	<p align="center">POLICIES AND PROCEDURES</p>
Policy #: 405-1312	Lead Department: Care Management
Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home	
Original Date: 09/13/2013	Date Published: 02/25/2025
Approved by: Utilization Management Work Group (UMWG)	


Purpose:

To describe the process and responsibilities of the Primary Care Provider (PCP) for physical and behavioral health care including Case Management Responsibilities and the Promotion of Patient Centered Medical Home as implemented by Central California Alliance for Health (the Alliance).

Policy:

In accordance with the Institute for Healthcare Improvement (IHI) Triple Aim initiative, the Alliance aims to achieve optimal health system performance through the following objectives:

1. To improve the patient experience and access of mental and physical health care by:
 - a. Fostering continuity of care and longitudinal provider/patient relationships within the Alliance's Service Area; and
 - b. Improving primary care clinic access especially for patients with complex and/or chronic conditions by promoting Patient Centered Medical Home practice models with same day walk-in appointment availability and team-based care.
 - c. Coordinating care and making referrals as appropriate to realize fully integrated care of both behavioral and physical health.
2. To improve population health by:
 - a. Coordinating the care of Alliance members behavioral and physical health care in order to achieve satisfactory care results; and
 - b. Facilitating members' understanding and use of disease prevention practices and early diagnostic services.
 - c. The Alliance ensures that the latest recommendations by the United States Preventive Services Task Force (USPSTF) are used to determine the provision of preventive services to asymptomatic, healthy members as described in Alliance Policies 401-1502 - Adult Preventive Care and 401-1505 - Childhood Preventive Care.
3. To reduce the cost of health care by:
 - a. Contributing to the reduction in the use of hospital emergency rooms as a source of non-emergency care;

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

- b. Reducing unnecessary referral of members to specialty providers; and
- c. Discouraging medically inappropriate use of pharmacy and drug benefits by members.

Definitions:

AMSC:

Alcohol Misuse Screening and Behavioral Counseling

Auditing:


A periodic random sample of medical records may be audited for appropriateness of case management activities by DHCS and DMHC.

Care Coordination:

Services included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functional Medical Home.

Case Management:

1. The California Department of Health Care Services (DHCS) defines case management as “Guiding the course of resolution of a personal medical problem (including the “problem” of the need for health education, screening, or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate time, in the most appropriate setting.” Case Management is a voluntary, collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members’ health care across the care continuum. It includes empowering members to exercise their options and access the services appropriate to meet their individual health needs, using communication, education and available resources to promote quality outcomes and optimize health care benefits.
2. The Alliance is committed to supporting PCP management efforts by coordinating care for Alliance members with the various agencies and providers involved in our member’s care. For more information on coordination of care please see the Coordination of Care information in your Provider Manual under each line of business.
3. Five requirements are necessary for case management systems to function. They are as follows:
 - a. Medi-Cal recipients and members of the Alliance Care In-Home Support Services

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

(IHSS) line of business (also referred to herein as “members”) are required to either select or be assigned to a Primary Care Provider (PCP). Alliance Medi-Cal Administrative members are not required to either select or be assigned a PCP;

- b. PCPs are required to provide targeted case management services as specified in Title 22 California Code of Regulations Section 51351. Please see Title 22 California Code of Regulations Section 51351 for a detailed list of those services;
- c. Participating PCP and referral physicians are required to contract with the Alliance for provision of the services at rates established by the Alliance and the DHCS;
- d. Through the referral process, PCPs will control member referrals to all specialty and ancillary services with the exception of those services that members may self-refer to within the parameters and constraints described by line of business in Alliance Policy 404-1309 - Member Access to Self-Referred Services. PCPs are required to use a referral tracking system for members sent to specialists for care and must, within a reasonable time frame, follow up to ensure that the member kept the appointment and obtain the specialist’s report and recommendations. PCPs may track referrals through the Alliance Referral Tracking report on the Alliance Provider Portal. For more information on the referral process, please see Alliance Policy 404-1303 - Referral Consultation Request Process; and
- e. To facilitate accessibility of care to Alliance members, individual and group practice PCPs, in private and public settings, will be geographically located throughout the Alliance’s Service Area.


For more information on the Alliance Care Management Program please see Care Management and Disease Management Program in the Provider Manual.

Complex Case Management:

The systematic coordination and assessment of care and services provided to members by a multidisciplinary team. Complex Case Management is provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

DBH Well-Child Visits (DBH)

The DBH well-child visit must be limited to those services not already covered in the medical well-child visit. When possible and operationally feasible, the DBH well-child visit should occur on the same day as the medical well-child visit. When this is not possible, the Alliance will ensure the DBH well-child visit is scheduled as close as possible to the medical well-child visit, consistent with timely access requirements. The Alliance’s provider network may deliver DBH well-child visits as

	POLICIES AND PROCEDURES
Policy #: 405-1312	Lead Department: Care Management
Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home	
Original Date: 09/13/2013	Date Published: 02/25/2025
Approved by: Utilization Management Work Group (UMWG)	

part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:


- Behavioral health history for child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.
- Developmental history of the child.
- Observation of behavior of child and parent(s) or caregiver(s) and interaction between child and parent(s) or caregiver(s).
- Mental status assessment of parent(s) or caregiver(s).
- Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.
- Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.
- Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include:
 - Educating parent(s) or caregiver(s) on how their life experiences (e.g., Adverse Childhood Experiences (ACEs)) impact their child's development and their parenting.
 - Educating parent(s) or caregiver(s) on how their child's life experiences (e.g., ACEs) impact their child's development.
 - Information and resources to support the child through different stages of development as indicated.
 - Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.

Dyadic Services

Dyadic Services benefit is a family and caregiver focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified and is designed to support the implementation of comprehensive models of dyadic care that works within the pediatric clinic setting to identify and address caregiver and family risk factors for the benefit of the child.

Dyadic Comprehensive Community Supports Services, separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports, help the child (member ages 20 or below) and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

- Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.
- Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.
- Assistance in finding and connecting to necessary resources other than covered services to

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

meet basic needs.

- Communication and coordination of care with the child's family, medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other state agencies.
- Outreach and follow-up of crisis contacts and missed appointments.
- Other activities as needed to address the dyad's identified treatment and/or support needs.

Dyadic Psychoeducational Services

These services are for psychoeducational purposes and are provided to the child aged 20 or below and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of behavioral health conditions and achieving optimal mental health and long-term resilience.

Dyadic Family Training and Counseling for Child Development

Family training and counseling provided to both the child aged 20 or below and parent(s) or caregiver(s). These services include brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and other related issues.


Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a child's visit that is attended by the child and parent or caregiver, including the following: assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the child (member ages 20 or below) as appropriate:

- Brief Emotional/Behavioral Assessment
- ACEs Screening
- Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
- Depression Screening
- Health Behavior Assessments and Interventions
- Psychiatric Diagnostic Evaluation
- Tobacco Cessation Counseling

Early and Periodic Screen, Diagnosis and Treatment (EPSDT):

A comprehensive and preventive child program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental and hearing services. EPSDT services are extra Medi-Cal services. This program helps find and care for health problems in children from birth to 21 years of age. As part of the EPSDT requirement, the Alliance provides services as recommended by the American Academy of Pediatrics (AAP) Bright Futures initiative for all members under 21 years of age. The AAP develops guidance and recommendations for preventive care screenings and well-

	POLICIES AND PROCEDURES
Policy #: 405-1312	Lead Department: Care Management
Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home	
Original Date: 09/13/2013	Date Published: 02/25/2025
Approved by: Utilization Management Work Group (UMWG)	

child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies.

Medical Home:

The medical home, also known as the patient-centered medical home (PCMH), is a team-based health care delivery model led by a Physician, Physician Assistant (PA), or Nurse Practitioner (NP) that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.

Patient Activation:

Patient activation refers to a person's ability to manage their health and health care.

Preventive Care:

Health care designed to prevent disease and/or its consequences.

Health Education:

The Joint Committee on Health Education and Promotion Terminology of 2001 defined Health Education as "any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions."

Person-Centered Planning:

A highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of Basic and Complex Case Management and Discharge Planning.


Substance Use Disorder (SUD):

The use of one or more substances that lead to a clinically significant impairment or distress. ⁱ

The United States Preventive Services Task Force (USPSTF):


The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for health consequences, but not meeting criteria for AUD. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. Additionally, the USPSTF recommends screening by asking questions about unhealthy drug use in adults aged 18 years or older.

Procedures:


	POLICIES AND PROCEDURES
Policy #: 405-1312	Lead Department: Care Management
Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home	
Original Date: 09/13/2013	Date Published: 02/25/2025
Approved by: Utilization Management Work Group (UMWG)	

Primary Care Provider (PCP) Responsibilities in Basic Case Management, in collaboration with the Alliance Health Services Division.

1. PCPs are required to provide preventive health care services in accordance to nationally recognized criteria, as described in Alliance Policies 401-1502 - Adult Preventive Care and 401-1505 - Childhood Preventive Care.
2. The responsibilities of the PCPs are the following:
 - a. To provide the specified scope of Primary Care Services to Alliance members who have designated or been assigned to the specific physician as the primary care provider.
 - i. For Medi-Cal members, PCPs are required to administer the Staying Healthy Assessment (SHA) or other DHCS-approved Individual Health Education Behavioral Assessment (IHEBA) within 120 days of the Medi-Cal member's enrollment with the plan and periodically re-administer it according to age-specific guidelines and timeframes. See Alliance Policy 401-1511 - Initial Health Appointment.
 - ii. PCPs are also required to screen for Alcohol Misuse: Screening and Behavioral Counseling Intervention (AMSC) and Substance Use Disorder (SUD) services to all members who are ages 11 years and older, including pregnant women, related to alcohol and/or drug misuse as recommended by the US Preventative Services Task Force (USPSTF) and by the American Academy of Pediatrics (AAP) Bright Futures initiative for all members under 21 years of age. AMSC and/or SUD services should be provided to members who respond affirmatively to the alcohol pre-screen question on the SHA or who PCPs otherwise identify as having risky or hazardous alcohol use or substance use. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. For those members who respond affirmatively to screening, using the Alcohol Use Disorder Identification Test - Consumption (AUDIT-C) or other validated alcohol screening and/or substance use questionnaires, PCPs will offer alcohol and/or substance use brief interventions (up to three 15 minute sessions in person or by phone) or refer members identified with possible alcohol use disorders and/or SUDs to County Behavioral Health Access in order to be referred to an appropriate alcohol and drug program in the county where the member resides for evaluation and treatment, including medications for addiction treatment (MAT). Prior authorization for referrals is not required.

	<p align="center">POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	


- (1.) Each member over 18 years of age is eligible for three screenings and up to three brief interventions per screening, per year in order to account for any change in PCP and provide flexibility in meeting a member's readiness for the intervention.
 - (2.) Other validated screening tools include, but are not limited to:
 - a. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Dugs (CAGE-AID);
 - b. Tobacco Alcohol, Prescription medication and other Substances (TAPS);
 - c. National Institute on Drug Abuse (NIDA) Quick Screen for adults
 - i. The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening;
 - d. Drug Abuse Screening Test (DAST-10), (DAST-20);
 - e. Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents;
 - f. Car, Relax, Alone, Forget, Friends, Trouble (CRAFT) for non-pregnant adolescents; and,
 - g. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.
 - (3.) Brief intervention sessions may be combined in one or two visits or administered as three separate visits.
 - (4.) Brief intervention services may be provided on the same date of service as the screening or on subsequent days.
 - (5.) Brief interventions must include the following:
 - a. Providing feedback to the member regarding screening and assessment results;
 - b. Discussing negative consequences that have occurred and the overall severity of the problem;
 - c. Supporting the patient in making behavioral changes; and
 - d. Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.
 - (6.) Additional sessions will be granted if approved as medically necessary, and that medical necessity is documented by the member's PCP.
- iii. If member answers "yes" to the IHEBA alcohol screening question, the PCP will refer to the alcohol and drug program where the member resides for

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

evaluation and treatment.


PCPs may offer AMSC in the primary care setting as long as they meet the following requirements:

- (1.) AMSC services may be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider, including but not limited to the following:
 - a. Licensed Physician
 - b. Physician Assistant
 - c. Nurse Practitioner
 - d. Psychologist
 - e. At least one supervising licensed provider per clinic or practice may take four hours of AMSC training after initiating AMSC services. The training is not required; however, it is recommended.
- iv. Per AAP/Bright Futures recommendations, tobacco alcohol, and drug use screening and assessment with appropriate follow-up action as necessary should begin to occur at 11 years of age.
- v. PCPs are responsible for screening for tobacco use in members and to make appropriate referrals per Alliance Policy 401-3109 Comprehensive Tobacco Cessation Services.
- vi. A PCP is responsible to coordinate care for mental health conditions that are responsive to physical health care-based treatment, non-specialty mental health (e.g. anxiety and depression) and may elect to offer care for members with severe mental illness (SMI) that the PCP deems are within their scope of practice.
- vii. PCPs are responsible for identifying the need for a mental health screening and referral to a licensed behavioral health provider through the Alliance's contracted Managed Behavioral Health Organization (MBHO) through 6/30/25. As of 7/1/25, PCPs will make such referrals through the Alliances Behavioral Health providers directly or can submit a Care management referral to the behavioral health Care management team at the Alliance
- viii. PCPs are responsible for making referrals to County alcohol and drug or other programs for evaluation and treatment for SUDs, and alcohol misuse, including medications for additional treatment. Prior authorization for referrals is not required.

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

- ix. PCPs are responsible for screening for developmental disabilities and making referrals for evaluation and care of autism spectrum disorder through Alliance's contracted MBHO through 6/30/25. As of 7/1/25, PCPs will make such referrals to the Alliances Utilization Management Behavioral Health team directly.


- b. To coordinate and direct appropriate care for members by means of initial diagnosis and treatment, obtaining second opinions as necessary, consultation with referral specialists and follow-up of care to assess the results of the primary care and specialty care, medication regimen, preventative care services, and special treatment within the framework of integrated, continuous care. This includes referring members to the network of licensed and license-eligible behavioral health providers for non-specialty mental health services and County Behavioral Health for Specialty Mental Health and alcohol and substance abuse treatment services, as needed.
 - i. PCP shall ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. Screenings should include and are not limited to adverse childhood experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, autism spectrum disorder screening, and other screening services.
 - ii. Consistent with USPSTF Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, the Alliance will provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services for members 11 years of age and older, including pregnant women. Tobacco cessation counseling and medications for addiction treatment (also known as medication-assisted treatment or MAT) may be offered to members in PCP offices. These services may be provided by providers within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists. PCPs must maintain documentation of SABIRT services provided to Members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services. For additional details please refer to the Medi-Cal Provider Manual.
 - iii. In providing SABIRT services, the Alliance will comply with all applicable

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	


laws and regulations relating to the privacy of SUD records, as well as state law concerning the right of minors over 12 years of age to consent to treatment, including, without limitation, Title 42 Code of Federal Regulations (CFR) Section 2.1 et seq., 42 CFR Section 2.14, and Family Code Section 6929.

- iv. The Alliance will include information about SABIRT services in their member-informing materials, including the Member Handbook.
- c. To keep record of all referrals, communications, and correspondence with members, referral providers and community based/local health department programs in the member's medical record.
 - i. PCP must assure the referral appointment is kept, and consultation information is returned in a timely manner.
 - ii. PCP reviews appropriate member information timely.
 - iii. All documentation is filed in member's record and includes:
 - (1.) The services provided (e.g., screening and brief intervention);
 - (2.) The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded within the electronic health record);
 - (3.) The name of the assessment instrument (as applicable) and score on the assessment (unless the screening tool is embedded in the electronic health record);
 - (4.) If and where a referral was made, including referrals to an AUD or SUD program; and,
 - (5.) Information regarding follow up care.
- d. To facilitate and ensure patient quality of care by establishing the following procedures:
 - i. To contact members when they miss appointments requiring rescheduling for additional visits, or confirming referrals to a specialist for care per Alliance policy;
 - ii. To adhere to access standards as specified in Alliance Policy 300-1509 Timely Access to Care;

Timely receipt of and follow-up of abnormal diagnostic reports with member notification of required action documented in medical record; and


	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

- iii. Timely receipt of information regarding emergency care rendered to member with documentation of any follow-up care required.
- e. To maintain patient medical records for members consistent with standard medical practice and to make the individual patient medical records available upon request for audit/review by the staff of the Alliance, DHCS and the Department of Managed Health Care (DMHC). For more information, please see Alliance Policy 401-1510 Medical Record Review and Requirements.
- f. To participate in and accept the Alliance's continuing peer review processes. For more information, please see Alliance Policy 300-4030 Credentialing Criteria and Identified Issues.
- g. To participate in the Alliance's quality improvement processes, as detailed in 401-1101 Quality Improvement & Health Equity Transformation Program
- h. (QIHETP).
- i. To use as appropriate the Provider Grievance Process as established by the Alliance and as detailed in the Provider Manual.
- j. To participate in the Alliance Provider Training.
- k. To preserve the dignity of the member.
- l. To accept corrective action plans from the Alliance and respond in a timely manner.
- m. Provisions for monitoring hospital admissions, continued stays, and post discharge care:
 - i. Schedule a hospital discharge follow-up appointment within 14 business days of member's hospital discharge date. Alliance Concurrent Review Nurses send a notification letter to members' Primary Care Provider upon member admission to the hospital, which includes reminder to schedule discharge follow-up appointment.
 - ii. To coordinate member discharge planning with hospital case managers and Alliance staff. Alliance Utilization Management Nurses review members' inpatient stays and identify members for referral to Utilization Management Care Programs for follow up post discharge. Discharge planning continues into the post discharge period and includes ensuring

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

that necessary care, services and supports are in place after discharge from the hospital or institution. Services should include scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver.

- n. Coordination of transitional care with the hospital team and, following hospital or facility discharge, provision of post-discharge appointments within seven to fourteen days.
- o. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs.
- p. Direct communication between the provider and Member/family.
- q. Member and family education, including healthy lifestyle changes when warranted.
 - i. Covered Dyadic Services are behavioral health services for children (members ages 20 or below) and/or their parent(s) or caregiver(s), and include:
 - (1.) DBH Well Child Visits
 - (2.) Dyadic Comprehensive Community Supports Services
 - (3.) Dyadic Psychoeducational Services
 - (4.) Dyadic Family Training and Counseling for Child Development
 - (5.) Dyadic Parent or Caregiver Services
 - ii. Children (Members ages 20 or below) and their parent(s)/caregiver(s) are eligible for Dyadic Behavioral Health (DBH) well-child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.
 - (1.) Under EPSDT standards, a diagnosis is not required to qualify for services. DBH well-child visits are intended to be universal per the Bright Futures periodicity schedule for behavioral/social/emotional screening assessment.
 - (2.) The DBH well-child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the member does not request them.
 - (3.) The family is eligible to receive Dyadic Care Services so long as the child is enrolled in Medi-Cal.
 - (4.) The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

- r. Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.
- s. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- t. Intense coordination of resources to ensure member regains optimal health or improved functionality.
 - i. With member and care team input, assisting with development and approval of care plans specific to individual needs, and updating of these plans at least annually for open cases.
 - ii. An assessment of transitional needs of Members into and out of Complex Case Management services.


Additional Primary Care Provider (PCP) Responsibilities:

Request for Member Reassignment

1. A physician's request for member reassignment to another PCP requires the approval of an Alliance Medical Director. For more information, please see Alliance Policy 300-6050 - Provider Request to Reassign Member.
2. Members may request a change of PCP at any time and for any reason. Member Requests for change of PCP will be noted to allow the Alliance to monitor members' reasons for reselecting and allow for appropriate follow-up with members and/or providers if needed.

Proper Authorization of Services

1. General Procedure
 - a. The Alliance will pay for authorized claims according to the specific terms of each physician, hospital and other provider contract. The provider should obtain the basic member identification information from the member or accompanying individual. The member should have the Alliance ID Card with the name and telephone number of the Primary Provider Physician.
 - b. Referral physicians / hospitals must obtain a Referral Consultation Request Form (RCR) from the PCP. Emergency care does not require an RCR.

	<p align="center">POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	


- c. Members may obtain some services without needing a referral from their PCP. The scope of services and the acceptable providers are outlined in detail in Alliance Policy 404-1309 - Member Access to Self-Referred Services.

2. Emergency Service Notification


- a. Emergency services are defined in Title 22, California Code of Regulations Section 51056 and the Primary Care Physician Services Agreement. Emergency services are health care services needed to evaluate or stabilize a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - i. Placing the health of member (or in the case of a pregnant member, the health of the member or her unborn child) in serious jeopardy;
 - ii. Serious impairment to bodily functions; or
 - iii. Serious dysfunction of any bodily organ or part. Emergency services also include screening, evaluation and examination by a physician, or other personnel acting within the scope of their licensure to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

NOTE: Emergency psychiatric services and care shall not apply to services provided under the Alliance's Medi-Cal line of business to the extent that such services are excluded under the contract.

- b. Emergency services rendered by hospitals and attending physicians or specialty providers during an emergency room visit do not require prior authorization. Follow-up care after an emergency room visit for conditions within the PCP scope of practice should be done with the PCP if any is needed.
- c. Hospital emergency admissions and emergency room outpatient services require the following procedures:
 - i. When a member presents an emergency condition to the Emergency Department (ED) for outpatient services, the attending physician / hospital should fulfill the following obligations:

	<p align="center">POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

- (1) To verify member eligibility and PCP or Administrative Member Status by telephoning the Alliance's 24-hour automated eligibility verification system.
 - (2) Forward a copy of the ED report or face sheet to the PCP subsequent to rendering services.
 - ii. When a member presents an emergency condition at a hospital or other provider facility and is admitted for in-patient services, the attending Physician / Hospital shall meet the following obligations:
 - (1) Notify the PCP as soon as possible;
 - (2) Notify the Alliance's Utilization Management Department immediately upon inpatient admission to obtain authorization for the admission. The Alliance's Utilization Management Department is available during regular business hours to authorize medically necessary post-stabilization services;
 - (a) Inpatient admission for specialty mental health services are the responsibility of the county mental health program.
 - (3) Authorization requests received outside of regular business hours are reviewed the following business day;
 - (4) The Alliance does not deny authorization requests for medically necessary post stabilization services and non-urgent care that is provided to a member following an exam in the ED when the Alliance is unavailable for contact; and
 - (5) The Alliance does not require pre-authorization for members requiring medically necessary emergency care.
 - d. Non-contracted hospitals will either be provided with authorization to provide post-stabilization care, or the Utilization Management Department will arrange for transportation to a contracted facility. For more information on post-stabilization authorizations at non-contracted hospitals, please see Alliance policies 404-1202 After Hours Availability of Plan or Contract Physician, and 404-1201 Authorization Request Process.
3. Non-Emergency Services Authorization:

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

- a. All members may self-refer to the ED for emergency services without authorization, based on the member's belief that they have an emergency;
 - b. All members presenting at the ED will receive a Medical Screening Exam (MSE) by an ED physician;
 - c. The Alliance reimburses for all MSEs, even if it is later shown that no true emergency existed;
 - d. The ED physician(s) use the MSE as the process to determine whether an emergency medical condition exists; and
 - e. The MSE will be performed in a non-discriminatory manner and regardless of the individual's ability to pay for medical care.
4. Medical Second Opinions

Members may request a second opinion about a recommended procedure or service. The Alliance honors all requests for second opinions without the need for a prior authorization as long as the second provider is within Alliance network and service areas. Second opinions may be rendered outside the Alliance's provider network in instances where a qualified specialist is not available in the network; this includes centers of excellence such as academic tertiary centers. If the second provider is an out-of-service area provider, prior authorization will be required. For more information on out-of-service-area authorizations, please see Alliance Policy 404-1310 - Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers. For more information on second medical opinions, please see Alliance Policy 404-1307 - Medical Second Opinion.


Provision of Medical Records

In addition to issuing an RCR, the PCP will provide to the Referral Physician significant physical findings, radiographic or laboratory results from the member's general medical record, which may assist the referral process.

Delegation of Treatment Responsibility

Certain patient conditions may demand ongoing treatment by a specialist physician.

1. The PCP may delegate the responsibility for continuing specialty care to a Referral Physician for a specified period of time. Long term referral authorizations specifically

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

do not alter the expectation for conscientious clinical communication from the specialist back to the referring PCP. For more information on long term referral authorization, please see Alliance Policy 404-1306 - Extended and Standing Referral Authorizations.

Utilization Controls

The Alliance has an active Utilization Management Program (see Alliance Policy 404-1101 - Utilization Management Program for details).

Directed Payments for Developmental Screening Services

PCPs will provide developmental screening services in accordance with the AAP/Bright Futures periodicity schedule and through the use of standardized tools. Standardized tools must align with the following:


- Include the following domains
 - Motor
 - Language
 - Cognitive
 - Social-Emotional
- Have reliability scores of approximately 0.70 or above.
- Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
- Sensitivity and specificity scores of approximately 0.70 or above.

Provider documentation of developmental screening services must include the following:

- The tool that was used
- That the completed screen was reviewed.
- The results of the screen.
- The interpretation of the results.
- Any discussions with the member and/or family; and any appropriate actions taken.

This documentation must remain in the member's medical record and be available upon request by the member and/or member's parent(s)/guardian(s).

For the purposes of directed payments for developmental screening services provided by a PCP for dates of service on or after January 1, 2020, Value Based Payments (VBP) the completion of the developmental screening should be documented with CPT code 96110 without the modifier KX. Any additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX.

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

Services for Children Under 21 Years of Age with Special Health Care Needs (CSHCNs)

For more information regarding CSHCNs please refer to Alliance Policy 405-1315 - Children with Special Health Care Needs.

California Children's Services (CCS)

For more information regarding CCS please refer to Alliance Policy 405-1319 - Screening and Referral of Medically Eligible Children to California Children's Services Program.

Early Intervention Services

For more information regarding early intervention services please refer to Alliance Policy 404-1316 - Identification and Monitoring of Members for the High-Risk Infant Follow-up (HRIF) Program.

Local Education Agency (LEA) Services

For more information regarding LEA services refer to Alliance Policy 405-1315 - Children with Special Health Care Needs, and Alliance Policy 405-1304 - Developmental Disabilities - Services to Plan Members.

School Linked Children's Health and Disability Prevention (CHDP) Services

For more information regarding school linked CHDP services please refer to Alliance Policies 401-1505 - Childhood Preventative Care and 405-1315 - Children with Special Health Care Needs.

Waiver Programs


For more information regarding Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Programs please refer to Alliance Policy 405-1107 - HIV/AIDS Home and Community Based Waiver Programs.

Dental

For more information regarding dental care please refer to policies 404-1705 - Dental Services for Medi-Cal Members and 401-1505 - Childhood Preventative Care.

Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

For more information regarding DOT for Tuberculosis please refer to policies 401-1519 - Infection Control Practices and 800-1002 - Memoranda of Understanding.

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

Women, Infants, and Children Supplemental Nutrition Program (WIC)

For more information regarding WIC please refer to Policies 401-1505 - Childhood Preventative Care, 401-3107 - Breastfeeding Promotion and Education Services, and 800-1002 - Memoranda of Understanding.

Immunization Registry Reporting

For more information regarding immunization registry reporting please refer to Alliance Policy 401-1505 - Childhood Preventative Care.


Erectile Dysfunction (ED) Drugs and Other ED Therapies

For more information regarding ED drugs please refer to Alliance Policy 403-1123 - Drugs for the Treatment of Sexual or Erectile Dysfunction.

References:

Alliance Policies:

- 300-4030 - Credentialing Criteria and Identified Issues
- 300-5377 - Provider Requirements for Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
- 300-6050 - Provider Request to Reassign Member
- 401-1502 - Adult Preventive Care
- 401-1505 - Childhood Preventative Care
- 401-1511 - Initial Health Appointment
- 401-1519 - Infection Control Practices
- 401-3107 - Breastfeeding Promotion and Education Services
- 401-3109 - Comprehensive Tobacco Cessation Services
- 403-1123 - Drugs for the Treatment of Sexual or Erectile Dysfunction
- 404-1101 - Utilization Management Program
- 404-1102 - Inpatient Review
- 404-1201 - Authorization Request Process
- 404-1202 - After Hours Availability of Plan or Contract Physician
- 404-1303 - Referral Consultation Request Process
- 405-1319 - Screening and Referral of Medically Eligible Children to California Children's Services (CCS) Program
- 404-1306 - Extended and Standing Referral Authorizations
- 404-1307 - Medical Second Opinions
- 404-1309 - Member Access to Self-Referred Services
- 404-1310 - Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers
- 404-1702 - Provision of Family Planning Services to Members

	<p>POLICIES AND PROCEDURES</p>
<p>Policy #: 405-1312</p>	<p>Lead Department: Care Management</p>
<p>Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home</p>	
<p>Original Date: 09/13/2013</p>	<p>Date Published: 02/25/2025</p>
<p>Approved by: Utilization Management Work Group (UMWG)</p>	

404-1705 - Dental Services for Medi-Cal Members
 404-1720 - Private Duty Nursing EPSDT Benefit
 405-1107 - HIV/AIDS Home and Community Based Waiver Programs
 405-1112 - Care Management of the Seniors and Persons with Disabilities for Medi-Cal
 405-1304 - Developmental Disabilities - Services to Plan Members
 405-1315 - Children with Special Health Care Needs
 405-1317 - Early Intervention Services
 405-1320 - Screening and Transition of Care Tools
 405-1321 - Behavioral Health Case Management
 408-1305 - Behavioral Health Services

Impacted Departments:

Provider Services
 Quality Improvement & Population Health
 Utilization Management and Complex Case Management

Regulatory:

Title 22 California Code of Regulations Section 51351
 Title 22 California Code of Regulations Section 51056
 Title 42 of the United States Code (USC), Section 1396d(r).
 Health and Safety Code Section 1383.15 (g)

Legislative:


California Knox-Keene Health Care Service Plan Act of 1975.

Contractual (Previous Contract):

DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Provisions 5.F
 DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Provision 6.B.1
 DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provisions 1-20
 DHCS Medi-Cal Contract, Exhibit A, Attachment 21, Provision 4
 DHCS Medi-Cal Contract, Exhibit A, Attachment 18, Provisions 10.a - c
 DHCS Medi-Cal Contract, Exhibit A, Attachment 18, Provisions 11.a, 11.c -f, 11.h & 11.w
 DHCS Medi-Cal Contract, Exhibit A, Attachment 18, Provisions 20.a & 20.k
 DHCS Medi-Cal Contract, Exhibit E, Attachment 3, Provision 5

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit E, Attachment 3, Subsection 5.5.2.F
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.3.7.E
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.3.7.K
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.3.A
 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.4.B &G.
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.4.1.C
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.5
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.5.1
 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.21.A
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 4.3.9.A-C
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 4.3.14.A-B

	<p align="center">POLICIES AND PROCEDURES</p>
Policy #: 405-1312	Lead Department: Care Management
Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home	
Original Date: 09/13/2013	Date Published: 02/25/2025
Approved by: Utilization Management Work Group (UMWG)	

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.15.A
 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.18.A
 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.19.A
 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.20.A
 Medi-Cal Contract, Exhibit A, Attachment 3, Section 5.5.2 C

DHCS All Plan Letter:

- APL 21-014 - Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
- APL 22-006-Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
- APL 22-029 Dyadic Care Services and Family Therapy Benefit
- APL 23-005 Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21
- APL 23-016 Directed Payments for Developmental Screening Services

NCQA:

Supersedes:

- Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home
- Policy 405-1101 - Physician Case Management Responsibilities
- APL 13-021-Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services was superseded by APLs 17-018 and 22-006
- APL 14-004 - Screening, Brief Intervention, and Referral to Treatment for Misuse of Alcohol was superseded by APLs 17-016, 18-014 and 21-014
- APL 19-010 Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21 was superseded by 23-005

Other References:

- Primary Care Physician Services Agreement
- Provider Manual, Care Management Program
- Provider Manual, Disease Management Program
- The Institute for Healthcare Improvement, Triple Aim Initiative [Improvement Area: Triple Aim and Population Health | Institute for Healthcare Improvement \(ihi.org\)](https://www.ihim.org/)

Attachments:

Lines of Business This Policy Applies To


- ☐ DSNP
- ☒ Medi-Cal
- ☒ Alliance Care IHSS

LOB Effective Dates

(01/01/2026 - present)
 (01/01/1996 - present)
 (07/01/2005 - present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
04/19/2022	03/23/2022	Paige Harris	UMWG

	<p align="center">POLICIES AND PROCEDURES</p>
Policy #: 405-1312	Lead Department: Care Management
Title: Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home	
Original Date: 09/13/2013	Date Published: 02/25/2025
Approved by: Utilization Management Work Group (UMWG)	

Reviewed Date	Revised Date	Changes Made By	Approved By
		UM/CCM Regulatory Reporting Supervisor	
6/24/2022	08/02/2022	Jessie Newton, RN Continuum of Care Manager-Adult	UMWG
03/16/2023	03/16/2023	Jennifer Mockus, Community Care Coordination Director	UMWG
8/25/23	8/25/23	Jennifer Mockus, Community Care Coordination Director	UMWG
9/18/23	9/18/23	Jennifer Mockus, Community Care Coordination Director	UMWG
8/5/24	8/5/24	Kelsey Riggs, Pediatric Complex Case Management Manager	UMWG
09/17/2024	09/17/2024	Jessie Newton, Adult Care Management Manager, RN	UMWG
11/12/2024		Rebecca McMullen, Behavioral Health Manager, LPCC	
01/03/2025	01/03/2025	Kelly Tlemcani, Business Analyst II	UMWG