Policy and Procedure No: CM 13.4	Revision No: 4
Division: Care Management	
Department: Care Management	
Title: PHC-CA Population Health Management	
Effective Date: 4/26/2023	
Supersedes Policy No: CM 13.0, CM 13.1 CM 13.3	
Reviewed/Revised by: Tiffany Jarrett	Review/Revision Date: 12/3/2025
Approving Committee: Utilization Management Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To define and outline PHC California (the Plan) policies and procedures for the Population Health Management (PHM) Program. The Health Plan has aligned the PHM program with NCQA standards and data elements required to attain Health Plan Accreditation. The PHC California program will be NCQA Health Plan and NCQA Health Equity accredited by 1/1/2026.

Policy:

1. **PHM Program & Framework**

   a. **PHM Program**

   The Plan's PHM Program ensures that PHC California members have access to a comprehensive set of services and resources focused on keeping members healthy, managing members with emerging risks, patient outcomes/safety across settings and managing multiple chronic illnesses. The PHM program is designed to:

   - Build trust with and meaningfully engage members
   - Gather, share, and assess timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes
   - Address upstream drivers of health through integration with public health and social services
   - Support all members in staying healthy
   - Provide care management services for members at higher risk of poor outcomes
   - Provide Transitional Care Services (TCS) for members transferring from one setting or level of care to another
   - Reduce health disparities
   - Identify and mitigate Social Drivers of Health (SDOH)

   b. **PHM Framework**

The PHM Framework includes four domains:

- PHM Strategy and Population Needs Assessment

- Gathering Member Information via initial screenings, claims/encounters, and other data.

- Understanding Risks, which includes the Risk Stratification, Segmentation and Tiering (RSST) process.

- Providing Services and Supports, including Basic Population Health Management, Care Management, and Transitional Care Services

2. Population Needs Assessment (PNA) and PHM Strategy

a. PNA

The PNA is the mechanism that the Health Plan uses to identify the priority needs of our local communities and members to identify health disparities. The Health Plan fulfills the PNA requirement by meaningfully participating in the multi-year cycle of LA County Local Health Jurisdiction (LHJ) Community Health Assessment (CHAs)/and Community Health Improvement Plan (CHIP) and developing shared goal(s) and "SMART" objective(s) that are aligned with DHCS Bold Goals. The Health Plan also:

- Submits an annual DHCS PHM Strategy Deliverable (using the DHCS template) to update DHCS on the progress of this engagement and provide other updates on the PHM Program to inform DHCS' monitoring efforts.

- Remains accountable for meeting cultural, linguistic and health education needs of members, as defined in state and federal regulations.

b. PHM Strategy

The Health Plan's PHM strategy considers the socioeconomic, environmental, genetic and behavioral factors that affect the overall health of a spectrum of people. PHM strategies not only offer continuous and personalized value-based healthcare across a stratified population of patients, but they also reduce the cost of health plans, relieving providers and payers some financial burden by promoting preventive care and lowering complication rates. It is noted that although the Health Plan is not contracted for services or care to members under 21 years of age, individuals who have aged out of foster care age 21-26 will be included in the Population of Focus for Children and Youth. At the center of this strategy are the four pillars of Population Health Management:

c. **Keeping Members Healthy** – focused on the overall health of the member including not only the illness/diagnosis presented but identifies any health-related biases through Health Risk Assessments, Social Determinants of Health, claims, encounters, other data and other supplemental surveys. The Plan's staff of Registered Nurse Care Team Managers (RNCTM), LVN Care Partner, Care Coordinators, Medical Social Worker and Community Health Worker (CHW), work in tandem with the Primary Care Providers (PCP) in our

network of care so that identified issues, concerns, and health biases are identified and resolved.

d. Managing Members with Emerging Risks: The Plan uses NCQA required elements for Risk Stratification & Segmentation and Tiering (RSST), which accesses information given from the Health Information Form (HIF) / Member Evaluation Tool (MET) Initial Health Appointment (formerly Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA), the Health Risk Assessment (HRA), claims, GAP lists and other screening tools to identify members with emerging risks. The HIF/MET and HRA are provided at enrollment with initial risk stratification within 44 days of enrollment using HIF/MET & HRA data if available. Follow-up includes two (2) phone calls within ninety (90) days of enrollment, per DHCS All Plan Letter (APL) 17-013. Note: after the launch of the statewide RSS approach, the Plan will incorporate the RSST methodologies but continue to use its own methods as needed to identify other members who require assessment. At minimum, the Plan will assess members who are identified as high-risk through the PHM Service.

e. The acuity stratification in the current care management software system uses an algorithm based on the data given by members, claims, hospitalizations, ER visits, Medication Adherence, PCP visits and Social Drivers of Health to determine a Low, Moderate or High. This tool stratifies all members at minimum annually, and a change in health status (i.e. hospital/SNF admission).

ACUITY DETERMINATION GUIDELINES DEFINITIONS			
Criteria	**Low -** Population Health Management	**Moderate -**Disease Management	**High/Complex**- Care Management
HIV Viral Load	Undetectable Viral Load	Detectable Viral Load	Increased Viral Load
CD4 count	CD4 Count >500	CD4 Count <200-499	CD4 Count <200
Medication Adherence	ARV Adherence 95% or greater	ARV Adherence 85% or greater	ARV Adherence less than 85%
Hospitalization Acute Utilization	No hospitalization within last 6 months	>1 hospitalization within last 6 months	>2 hospitalization within last 6 months
Emergency Department Utilization	No Emergency Department visits in the past 6 months	>1 Emergency Department visits in the past 6 months	>3 Emergency Department visits in the past 6 months
Substance Abuse or Use/Addiction Disorder	No current abuse or active use/addiction disorder	Active abuse or active use/addiction disorder, not in remission or relapse in last 3 months	Active substance use/addiction disorder
Depression Screening PHQ9 Score	0-4	5-15	16 or greater
Mental Health Conditions (other)	May have diagnosis but no active	Active diagnosis with questions or concerns	Active diagnosis with chief complaints

	complaints or concerns		
Uncontrolled Co-morbidities	3 or less	4 to 6	6 or more
Food Insecurity	Able to access or and obtain steady food supply without assistance	Needs occasional assistance to obtain steady food supply	Needs ongoing assistance in obtaining steady food supply
Interpersonal Security	Feels safe with support system	Has concerns regarding safety and limited support system	Does not feel safe and/or is in need of support system
Housing	Stable Housing	Unstable or transitional Housing	Transitional housing or homeless
Transportation	Access to reliable transportation	Needs occasional assistance in accessing transportation	Unable to gain access to transportation – needs ongoing assistance
Contact Frequency	Quarterly outreach & Annual Reassessment	Bi-Monthly (Q8 weeks) outreach & Annual Reassessment	Monthly outreach & Annual Reassessment

The RNCTM then reviews and adds their clinical expertise to determine agreement with the score or to change with justification. It is noted that once the PHM Service RSST and risk tiering functionalities become available, the Plan will not be manually able to override a risk tier given by the service. Instead, the Plan will work with network providers to collaborate with the member about service needs with the assigned RSST as a starting point, rather than a barrier to services. It is noted that all Plan members receive a Health Risk assessment and RSST.

f. **Member Safety/Outcomes Across Different Settings** Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other 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. The Plan ensures ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact, the RNCTM assists members throughout their transition and ensures all required services are complete. Transitional Care Services include the following requirements:

   i. **Admission, Discharge and Transfer:** The Plan utilizes Health Information Exchange (HIE) platforms (LANES and PointClickCare) so that meaningful real-time information regarding member status during visit, observation or admission to facilities requiring different levels of care. The HIE platforms notify the Utilization Management (UM) and Care Management (CM) teams via

email/portals including the single point of contact assigned RN Care Team Manager.

ii. **Prior Authorizations and Timely Discharges:** The Plan ensures timely prior authorizations and discharges through the Utilization Review processes including use of InterQual guidelines, Medical Director decision and review and Utilization Management RN (UMRN).

iii. **Care Manager Responsible for TCS:** Once a member has been identified as being admitted, the UMRN notifies the RNCTM, who, as noted, is the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

a. For members enrolled in ECM or CCM, the member's assigned ECM Lead Care Manager or CCM care manager provides all TCS.

b. For members who do not already have a care manager through ECM or CCM, the Health Plan non-CCM RNCTM provides TCS.

c. The RNCTM is assigned to the member as point of contact at enrollment and throughout transitional care services. As noted above, the HIE data feed is utilized by the RNCTM so that all information is known as soon as the data is entered into the HIE (usually within 1-1.5 of admission/visit/etc.).

d. The RNCTM will complete the transition of care assessment/survey in the care management software system, contact the member and arrange for a face-to-face visit while in transitional care. In the event, a face-to-face visit is not advised or cannot be accommodated, the RNCTM will call the member, collaborate with the facility discharge planner and UM.

e. Members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager ensures that discharging facilities comply with federal and state discharge planning requirements listed above and that the care manager assists in all care coordination among the discharging facility, the PCP, or any other identified follow-up providers, and the follow-up is complete. .

g. Managing multiple chronic illnesses

The Plan's Chronic Care Model Policy and Procedure PHC-CA Chronic Care Management Program provides Complex Case Management (CCM) to members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. The Plan's ECM CM managed care benefit addresses the clinical and nonclinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services. The Plan supports all members in the Care Management Program. It

is noted that members cannot be enrolled in ECM and CCM at the same time; however, CCM supports members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all members in CCM previously received ECM, and not all members who step down from ECM require CCM.

3. **Assessment/Reassessment**

The Plan uses a Health Risk Assessment Tool (HRA) which has been approved by DHCS and aligns with NCQA standards as meeting needed criteria. All Plan members receive the HRA, Acuity Determination and Plan of Care which is in accord with the mandated requirements by federal and/or state law, by NCQA, or by DHCS' new PHM requirements. Populations required to receive an assessment include:

- Those with long-term services and supports (LTSS) needs
- Those entering CCM
- Those entering ECM
- Pregnant individuals in accord with American College of Obstetricians and Comprehensive Perinatal Services Program (CPSP) Standards per Title 22 CCR
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing DHCS APL requirements, namely:
  - Members who have been authorized to receive:
    - IHSS greater than, or equal to, 195 hours per month
    - Community-Based Adult Services (CBAS)
    - Multipurpose Senior Services Program (MSSP) Services
  - Members who:
    - Have been on oxygen within the past ninety (90) days
    - Are residing in an acute hospital setting
    - Have been hospitalized within the last ninety (90) days or have had three (3) or more hospitalizations within the past year
    - Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
    - Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness)
    - Have end-stage renal disease, acquired immunodeficiency syndrome

(AIDS), and/or a recent organ transplant

- Have cancer and are currently being treated;
- Are pregnant
  - *Because Plan members who become pregnant are considered High Risk, they are referred to Specialized High Risk Pregnancy Care.
- Have been prescribed antipsychotic medication within the past ninety (90) days
- Have been prescribed fifteen (15) or more prescriptions in the past ninety (90) days
- Have a self-report of a deteriorating condition
- Have other conditions as determined by the Plan, based on local resources

The Health Plan completes a reassessment for all members annually or upon change in clinical status.

4. PHM Program Services & Support

Basic Population Health Management (BPHM) is an approach to care that ensures needed programs and services are made available to each member, regardless of the member's risk tier, at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all Plan members receive BPHM, regardless of their level of need. BPHM includes access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs), wellness and prevention programs, chronic disease programs and programs focused on improving maternal health outcomes. The Plan, in collaboration with the PCP, follows all members through telephone outreach, telehealth, or face to face visits to ensure all members have access to and are utilizing primary care. Positive screenings in the assessment result in more in-depth surveys and follow-up and a higher stratification level. BPHM is described to qualifying members as Basic Care Management. Members do have the ability to opt out of the program but understand they will be able to receive care management for utilization such as hospitalization. The required elements of BPHM are addressed as follows:

a. Access, Utilization, and Engagement with Primary Care

To ensure all members have access to and are utilizing primary care the RNCTM and Care Coordination Team:

- Ensure members have an ongoing source of primary care

- Ensure members are engaged with their assigned PCPs (such as helping to make appointments, arranging transportation, and providing health education on the importance of primary care)

- Identify members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity

- Develop strategies to address different utilization patterns

- Ensure non-duplication of services.

- Culturally and Linguistically Appropriate Services (CLAS) standards are followed by all Plan staff. Annual educational courses are required including Applying Concepts of Cultural Competency (2 parts). The Language line is available for use by all staff ensuring that communication can be completed in the member's preferred language.

b. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports
To ensure seamless experience for members, the RNCTM and Care Coordination Team:

   - Ensure members have access to services addressing developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

   - Partner with primary care and other delivery systems to guarantee that members' needs are addressed. This includes:

      - Ensuring that each member's assigned PCP plays a key role in coordination of care
      - Ensuring each member has sufficient care coordination and continuity of care with out-of-network providers
      - Communicating with all relevant parties on the care coordination provided
      - Assisting members in navigation, provider referrals, and coordination of health and services across health plans, settings, and delivery systems

   - Coordinate warm handoffs with local health departments and other public benefits programs, as specified in collaborative Memorandums of Understanding (MOUs) with county agencies.

c. Closed-Loop Referrals

To increase the share of members successfully connected to the services they need the RNCTM and Care Coordination Team:

   - Utilizes a closed loop referral (CLR) process to identify and close gaps in referral practices and service availability

- Ensure that referrals that are initiated on behalf of a member are tracked, supported, monitored and results in a known closure

d. Information Sharing and Referral Support Infrastructure.
The RNCTM and Care Coordination Team ensure that information sharing and a referral support infrastructure are met using the EMR when appropriate to care, a weekly Interdisciplinary Team Meeting (ICT) and case management software system.

e. Integration of Community Health Workers (CHWs) in PHM.
CHWs may be able to address a variety of health and health-related issues, including, but not limited to: supporting members' engagement with their PCP, identifying and connecting members to services that address SDOH needs, promoting wellness and prevention, helping members manage their chronic disease, and supporting efforts to improve maternal and child health. CHWs may include individuals known by a variety of job titles, including promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

  - Community Health Workers are integrated into the Care Coordination team and provide support as outlined in Community Health Worker guidelines and detailed in the Plan's Policy and Procedure PHC-CA 41.0 Community Health Worker Service Benefit and are outlined in the CHW Integration Plan (see **Attachment** "A").

f. Wellness and Prevention Programs
The Health Plan provides comprehensive wellness and prevention programs that, at minimum, meet NCQA requirements, including offering evidence-based self-management tools that include, but are not limited to, smoking cessation programs, exercise, healthy eating, healthy weight (BMI) maintenance, managing stress, at-risk alcohol use and identifying depressive symptoms. The HRA addresses these areas and are reinforced when members are contacted. Wellness and prevention strategies are designed to align with community-specific information in the Population Needs Assessment and to drive improvement in DHSC-identified Clinical Focus Areas and BOLD Goals when applicable to the Health Plan's specific population.

g. Programs Addressing Chronic Disease.

  - The Health Plan offers evidence-based disease management programs in line with NCQA requirements at a minimum. The PCP, RNCTM and Care Coordination team incorporate health education interventions, identify members for engagement, and seek to close care gaps for the cohorts of members participating in the interventions with a focus on improving equity and reducing health disparities. These programs specifically address HIV/AIDS, diabetes, cardiovascular disease, asthma and depression, at minimum.

  - Chronic Disease and Maternal Health are part of the Model of Care and Plan Policy and Procedure PHC-CA Chronic Care Model and PHC-CA Provisions of Service for Pregnant Women. Plan members' specific needs (members have a diagnosis of HIV/AIDS), targeted care related to HIV is embedded in the care

management of all co-morbidities including Diabetes, Cardiovascular disease, Asthma and Depression. Because of the HIV/AIDS diagnosis, all pregnant members are considered high-risk and are referred to an OBGYN specialist for care. For those members, care management continues by the RNCTM with focus on maternal health. Members do have the ability to opt out of the program but understand they will be able to receive care management for utilization such as hospitalization.

5. **Complex Care Management (CCM**) PHM provides members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. The Plan approach to CCM, as part of our Chronic Care Model, will integrate with the PHM model to provide CCM. There are multiple avenues of referrals to CCM, including, but not limited to, self/caregiver referrals, provider referrals, referrals from Utilization Management, Care Management, or Enhanced Care Management staff, and referrals from facility discharge planners. Members do have the ability to opt out of the program but understand they will be able to receive care management for utilization such as hospitalization.

Every member receiving CCM is assigned a care manager. The role and responsibilities of the RNCTM / CCM Care Manager: coordinate the Interdisciplinary Care Team (ICT), oversee the comprehensive Health Risk Assessment process, which includes identifying and closing any gaps in care, lead the development and implementation of the member's individual care plan (ICP), implementation of ICP interventions, monitor member progress in the attainment of ICP goals, provide direct educational support and coordinate group educational experiences with the Health Educator, and integrate the ICP with the Care Coordination team to produce a fully integrated approach to individual member care coordination. He or she must maintain a current RN license. Responsibilities and oversight include:

- Care coordination focused on longer-term chronic conditions
- Interventions for episodic, temporary member needs
- Disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education
- Community Supports, if available and medically appropriate, and cost-effective
- Coordinate and lead the ICT
- Coordinates care management between medical and behavioral health providers, members of the ICT and the memberDirect members' care through the ICP
- Educates the member on self-management and supports the member in empowering them to become active participants in determining their plan of care.
- Conducts an HIF within ninety (90) days and an HRA within forty-five (45) days of enrollment
- Conducts an annual HRA within a year from the members' last HRA.
- Conducts nursing assessments when there are significant changes in the member's health status outside of the standard annual HRA. Assign Acuity level (risk assessment) based upon the HRA algorithm and clinical expertise which determines the minimum frequency of member contacts
- Develops an ICP based upon the HRA, transition or change in health condition with input from the member, member family/support system where appropriate, medical providers, ICT and allied health providers.

- Facilitates and monitors the implementation of the individualized care plan interventions and attainment of goals.
- Provides education and reinforcement of techniques to self-manage chronic medical and behavioral health conditions
- Facilitates access to specialists and treatment as needed or when requested
- Makes referrals to behavioral health providers and collaborates with behavioral health care management as appropriate
- Coordinates care across different settings and providers to ensure non-duplication of services
- Works with member to schedule or facilitate scheduling appointments and follow-up services when necessary.
- Assures care and pharmacotherapy are delivered as planned by the interdisciplinary team
- Triage members' care needs
- Identify and facilitate access to community resources and social services
- Advocate, inform and educate members on services and benefits
- Conducts Medication Therapy Management Program processes (Comprehensive Medication Review) as part of an Initial Health Risk Assessment and as clinically necessary.
- Assesses members' medication adherence and communicates needs to medical provider when necessary.
- Consults and collaborates with Plan Pharmacist as part of ICT and for medication concerns as needed.
- Participates in the Transition of Care (TOC) process. Educates members on transition plans, and contacts or visits patients transitioning from acute care settings.
- Documents all member encounters through session notes in the care management software system.

6. Enhanced Care Management (ECM)

ECM is a statewide managed care benefit that addresses the clinical and non-clinical needs of Medi-Cal's highest-need members through intensive coordination of health and health-related services.

- The Health Plan contract with ECM providers to ensure that eligible members receive community-based, interdisciplinary, high touch, person-centered services that are primarily through in-person interactions

- The Lead Care Manager meets members wherever they are – on the street, in a shelter, in their doctor's office, or at home

7. Transitional Care Services

The Health Plan provides strengthened TCS for all members across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports.

- Members are assigned to an RNCTM, who serves as a single point of contact, and assists members throughout their transition and ensures all required services are completed and addressed in this policy under Member Safety/outcomes across

different settings.

- The RNCTM performs TCS tasks such as ensuring that medication reconciliation is completed upon discharge by the discharging facility, and that every member has follow-up care by a provider, including another medication reconciliation completed post-discharge to reduce medication discrepancies, errors, and adverse drug events.

- Emergency Department (ED) visits are included in TCS

.

8. Multiple payors

Consistent with the policy that the MCP is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the Plan RNCTM is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the Plan is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MCP. For all members enrolled with multiple payors undergoing any transition, MCPs must know when their members are admitted, discharged, or transferred; the Plan meets this requirement by the use of the Health Information Exchange as noted in this policy under 1Ci. The RNCTM and Utilization Management RN are notified and collaborate together with the Medical Director of admissions, discharges, and transfers. The UM department processes prior authorizations and coordinate, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor.

Requirements for Members Dual-Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):

For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Medi-Cal MCP is not responsible for assigning a transitional care manager or any transitional care manager responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the MCP is responsible for notifying that care manager of the admission, discharge or transfer.

Requirements for When County MHPs or DMC-ODS Are the Primary Payors:

For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge.

Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:

For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital): the Plan Utilization team and assigned RNCTM are responsible for all TCS during the transfer/discharge to the behavioral health facility. TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete. After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, the Plan follows the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

9. PHM Implementation Monitoring

a) Beginning in Q4 2025, DHCS reviews the holistic performance of the Heath Plan's PHM Program implementation through monitoring performance across multiple PHM categories. These categories are organized by the following monitoring domains:

PHM program areas/themes, populations, and cross-cutting priorities

i) PHM Program Areas/Themes

(1) Basic Population Health Management (BPHM)

(a) Prevention Services
(b) Primary Care Engagement/ Appropriate Utilization
(c) Chronic Disease Management
(d) CHW Integration
(e) Risk Stratification Segmentation and Tiering (RSST)
(f) Complex Care Management (CCM)
(g) Enhanced Care Management (ECM)
(h) Transitional Care Services (TCS)

(2) Populations

(a) Children and Youth
(b) Birthing Populations
(c) Individuals with Behavioral Health Needs

(3) Cross Cutting Priorities

(a) Equity (include all stratified measures)

b) As of Q4 2025, DHCS-defined KPIs and MCAS measures will be monitored to determine the Health Plan's PHM Program's impact on outcomes and access to services.

i) The reporting frequencies for different KPIs for PHM monitoring are as follows:

(1) PHM Monitoring KPIs: Quarterly

(2) MCAS measures: No additional reporting mechanisms or cadence are required.

(3) The Plan uses our own data and Key Performance Indicators (KPIs) to continuously assess the efficacy of our programs and wellness and prevention approaches, to gain an internal understanding of the impact on quality and equity for the groups served by the intervention until the Q4 2025 go live date..

c) The Plan has held certification by the Accreditation Association for Ambulatory Health Care (AAAHC) since 2011 and the re-accreditation survey was successfully passed June 2023 for a three (3) year duration through June 2026.

d) The Plan is currently participating in the NCQA Health Plan and NCQA Health Equity Accreditation surveys and expect certification by the end of 2025. Both surveys will be completed to meet the 1/1/26 deadline for both certifications.

10. Community Services

a. The Plan shall establish Memorandums of Understanding (MOU) with the Los Angeles County Department of Social Services (DPSS) to effect closed loop referrals for CalWORKs, CalFresh (formerly SNAP), Women, Infants and Children (WIC), and Supplemental Security Income (SSI) by January 2025 pursuant to CalAIM Population Health Management Policy Guideline 9/2022 and DHCS APL 22-005.

b. The Plan has or shall establish MOUs with AHF Healthy Housing, Angel Food, Project Room Key, APLA, Volunteers of America, Catalyst Foundation, Mom’s Meals, Wright Homecare and Envoy Homecare beginning January 2024.

11. Documentation

Health Plan Care Management & Utilization Management staff, as well as AHF ECM staff documents in a care management software system that supports:

a. Evidence-based clinical guidelines or algorithms to conduct assessment and management.

b. Automatic documentation of staff name, and the date and time of action on the case or when interaction with the member occurred.

c. Automated prompts for follow-up, as required by the case management plan

Procedure:

The following procedures guide the PHC Care Management team in the provision of Population Health Management (PHM) services for all members:

1. PHM Program Implementation

- Establish and maintain a multidisciplinary PHM team including RN Care Team Managers, LVN Care Partners, Care Coordinators, Medical Social Workers, and Community Health Workers.
- Ensure all PHM staff are trained in NCQA standards, PHM framework domains, and data collection protocols.

- Engage members through culturally and linguistically appropriate outreach strategies to build trust and encourage participation in PHM services.

2. Data Collection and Risk Identification

- Collect member data from multiple sources including:
  - Health Information Form (HIF) / Member Evaluation Tool (MET)
  - Health Risk Assessment (HRA)
  - Claims and encounter data
  - GAP lists and supplemental surveys
- Conduct initial risk stratification within forty-four (44) days of member enrollment using available HIF/MET and HRA data.
- Complete two (2) follow-up phone calls within ninety (90) days of enrollment, per DHCS APL 17-013
  .
- Apply predictive analytics and standardized assessment tools to identify members with emerging risks and gaps in care.

3. Risk Stratification and Tiering (RSST)

Use NCQA-compliant RSST methodologies to segment members into risk tiers (Low, Moderate, High).

Update stratification annually or upon significant changes in health status (e.g., hospitalization, SNF admission).

Incorporate statewide RSS methodology when launched, while maintaining Plan-specific stratification tools as needed.

4. Service Delivery

- Provide services across four PHM domains:
  - Keeping Members Healthy: Preventive care, health bias identification, and resolution through PCP collaboration.
  - Managing Emerging Risks: Targeted interventions for members identified through RSST.
  - Care Management: Personalized support for high-risk members.
  - Transitional Care Services (TCS): Coordination during transitions between care settings.
- Address Social Drivers of Health (SDOH) through integration with public health and social service agencies.

5. Population Needs Assessment (PNA)

- Participate in LA County LHJ Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) cycles.
- Develop shared goals and SMART objectives aligned with DHCS Bold Goals.
- Submit annual PHM Strategy Deliverable to DHCS using the required template.

- Ensure compliance with cultural, linguistic, and health education standards per state and federal regulations.

6. Monitoring and Evaluation

- Conduct regular audits of PHM activities to ensure alignment with NCQA standards and accreditation goals.
- Track performance metrics related to member engagement, health outcomes, and disparity reduction.
- Document all PHM activities, assessments, and interventions in the care management system for reporting and quality improvement.

7. Risk Tier Review and Clinical Validation

- After initial RSST scoring, the assigned RN Care Team Manager (RNCTM) reviews the member's clinical data and applies professional judgment to validate or adjust the risk tier.
- Any changes to the RSST score must be documented with clinical justification in the care management system.
- Once the PHM Service RSST functionality is fully implemented, manual overrides of risk tiers will no longer be permitted.
- The RNCTM will collaborate with network providers to ensure member needs are addressed using the assigned RSST tier as a guide—not a barrier—to services.
- All Plan members will continue to receive a Health Risk Assessment (HRA) and RSST as part of their care management onboarding.

8. Transitional Care Services (TCS)

a. Admission, Discharge, and Transfer Monitoring

- The Plan uses Health Information Exchange (HIE) platforms (LANES and PointClickCare) to receive real-time alerts on member admissions, discharges, and transfers.
- Notifications are sent to Utilization Management (UM) and Care Management (CM) teams, including the assigned RNCTM.

b. Prior Authorization and Discharge Coordination

- UM staff ensure timely processing of prior authorizations using InterQual guidelines and Medical Director review.

Discharge planning is coordinated with facilities to prevent delays and ensure continuity of care.

c. RNCTM Role in TCS

- Upon notification of admission, the UMRN alerts the RNCTM, who becomes the single point of contact for the member throughout the transition.
- The RNCTM uses HIE data to track member status and initiate transitional care services within 1–1.5 days of admission.
- The RNCTM completes a transition of care assessment in the care management system and contacts the member to arrange a face-to-face visit.
- If an in-person visit is not feasible, the RNCTM will conduct a phone assessment and coordinate with the facility discharge planner and UM team.

- If a member declines contact, the RNCTM ensures discharge planning compliance and coordinates follow-up with the PCP and other providers.

d. Assignment Based on Program Enrollment

- Members enrolled in ECM or CCM receive TCS from their assigned ECM Lead Care Manager or CCM Care Manager.
- Members not enrolled in ECM or CCM receive TCS from the Health Plan's RNCTM.

9. Chronic Illness Management

- Members with multiple chronic conditions are assessed for enrollment in Complex Case Management (CCM) or Enhanced Care Management (ECM).
- Members cannot be enrolled in both ECM and CCM simultaneously.
- Members transitioning out of ECM may be considered for CCM if ongoing support is needed.
- CCM provides both long-term chronic care coordination and short-term interventions to improve health outcomes and functional status.
- ECM addresses both clinical and nonclinical needs for the highest-risk Medi-Cal members through intensive service coordination.

10. Assessment and Reassessment

a. Initial Assessment

- All Plan members receive a Health Risk Assessment (HRA), Acuity Determination, and Plan of Care upon enrollment.
- The HRA tool is approved by DHCS and meets NCQA standards.
- The Health Plan's Care Management staff also assesses the characteristics and needs of the member population, including social determinants of health (SDOH), the needs of members of racial or ethnic groups, and the needs of members with limited English proficiency.
- Assessment data is used to inform RSST scoring and care planning.

b. Required Populations for Assessment

- Members with LTSS needs
- Members entering CCM or ECM
- Pregnant individuals (per CPSP and Title 22 CCR)
- Seniors and persons with disabilities
- Members with recent hospitalizations, ER visits, or high medication usage
- Members with behavioral health diagnoses, developmental disabilities, or social risk factors
- Members with serious medical conditions (e.g., ESRD, AIDS, cancer, organ transplant)
- Members serious mental illness or serious emotional disturbance / prescribed antipsychotic medications in the past 90 days
- Members prescribed 15+ prescriptions in the past 90 days
- Members self-reporting deteriorating health
- Other members identified by the Plan based on local needs and the needs of relevant member subpopulations

c. Reassessment

- All members are reassessed annually (including the HRA & SDOH surveys) or upon a significant change in clinical status.
- Updated assessments are documented in the care management system and used to adjust care plans and risk stratification as needed.

11. Member Outreach and Engagement

- Conduct outreach to all members via telephone, telehealth, or face-to-face visits to assess primary care engagement and overall health needs.
- Document all outreach efforts in the care management system, including member preferences, barriers to care, and follow-up actions.
- Provide education on the importance of primary care and preventive services during outreach interactions.
- Offer members the opportunity to opt out of BPHM while informing them of continued eligibility for care management during high utilization events (e.g., hospitalization).

12. Access, Utilization, and Engagement with Primary Care

- Ensure each member has an assigned Primary Care Provider (PCP) and an ongoing source of primary care.
- Assist members with scheduling PCP appointments and arranging transportation when needed.
- Use utilization reports and enrollment data—stratified by race and ethnicity—to identify members not actively using primary care.
- Develop targeted strategies to address disparities in utilization, including culturally tailored outreach and education.
- Monitor for duplication of services and coordinate efforts to streamline care delivery.
- Ensure all staff adhere to Culturally and Linguistically Appropriate Services (CLAS) standards:
    - Complete annual training on cultural competency.
    - Use Language Line services to communicate in the member's preferred language.

13. Care Coordination, Navigation, and Referrals

- Provide navigation support to help members access services across the full spectrum of health and social needs, including:
    - Developmental, physical, and behavioral health
    - Substance use disorder (SUD) treatment
    - Dementia and long-term services and supports (LTSS)
    - Palliative care, oral health, vision, and pharmacy
- Partner with PCPs and other providers to ensure coordinated care:
    - Confirm PCP involvement in care planning and referrals.
    - Facilitate continuity of care with out-of-network providers.
    - Communicate care coordination activities with all relevant stakeholders.
- Assist members in navigating health systems and public benefit programs.
- Coordinate warm handoffs to county agencies and local health departments per established Memorandums of Understanding (MOUs).

14. Closed-Loop Referral (CLR) Process

- Initiate referrals based on member needs identified during assessments or care coordination.
- Track each referral from initiation to closure using the care management system.
- Follow up with referral partners to confirm service delivery and address any barriers.
- Ensure that referral outcomes are documented and that members are successfully connected to services.
- Monitor referral completion rates and identify gaps in service availability for continuous improvement.

15. Positive Screening Follow-Up

- When a member's assessment results in a positive screening (e.g., for SDOH, behavioral health, or chronic conditions):
  - Administer more in-depth surveys to gather additional information.
  - Reassess the member's risk tier using updated data.
  - Initiate appropriate care coordination or escalate to Complex Case Management (CCM) or Enhanced Care Management (ECM) as needed.

16. Information Sharing and Referral Support Infrastructure

To ensure seamless coordination and continuity of care, the RN Care Team Manager (RNCTM) and Care Coordination Team follow these procedures:

- **Electronic Medical Record (EMR) Use**
  - Access and document member health information in the EMR when appropriate to care delivery.
  - Ensure timely updates to member records to reflect assessments, referrals, and care coordination activities.
- **Weekly Interdisciplinary Team (ICT) Meetings**
  - Participate in weekly ICT meetings to review complex cases, share updates, and align care strategies across disciplines.
  - Include representatives from medical, behavioral health, social services, and community-based organizations as needed.
  - Document meeting outcomes and action items in the case management system.
- **Case Management Software System**
  - Use the system to track member assessments, care plans, referrals, and service outcomes.
  - Ensure closed-loop documentation for all referrals and follow-ups.
  - Maintain real-time visibility into member status and service engagement across the care team.
- **Referral Support Infrastructure**
  - Initiate, monitor, and close referrals using standardized workflows.

- Collaborate with internal and external providers to ensure timely service delivery.
- Identify gaps in referral networks and escalate unresolved needs to leadership for system-level solutions.

17. Integration of Community Health Workers (CHWs)

To enhance member engagement and address social and clinical needs, the Plan integrates CHWs into the PHM Program through the following procedures:

- **Team Integration**
  - CHWs are embedded within the Care Coordination Team and participate in member outreach, education, and navigation.
  - Roles and responsibilities are defined in PHC-CA 41.0 Community Health Worker Service Benefit and the CHW Integration Plan (Attachment "A").
- **Member Engagement and Support**
  - CHWs assist members in engaging with their PCPs, including appointment scheduling, transportation coordination, and health literacy support.
  - Promote wellness and prevention programs, including chronic disease self-management and maternal health initiatives.
- **Addressing Social Drivers of Health (SDOH)**
  - Identify unmet social needs through assessments and member interactions.
  - Connect members to community resources such as housing, food assistance, employment services, and violence prevention programs.
  - Track referrals and outcomes using the case management system and closed-loop referral protocols.
- **Culturally Responsive Outreach**
  - CHWs reflect the communities they serve and provide culturally and linguistically appropriate support.
  - Use member-preferred communication methods and languages to build trust and improve service uptake.
- **Monitoring and Evaluation**
  - CHW activities are tracked and evaluated for impact on member outcomes, engagement, and disparities reduction.
  - Data is used to inform program improvements and report to stakeholders.

18. Wellness and Prevention Programs

To promote member well-being and prevent the onset or worsening of chronic conditions, the Health Plan implements the following procedures:

- **Health Risk Assessment (HRA) Integration**
  - Administer the HRA to all members at enrollment and during reassessment cycles.

- Use HRA results to identify needs related to smoking cessation, physical activity, nutrition, stress management, alcohol use, and depressive symptoms.
- Reinforce HRA findings during member outreach and care coordination contacts.

- **Evidence-Based Self-Management Tools**
  - Offer programs that meet NCQA standards, including:
    - Smoking cessation support
    - Exercise and fitness guidance
    - Healthy eating education
    - Stress reduction techniques
    - Screening and support for at-risk alcohol use
    - Depression identification and referral
  - Provide access to these tools via telehealth, in-person sessions, printed materials, and digital platforms.

- **Member Engagement and Education**
  - RNCTMs and Care Coordinators educate members on available wellness programs during outreach.
  - Track participation and outcomes in the care management system.
  - Refer members to additional services based on screening results and expressed interest.

19. Programs Addressing Chronic Disease

To improve outcomes and reduce disparities among members with chronic conditions, the Health Plan follows these procedures:

- **Disease Management Program Delivery**
  - Implement evidence-based programs for HIV/AIDS, diabetes, cardiovascular disease, asthma, and depression.
  - Ensure alignment with NCQA standards and integrate health education into care coordination.

- **Multidisciplinary Team Coordination**
  - PCPs, RNCTMs, and Care Coordinators collaborate to:
    - Identify members for program enrollment
    - Close care gaps through targeted interventions
    - Monitor progress and adjust care plans as needed

- **Equity and Disparity Reduction**
  - Stratify member data by race, ethnicity, and social determinants to identify disparities.
  - Tailor interventions to address barriers and promote equitable access to care.

- **Maternal Health Integration**
  - For members with HIV/AIDS who are pregnant:
    - Refer to OBGYN specialists for high-risk prenatal care
    - Continue care management through RNCTM with a focus on maternal health
    - Coordinate services for co-morbidities including diabetes, cardiovascular disease, asthma, and depression
  - Document all maternal health interventions in the care management system.
- **Opt-Out Protocol**
  - Inform members of their right to opt out of chronic disease programs.
  - Ensure continued care management for high utilization events such as hospitalization.

20. Complex Care Management (CCM)

To support members with complex health needs who are not eligible for ECM, the Plan implements the following CCM procedures:

1. **Referral Pathways**
   a. Accept referrals from:
      i. Members or caregivers
      ii. PCPs and other providers
      iii. Utilization Management and Care Management staff
      iv. ECM staff
      v. Facility discharge planners
   b. Document referral source and reason in the care management system.
2. **Care Manager Assignment**
   a. Assign each CCM member a dedicated RNCTM or CCM Care Manager.
   b. Ensure the Care Manager holds a current RN license and is trained in PHM and CCM protocols.
3. **Interdisciplinary Care Team (ICT) Coordination**
   a. Lead weekly ICT meetings to review member progress and adjust care plans.
   b. Include input from medical, behavioral health, and social service providers.
4. **Health Risk Assessment and Individual Care Plan (ICP)**
   a. Conduct a comprehensive HRA upon enrollment and reassessment.
   b. Develop and implement an ICP tailored to the member's needs and goals.
   c. Monitor progress toward ICP goals and update interventions as needed.

5. **Education and Support**

    a. Provide direct education to members on managing their conditions.
    b. Coordinate group education sessions with Health Educators.
    c. Track educational engagement and outcomes.

6. **Integrated Care Coordination**

    a. Align ICP activities with broader PHM strategies.
    b. Ensure seamless communication across the Care Coordination Team.
    c. Document all care coordination activities in the case management system.

    d. Additionally, CCM procedures include:

        i. Initial assessment of member health status, including condition-specific issues.
        ii. Documentation of clinical history, including medications.
        iii. Initial assessment of the activities of daily living.
        iv. Initial assessment of behavioral health status, including cognitive functions.
        v. Initial assessment of social determinants of health.
        vi. Initial assessment of life-planning activities.
        vii. Evaluation of cultural and linguistic needs, preferences or limitations.
        viii. Evaluation of visual and hearing needs, preferences or limitations.
        ix. Evaluation of caregiver resources and involvement.
        x. Evaluation of available benefits.
        xi. Evaluation of community resources.
        xii. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.
        xiii. Identification of barriers to the member meeting goals or complying with the case management plan.
        xiv. Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.
        xv. Development of a schedule for follow-up and communication with members.
        xvi. Development and communication of a member self-management plan.
        xvii. A process to assess member progress against the case management plan.

21. Care Coordination for Chronic and Episodic Needs

- **Long-Term Chronic Condition Management**
    - RNCTMs coordinate care for members with chronic conditions using the Chronic Care Model.
    - Develop and monitor Individualized Care Plans (ICPs) based on HRA results, clinical assessments, and member input.
    - Ensure continuity of care across settings and providers, avoiding duplication of services.
    - Facilitate access to specialists and community supports when medically appropriate and cost-effective.

- **Episodic and Temporary Interventions**

    - Identify members with short-term needs due to acute episodes, transitions, or social disruptions.
    - Provide time-limited care coordination and support to stabilize health and connect members to appropriate services.
    - Reassess members post-intervention to determine ongoing care needs or discharge from CCM.

- **Disease-Specific Management Programs**

    - Implement evidence-based programs for asthma, diabetes, HIV/AIDS, cardiovascular disease, and depression.
    - Provide self-management education and health literacy support.
    - Track member progress and adjust interventions to improve outcomes and reduce disparities.

22. Interdisciplinary Care Team (ICT) Leadership

- RNCTMs or CCM Care Managers coordinate and lead ICT meetings for assigned members.

- Include medical, behavioral health, pharmacy, social services, and community-based providers.

- Review member progress, update care plans, and resolve barriers to care.

- Ensure care decisions are person-centered and culturally appropriate.

23. Health Assessments and Acuity Determination

- Conduct Health Information Form (HIF) within ninety (90) days of enrollment.

- Complete Health Risk Assessment (HRA) within forty-five (45) days of enrollment and annually thereafter.

- Perform nursing assessments when significant changes in health status occur.

- Assign acuity level using HRA algorithm and clinical expertise to determine contact frequency and care intensity.

24. Individualized Care Plan (ICP) Development and Monitoring

- Develop ICPs based on HRA, clinical assessments, and member/family/provider input.

- Set measurable goals and interventions tailored to member needs.

- Monitor implementation and progress toward goals.

- Provide education and reinforcement of self-management techniques for chronic and behavioral health conditions.

25. Medication Management

- Conduct Medication Therapy Management (MTM) reviews during initial HRA and as clinically indicated.
- Assess medication adherence and communicate concerns to prescribing providers.
- Collaborate with Plan Pharmacist and ICT for medication-related issues.
- Ensure medication reconciliation occurs post-discharge to prevent adverse drug events.

26. Behavioral Health Coordination

- Refer members to behavioral health providers as needed.
- Collaborate with behavioral health care managers to align treatment plans.
- Coordinate transitions between medical and behavioral health settings.

27. Member Empowerment and Education

- Educate members on their conditions, care plans, and available services.
- Support members in becoming active participants in their care decisions.
- Assist with scheduling appointments and follow-up services.
- Advocate for member access to community resources and social services.

28. Documentation and Reporting

- Document all member interactions, assessments, referrals, and care coordination activities in the care management software system.
- Maintain session notes and ensure timely updates to member records.
- Use documentation to support quality improvement and compliance reporting.

29. Enhanced Care Management (ECM)

- ECM providers deliver high-touch, person-centered services primarily through in-person interactions.
- Lead Care Managers meet members wherever they are—home, clinic, shelter, or street.
- Coordinate interdisciplinary services addressing clinical and non-clinical needs.
- Notify ECM Care Managers of member transitions, even when MCP is not the primary payor.

30. Transitional Care Services (TCS)

- RNCTMs serve as single points of contact for members during transitions.

- Ensure medication reconciliation at discharge and post-discharge.
- Confirm follow-up care appointments and provider engagement.
- Include Emergency Department visits in TCS protocols.
- Document all TCS activities and outcomes.

31. Coordination Across Multiple Payors

- Use Health Information Exchange (HIE) to track admissions, discharges, and transfers.
- RNCTMs and UM RNs collaborate with the Medical Director for transitions involving other payors.
- Process timely prior authorizations for Medi-Cal-covered services.
- Notify ECM or CCM Care Managers of transitions for dual-eligible members enrolled in MMPs or D-SNPs.

32. Behavioral Health and SUD Transitions

- For County MHP or DMC-ODS-covered admissions, those entities coordinate discharge care.
- For medical admissions transferring to behavioral health facilities, RNCTMs and UM teams manage TCS until the member is admitted and connected to services.
- Resume TCS responsibilities post-treatment discharge from behavioral health or SUD facilities.

33. PHM Implementation Monitoring

To ensure compliance with DHCS requirements and continuous improvement of the PHM Program, the Health Plan follows these procedures:

a. DHCS Performance Monitoring (Effective Q4 2025)

- Monitor performance across three domains
  - **PHM Program Areas/Themes**: BPHM, Prevention Services, Primary Care Engagement, Chronic Disease Management, CHW Integration, RSST, CCM, ECM, and TCS.
  - **Populations**: Children and Youth, Birthing Populations, Individuals with Behavioral Health Needs.
  - **Cross-Cutting Priorities**: Equity, including stratified measures by race, ethnicity, language, and geography.
- **Reporting Cadence**
  - Submit PHM Monitoring KPIs to DHCS quarterly.
  - Monitor MCAS measures internally; no additional reporting cadence required.

- **Internal Performance Review**
    - Use internal KPIs to assess program effectiveness, equity impact, and service access.
    - Conduct quarterly reviews of wellness and prevention programs to identify gaps and opportunities for improvement.
    - Prepare for DHCS audits and reviews by maintaining up-to-date documentation and performance dashboards.

b. Accreditation Oversight

- Maintain AAAHC accreditation through June 2026, including compliance with ambulatory care standards.
- Complete NCQA Health Plan and Health Equity Accreditation surveys by Q4 2025.
- Ensure all PHM activities align with NCQA standards and are documented for certification readiness.

34. Community Services Coordination

To strengthen member access to social supports and public benefits, the Plan implements the following procedures:

a. County-Level MOUs

- Establish and maintain MOUs with Los Angeles County DPSS for closed-loop referrals to
    - CalWORKs
    - CalFresh (SNAP)
    - SSI

- Establish and maintain an MOU with the Los Angeles County Department of Mental Health, which is the county mental health plan in PHC California's service area.

- Establish and maintain an MOU with the Los Angeles County Department of Public Health's Substance Abuse Prevention and Control program, which is the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan in PHC California's service area.

- Ensure operational readiness for referral tracking by January 2025, per CalAIM PHM Policy Guideline 9/2022 and DHCS APL 22-005.

b. Community-Based Partnerships

- Formalize MOUs with the following organizations beginning January 2024:
    - AHF Health Housing
    - Angel Food
    - Project Room Key
    - APLA
    - Volunteers of America
    - Catalyst Foundation
    - Mom's Meals

- Wright Homecare
- Envoy Homecare

- Integrate these partners into the care coordination workflow to support housing, nutrition, home care, and other SDOH needs.

- Track referral outcomes and service delivery using the care management system.

35. Documentation Standards

To ensure accountability, continuity, and compliance, all Care Management and Utilization Management staff follow these documentation procedures:

- Use the approved care management software system to record all member interactions, assessments, and interventions.

- Apply evidence-based clinical guidelines and algorithms during assessments and care planning.

- Ensure automatic logging of:

  - Staff name
  - Date and time of each action or member interaction

- Maintain session notes that reflect:

  - Member status and acuity
  - Care plan progress
  - Referral outcomes
  - Medication reconciliation and adherence
  - Transition of care activities

- Conduct regular audits of documentation for completeness, accuracy, and compliance with DHCS and NCQA standards.

Definitions:

1. AMCS:Alcohol Misuse Screening and Behavior Counseling Services

2. Basic Population Health Management (Basic PHM): means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

3. Community Based Adult Services (CBAS): means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the CalAIM Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

4. Community Health Worker (CHW): means an individual known by a variety of job titles, such as promotes, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in APL 22-016.

5. Complex Care Management (CCM): means an approach to care management that meets differing needs of high and rising-risk Members, including both longer-term chronic Care Coordination for chronic conditions and interventions for episodic, temporary needs. The Health Plan must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

6. Enhanced Care Management (ECM): means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus (POF) eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

7. ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus (POF) for Enhanced Care Management (ECM).

8. Population Health Management (PHM): means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized screening, assessment processes, and holistic care/case management interventions.

9. Primary Care Provider (PCP): means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

10. RNCTM – Registered Nurse Care Team Manager

Monitoring:

This policy will be reviewed and revised, as necessary and approved at least annually by the Utilization Management Committee.

References:

1. CalAIM Population Health Management Policy Guideline 07/2025

2. NCQA Health Plan Accreditation PHM Standards 2024

3. NCQA Health Equity Accreditation Standards 2024

4. Title 22 CCR Comprehensive Perinatal Services Program (CPSP)

Regulatory Agency Approval(s):

Date	Version	Regulatory Agency	Purpose	Response

6/1/2023	13.0 rev. 4/30/23	Department of Health Care Services (DHCS)	APL 22-024	AIR1
	13.0 rev.	DHCS	APL 22-024 AIR1	
11/9/2023	13.0	DHCS	2024 Operational Readiness (O/R) R.0125	Approved
Not avail.	13.0	DHCS	2024 O/R R.0111	Approved
10/4/2023	13.0	DHCS	2024 O/R R.0120	Approved
11/9/2023	13.0	DHCS	2024 O/R R.0121	Approved
12/13/2023	13.0	DHCS	2024 O/R R.0134	Approved
11/10/2023	13.1	DHCS	2024 O/R R.0110	Approved
12/12/2023	13.1	DHCS	2024 O/R R.0112	Approved
12/12/2023	13.1	DHCS	2024 O/R R.0113	Approved
12/12/2023	13.1	DHCS	2024 O/R R.0114	Approved
10/5/2023	13.1	DHCS	2024 O/R R.0116	Approved
12/13/2023	13.1	DHCS	2024 O/R R.0126	Approved
10/5/2023	13.1	DHCS	2024 O/R R.0118	Approved
12/8/2023	13.2	DHCS	2024 O/R R.0074	Approved
11/30/2023	13.2	DHCS	2024 O/R R.0117 AIR1	Approved
12/12/2023	13.2	DHCS	2024 O/R R.0119	Approved
12/4/2025	13.3	DHCS	MCOD Portal Item D.0330.23	AIR1
12/18/2025	13.4	DHCS	MCOD Portal Item D.0330.23 AIR1	Approved

Attachment A

CHW Integration Plan	
Requirement	Element
1. Integrate CHWs into health care delivery services	• How the MCP will assess Member needs, determine priority populations using a data driven approach, and connect identified Members to needed services • How the MCP's approach for integrating CHWs particularly addresses the following Quality Strategy clinical priorities: children's preventive care, underutilization of primary care, and maternity care and birth equity, and integrated behavioral health • How the MCP plans to use CHWs to help address its priorities related to engagement, population health, improved quality and health equity and improved efficiencies • Approach for how the MCP may use CHWs in serving as ECM Providers and providing care coordination to Community Support services in a non-duplicative manner • The MCP's referral pathways to CHW services
2. Build capacity in Provider Networks to employ CHWs	• Strategies for recruiting and growing the Provider Network • Whether the MCP will use its existing Provider Network and partnerships with CBOs to fill identified service gaps, including ECM and Community Supports • Approach for integrating CHWs with services that are already being provided through existing MCP contractual requirements, and with health workers that currently provide health education, health navigation, and ECM services, to ensure non-duplication • Approach to leverage the skills and assets of external organizations such as Providers, health systems, CBOs, and LHJs to support CHWs
3. Communicate to Members about the scope of practice, benefits, and availability of CHW services	• Approach for Member communication in a culturally and linguistically appropriate manner including written notice, webpage, and other communication tools that inform Members how to avail and utilize CHW services
4. Communicate to Providers about the scope of practice, benefits, and availability of CHW services	• Inclusion of scope of service in MCP's Provider Manual • Approach for Provider training on scope of practice, integration of CHWs in care teams, and referrals to CHW services
5. MCP monitoring strategies	• Approach for measuring baseline utilization and strategies for increasing Member utilization of CHW services over time • Approach to monitoring and evaluating the success of CHWs in improving health outcomes, reducing health disparities, and achieve health equity in the short and long term