Policy:	GG.1324
Title:	**Seniors and Persons with Disabilities (SPD) Comprehensive Case Management**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 08/23/2023*
Effective Date:	11/01/2012
Revised Date:	03/01/2023
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for ensuring the provision of Comprehensive Medical Case Management to CalOptima Health Seniors and Persons with Disabilities (SPD).

II. POLICY

A. CalOptima Health or a Health Network shall ensure the provision of Comprehensive Medical Case Management, including coordination of care services, to all high risk SPD Members according to Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide

B. The goal of Comprehensive Medical Case Management is to facilitate the coordination of care and access to services for SPD Members.

C. CalOptima Health or a Health Network shall ensure a systematic process for the identification of a Member who may benefit from Comprehensive Medical Case Management Services.

D. Comprehensive Medical Case Management Services:

1. A Primary Care Provider (PCP) shall provide Basic Case Management services, in collaboration with CalOptima Health or a Health Network.

2. CalOptima Health or a Health Network shall provide Complex Case Management services, in collaboration with the PCP.

3. CalOptima Health or a Health Network shall provide Person-Centered Planning as part of Basic and Complex Case Management.

E. Comprehensive Medical Case Management includes a complete assessment of a Member's condition, determination of available benefits and resources, and development and implementation of an Individual Care Plan (ICP), with goals, monitoring, and follow-up.

F. CalOptima Health or a Health Network shall ensure eligible Members are offered an Interdisciplinary Care Team (ICT) meeting in accordance with the Member's functional status, assessed needs, and ICP.

G. CalOptima Health or a Health Network shall review a Member's need for an ICT or ICP upon request of the Member or his/her PCP or as conditions or circumstances of the Member changes.

H. CalOptima Health or a Health Network shall ensure the provision of Discharge Planning and Care Coordination to Members who are hospitalized and institutionalized.

I. CalOptima Health or a Health Network shall ensure ongoing assessment of Member needs as they transition in and out of case management levels.

J. CalOptima Health or a Health Network shall ensure coordination of care and provision of all Medically Necessary Covered Services delivered within or outside of the contracted Provider network.

K. CalOptima Health, or a Health Network, shall ensure coordination of services and benefits for Children with Special Health Care Needs, including children who have or are at risk for chronic physical, behavioral, developmental or emotional conditions in accordance with CalOptima Health Policies GG.1101: California Children's Services (CCS) Whole-Child Model – Coordination with County CCS Program, GG.1302a: Coordination of Care for RCOC Members, and GG.1321: Coordination of Care for Local Education Agency Services.

L. CalOptima Health or a Health Network shall provide Member Information, and Interpreter services in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

M. CalOptima Health, or a Health Network, shall ensure a process for measuring the effectiveness of Comprehensive Medical Case Management, and a mechanism for the identification and referral of quality of care issues to CalOptima Health's Quality Improvement (QI) Department.

III. PROCEDURE

A. Identification of Members for Comprehensive Medical Case Management

1. CalOptima Health or a Health Network shall identify Members for Comprehensive Medical Case Management utilizing the following data sources:

    a. Health Risk Assessment Data;

    b. Claims or Encounter data;

    c. Hospital discharge data;

    d. Pharmacy data;

    e. Laboratory results;

    f. Health Information Form (HIF) or Member Evaluation Tool (MET), if available;

    g. Data collected through the utilization management (UM) process; and

    h. Predictive modeling risk scores.

2. A Member may be referred to Comprehensive Medical Case Management by self-referral, the Member's Authorized Representative, the Member's family or caregiver, community agency, Health Network, Provider, Practitioner, discharge planner, Disease Management program, or Utilization Management program.

3. CalOptima Health or a Health Network may receive referrals by electronic transmission, telephone, or written correspondence.

4. Upon enrollment, CalOptima Health shall provide Members with information about the availability of the ICT and ICP for high-risk Members.

B. Provision of Comprehensive Medical Case Management Services

1. CalOptima Health or a Health Network shall obtain the Member's consent prior to initiating Comprehensive Medical Case Management.

2. CalOptima Health or a Health Network shall collaborate with Primary Care Providers (PCP) to ensure eligible Members receive Basic Case Management services, which include, but are not limited to:

   a. Initial Health Assessment (IHA);

   b. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs;

   c. Direct communication between the Provider and Member/family;

   d. Member and family education, including healthy lifestyle changes, when warranted; and

   e. Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

3. CalOptima Health or a Health Network shall collaborate with PCPs to ensure eligible Members receive Complex Case Management services.

4. Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

5. Complex Case Management services for SPD eligible Members include, but are not limited to:

   a. Basic Case Management services;

   b. Management of Member's acute or chronic illness, including emotional and social support issues, by a multidisciplinary case management team;

   c. Intense coordination of resources to ensure Member regains optimal health or improved functionality;

   d. Development, implementation, and modification of a Member's ICP in conjunction with the provider, Member and/or their caregiver;

e. Ongoing assessment of transitional needs of Members into and out of Complex Case Management;

f. Scheduled time frame for re-evaluation, monitoring, and follow-up activities; and

g. Person-Centered Planning.

6. CalOptima Health or a Health Network shall provide Person-Centered Planning to eligible Members, which includes, but is not limited to:

a. Treatment approaches that are collaborative and responsive to the Member's continuing health care needs;

b. Identifying Member's preferences and choices regarding treatments, services, and abilities;

c. Facilitating and encouraging the full participation of the Member, county social worker (if receiving In-Home Supportive Services (IHSS)), and professionals, including a Member's PCP or specialist, or with the Member's consent, the Member's family, caregiver or friends, of the Member's choosing in the following:

i. ICT meetings.

a) If a Member's PCP or specialist is unwilling or unable to participate in the ICT, the other individuals listed in Section III.B.6.c are sufficient.

ii. Discussions and decisions regarding the Member's treatments and services.

d. Ensuring that the Member receives all necessary information regarding treatment and services required to make an informed choice.

C. Comprehensive Medical Case Management Member Assessment

1. CalOptima Health or a Health Network shall ensure the comprehensive assessment and periodic reassessment of an eligible Member's health care status, condition-specific issues, support systems and resources, to determine the need for any medical, educational, social, or other services and benefits.

2. CalOptima Health or a Health Network shall conduct a reassessment of an eligible Member's health status under the following circumstances:

a. With changes to Member's health status;

b. With identification of barriers; and

c. At least annually.

3. CalOptima Health or a Health Network shall include the following in the Member's assessment:

a. Review of past medical history and co-morbidities;

b. Review of medication history;

c. Assessment of functional status, activities of daily living (ADLs), and instrumental activities of daily living (IADLs);

d. Assessment of Member's mental health status, psychosocial factors, and cognitive function;

e. Assessment of visual and hearing needs, preferences, or limitations;

f. Evaluation of cultural and linguistic needs, preferences, or limitations;

g. Assessment of Member's support systems, caregiver resources, and level of involvement;

h. Assessment of Member's current living arrangements and resources utilized;

i. Assessment of life-planning activities; and

j. Evaluation of need for referrals to community resources, LTSS, and available benefits and services.

4. CalOptima Health or a Health Network shall ensure ongoing assessment of Members for Complex Case Management when transitions occur, which includes, but is not limited to:

a. Change of healthcare settings;

b. Loss or change in benefits;

c. Member non-compliance;

d. Provider request;

e. Member self-referral; and

f. Achievement of targeted goals.

D. Member ICT

1. CalOptima Health or a Health Network shall offer an ICT to all high-risk SPD Members, or upon Member request.

a. The ICT shall facilitate care management, including assessment, care-planning, authorization of services, and transitional care issues. The ICT will work closely with a Member to stabilize medical conditions, increase compliance with ICPs, maintain functional status and meet individual Member ICP goals. ICT functions shall include:

i. Development of an ICP that is coordinated around the Member's medical and Long Term Supports and Services (LTSS) needs to include the following functions:

a) Facilitation of regular ICT meetings, including at the Member's request;

b) Management of communication regarding referrals and transition and care;

c) Maintenance of a call line or other mechanism for Member inquiries and input and a process for referring to other agencies, as appropriate; and

d) Facilitation of conference calls with CalOptima Health or a Health Network, providers, and the Member, as appropriate.

1) CalOptima Health or a Health Network shall ensure secured email, facsimile, web portals, or written correspondence is used when communicating with Members. The ICT must take the Member's individual needs (e.g. communication, cognitive, or other barriers) into account when communicating with the Member.

b. The ICT shall be person-centered and include individuals as described in Section III.B.6.c of this policy, and if appropriate, a Member's:

i. Hospital discharge planner;

ii. Nurse;

iii. Social worker;

iv. Nursing facility representative;

v. Specialized provider, such as physician specialists, pharmacists and physical therapists, and occupational therapists;

vi. IHSS provider, as applicable and with Member consent;

vii. Community Based Adult Services (CBAS) provider, as applicable;

viii. Multipurpose Senior Services Program (MSSP) coordinator, as applicable; and

ix. Other professionals, as appropriate.

2. CalOptima Health or a Health Network is not required to compensate any individuals who are not directly employed by, or contracted with, CalOptima Health or a Health Network for participation in the ICT.

E. Member ICP

1. CalOptima Health or a Health Network shall ensure the development, implementation, and modification of a Member's ICP, through an interdisciplinary and collaborative team process, in conjunction with the Provider, Member and/or their caregiver, as applicable.

2. The ICP shall include:

a. Prioritized goals, personalized to meet a Member's specific needs that consider the Member and caregiver's preferences, and desired level of involvement in the case management plan.

b. Scheduled time frame for re-evaluation, monitoring, and follow-up;

c. LTSS and resources to be utilized, including the appropriate level of care;

d. Evaluation of Member social needs and personal preferences;

e. Facilitation of Member referrals to resources, and follow up process to determine whether Members act on referrals, including referrals to external resources;

f. Assessment of progress towards goals, with modifications as needed;

g. Identification of barriers to meeting goals or complying with ICP;

h. Planning for continuity or transition of care, both between and across ambulatory and inpatient or other care settings, as necessary;

i. Measurable objectives and timetables to meet physical health and LTSS needs, as determined through the assessment process, IHSS assessment results, MSSP and CBAS records and input from ICT Members, as appropriate; and

j. Coordination of carved out and linked services and referrals to appropriate community resources and other agencies, when appropriate.

3. Upon request, CalOptima Health or a Health Network shall offer and make a copy of the ICP available to the Member in alternative formats and in the Member's or Authorized Representative's preferred written or spoken language.

4. CalOptima Health or a Health Network shall ensure communication of the Member's ICP to the Member, family, caregiver, and all participants of the ICT.

5. At least annually, and as needed, CalOptima Health, or a Health Network, shall update a Member's ICP based on the Member's level of complexity and clinical needs.

F. Discharge Planning and Care Coordination

1. CalOptima Health or a Health Network shall ensure the provision of Discharge Planning when a Member is admitted to a hospital or institution and continuation of care into the post discharge period.

2. Discharge Planning is defined as ensuring that necessary care, services, and supports are in place in the community for the Member once they are discharged from a hospital or institution.

a. Discharge Planning includes scheduling of outpatient appointments, and/or conducting follow-up with the patient and/or caregiver.

3. CalOptima Health or a Health Network shall utilize a Discharge Planning checklist, which includes, but is not limited to, documentation of:

a. Pre-admission status, including:

i. Living arrangements;

ii. Physical and mental function;

iii. Social support;

iv. Long term supportive services;

v. Durable Medical Equipment (DME);

vi. Medical supplies; and

vii. Other services currently in place.

b. Pre-discharge factors, which include, but are not limited to:

i. Member or Authorized Representative understands of the Medical Condition, as applicable;

ii. Physical and mental function;

iii. Financial resources;

iv. Long Term Supportive Services (LTSS); and

v. Social supports.

c. Pre-discharge counseling to evaluate services needed after discharge, which includes but is not limited to:

i. Member or Authorized Representative and hospital/institution's preference regarding type of placement;

ii. Type of placement agreed to by the Member or Authorized Representative;

iii. Specific agency/home recommended by the hospital and agreed to by the Member or Authorized Representative; and

iv. The nature and outcome of Member or Authorized Representative's involvement in Discharge Planning process, including;

a) Anticipated problems in implementing post-discharge plans; and

b) Additional action required by the hospital/institution.

G. Comprehensive Case Closure Criteria

1. CalOptima Health or a Health Network shall terminate a Comprehensive Medical Case Management case when the Member:

a. Declines case management;

b. Becomes ineligible with CalOptima Health or a Health Network; or

c. Has met his or her goals.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Health Policy GG.1101: California Children's Services (CCS) Whole-Child Model – Coordination with County CCS Program
D. CalOptima Health Policy GG.1302a: Coordination of Care for RCOC Members
E. CalOptima Health Policy GG.1321: Coordination of Care for Local Education Agency Services
F. Department of Health Care Services (DHCS) CalAIM Population Health Management Policy Guide, Issued September 2022
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide
H. Title 42, Code of Federal Regulations (CFR), § 438.208(b)(3) and (b)(4)
I. Title 42, Code of Federal Regulations (CFR), § 438.208(c)(2-4)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/22/2015	Department of Health Care Services (DHCS)	Approved as Submitted
05/21/2015	Department of Health Care Services (DHCS)	Approved as Submitted
02/05/2016	Department of Health Care Services (DHCS)	Approved as Submitted
07/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2012	GG.1324	SPD Comprehensive Case Management	Medi-Cal
Revised	10/01/2014	GG.1324	SPD Comprehensive Case Management	Medi-Cal
Revised	07/01/2015	GG.1324	SPD Comprehensive Case Management	Medi-Cal
Revised	11/01/2015	GG.1324	SPD Comprehensive Case Management	Medi-Cal
Revised	12/01/2016	GG.1324	Seniors and Persons with Disabilities (SPD)	Medi-Cal
Revised	12/01/2018	GG.1324	Seniors and Persons with Disabilities (SPD)	Medi-Cal
Revised	04/01/2020	GG.1324	Seniors and Persons with Disabilities (SPD)	Medi-Cal
Revised	07/01/2021	GG.1324	Seniors and Persons with Disabilities (SPD)	Medi-Cal
Revised	05/01/2022	GG.1324	Seniors and Persons with Disabilities (SPD) Comprehensive Case Management	Medi-Cal
Revised	03/01/2023	GG.1324	Seniors and Persons with Disabilities (SPD) Comprehensive Case Management	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Basic Case Management	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP), or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered Basic Case Management services.
Care Coordination	Services which are 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 functioning Medical Home.
Children with Special Health Care Needs (CSHCN)	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 438.208(c)(2), (c)(3), and (c)(4).
Community-Based Adult Services (CBAS)	An outpatient, facility-based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal 2020 Waiver, to eligible Members who meet applicable eligibility criteria.
Complex Case Management	The systematic coordination and assessment of care and services 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.
Comprehensive Medical Case Management	Services provided by a Primary Care Provider, in collaboration with CalOptima Health or a Health Network to ensure the coordination of Medically Necessary health care services, the provision of preventive services, in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Term	Definition
Durable Medical Equipment (DME)	Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
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 health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
In-Home Supportive Services (IHSS)	Services provided to Members by the County in accordance with the requirements set forth in Welfare & Institutions Code Section 14186.1(c)(1), and Article 7 of the Welfare & Institutions Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.
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).
Interpreter	A person who renders a message spoken in one language into one or more languages. An interpreter must be qualified per requirements outlined in WIC 14029.91(a)(1)(B) and 45 CFR 92.101(b)(3).
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled Nursing Facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Member Information	Documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health.
Multipurpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.
Person-Centered Planning	An ongoing process designed to develop an individualized care plan specific to each person’s abilities and preferences. Person Centered planning, includes consideration of the current and unique bio-psycho-social and medical history of the individual Member, as well as the Member’s functional level, support systems and continuum of care needs. Person Centered Planning is an integral part of Basic and Complex Care Management and Discharge Planning.
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), or Speech and Language Therapist, furnishing Covered Services.

Term	Definition
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the Department of Health Care Services (DHCS).