

Existing Care Management Contract Standards and Coordination of Carve Out Services

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Introduction

- All Medi-Cal Managed Care Plans must adhere to DHCS contract standards
- COHS plans have mandatory SPD enrollment for more than 20 years
- Plans must coordinate across all programs, settings, and payers
- Plans must provide care management and care coordination to all members including SPDs

Terminology to Be Defined

- Case Management
- Care Management
- Coordination of Care
- Continuity of Care
- Disease Management
- Carved Out Services
- Contract Standards
- Medical Home

Care Management/Coordination of Care Plan Contract Requirements

- Every member shall be assigned a primary care physician
- The primary care physician shall serve as a medical home
- The medical home is where care is accessible, continuous, comprehensive and culturally competent

Care Management/Coordination of Care Contract Requirements (continued)

- Every member must have a primary care provider (PCP)
- The PCP is responsible for:
 - Supervising, coordinating, and providing initial and primary care to all patients, including SPDs
 - Initiating referrals
 - Maintaining the continuity of patient care
 - The PCP may be a physician or non-physician medical practitioner

Care Management/Coordination of Care Contract Requirements (continued)

- Plans must ensure members who have an established relationship with a network provider are assigned to that provider, if they wish, without disruption in their care
- Plans must ensure that all members receive an Initial Health Assessment (IHA), including a behavioral assessment, within 120 days of enrollment
- Ensure problems discovered during the IHA are followed up within 60 days, including high risk pregnancies, health risk behaviors, and assist providers to provide appropriate interventions

Care Management/Coordination of Care Contract Requirements (continued)

- Plans must ensure that contracted providers provide basic case management to each member and monitor the coordination of care provided to members
- The contract defines Comprehensive Medical Case Management Services
- These services are provided by a primary care provider to all members, including SPDs

Care Management/Coordination of Care Contract Requirements (continued)

- Comprehensive Medical Case Management Services ensure:
 - Coordination of medically necessary health care services
 - Provision of preventive services in accordance with established standards and periodicity schedules
 - Continuity of care for Medi-Cal enrollees
 - Health risk assessment and treatment planning
 - Coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs

Care Management/Coordination of Care Contract Requirements (continued)

- Plans must implement and maintain a written description of its Quality Improvement System, to include provision of case management, coordination and continuity of care services
- This assures that case management, coordination and continuity of care activities are integral to the plans operations

Care Management/Coordination of Care Contract Requirements (continued)

- Plans must provide disease management services for members who are at risk of adverse health outcomes and/or higher utilization of services
- Access without prior authorization to emergency services, including follow-up and coordination of emergency services

Care Management/Coordination of Care Contract Requirements (continued)

- Submit policies and procedures regarding access for disabled members pursuant to ADA
- Maintain adequate numbers and types of specialists within the network and provide accessibility to medically required specialists through contracting or referral

Coordination of Care for Carved Out Services Contract Requirements

- The member is never “carved out”.
- Services and/or payment may be “carved out” but never the member
- Plans must implement procedures to identify individuals who need or are receiving “carved out” services from out-of-plan providers and/or programs
- Plans must ensure coordinated service delivery and efficient and effective joint case management for individuals requiring services from out-of-plan providers and/or programs

Coordination of Care for Carved Out Services

Contract Requirements (continued)

- Plans must identify, monitor, and coordinate care provided to members who require carved out services and for services obtained from non-network providers and other programs.
- Some examples include:
 - Mental Health/Alcohol and Substance Abuse
 - Children with Special Health Care Needs
 - Children with CCS eligible conditions
 - Members with developmental disabilities or at risk of developmental delay
 - Members receiving Local Education Agency services

Coordination of Care for Carved Out Services

Contract Requirements (continued)

- Children in Foster Care
- Members participating in the HIV/AIDS Home and Community Based Waiver Program
- Dental Services
- Members receiving care through local health departments (TB, Family Planning, STD, HIV, IZ)
- Maternal and Child Health, CHDP and WIC programs
- Regional Centers
- Members in need of major organ transplants, Hospice, Long Term Care

Recent Contract Updates based on Stakeholder Recommendations

- Plan member service staff must provide necessary support to members with chronic conditions and disabilities, including assisting members with resolution of complaints, access barriers, disability issues and referral to appropriate clinical services staff
- Requirement for SPDs or persons with chronic conditions to participate in the plans' community advisory committee
- Members must be able to make a standing request to receive informing material in a specified alternative format

Recent Contract Updates based on Stakeholder Recommendations (continued)

- Plans must provide information to providers and train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines for SPDs and people with chronic conditions.
- The educational program must include health needs specific to this population and utilize a variety of strategies, including websites and other outreach to providers

Recent Contract Updates based on Stakeholder Recommendations (continued)

- Plans shall include providers who provide health care services to SPDs and people with chronic conditions on their Quality Improvement Committee accountable to the Plans' governing body
- Plans' written Quality Improvement System regarding case management and coordination and continuity of care services must include activities used by SPDs, including those assuring availability and access to care, clinical services and care management

Ensuring Plan Compliance

- DHCS monitoring activities include:
 - Review of Policies and Procedures
 - A&I/DMHC Joint Audits on site
 - MMCD Medical Monitoring Unit provider site reviews
 - MMCD Member Rights on site reviews
 - Formulary Reviews
 - CAHPS survey
 - Office of the Ombudsman
 - Monitoring of HEDIS measures

Current DHCS Projects Based on Stakeholder Recommendations

- Member Evaluation Tool (Health Information Form)
- Staying Healthy Assessment revision
- Care Management and Care Coordination Policy Letter
- Vendor contract to train plans to train providers about the needs of SPDs

Summary

- **Plans must provide care management and care coordination for all members including SPDs**
- **Plans must coordinate care across all programs, payers, settings**
- **The member is never “carved out”**
- **DHCS is continuously working to improve plan contracts to assure quality health care for all members**