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SECTION 9: CARE COORDINATION

PROVIDER RESPONSIBILITIES FOR CARE COORDINATION

Health Plan Care Coordination teams coordinate services and complex care for the best clinical and functional outcomes for our members. D-SNP Members select a Primary Care Provider (PCP) at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to Members, including the coordination of primary and specialty care, hospital care, diagnostic testing, and therapeutic care.

For the D-SNP population, PCPs play an integral role as members of the Interdisciplinary Care Team (ICT), collaborating with the Health Plan on all care planning and health education needs. Health Plan is responsible for managing the Member's care via the Individualized Care Plan (ICP), which is regularly updated to reflect current needs. Health Plan is required to share the ICP with the PCP and make it available to all members of the ICT, as needed. Health Plan relies on the collaboration of ICT members for the accuracy and effectiveness of the D-SNP care plan.

INTEGRATED MEDICAL AND BEHAVIORAL CARE COORDINATION

D-SNP Members are automatically enrolled in Health Plan's case management program where care is managed via an ICP, customized to meet the specific needs of the Member, depending on their risk level, primary health driver and the complexity of their healthcare needs. Each Member is assigned a primary case manager, either a physical health clinician or behavioral health clinician, who interacts regularly with the Member throughout their D-SNP enrollment. The specific goals of the care coordination programs are to (1) facilitate efficient and effective communication between Members and Providers, (2) utilize appropriate resources enabling Members to improve their health status and self-management skills, and (3) fully integrate whole-person health solutions addressing all medical, psychosocial, cognitive, and mental/behavioral health and/or substance use disorder needs.

The primary goals of the Case Manager are:

- Complete initial and annual assessments, monitoring for increased risks and changes to health status.
- Determine benefits and resources available to the Member and remove health literacy barriers.
- Develop and implement an ICP in partnership with the Member, Provider(s), and family or caregiver, as appropriate to the Member's needs.
- Coordinate and communicate all needs amongst members of the Member's ICT to identify and mitigate barriers to care.
- Monitor, evaluate and follow up on progress toward collaborative care management goals.

Attention to behavioral and mental health, including substance use disorder and social determinants of health is integrated into the holistic care provided by the Case Management Department. Health Plan's Behavioral Health/Social Work (BH/SW) Department has a primary aim to enhance human well-being and help meet basic and complex needs of all people with a particular focus on those who are vulnerable, oppressed and living in poverty.

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This part of the care management team includes behavioral health and social work coordinators/navigators, case managers and leadership to ensure:

- Timely access
- Coordination of care
- Quality of care
- Support linkages

Based on results from the initial and annual Health Risk Assessment (HRA), or any direct referral from the PCP or specialty Provider, Members may be referred directly to the BH/SW team for targeted assistance in a number of areas, including:

- Housing instability/insecure living situation
- Safety needs including signs or reports of domestic violence
- Cognitive changes, including thinking, remembering and decision-making
- Lack of caregiver support
- High-risk on behavioral health screening tools
- Social isolation
- Risks related to suicidal/homicidal ideation or activities
- High-risk behavioral or mental health diagnoses not currently treated
- Substance use disorder not currently treated
- Financial insecurity
- Food insecurity

Health Plan's BH/SW team regularly provides assistance with:

- Linkage to transportation via dial-a-ride or van services
- LTSS, CBAS and IHSS referrals
- Food and Utility resources
- Maternal child/adolescent health resources and education
- Mental health resources
- Substance Use Disorder resources

Providers needing assistance coordinating mental or behavioral health or social services can access the Behavioral Health Case Management Department, please call our Behavioral Health Customer Service line at 1-888-581-7526 and request to speak to a Behavioral Health Case Manager.

Risks related to the Members' health are stratified according to a risk stratification algorithm which aligns the Member with one of three case management categories:

- Complex case management (high-risk)
- Standard case management (moderate-risk)
- Community-well case management (low-risk)

Members are frequently evaluated for changes to health care needs and risk level and are linked to appropriate clinical, social or behavioral health services, as needed. Health Plan views care coordination as a collaboration between the Member, medical and behavioral care Providers, and Health Plan with a common goal of ensuring high-quality, cost-effective care.

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COMPLEX CASE MANAGEMENT (CCM)

Complex Case Management (CCM) Program focuses on coordinating care for the highest-risk Members. Members in this category have experienced a critical event or diagnosis requiring extensive use of resources and need help navigating the health care system to facilitate appropriate delivery of care and services.

CCM addresses the Member's social, physical, and behavioral health needs to maximize disease prevention and promote Member wellness in a high-quality, cost-effective manner.

Health Plan's CCM program is designed to improve communication between Members and Providers and to make efficient use of the available health care and community-based resources.

Members are identified for the CCM Program through analysis of assessment information including HRA information, authorization data, claims and encounter data, and pharmacy reporting.

Providers can refer Members with complex health care and coordination needs directly to the Case Management Department by calling 1-800-822-6226. The case management Department will take all available information and reach out to Members as quickly as possible. Members can also self-refer to this program by calling the case management number above.

STANDARD CASE MANAGEMENT (SCM)

Standard case management program offers member centered approach. In this program, a case management staff member will be assigned to the member to assess member needs, develop plan of care, implement and coordinate case management services. Case Managers will monitor the progress of care plan to achieve optimal health outcomes. Case Managers will also collaborate among multiple providers and member/authorized representatives (AR) to deliver and evaluate member progress to achieve goals.

COMMUNITY-WELL CASE MANAGEMENT (CWCM)

Community-well case management program will enroll members with a score of <15 on a 0-99 risk score. And are placed in the Community-Well (low) stratification bucket. Members will be assigned a primary Case Manager who is in the Patient Health Navigator role to conduct annual HRAs and will collaborate with the RN Case Manager who oversees the Care Plan.

All case management tiers of care focus on addressing all medical, psychosocial, cognitive, functional and mental health needs. Collaboration with the BH/SW Department occurs holistically as needs arise. Attention to the management of all medical and behavioral illness is a top priority, and all clinicians have the skills to address the needs related to these diagnoses.

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CARE TRANSITION SERVICES

Health Plan defines transition of care as the movement of Members between health care settings as their condition and care needs change during the course of a chronic or acute illness. Health Plan recognizes that older or disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated. Health Plan case management clinicians are committed to working actively to coordinate care transitions for the best possible outcome. Health Plan delivers care through formal care transition protocols for every D-SNP Member. Case Managers provide seamless support and coordination of services during care transitions across healthcare settings for both medical and behavioral admissions.

Paramount to a successful transition is timely notification of transitions and engagement and collaboration with PCP and all care team members. Health Plan is committed to notifying the PCP office within Three (3) business days from the date of Health Plan notification of a care transition. A Case Manager will work in partnership with Providers and care team members to formulate a safe plan for transition, including the updating and sharing of the revised care plan.

A primary goal during care transition is to connect the Member with primary care services and facilitate a timely post-discharge follow-up visit to review care, medications and discharge instructions. Case managers work with all Providers to ensure care transition needs are reflected in the care plan and all Providers have input to care management.

Changes in healthcare status and needs, including those following a hospital discharge, may be escalated and addressed during the ICT meeting. Primary Care and Specialty Physicians, as well as community-based service providers, may periodically be invited to attend a virtual ICT meeting to provide input and guidance on the care needed.

CALIFORNIA INTEGRATED CASE MANAGEMENT (CICM)

CICM is the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. The goal of CICM program is to ensure delivery of extra medical and behavioral interventions, services and benefits that meet the specialized needs of these most vulnerable beneficiaries as evidenced by measures from psychosocial, functional, and end-of-life domains. Health Plan relies heavily on Provider partnerships to meet these complex needs.

Key features of this program are:

- Clearly identify the target populations
- Enhance care coordination between all Providers
- Integrate all services to help reduce fragmentation, improving overall quality of care
- Reduce health disparities by providing more comprehensive care to those who often face barriers
- Involve ICT to guide individuals to receive appropriate services

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Health Plan is committed to strong collaboration with Providers to deliver the highest quality care possible for these eight most vulnerable subpopulations, as defined by the State of California:

- Adults experiencing homelessness
- Adults with serious mental health or substance use disorder needs
- Adults transitioning from incarceration
- Adults at risk for avoidable hospital or emergency room (ER) utilization
- Adults with documented dementia needs
- Adults pregnant or postpartum and subject to racial and ethnic disparities
- Adult nursing facility residents transitioning to the community
- Adults living in the community at-risk for long-term care institutionalization

CICM Members are specifically identified for the Case Management Department and stratified into the CCM program for intense intervention. Health Plan seeks to actively engage PCPs, specialists and community-based organizations in the development, implementation and evaluation of the ICP.

CHRONIC CONDITIONS IMPROVEMENT PLAN (CCIP)

Health Plan is required to implement a CCIP for its D-SNP. The CCIP is a quality initiative which aims to improve the health for D-SNP Members diagnosed with diabetes mellitus, are of Hispanic/Latino ethnicity, and have a HbgA1c result >9.

Members identified for CCIP are stratified into the CCM or Standard level of case management based on their HRA score and receive the appropriate level of case management interventions. Care is focused on improving health outcomes, slowing disease progression, preventing health complications and decreasing inpatient stays.

Elements of the CCIP, additionally described in Section 13, Quality Improvement, include appropriate identification of Members meeting program criteria, mechanisms for monitoring the health and status of Members in the program, evaluating outcomes related to health disparity and HgbA1C results.

PCPs and endocrinologists helping to manage diabetes mellitus for Members are valuable partners to the case managers working to track bloodwork results and provide disease education to Members.

REQUIREMENTS FOR FACE-TO-FACE ENCOUNTER

In compliance with CMS regulations, the D-SNP must provide for face-to-face encounters for the delivery of healthcare, case management or care coordination services. The minimum requirement for a qualified encounter is at least annually, beginning within the first 12 months of enrollment. The purpose of this visit is for an in-person or real-time visual/interactive encounter focused on coordination of services between the Member, his/her healthcare Providers and Health Plan.

As described in its SNP Model of Care (MOC), Health Plan utilizes the PCP to meet this requirement on an annual basis. Face-to-face encounters serve to deliver clinical and/or case management/care coordination services which focus on meeting the individualized needs of the member and are a mechanism to ensure the goals of the program are met.

A qualified face-to-face encounter can be conducted via either an in-network PCP, any member of the Member's ICT or Health Plan's case management and coordination staff. Health Plan case management staff actively engage with PCPs as part of regularly scheduled clinical case review process and coordinate with PCPs on visit goals and care planning. Case managers regularly provide education on the importance of at least an annual face-to-face PCP visit.

Health Plan's Case Management Department utilizes claims data and case management documentation to track completion of an annual face-to-face encounter with the appropriate party, annually. The Member may decline a face-to-face encounter at any time.

Face-to-face interactions between a Member and his/her ICT facilitate optimal outcomes through a person-centered approach, promotes advocacy, collaboration, communication, continuity of care and timely connection with programs and services. The expected outcome of the face-to-face visit includes:

- The sharing of critical health information
- Integration of needed services and referrals
- Monitoring health status including diagnoses
- Monitoring and assessment of home safety and social determinants of health
- Monitoring preventive health activities (i.e., blood pressure, HgbA1c, GYN/Mammogram, etc.)
- Assessment of gaps related to medication regimen adherence
- Assessment of specialist engagement and/or needs

The Case Management Department engages in robust collaboration with Providers to support Member health and comply with this federal regulation.

LONG-TERM SERVICES AND SUPPORTS (LTSS)

All D-SNP Members are assessed via the initial and annual HRA for any needed LTSS needs including In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS). California's Department of Health Care Services (DHCS) requires specific assessment questions in order to identify current services or those potentially needed by the Member questions used to assess for LTSS needs include:

- Evaluation of Activities of Daily Living (ADL), limitations and functional supports
- Evaluation of housing environment
- Evaluation of health literacy
- Caregiver stress
- Risk of abuse and neglect
- Evidence of cognitive impairment

- History of falls
- Evidence of financial insecurity
- Evidence of social isolation

PCPs may identify that Members requiring LTSS need referral to a participating LTSS Provider. Some ways to identify LTSS needs are:

- If the Member 1) already receives home care, adult day care, or other home care services.
- If the Member requests a home health aide, personal care assistant services, or other non-skilled assistance to support ADLs where assistance is needed but not available.
- If the Member meets criteria for Adult Day Health Care (ADHC) services.
- If the Member is receiving short-term rehab or nursing care and is qualified to return to the community with home care.
- If the Member is diagnosed with Alzheimer's disease or related dementia, and/or other cognitive deficits with a need for assistance with his/her ADL, or someone to direct his/her care in the community.
- If the Member requests a power wheelchair or a hospital bed and has an unmet need for assistance with his/her ADL.
- If the Member has a history of falling and a deficit in his/her ADL.

D-SNP care coordinators and managers supporting D-SNP Members are trained by the Health Plan to understand the full spectrum of Medicare and Medi-Cal LTSS programs.

PROVIDER TRAINING

Health Plan offers a variety of training modules, including MOC training to contracted Providers and their staff via Health Plan's website. Non-contracted Providers may also visit Health Plan's website to obtain the MOC training. Because the trainings may be accessed at any time, it is easy for busy Providers and their staff to complete the training as their schedule permits.

Within 10 business days of a Provider becoming effective in the Health Plan network, a Provider Services Representative will reach out to the Provider's office staff to schedule Provider orientation (i.e., in-service), which is completed within 30 business days from becoming a contracted Provider. The orientation session may be held on-location at the provider office/clinic or through electronic methods including webinar; and includes, but is not limited to:

- Overview of Health Plan
- Fraud Waste & Abuse training
- Cultural Competency & Language training
- Seniors and Persons with Disability (SPD) Awareness and Sensitivity training
- Health Insurance Portability and Accountability Act (HIPAA) training
- Diversity and Equity and Inclusion training

- Explanation of and assistance setting up access to Doctors Referral Express (DRE). Health Plan's HIPAA-compliant secure provider portal is available 24/7 to contracted Providers
- Guidance on electronic claims submission and online authorization
- Guidance on coordinating preventive services (HEDIS) and standards, if applicable
- Members' rights and responsibilities, including advanced directives
- Member grievance and appeals process
- Provider rights and responsibilities, including the provider dispute resolution process

The Provider Relations Representative provides a brief introduction of Health Plan's benefits and program guidelines. The following topics are also discussed with the provider's office:

- D-SNP Overview
- SNP MOC training
- Coordination of services
- Covered and non-covered services

During the orientation, Providers are encouraged to access the Provider portal to view all Provider materials and the Health Plan's website for the current MOC. Providers accessing the training on the website are required to electronically sign a document attesting to the completion of the training. The Provider MOC training includes information on the various ways Providers are encouraged to participate in Health Plan's MOC.

For contracted Providers and their staff, MOC training content is updated when there is a significant change. Provider communications may include reminders that training is available. Provider Relations Representatives maintain lists of Providers still required to complete training and offer reminders during routine site visits or provider notices.

The Provider MOC training content reviews the four key elements of the Health Plan's D-SNP MOC:

- Description of the SNP population
- Care coordination
- Provider network
- Quality Measurement and Performance Improvement (QMPI)

In instances where the Member is authorized to routinely seek care from an out-of-network Provider, the care manager is responsible for educating the Provider regarding the MOC, as necessary. Out-of-network Providers and their staff may access the MOC training on Health Plan's web page specifically for non-contracted Providers:< https://www.hpsj-mvhp.org>.