ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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POLICY AND PROCEDURE

Policy Number	LTC-003
Policy Name	LTC Case Management Member Identification and Enrollment and Management Process
Department Name	Long Term Care
Department Officer	CMO
Policy Owner	Manager, Long Term Care
Line(s) of Business	Medi-Cal
Effective Date	02/21/2023
Approval/Revision Date	~~02/21/2023~~TBD

POLICY STATEMENT

This policy outlines the requirements for providing ~~case~~ care management services for members in Long Term Care (LTC) settings. Long Term Care settings include:

- Nursing Facility (NF)
- Intermediate Care Facility-Developmental Disability (ICF-DD)
- Subacute Facility (SA)
- Pediatric Subacute Facility (PSA)

Policy:

Alameda Alliance for Health (AAH) authorizes and covers medically necessary services provided in ~~SNF~~NF/ICF-DD/SA/PSAs (both freestanding and hospital-based facilities), consistent with definitions in the current Medi-Cal Provider Manual and any subsequent updates. AAH ensures that Members in need of ~~SNF~~NF/ICF-DD/SA/PSA services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, as outlined in the ~~MCP~~ AAH contract with DHCS and as documented by the Member's Provider(s). Members who are admitted into a SNF will remain enrolled in ~~managed care~~AAH. ~~Starting~~As of January 1, 2024, Members who ~~are~~ admit~~ted~~ into an ICF-DD/SA/PSA will remain enrolled in AAH.

AAH has implemented programming that ensures all Medi-Cal managed care Members, including those using ~~SNF~~NF/ICF-DD/SA/PSA services, have access to a comprehensive set of services based on their needs and preferences across the care continuum, including Basic Population Health Management (BPHM), Transitional Care Services, C~~c~~are M~~m~~anagement P~~p~~rograms, Enhanced Care Management (ECM) and Community Supports.

AAH provides Population Health Management (PHM) and Case Management services to members in Long Term Care facilities to assist the facilities in coordinating members' care, ensure that the care members receive is of high quality and geared to their unique needs, identify members who may be able to transition to lower levels of care or home, and facilitate appropriate members to other settings suited to their needs. The CM services ~~is~~ are provided ~~for both~~if the member is at a contracted ~~and~~ or non-contracted facility~~ies.~~ . AAH offers four ~~Case~~ Care Management programs for Long Term Care members based on their unique needs. These programs ensure AAH works collaboratively with ~~SNF~~NF/ICF-DD/SA/PSA facilities in a team-based, person-centered approach to supporting the member. These programs are:

1. Basic Population Health Management (BPHM)
    a. Coordination of care needs and access to benefits
2. Transitional Care Services (TCS)
    a. Ensuring safe transitions across settings by stabilizing the discharge plan.
3. ~~Complex Case~~ Care Management (~~C~~CM)
    a. Assessment and ~~care~~ planning for high risk members
4. Enhanced Care Management ECM)
    a. Comprehensive wrap around care planning for highest risk members in coordination with community based CM providers.
        ~~a.~~i. Members in ICF-DD facilities may become eligible for ECM if they are to transition out of the facility, and the restriction on duplicative services is removed.

- AAH will coordinate services for Members receiving services from California Children's Services (CCS), coordinating care not carved out to CCS.
- AAH adheres to the requirements of the Lanterman Act, working with the Regional Center of the East Bay (RCEB) to ensure that Members obtain all rights to comprehensive services and supports to enable people to live more independent, productive, and fulfilled lives. AAH will work with the RCEB to support the member's Individualized Program Plan (IPP). The IPP serves as a contract between the Member and RCEB. The IPP~~PP~~ identifies all services and supports the Member needs and is entitled to receive and whether the Regional Center will provide, supervise, or pay for the service, or another agency will. The IPP includes all services and supports the Member needs, even if ~~the~~they will be provided by another source, such as AAH. The IPP process centers on the individual, and if appropriate, the individual's parents, legal guardian or conservator, or authorized representative. The individual may choose whomever they wish to take part in their IPP meeting.

~~The LTC Case Management Program has defined criteria for identifying members in a LTC facility who would benefit from case management, Transitional Care Services, and coordination of care delivery services. Using a systematic and proactive process, AAH performs outreach to enroll members residing in an LTC facility into an appropriate Case Management Program. See LTC-001 Long Term Care for a full description of the PHM program for LTC.~~ .

Procedure

The LTC Care Management Program has defined criteria for identifying members residing in a LTC facility who would benefit from Care Management, Transitional Care, and/or Care Coordination services. Using a systematic and proactive process, AAH performs outreach to assist members residing in an LTC facility and refer to appropriate Care Management Programs.

1. When a member is admitted to a ~~custodial care~~ bed at an LTC facility, including ICF-DD, NF, and Subacute types ~~(and for members transitioning from FFS on~~

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1/1/23), , communication is sent to the facility notifying staff that the member is eligible to receive Basic Population Health Management (BPMH) services. Communication includes information on how LTC staff can access BPMH services if coordination of care or service needs are identified.the member is evaluated by the LTC staff to determine if the member would benefit for any care management services.

2. AAH uses the Johns Hopkins ACG modeler risk screening scores, PHM Risk Stratification algorithm, (AAH and from DHCS when available,) and reports generated by the AAH Analytics team to identify members who may be appropriate for other Case Management Programs (CCM, Transitions of Care and ECM). Examples of data sources includes but is not limited to:
    - Hospital Admission/Discharge data
    - Pharmacy data
    - Health risk appraisal data
    - Data collected through the Utilization Management process.
    - Data provided from state agencies – medical assistance category codes
    - Data supplied by practitioners.
    - Data supplied by member or caregiver
3. This analysis is completed at a minimum monthly. Once a member is identified as a potential candidate for an appropriate Case Management Program or Community Supports service, a referral is sent to the appropriate program within the electronic system of record. In addition to the automated risk modeling methodology described above, additional referrals may be obtained through the following methods:
    - AAH internal program referral
    - LTC Provider/Practitioner referral
    - Member/Caregiver referral
    - Community Partners
    - Providers
4. Once a member is identified for LTC Case Care Management, an LTC Case Care Manager (CM) or LTC Social Worker (SW) outreaches the LTC facility in which the member is enrolled and completes the LTC Initial Assessment (except for members identified for the other Care Management Program such as TCS, ECM or Community Supports).

***Member Screening ProcessLTC Care Management Process*:**

1. Member is identified or referred for an LTC CM program;
2. Member is screened by LTC CM or LTC SW for appropriateness for program (i.e., member resides in LTC, Member is transitioning to/from LTC, Member coverage is active);
3. If the Member's case is screened and appropriate for enrollment into a LTC CM Program, outreach to the facility is initiated by the LTC CM or LTC SW to coordinate care and services.
4. If the member is not appropriate for the LTC CM program, but appropriate for other services (ECM, Community Supports, CCM, etc.), the LTC team will make those referrals.
    - If the member's case is not screened in as appropriate for an LTC CM Program enrollment, documentation of clinical rationale is completed in the electronic medical management system and the referral is closed (when possible, a warm hand off is provided to appropriate resources as needed);
        - If the Member's case is screened in as appropriate for enrollment into a LTC CM Program, outreach to the facility is initiated by the LTC CM or LTC SW.

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Engagement and Enrollment Process:

1. Initial facility telephonic outreach includes at least 3 attempts made during working hours Monday through Friday from 8:00 AM-5:00 ~~PM.~~ PM. If LTC staff are still not able to reach the facility, a letter is mailed to the facility and the member~~.~~. The ~~LTC staff will escalate to the LTC Manager in accordance with the internal escalation pathway to outreach and engage the facility.~~

2. Once a staff member at the facility who is actively caring for the member is reached, he/she will be educated on LTC CM program available to the member.
   - If the facility and/or member agrees with the ~~proceeds with~~ enrollment into the LTC CM Program, the LTC CM nurse or social worker will complete an LTC Initial Assessment ~~and develop a care plan~~. If LTC CM is unable to complete the assessment ~~and care plan~~at that time, a follow up call will be scheduled within 5 business days.
   - If the facility and/or member is not agreeable to the enrollment into the LTC CM Program, documentation will be included as to why the enrollment was declined. This does not prevent the LTC CM from sending referrals to other programs that the member may benefit from.

Follow-up Contact Process:

1. After the initial assessment and care plan are completed, the LTC ~~Case Manager~~CM or LTC SW schedules a follow-up call ~~within 2 weeks~~ with the facility to reassess member's progress towards goals and to update ~~the care~~any plans.
2. At the time of the follow-up contact, the LTC ~~Case Manager~~CM or LTC SW determines whether or not there is a need to outreach to the interdisciplinary team – PCP, Specialist, community resource, etc. for additional input or guidance.
3. Contacts are continued ~~every two weeks~~as needed depending on the acuity of the needs and the planned timeline, but no less than every 3 months. ~~and each~~Each contact will include documentation of a follow-up assessment and any appropriate updates ~~to the care~~ plan.
4. Members are discharged from LTC Case Management Program when goals are met, ~~or~~ when all care coordination needs identified by the facility are resolved or member is discharged from the LTC facility.

~~If a member is enrolled > 60 days without meeting goals, the Case Manager will present the case in LTC IDT Rounds for feedback/support/guidance.~~

DEFINITIONS / ACRONYMS

A. Acute Care Hospital means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

B. Authorization Status evaluation of whether care is medically necessary and otherwise covered

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C. **Bed Hold** is a temporary reimbursable status that allows one to return to a nursing facility after an acute care hospitalization

D. **Community Support Services** includes support that may be organized through extended family members, friends, neighbors, religious organizations, community programs, cultural and ethnic organizations, or other support groups or organizations

E. **Concurrent Review** is a review of medical necessity decisions made while the patient is currently in an acute or post-acute setting

F. **Discharge Planner** is one who identifies and prepares for a patient's anticipated health care needs after they leave the hospital

G. **Intermediate Care Facilities/Developmental Disability (ICF/DD)** provides care for members with a developmental disability with complex medical problems requiring skilled care or observation on an ongoing intermittent basis and 24 hour supervision. Criteria for Subacute Services is in section 7.3 and 7.4 of the Medical Provider Manual. ~~F.~~

~~G. LTC refers to Long Term Care~~

H. **Member** means any eligible beneficiary who has enrolled in AAH and who has been assigned to or selected a Plan.

I. **Nursing Facilities** are defined by DHCS as:
   a. Freestanding Skilled Nursing Facilities Level-B (FS/NF-B),
   b. Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B),
   c. NF-Bs designated as
      i. Institutions for Mental Diseases (IMD),
      ii. Distinct Part Pediatric Subacute (DP/PSA) and
      iii. Freestanding Pediatric Subacute Facilities Level B (FS/PSA).

J. **Pediatric Subacute Care** Services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

~~H.~~

~~I.~~K. **OAHA is the Office of Administrative Hearings and Appeals** is an administrative hearing forum created by the Department of Health Care Services to provide a fair and impartial appeal process for providers and individuals.

~~J.~~L. **RTR Appeals is Refusal to Readmit:** under federal and state law, when a resident is transferred to the hospital or approved for therapeutic leave, they have a right to return to the nursing facility after they are hospitalized or when the period of therapeutic leave has concluded. When the resident is hospitalized and the nursing facility refuses to readmit the resident, the resident may request a hearing~~.~~.

M. **Skilled nursing facility** means any institution, place, building, or agency which is licensed as a skilled nursing facility by the Department or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a skilled nursing facility) and has been certified by the Department for participation as a skilled nursing facility in the Medi-Cal program. This term includes "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility."

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~~K. **Skilled Nursing Facility (SNF) is** a health facility that provides skilled nursing and supportive care to persons who need this type of care on an extended basis.~~

N. **Subacute Facilities** provide a level of care needed by a member who does not need hospital acute care but who requires more intensive skilled nursing care than is provided to most patients in a SNF. Criteria for Subacute Services is in section 7.2 of the Medical Provider Manual. Subacute care patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Adult subacute care is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process.

~~L.~~O. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

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AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Long Term Care
Case Management
Claims
Billing

RELATED POLICIES AND PROCEDURES

LTC-001
LTC-002
LTC-004
CM-034
UM-001
UM-057

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

02/21/2023

REFERENCES

Department of Health Care Services (DHCS) and Alameda Alliance for Health ~~Two Plan Model~~ Contract
Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services
Alliance Policy EE.1135: Long Term Care Facility Contracting
UM Policy 057- Authorization and Processing of Referrals
AGD Policy – Grievance and Appeals
Claims Policy – Provider Disputes Resolution
The Alliance Provider Manual
The Alliance Utilization Management Program
Department of Health Care Services (DHCS) All Plan Letter (APL) ~~17-006~~21-011: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
Department of Health Care Services All Plan Letter (APL) ~~14-004~~~~22-032~~23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care
Department of Health Care Services All Plan Letter (APL) ~~16-003: Long Term Care~~23-004 Skilled Nursing Facilities-Long Term Care Benefit Standardization and Transition of Members to Managed Care

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Department of Health Care Services All Plan Letter (APL) 23-023: Intermediate Care Facilities for Individuals with Developmental Disabilities- Long Term Care Benefit Standardization and Transition of Members to Managed Care
Department of Health Care Services All Plan Letter (APL) 23-027: Subacute Care Facilities Long Term Care Benefit Standardization and Transition of Members to Managed Care
~~Skilled Nursing Facilities Long Term Care Benefit Standardization and Transition of Members to Managed Care~~
Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
Title 22, California Code of Regulations (CCR), §§ 51120, 51121, 51124, 51215, 51118 and 51212
Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

CA Code of Regulations Title 22, Sections 51335, 51535.1, 51335.5, 51335.6, 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, and 51334

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MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Health Care Quality Committee annually