Policy:	MA.6009
Title:	**Care Management and Coordination Process**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 08/22/2024*
Effective Date:	08/01/2005
Revised Date:	08/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines and processes for providing Care Management and Coordination to OneCare Members with multiple, or complex, conditions across the care continuum.

II. POLICY

A. CalOptima Health shall maintain a Care Management program that helps all Members, including those with multiple, or complex, conditions, to obtain access to care and services and coordinate their care.

B. CalOptima Health and its delegated Health Networks shall ensure appropriate Care Management programs to coordinate Member services and access to needed resources.

C. The Care Management program description shall include the following:

1. Evidence used to develop the program;
2. Criteria for identifying Members who are eligible for the program;
3. Services offered to Members; and
4. Defined program goals.

D. The Care Management program may include, but is not limited to the following most vulnerable Members:

1. Adults and their families experiencing homelessness;
2. Individuals at risk for avoidable hospital or emergency department admission;
3. Individuals with serious mental illness and/or Substance Use Disorder (SUD);
4. Individuals at risk for institutionalization or long-term care;
5. Individuals eligible for palliative care;

6. Homebound individuals; and

7. Individuals with cognitive impairment, Alzheimer's, or dementia.

E. The goal of Care Management and Coordination is to help a Member regain optimum health or improve functional capability in the right setting.

F. Care Management and Coordination involves a comprehensive assessment of a Member's condition, determination of available benefits and resources, and development and implementation of an Individual Care Plan (ICP) with problems, measurable goals, barriers, and interventions.

G. The Care Management and Coordination process is the responsibility of CalOptima Health and delegated Health Networks in collaboration with the Members' assigned Primary Care Provider (PCP), in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

H. The Care Management process shall include, but is not limited to:

1. Identification of all Members in need of Care Management and Coordination;

2. Standardized mechanisms to systematically identify high-risk Members;

3. Access to Care Management and Coordination by ensuring multiple avenues for referrals;

4. Management of Members using a documented and evidence-based Case Management system;

5. Documented care management process;

6. Process to inform eligible Members of Covered Services provided and ability to elect, or decline, the Covered Services;

7. Initial assessment process;

8. Process for providing ongoing Care Management and Coordination;

9. Process for measuring the effectiveness of care management;

10. Coordination of carve-out services as outline in Section III.B.1.e.ii. of this Policy;

11. Coordination of Out-of-Network services;

12. Coordination of long term services and supports (LTSS);

13. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department;

14. Ensuring a care management process that assesses and evaluates the needs of each Member in collaboration with the PCP in order to develop an Individual Care Plan (ICP);

15. Incorporating the Health Risk Assessment data and all available information and in the development of the Member's care plan; and

16. Informing and educating Practitioners in writing and verbally about the program.

I. CalOptima Health and its delegated Health Networks shall utilize a variety of sources to identify Members for Care Management.

J. CalOptima Health shall assess a Member for Care Management and Coordination based on response to the Health Risk Assessment (HRA) questions and provide a recommended Care Management Level (CML) based on review of the available data.

K. A Member shall have the right to decline participation in Care Management and may choose to participate in the program at a later date.

L. CalOptima Health shall evaluate Member satisfaction and effectiveness of its OneCare, or delegated Health Networks, Care Management programs in accordance with CalOptima Health Policy MA.6032: Model of Care.

O. CalOptima Health shall provide ongoing oversight of the CalOptima Health Community Network (CCN) and its delegated Health Networks to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements, which shall include but is not limited to oversight of the structures, processes, and outcomes of the Health Network operations, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

P. CalOptima Health and its delegated Health Networks shall ensure appropriate staff members are trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home and community-based services and long-term institutional care, including payment and coverage rules.

Q. CalOptima Health and its delegated Health Networks shall provide Palliative Care Services in accordance with CalOptima Health Policy GG.1550: Palliative Care Services.

R. CalOptima Health and its delegated Health Networks shall provide face-to-face encounters for the delivery of Care Management and Coordination services, or Enhanced Care Management-like (ECM-like) equivalent services at least on an annual basis, as feasible, and with the Member's consent.

S. CalOptima Health and its delegated Health Networks shall ensure the ICP and Interdisciplinary Care Team (ICT) process, including the formal ICT meeting, is developed and shared in accordance with CalOptima Health Policy MA.6040: First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements.

T. CalOptima Health and its delegated Health Networks shall provide Care Management and Coordination for planned and unplanned transitions across the care continuum, in accordance with CalOptima Health Policy MA.6030: Transition of Care.

III. PROCEDURE

A. Identifying and Referring Members for Care Management and Coordination.

1. During the Initial and Annual HRA outreach, CalOptima Health shall identify Members for Care Management and Coordination based on HRA answers. After review by the OneCare case manager, a CML is recommended for each Member. CMLs and associated risk level include:

   a. Low Risk: Basic Case Management;

   b. Moderate Risk: Care Coordination;

c. High Risk: Complex Case Management (ECM-like Care Management and Coordination) interventions are provided at this level for Members who meet ECM Population of Focus and Members may receive face-to-face outreach and interventions based on their needs and preferences. Focused interventions are provided to stabilize Members chronic and acute conditions including Provider-centric communication and proactive identification of transitions in care settings.

d. Monitoring: Members who are unable to be contacted during the HRA outreach and Members who decline to participate in case management shall be monitored for changes in health status and assigned a single point of contact for care navigation and to coordinate ICT communications.

2. CalOptima Health or the Health Network case manager shall review the HRA responses, conduct additional assessments as indicated, including facilitating PCP screening for dementia and Alzheimer's disease, and facilitate scheduling an ICT formal meeting if applicable.

   a. The ICT should include Providers of any Medi-Cal services the Member is receiving including LTSS.

   b. The ICT must include the Member's caregiver and a trained Dementia Care Specialist to the extent possible and as consistent with the Member's preferences if a Members has a documented dementia care need, including but not limited to:

      i. Wandering;

      ii. Home safety concerns;

      iii. Poor self-care;

      iv. Behavioral issues;

      v. Issues with medications adherence;

      vi. Poor compliance with management of coexisting conditions; and/or

      vii. Inability to manage ADLs/IADLs.

3. The ICT shall review the Member's current health care needs and identify a plan to support the Member within the health care system by facilitating access to care and services. The Member's Individualized Care Plan (ICP) is developed with the ICT.

4. CalOptima Health and the Health Networks will monitor Key Event alerts for changes in health status which may require reassessment of the Member's health care needs.

5. CalOptima Health and its delegated Health Networks shall utilize the following sources to identify Members for Care Management and Coordination:

   a. Disease management program referral;

   b. Discharge planner referral;

   c. Utilization management referral;

d. Member self-referral;

e. Practitioner referral; or

f. Other referral sources, including, but not limited to: family members and caregivers, ancillary providers, behavioral health/substance abuse specialists, pharmacists, the Aging and Disability Resource Center (ADRC), specialty programs, disability programs, long term service and support providers, community resources, Medication Therapy Management (MTM) Program, and social workers.

6. CalOptima Health may receive referrals by electronic transmission, telephone, or written correspondence.

7. CalOptima Health shall communicate the availability of Care Management and Coordination programs to Members and Providers, including the telephone number to call for referrals.

B. Care Management and Coordination Process

1. Individual Care Plan (ICP)

a. A Member should actively participate in the development of their ICP, in accordance with their individual physical and psychosocial capabilities and their desired level of involvement.

b. The ICP shall be used to meet both Medicare and Medi-Cal requirements. If the Medicare and Medi-Cal guidance for ICPs conflict, Medicare guidance will be followed.

c. For Basic Case Management, the ICP shall be developed, implemented and modified in collaboration with the Member's PCP.

d. For Care Management and Coordination, the ICP shall be developed, implemented, and modified by the case manager in collaboration with the PCP.

e. The ICP shall be person-centered and informed by the Member's Health Risk Assessment and past utilization of both Medicare and Medi-Cal services. The ICP shall include the following elements:

i. Identification of prioritized goals that consider the Member's and caregiver's goals, preferences, and desired level of involvement in the Care Management plan. Target completion dates shall be included for each goal with the evaluation of progress.;

ii. Identification and facilitation of referrals for any carved-out services the Member needs including but not limited to:

a) Community Based Organizations such as those serving Members with disabilities (e.g. independent living centers), Caregiver Resource Centers, and those serving Members with dementia (e.g. Alzheimer's organizations);

b) County Mental Health and substance use disorder services;

c) Housing and homelessness providers;

d) Community Supports providers in the network (including but not limited to support for housing stability, food security, and caregiver support needs);

e) 1915(c) waiver programs, including MSSP;

f) LTSS programs including IHSS and Community-Based Adult Services (CBAS)with facilitation of assessments and medical certification forms as part of eligibility process as appropriate;

g) Medi-Cal transportation to access Medicare and Medi-Cal services;

h) Medi-Cal dental benefits;

i) Podiatry Care;

j) No cost gym benefit;

k) Vision benefit; and

l) Advanced Care Planning.

i. Identification of barriers to meeting goals, or compliance with ICP;

a) Barrier analysis shall include issues such as language or literacy, lack of or limited access to reliable transportation, lack of understanding of condition, lack of motivation, financial or health insurance issues, cultural beliefs, hearing or vision limits, and psychological impairment.

iv. Development of a schedule for follow-up and communication with a Member which may include, but not be limited to, counseling, referral to the disease management program, education and self-management support. Documentation of when and how a case manager will follow up with a Member after facilitating a referral to a health resource. Documentation can specify that follow-up is not applicable in all situations;

v. Development and communication of a Member's self-management plan is designed to shift the focus from Members receiving care from a Practitioner, or a care team, to Members providing care for themselves, when appropriate. Member self-management plan activities include, but is not limited to:

a) Maintaining a prescribed diet;

b) Charting daily readings (e.g., weight, blood sugar); or

c) Changing a wound dressing as directed.

vi. A process to assess progress towards meeting Care Management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals, as needed;

vii. Planning for Continuity, or Transition of Care when benefit coverage ends. CalOptima Health or a Health Network shall:

a) Identify transitioning Members who are receiving approved services, but whose benefit coverage shall end while still needing Medically Necessary care;

b) Identify available community resources and alternative care; and

c) Notify and educate transitioning Members regarding alternative care and community resources.

viii. Collaborative approaches to be used, including family participation;

ix. Resources to be utilized, including the appropriate level of care; and

x. Planning for Continuity, or Transition of Care.

f. CalOptima Health and a Health Network shall re-evaluate and update a Member's ICP based on changes in the Member's condition, level of complexity and clinical needs.

i. The ICP shall be re-evaluated according to the Member's prioritized goals, levels of complexity and clinical needs.

C. Informing and Educating Providers

1. CalOptima Health and the delegated Health Networks shall provide Practitioners with written information about the program:

a. CalOptima Health provides instructions to the Health Networks and Practitioners regarding how to use the services of the Care Management and Coordination program. This information is provided in the Provider Manual, Provider training and quarterly newsletters, and through CalOptima's Provider Relations Department.

b. CalOptima Health educates the Health Networks about its role in the Member's Care Management and Coordination program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Provider Manual
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide, Updated CY 2024, January 2024
D. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Policy Guide, Updated February 2024
E. CalOptima Health Policy GG.1110 Primary Care Practitioner Definition, Role, and Responsibilities
F. CalOptima Health Policy GG.1550: Palliative Care Services
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy MA.6030: Transition of Care
I. CalOptima Health Policy MA.6032: Model of Care
J. CalOptima Health Policy MA.6040: First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/24/2021	Department of Health Care Services (DHCS)	Approved as Submitted
11/02/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HIS

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.6009	Case Management Process	OneCare
Revised	09/01/2008	MA.6009	Case Management Process	OneCare
Revised	12/01/2010	MA.6009	Complex Case Management Process	OneCare
Revised	10/01/2013	MA.6009	Complex Case Management Process	OneCare
Revised	01/01/2016	MA.6009	Care Management and Coordination Process	OneCare
Revised	01/01/2017	MA.6009	Care Management and Coordination Process	OneCare
Revised	10/01/2017	MA.6009	Care Management and Coordination Process	OneCare
Revised	08/01/2018	MA.6009	Care Management and Coordination Process	OneCare
Revised	02/01/2020	MA.6009	Care Management and Coordination Process	OneCare
Revised	12/31/2022	MA.6009	Care Management and Coordination Process	OneCare
Revised	08/01/2024	MA.6009	Care Management and Coordination Process	OneCare

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Basic Case Management (Care Management Level)	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member's health and functional needs. Services are provided by the Primary Care Physician (PC) or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.
Care Management and Coordination	A collaborative process of assessment, planning facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost effective outcomes.
Complex Case Management (Care Management Level)	Case Management provided to Members who are at high-risk; defined as having medically complex conditions that include the following but is not limited to: 1. Spinal injuries; 2. Transplants; 3. Cancer; 4. Serious Trauma; 5. AIDS; 6. Multiple chronic illness; or 7. Chronic illnesses that result in high utilization.
Continuity of Care	Refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care
Dementia Care Specialist	D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.

Term	Definition
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep their best physical, mental, and social well-being.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Key Event	Key Event alerts include, but are not limited to: 1. Hospital or skilled nursing facility (SNF) admission; 2. Emergency Department (ED) visit; 3. New behavioral health referral; 4. Alteration in mental or functional status; 5. Change in care setting; 6. Change in medication 7. Increase in the number of medications used; 8. Change in Managed Long Term Services and Supports (MLTSS) level; 9. Multiple falls; 10. Authorization request for out of area provider; and 11. Unsafe home environment.
Medically Necessary	The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
Medication Therapy Management (MTM) Program	A program of drug therapy management furnished by a pharmacist or other qualified provider that is designed to: 1. Ensure covered Part D drugs under OneCare are appropriately used to optimize therapeutic outcomes through improved medication use; and 2. Reduce the risk of adverse events, including adverse drug interactions for targeted beneficiaries.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Out-of-Network	Outside of the selected Physician Medical Group's participating provider network within the Service Area.
Populations of Focus (POF)	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; g. Individuals with Intellectual and Developmental Disabilities (I/DD); and h. Pregnancy, Postpartum and Birth Equity and members. 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers;

Term	Definition
	c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); f. Transitioning from incarceration; and g. Pregnancy, Postpartum and Birth Equity Members.
Practitioner	A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Pharmacy (PharmD), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Policies.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.