Policy:	MA.6040
Title:	**First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 11/22/2024*
Effective Date:	06/01/2016
Revised Date:	11/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the roles and specific responsibilities of the Personal Care Coordinator (PCC) through the CalOptima Health OneCare program, CalOptima Health CCN, and contracted Health Networks.

II. POLICY

A. The PCC shall assist the OneCare Member in navigating the healthcare delivery system and facilitate access to care and services.

B. The PCC shall promote coordination of care by facilitating communication between CalOptima Health, the Health Networks, the Primary Care Provider (PCP), and the Interdisciplinary Care Team (ICT).

C. The goal of the comprehensive Model of Care (MOC) process is to serve beneficiaries through integration of care on a real-time basis with the following:

1. A standardized, consistent approach to providing care based on firm data and medical necessity;
2. Specific, actionable requirements for all aspects of healthcare needs;
3. Communication of important data across the continuum of care;
4. Efficient, transparent documentation in the Health Network and CalOptima Health electronic medical management systems;
5. Methodical identification of those “at risk” for adverse outcomes and expensive care with improved detection of actionable areas for intervention;
6. Coordinated healthcare at multiple points of service;

7. Improving access to essential services and affordable care;

8. Improving access to preventive health services;

9. Assuring appropriate utilization of services;

10. Reducing avoidable hospitalizations;

11. Improving seamless transitions of care across healthcare settings, providers and health services;

12. Improved outcomes at the individual Member level;

13. Improved provider satisfaction; and

14. Assure availability of high-quality health care programs.

D. The Centers for Medicare & Medicaid Services (CMS) requires that all Members in a Medicare Advantage Special Needs Plan receive care management services at a level consistent with the Members' degree of medical complexity.

E. The OneCare Model of Care (MOC) components and requirements include the following guidelines:

1. CalOptima Health and Health Network combined staff service ratio shall be one (1) PCC for every four hundred (400) Members (1:400).

2. The staffing mix may be a combination of licensed (RN, LCSW) and non-licensed personnel (PCC).

3. All Health Risk Assessments (HRAs) and Individualized Care Plans (ICPs) shall be reviewed by a licensed healthcare professional, in accordance with CMS regulations to ensure identified HRA needs are addressed.

4. The OneCare RN Case Manager reviews and validates the contents of the HRA for accuracy and relevance. Care Management Levels (CML) and licensed staffing ratios for servicing Members are as follows:

   a. Complex Care Management: One to thirty-four Members (1:34)

   b. Care Coordination: One to five hundred Members (1:500)

   c. Basic Care Management and Monitoring: One to one thousand (1:1,000)

5. Staffing ratios, PCC assignment, CML, ICP, care goal discussion, and ICT dates must be reported monthly by Health Networks to CalOptima Health.

6. The Health Networks will notify CalOptima Health immediately of any changes to Health Networks PCC staffing levels or personnel.

7. CalOptima Health and its delegated Health Networks must ensure a Health Network PCC completes all responsibilities as defined in job description, which may include documentation in duplicate systems.

F. All OneCare Members will be assigned a CalOptima Health CCN or a Health Network PCC who will be the Member's primary point of contact unless a Case Manager is assigned to the Member.

G. PCCs are associated directly with both CalOptima Health, the Health Networks and CalOptima Health CCN.

1. CalOptima Health's OneCare PCCs shall coordinate the HRA process and outreach to assist Members with telephonic HRA completion. Additional roles and responsibilities include, but are not limited to, the following:

a. Collaborate with CalOptima Health CCN and Health Network PCC to ensure timely communication of Member's clinical information;

b. Collaborate with respective licensed professionals in the creation of an ICP;

c. Facilitate communication of a Member's HRA, to the assigned CalOptima Health CCN or Health Network PCC;

d. Facilitate warm transfers of Member to assigned CalOptima Health CCN or Health Network PCC or case manager, when appropriate; and

e. Maintain documentation of Member's case, HRA, ICP and ICT within CalOptima Health's or a Health Network's medical management system.

2. Health Network and CalOptima Health CCN PCCs will support the Member within the health care system and facilitate access to care and services including, but not limited to, the following:

a. Collaborate with the CalOptima Health PCC to ensure timely communication of Member's care plan to the PCP, Health Network, CalOptima Health and Member;

b. Assists in retrieval of all necessary documentation for creating ICP and in advance of the ICT meeting (e.g. ED visits, inpatient admissions, outpatient procedures, medication list, problem list (Diagnoses) as needed, early detection studies, vaccination records, Advance Directive information, test results, imaging studies, social issues as applicable, Long Term Services and Supports (LTSS) information, Behavioral Health information as indicated);

c. Guide Members in understanding and accessing the benefits they are entitled to under Medicare and Medi-Cal through the CalOptima Health OneCare program; including but not limited to:

i) Denti-Cal;

ii) Palliative Care; and

iii) Hearing Aid benefit.

d. Work collaboratively with the Case Management team to assist the Member in meeting their preventive care goals;

e. Assist with scheduling of appointments;

f. Facilitate appropriate referrals to Long Term Supports and Services (LTSS), behavioral health, and community resources;

g. Facilitate warm transfers of Member to assigned case manager when appropriate;

h. Outreach to Member to complete an assessment when there are changes to a Member's health status if indicated;

i. Communicate a Member's case notes, HRA, ICP, and ICT proceedings to CalOptima Health for integration in CalOptima Health's medical management system as requested.

j. Document thoroughly and accurately in the appropriate medical management system, as indicated, for every interaction with a date and time stamp with the understanding that this becomes part of the Member's legal record;

k. Be responsible for ICT meeting invitations by phone call, encrypted email, letter faxed or mailed; all documented with date and time stamps as described in Section II.G.2.k. of this policy;

l. Schedule and participate in ICT meetings as appropriate within the defined time requirement;

m. Communicate within the defined time requirement, the completed ICP to the Member and ICT participants;

n. Follow up and notify the health care team of alerts for Key Events/triggers which may signal a change in the Member's health status requiring increased interventions;

o. Manage communication and information flow regarding referrals, transitions, and care delivered outside of the primary care site; and

p. Activate appropriate protocols in situations where a Member's health may be endangered, i.e. initiate suicide protocols or welfare checks.

H. Turn-around times for CalOptima Health CCN or Health Network's ICT and ICP documentation shall be determined by CML and adhered to as follows:

1. Complex Case Management: ICP shall be developed within thirty (30) calendar days from the date of HRA collection or posting-date for returned mailed HRA, or ninety (90) calendar days from the date of enrollment, whichever is earlier.

   a. The formal ICT meeting shall take place within sixty (60) calendar days from HRA collection date.

2. Care Coordination: ICP shall be developed within thirty (30) calendar days from the date of HRA collection or posting-date for returned mailed HRA, or ninety (90) calendar days from enrollment, whichever is earlier.

   a. The formal ICT meeting shall take place within ninety (90) calendar days from HRA collection date.

3. Basic Case Management and Monitoring: ICP shall be developed thirty (30) calendar days from posting of the completed HRA, or ninety (90) calendar days from the date of enrollment, whichever is earlier.

   a. The formal ICT meeting, when indicated, shall take place within ninety (90) calendar days from HRA collection date.

4. All Members must be offered a formal ICT meeting.

    a. A formal ICT meeting is required when it is:

        i. Requested by Member's PCP;

        ii. Requested by Member; or

        iii. Identified in a vulnerable population:

            a) Eligible for ECM Population of Focus per CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management - Eligibility and Outreach;

            b) Eligible for Palliative Care;

            c) Homebound; or

            d) Individuals with cognitive impairment, Alzheimer's, or dementia.

I. CalOptima Health and Health Network PCCs must complete mandatory PCC training in accordance with CalOptima Health Policy MA.6032: Model of Care.

III. PROCEDURE

A. CalOptima Health OneCare Processes Utilizing the PCC:

1. HRA Outreach by CalOptima Health OneCare in accordance with CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment.

2. CalOptima Health CCN and Health Network PCCs will monitor and follow up on Key Event alerts for changes in health status which may require further intervention of the Member's health care needs.

3. The CalOptima Health CCN and Health Network PCC shall be responsible for:

    a. Referring Members to the Health Network Case Manager as needed;

    b. Convening a formal ICT meeting if appropriate including but not limited to:

        i. Members in Care Coordination or Complex Case Management;

        ii. Members in Basic Case Management who are offered and who request ICT meeting; and

        iii. Members in any sub-population considered most vulnerable.

    c. Updating the ICP if appropriate; and

    d. Communicating the updated ICP to Members of the ICT.

4. If an HRA packet is returned "Undeliverable" by the postal service, the HRA returned packet will be handled as follows:

a. For returned mail that was undeliverable and DOES have a forwarding/updated address, route the unopened packages to Customer Service (CS) data entry queue.

i. CS verifies the forwarding address and updates the address in Facets and resends the HRA to the new address, per the current process.

b. For returned mail that was undeliverable and DOES NOT have a forwarding/updated address, route the unopened packages to CS data entry queue.

i. PCC will document in medical management system for no valid address.

5. Response to the HRA questions are reviewed and used to stratify the Members into recommended CMLs.

6. ICP HRA Process:

a. With Completed HRA:

i. Once an HRA is completed for a Member, whether telephonic, mailed, video, or in person the OneCare PCC shall enter the data into CalOptima Health's medical management system.

ii. The HRA responses are shared with recommended CML to Health Networks.

iii. The HRA is assigned to OneCare PCC or OneCare Case Manager who will review the responses and follow up with HRA related needs.

iv. The OneCare RN Case Manager:

a) Reviews the HRA to ensure appropriate capture of "actionable" items or Key Events based upon the Member's HRA responses;

b) Identifies any urgent care issues that may require an expedited review by the CalOptima Health CCN or Health Network Case Manager;

c) Contacts the CalOptima Health CCN or Health Network Case Manager within the same day, as appropriate, to facilitate review of urgent care issues;

d) Notes change in recommended CML with applicable justification, as appropriate;

e) Health Network files will be uploaded periodically throughout the day through an automated process to CalOptima Health's Secure File Transfer Protocol (SFTP) site for retrieval by the Health Networks;

1) CalOptima Health CCN Members will have an activity set for the Triage queue in CalOptima's Medical Management system to facilitate Member assignment to a case manager for Members with Complex or Care Coordination CML.

2) CCN Members with a basic CML will have an activity set for the CalOptima Health CCN PCC.

f) The OneCare CM Supervisor receives and analyzes SFTP error report to ensure successful upload of all files.

b. Without Completed HRA:

i. There are times when HRA data may not be available, these include:

a) A Member may refuse to complete an HRA; and

b) The Member may not have a valid address or phone number on file preventing completion of the HRA.

ii. CalOptima Health, in an automated process, will construct a risk tool to be posted via secure FTP to the Health Networks, when the HRA outreach attempts are unsuccessful or for Members who choose not to complete the HRA using all available data such as utilization, claims, encounters, and pharmacy.

B. CalOptima Health CCN or Health Network Processes Utilizing the CalOptima Health CCN or Health Network PCC.

1. On a daily basis, the CalOptima Health CCN or Health Network PCC shall access their CalOptima Health SFTP site to retrieve the HRA bundle files uploaded from the previous day.

2. Using a standardized protocol, the CalOptima Health CCN or Health Network PCC will review and distribute each patient level HRA bundle to the appropriate professional(s) for review.

3. The CalOptima Health CCN or Health Network Case Management staff shall:

a. Reviews the HRA and ICP for CML level, acute clinical needs and acts on or delegates to an appropriate Member of the care team;

b. Reviews the HRA and for appropriate CML;

i. Complex Case Management: CalOptima Health CCN or Health Network RN Case Manager to review and act on in accordance with CalOptima Health Policy MA.6009: Care Management and Coordination Process.

ii. Care Coordination: CalOptima Health CCN or Health Network RN Case Manager to review and act on in accordance with CalOptima Health Policy MA.6009: Care Management and Coordination Process.

iii. Basic Case Management: CalOptima Health CCN or Health Network PCC/Case Manager to send to PCP for follow up.

iv. Basic Monitoring: CalOptima Health CCN or the Health Network will assign a PCC as single point of contact who will monitor for changes in health status and coordinate ICT communication.

c. Facilitates assessment for LTSS needs (if indicated on HRA and not currently receiving). Assessments may be completed at the ICT meeting;

d. Facilitates PCP completion of medical certification form as part of the eligibility process for LTSS;

e. Facilitates PCP assessment if appropriate for dementia and Alzheimer's disease through resources such as Dementia Care Aware;

f. Facilitates coordination and referral to Community Supports for housing stability, food security, access to transportation, and caregiver support needs;

g. Supplemental assessments including caregiver assessments which may include but are not limited to the Benjamin Rose Caregiver Strain Instrument; and

h. If a Behavioral Health need has been identified, the CalOptima Health CCN or Health Network Case Manager facilitates an appointment with the PCP to rule out medical etiology for Member-reported symptoms.

4. The CalOptima Health CCN or Health Network PCC shall engage and coordinate with the ICT, development and completion of ICP and facilitate a formal ICT meeting as needed according to the member's needs. Turn-around times for CalOptima Health CCN or Health Network's ICT and ICP documentation shall be determined by CML and adhered to as in Section II.H. of this policy as follows:

   a. Complex Case Management: ICP is developed within thirty (30) calendar days from the date of HRA collection or posting-date for returned mailed HRA, or ninety (90) calendar days from the date of enrollment, whichever is earlier.

      i. The formal ICT meeting shall take place within sixty (60) calendar days from HRA collection date.

   b. Care Coordination: ICP is developed within thirty (30) calendar days from the date of HRA collection or posting-date for returned mailed HRA, or ninety (90) calendar days from enrollment, whichever is earlier.

      i. Formal ICT meeting shall take place within ninety (90) calendar days from HRA collection date.

   c. Basic Case Management and Basic Monitoring: ICP is developed thirty (30) calendar days from the date of HRA collection or posting-date for returned mailed HRA, or ninety (90) calendar days from the date of enrollment, whichever is earlier.

      i. Formal ICT meeting, when indicated as defined in Section II.H.4. of this policy, shall take place within ninety (90) calendar days from HRA collection date.

5. The ICP completion date will be when the licensed care professional signs off on the care plan.

6. All ICPs shall be updated on an annual basis at least within three hundred and sixty-five (365) days from prior ICP.

7. All members have an ICT where all ICT participants are encouraged formally or informally develop and coordinate the implementation of the ICP. The composition of the ICT shall be individualized to meet the Member's needs.

8. All members must be offered a formal ICT meeting and required when requested by member or PCP, those eligible for ECM, palliative care, homebound, stratified as high risk.

a. At minimum, core participants of the formal ICT meeting shall include the Member, caregiver or Authorized Representative, PCP or PCP support staff, and CalOptima Health CCN or Health Network PCC, Case Manager, Social Worker, and Health Network Medical Director

b. Additional ICT meeting participants will vary according to the needs of the Member and can include disciplines such as but not limited to:

   i. Specialists;

   ii. Hospitalist or SNF;

   iii. Hospital Case Manager and/or Discharge Planners;

   iv. Health Network Utilization Management staff;

   v. LTC staff;

   vi. Behavioral Health Specialist;

   vii. Social Worker;

   viii. Dementia Care Specialist;

   ix. Transition Coordinator/LTSS Liaison;

   x. Dietician;

   xi. Clinical Pharmacist;

   xii. Palliative Care Team; and

   xiii. Skilled nursing facility or sub-acute care facility staff.

c. Documentation of the formal ICT meeting shall include:

   i. List of all invited participants including the Member;

   ii. Participants who attended and those who did not attend and the reasons they did not attend;

   iii. Summary notes of the items discussed, Member preferences, any follow up items, and the parties responsible for following up;

   iv. Copies of the finalized ICP shall be distributed to the PCP and all other Members of the ICT and the Member in the Member's preferred language and format; and

   v. Documentation shall include confirmation that the ICP was shared with the Member and Members of the ICT.

d. The finalized ICP shall consider the Members Cultural, Language, Alternative Format and Health Literacy needs.

C. Quarterly audits are conducted using sample methodology for quality assurance check to ensure appropriate composition of the ICT and essential components of the ICP are present.

1. The OneCare RN Case Manager will complete an audit of the submitted documentation and provide feedback to CalOptima Health CCN or Health Network PCC if the documentation does not fully meet established criteria.

2. If CalOptima Health CCN or a Health Network's documentation continues to be out of compliance, the OneCare RN Case Manager will notify the Manager of Case Management for additional education and/or referral to the Delegation Oversight Committee (DOC).

3. The DOC will review and issue a Corrective Action Plan (CAP) or refer to OneCare's Compliance department for further action.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract Year 2024, August 2024
C. CalOptima Health 2023 MOC, July 8, 2022
D. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management - Eligibility and Outreach
E. CalOptima Health Policy GG.1550: Palliative Care Services
F. CalOptima Health Policy MA.6009: Care Management and Coordination Process
G. CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
H. CalOptima Health Policy MA.6032: Model of Care
I. Medicare Improvements for Patients and Providers Act (MIPPA)
J. Medicare Managed Care Manual, Chapter 5 – Quality Assessment, §20.2, Revised 08/08/2014
K. Medicare Managed Care Manual, Chapter 16B – Special Needs Plans, Revised 01/12/2024

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2016	MA.6040	First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements	OneCare
Revised	07/01/2017	MA.6040	First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2018	MA.6040	First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements	OneCare
Revised	05/01/2019	MA.6040	First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements	OneCare
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IX. GLOSSARY

Term	Definition
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 Coordination (Care Management Level)	Case management provided to Members who are at moderate risk, but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting; it is provided by the Member's Health Network, in collaboration with their PCP.
Case Management	A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality 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.
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.
FDR	First Tier, Downstream, or Related Entity.
Health Network	A Physician Hospital Consortium (PHC), physician group 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.
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 his or her best physical, mental, and social well-being.

Term	Definition
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 Events	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. Entry into Medication Therapy Management (MTM); 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.
Long Term Care	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Model of Care (MOC)	A care management process which supports the unique health care needs of a population. MOCs provide the needed infrastructure to promote quality care management and care coordination processes.
Personal Care Coordinator	A para-professional whose function is to promote coordination of care by bridging the gap between OneCare and the Health Network (HN). The role of the PCC is to facilitate communication between the Member, OneCare, the Health Network, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.
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 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.
Primary Care Provider (PCP)	A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under OneCare.