blue california
Promise Health Plan

Policy Title: Coordination of Care		POLICY #: 10.2.16 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 4/03	**Effective Date** 5/19	**Revision Date** 12/18, 2/21, 9/22, 2/23
VP Approval			**Date of Approval:** 2/10/2023
Medical Services/P&T Committee: (If Applicable) PHP CMO			**Date of Committee Review: 2/9/2023**

A. PURPOSE:
To define the policy and procedure and provide guidance on how Blue Shield Promise Health Plan (BSCPHP) will ensure that Utilization Management (UM) is based on the integration of clinical and contracting, services in order to provide optimum health care with the most appropriate resources available and to delineate a process that identifies individuals with chronic conditions, illnesses, injuries or multiple diagnoses at risk of a catastrophic event resulting in permanent or lifelong disabilities.

B. DEFINITIONS:
1. High-Risk/Complex Care Management: is an approach to comprehensive care management that meets differing needs of high and rising-risk Members through both ongoing chronic Care Coordination and interventions for episodic, temporary needs.
2. Severe Chronic Conditions: Any condition that is persistent and substantially disabling or life-threatening that requires treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique member. These conditions may include, but are not limited to the following:
    a. Life-threatening conditions
    b. Conditions that cause serious disability without necessarily being life-threatening
    c. Conditions associated with severe consequences, conditions affecting multiple organ systems
    d. Conditions that carry a risk of serious complications

C. POLICY:
I. BSCPHP has a formal process in place to identify individuals who may have (a) complex care need(s) and may benefit from care management. This may include members with chronic illness, injury and/or multiple diagnoses, or members who are at risk for catastrophic events resulting in lifelong disabilities and who require multidisciplinary care/services, which may or may not result in full or potential recovery, may be referred into care management.

II. This care management process facilities active communication and information exchange among all treating health care professionals.

III. BSCPHP utilizes a broad strategy for care management to enable members and providers to achieve the best possible outcomes for each unique member with multiple or severe chronic conditions.

IV. BSCPHP monitors members' care needs and takes action to facilitate the coordination of their care through arrangements with community and social service programs. BSCPHP allows members who are incapable of making decisions concerning their health care due to mental or physical incapacity to have a representative who is permitted to make such decisions for them.

V. BSCPHP members helps members obtain services funded by either program when assistance is needed.

VI. BSCPHP members are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

D. PROCEDURES:

I. Severe Chronic Conditions:

a. Severe and chronic conditions that are prevalent in the care management population, and those for which continuity and effectiveness of care can be targeted to improve care include, but are not limited to:

i. Autoimmune disorders, limited to: Polyarteritis nodosa, Polymyalgia rheumatica,
ii. Cancer, excluding pre-cancer conditions or in-situ status;
iii. Cardiovascular disorders, limited to: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, and Chronic venous thromboembolic disorder; Chronic heart failure;
iv. Chronic alcohol and other drug dependence;
v. Chronic and disabling mental health conditions, limited to: Bipolar disorders, Major depressive disorders, Paranoid disorder, Schizophrenia, and Schizoaffective disorder;
vi. Chronic lung disorders, limited to: Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis, and Pulmonary hypertension;
vii. Dementia;
viii. Diabetes mellitus;
ix. End-stage liver disease;
x. End-stage renal disease (ESRD) requiring dialysis;
xi. Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, Multiple sclerosis, Parkinson's

disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit;

xii. HIV/AIDS;

xiii. Neurologic disorders, limited to: Amyotrophic lateral sclerosis (ALS), Epilepsy,

xiv. Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus;

xv. Severe hematologic disorders, limited to: Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplatic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder;

xvi. Stroke

b. Members identified with any of these conditions will be referred to the BSCPHP Case Management Department.

II. High Risk/Complex Care Management Conditions:

a. Prior authorizations are processed and tracked.
b. Out of area or additional services or contracts are researched, implemented, and followed for appropriateness and timeliness.
c. Assistance with arranging these services is provided.
d. Concurrent review for early discharge planning includes levels of care (SNF, Home Care, etc.), care management screens and concurrent quality case finding, and intervention is an important case management activity.
e. The targeted diagnoses (ICD-10 numbers inclusive) are referenced as a means of identification for persons requiring ongoing or intermittent medical intervention. Contract Medical Groups/IPAs are NOT delegated to manage Complex Care Management of BSCPHP members.

III. Targeted Care Management (TCM) Services

a. BSCPHP is responsible for determining whether a member requires TCM services and must refer members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.
b. BSCPHP shall be responsible for coordinating the member's health care with the Targeted Care Management provider and for determining the Medical Necessity of diagnostic and treatment of services recommended by the Targeted Care Management provider that are Medi-Cal Covered Services for members receiving TCM services specified in Title 22, CCR, Section 51351. If members under age twenty-one (21) are referred to and not accepted for TCM services, the TCM Care Manager shall ensure the members have the access to services comparable to EPSDT TCM services.
c. TCM persons eligible to receive TCM services shall consist of the following Medi-Cal beneficiary groups:

i. Persons who have language or other comprehension barriers and are unable to access or appropriately utilize services themselves
ii. Have demonstrated noncompliance with their medical regimen
iii. Are unable to understand medical directions because of language or other comprehension barriers; or
iv. Have no community support system to assist in follow-up care at home.
v. Persons who are 18 years of age and older who:
vi. Are on probation and have a medical and/or mental condition; or
vii. Have exhibited an inability to handle personal, medical, or other affairs; or
viii. Are under public conservatorship of person and/or estate; or
ix. Have a representative payee; or
x. Are in frail health and in need of assistance to access services to prevent institutionalization.
xi. High-risk persons means those persons who have failed to take advantage of necessary health care services, or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect, or violence, including, but not limited to, the following individuals:
    1. Women, infants, children, and young adults to age 21
    2. Pregnant women
    3. Persons with Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome
    4. Persons with reportable communicable disease
    5. Persons who are technology dependent. Solely for the purposes of the TCM Services program, "technology dependent persons" means those persons who use a medical technology, embodied in a medical device, that compensates for the loss of normal use of a vital body function and require skilled nursing care to avert death or further disability.
    6. Persons with multiple diagnoses who require services from multiple health/social service providers
    7. Persons who are medically fragile. Solely for the purposes of the Targeted Care Management Services program, "medically fragile persons" mean those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.

IV. Out of Network Care Management/Coordination of Care
    a. BSCPHP Utilization Management staff (qualified and appropriately licensed health professionals) will manage and track out-of-network emergency room visits and hospitalizations for members and arrange transfer to an in-network

facility/hospital as soon as the member is stable for transfer in order to ensure continuity of care for the Ambulatory Care setting to inpatient care and vice versa as indicated.

b. The BSCPHP care management staff will collaborate efforts with their providers according to the contractual agreements. A BSCPHP physician is closely involved in the out-of-network care management process. When required cases are referred to a board-certified physician for the specialty area to assist in making determination of medical appropriateness.
c. BSCPHP will implement and maintain procedures to monitor quality of care provided in an inpatient setting to its members, and maintain procedures for monitoring the coordination of care provided to the member, including but not limited to coordination of discharge planning from inpatient facilities, and coordination of all medically necessary services both within and outside of the BSCPHP provider network. BSCPHP will arrange care outside of the network when network practitioners are unavailable or inadequate to meet a member's medical needs.

V. Criteria for Referral to Care Management Program:

a. Members selection can be captured through the UM process including, precertification data, concurrent review data, prior authorization data and/or admission data; or through conditions, diseases or high-risk groups most frequently managed (i.e. spinal injuries, transplants, cancer, serious trauma, AIDS. Multiple chronic illnesses that result in high utilization).

b. The following conditions and health problems are examples of reasons for referral into the Care Management Program. The members may:
    i. Be frail, chronically disabled, functionally, and/or emotionally impaired
    ii. Have chronic, medically complex problem(s) requiring multifaceted or complex care
    iii. Be severely compromised by acute episode of illness or an acute exacerbation of chronic illness

VI. Case Identification and Referral Process:

In accordance with NCQA PHM 5-Standards, BSCPHP members have multiple avenues to be considered for care management services, including referral to case management by:

a. Practitioner referral (i.e. PCP, Attending Physician, Specialty Care Physician, and/or licensed physician support staff).
b. UM department, concurrent review staff, discharge planner, disease management, social services
c. Health education, health information
d. Member Services
e. Inpatient nursing/hospital staff or inpatient discharge planners
f. Primary Medical Group

g. Claims department
h. Medical Director upon review of quality or utilization data
i. Referral from community resource programs
j. Member self and/or family referral
k. BSCPHP or its contracted/delegated medical groups will identify conditions for which more intensive case management is necessary
l. Routine screening and selection should be performed to identify those beneficiaries with multiple or severe chronic medical conditions who would benefit from a coordinated care management strategy.

E. MONITORING: N/A

F. REPORTING: N/A

G. REFERENCES & ATTACHMENTS:

1. DHCS Contract Exhibit A Attachment 11
2. LA Care Contract
3. Title 22, CCR, Section 5135
4. NCQA PHM 5

H. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
2/2023	Updated Regulatory Requirements DHCS	