PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MCUP3143</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)</td><td colspan="3">☒ External Policy
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<tr><td colspan="2">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: 01/10/2025
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<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/10/2024</td></tr>
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I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. Community Supports Criteria Matrix and Community Supports HCPCS Code Chart
B. Enhance Care Management HCPCS Code Chart
C. Community Support Services Referral Form

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Original Date: 03/09/2022 Effective Date: 01/01/2022 vs. DHCS	**Next Review Date: 01/10/2025** **Last Review Date: 01/10/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

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

VI. POLICY / PROCEDURE: /

A. ENHANCED CARE MANAGEMENT (ECM)

1. A Treatment Authorization Request (TAR) is required for all members receiving the ECM Benefit.
2. Providers shall submit a TAR to request ECM services electronically or via fax to PHC's Health Services Department for review. Instructions on how to submit a TAR and PHC's TAR processing timelines are described in PHC policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
3. ECM Eligibility Criteria:
   a. Member meets eligibility criteria as outlined in section VI.A. of policy MCCP2032 CalAIM Enhanced Care Management (ECM).
4. ECM TAR Requirements
   TARs submitted to PHC for ECM services shall contain:
   a. Documentation of the ECM Population(s) of Focus that the member meets criteria for
   b. Proposed ECM date(s) of services
      1) Dates should include the initial date of outreach and engagement, as well as the length of service anticipated, up to a maximum of 12 months initially
      2) If additional time or service is necessary, a new TAR shall be submitted
      3) Renewal TARs shall be submitted at least 10 days prior to the end of the prior approval to avoid gaps in care.
      4) Reauthorization will be approved up to a maximum of 6 months
   c. Service codes for ECM as outlined in Attachment B, ECM HCPCS Code Chart.
5. ECM providers are responsible for notifying PHC if a member discontinues ECM services. See PHC Policy MCCP2032 CalAIM Enhanced Care Management (ECM), section VI.F. Discontinuation of ECM.
6. For information on the process for a member, member's authorized representative, or a provider on behalf of a member, to appeal PHC UM decisions, see PHC policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

B. COMMUNITY SUPPORTS (CS)

1. A Treatment Authorization Request (TAR) is required for all members receiving a CS service.
2. Providers shall submit a TAR to request a CS service electronically or via fax to PHC's Health Services Department for review. Instructions on how to submit a TAR and PHC's TAR processing timelines are described in PHC policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
3. PHC is not required to offer CS services to all members in all of its service areas. To see a list of CS services that PHC currently offers, see section VI.A. of policy MCUP3142 CalAIM Community Supports.
4. CS Eligibility Criteria:
   a. To be eligible for a CS service, members must meet the medical necessity criteria outlined for the CS in Attachment A - Community Supports Criteria Matrix and Community Supports HCPCS Code Chart.
   b. PHC shall review all CS TARs on an individual basis to ensure the services requested are appropriate and cost-effective as outlined in DHCS APL 21-017 Community Supports Requirements.
5. CS TAR Requirements:
   a. TARs submitted to PHC for a CS service shall contain:
      1) A Community Support Services Referral Form (Attachment C)

2) Documentation of the medical necessity criteria as outlined in Attachment A.
   a) Depending on the type of CS service(s) requested, additional documentation may be required such as Housing Supportive Plan, Contract and/or Legal Agreement between the landlord and individual, etc.
3) Proposed date(s) of service
4) Service codes for the CS service as outlined in Attachment A.

6. Electronic Visit Verification (EVV) Requirements:
   Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   a. Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator no later than October 19, 2022.
   b. Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.
7. For information on the process for a member, member's authorized representative, or a provider on behalf of a member, to appeal PHC UM decisions, see PHC policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

C. MEMBERS TRANSITIONING FROM ANOTHER MANAGED CARE PLAN (MCP)
1. Members transitioning to PHC from another managed care plan and/or fee-for-service Medi-Cal who are currently receiving ECM and/or CS, shall automatically be authorized for ECM and/or CS.
   a. ECM and/or CS providers are not required to submit a TAR to PHC for transitioning members. For these members, PHC shall enter a presumptive TAR on the provider's behalf.
   b. All TARs submitted after the presumptive TAR must contain the documents required for the services above.
   c. All members continuing ECM and/or CS services must meet criteria as outlined in MCCP2032 CalAIM Enhanced Care Management (ECM) and/or MCUP3142 CalAIM Community Supports (CS)
2. Beginning January 1, 2024, members receiving ECM and/or CS services who are enrolled in the expansion counties transitioning to PHC will automatically be authorized for ECM and/or CS services, for these members:
   a. Under the Continuity of Care for Providers requirement, members may continue to see their out-of-network ECM provider who they have a pre-existing relationship with for up to 12 months. PHC will not require a TAR for transitioning members. For these members, PHC shall enter a presumptive TAR for 12 months.
   b. ECM providers are not required to submit a TAR to PHC for transitioning members. For these members, PHC shall enter a presumptive TAR for six (6) months.
   c. CS providers are not required to submit a TAR to PHC for transitioning members. For these members, PHC shall enter a presumptive TAR for six (6) months on the provider's behalf.
   d. All TARs submitted after the presumptive TAR must contain the documents required for the services above.
   e. All members continuing ECM and/or CS services must meet criteria as outlined in MCCP2032 CalAIM Enhanced Care Management (ECM) and/or MCUP3142 CalAIM Community Supports (CS)

D. WHOLE PERSON CARE TRANSITION TO ECM OR CS
1. Beginning January 1, 2022, PHC shall automatically authorize ECM and/or CS services for member who are identified by the Whole Person Care Lead Entity as eligible and transitioning from a Whole Person Care Pilot.

2. ECM and CS provider are not required to submit a TAR to PHC for transitioning members. For these members, PHC shall enter a presumptive TAR for six (6) months on the provider's behalf.
3. ECM and CS providers shall submit to PHC a renewal TAR ten (10) days prior to the expiration of the presumptive TAR to avoid gaps in care for the member.
   a. All TARs submitted after the presumptive TAR must contain the documents required for services above.
   b. All members continuing ECM and/or CS services must meet the benefit criteria as outlined in MCCP2032 CalAIM Enhanced Care Management (ECM) and/or MCUP3142 CalAIM Community Supports (CS).

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

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) 438.3(e)(2)
B. DHCS CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract
C. DHCS Contract Exhibit A, Attachment 5 Utilization Management and Attachment 6, Provision 13, Ethnic and Cultural Composition
D. DHCS Contract Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals
E. DHCS APL 21-012 Enhanced Care Management Requirements (09/15/2021)
F. DHCS APL 21-017 *Revised* Community Supports Requirements (03/01/2022)
G. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
H. DHCS CalAIM ECM Policy Guide (September 2023)
I. DHCS Medi-Cal CalAIM Community Supports, or In Lieu of Services (ILOS), Policy Guide (July 2023)
J. DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide (09/29/2023)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer; Director of Utilization Management Strategies

X. REVISION DATES: 01/11/23; 06/14/23; 01/10/24

PREVIOUSLY APPLIED TO: N/A

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

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually

- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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

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