<table>
<tr><td colspan="3">Policy Title:
Complex Case Management Process</td><td colspan="2">Policy #: PHMCM-002
Line of Business: Medi-Cal</td></tr>
<tr><td>Department Name:
Population Health
Care Management</td><td colspan="2">Original Date:
2/11</td><td>Effective Date:
12/18</td><td>Revision Date:
2,2026,
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4/2026</td></tr>
<tr><td colspan="5">Governing Committee: (If Applicable) Medical Services/P&T</td></tr>
<tr><td colspan="4">Governing Committee Approval: (If Applicable)
Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer
[signature]</td><td>Date of Committee Review:
5/5/2026</td></tr>
<tr><td colspan="4">Vice President (VP) Approval:
Tracy Alvarez, Vice President, Medical Care Solutions
[signature]</td><td>Date of Approval:
5/5/2026</td></tr>
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A. PURPOSE

The purpose of this policy is to delineate and describe the Blue Shield of California Promise Health Plan (Blue Shield Promise) Medi-Cal Complex Case Management (CCM) Program. This program is under the umbrella of the Population Health Program and includes a process that identifies individuals with complex, chronic conditions, illnesses, injuries or multiple diagnoses at risk of a catastrophic event resulting in permanent or lifelong disabilities that may need CCM based on various referral reasons that are outlined in the process. The process also includes the Blue Shield Promise Care Management System for documentation, comprehensive member assessment, follow-up communication process, notification, and coordination with the members health care providers (included but not limited to primary care physician (PCP), Enhanced Care Management (ECM) Providers, and any other Community-Based Organizations. This is in accordance with Population Health Management (PHM) Standards other Medi-Cal

Enhanced Care Management (ECM) program, and Department of Health Care Services (DHCS) 2024 contract section 4.3.7

FOR CASE MANAGEMENT (CM) OR CARE COORDINATION (CC), PLEASE SEE POLICY 10.4.19 PHM CASE MANAGEMENT AND CARE COORDINATION

B. DEFINITIONS

1. Complex Care Management: is an approach to comprehensive care management that meets differing needs of high and risk-risk members through both ongoing chronic Care Coordination and interventions for episodic, temporary needs
2. Life-threatening conditions: Conditions that cause serious disability without necessarily being life- threatening. Conditions associated with severe consequences, conditions affecting multiple organ systems. Conditions that carry a risk of serious complications
3. Severe Chronic Conditions: Any condition that is persistent and substantially disabling or life-threatening that requires treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique member.

C. POLICY

Blue Shield Promise utilizes a broad strategy for complex care management to enable members and providers to achieve the best possible outcomes for each unique member with multiple or severe chronic conditions.

a. Blue Shield Promise monitors members' care needs and takes action to facilitate the coordination of their care through arrangements with community and social service programs. Blue Shield Promise allows members who are incapable of making decisions concerning their health care due to mental or physical incapacity to have a representative who is permitted to make such decisions for them.

   Complex Care Management is defined as monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. The care management staff plays a key role in assisting the PCP with his/her care management duties. The care management nurses within Blue Shield Promise Health Plan perform the care management function and can perform at both the basic and high risk/complex levels of care management.

II. Blue Shield Promise maintains standard qualifications for all its care managers, including licensure, certification, and supervision necessary to perform complex case management functions, based on industry standards or regulatory requirements. Blue Shield Promise Complex Care Managers are certified

Registered Nurses who hold unrestricted licenses issued by the California Board of Registered Nursing.

Identification Process:

The CCM Program has a formal process in place through prospective, concurrent, or retrospective review to identify individuals who may have (a) complex care need(s) and may benefit from CCM services. This may include members with chronic illness, injury and/or multiple diagnoses, or members who are at risk for catastrophic events resulting in lifelong disabilities and who require multidisciplinary care/services, which may or may not result in full or potential recovery, requiring extensive use of resources and needing assistance to facilitate appropriate delivery of care and services to optimize outcomes.

Blue Shield Promise utilizes multiple data sources to identify members for enrollment in CCM, including electronic and referral identification sources. Administrative data reports are reviewed on a minimum monthly basis, and identification via referrals are done concurrently.

a. Electronic identification sources include but are not limited to the following:

- Medical and behavioral claims data Encounters Data
- Hospital Discharge Data
- Pharmacy Data
- Laboratory Data
- Electronic health records
- Advanced data sources
- Risk Stratification, Segmentation and Tiering (RSST)
    - High risk/Complex member identification into Care Management systems per Risk Stratification and Segmentation policy 10.4.11

In accordance with NCQA PHM 5-Standards, Blue Shield Promise members have multiple avenues to be considered for care management services, including referral to case management by:

a) Practitioner referral (i.e. PCP, Attending Physician, Specialty Care Physician, and/or licensed physician support staff).
b) UM department, concurrent review staff, discharge planner, disease management, social services
c) Health education, health information
d) Customer Care
e) Inpatient nursing/hospital staff or inpatient discharge planners

f) Primary Medical Group

g) Claims department

h) Medical Director upon review of quality or utilization data

i) Referral from community resource programs

j) Member self and/or family referral

k) Blue Shield Promise or its contracted/delegated medical groups shall identify conditions for which more intensive case management is necessary

l) Routine screening and selection should be performed to identify those beneficiaries with multiple or severe chronic medical conditions who would benefit from a coordinated care management strategy

Complex Case Management Software Application:

Blue Shield Promise utilizes an electronic Care Management (CM) System as the primary application to support CCM functions and workflow. This system provides the tools and functionalities for a comprehensive approach to care management. This includes the ability to stratify members based on risk/acuity in addition, this CM system is an integrated approach to member management and improves communication among the inter-disciplinary team to optimize outcomes.

The CM system has the ability to prompt and set reminder tasks for the care manager for member next steps or follow up care. Once the Care Manager discusses the next scheduled contact with the member (may be an exact date or relative date), the Care Manager sets up the task. The method of communication with the member is telephonic, unless stated otherwise.

The CM system automatically populates date, time, and Care Manager's name with every entry/documentation by the Care Manager. The CM system uses evidence-based clinical guidelines and customizable functions to create assessments for the management of distinct populations.

Clinical Guidelines:

The CM system is pre-loaded with multiple evidence-based assessments for most disease states. These assessments are called focused assessments. In addition, Blue Shield Promise uses the following guidelines, but are not limited, in development of assessments and management:

- National Heart, Lung, and Blood Institute (NHLBI)
- National Education and Prevention Program (NAEPP)

- Expert Panel Report 3 (EPR3): Guidelines for Diagnosis and Management of Asthma 2007
- Global Initiative for Chronic Obstructive Lung Disease 2016
- Heart Failure Society of America Comprehensive Heart Failure Practice Guideline
- ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults
- American Diabetes Association
- Agency for Healthcare Research and Quality
- Center for Disease Control (CDC)
- MCG Chronic Care Guidelines, 2021, 25th Edition
- Regulatory Agency Guidelines
- NCQA Guidelines
- EPSDT (Early and Periodic Screening Diagnostic and Treatment) Policy
- American College of Obstetricians and Gynecology (ACOG)
- DHCS Provider Manual

D. PROCEDURE

Eligibility/Selection Criteria for CCM:

The following criteria meet the definition of CCM:

- Major Organ Transplant (pre-transplant workup, awaiting transplant, or post-transplant)
- Major Trauma, including traumatic brain injury
- Multiple Chronic Conditions that significantly impair member's health
- 3 or more hospital and/or Emergency Department admits within a 12-month period
- Readmission with thirty (30) days with the same/similar diagnosis/condition
- Polypharmacy utilization consisting of > 30 prescriptions per quarter
- Diagnosis of cancer requiring multiple modalities of treatment with complex coordination of care across multiple disciplines
- Members with disabilities requiring special care
- Members with major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia)

- Chronic illnesses that result in high utilization (see below)
- Chronic Condition that requires member to receive Private Duty Nursing Services
- High-Cost Claimants

Chronic Conditions that Qualify for CCM:

- Diabetes
- Chronic Kidney Disease
- End Stage Renal Disease (ESRD)
- Hypertension
- Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Respiratory Failure, Pulmonary Hypertension (HTN), Emphysema, Chronic Bronchitis, Pulmonary Fibrosis,
- Chronic Heart Failure (CHF), Cardiomyopathy, Coronary Artery Disease (CAD), Arrythmias, Peripheral Vascular Disease, Chronic Venous Thromboembolic disorder
- Lupus, Rheumatoid Arthritis
- Diseases of Musculoskeletal System: Multiple Sclerosis
- Parkinson's Disease, Alzheimer's, Advanced Dementia
- Cirrhosis of Liver / Chronic Liver Disease
- Pressure Ulcers
- Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)
- Metastatic Cancer
- Severe, persistent mental illness
- Spinal injuries that can include Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit;
- Major organ transplant (pre-transplant workup, awaiting transplant, or post-transplant)
- Severe hematologic disorders, limited to: Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplatic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder;
- Chronic Condition that requires member to receive Private Duty Nursing Services

Exclusion Criteria:

- Member is determined through further assessment to be sufficiently well managed through self-management or through another program.
- Member is determined to not fit the high-risk eligibility criteria.

- Members who cannot be reached after 3 attempts by phone and/or letter correspondence
- Member is enrolled in Hospice program.
- Member declines case management program.
- Member opts in and is enrolled in to Targeted Case Management or Enhanced Care Management

Member Enrollment/Engagement Process:

- Identify members eligible for CCM as outlined above either concurrently or on a minimum on a monthly basis through data reports.
- The Complex Care Manager is sent an electronic referral in the CM system for each identified member to evaluate for CCM. The CM system nomenclature for this process is called "Case and Task."
- The Complex Care Manager receives an automated "task" in the CM system identifying the member for "review". Upon receipt of the "task" the Complex Care Manager is required to complete the following steps:
    - Review member information in, including pharmacy, Utilization Management (UM)/authorization, claims data, previous hospitalizations, current and previous notes, and assessments, if applicable
        - Contact the member telephonically to explain the CCM Program and engage. Three (3) attempts are made to reach the member within a 2-week period using a telephonic and letter method.
- If the member agrees, mail the Welcome Letter and *Member Bill of Rights*.

Care Management Evaluation Process:

I. Prior to outreaching the member, the Complex Care Manager utilizes Preppy AI to obtain a summary of the member's history, case status, and care management needs to enable focused and member-centered conversations. Preppy AI supports but does not replace the nurse's clinical judgement when assessing member's needs. The Complex Care Manager initially contacts the member to explain their role, the process for using the care management services, how the member became eligible to participate, what the program offers, and their ability to opt in/opt-out of the care management service. If the member opts out of the program, care coordination support is offered to the member for basic coordination needs – refer to policy 10.4.19 Case Management and Care Coordination. After receiving verbal agreement to participate from the member and documenting this in the CM system, the Complex Care Manager validates the Preppy AI summary with the member and conducts the comprehensive General Health Assessment. This assessment is required to be conducted with every member identified for potential enrollment in

CCM. The questions within this assessment were developed to capture the critical information to develop an effective Individualized Care Plan (ICP). The General Health Assessment (GAC) is periodically reviewed and updated to meet the needs of this distinct population and in accordance with regulatory requirements. The assessment is done as expeditiously as the member's condition requires. It must be initiated within 30 calendar days from the date that the member was identified as eligible for complex care management services and must be completed within 60 calendar days.

The date of identification for complex care management is based on the date of referral into the CM system if the member is directly identified for complex case management after successful engagement with a care manager, and provides verbal consent to program enrollment. Or, the date the member is placed into CCM acuity by the care manager if the member opts into Case Management or Care Coordination prior to opting into Complex Case Management.

The assessment questions were created to illicit the following information below, but is not limited to:

- Current health status, including condition-specific issues, the member's self-reported health status, information on the event or diagnosis that led to the member's eligibility for care management, screening for likely comorbidities (e.g., high-risk pregnancy and heart disease, diabetes, etc.), and current medication including schedules and dosages.
- Clinical history, including condition onset, acute phases, inpatient stays and major procedures including surgeries, treatment history, and current and past medications, including schedule and dose. To the extent possible, collect dates when documenting clinical history.
- Activities of daily living (ADL), including bathing, dressing, going to the toilet, transferring (e.g., getting in and out of chairs), feeding and continence, and the reason for the need for assistance and the type of assistance required; if member does not need assistance with any ADLs, this will be documented as well, e.g., "Member is fully independent with ADLs."
- Behavioral health status, mental health disorders, and substance use that may impact the member's ability to process information or communicate and understand instructions.
- Cognitive function is assessed in order to determine the members ability to communicate and understand instructions and the ability to process information about their illness.
- Social Determinants of Health such as financial, transportation, housing, food insecurity, personal safety, etc., are barriers that can impact the members' health and plan of care. If member does not want to discuss any of these areas, this will be documented as well, e.g., "Member declined to discuss [enter subject(s) member does not want to discuss] at this time."

- Psychosocial issues that may present barriers to following the care plan, such as beliefs or concerns about the condition or treatment
- Cultural and linguistic needs, preferences, or limitations with consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs that may be potential barriers to effective communication or care and acceptability of specific treatment
- Visual and hearing needs, preferences, or limitations to identity potential barriers to effective communication or care.
- Caregiver resources and involvement (e.g., family involvement in and decision making about the care plan).
- Adequacy of available benefits that will be needed to fulfill a treatment plan; includes assessment of benefits covered by the organization and by providers, services carved out by the purchaser, services that supplement those the organization has been contracted to provide.
- Available community resources to supplement Blue Shield benefits to fulfill the treatment plan, including community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. If member does not need community resources, this will be documented as well, e.g., "Member does not need any of the available community resources."
- Life-planning activities, including wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms
- Medication safety, including knowledge and adherence.
- Resources required addressing immediate needs such as inpatient or outpatient referrals and may include alternative benefits when medically necessary and cost effective.
- Care coordination and transitions of care needs.
- Safety concerns
- The right to decline participation or disenrollment at any time during the care management process.
- A narrative summary of identified issues will be explained and whether or not if it necessitates follow-up.

PCP Notification Process:

- After the member is enrolled in CCM their PCP is notified in writing which includes an explanation on the services of the CCM Program and Care Manager contact information.

II. The PCP will receive a copy of the welcome letter, individualized care plan, and closure letter, as applicable.

- The PCP will periodically receive written correspondence from the Complex Care Manager with a clinical status update on their member.

III. The Complex Care Manager is required to telephonically contact the member's PCP when there is a change in member condition and/or to coordinate care/services when applicable.

Member Call Frequency Level:

Upon completion of the initial General Health Assessment the Care Manager determines the member call frequency per member's individual needs.

- The Complex Care Manager sets a reminder task in the CM system when the member needs to be contacted.
- The reminder task for member communication is as follows:
  - Every 3 months for members who are not actively engaged but are being monitored per clinical judgement
  - At minimum, every 30 days for actively engaged members
- Typically, outreach can be made every 14 days or more often if necessary per member's active individual needs The purpose of member contact is to reassess the member's condition as compared to their developed care plan, update the general health assessment, or complete a medication review. Members can shift at any time to different levels of follow up frequency based on their needs or change in health status. Interventions are based on the member centric care plan that was created.

Care Management Plan:

- The General Health Assessment completed with the initial member contact has automated functions to develop an individualized Care Plan based on the member's responses to specific questions.
- The Care Plan generated populates specific Problems, Goals, and Interventions. It is the Complex Care Manager's responsibility to initially review the Problems, Goals, and Interventions and adjust and prioritize them as indicated to appropriately address the member's needs and desires.
- Problems, Goals, and Interventions to meet member/caregiver needs can be manually selected at the discretion of the Complex Care Manager at any time when indicated.

IV. A member self-management care plan will be developed, agreed upon, and communicated to the member. It incorporates disease specific management programs, as applicable. (Including, but not limited to, asthma and diabetes).

- The Complex Care Manager is required to do the following for each goal and Intervention:
    - Determine target date and actual date for each goal/intervention completion
    - Document progress/status
    - Document member compliance with achievement
    - Select barriers to achieving the goal
- The Complex Care Manager is required to utilize the Care Plan Module and update the General Health Assessment in the CM system:
    - Identify member and caregiver barriers to meeting Goals, Problems, and Interventions
    - Assessment of member and caregiver progress to care management plans and specific Problems, Goals, and interventions and documentation of modification as needed
    - Assessment of member progress to self-management plans
    - Member/caregiver participation level in care management program
- The Complex Care Manager utilizes motivational interviewing skills to promote continued member engagement, self-autonomy, shared decision-making, and achievement of goals
- General and disease specific educational materials are shared with the member specific to their care needs identified on the assessment data and Care Plan development

Inpatient Care Coordination:

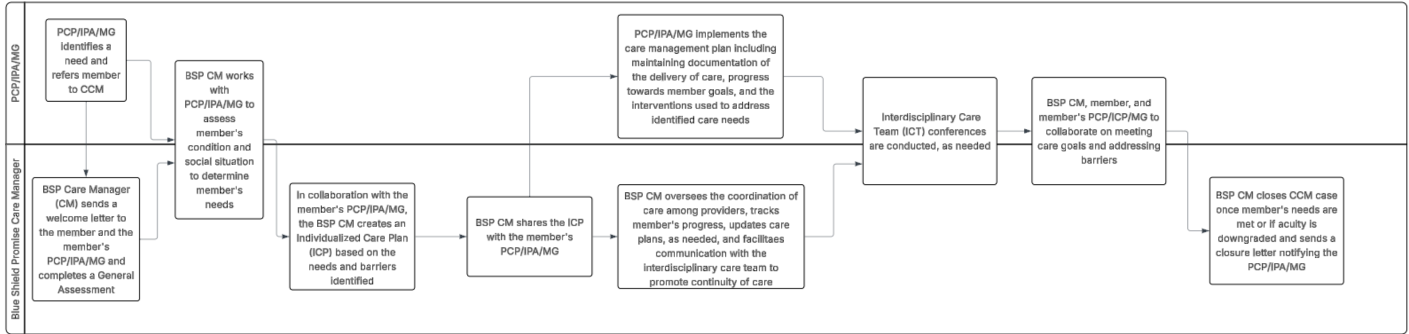
- When a member enrolled in CCM is admitted to a hospital the respective Complex Care Manager receives notification via an automated Task Reminder in the CM system.
- The Complex Care Manager tracks the clinical progression of the member through documentation in Auth Accel (utilization management system) by the inpatient care manager.

V. The Complex Care Manager's level of involvement required while the member is hospitalized is discussed and coordinated with the Inpatient Care Manager

PCP Coordination:

The PCP, IPA, or Medical Group is responsible for coordinating basic care management services to meet the specific needs of each member and for implementing the care management plan under the oversight of Blue Shield Promise. Blue Shield Promise oversees the coordination of care among providers, tracks member progress, updates care plans as needed and facilitates communication with other providers to promote continuity of care. The PCP, IPA,

or Medical Group must maintain thorough documentation that captures the delivery of care, progress toward member goals, and the interventions used to address identified care needs. The following outlines the process for PHP and PCP, IPA, or Medical Group collaboration for Complex Care Management (CCM).



Multi-Disciplinary Coordination:

VI. The Complex Care Managers work collaboratively with additional staff for a multi- disciplinary approach to optimize member outcomes. Occasionally, the Complex Care Managers may convene Inter-Disciplinary Care Teams (ICT) to coordinate and address members' needs.

- Member is invited to participate in ICT to participate in their care goal discussions.
- Members of the ICT include but not limited to the following:
  - Social Workers
  - Pharmacists
  - Care Managers
  - Health Educators
  - Behavioral Health Workers
  - Medical Director
  - Primary Care Physician (PCP)

Shared Decision-Making/Person-Centered Planning:

All services provided by Blue Shield Promise Care Management shall incorporate Shared Decision-making/Person-Centered Planning approaches that are collaborative and responsive to the members' continuing health care needs. This will include:

- Identifying each members' preferences and choices regarding treatments

and services, and abilities

- Ensuring the participation of the member and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services
- Ensuring that members receive all necessary information regarding treatment and services so that they may make an informed choice

Communication

Language assistance is available for members which includes but is not limited to: aids and services for people with disabilities, like documents in braille and large print. Member communication is sent to member in the format the member requested.

Population Assessment:

On a minimum of an annual basis Blue Shield Promise assesses the characteristics of all members to determine if there is a need to address a specific population or subpopulation. This information along with the monthly evaluation of Complex Care Managed member acuity utilized to determine current CCM resources to ensure appropriate staffing ratios to meet the needs of the members.

Reports used for population assessment for all lines of business including but not limited to the following:

- Age and gender breakdown
- Language percentage breakdown
- Utilization statistical reports by line of business including:
  - Acute admissions
  - Acute readmissions
  - Emergency room visits
  - Bed days
- Health Risk Assessment acuity tiering
- Health Risk Assessment Quantitative Analysis

Based on these reports the CCM processes will be reviewed and updated on an annual basis to ensure the program is adequately addressing member needs.

Discharge of Member from CCM:

The Complex Care Manager appropriately discharges the member from care

management services based upon industry standard established case closure guidelines.

- Achievement of targeted outcomes
- Maximum benefit reached
- Change of health setting
- Loss or change in benefits
- Member can no longer be reached after 3 attempts
- Member refuses to participate
- Member has, or develops, an exclusion criterion
- Member or plan initiated disenrollment from case management services due to the irreconcilable breakdown in the case manager-member relationship, or for any other reasons determined by the department to constitute "good cause".
    - "Good cause" can include: persistent and/or unrealistic demands, member refusing to comply with reasonable accommodations or appropriate solutions, lack of courteous and respectful interactions leading to disruption of regular operations, verbal or physical intimidation, violence or threat of violence towards plan staff.
- Death of the member

E. MONITORING

I. PHM clinical nursing staff, senior clinical leadership, and Medical Directors are formally, consistently, and systematically engaged in the design, development, oversight, and implementation of Population Health Management (PHM) Care Management activities. Such engagement is conducted pursuant to established and documented governance processes, including but not limited to ongoing consultation, formal review mechanisms, documented oversight, and structured interdisciplinary collaboration. These processes are intended to ensure regulatory compliance, operational accountability, and the effective delivery of care management services, including coordination of case management functions and transitions of care. The Director of Population Health Management (PHM) Clinical Programs maintains a dotted-line reporting relationship with the Promise Chief Medical Officer and the Medical Directors for the purpose of collaboration, clinical alignment, and oversight related to care management and transitions of care. Nursing staff questions of a clinical nature are to be resolved with a Promise Medical Director responsible for clinical oversight.

II. The Blue Shield Promise internal committees, Medical Services Committee

Meeting, is responsible for the monitoring and oversight of Complex Care Management services for all eligible members under Cal-AIM on a quarterly basis. In addition, Blue Sheild Promise is under regular reporting and monitoring of external regulators on a monthly and quarterly basis. This is done to ensure compliance with Cal-AIM contract requirements, and other DHCS guidance. In addition, Blue Shield Promise teams use the following ways to ensure coordination of care needs monitored and addressed:

- Ongoing monitoring of NCQA compliance via weekly report to monitor all identified CCM cases to ensure timely completion of requirements.
- Ongoing monitoring of primary care physician (PCP) correspondence and notification via weekly report to ensure that PCP are informed of the member's enrollment in CCM services.
- Monthly monitoring of member engagement

III. Monthly CCM audits by the clinical auditing team to ensure 90% or higher compliance. Cases falling less than benchmark are reviewed and addressed with the care manager.

F. REPORTING

Reports Table						
Report Name	Report Description	Regulator/ Internal	Prepared by	Reviewer/ Approver	Method of Submission	Frequency
HICE	Care Management outcome reporting	Regulatory	Dave Dwelley	CM Director	Email	Quarterly
JSON	Care Management engagement by county	Regulatory	Praveena Chennakes	CM Directors	Email	Monthly
NCQA Mock Audit	Care Manageme compliance with assessment timelines	Ashley Davis		CM Leadershi teams	Email	Weekly
MCS Care Management Member Satisfaction	Care Manageme Engagement	Internal	Tableau	CM Leadershi teams	Meeting Documentat	Monthly

Member Satisfaction	Care Manageme satisfaction survey results	Internal	Vivian Demonico	CM Leadershi Team	Excel/ Meeting documentati	Monthly

G. ATTACHMENTS

P&P PHMCM-003	Health Risk Stratification and Assessment Process
P&P 60.10.20	Population Needs Assessment
PHMSS-004	CalAIM Community Supports
P&P 10.4.11	Risk Stratification and Segmentation
PHM-008	Case Management and Care Coordination
	Blue Shield of California Promise Health Plan CCM Program Description 2021 NCQA Guidelines 2022

H. REFERENCES

I. DHCS Primary Contract Exhibit A Att. III SOW

II. LA Care Contract

III. Title 22, CCR, Section 5135

IV. NCQA Population Health Management Standards

V. APL 23-029: Memorandum of Understanding requirements for Medi-Cal managed care plans and third-party entities.

VI. APL 25-016 Alternative Format Selection for Members with Visual Impairment

I. REVISION HISTORY

Date	Modification (Reviewed and/or revised)

04/2 026	Update to address NCQA PHM 3 requirements and added CMO oversight verbiage
02/2026	Annual review, Updates to address APL 25-016, NCQA PHM 3A, NCQA PHM 5C, and program clarification
10/2025	Review and update to include language from retiring P&P 10.4.20. Updated Policy # to PHMCM-002 from 10.27.2
1/2025	Updated language in "Case Management Evaluation Process" added reference to 10.4.19 Case Management and Care Coordination P&P. Updated member communication frequency for low level acuity
08/2024	10.04.06 Complex Case Management – New ID 10.27.02
2/2023	Updated Regulatory Requirements DHCS
11/2023	Revised to align with RFP efforts
07/2024	Annual review, updated template