PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPCP2007 (previously MCCP2007, MPCP2007)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Complex Case Management</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/20/2012</td><td colspan="4">Next Review Date: 09/10/2026
Last Review Date: 09/10/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/10/2025</td></tr>
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I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MPCP2014 – Continuity of Care
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCAP7002 – CalAIM: Enhanced Care Management (ECM)
F. MCND9001 – Population Health Management Strategy & Program Description
G. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
H. MPQP1038 - Physician Orders for Life-Sustaining Treatment (POLST)
I. MPQP1047 - Advance Directives
J. MPCP2034 - Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A State program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Complex Case Management (CCM): The process of applying evidence-based practices to individual Members to assist them with the coordination of their care and promote their well-being.
C. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
D. HIPAA: The Health Insurance Portability and Accountability Act
E. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.
F. Medical Home: The provider identified as the member's medical home or primary care provider (PCP) is responsible for managing the member's primary care needs.
G. Partnership Advantage: Effective January 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)–approved Dual-Eligible Special Needs Plan (D-SNP)

in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

H. Partnership CC: Partnership HealthPlan of California's Care Coordination department
I. Seniors and Persons with Disabilities (SPD): A group of Medi-Cal beneficiaries who are most vulnerable to adverse health outcomes.
J. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the process by which Partnership HealthPlan of California's (Partnership's) Members are reviewed for the Complex Case Management (CCM) program. CCM is a voluntary program that provides interventions aimed at both improving the Member's self-management of their health, and also increasing appropriate usage of health and medical resources while reducing the inappropriate utilization of healthcare resources. These goals are achieved by working with the Member/caregiver and Member's interdisciplinary care team to do the following:

A. Educate the Member about their benefits with managed care and how to use available resources
B. Identify and help the Member understand their medical condition(s)
C. Support and encourage self-management skills to promote and optimize the Member's personal health goals and well-being
D. Coordinate necessary health care services, and
E. Refer to appropriate medical or social community resources, when applicable

VI. POLICY / PROCEDURE:

A. Identification of Participants
    1. Operating within HIPAA regulations, Partnership proactively identifies Members eligible for CCM services from many data sources that may include:
        a. New Member assessments such as the Health Information Form (HIF), Health Risk Assessment (HRA), or Pediatric Health Risk Assessment (PHRA)
        b. Internal Reports such as:
            1) Weekly Hospital Discharge Report
            2) Monthly Utilization Report
            3) Monthly Pediatric Case Finding Report
        c. Referrals from other Care Coordination interventions when a Member meets the criteria for inclusion in CCM. Examples of services that may provide a source of referral include:
            1) Access to Care
            2) Transitional Care Services (TCS)
            3) Growing Together Program (GTP)
        d. Member/Caregiver self-referral: via telephone, or through Partnership's Member Portal
        e. Provider referral: via telephone or Provider website referral form
        f. External Reports such as:
            1) County CCS enrollment

2) Members served by Targeted Case Management Services

2. Additional Sources of referrals
   a. Partnership performs outreach activities such as meetings and education notices to primary care providers (PCPs) within Partnership's network to discuss the CCM program and to identify Members who may benefit from the program. Partnership's outreach activities extend beyond PCPs; education regarding the CCM program, participant eligibility, and referral process is also shared. Referral sources may also include, but not limited to: :
      1) Internal Department Referrals: Claims, Utilization Management, Pharmacy, etc.
      2) Vendor/Delegated Entity Reports including: Advice Nurse Report, etc.
      3) Specialists
      4) Hospital Discharge Planners
      5) Ancillary Providers
      6) Behavioral Health Specialists
      7) Community Partners (e.g., Case Managers, County Public Health Departments, etc.)
      8) Regional Centers
      9) California Children's Services (CCS)
      10) Enhanced Care Management (ECM) Providers
   b. Members or their caregiver/representative are provided information on the CCM program through Member newsletters, the Partnership Member Portal, from their providers, and through direct outreach by Partnership's Care Coordination team, and may request CCM assistance at any time.

B. Eligibility

To be eligible for CCM services, Members must have Partnership Medi-Cal as their primary health plan be a Partnership Advantage Member, or have an eligible condition for which Partnership may be responsible (e.g., Partnership is secondary). Partnership Members cannot be enrolled in CCM and the ECM benefit simultaneously. For more information on the ECM benefit, see Partnership policy MCAP7002 CalAIM Enhanced Care Management (ECM). Partnership will identify Members who meet at least one of the following criteria as potential candidates for CCM services:

1. Members who have barriers to managing their care without the support of CCM, (e.g., poor support systems, fragmented care, health literacy barriers), or
2. Seniors and Persons with Disability identified as needing CCM to reduce risk of adverse effects, according to the parameters outlined in policy MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services, or
3. Pediatric Members identified as needing CCM to reduce risk factors according to the parameters outlined in policy MCCP2024 Whole Child Model for California Children's Services or
4. One (1) or more California Children's Services (CCS)–eligible conditions and requiring the support of an individualized care plan; or
5. Two (2) or more chronic medical conditions (e.g. Chronic Kidney Disease [CKD], Chronic Obstructive Pulmonary Disease [COPD], Congestive Heart Failure [CHF], Diabetes Mellitus [DM], Hypertension [HTN], hyperlipidemia), and requiring the support of an individualized care plan.

C. Initial Assessment

1. Members identified as candidates for the CCM program will be contacted within 30 days of identification and offered the opportunity to enroll in CCM. If the Member agrees to enrollment, the assigned Partnership Care Coordination (CC) Staff will initiate a detailed assessment of the Member, which will be completed within 60 days of identification. Partnership CC Staff will make two (2) attempts to reach the referred Member by phone, followed by a mailed letter inviting the Member to participate in the CCM program. These three attempts will be completed within 14 calendar days. If the Member does not respond to outreach efforts, the case will be closed. The case may be re-opened at any time should the Member opt in to participation in the program.

2. When a Member agrees to participate in the CCM program, Partnership CC Staff performs a Complex Case Management Assessment to address and document the Member's self-reported health status. This assessment gathers information about the Member, including the Member's medical history (e.g., major procedures and surgeries and the dates these interventions occurred, when known), current medical conditions (e.g., the presence or absence of comorbidities), ability to manage condition-specific issues, caregiver ability and willingness to participate in care, current and past medications (including schedules and doses), mental and behavioral health status, ability to perform self-care, and their engagement in enjoyable activities.
    a. In select cases, the initial assessment may be performed in person.
3. Assessments will be tailored to the needs of the individual Member. Branching logic will be utilized to prevent Members from being asked questions that may not apply (e.g., if a Member says they are completely independent in daily activities, we will not ask if they get help when they need it). In addition to the Adult Complex Case Management Assessment, there is a Perinatal Complex Case Management Assessment for pregnant Members. Pediatric cases will be assessed using a Pediatric Complex Case Management Assessment (through an interview with the Member's parent or caregiver) along with an Age-Specific Questionnaire that will be updated each year to capture developmental and psychosocial changes. In cases where cognition, literacy, or other issues limit a Member's ability to accurately complete the assessment, the staff member will be prompted to seek other means of gathering the appropriate and necessary information to evaluate the Member's needs.
4. All efforts and methods to contact the Member to complete the assessment will be documented in the case management system. In certain events beyond Partnership's control, the CCM assessment may not be completed within 30 days of enrollment in the CCM program. In these instances, the case status will be updated to show the reason for delay/incompletion of the assessment; these circumstances include the following:
    a. Member is hospitalized during the initial assessment period
    b. Member cannot be contacted or reached through telephone, letter, e-mail, or fax after at least three attempts over two or more weeks
    c. Natural disaster
    d. Member is deceased
    e. Member is no longer eligible for Partnership managed care services
5. Through the initial assessment process, Partnership CC Staff will collect, document and review the information below. The information collected during the assessment process will be analyzed by the Partnership CC Staff to develop the Individualized Care Plan (ICP) for the Member. A summary statement of this analysis is captured at either the end of each question or at the end of the Complex Case Management assessment. For any area of the assessment where the information below is considered inappropriate or not applicable to the Member, Partnership CC Staff will indicate an 'N/A' on the assessment next to that question followed by a clear reason or explanation why the assessment was marked N/A. If a Member is unable to recall information on the assessment or refuses to answer a particular question on the assessment, Partnership CC Staff will notate applicable areas.
    a. The referral source and condition that led to the Member's eligibility for CCM.
    b. A comprehensive clinical history of medical conditions based on available medical records from the 30 days prior to referral to the CCM program, and retrieved from provider offices for diagnostic and treatment information, plan of care and medications. Other resources of treatment history may be obtained by Treatment Authorization Requests (TARs), Service Authorization Requests (SARs), and Medical/Pharmacy Claims.
    c. Member's ability to function with or without assistance to perform activities of daily living (e.g., grooming, dressing, bathing, toileting, continence, eating, transferring, walking), caregiver availability and involvement, as well as Member's ability/motivation for self-

management.

d. Age specific questions including developmental milestones, school-related concerns, family interactions, etc.
e. History of alcohol or other substance use disorders along with any treatment(s) for these conditions, as well as the use of tobacco products and willingness to quit.
f. Evaluation of mental health status, memory/retention, and cognition. The Patient Health Questionnaire-2 (PHQ-2) is administered to assess for depression, and how often the Member feels lonely. Questions included in the assessment ask if the Member has trouble getting thoughts out, remembering things, or understanding directions, and Partnership CC staff are prompted to evaluate the Member's understanding and retention throughout the assessment process.
g. Potential social barriers to health that may include Member's education, economic stability, or access to safe housing, transportation, food, social support and the healthcare system.
h. Whether Member has family, caregivers, friends and/or care providers who may help make decisions about Member's health. Partnership CC Staff will explain and offer Advanced Care Directive and Physician's Orders for Life-Sustaining Treatment (POLST) forms to the Member if they do not currently have these forms completed and available for use. See Partnership policies MPQP1047 Advance Directives and MPQP1038 Physician Orders for Life-Sustaining Treatment for more details.
i. Evaluation of language preference, cultural or religious beliefs, health literacy, mental health, cognition, memory and understanding, as well as communication needs that include possible visual and hearing accommodations.
j. Information about available benefits and resources within Partnership and the community. This includes, but is not limited to, information regarding copays or pharmacy benefits, dental benefits, enhanced benefits, the authorization process, and community resources on mental health, wellness, nutrition, transportation, In Home Support Services (IHSS) and palliative care programs. The assessment will also evaluate the Member's awareness of their available benefits and determine whether the benefits and resources available to the Member are adequate to fulfill the treatment plan.
k. The Member's readiness to change existing behaviors to improve their health and which behavior(s)/health condition(s) are the Member's priorities. Included in this assessment is an evaluation of the caregiver's involvement in and decision-making about the care plan, and how adequate that support is for the Member's needs.
l. Provider(s)' treatment plan and objectives.

D. All Partnership CC activities are documented in an electronic case management system that automatically documents the ID of the staff member who completed the activity as well as the date and time completed. Screening and assessment questions and interventions are built on evidenced-based protocols such as the PHQ-2 for depression screening, the Alcohol Use Disorders Identification Test (AUDIT-C) for substance use, etc. Automated prompts direct staff to schedule further assessments and interventions to support the goals of the care plan. The staff user manual includes detailed instructions and workflows for how to perform and document case management activity by program.
E. Upon completion of the assessment, Partnership CC Staff and the Member/caregiver collaborate to develop the person-centered Individualized Care Plan (ICP), comprised of the following:
   1. Identified and prioritized goals (high, medium, low) that address personal, clinical, and psychosocial needs identified during the assessment process. The prioritization of which goals are addressed during the CCM program will be a collaborative decision between Partnership CC staff and the Member/caregiver. Each prioritized goal will be specific, measurable, and have a targeted completion date.
   2. Barriers to achieving each goal are identified by Partnership CC staff or the Member.
   3. Identification of evidence-based interventions to overcome barriers and advance the plan of care.

Reminders to follow up on the interventions can be scheduled for future dates through the case management system and are tracked through system reports.

4. Identification, referral and coordination for community resources beyond the benefits available through Partnership when/where applicable (e.g., Energy Assistance Programs, In-Home Support Services, Meals on Wheels, health education classes, wellness programs, local food banks, parenting/caregiving support programs, etc.).
5. A schedule for when follow-up calls will occur.
    a. Partnership CC staff will attempt to contact Members enrolled in CCM at a minimum of every 30 days. Follow-up calls may be scheduled after:
        1) planned physician visits
        2) transitions across care settings
        3) therapy visits
        4) other scheduled activities
        5) as agreed for follow-up and support
    b. Partnership CC staff will also follow up on referrals to community resources, wellness programs, and other means by which Members may demonstrate increasing self-management and engagement in their care.
6. As the Member's care plan is developed, Partnership CC Staff will educate/reinforce self-management activities that the Member can adopt. The Member/caregiver will select up to three behaviors to target as their self-management plan, to be incorporated into the ICP.
7. Partnership CC Staff sends a confirmation letter to the Member advising of their enrollment into CCM, providing contact information for the CCM team, and giving the Member the option to withdraw from the program at any time. Partnership CC Staff also sends a letter and a copy of the ICP to the Member (if desired) and to the Member's PCP and/or specialist(s) to advise them of their enrollment into CCM and to promote communication between the interdisciplinary care team.
8. A timeline for meeting the overall goals of the ICP. The ICP will be reviewed at scheduled intervals to assess overall progress toward the goals of the care plan. The initial re-evaluation will take place 60 days after enrollment. The case may be closed at this point or remain open for on-going case management for as long as the Member remains with Partnership and has an appropriate medical need.
9. A strategy to ensure communication of care needs across transitions of care, (e.g., hospitalizations, transitioning to a new provider(s), or transitioning from pediatric providers to adult providers).
10. Discussion of health plan benefits, Member's eligibility for these benefits, and any concerns the Member may have with limitations to the benefits.

F. Ongoing Case Management

1. Partnership CC Staff collaborate with the Member and/or the Member's caregiver to help the Member reach the goals outlined in the ICP through the use of Member engagement, motivational interviewing techniques, continual review of the ICP goals, barriers, and overall progress of the case.
2. As the case progresses, goals and barriers and the Member's self-management plan will be reviewed and updated. New goals and behaviors may be identified through the collaboration between the Member/caregiver and Partnership staff. Should a Member be admitted to a facility and have a length of stay longer than 30 days, the Member will be re-assessed after discharge and upon resumption of case management activities.
3. Over the course of the ICP, the Member/caregiver has the opportunity to participate in discussions or decisions about any treatments or services offered. The Member/caregiver may request the involvement of additional family/friends or professionals of their choosing in the case management process. Partnership CC Staff will coordinate family/provider conferences when requested by the Member/caregiver or when the case will benefit from a collaborative multi-disciplinary discussion.
4. Partnership Clinical Supervisors perform case-reviews on the caseloads of their assigned

Partnership CC Staff. Cases are reviewed to ensure adherence to CCM policy, that the Member's ICP is followed, and that barriers to care are addressed in a timely manner. If there are concerns about the trajectory or needs of a specific case, the Clinical Supervisor may escalate the concern to CC Leadership and/or to a Partnership Medical Director.

5. Partnership CC staff maintain frequent communication with the Member/caregiver, PCP, and other members of the Member's care team and support system throughout the duration of the CCM program.
6. In instances where the Member has multiple care coordination services, Partnership will collaborate with other care providers to ensure there is no duplication in services.

G. Case Closure

Partnership CCM services are voluntary and based on active participation from the Member. Members who do not demonstrate active participation, are uncooperative, whose behavior or environment is unsafe for staff, or those who would be better managed in another care program, will be reviewed for disenrollment from CCM services. Partnership Staff may recommend the Member be transitioned to another case management program or that the Member be disenrolled from Partnership's case management. Examples of when Partnership may discontinue CCM services include:

1. The Member elects to participate in CCM services, but after 45 days of enrollment the Member is non-responsive to Partnership's outreach attempts.
2. Agreement by Partnership CC Staff and Partnership Clinical Leadership that the Member is uncooperative as evidenced by not demonstrating consistent adherence to the ICP.
3. Goals and self-management behaviors identified on the ICP have been reached per agreement between Partnership CC Staff and the Member, and the Member has demonstrated readiness to be transitioned from CCM services.
4. Member has been established with their Medical Home as evidenced by one or more visits with Primary Care/Medical Home with additional visit(s) scheduled, and Member/caregiver agrees that their care needs are met in that environment.
5. The Member has been enrolled in Partnership's Enhanced Care Management (ECM) benefit.
6. Members found to have either Severe Mental Illness (SMI) or a Substance Use Disorder (SUD) upon initial assessment will be referred to alternative case management programs according to their county of residence, and CCM interventions will focus on coordination of care between Partnership-contracted providers and the Member's other service providers.
7. Members who have been closed to case management may be considered for re-enrollment if there is a change in their condition or desire to engage in CCM.

H. CCM Services Outcome Measurement

1. Outcomes associated with Partnership's CCM services are reviewed and analyzed no less than annually by Partnership. Tools utilized to analyze CCM program outcomes include:
   a. Aggregate outcomes for member satisfaction surveys received by Partnership
   b. A series of measures that evaluate member utilization data as specified below, and how that data has trended with the intervention of CCM:
      1) Number of ED Visits
      2) Number of Hospital Stays
      3) Total Number of Hospital Days
      4) Number of Outpatient Visits
2. The data will compare three (3) data collection points: the six (6) months prior to CCM program enrollment, six (6) months from the start of CCM services and, when available, the six (6) months after the case has been closed to CCM.
3. Partnership CC Staff will obtain reports from Grievance and Appeals department on member concerns regarding the services they received in the CCM program. Information is to be collected and analyzed in order to help Partnership identify opportunities to better identify candidates for the CCM program, to improve CCM services, and to make timely adjustments to CCM services to better

meet the needs of our Members, providers and communities.

VII. REFERENCES:

A. National Committee for Quality Assurance (NCQA) Health Plan Standards 2025. Population Health Management 5 Complex Case Management
B. Partnership Complex Case Management Assessment
C. The Playbook (2024). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032 Enhanced Care Management Requirements (12/22/2023 *supersedes* APL 21-012)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
N/A

Medi-Cal
05/21/14; 01/20/16; 04/19/17; *02/14/18; 04/10/19; 11/13/19; 04/08/20; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 02/14/24; 09/11/24; 09/10/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Partnership Advantage:
PACP2007, MPCP2007 - 04/16/2008 to 01/01/2013

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

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

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

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