dental care, then MCPs should ensure ECM providers are aware of MCP care coordination services and resources.

Requirement	Documentation to Review	Examples of Best Practices
	ECM core service components. ○ Sample methodology: ▪ Select Members from 4 – 5 Populations of Focus ▪ Review grievance universe for potential POFs of higher risk Results show care management records document compliance with contract requirements for ECM services (e.g., records document goal creation, care coordination, comprehensive assessment of member conditions/status, and outreach. Care management records document completion of ECM core service components.	Refer to the CalAIM ECM Policy Guide (Pages 9 – 57) for DHCS defined examples of best practices and operational guidance for appropriate delivery of ECM services as it pertains to each POF.

Requirement	Documentation to Review	Examples of Best Practices

CalAIM ECM Policy Guide (Page 58)
 	
Core Service Component: Outreach and Engagement
 	
Plans must develop comprehensive outreach Policies and Procedures as part of the MOC. Activities in the Outreach and Engagement core service can include, but are not limited to:
 	
a. Attempting to locate, contact and engage Members (and/or their parent, caregiver, guardian) who have been identified as good candidates to receive ECM services, promptly after assignment.
d. Documenting outreach and engagement attempts and modalities.
	» Policies & Procedures (P&Ps)
	
	» Information Dissemination:
	  ○ Provider Education:
	  ▪ Provision of ECM Services, Referrals, and Follow-Up
	
	» Medical Records
	
	» ECM Case Notes
	
	» ECM Care Plan
		Plan P&Ps describe processes to locate and engage member and/or their family supports through in-person meetings, mail, email, text, telephone, etc., including ensuring ECM members and their support persons receive the CMP and information about requesting updates.
		
		Note: MCPs should be focused on ensuring community-based referrals from trusted messengers rather than data-mining processes.
		
		Once MCPs are required to provide Transitional Rent (effective Jan 2026) there will be a required in-person outreach requirement only for members who are receiving transitional rent.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.4.12 **Data System Requirements and Data Sharing to Support ECM** A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to: 1. Consume and use claims and Encounter Data, as well as other data types listed in Exhibit A, Attachment III, Subsection 4.4.6 (Member Identification for Enhanced Care Management); 2. Assign Members to ECM Providers; 3. Keep records of Members receiving ECM and authorizations necessary for sharing PHI and PI between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor; 4. Securely share data with ECM Providers and other Providers in support of ECM; 5. Receive, process, and send Encounter Data from ECM Providers to DHCS; 6. Receive and process supplemental reports from ECM Providers; 7. Send ECM supplemental reports to DHCS; and 8. Open, track, and manage referrals to Community Supports Providers.	» Policies & Procedures (P&Ps) » Provider Education » Workflow of Logs: ○ Contains records of the MCP providing ECM providers with the following: member assignment files; encounter and claims data; and physical, behavioral, administrative, and social drivers of health data (HMIS data) for all members assigned to the ECM provider	Plan P&Ps detail support capabilities as outlined in this Contract section. MCPs should ensure P&Ps provide sufficient detail on how requirements on the following page can be met. Plan P&Ps and practices have systematic processes to provide data to ECM providers, such as access to Admission, Discharge, and Transfer information to ensure that ECM providers can provide timely transitional care services and/or access to the MCP's provider portal to access information, as appropriate.

Requirement	Documentation to Review	Examples of Best Practices
B. To support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers. 1. Member Assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider; 2. Encounter Data and claims data; 3. Physical, behavioral, administrative, and Social Drivers of Health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and 4. Reports of performance on quality measures and metrics, as requested. C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework, in accordance with H&S section 130290.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.4.13 **Oversight of ECM Providers** A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, APLs, and Contractor's MOC. 1. Contractor must evaluate the prospective Subcontractor's and Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*); 2. Contractor must ensure the Subcontractor's and Downstream Subcontractor's capacity is sufficient to serve all Populations of Focus; 3. Contractor must report to DHCS the names of all Subcontractors, Network Providers, and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit*	» Policies & Procedures (P&Ps) » MOC Description » Oversight Documents: ○ Grievance Logs / Files ○ Tracking Logs and Reports – to track outreach efforts of potential ECM Members ○ ECM Provider Reporting ○ Tracking/Monitoring Reports to Committee ▪ Governing Body ▪ UM ▪ QIHEC ○ Meeting Minutes ▪ Governing Body ▪ UM ▪ QIHEC ○ Oversight Audit Reports ○ Corrective Action Plans » ECM Provider Agreements	*Note: Program considers this a critical area for ensuring MCP contracts and oversight processes include documentation that every ECM provider must have the capability to provide all core services or arrange/have arrangements to offer core services through other means.* *For example, if a community provider didn't specialize in clinical assessment and/or care, the provider is still responsible for staffing or utilizing a service/third party to have the clinical needs of members assessed or reviewed to determine if there is a need to include clinical needs in the care plan.* *This is especially the case if the MCP has delegated this function. If delegated, the MCP must maintain the same amount of oversight and responsibility. If the MCP is using a hub or network lead entities, it must remain accountable for maintaining this standard.* Plan P&Ps and MOC describe oversight processes, e.g., audits, monitoring the utilization of and/or outcomes resulting from ECM and training/technical assistance to ECM providers. The Plan conducts ongoing ECM monitoring and submits monitoring documentation e.g., periodic audits that assess its ECM provider network's compliance with the Contract requirements such as: review of care plans, involvement of clinicians, outreach, and core ECM service components. Minimal or no ECM-related Grievances; The Plan follows appropriate and timely grievance

Requirement	Documentation to Review	Examples of Best Practices
Delegation Reporting and Compliance Plan); and 4. Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5.B *(Subcontractor and Downstream Subcontractor Agreement Requirements)*. Services Data Exchange Framework, in accordance with H&S section 130290. B. Contractor may hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS to support data collection and reporting. 1. Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and 2. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers. C. Contractor must not utilize tools developed or promulgated by NCQA to perform		resolution and takes follow-up action to correct any deficiencies identified.

Requirement	Documentation to Review	Examples of Best Practices
oversight of ECM Providers, unless by mutual consent with the ECM Provider. D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements, as applicable, described in Exhibit A, Attachment III, Subsection 3.2.5 *(Network Provider Training)*. E. Contractor must ensure the Subcontractor Agreement and Downstream Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with APLs, as applicable to Subcontractor. Contractor may collaborate with its Subcontractors and Downstream Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for ECM Providers and Members. **CalAIM ECM Policy Guide (Pages 107 – 109)** **ECM Provider Oversight** MCPs are required to perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS.		

Requirement	Documentation to Review	Examples of Best Practices
The Plan may subcontract with other entities to administer ECM, the Plan will be responsible for the following: Oversight of compliance with Contract provisions and Covered Services, regardless of the number of layers; Developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions; Evaluating the prospective Subcontractor's ability to perform services.		
Contract Exhibit A, Attachment III, Section 4.4.14 **Payment of ECM Providers** A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider. B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as described in Exhibit A, Attachment III, Subsection 4.4.9 (Initiating Delivery of Enhanced Care Management). C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving	» Policies & Procedures (P&Ps) » Written Criteria/Guidelines ○ Claims Payments Review and Monitoring ○ Billing Guides ○ Technical Assistance Guides for ECM Providers » Desktop Guides » Oversight Documents: ○ Claims processing logs or system-generated reports ○ Documentation of late payment interest	*Note: Program considers this a critical area for ensuring MCP contracts and oversight processes include documentation that every ECM provider must have the capability to provide all core services or arrange/have arrangements to offer core services through other means.* Documentation shows the Plan pays 90% of claim claims within 30 calendar days and 99% within 90 days of receipt. Interest at 15% per annum is automatically included in claims paid after 45 working days. Receipt and payment dates are clearly documented and used consistently for compliance tracking. Written agreements are in place for any alternative payment schedules with Providers.

Requirement	Documentation to Review	Examples of Best Practices
outcomes related to high-quality care and improved health status. D. Contractor must utilize the claims timeline as described in Exhibit A, Attachment III, Subsection 3.3.5 (Claims Processing).	calculations and payments made ○ Internal audit reports or monitoring tools ○ Provider grievances related to claims/payments » Verification Study: ○ Conduct verification study of claim details, remittance advice details, and supporting documentation submitted with the claim. Sample of ECM encounters, with analysis of date of clean claim submission vs. claim payout, compared to DHCS standards.	
Contract Exhibit A, Attachment III, Section 4.4.15 **ECM Reporting Requirements** A. Contractor must submit the following data and reports to DHCS to support DHCS' oversight of ECM: 1. Encounter Data: a. Contractor must submit all ECM Encounter Data to DHCS using national	» Discussion with Programs deferred to next SFY/audit cycle and will include at a minimum: ○ A&I ○ PHMD ○ CRDD ○ EDIM/PDRD	*Note: As of March 2026, DHCS has identified that improvement in this area is needed; however, the approach taken should be decided in forthcoming and ongoing discussions between impacted programs beginning next SFY.* *In the interim, DHCS has identified that many MCPs encounter data for ECM may accurately reflect ECM services provided. For example, when CRDD conducted a targeted data release, the number of average ECM services received by members was approximately 1 service per member*

Requirement	Documentation to Review	Examples of Best Practices
standard specifications and code sets to be defined by DHCS. b. Contractor must submit to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation and/or sub-delegation between Contractor and the ECM Provider. c. In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS. 2. ECM supplemental reports, on a schedule and in a format to be defined by DHCS. B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Potential Members to be enrolled in ECM. C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Section 1.19 (Sanctions).		*per month higher than analysis based on encounter data alone.*

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.4.16 **ECM Quality and Performance Incentive Program** A. Contractor must meet all quality management and Quality Improvement requirements in Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program (QIHETP)) and any additional quality requirements set forth in associated guidance from DHCS for ECM. B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.	Not applicable – this program has sunsetted until further notice	*Note: As of March 2026, DHCS identified that the ECM Quality and Performance Incentive Program has ended and therefore including it in audit scope is not recommended. Review of performance incentive program related milestones has been finalized by PHMD and MCQMD.*

CATEGORY 2.26: COMMUNITY SUPPORTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.1 **Administration of Community Supports** B. In accordance with 42 Code of Federal Regulations (CFR) section 438.3(e)(2), all applicable All Plan Letters (APLs), and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan. 1. Contractor must ensure medically appropriate California Medicaid State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past. 2. Contractor must not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan services on the same terms as would apply if Community Supports was not an option in accordance with regulatory requirements.	» Policies & Procedures (P&Ps): The Plan: ○ May select Community Supports (CS) from DHCS' pre-approved list ○ Must ensure availability of medically appropriate California Medicaid State Plan services ○ Must not require Member to utilize CS ○ Must not use CS to reduce, discourage, jeopardize Member's access to State Plan services » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents ○ Meeting Minutes:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented Relevant entities (Providers, Members) are informed about the Plan's provision of CS and the process to access these services The Plan offers CS from the pre-approved DHCS list.

Requirement	Documentation to Review	Examples of Best Practices
3. Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services. 4. Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.	▪ QIHEC ▪ CAC » List of CS Offered by the Plan	
Contract Exhibit A, Attachment III, Section 4.5.1 **Administration of Community Supports** C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support that Contractor chooses to provide, as referenced in APL 21-017 and the Community Supports Policy Guide. 1. Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations incorporated in the Community Supports Policy Guide. 2. Contractor may not adopt a more narrowly defined eligible population for	» Policies & Procedures (P&Ps): The Plan: ○ May not extend CS (beyond those for whom DHCS deems CS to be cost-effective and medically appropriate) ○ May not adopt a more narrowly defined eligible population ○ If electing to offer one or more CS, the Plan needs not offer CS in each County it serves ○ Must report to DHCS which County it offers CS and offer these services in the County selected by the Plan	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
Community Supports than outlined in the Community Supports Policy Guide. D. If Contractor elects to offer one or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.4 (Community Supports Provider Capacity).	» List of CS Offered by the Plan and Location/County it is offered.	
Contract Exhibit A, Attachment III, Section 4.5.1 **Administration of Community Supports** E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.6 *(Identifying Members for Community Supports)*. F. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III,	» Policies & Procedures (P&Ps): ○ Include guidelines to identify Members who may benefit from CS and accept requests for CS from Members, providers, and organizations that serve them (e.g., community-based organizations) ○ Specifies authorization of CS for eligible Members ○ Includes provision that Plan may elect to offer value-added services in addition to offering one or more CS	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
Subsection 4.5.7 *(Authorizing Members for Community Supports and Communication of Authorization Status)*. G. Contractor may elect to offer value-added services in addition to offering one or more Community Supports. Offering or not offering Community Supports does not preclude Contractor from offering value-added services. H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.9 (*Network and Access Changes to Covered Services)*. I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports. J. Contractor must not require Members to use Community Supports.	○ Encourages coordination with the Medicare Advantage Plan in the provision of CS (for dual eligible and enrolled in a Medicare Advantage Plan, including D-SNPs) ○ Must not require Members to use CS	
Contract Exhibit A, Attachment III, Section 4.5.2 **DHCS Pre-Approved Community Supports** A. Contractor may choose to offer Members one or more of the following pre-approved Community Supports, and any subsequent	» Policies & Procedures (P&Ps): ○ May select Community Supports (CS) from DHCS' pre-approved list » Information Dissemination: ○ Provider Manual	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members) are informed about the Plan's provision of CS and the process to access these services.

Requirement	Documentation to Review	Examples of Best Practices
Community Supports additions pre-approved by DHCS, in each county: 1. Housing transition navigation services; 2. Housing deposits; 3. Housing tenancy and sustaining services; 4. Short-term post-hospitalization housing; 5. Recuperative care (medical respite); 6. Respite services; 7. Day habilitation programs; 8. Nursing facility transition/diversion to assisted living facilities; 9. Community transition services/nursing facility transition to a home; 10. Personal care and homemaker services; 11. Environmental accessibility adaptations; 12. Medically tailored meals/medically supportive food; 13. Sobering centers; and 14. Asthma remediation. B. Contractor must list all Community Supports it offers in its Community Supports Model of Care (MOC) template and Community Supports MOC amendments. C. Contractor must ensure Community Supports are provided in accordance with APLs and DHCS' Community Supports Policy Guide.	○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents ○ Meeting Minutes: ▪ QIHEC ▪ CAC ○ CS Tracking/Monitoring Reports » List of CS Offered by the Plan	The Plan offers CS from the pre-approved DHCS list List of CS offered by the Plan is in the CS MOC.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.2 **DHCS Pre-Approved Community Supports** D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports. E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date. Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs. F. At least 30 calendar days before discontinuing one or more Community Supports, Contractor must notify impacted Members of the following: 1. The change and timing of discontinuation, and 2. The procedures that will be used to ensure completion of the authorized Community	» Policies & Procedures (P&Ps): ○ Ensure CS are provided in a timely manner ○ Manage CS Provider shortages or other barriers to ensure timely provision of CS ○ May discontinue offering CS annually with notice to DHCS at least 90 calendar days prior to discontinuation ○ Must notify impacted Members at least 30 calendar days before discontinuing one or more CS	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented

Requirement	Documentation to Review	Examples of Best Practices
Supports or a transition into other comparable Medically Necessary services. G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of this Section 4.5 and are subject to the limitations of 42 CFR section 438.3(e)(1).		
Contract Exhibit A, Attachment III, Section 4.5.3 **Community Supports Providers** A. Community Supports Providers are entities that Contractor has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees). B. Contractor must enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers for the delivery of Community Supports elected by Contractor. C. Contractor must ensure all Community Supports Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-	» Policies & Procedures (P&Ps): ○ Specify that CS Providers provide services in an effective manner consistent with culturally and linguistically appropriate care ○ Enter into agreements, as appropriate, with CS Providers for the delivery of CS elected by the Plan ○ Ensure all CS Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal (otherwise, the Plan must have a process for verifying qualifications and experience)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan has copies of agreements with Network Providers and others who provide CS.

Requirement	Documentation to Review	Examples of Best Practices
013. If APL 22-013 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.	» Agreements with Network Providers (and others) Who Provide CS	
Contract Exhibit A, Attachment III, Section 4.5.3 **Community Supports Providers** D. In accordance with Exhibit A, Attachment III, Subsection 4.5.9 (Data System Requirements and Data Sharing to Support Community Supports), Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum: 1. Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and 2. Support Community Supports Provider notification to Contractor, ECM Providers, and Member's Primary Care Provider	» Policies & Procedures (P&Ps): ○ Include specifications that support CS Provider access to systems and processes (e.g., obtain and document Member information, support CS Provider notification process) ○ May coordinate with other Medi-Cal managed care plans offering CS in the same county ○ Prioritize contracting with locally available community-based organizations with experience (e.g., supportive housing	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan's CS Providers have experience servicing CS-eligible Members.

Requirement	Documentation to Review	Examples of Best Practices
(PCP), as applicable, when a referral has been fulfilled, as described in Exhibit A, Attachment III, Subsection 4.5.9 (Data System Requirements and Data Sharing to Support Community Supports). E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal managed care health plans offering Community Supports in the same county. F. Contractor must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., Supportive housing providers, Skilled Nursing Facilities (SNFs), medically tailored meals providers).	providers, SNFs, medically tailored providers)	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.4 **Community Supports Provider Capacity** A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports. B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS. C. Contractor must ensure all of its Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.	» Policies & Procedures (P&Ps): ○ Develop a robust network of CS Providers to deliver all elected CS ○ If unable to offer its elected CS to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, then Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS ○ Ensure all of its CS Providers have sufficient capacity to receive referrals for CS and provide the agreed-upon volume of CS to Members who are authorized for such services on an ongoing basis	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.5 **Community Supports Model of Care** A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports. B. In developing and executing Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to APLs. C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its Community Supports MOC. D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in	» Policies & Procedures (P&Ps): The Plan will: ○ Develop a CS MOC ○ Collaborate with other Medi-Cal managed care plans within the same county on the development of its CS MOC ○ Submit its CS MOC for DHCS review and approval » Copy of Plan's CS MOC	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan maintains a CS MOC that is reviewed and approved by DHCS.

Requirement	Documentation to Review	Examples of Best Practices
advance of any such occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.		
Contract Exhibit A, Attachment III, Section 4.5.6 **Identifying Members for Community Supports** A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable DCHS APLs. B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to implementation. Contractor's policies and procedures must address the following, at a minimum: 1. How Contractor will identify Members eligible for Community Supports; 2. How Contractor will notify Members; and 3. How Contractor will receive requests to evaluate Members for Community	» Policies & Procedures (P&Ps): ○ Utilize a variety of methods to identify Members who may benefit from CS ○ Develop P&P for CS, and submit to DHCS for review and approval prior to implementation: ▪ Process to identify Members eligible for CS; ▪ Process to notify Members; ▪ Process to receive requests to evaluate Members for CS from Providers; community-based entities; and	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan maintains a CS MOC that is reviewed and approved by DHCS.

Requirement	Documentation to Review	Examples of Best Practices
Supports from Providers; community-based entities; and Member or Member's family, legal guardians, Authorized Representatives (ARs), and caregivers. C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation. D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.	Member or Member's family, legal guardians, ARs, and caregivers. ○ Submit all Member notices to DHCS for review / approval prior to implementation. ○ Ensure that Member identification methods for CS are equitable.	
Contract Exhibit A, Attachment III, Section 4.5.7 **Authorizing Members for Community Supports and Communication of Authorization Status** A. Contractor must develop and maintain policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor must submit its policies and procedures to DHCS for review and approval prior to implementation. 1. Contractor's policies and procedures must include a framework for considering medical appropriateness in relation to Contractor's proposed approach for providing Community Supports.	» Policies & Procedures (P&Ps): ○ P&Ps must include a framework for considering medical appropriateness in relation to the Plan's proposed approach for providing CS ○ Each CS authorization request must be considered separately for a Member ○ Monitor and evaluate CS authorizations to ensure they are equitable and non-discriminatory » Oversight Documents	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented UM Tracking and Monitoring Reports of CS authorizations show equitable patterns of adjudication

Requirement	Documentation to Review	Examples of Best Practices
2. Each Community Support authorization request must be considered separately for a Member. Contractor must evaluate each authorization request for medical appropriateness. Receiving one Community Support does not preclude a member from being authorized for additional Community Supports unless a conflict is specified by DHCS. B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that it will undertake if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.	○ UM Tracking and Monitoring Reports of CS authorizations	
Contract Exhibit A, Attachment III, Section 4.5.7 **Authorizing Members for Community Supports and Communication of Authorization Status** C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, Skilled Nursing Facility (SNF) stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for	» Policies & Procedures (P&Ps): ○ Outline guidelines to ensure appropriate clinical support authorization of CS for Members ○ Specify procedures to ensure Members do not experience undue delays pending the authorization of CS ○ Includes process for expediting the	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. UM Tracking and Monitoring Reports of CS authorizations show that the Plan expedites CS authorization appropriately.

Requirement	Documentation to Review	Examples of Best Practices
Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with APLs and to be defined in forthcoming guidance. D. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports. If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replace, pending authorization of the requested Community Supports. E. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with APLs.	authorization of certain CS for urgent needs » Oversight Documents ○ UM Tracking and Monitoring Reports of CS authorizations	
Contract Exhibit A, Attachment III, Section 4.5.7 **Authorizing Members for Community Supports and Communication of Authorization Status**	» Policies & Procedures (P&Ps): ○ Specify that when a Member has requested CS (directly or through a Provider, community-	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan sends Member notices of CS authorizations.

Requirement	Documentation to Review	Examples of Best Practices
F. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requestor and the Member of Contractor's decision regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision. G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost-effective. H. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (Member Grievance and Appeal System) and APL 21-011.	based organization, or other entity), the Plan must notify the requestor and the Member of the Plan's decision regarding CS authorization ○ Members always retain the right to file appeals and/or grievances ○ For Members who sought CS offered by the Plan but were not authorized to receive the CS, the Plan must submit necessary data to monitor appeals and grievances » Notice of Action Templates	
Contract Exhibit A, Attachment III, Section 4.5.8 **Referring Members to Community Supports Providers**	» Policies & Procedures (P&Ps): The Plan will: ○ Develop and maintain P&Ps to define how CS	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor must submit to DHCS policies and procedures for review and approval prior to implementation. 1. For Members enrolled in ECM, Contractor's policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider. 2. Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization. B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable. C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member. If the Member receiving Community Supports is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.	Provider referrals will occur ○ Track referrals to verify if the authorized service has been delivered to the Member ○ If the Member receiving CS is also receiving ECM, the Plan must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the CS Provider » Oversight Documents ○ UM Tracking and Monitoring Reports of CS authorizations.	UM Tracking and Monitoring Reports of CS authorizations show timely CS authorizations.

Requirement	Documentation to Review	Examples of Best Practices
D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.		
Contract Exhibit A, Attachment III, Section 4.5.8 **Referring Members to Community Supports Providers** E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to: 1. Ensure the Member agrees to receive Community Supports; 2. Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization. 3. Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with APLs, laws, and regulations; 4. Provide Contractor with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to	» Policies & Procedures (P&Ps): The Plan's network of CS Providers will: ○ Ensure the Member agrees to receive CS ○ Follow the Plan's P&P expectations and procedures to ensure referrals occur in a timely manner after service authorization ○ Where required by applicable law, ensure that Members authorize information-sharing with the Plan and all others involved in the Member's care as needed to support the Member and maximize the benefits of CS » Authorized Consent Forms (data sharing)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan completes authorization forms for data sharing in the provision of CS.

Requirement	Documentation to Review	Examples of Best Practices
facilitate ongoing data sharing with Contractor; and 5. Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, ARs, caregivers, and other authorized support persons, if Contractor intends to do so.		
Contract Exhibit A, Attachment III, Section 4.5.9 **Data System Requirements and Data Sharing** A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals. Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information. B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral process to Community Supports Providers: 1. Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;	» Policies & Procedures (P&Ps): The Plan will: ○ Use systems and processes capable of tracking CS referrals, access to CS, and grievances and appeals ○ Use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with CS Providers and with DHCS in compliance with data exchange P&Ps » Oversight Documents ○ UM Tracking and Monitoring Reports of CS authorizations	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan has UM Tracking and Monitoring Reports of CS authorizations that show timely adjudication of services. The Plan has a grievance system that monitors CS-related grievances and appeals.

Requirement	Documentation to Review	Examples of Best Practices
2. Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and 3. Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor. C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS in compliance with data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with H&S section 130290, when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.	○ Grievance and Appeal Logs	
Contract Exhibit A, Attachment III, Section 4.5.10 **Data System Requirements and Data Sharing** A. Contractor must comply with all State and federal reporting requirements. B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community	» Policies & Procedures (P&Ps): ○ The Plan must perform oversight of CS Providers, holding them accountable for all CS requirements contained in the Contract and APLs ○ The Plan may collaborate with other Medi-Cal	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan has a grievance system that monitors CS-related grievances and appeals. The Plan has several methods for CS oversight.

Requirement	Documentation to Review	Examples of Best Practices
Supports requirements contained in this Contract, and APLs. C. Contractor must use APLs to develop its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS. D. To streamline Community Supports implementation: 1. Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS; 2. Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter Data and supplemental reporting as described in Subsection 4.5.13 (Community Supports Reporting Requirements); and 3. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on reporting requirements and oversight.	managed care plans within the same county on reporting requirements and oversight » Oversight Documents ○ Grievance and Appeal Logs ○ Workflow of Plan's CS Oversight	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.10 **Data System Requirements and Data Sharing** E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider. F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment III, Subsection 3.2.5 (Network Provider Training). G. Contractor must not require Community Supports Providers to use a contractor-specific portal for day-to-day documentation of services. However, this prohibition does not preclude providers and Contractor from mutually agreeing to use of portals to facilitate reporting and other administrative transactions.	» Policies & Procedures (P&Ps): ○ The Plan must not utilize tools developed or promulgated by NCQA to perform oversight of CS Providers, unless there is mutual consent with the CS Provider ○ The Plan must provide CS training and technical assistance to CS Providers ○ The Plan must not require CS Providers to use a contractor-specific portal for day-to-day documentation of services » CS Training Materials	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan has several methods to provide CS training.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.11 **Delegation of Community Supports Administration** A. Contractor may enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with other entities to administer Community Supports in accordance with the following: 1. Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment III, Section 3.1 *(Network Provider Agreements…and Contractor's Oversight Duties);* 2. Contractor must develop and maintain DHCS-approved policies and procedures to ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment III, Subsection 3.1.4 *(Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance);* 3. Contractor must evaluate the prospective Network Provider's, Subcontractor's, or Downstream Subcontractor's ability to perform services as described in Exhibit A,	» Policies & Procedures (P&Ps): ○ Maintain and be responsible for oversight of compliance with all Contract provisions and covered services ○ Ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions ○ Evaluate the prospective Network Provider's Subcontractor's or Downstream Subcontractor's ability to perform services ○ Ensure the Network Provider's Subcontractor's or Downstream Subcontractor's CS Provider capacity is sufficient to serve all Populations of Focus	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance);* 4. Contractor must ensure the Network Provider's, Subcontractor's, or Downstream Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;		
Contract Exhibit A, Attachment III, Section 4.5.11 **Delegation of Community Supports Administration** 5. Contractor must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 *(Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan);* and 6. Contractor must make all Network Provider Agreements, Subcontractor Agreements…available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount	» Policies & Procedures (P&Ps): ○ The Plan must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors, their provider type and services provided and identify the county or counties in which Members are served ○ The Plan must make all Network Provider, Subcontractors and Downstream Subcontractors agreements available to DHCS upon request ○ The Plan may collaborate with its Network Providers on its approach to CS to	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Upon request, the Plan is able to make all Network Provider, Subcontractor and Downstream Subcontractor agreements available to DHCS.

Requirement	Documentation to Review	Examples of Best Practices
of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5. *(Requirements for Network Provider Agreements, Subcontractor Agreements…).* B. Contractor must ensure all Network Provider Agreements, Subcontractor Agreements…mirror the requirements set forth in this Contract and APLs, as applicable to the Network Provider, Subcontractor, or Downstream Subcontractor. C. Contractor may collaborate with its Network Providers, Subcontractors, and Downstream Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Network Providers, Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for Community Supports Providers and Members.	minimize divergence in how CS will be implemented » Copies of Subcontractor Contracts	
Contract Exhibit A, Attachment III, Section 4.5.12 **Payment of Community Supports Providers** A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Network Provider Agreements, Subcontractor Agreements…between Contractor and each Community Supports Provider.	» Policies & Procedures (P&Ps): ○ The Plan must pay contracted CS Providers for the provision of authorized services to Members ○ The Plan must utilize the claims timeline and process	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) to ensure timely payment of claims, bills, or invoices. C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for a Member who is homeless and being discharged from the hospital. For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval. D. Contractor must ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible. 1. If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider apply the DHCS approved billing and guidance to submit invoices. 2. Upon receipt of such an invoice, Contractor must document the Encounter for the Community Supports rendered.	○ The Plam must identify any circumstances under which payment for CS must be expedited to facilitate timely delivery of CS ○ Ensure CS Providers submit a claim for rendered CS services, to the greatest extent possible	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 4.5.13 **Community Supports Reporting Requirements** A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with APLs. B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports: 1. Encounter Data a. Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must comply with DHCS guidance on billing and invoicing standards... b. Contractor must submit to DHCS all Community Supports Encounter Data... c. In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoicing and billing	» Policies & Procedures (P&Ps): ○ After implementation of CS, the Plan must submit the following data and reports to DHCS to support DHCS oversight of CS: ▪ Encounter Data ▪ Supplemental reporting on a schedule and in a form to be defined by DHCS	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
data into the national standard specifications and code sets, for submission to DHCS. d. Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities... 2. Supplemental reporting on a schedule and in a form to be defined by DHCS.		
Contract Exhibit A, Attachment III, Section 4.5.13 **Community Supports Reporting Requirements** C. Contractor must timely submit any related data requested by DHCS, Centers for Medicare & Medicaid Services (CMS), or an independent entity conducting an evaluation of Community Supports including, but not limited to: 1. Data to evaluate the utilization and effectiveness of Community Supports. 2. Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by	» Policies & Procedures (P&Ps): ○ The Plan must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of CS ○ In the event of underperformance by the Contractor in relation to its administration of CS, DHCS may impose sanctions	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
age, sex, race, ethnicity, and language spoken. 3. Data necessary to monitor Member Appeals and Grievances associated with Community Supports. D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Section 1.19 (*Sanctions)*.		
Contract Exhibit A, Attachment III, Section 4.5.14 **Quality and Performance Incentive Program** A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program (QIHETP)), and any additional quality requirements for Community Supports set forth in associated guidance from DHCS. B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.	» Policies & Procedures (P&Ps): ○ The Plan must meet all quality management and quality improvement requirements as described in Contract Section 2.2 and any additional quality requirements for CS set forth in associated guidance from DHCS ○ The Plan may participate in a performance incentive program related to adoption of CS, building infrastructure and provider capacity of CS, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan is able to demonstrate it meets all DHCS QI requirements.

Requirement	Documentation to Review	Examples of Best Practices
	003 or other technical guidance	

CATEGORY 2.27: COMMUNITY BASED ADULT SERVICES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.4.2 **Coordination of Care** A. Contractor must provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This requirement includes out-of-Network Providers if there are no Quality of Care issues and the Provider will accept Contractor's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher. B. Contractor must ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning and completed in accordance with the CalAIM STCs Section V.A.20., "Individual Plan of Care". C. Contractor must conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, Sections VIII.A.19.e and 23.b. In addition, Contractor must: 1. Within 30 calendar days from the initial eligibility inquiry request, Contractor must conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility	» Policies & Procedures (P&Ps): ○ Provide continuity of care to a CBAS provider ○ CBAS IPCs must be consistent with the Member's overall care plans and goals ○ Conduct eligibility determination within 30 calendar days from the initial eligibility inquiry request ○ Conduct the initial assessment and reassessments » Information Dissemination: ○ Provider Manual ○ Member Handbook ○ Plan Website ○ Brochures » Oversight Documents: ○ Org Chart: CBAS Team / Staff	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. CBAS IPCs are developed based on person-centered planning. CBAS eligibility determinations are conducted using a DHCS-approved assessment tool. Relevant entities (Providers, Members) are informed about the process to access the CBAS benefit. Oversight of the Plan's CBAS care coordination is evident.

Requirement	Documentation to Review	Examples of Best Practices
determinations shall include a face-to-face review with the Member by a Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal Managed Care Health Plan. Contractor may forgo a face-to-face review if Contractor has already determined Contractor must not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review.	○ Tracking and Monitoring Reports for CBAS ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	
Contract Exhibit A, Attachment III, Section 5.4.2 **Coordination of Care** 2. Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health; 3. Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate.	» Policies & Procedures (P&Ps): ○ Provide expedited CBAS eligibility determination for Members in a hospital or SNF whose discharge plan includes CBAS ○ Conduct reassessment with family involvement and at least every 6 months (or up to 12 months) after the initial assessment ○ Notify Members of CBAS assessment determination » Information Dissemination: ○ Provider Manual ○ Newsletters, Education	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan has a process to conduct an expedited CBAS eligibility determination (within 72 hours). The Plan sends timely CBAS notifications of assessment determinations. Oversight of the Plan's CBAS care coordination is evident.

Requirement	Documentation to Review	Examples of Best Practices
When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider; 4. Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 *(Member Grievance and Appeal System)*;	○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ Grievances (CBAS) ○ Tracking and Monitoring Records for CBAS ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	
Contract Exhibit A, Attachment III, Section 5.4.2 **Coordination of Care** C. In addition, Contractor must: 5. Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include: [see a – h for criteria].	» Policies & Procedures (P&Ps): ○ The Plan ensures Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to the Plan whenever a Member's CBAS services are terminated ○ Coordinate with the CBAS Provider to ensure all CBAS IPCs are consistent	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. There is a timely exchange of care coordination information (e.g., Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition. When applicable, providers provide a copy of the Discharge Plan of Care to the Member and to the Plan whenever a Member's CBAS services are terminated.

Requirement	Documentation to Review	Examples of Best Practices
D. Contractor must coordinate with the CBAS Provider to ensure the following: 1. CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor; 2. Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;	with goals developed by the Plan ○ There must be a timely exchange of care coordination information » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ Grievances (CBAS) ○ Tracking and Monitoring Records for CBAS ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	
Contract Exhibit A, Attachment III, Section 5.4.2 **Coordination of Care** 3. Clear communication pathways between the appropriate CBAS Provider staff and	» Policies & Procedures (P&Ps): ○ The Plan will coordinate care for unbundled CBAS that are not covered services, based on the	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. There are clear communication pathways between the appropriate CBAS Provider staff.

Requirement	Documentation to Review	Examples of Best Practices
Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management; and 4. The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS. E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 *(Covered Services),* and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 *(Coordination of Care),* Contractor must coordinate care for unbundled CBAS that are not Covered Services, based on the assessed needs of the Member eligible for CBAS, including: 1. Personal Care Services 2. Social Services 3. Physical and Occupational Maintenance Therapy 4. Meals 5. SMHS 6. SUD services that are not Covered Services.	assessed needs of the Member eligible for CBAS ○ The CBAS Provider receives advance written notification and training prior to any substantive changes in the Plan's P&Ps related to CBAS » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ Grievances (CBAS) ○ Tracking and Monitoring Records for CBAS ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	There is evidence the Plan coordinates care for unbundled CBAS that are not covered services, based on the assessed needs of the Member eligible for CBAS. Oversight of the Plan's CBAS care coordination is evident.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.4.3 **Required Reports for the CBAS Program** Contractor must submit to DHCS the following reports 30 calendar days following the end of each reporting period and in a format specified by DHCS: A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis; B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5% drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. *(Network Reports);* C. A summary of any complaints surrounding the provision of CBAS; and D. Reports on the following areas: 1. Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested; 2. Appeals related to requesting a particular CBAS Provider and the inability to access that Provider; 3. Excessive travel times to access CBAS; 4. Grievances regarding CBAS Providers; 5. Grievances regarding Contractor assessment and/or reassessment; and	» Policies & Procedures (P&Ps): ○ The Plan must submit to DHCS certain required reports 30 calendar days following the end of each reporting period and in a format specified by DHCS	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.

Requirement	Documentation to Review	Examples of Best Practices
6. Any reports pertaining to the health and welfare of Members utilizing CBAS. E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.		

CATEGORY 2.28: SERVICES FOR MEMBERS LESS THAN 21 YEARS OF AGE

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.5.4 **B. Children's Preventive Services** 1. Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures. 2. Where a request is made for Children's preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, 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.	» Policies & Procedures (P&Ps): ○ The Plan will provide preventive health visits for Members < 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Scheule, with anticipatory guidance as outlined in the AAP Scheule ○ The Plan will make an appointment within 10 working days when a request for a preventive service is made by the Member, the Member's parent, legal guardian or authorized rep, or through a referral » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. There are clear communication pathways between the appropriate CBAS Provider staff. There is evidence the Plan coordinates care for unbundled CBAS that are not covered services, based on the assessed needs of the Member eligible for CBAS.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.5.4 **B. Children's Preventive Services** 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, legal guardian, or AR of the Member, must be advised of the Children's preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children's preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these services. 4. All children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2 *(Encounter Data Reporting)*. Contractor must ensure appropriate acquisition for	» Policies & Procedures (P&Ps): ○ The Plan will provide Blood Lead Screening Tests to child Members at ages specified in APL 20-016 (12 months to 24 months, or at 24 to 72 months for no documented lead screening ○ Documentation (in medical records) or all screenings performed for child Members » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Medical Records » Blood Lead Screening Records	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's efforts to reach out to Members to schedule an IHA and age-appropriate preventive services. Relevant entities (Providers, Members) are informed about the need for Children's preventive services.

Requirement	Documentation to Review	Examples of Best Practices
missed reporting of Children's preventive services. **APL 20-016** **Blood Lead Screening of Young Children** Includes requirements for blood lead screening tests and associated monitoring and reporting.		
Contract Exhibit A, Attachment III, Section 5.5.4 **E. EPSDT** 1. For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 23-005. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the California Medicaid State Plan, unless expressly excluded in this Contract. Covered Services will include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per	» Policies & Procedures (P&Ps): ○ The Plan will provide, or arrange and pay for, all medically necessary EPSDT services, including all Medicaid services ○ Assigning Care Managers (CMs) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ Governing Board	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the compliance in meeting EPSDT requirements. Relevant entities (Providers, Members) are informed about the Plan's provisions of EPSDT services and the process to access these services.

Requirement	Documentation to Review	Examples of Best Practices
requirements in Exhibit A, Attachment III, Section 5.6 (MOUs with Local Government Agencies, County Programs, and Third Parties), Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 23-005.	▪ CAC ○ UM Records of Members receiving PDN Services » Medical Records	
Contract Exhibit A, Attachment III, Section 5.5.4 **E. EPSDT** 2. Contractor must arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C), APL 23-005, and APL 20-012. Contractor must ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Exhibit A, Attachment III, Subsection 5.3.4.E.1) (Services for Members Less Than 21 Years of Age), above, as well as EPSDT services carved out of this Contract, 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 diagnosis or	» Policies & Procedures (P&Ps): ○ The Plan will arrange for medically necessary EPSDT services, either directly or through referral to appropriate agencies, organizations or individuals ○ The Plan will ensure EPSDT services carved out of the Contract are provided in a timely manner (ASAP but no later than 60 calendar days following the preventive screening) ○ Assigning Care Managers (CMs) » Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ UM	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's efforts to comply with EPSDT requirements (e.g., through appointment scheduling assistance and necessary transportation to and from medical appointments and covered services). There is oversight of the Plan's provision of EPSDT services (e.g., PDN services).

Requirement	Documentation to Review	Examples of Best Practices
treatment. Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.	▪ Governing Board ▪ CAC ○ UM Records of Members receiving PDN Services » Medical Records	
Contract Exhibit A, Attachment III, Section 5.5.4 **E. EPSDT** 3. Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services)*. Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System	» Policies & Procedures (P&Ps): ○ The Plan will arrange for medically necessary EPSDT services, either directly or through referral to appropriate agencies, organizations or individuals ○ CCS is not covered in EPSDT ○ Mental health services are covered ○ Assigning Care Managers (CMs)	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's efforts to comply with EPSDT requirements (e.g., through care coordination to assist Members in accessing medically necessary mental health services).

Requirement	Documentation to Review	Examples of Best Practices
(DMC-ODS)Plans under this Subsection is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and Behavioral Health needs.	» Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ UM ▪ Governing Board ▪ CAC ○ UM Records of Members receiving PDN Services » Medical Records	
Contract Exhibit A, Attachment III, Section 5.5.4 **F. Behavioral Health Treatment Services** For Members less than 21 years of age, Contractor must cover Medically Necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with APL 22-006 and APL 23-010. 1. Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care. 2. The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service	» Policies & Procedures (P&Ps): ○ Eligibility determination and authorization of BHT services ○ Timely Care Plan review, revision, renewal, and authorization requests » Oversight Documents: ○ BHT Tracking and Monitoring Reports of Members ○ Grievance Logs for BHT-related grievances » List of BHT Providers » Verification Study:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate compliance with BHT Contract requirements, including the requirement that treatment plans are reviewed at least every six months. Verification Study results show the Plan is deemed compliant with BHT requirements: 1. BHT Members are identified and tracked 2. UM authorizations every six months based on medical necessity and medical record and CMP review 3. There are minimal or no BHT-related grievances

Requirement	Documentation to Review	Examples of Best Practices
Provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.	○ Conduct verification study to determine compliance with BHT requirements by evaluating: ▪ BHT Universe ▪ Grievance Logs BHT-related ▪ Medical Records ▪ BHT Case Notes ▪ BHT Care Plans (Crisis Transition, Exit Plans)	
Contract Exhibit A, Attachment III, Section 5.5.4 **F. Behavioral Health Treatment Services** 3. Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must coordinate with, and make good faith attempts to enter into Memorandum of Understandings	» Policies & Procedures (P&Ps): ○ Execute an MOU with the local RC and applicable LEAs for care coordination in the provision of adequate and timely BHT services ○ Ensure non-duplication of services ○ Enter into an MOU with the local MHP to facilitate coordination of services for Members with developmental disabilities, including Autism Spectrum Disorder	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan executed an MOU with the local RC for care coordination of BHT services. Relevant entities (Providers, Members) are informed about the Plan's provision of BHT services and the process to avail of these services. There are BHT-related grievances (e.g., delayed access to appointments due to inadequate Provider Network.

Requirement	Documentation to Review	Examples of Best Practices
(MOUs) with RCs and LEAs, and Contractor must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (MOU Purpose), to facilitate the coordination of services for Members with Developmental Disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 22-005 and APL 22-006. If Contractor is unable to enter into an MOU or a one-time case agreement with a RC, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.	» Information Dissemination: ○ Provider Manual ○ Member Handbook » Oversight Documents: ○ Grievance Logs for BHT-related grievances ○ BHT Tracking/Monitoring Reports of Members ○ Meeting Minutes ▪ QIHEC ▪ UM ▪ Governing Board ▪ CAC » List of BHT Providers	

CATEGORY 2.29: INITIAL HEALTH APPOINTMENT

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.3.3 **Initial Health Appointment (General Overview)** Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 California Code of Regulations (CCR) sections 53851(b)(1), 53910.5(a)(1) and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.	» Policies & Procedures (P&Ps): IHA Records will contain: ○ History ▪ Physical ▪ Mental Health ○ Identification of risks ○ Needs Assessment ▪ Preventive Screens/Timely USPSTF Services ▪ Health Education ○ Physical Exam ○ Diagnosis ○ Treatment Plan ▪ For any diseases ○ 120-Day timeframe for IHA completion (see timeline for children) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Relevant entities (Providers, Members, Caregivers) are informed about the Plan's provision of IHA, including the completion timeframe. The Plan implements QI initiatives to improve IHA completion rates. The Plan implements IHA completion oversight measures (e.g., FSR/MRR).

Requirement	Documentation to Review	Examples of Best Practices
A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.	○ Plan Website » Oversight Documents: ○ IHA Tracking/Monitoring Reports ○ IHA Completion Rates ○ FSR/MRR Scores	
Contract Exhibit A, Attachment III, Section 5.3.3 **IHA General Overview and Outreach Attempts** B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits. C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (Overview of Contractor's Duties and Obligations).	» Policies & Procedures (P&Ps): ○ IHA outreach for scheduling ○ IHAs will be documented in the medical record ○ The IHA can be completed over several visits ○ Timely adherence to USPSTF screenings is encouraged ○ Screenings may be performed during the IHA or at other times within the recommended age or timeframe criteria » Medical Records ○ HIF/MET ○ HRAs, as applicable » Communication/Phone Logs	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical records may document several medical care visits to complete the IHA within 120 days of enrollment. Oversight of IHAs include the Plan's FSR/MRR process.

Requirement	Documentation to Review	Examples of Best Practices
	» Delegation Agreement (if IHA is delegated)	
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** Contractor must cover and ensure 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), W&I section 14132(v), and APL 23-005. 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 California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract. A. Provision of IHA for Members Less Than 21 Years of Age 1. For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.	» Policies & Procedures (P&Ps): ○ The Plan will provide and complete required screenings and assessments, such as: ▪ Blood Lead Screening ▪ ACEs Screening ▪ Risk Assessments ○ The Plan will assign Care Managers (CMs) to ensure care coordination if IHA is not completed ○ Immunizations need to be up to date and can be provided during the IHA visit » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Medical records document the provision of age-appropriate health screenings and immunizations. Relevant entities (Members, Providers) are informed about the Plan's provision of IHA and associated timeframes (120 days). Medical records show timely IHA completion (120 days) for Members <21 years of age. IHAs are discussed in QIHEC meetings.

Requirement	Documentation to Review	Examples of Best Practices
2. For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment. 3. The IHA 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. 4. If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.	» Oversight Documents: ○ MCAS Surveys (immunizations) ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** B. Children's Preventive Services 1. Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic	» Policies & Procedures (P&Ps): ○ The Plan will provide preventive health visits for Members < 21 years at times specified by the most recent AAP Bright Futures Periodicity Schedule with anticipatory guidance as outlined in the Schedule ○ The Plan will make an appointment within 10 working days when a	All documents reviewed demonstrate the Plan's efforts to comply with the requirement for Children's preventive services. During IHA visits, child Members can access preventive services.

Requirement	Documentation to Review	Examples of Best Practices
preventive visit, all age-specific assessments and services required by AAP Bright Futures. 2. Where a request is made for Children's preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, 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.	request for a preventive service is made by the Member, the Members parent, legal guardian or authorized rep, or through a referral » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Medical Records	
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** C. Immunizations 1. Contractor must cover 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 ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory	» Policies & Procedures (P&Ps): ○ PHM Care Management Programs ○ Assigning Care Managers (CM) ○ Documenting and maintaining Care Management Plans (CMP) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's care management programs meet Contract requirements. Relevant entities (Members, Providers) are informed about the Plan's care management programs and the process to access these services. Oversight of the Plan's PHM care management programs is evident, specifically as it relates to screenings and assessments such as an IHA.

Requirement	Documentation to Review	Examples of Best Practices
Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should 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, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is	○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ PHM CM Org Chart ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	

Requirement	Documentation to Review	Examples of Best Practices
required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.		
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** C. Immunizations 3. Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA 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. 4. Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of	» Policies & Procedures (P&Ps): ○ PHM Care Management Programs ○ Assigning Care Managers (CM) ○ Documenting and maintaining Care Management Plans (CMP) » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents: ○ MCAS (Immunizations) ○ Meeting Minutes ▪ QIHEC ▪ Governing Board	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Plan Network Providers report Member-specific vaccination information to immunization registries. The Plan provides information to its Network Providers educating them about the VCF Program (e.g., Providers are encouraged to support enrollment in the VCF Program).

Requirement	Documentation to Review	Examples of Best Practices
whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations. 5. Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.	▪ CAC	
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** D. Screening for Childhood Lead Poisoning 1. Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure 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.	» Policies & Procedures (P&Ps): ○ Provide Blood Lead Screening Tests to child Members at ages specified in APL 20-016 (12 months to 24 months or at 24 to 72 months for no documented lead screening) ○ Documentation (in medical records) or all screenings performed for child Members » Information Dissemination: ○ Provider Manual ○ Newsletters, Education	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's efforts to reach out to Members to schedule an IHA and age-appropriate Preventive Services, including Blood Lead Screening Tests. Relevant entities (Providers, Members) are informed about the need for Blood Lead Screening.

Requirement	Documentation to Review	Examples of Best Practices
a. While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary. b. Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.	○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Medical Records » Blood Lead Screening Records	
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** D. Screening for Childhood Lead Poisoning 2. Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required blood lead screening test. Contractor must identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor must notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required	» Policies & Procedures (P&Ps): ○ Perform quarterly monitoring of Blood Lead Screening tests ○ The Plan will maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually and upon request » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. The Plan identifies Members < 6 years of age with no records of a Blood Lead Level Test and the Plan notifies Network Providers responsible for the Member's care of the missing test, with instructions for Providers to test the Member and provide anticipatory guidance.

Requirement	Documentation to Review	Examples of Best Practices
pursuant to 17 CCR section 37100. For a period of no less than ten years, Contractor must maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.	○ Plan Website » Oversight Documents: ○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC » Blood Lead Monitoring Reports (sent annually to DHCS)	
Contract Exhibit A, Attachment III, Section 5.3.4 **Services for Members Less Than 21 Years of Age** D. Screening for Childhood Lead Poisoning 3. If the Member, or the Member's parent, legal guardian, or AR, refuses the blood lead screening test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, is documented in the Member's Medical Record. 4. If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent, legal guardian, or AR	» Policies & Procedures (P&Ps): ○ Ensure signed statement if refusing Blood Lead Screening Test » Voluntary Refusal Forms » Medical Record ○ Includes documentation of the Plan's outreach and attempts to have Member get the needed Blood Lead Screening Test	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. If Member refuses the Blood Lead Screening Test, then they have the option to sign a refusal note.

Requirement	Documentation to Review	Examples of Best Practices
refuses or declines to sign, or is unable to sign, such as when services are provided through a Telehealth modality, Contractor must ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record. 5. DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment III, Subsection 5.3.4.D. (Services for Members Less Than 21 Years of Age) as evidence of Contractor's compliance with blood lead screening test requirements.		
Contract Exhibit A, Attachment III, Section 5.3.5 **Services for Adults** **A. Initial Health Appointment for Adults Ages 21 and Over** 1. Contractor must cover and ensure that IHAs for adult Members are performed within 120 calendar days of Enrollment. 2. Contractor must ensure that the IHA for adults includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services	» Policies & Procedures (P&Ps): IHA Records will contain: ○ History ○ Physical ○ Mental Health ○ Identification of risks ○ Needs Assessment ○ Preventive Screens/Timely USPSTF ○ Services ○ Health Education	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's effort to comply with IHA requirements. Relevant entities (Providers, Members) are informed about the 120-day timeframe to complete the IHA. Oversight of the Plan's PHM care management programs is evident Verification Study results show compliance with Contract and PHM Policy Guide for IHA requirements. There is documentation of timely

Requirement	Documentation to Review	Examples of Best Practices
Taskforce (USPSTF) grade A and B recommendations.	○ Physical Exam ○ Diagnosis ○ Treatment Plan ○ For any diseases ○ 120-Day timeframe for IHA completion » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ IHA Tracking/Monitoring Reports ○ IHA Completion Rates » Verification Study: Conduct verification study to determine compliance with IHA requirements by evaluating: ○ IHA (New Enrollees) Universe ○ FSR/MRR Scores ○ The Plan's IHA Completion Rate	completion (120 days) of an IHA that includes all required elements: comprehensive history (mental and physical) and physical exam, identification of risks, needs assessment for screening and preventive services, diagnosis and treatment plan of needs, etc.

Requirement	Documentation to Review	Examples of Best Practices
	○ Grievance Logs (IHA-related) ○ Medical Records, including outreach attempts to schedule the IHA	
Contract Exhibit A, Attachment III, Section 5.3.5 **Services for Adults** **B. Adult Preventive Services** Contractor must cover and ensure the provision of all preventive services and Medically Necessary diagnostic and treatment services for adult Members as follows: 1. Contractor must ensure provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF. 2. Contractor must cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. Contractor must ensure that these services are initiated as soon as possible but no later than 60 calendar days	» Policies & Procedures (P&Ps): IHA Records will contain: ○ History ▪ Physical ▪ Mental Health ○ Identification of risks ○ Needs Assessment ▪ Preventive Screens/Timely USPSTF ▪ Services ▪ Health Education ○ Physical Exam ○ Diagnosis ○ Treatment Plan ▪ For any diseases ○ 120-Day timeframe for IHA completion » Information Dissemination: ○ Provider Manual	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's compliance with Adult Preventive Service requirements. The Plan complies with APL 22-025; The Plan provides an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

Requirement	Documentation to Review	Examples of Best Practices
following discovery of a problem requiring follow up. 3. Contractor must comply with APL 22-025 and ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.	○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ IHA Tracking/Monitoring Reports ▪ IHA Completion Rates	
Contract Exhibit A, Attachment III, Section 5.3.5 **Services for Adults** **C. Immunizations** 1. Contractor must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. 2. In addition, Contractor must cover and ensure the provision of age and risk appropriate vaccinations in accordance	» Policies & Procedures (P&Ps): ○ Adult Members need to be up to date with immunizations ○ If unable to give an immunization due to the Member's refusal, document this in the medical records » Information Dissemination: ○ Provider Manual, ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures » Oversight Documents:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. All documents reviewed demonstrate the Plan's efforts to encourage timely immunizations of adult Members.

Requirement	Documentation to Review	Examples of Best Practices
with the findings of the IHA, or other preventive screenings.	○ Meeting Minutes ▪ QIHEC ▪ Governing Board ▪ CAC	

CATEGORY 2.30: CONTINUITY OF CARE FOR SENIORS AND PERSONS WITH DISABILITIES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.12 **General Overview** A. For newly enrolled Seniors and Persons with Disabilities (SPD) who request continuity of care, Contractor must provide continued access for up to 12 months to an out-of-Network Provider with whom the SPD Member has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either Contractor's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I section 14182(b)(13) - (14). Contractor must use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider. B. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 23-022.	» Policies & Procedures (P&Ps): ○ Provision of continuity of care in accordance with APL 23-022 » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Org Chart: Team for processing continuity of care requests ○ Grievance Files ○ Tracking/Monitoring Reports ○ Meeting Minutes ▪ QIHEC ▪ UM ▪ Governing Board	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Documents reviewed demonstrate the Plan meets continuity of care Contract requirements for SPDs in accordance with APL 23-002, as long as the Plan has no quality of care issues with the Provider and the Provider will accept either the Plan's or the Medi-Cal FFS rates. Relevant entities (Providers, Members) are informed about the continuation of care benefit and the process to request/avail of this benefit. VS results show compliance with Contract requirements for the provision of continuity of care services (e.g., medical records document meeting requirements for timeframes, steps of completion, and member notification upon approval of continuity of care request.

Requirement	Documentation to Review	Examples of Best Practices
	▪ CAC » Workflow Diagram for Continuity of Care Process » Verification Study: Conduct a verification study confirming the steps taken by the Plan to meet continuity of care requirements (e.g., timeframes, steps of completion, and member notification upon approval of a continuity of care request.	
Contract Exhibit A, Attachment III, Section 5.2.12 **Pre-Existing Provider Relationships and Completion of Covered Services** C. Contractor must provide for the completion of Covered Services at the request of a Member in accordance with H&S section 1373.96. All Members with pre-existing Provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months with an out-of-Network Provider, if the following criteria are met: 1. The Member has seen the out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;	» Policies & Procedures (P&Ps): ○ Provision of continuity of care in accordance with APL 23-022, including the meeting of criteria that: ▪ The Member has seen the out of network Provider at least once within the 12 months before enrollment with the Plan ▪ The out of network Provider accepts the Plan's rate and meets applicable professional standards and has no	Documents reviewed demonstrate the Plan meets continuity of care Contract requirements for SPDs in accordance with APL 23-002, as long as the Plan has no quality of care issues with the Provider and the Provider will accept either the Plan's or the Medi-Cal FFS rates. Relevant entities (Providers, Members) are informed about the continuation of care benefit and the process to request/avail of this benefit. Oversight of the provision of continuity of care is evident.

Requirement	Documentation to Review	Examples of Best Practices
2. The out-of-Network Provider accepts Contractor's rate offered in accordance with H&S section 1373.96(d)(2) or (e)(2); and 3. The out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.	disqualifying quality of care issues » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Tracking/Monitoring Reports ○ Meeting Minutes ▪ QIHEC ▪ UM ▪ Governing Board ▪ CAC	
Contract Exhibit A, Attachment III, Section 5.2.12 **Person-Centered Planning** D. Contractor must conduct Person-Centered Planning for SPD Members as follows: 1. Upon the Enrollment of a SPD Member, Contractor must provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are	» Policies & Procedures (P&Ps): ○ Upon enrollment, there is person-centered planning that is collaborative and involves reviewing treatment approaches based on health care needs ○ Identification of each SPD Member's preferences and	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Documents reviewed show that the SPD Member received all necessary information regarding treatment and services so that they may make an informed choice. Relevant entities (Providers, Members) are informed about the continuation of care related person-centered planning for SPDs.

Requirement	Documentation to Review	Examples of Best Practices
collaborative and responsive to the SPD Member's continuing health care needs. 2. Contractor must include identifying each SPD Member's preferences and choices regarding treatments and services, and abilities. 3. Contractor must allow or ensure the participation of the SPD Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services. 4. Contractor must ensure that SPD Members receive all necessary information regarding treatment and services so that they may make an informed choice. 5. Complex Case Management services for SPD Members must include the concepts of Person-Centered Planning.	choices regarding treatments and services and abilities ○ If Member is in CCM, then guidelines must include concepts of person-centered planning » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents: ○ Grievance Files ○ Tracking/Monitoring Reports ○ Meeting Minutes ▪ QIHEC ▪ UM ▪ CAC » Medical Records » Care Plan	Oversight of individualized planning during the provision of continuity of care is evident.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III, Section 5.2.12 **Discharge Planning** E. Contractor must ensure the provision of Discharge Planning when a SPD Member is admitted to a hospital or institution and continuation into the post-discharge period. Discharge Planning must include ensuring that necessary care, services, and supports are in place in the community for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the SPD Member and/or caregiver. The minimum criteria for a Discharge Planning checklist must include: 1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received. 2. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD Member or an AR of the SPD Member as applicable, physical and mental function, financial resources, and social supports. 3. Services needed after discharge, the type of placement preferred by the SPD Member or their AR and hospital/institution, type of placement	» Policies & Procedures (P&Ps): ○ The minimum criteria for a Discharge Planning Checking checklist must include: ▪ Documentation of pre-admission status ▪ Pre-discharge factors ▪ Services needed after discharge ▪ Summary of the nature and outcome of the SPD Member's or their authorized rep's involvement in the discharge planning process » Information Dissemination: ○ Provider Manual ○ Newsletters, Education ○ Member Handbook and Newsletters ○ Plan Website ○ Brochures ○ Trainings: Discharge Planning	Documents reviewed demonstrate the Plan met continuity of care related discharge planning requirements (e.g., ensuring that necessary care, services and supports are in place in the community for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the SPD Member and/or caregiver. Oversight of the Plans' continuity of care related discharge planning process is evident.

Requirement	Documentation to Review	Examples of Best Practices
agreed to by the SPD Member or their AR, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD Member or their AR, and the pre-discharge counseling that is recommended. 4. Summary of the nature and outcome of the SPD Member's, or their AR's, involvement in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.	» Oversight Documents: ○ Grievance Files ○ Tracking/Monitoring Reports ○ Meeting Minutes ▪ QIHEC ▪ UM » Medical Records » Care Plan	

CATEGORY 2.31: PREGNANT AND POSTPARTUM MEMBERS

Requirement	Documentation to Review	Examples of Best Practices

Contract Exhibit A, Attachment III, Section 5.3.6
 	
A. Prenatal and Postpartum Care
 	
Contractor must cover and ensure the provision of all Medically Necessary services for Members who are pregnant and postpartum.
 	
Contractor must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure Members receive quality perinatal and postpartum services.
 	
B. Risk Assessment
 	
Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348.
 	
Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/ obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then Contractor must ensure case management and
	» Policies & Procedures (P&Ps):
	  ○ Services for pregnant and postpartum Members includes the utilization of the most current ACOG and CPSP standards, risk assessment, and referrals to specialists
	
	» Information Dissemination:
	  ○ Provider Manual
	  ○ Newsletters
	  ○ Member Handbook and Newsletters
	  ○ Plan Website
	
	» Oversight Documents:
	  ○ Tracking/Monitoring Reports
	  ○ Meeting Minutes
	  ▪ QIHEC
	  ▪ UM
	  ▪ Governing Board
	  ▪ CAC
		P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented.
		
		Documents reviewed demonstrate the Plan meets requirements for pregnant and postpartum Members (e.g., care utilizing the most current ACOG and CPSP standards, risk assessment, and referrals to specialists).
		
		Relevant entities (Providers, Members) are informed about the pregnancy and postpartum benefit and the process to request/avail of this benefit.

Requirement	Documentation to Review	Examples of Best Practices
Care Coordination are working directly with the Member to accomplish the assessment. Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record. The risk assessment may be completed virtually through a Telehealth visit with the Member's consent.	» Medical Records » Verification Study	
Contract Exhibit A, Attachment III, Section 5.3.6 **C. Referral to Specialists** Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives (CNMs), Licensed Midwives, and, are informed about Doula coverage. Pregnant Members may request and receive a recommendation for Doula services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law and receive services. Contractor must ensure that pregnant and postpartum Members receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and must ensure access to genetic screening with appropriate referrals. Members may receive one initial visit; eight visits at any time during the	» Policies & Procedures (P&Ps): ○ Pregnant Members are referred to medically appropriate specialists (perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives (CNMs), Licensed Midwives, and are informed about Doula coverage) » Information Dissemination: ○ Provider Manual ○ Newsletters ○ Member Handbook and Newsletters ○ Plan Website » Oversight Documents:	P&Ps that reflect Contract requirements are established, maintained, reviewed, updated, and implemented. Documents reviewed demonstrate the Plan meets requirements for pregnant and postpartum Members (e.g., pregnant and postpartum Members receive a recommendation for Doula services within one year after pregnancy, if required by the Member, and must ensure access to genetic screening with appropriate referrals).

Requirement	Documentation to Review	Examples of Best Practices
perinatal period; services during labor and delivery, miscarriage, or abortion; and two extended postpartum visits with the standing recommendation issued by DHCS. An additional nine visits during the postpartum period is available with a second recommendation from a licensed provider. Contractor must comply with section 440.130(c) of Title 42 of the Code of Federal Regulations when making a recommendation for Doula services. Doula services are a preventive benefit for Medi-Cal Members, and services include but are not limited to personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.	○ Grievance Files ○ Tracking/Monitoring Reports for Referrals ○ Meeting Minutes ▪ QIHEC ▪ UM ▪ Governing Board ▪ CAC » Medical Records » Verification Study	