

CONTRA COSTA HEALTH PLAN

Utilization Management

Title: **Coordination of Care for Members (desk reference)**

Policy #: **UM15.039**

Origin Date: 06/06

Author: Florence Chan, Director of Auth/UM/CM

Revised: 1/29/07, 4/17/07, 6/11/07, 7/11/07, 5/26/12, 5/12/14

Author: Florence Chan, Director of Auth/UM/CM

Reviewed 5/2015, 3/2016, 01/2017, 01/2018, 01/2019

Reviewed: Lynn Soloway RN, Auth & UM Director

Reviewed: 4/12/2021, 6/2021, 5/20/2022

Reviewed: Dennis Hsieh, MD, JD, CMO

Reviewed and approved by Quality Council: 6/9/16,

4/27/17, 12/14/17, 2/28/19, 6/2021, 7/2023

Presented in UM Committee: 5/2022

Applies to:

Medi-Cal

Medicare

Commercial

BAC

State Sponsored

All

N/A

Regulatory / Accreditation:

Department of Managed Care

HCFA:

DHS:

Other Reg. References:

NCQA

N/A

Units:

Administration

Advice Nurses

All Staff

Business Services

Case Management

Health Ed/Cultural Livng

Marketing

Member Services

Planning, Survey, Reg. Affairs

Provider Affairs

Quality Management

Auth/Utilization Management

OPS Council Approval Date & Sign Off

Desk Reference Only

POLICY

Contra Costa Health Plan (CCHP) Utilization Management Unit will establish a collaborative method to effectively communicate between primary care providers, specialists, hospitals, and/or specialized programs such as, but not limited to:

- California Children Services (CCS)
- Child Health Disability Prevention (CHDP)
- Women, Infant, and Children (WIC)
- Local School Districts (Local Education Agencies)
- Developmental Disabilities/Regional Center-includes children from 0-36 months (through the Early Start program), children over 36 months, and adults suspected of having developmental disabilities. Also, includes referrals to home and community-based services (HCBS) waiver program
- Child Welfare Agency (foster care)
- Contra Costa County Employment and Human Services (EHSD)
- Contra Costa County Public Health
- Community Connect/Whole Person Care
- Community based organizations (CBOs) providing services to address patients' needs

Please note that CCHP will collaboratively work with the above entities to coordinate these services for members who are eligible for such programs. Not all product lines are eligible for these programs.

PURPOSE

To establish and document a collaborative process used by the Health Plan to coordinate care with specialized programs, hospitals, and primary care providers in order to provide basic comprehensive medical case management and access to non-medical services for eligible members.

PROCEDURE

Upon identification of a member who qualifies for one or more of the above programs, a Utilization Management (UM) Nurse, Case Management (CM) Nurse or the Pediatric Clinic Social Worker (SW) liaison at Contra Costa Regional Medical Center (CCRMC) will initiate a referral to the appropriate program. The UM, CM or SW acts as a liaison and contacts the specialized program to assist with the coordination of services, which may include coordinating primary care services that are not available through the specialized program. However, in general terms, the assigned primary care provider (PCP) is responsible for identifying, referring, providing comprehensive case management, and coordinating care for their members with developmental disabilities (i.e. mental retardation, cerebral palsy, epilepsy and autism) or other conditions eligible to specialized programs listed above. During the initial health assessment, diagnostic evaluation, and periodic follow up, the PCP will screen their members to determine eligibility for these programs. Provider Relations Department is responsible for educating providers about these programs and how they can refer their members.

Coordinating Care for Hospitalized Members

Upon notification of a member's hospitalization, the Authorization Unit notifies the assigned PCP in writing (via ccLink (InBasket message), email, fax, or letter) or voice mail message and documents the notification in the ccLink system. Upon discharge from the hospital, the PCP is notified via written notice.

UM case conferences are held, no less than bimonthly to discuss members who are hospitalized in community contracted and non-contracted hospitals that are anticipated to be high dollar and/or complex cases. Case conference attendees may include, but are not limited to, the Chief Medical Director or designee, Auth/UM Director, Director of Case Management or designee, Authorization Manager, and UM nurses. Referrals to CCHP Case Management, CCS, Regional Center, or specialized programs can be identified during this conference. Eligibility for specialized programs may also be identified before the next scheduled case conference, in which case, the UM nurse initiates the referral and relays the information during the case conference.

Coordinating Care with CCS

CCHP collaborates with CCS in accordance with the Memorandum of Understanding (MOU). The PCP has primary responsible for identifying and referring their members eligible to CCS. Through provider education, PCPs will be made aware of CCS reimbursement guidelines and importance of providing medically necessary covered services until CCS eligibility is confirmed, or if denied by CCS, covered by Health Plan.

In addition to PCP identification of eligible members, the UM and CM departments can also identify and refer members to CCS. Upon identification of a member that appears to have a CCS eligible condition, the CCHP UM liaison nurse, initiates a referral to CCS. On a periodic basis or as agreed upon by entities, the CCHP UM liaison nurse and CCS CM liaison meet to discuss and coordinate care for CCS members. Written communications via email between both entities regarding pending and open CCS members are also available.

In order to facilitate coordination of care between the PCP and CCS specialty providers, the Utilization Management Unit or designee will inform contracted PCPs of CCHP members receiving care with a CCS specialty provider by one of two methods listed below:

- a. If member's assigned PCP is known or if the specialty service was requested by the PCP, CCS will directly forward a copy of their Notice of Action (approval, deferral, or denial letter) to the provider to allow the PCP the ability to coordinate necessary follow up care.
- b. If the assigned PCP is unknown to CCS at the time the authorization request was submitted, CCHP would forward a copy of the CCS's NOA to the PCP.

When a coverage dispute arises regarding CCS eligibility that cannot be resolved by the liaisons, the case will be referred to their director for a resolution.

Coordinating Care with CHDP

On no less than a quarterly basis, CHDP generates a report for CCHP of all members receiving CHDP services. CHDP is responsible for coordinating care with the PCP. CHDP keeps files for each member receiving services, and the Health Plan, if necessary, has access to these files. On a quarterly basis, a CHDP Public Health Nurse attends Quality Council and reports on the program performance. If issues are identified, CCHP and CHDP will confer and, if warranted, develop action plan for resolution.

Coordinating with Other Specialized Programs

The Pediatric Clinic SW liaison in the CAAD clinic is the contact person for children who are eligible for other specialized programs, such as Regional Center of the East Bay (RCEB), which includes the Department of Developmental Services (DDS) administered HCBS waiver program and local school districts. The SW liaison coordinates referrals received from CCRMC and Community Provider Networks for children eligible to specialized services; services include developmental delays, Local Early Start Programs, and assistance with developing Individual Education Plan (IEP) with the physician.

Delegation of case management activities for these specialized programs is through the Pediatric Clinic SW liaison. However, the assigned PCP is responsible for identifying their members that may qualify for these programs and referring these members to the SW liaison for program eligibility assessment and service coordination. A manual tracking system for specialized program referrals is kept by the SW. S/he is responsible for coordinating care for the member, which includes coordinating with the PCP and the specialized program(s). To ensure care coordination activities are performed by the SW liaison, CCHP will receive, upon request, copies of PCP correspondences and member listing.

Refer to UM15.038, Coordinating Care with Specialized Programs for additional information on monitoring, coordinating care, and the CCS process.

Coordinating Care with CBOs:

For patients with complex social situations, high utilization of acute care services, and other high-risk categories, the Utilization Management Nurses will identify and refer these patients to care management services (including, but not limited to CCHP case management) for assistance in

addressing their barriers in order to improve health outcomes and optimizing access to an appropriate level of care.