12. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care.

PROCEDURES:

A. PCPs are responsible for coordinating care management services for assigned Members, when indicated.

B. PCPs are responsible for identifying Members who may potentially require care management services and notifying the IPA Care Management (CM) Department. PCPs may also submit a completed CM Referral Form to IEHP to refer the Member for care management. This form is found in the "Providers" portal of the IEHP website.[1] IEHP shall coordinate with the Member's IPA, as needed. Members, who may benefit from care management include, but are not limited to:

   1. Members with complex medical or behavioral health conditions requiring multiple Providers or multiple interventions and care coordination needs;
   2. Potential major organ transplant candidates;
   3. Members with suspected or confirmed developmental disabilities that can benefit from a care management program;
   4. Members frequently accessing Emergency Room services;
   5. Members who live alone, are frail, have inadequate family support systems, need continuity of care services, and could benefit from Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), and/or Multipurpose Senior Services Program (MSSP) services; and
   6. Any other Member that could benefit from CM services.

C. PCPs are responsible for referring Members to IEHP for health education classes, care management programs, disease management programs, and behavioral health services.

[1] https://www.iehp.org/en/providers/provider-resources?target=forms

12. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

D. PCPs are responsible for coordinating care for the Member with the IPA CM or IEHP CM including but not limited to contacting other clinicians or entities, facilitating transfer of medical records as necessary and initiating specialty referrals.

E. PCPs are responsible for ensuring Members receive preventive care in accordance with IEHP's approved guidelines.

F. PCPs are responsible for referring Members to the appropriate Long-Term Services and Support (LTSS) services, covered as Medi-Cal benefits, when it is determined that the Member is a potential candidate for any of these LTSS services:

1. CBAS – See Policy 12H, "Community-Based Adult Services."
2. Long Term Care (LTC) – See Policies 14F1, "Long-Term Care - Custodial Level," and 14F2, "Long-Term Care - Skilled Level."
3. IHSS – See Policy 12F, "In-Home Supportive Services."
4. MSSP – See Policy 12B, "Multipurpose Senior Services Programs."

G. PCPs shall not charge a fee for the completion of certification forms, which is required for referral to the IHSS program.[2]

H. PCPs are responsible for logging onto the secure IEHP Provider portal to review the Member's Health Risk Assessment (HRA) results and Individualized Care Plan (ICP) and incorporate the results into the Member's medical record.

I. IEHP notifies PCPs of their assigned Members, who have not completed an HRA or whom the Plan has not been able to contact. PCPs are encouraged to conduct outreach to these Members and to schedule visits.

1. PCPs are expected to participate in the development of Member's ICP and in Interdisciplinary Care Team (ICT) case conferences, as needed.

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[2] California Welfare and Institutions Code (Welf. & Inst. Code) § 12309.1(f)

12. COORDINATION OF CARE

A. Care Management Requirements

2. Health Risk Assessment

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO-D-SNP) Members.

POLICY:

A. IEHP makes every effort to contact all IEHP DualChoice Members to conduct the Health Risk Assessment (HRA) within regulatory timeframes from the effective date of enrollment. Reassessment occurs annually thereafter, and as often as the health and/or functional status of the Member requires.[1]

PURPOSE:

A. To ensure the timely assessment of newly enrolled IEHP DualChoice Members and review, identification of their medical, functional, cognitive, and/or psychosocial health care needs that may require coordination of essential care and services.

PROCEDURES:

Initial Member Stratification

A. IEHP performs initial risk stratification for all newly enrolled IEHP DualChoice Members to stratify them to either a high, rising, or low risk to address co-morbid conditions, and/or complex healthcare needs. The risk factors utilized to stratify the newly enrolled Member may include, but is not limited to the following:[2]

1. Any available utilization data, including Medi-Cal, IEHP DualChoice Plan (Medicare-Medicaid Plan) and long-term care utilization;
2. Any other relevant and available data from delivery systems such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and Home and Community-Based Waiver Programs, behavioral health (both mental health and substance use disorder) and pharmacy data, if available;
3. Results of previously administered Medi-Cal or IEHP DualChoice Plan (Medicare-Medicaid Plan) health risk assessments, if available;
4. Medical encounter data, if available;
5. Emergency room utilization data, if available; and
6. Any data and risk stratification available through the Department of Health Care Services (DHCS) Population Health Management platform (when it becomes available).

[1] Medicare Managed Care Manual, "Chapter 5 – Quality Assessment," Section 20.2.3
[2] Department of Health Care Services (DHCS) CalAIM, Dual Eligible Special Needs Plans Policy Guide, Section I. Care Coordination Requirements

Health Risk Assessment Survey Tool

A. IEHP uses a standardized HRA tool that is based on Centers for Medicare and Medicaid Services (CMS) and DHCS standards to assess medical, behavioral, cognitive, functional needs, psychosocial, and social determinants of health status of the Members.[3] In order to ensure efficiencies and minimize the burden on Members, the same survey tool is used to administer the HRA on IEHP Medi-Cal and IEHP DualChoice Members, as appropriate.[4]

B. The HRA survey is an assessment tool which identifies primary, acute, long-term services and supports, behavioral health and functional needs. The HRA is conducted, reviewed, and stratified by license personnel (RN, LCSW, LVN). For all Members, the HRA process will identify, at a minimum:

1. Referrals to appropriate Long-Term Services and Supports (LTSS) and home- and community-based programs;
2. Caregivers, Members, and authorized representatives' participation;
3. Facilitation of timely access to primary care, specialty care, durable medical equipment (DME), medications, and other health services needed by the Member, including referrals to resolve physical or cognitive barriers to access, and Medi-Cal Dental Services;
4. Facilitation of communication among the Member's providers, including Behavioral Health Providers as appropriate;
5. Identification of the need for providing other activities or services needed to assist Members in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status;
6. Need for additional screening or services, including dementia and Alzheimer's disease;[5] and
7. Support for Members who need more complex case management.

HRA Survey Completion

A. IEHP attempts to contact Members within regulatory timeframes to conduct the HRA survey. Members have the option to complete the HRA in person, by telephone, or by mail.[6]

1. IEHP DualChoice Members must be contacted to complete the HRA within ninety (90) calendar days from the date of enrollment.[7]
2. If the Member cannot be reached by phone and/or declines to complete the HRA, IEHP

[3] Medicare Managed Care Manual, "Chapter 5 – Quality Assessment," Section 20.2.1
[4] DHCS CalAIM, Dual Eligible Special Needs Plans Policy Guide, Section I. Care Coordination Requirements
[5] Ibid.
[6] Medicare Managed Care Manual, "Chapter 5 – Quality Assessment," Section 20.2.3
[7] Ibid.

ensures the reason for declining is documented.

B. Members in Long-Term Care are excluded from HRA outreach. IEHP Utilization Management (UM) Department reviews the Minimum Data Set (MDS) Assessment quarterly for Members who are in custodial care and updates the Individualized Care Plan (ICP) as appropriate. The MDS tool is accepted as an HRA completion for Members in custodial care.

C. If IEHP, while performing the HRA, identifies a potential need for continuity of care, IEHP will refer the Member to their IPA for assistance. See Policy 12A5, "Care Management Requirements – Continuity of Care" for more information.

D. IEHP notifies Primary Care Providers (PCPs) of any new Members who have not completed an HRA within the time period set forth above or whom IEHP has not been able to contact. IEHP encourages PCPs to conduct outreach to their Members to schedule health maintenance visits and encourage them to complete the HRA.

E. IEHP conducts the HRA reassessment at least annually, within twelve (12) months of the previous HRA assessment or as often as the health and/or functional status of the Member requires. Survey may be conducted by mail, phone, or in person at the setting of Member's choice.

1. In addition to annual reassessments, the IPA is responsible for conducting reassessments when there is a change in the Member's condition, a change in PCP, and per the Member's request.

2. IPAs may use their own assessment tool for reassessments and are required to clearly document the reason for completing the reassessment as outlined above.

Post-HRA Risk Stratification and ICP Development

A. Based on their completed HRA, and additional information provided by the Member/Caregiver, data, or Providers, the Member is re-stratified as High, Rising, or Low Risk for enrollment in the appropriate level of CM program.

1. IPAs are required to provide a mapping of stratification levels to High, Rising, and Low within their Care Management policies.

2. The IPA must have a process in place to stratify the Members without an HRA by using data that is available to them. If no additional data is available to the IPA, then the IPA should use the stratification level that was assigned to the Member on the daily HRA data transmission on the Provider portal, and/or other IEHP risk stratification designation.

B. Careful consideration needs to be applied when stratifying Members lower than the post-HRA stratification level. IEHP understands that IPAs have developed their own stratification levels, but if a Member is re-stratified to a lower risk level by the IPA then supporting documentation is required.

C. The HRA survey responses serve as a foundation to develop an ICP for each Member, identify

their care coordination needs and stratify them for care management interventions.

D. The completed HRA results are loaded onto the IEHP secure Provider web portal daily for PCPs and IPAs to access. The IPA is required to review completed HRA results, post-HRA risk stratification and utilize all available data to determine a final risk stratification level for their Member.

1. IPAs are expected to retrieve and review completed HRAs from the Secure File Transfer Protocol (SFTP) server or the secure Provider portal and outreach to the Member to update and/or develop their ICP. The ICP must be completed within ninety (90) days of the Member's enrollment date. See Policy 12A3, "Individualized Care Plan."
2. IPAs are required to:
    a. Review the HRA results with the Member timely and assign a stratification;
    b. Document the review of the HRA in the medical management system;
    c. Document and review post-HRA results or lack thereof within the medical management system;
    d. Address identified risks and the plans to mitigate; and
    e. Develop/update care plan with Member upon discussion of identified risks.
3. If IEHP is unable to contact the Member to complete the HRA, the HRA status under the "Assigned Roster" on the secure Provider portal will display as "Incomplete." The IPA must continue to outreach to the Member for ICP completion within ninety (90) calendar days of the Member's enrollment date. If the Member is successfully contacted, the ICP must be developed with the Member's participation.
4. In the event there is an IEHP-developed ICP, the IPA is expected to retrieve and review the posted ICP on the secure Provider portal to complete and/or update with the Member, making every attempt to complete the ICP within ninety (90) days of enrollment date.
5. ICPs can be developed without having a completed HRA, utilizing available data such as utilization and pharmacy data, and/or other available assessments.
6. Successful Member outreach attempt must align with date of ICP development or documentation must support discrepancies in dates.
7. If IEHP is unable to contact the Member to review HRA or to complete an assessment, the IPA must make and document, at a minimum, three (3) separate contact attempts to locate Member.
    a. Contact attempts must be made within thirty (30) calendar days of HRA status notification.
    b. Attempts may be telephonic, by mail, by email, etc.
    c. All contact attempts of the same type on the same day are considered one (1) attempt.

E. The post-risk stratification process should include, at a minimum, the post-HRA risk score, utilization patterns, pharmacy data, medical history, behavioral health diagnosis, social determinants, and enrollment into an LTSS program (IHSS, Community-Based Adult Services (CBAS) or Multipurpose Senior Services Program (MSSP).

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12. COORDINATION OF CARE

A. Care Management Requirements
3. Individualized Care Plan

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO-DSNP) Members.

POLICY:

A. IEHP delegates to its IPAs and their Provider network the responsibility of providing case management services and coordination of care for their assigned Member. This includes but is not limited to ensuring the coordination of medically necessary health care services delivered within and outside their network, provision of preventive services in accordance with established standards, continuity of care, health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health needs.

B. IEHP and its IPAs develop an individualized care plan (ICP) with each Member and engage the Member and/or Member's authorized representatives in its design, reassessment, and updates.

PURPOSE:

A. To ensure that IEHP Members with multiple or complex medical conditions and Enhanced Case Management (ECM)-like services are identified and that ICPs are developed to assist in the management of Members' health care needs.

B. To have a centralized plan for Members' comprehensive care goals that may include physical, behavioral, psychosocial, long-term care and spiritual needs.

DEFINITION:

A. Individualized Care Plan (ICP) – Plan of care developed in collaboration with the Member and their Interdisciplinary Care Team (ICT).

PROCEDURES:

A. Members will be assigned to a Care Manager (RN, LCSW, LVN, MSW) with the appropriate experience and qualifications based on the Member's assigned risk level and individual needs.

   1. The Care Manager encourages participation of the Member or authorized representative and their Primary Care Provider (PCP) in the development of their ICP.[1] If cognitive impairment is present, caregivers should also be involved.

[1] Department of Health Care Services (DHCS), CalAIM Dual Eligible Special Needs Plan (DSNP) Policy Guide, Section I. Care Coordination Requirements

2. The Care Manager uses clinical judgement to ensure timely and appropriate interventions and follow up is planned and works with the Member to prioritize goals according to the Member's preference.
3. The Care Manager facilitates access and documents referrals and connections to the following services, which must include at least three (3) outreach attempts, as appropriate:[2]
    a. Community-Based Organizations (CBOs) such as those serving Members with disabilities and/or dementia-related diagnoses;
    b. County mental health and substance use disorder services;
    c. Housing and homelessness providers;
    d. 1915(c) waiver programs, including Multipurpose Senior Services Program (MSSP);
    e. Long-Term Services and Supports (LTSS), including In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS);
    f. Transportation services; and
    g. Dental benefits.

B. IEHP and its IPAs must maintain only one (1) ICP for their assigned IEHP DualChoice Members to meet both Medicare and Medi-Cal ICP requirements. To the extent that Medi-Cal and Medicare guidance for ICPs conflict, IEHP and its IPAs must follow Medicare guidance.[3]

C. For High, Rising, and Low Risk Members, the initial ICP is developed within a timeframe that is appropriate to address the issues identified in the Health Risk Assessment (HRA) or other presenting information and no more than ninety (90) calendar days from enrollment.

D. The ICP is a comprehensive, person-centered, and when cognitive impairment is present, family-center plan of care that is developed utilizing HRA survey responses, utilization, pharmacy, encounter and other Member data, ICT advisement, and if available, information related to Community-Based Adult Services (CBAS), IHSS, and MSSP.[4] The ICP should be developed and updated by, and/or shared with the member's palliative care team, as appropriate.

E. If a Member refuses to be involved in ICP development, the IPA will seek to re-visit the refusal at least at the time of reassessment, which occurs annually, when the Member experiences a change in condition, or if the Member has a change in PCP.

[2] DHCS, CalAIM DSNP Policy Guide, Section I. Care Coordination Requirements
[3] Ibid.
[4] Ibid.

F. The ICP is the responsibility of the Member's IPA and is separate and distinct from the medical care plan which is created, established, and maintained by PCP.

1. IPAs are expected to retrieve and review completed HRAs from IEHP's Secure File Transfer Protocol (SFTP) and secure IEHP Provider portal daily and outreach to the Member timely to update and/or develop ICP.

    a. If the Member identifies a caregiver, the IPA must assess for caregiver support needs.

2. If IEHP was unable to contact the Member to complete their HRA, the HRA status under the "Assigned Roster" on the secure IEHP Provider portal will display as "Incomplete." The IPA shall continue to outreach to the Member for ICP completion within ninety (90) calendar days of the Member's enrollment date. If the Member is not successfully contacted, ICPs can be developed without a completed HRA, utilizing data such as utilization and pharmacy data, and/or any other available assessments.

3. In the event there is an IEHP-developed ICP, the IPA is expected to retrieve and review the posted ICP on the secure IEHP Provider portal to complete and/or update with the Member, and/or authorized representative, making every attempt to complete the ICP within ninety (90) calendar days of enrollment date.

4. Successful Member outreach attempt must align with the date of ICP development or documentation must support discrepancies in dates. For example, if the Member is contacted on January 1, 2024 to develop their ICP, both the ICP creation and contact dates should be January 1, 2024.

5. IPAs are expected to make three (3) separate attempts (at a minimum) to contact the Member to review HRA results, conducted face-to-face visit to engage the Member if HRA has not been completed (due to IEHP not being able to contact the Member)and/or to develop/update ICP.

    a. Contact attempts must be made within thirty (30) calendar days of HRA status notification.

    b. Attempts may be telephonic, by mail, by email, etc.

    c. All contact attempts of the same type on the same day are considered one (1) attempt.

G. IPA is responsible for Coordination of care for Palliative services with members of the ICT that includes but is not limited to assessments for service, pain and symptom management, mental health and medical social services based on Member preference.

H. IPA is responsible for Coordination of care for Members identified with cognitive impairment that includes but is not limited to assessments and early interventions based on Members preference.

I. IPA is responsible for Coordination of ECM-like services for the most vulnerable population based on population of focus such as Individuals with Serious Mental Health (SMI); Adults

Living in the Community and are at Risk for LTC Institutionalization; Pregnancy, Postpartum and Birth Equity; and member's transitioning from long-term facility. The ICP is updated per Member's care management stratification level and/or Member preference.

J. IPA is responsible for following transition of care process for those Member's that transition from a long-term care facility into the community. See Policy 12A7, "Care Management Requirements- Transition of Care."

K. The IPA must obtain the Member's approval for the involvement of any caregivers in the development of the ICP.

L. The care plan includes, but is not limited to, the following elements as appropriate:

1. Name and contact information of the Member's current assigned Care Manager. Member Services phone numbers may only be used if the number will transfer the Member to her/his assigned Care Manager;
2. The name and contact information for the Member's PCP and any Specialists;
3. A complete and current list of the Member's medications;
4. Member goals and preferences, choices and abilities;
5. Measurable objectives and timetables to meet medical, behavioral health, and Long-Term Services and Supports (LTSS) needs;
6. Identification of barriers;
7. Timeframes for reassessment and updating of care plan;
8. Care coordination needs such as arranging transportation, obtaining appointments, referral status updates, coordinating interpreter services, and educating on importance of preventive services;
9. Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies;
10. Coordination of benefits and services covered by both Medicare and Medi-Cal, including when Medi-Cal services are delivered via Medi-Cal Fee-For-Services (FFS), Medi-Cal Dental Services, managed care, or other Medi-Cal delivery systems; and
11. Consultation with the Member, PCP, and other members of the ICT, via ICT case conference, telephone, fax, or email, as appropriate.

M. If the Member is receiving county behavioral health services, IPAs should involve IEHP for care planning needs, as appropriate. The ICP must also include:

1. The name and contact information of the primary county or county-contracted behavioral health provider.

N. In the event a Provider does not agree with the ICP, the IPA is required to coordinate with IEHP, County BH Provider and PCP to meet the Member's behavioral health needs.

O. If the Member is receiving In-Home Supportive Services (IHSS), the ICP must also include:

1. The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and
2. The name and contact information for the IHSS caregiver.

P. For Members receiving county behavioral health services, IEHP and IPA Care Manager interventions should also include:[5]

1. Communication with county behavioral health clinics to discuss diagnoses (medical, behavioral, and social needs), review treatment plans, and/or coordinate mental health services provided by the county with other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.
2. Member communication to discuss the Member's behavioral health needs and services and how those services may be coordinated with other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.

Q. IPA Care Management team defines and sets timeframes for review and follow up for each Member ICP based on the clinical needs. The ICP is updated at least annually, and in the following instances, at minimum:

1. A change in Member's assigned PCP;
2. A change in the Member's health condition, including but not limited to a change in the level of care;
3. A new problem has been identified with the Member;
4. A goal has changed priority, has been met or is no longer applicable; and
5. ICP is closed or completed.

R. IPA Care Management staff ensure the Member receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process. This includes providing:

1. Educational material on Member conditions and available treatment options, support and/or alternative courses of care;
2. Information on how family members and social supports can be involved in care planning, as the Member chooses;

[5] Medicare-Medicaid Capitated Financial Alignment Model Reporting California-Specific Reporting Requirements, February 2021

3. Options and assistance available to self-direct their care; and
4. Information on how to access available resources.

S. Upon request, IPAs ensure that the ICP is available in Member's preferred written or spoken language and/or alternate formats that effectively communicate information.

T. Members or their authorized representative must have the opportunity to review and sign the ICP and any amendments to the ICP. IPAs are required to provide Members a copy of their ICP and any amendments at least annually and upon request. IPAs must send a copy of the updated ICP to the Member in these scenarios, at minimum:

1. The ICP is completed or closed;
2. A change in Member's assigned PCP;
3. A change in the Member's condition (e.g., a change in the level of care); and
4. A new problem is identified with the Member and added to the ICP, as discussed with the Care Manager.

Data Sharing

A. IEHP transfers to another health plan all information necessary to support continuity of care when the Member disenrolls from the health plan. This information includes, but is not limited to: assessment, ICP, and other pertinent information. IEHP provides the information to the Member's new health plan no later than thirty (30) calendar days from receipt of the notice of disenrollment to IEHP and no later than the effective date of transfer in the method and format specified by the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS).

B. The IPA shares the ICP with the Provider and ICT as necessary or requested.

C. On a monthly basis, IEHP provides IPAs a list of newly assigned Members that identifies their previous IPA. IPAs are encouraged to coordinate with the Member's previous IPA to request information to ensure continuity and coordination of medical care. Important information includes, but is not limited to, assessments, ICP, and other pertinent information.

D. Information is shared according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

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12. COORDINATION OF CARE

A. Care Management Requirements
4. Interdisciplinary Care Team

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs ensure that every IEHP DualChoice Member is offered an interdisciplinary care team (ICT). An ICT is a team of individuals who are involved in the Member's health care. This team is person-centered and collaborates with the Member and one another to develop an individualized care plan (ICP) and assist in the coordination of the Member's health care needs. The ICT must:

1. Be Member-centered and developed around the Member's specific needs and preferences;
2. Deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity; and
3. Ensure the integration of the Member's medical and Long-Term Services and Supports (LTSS) and the coordination of behavioral health services and In-Home Supportive Services (IHSS), when applicable.

PURPOSE:

A. To provide a multi-disciplinary approach to assessing, monitoring, and coordinating the care of a targeted population.

B. To address the multiple issues that affect these Members (e.g. medical, behavioral health, psychosocial, cognitive, and functional issues).

C. To promote a collaborative, interdisciplinary, Member-focused, and interactive approach to developing, implementing, and monitoring individualized Member care plans.

D. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site.

PROCEDURES:

ICT Composition

A. ICT is led by professionally knowledgeable and credentialed personnel and consists of the following, at minimum:[1]

1. Member and/or Member's authorized representative;

[1] Department of Health Care Services (DHCS), CalAIM Dual Eligible Special Needs Plan (DSNP) Policy Guide, Section I. Care Coordination Requirements

2. Family member and/or caregiver, as approved by the Member;
3. Care Manager; and
4. Primary Care Provider (PCP) or Specialist if the Specialist is serving as the Member's PCP.

B. The Member or their authorized representative and their Primary Care Provider (PCP) are encouraged to participate in the development of the Member's ICT.

C. IEHP and its IPAs will invite and engage into the Member's ICT individuals and/or Providers, who are actively involved in the Member's care and are willing to participate and contribute in care planning, as approved by the Member.[2] If cognitive impairment is present, caregivers should also be involved. Members may request the exclusion of any ICT member. Examples of ICT members that will be invited and engaged include, but are not limited to the following individuals:

1. Hospital discharge planner such as IEHP and/or IPA Utilization Management staff (inpatient/outpatient nurses);
2. Nursing facility representative;
3. Social Worker, including the IHSS social worker if IHSS services are provided;
4. Specialized providers, such as Member's Physician Specialists, Pharmacists, Physical Therapists, and Occupational Therapists;
5. If receiving In-Home Supportive Services (IHSS), the IHSS provider;
6. If participating in Community-Based Adult Services (CBAS), the CBAS provider;
7. If enrolled in the Multipurpose Senior Services Program (MSSP), the MSSP case manager;[3]
8. Behavioral Health Provider, which may include, but is not limited to, a specialty mental health Provider, county BH Provider or a substance use disorder counselor;
9. Dementia care specialist, as needed;
10. Palliative Care Provider;
11. If receiving LTSS services, IEHP's LTSS Liaison, as appropriate;[4] and
12. Other professionals, as appropriate.

D. For members with serious illness participating in a palliative care program, IEHP and its IPAs must use a palliative care ICT.

[2] DHCS, CalAIM DSNP Policy Guide, Section I. Care Coordination Requirements
[3] Ibid.
[4] Ibid.

E. Irrespective of having a formal Alzheimer's or dementia-related diagnosis, if the Member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage activities of daily living (ADL) or instrumental ADL, the ICT must include the Member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the Member's preferences. Training for Dementia care specialists must include:[5]

1. Understanding Alzheimer's Disease and Related Dementias (ADRD), symptoms and progression;
2. Understanding and managing behaviors and communication problems caused by ADRD;
3. Symptoms and progression;
4. Understanding and managing behaviors and communication problems caused by ADRD;
5. Caregiver stress and its management; and
6. Community resources for Members and caregivers.

F. Each Member, or authorized representative, has the primary decision-making role in identifying needs, preferences, and strengths and has a shared decision-making role in determining the services and supports that are most effective and helpful.

ICT Function and Communication

A. IEHP and its IPAs perform the following functions through the ICT:

1. Facilitates care management, including assessment, care planning, authorization of services, and transitional care issues;
2. Works closely with the Member's PCP, Specialists, and other Providers involved in the Member's care to stabilize their medical conditions, increase compliance with ICPs, maintain functional status, and meet the Member's care plan goals;
3. Develops and implement an ICP that is agreed upon by the Member and/or caregiver;
4. Conducts interdisciplinary case conferences (ICC) as needed, including at the Member's request;
5. Manages communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;
6. Maintains a call line or other mechanism for Member inquiries and input, and a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;

[5] DHCS, CalAIM DSNP Policy Guide, Section I. Care Coordination Requirements

7. Conducts conference calls with Providers, the Member, and appropriate individuals, as needed;
8. Maintains a mechanism for monitoring Member complaints and grievances, which is provided to IPAs by IEHP; and
9. Uses secure email, fax, web portals or written correspondence to communicate to entire ICT, community and other stakeholders while taking the Member's individual needs, communication, cognitive, or other barriers into account.

B. IEHP and its IPAs have a process to assemble the ICT in the form of a case conference. Examples of situations which may require a formal case conference with the members of the ICT are as follows:

1. A Member or IEHP requesting the ICT be assembled to discuss the Member's issues; Need to assess a Member, who is not achieving goals as stated on the ICP;
2. Need to assess a Member receiving care out-of-network;
3. Need to assess a Member transitioning from one (1) health setting to another or moving from one level of care management to another risk level;
4. Homebound Members that require a face-to-face assessment;
5. Members needing complex care coordination (i.e. homelessness, homebound, multiple co-morbidities, dual diagnosis, etc.); or
6. Members needing LTSS benefit coordination as well as other complex cases.

C. IPAs are responsible for documenting all invitees and attendees of the ICT, as well as offering and providing an updated ICP to the Member and the ICT as the Member's health status changes. If the IPA does not have a certain discipline type available to them, they may utilize the members of IEHP's ICT. These include Behavioral Health & Care Management (BH&CM) staff, Pharmacists, Independent Living and Diversity Program staff, LTSS care managers, Health Education staff, and dieticians.

D. IEHP has case conferences on a regular basis and can support the IPA if assistance is needed. The IPA may contact the IEHP BH&CM Department via email at CMGM@iehp.org or by calling Provider Call Center at (909) 890-2054 if it needs assistance with coordination of the ICT case conference, including to contact IEHP's LTSS Liaison. IEHP recommends that the IPA hold case conferences periodically, or at the Member's discretion. In addition, IEHP also recommends IPAs to consider a case conference after conducting the Member's annual assessment.

G. IPAs support multiple levels of interdisciplinary communication and coordination, such as individual consultations among Providers, county agencies and Members. IEHP and its IPAs have a documented process for coordinating the exchange of information amongst all ICT members.

H. IPAs have procedures for notifying the ICT of emergency department use, psychiatric or acute hospital or skilled nursing facility (SNF) admission and coordinating a discharge plan.

I. IPAs allow the Member to opt-out of the ICT at any time without affecting the ICT's ability to continue its operations. Members may not be disenrolled for lack of participation on the ICT. At a minimum, the Care Manager provides his or her contact information to the Member and re-visits the refusal at the time of reassessment, or if the Member's PCP changes.

ICT Training

A. IEHP and its IPAs provide competency training for ICT members initially and on an annual basis. See Policy 12A6, "Care Management Requirements – Model of Care Training," for information on how training on these and other topics may be provided:

1. Person-centered planning processes;
2. Accessibility and accommodations;
3. Cultural and linguistic competency;
4. Long-Term Services and Supports, including home and community-based services and long-term institutional care;[6]
5. Independent living philosophy as well as recovery and wellness principles;
6. Information about LTSS programs, eligibility for these services, and program limitations; and
7. Coordination with Counties on IHSS

Individuals who serve on the Member's ICT on an ad hoc basis are provided an ICT Fact Sheet by mail or fax prior to participating in a case conference. The ICT Fact Sheet is also available on the non-secure Provider portal at https://www.iehp.org/en/providers/provider-resources?target=compliance

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[6] DHCS, CalAIM DSNP Policy Guide, Section I. Care Coordination Requirements

12. COORDINATION OF CARE

A. Care Management Requirements

5. Continuity of Care

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs allow Members with pre-existing provider relationships, to request Continuity of Care (COC) for up to 12 months with an out-of-network provider.[1,2] IEHP and its IPAs will initiate the process described herein immediately upon request, unless otherwise specified.

   1. COC extends to primary, specialty, durable medical equipment (DME), medical supplies, mental health, and select ancillary care providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health therapy, and speech therapy providers.

B. IEHP and its IPAs provide COC with an out-of-network provider when all of the following requirements are met:

   1. IEHP or its IPAs are able to determine that the Member has a pre-existing relationship with the provider;
   2. The provider is willing to accept IEHP contract rates or the Member's IPA contract rates based on the current Medicare or Medi-Cal fee schedule, as applicable;
   3. IEHP or the Member's IPA determines that the provider meets applicable professional standards and has no disqualifying quality of care issues that would otherwise exclude the provider from their network.

C. If a Member changes health plans by choice following their initial enrollment with IEHP or if a Member loses and then later regains IEHP eligibility during the 12-month COC period, the 12-month COC period may start over one (1) time. If the Member changes health plans a second time or more, the COC period does not start over, which means that the Member does not have the right to a new 12 months of COC. If the Member returns to FFS and later re-enrolls with IEHP, the COC period does not start over.[3] If the Member changes IPA during their enrollment with IEHP, the COC period does not start over.

D. The Member is assigned to IEHP or a IPA that has the Member's preferred PCP in its network. For example, if a Member has an existing relationship with a PCP and a specialist

[1] State Medicaid Agency Contract (SMAC), Exhibit A, Attachment 1, Provision 9, Provider Network Requirements
[2] Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[3] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs

in IPA #1, as well as a specialist in IPA #2, IEHP assigns the Member to IPA #1, who is contracted the Member's preferred PCP. IPA #1 is responsible for allowing the Member to continue treatment with both specialists, pursuant to COC requirements.[4]

PURPOSE:

A. To achieve an improved quality of care, support coordination and continuity of care, increase Member satisfaction with care, and enhance system efficiencies.

DEFINITIONS:

A. **Assessment:** A process by which a Member is seen by an in-network Provider, who then conducts a review of the Member's current condition and completes a new treatment plan which includes an evaluation of the services specified by the pre-transition active treatment authorization.

PROCEDURES:

Continuity of Care

A. Requesting for COC

1. Members, their authorized representative, or their Provider, may make a direct request to IEHP or the Member's IPA for COC.
2. IEHP and its IPAs accept requests for COC over the telephone and do not require the requester to complete or submit a paper or computer form if the requester prefers to request telephonically.[5]
3. IEHP provides acknowledgment of the COC request advising the Member that the COC request has been received, the date of receipt, and the estimated timeframe for resolution. Acknowledgement of COC request will be provided within the following timeframes, using the Member's known preference of communication or by one of these methods in the following order – telephone call, text message, and then notice by mail:
    a. Within 7 calendar days of receipt of non-urgent requests; and
    b. Within the shortest applicable timeframe that is appropriate for the Member's condition, but no later than three (3) calendar days of receipt of urgent requests.

[4] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[5] Ibid.

2. If requested by a newly enrolled or transitioning Member, their authorized representative, or provider, IEHP allows the Member to keep previously authorized and scheduled specialist appointments with out-of-network specialists when COC has been established and the appointment(s) occur within the 12- month COC period.

    a. If pre-existing relationship with the out-of-network provider has not been established, IEHP and its Delegates are encouraged to make a good faith effort to either, arrange for an alternative in-network Provider on or before the scheduled appointment date, or keep the appointment with the out-of-network provider. However, since the appointment with the out-of-network provider occurs after the Member's transition to IEHP, it does not establish the requisite pre-existing provider relationship for the Member to submit a Continuity of Care request.

4. As part of the Health Risk Assessment, IEHP asks its Members if there are upcoming health care appointment or treatment scheduled and assist them in initiating a COC request if the Member chooses to do so.

B. Retroactive Approval of COC Requests[6]

1. IEHP and its IPAs approve and reimburse out-of-network providers for services that were already provided if the claim meets all COC requirements described in this policy as well as the following:

    a. Services were provided after the Member's enrollment into IEHP; and

    b. Dates of service are within 30 calendar days of the first service for which the provider requests retroactive COC reimbursement.

2. Retroactive COC reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

3. IEHP and its IPAs must however, accept retroactive COC reimbursement requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the rest to the incorrect entity and the request is sent within thirty (30) days of the denial from the other entity.[7]

C. Validating Pre-Existing Provider Relationship

1. A pre-existing relationship means the Member has been seen by the out-of-network Primary Care Provider (PCP), specialist, or select ancillary provider including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment (BHT), and speech therapy provider for a non-emergency visit, at least once during the 12 months prior to the Member's initial enrollment with IEHP.

[6] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[7] Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, Section V, Continuity of Care

2. IEHP and its IPAs determine if the Member has an existing relationship with the out-of-network provider through the following:
    a. Review of data provided by DHCS or a terminating plan, such as Medi-Cal FFS utilization or claims data; and/or
    b. Information or documentation provided by the Member, their authorized representative, or their provider (self-attestation from the Member is not sufficient proof).
3. Upon validation of the Member's pre-existing relationship with the provider, IEHP or the Member's IPA will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other form of relationship to establish a COC relationship for the Member.
    a. If the provider is in-network, the Member is allowed to continue seeing the Provider.
4. IEHP requests from the out-of-network provider all relevant treatment information, for the purposes of determining medical necessity, as well as current treatment plan, if it is allowable under federal and state privacy laws and regulations.

D. Completing COC Request

1. IEHP and it's IPAs begins to process a COC request within five (5) working days following receipt of the request. The COC process begins when IEHP starts the process to determine if the Member has a pre-existing relationship with the Provider.[8]
2. IEHP and its IPAs complete COC requests within the following timelines:[9]
    a. 30 calendar days from the date of receipt of COC request;
    b. 15 calendar days from the date of receipt of the COC request if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
    c. As soon as possible, but no longer than three (3) calendar days from receipt of an urgent request (i.e., there is identified risk of harm to the Member).

    To ensure that decisions are rendered as expeditiously as required by the Member's condition, IEHP has developed and applies a standard for assessing the Member's medical condition and determining the urgency of their request.
3. A COC request is considered completed when:[10]

[8] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[9] Ibid.
[10] Ibid.

a. IEHP or the Member's IPA notifies the Member that the request has been approved or denied;

b. IEHP or the Member's IPA and the out-of-network provider are unable to agree to a rate;

c. IEHP or the Member's IPA has documented quality of care issues with the out-of-network provider; or

d. IEHP or the Member's IPA makes a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

4. IEHP or the Member's IPA notifies the Member of the decision, using the Member's preferred method of communication or by telephone, and by mail within seven (7) calendar days of the decision.[11]

   a. IEHP and it's IPAs include the following in approval notices:

      1) A statement of the Plan's decision;

      2) Duration of the COC arrangement;

      3) The process that will occur to transition the Member's care back into the network at the end of the COC period; and

      4) The Member's right to choose a different provider from IEHP's or the IPA's network.

   b. IEHP and it's IPAs include the following in denial notices:

      1) A statement of the Plan's decision;

      2) A clear and concise explanation of the reason for denial; and

      3) The Member's right to file a grievance or appeal.

   IEHP or the Member's IPA must notify the Member utilizing the IEHP-approved "Continuity of Care Authorization Letter" template. These IEHP-approved notification templates are available online at: www.iehp.org.

5. If the provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement or other forms of relationship with IEHP or the Member's IPA, the Member is allowed to access the provider for the length of the COC period unless the provider is only willing to work with IEHP or the IPA for a shorter timeframe; in which case, IEHP or the IPA will allow the Member to have access to that provider for the shorter period of time.[12]

[11] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[12] Ibid.

6. IEHP and it's IPAs will work with the out-of-network provider and communicate its requirements on letters of agreements, including referral and authorization process, to ensure that Members are not referred to another out-of-network provider without authorization from the Plan. IEHP and it's IPAs will review requests for referrals and approve if the request is deemed medically necessary and if there is not an appropriate Provider available in-network.
7. IEHP an it's IPAs will work with providers to establish a plan of care for the Member.
8. If IEHP or the IPA and the out-of-network provider are unable to reach an agreement, or if the provider has documented quality of care issues, IEHP or the IPA will assign the Member an in-network alternative. If the Member does not make a selection, one will be assigned to them.[13]

Transitioning the Member's Care to an In-Network Provider

1. IEHP and its IPAs may choose to allow the Member continued access to the out-of-network provider past the 12 month COC period; however, neither IEHP nor its IPAs are required to do so.
2. Members may change their provider to an in-network Provider at any time, regardless of whether a COC relationship has been established.[14]
3. IEHP and its IPAs must notify Members at least thirty (30) calendar days before the end of the COC period to assist in transitioning their care to an in-network Provider at the end of the COC period. This process includes engaging with the Member and the out-of-network provider before the end of the COC period to ensure continuity of services and patient safety through the transition to the in-network Provider.[15]
    a. IEHP or the Member's IPA must notify the Member utilizing the IEHP-approved "Continuity of Care Terminate Letter" template. These IEHP-approved notification templates are available online at: www.iehp.org.

Durable Medical Equipment (DME) and medical supplies

1. IEHP and it's IPAs allow transitioning Members to keep their existing DME rentals and medical supplies from their existing Provider, under the previous prior authorization for a minimum of 90 days following enrollment with IEHP and until IEHP or the IPA is able to reassess.[16]
2. Continuity of DME and medical supplies is honored without need for request by the Member, their authorized representative, or Provider.

[13] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[14] Ibid.
[15] Ibid.
[16] Ibid.

3. If DME or medical supplies have been arranged for a transitioning Member, but have not yet been delivered, IEHP and it's IPAs allow for delivery and for the Member to keep the DME or medical supplies for a minimum of 90 days following enrollment and until IEHP or the IPA is able to reassess.
4. If IEHP or the IPA does not complete a new assessment, authorizations for DME and medical supplies remain in effect for 90 days, after which IEHP and it's IPAs may reassess the Member's authorization at any time and require the Member to switch to a network DME Provider.

B. Transportation

1. IEHP allows Members to keep the modality of transportation under previous prior authorizations with a network Transportation Provider, until IEHP is able to reassess the Member's continued transportation needs. Transportation services for IEHP DualChoice Members are covered by Medi-Cal. Please see policy MA_09G "Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses" for additional information.

C. Other COC Provisions

1. IEHP informs Members upon their enrollment through the Member Handbook (Evidence of Coverage) of their COC protections, including how Members, their authorized representatives, and Providers can initiate a COC request. This information is also accessible via the IEHP website. The Member Handbook and all Member-informing materials are translated into IEHP's threshold languages and are available in alternative formats, upon request.[17]
2. IEHP allows Members to continue use of any (single-source) drugs that are part of a therapy prescribed by a contracted or non-contracted provider and in effect for the Member immediately prior to the date of enrollment, regardless of the drug coverage status by IEHP. The therapy can continue until it is no longer prescribed or medically necessary. Providing samples does not constitute continuation or step therapy.[18,19]
3. Members currently in a Skilled Nursing Facility (SNF) will not be required to change SNFs prior to their enrollment if the facility meets the following criteria:
   a. Facility is licensed by the California Department of Public Health (CDPH);
   b. Meets acceptable quality standards; and
   c. Facility and IEHP agree to payment rates that meet state statutory requirements.

[17] DHCS CalAIM D-SNP Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[18] California Welfare and Institutions Code (Welf & Inst. Code) § 14185(b)
[19] CA Health and Safety Code (Health & Saf. Code) § 1367.22

Members currently in a SNF do not have to make a request to IEHP to invoke the above provision.

4. IEHP uses treatment authorization request (TAR) and/or prior authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. IEHP pays claims for prior and existing authorizations when data is incomplete.
5. Members have the right to file their grievance at any time following any incident or action that is the subject of the Member's dissatisfaction during the COC process. Please refer to Policy 16A, "Grievance and Appeals Resolution for Members (Standard and Expedited)" for more information.
6. Members have the right to seek review of IEHP's final decisions as well as obtain copies of this policy. Members desiring review of a decision, or wanting a copy of this policy, should contact IEHP's Member Call Center at (877) 273-4347.
7. IEHP reports on existing metrics related to COC provisions as outlined in state and federal guidance materials.
8. All Members have the right to continue receiving Medicare services covered under the MCP's contract. IEHP or the Member's IPA will arrange for continuity of care for covered services without delay to the Member with an in-network Provider, or if there is no in-network Provider available within applicable timeframes and access standards, with a suitable out-of-network provider. If a Member would like their out-of-network provider to provide a service, they can submit a request for COC in accordance with this policy.

Obtaining Care from Terminating or Out-of-Network Providers

A. Upon their request, current or newly enrolled Members with specified conditions may continue to obtain health care services from a Provider ending their contract with their IPA. This is not applicable to Providers with disciplinary actions or sanctions or a non-contracted provider:[20]

   1. Acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
   2. Serious chronic condition is a medical condition due to a disease, illness, medical problem, or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided

[20] CA Health & Saf. Code § 1373.96

for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultant with the Member and the terminating or nonparticipating provider. Completion of covered services shall not exceed 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered Member.

3. Throughout the Member's pregnancy, which includes three (3) trimesters of the Member's pregnancy and the first 12 months into the post-partum period.[21]
4. For Members who present written documentation of being diagnosed with a maternal mental health condition from their treating provider, completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.[22]
5. Care of a newborn child between birth and age 36 months. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
6. Performance of a surgery or other procedure that is authorized by IEHP or the IPA as part of a documented course of treatment and has been recommended and documented by the Provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.
7. Completion of covered services of a Member with a documented terminal illness. Completion of these covered services are provided for the duration of the terminal illness, even if it exceeds 12 moths from the contract termination date or 12 months from the Member's enrollment.

B. If IEHP or the IPA is unable to come to an agreement with a terminated or out-of-network Provider, or if the Member, their authorized representative, or their Provider fails to submit a request for completion of covered services, IEHP is not required to continue to cover the Provider's services. In these instances, IEHP will assist the Member with obtaining care from a suitable in-network alternative.[23]

C. IEHP or the IPA's Medical Director is responsible for determining whether the Member may continue to obtain care from their terminating or out-of-network provider.

1. In determining whether or not a Member remains under the care of their current practitioner or maintains a previously scheduled treatment/procedure, the most important factor considered is the impact that a change of Practitioner or change in treatment/procedure has on the clinical status of the Member.

[21] H.R. 1319, the American Rescue Plan Act of the 117th Congress 2021–2022 (ARPA) (Pub. Law 117-2), Section 9812 "Modification to Certain Coverage Under Medicaid for Pregnant and Postpartum Women"
[22] Assembly Bill (AB) 577, Eggman. Health care coverage: maternal mental health
[23] DHCS APL 22-032

2. Care may continue beyond the specified timeframe if necessary, for a safe transfer to another practitioner.
3. If the decision is made to have the Member continue receiving care through their current practitioner, or maintain their previously scheduled treatment or procedure, the Member's IPA and/or Hospital is financially responsible per the IEHP Capitated Agreement.

D. Members currently under the care of a terminating provider are notified in writing by IEHP or the Member's IPA to avoid any disruption in care. Please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers" for information on Plan and IPA responsibilities.

E. If a terminating provider refuses to accept terms and conditions consistent with those that were imposed prior to the contract termination date, the IPA can request that IEHP deny the Member's request. Final decisions rest with the IEHP Medical Director.

F. If a Member is under the care of a provider, whose IPA terminates their contract with IEHP, the health plan will make all efforts to assist the Provider with contracting with IEHP or another IPA within the health plan's network.

G. Unless otherwise agreed upon by the terminating provider and IEHP or by the terminating provider and an IPA, the services rendered under this Policy will be compensated at rates and methods of payment similar to those used by IEHP or the IPA for currently contracted Providers providing similar services who are not capitated and who are practicing in the same geographic area as the terminating Provider.

H. For information on block transfers in the event of the termination of a provider contract, please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers."

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12. COORDINATION OF CARE

A. Care Management Requirements
6. Model of Care Training

APPLIES TO:

A. This policy applies to IEHP, IPAs and their staff and Providers caring for IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs provide initial and annual training on the Model of Care (MOC) to its full-time and temporary staff, as well as network and out-of-network providers, who are routinely seen by Members, including but not limited to Primary Care, Specialty Care, Hospital, Ancillary, and Transportation Providers.

PURPOSE:

A. To ensure that IPAs, Providers, and staff are appropriately trained to support the health plan's model of care.

PROCEDURES:

A. IEHP supports its network in fulfilling this requirement by providing the Model of Care Training.
   1. Training topics include, but are not limited to, roles and responsibilities of the care team, health risk assessment, individualized care plan, interdisciplinary care team, care transitions, cultural and cognitive competency, Long-Term Services and Supports (LTSS) programs, integration of Medicare and Medi-Cal benefits, Member self-direction[1] and dementia care.
   2. This training is available in online learning and printable formats on IEHP's website at www.iehp.org through the following path: Home \ For Providers \ Provider Resources \ Compliance.

B. Health plan and IPA staff that are appropriate to receive this training include but are not limited to the following:
   1. Utilization Management Staff (outpatient, inpatient);
   2. Care Management Staff;
   3. Behavioral Health Staff;
   4. Medical Directors; and
   5. Member/Customer Service Staff.

C. Provider types that are appropriate to receive this training include but are not limited to the

[1] Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, CA3.2, "Care Coordinator Training for Supporting Self-Direction under the Demonstration"

following:

1. Primary Care Providers;
2. Specialty Care Providers, including Behavioral Health Providers;
3. Advanced Practice Practitioners, such as Nurse Practitioners and Physician Assistants; and
4. Hospitals and Skilled Nursing Facilities;
5. Ancillary Providers, such as Transportation, Long-Term Care and Community-Based Adult Services Providers; and
6. Out-of-network Providers routinely seen by Members.

D. IEHP and its IPAs ensure that initial and annual trainings are demonstrated by attendance lists, attestations, learning management system reports, and/or evaluations, if requested.

1. IEHP requires its IPAs and Providers to acknowledge receipt of the MOC training requirement, as well as attest to having established plan and timeline for its completion.
2. IEHP makes good faith efforts to ensure IPAs and Providers complete this training. Continued non-compliance however, may result in interventions including but not limited to Provider education, and issuance of a corrective action plan.

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12. COORDINATION OF CARE

A. Care Management Requirements
7. Transition of Care

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs ensure Members transitioning across all healthcare settings, Providers, and services, including those preparing for discharge, receive appropriate continuity and coordination of care.

B. IPAs must maintain similar policies and procedures for transitions of care and have these be available upon IEHP's request.

PURPOSE:

A. To manage the process of care transitions, identify problems that could cause transitions, and where possible, prevent or minimize unplanned transitions.

B. To ensure quality of care and minimize risk to patient safety as Members move from one setting to another.

DEFINITIONS:

A. **Transition**: Movement of a Member from one care setting to another as the Member's health status changes (e.g., moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery).

B. **Planned Transition**: Includes elective surgery or a decision to enter a long-term facility.

C. **Care setting**: The Provider or place from which the Member received health care and health-related services. In any setting, a designated Provider has ongoing responsibility for the Member's medical care. Settings include: home, home health care, acute care, sub-acute, long-term acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility.

D. **Care Plan / Plan of Care**: A set of information about the Member that facilitates communication, collaboration, and continuity of care across settings. The Care Plan is tailored to each Member and takes Member health status into consideration. The Care Plan may contain both medical and non-medical information, including but not limited to: current problem list, medication regimen, allergies, advance health care directives, baseline physical and cognitive function.

E. **Usual Setting**: The setting where the Member receives care on a regular basis. This may be the Member's home or a residential care facility.

F. **Receiving Setting**: The setting responsible for the Member's care after a transition. For Members who transition to home, the receiving setting is the Member's usual source of care.

G. **Sending Setting**: The setting responsible for the Member's care before a transition. For Members who transition from home, the sending setting is the Member's usual source of care.

H. **Transition Process**: The period from identifying a Member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another. It includes planning and preparation for transitions and the follow-up care after transitions are completed.

I. **Aggregate Performance**: The extent to which the organization and Providers succeeded in performing functions needed to manage transitions. There should be monthly, quarterly, and annual performance data collected and analyzed.

PROCEDURES:

Care Transitions Protocols

A. IEHP's Care Transitions processes include a comprehensive set of protocols that include logistical arrangements, providing education to the Member and/or caregiver, coordination between health care professionals regardless of network affiliation, facilitating authorizations for services, and a Provider network with appropriate Specialists who can address the complex needs of the IEHP DualChoice population. Protocols attempt to establish a smooth process that results in transitions that have the least amount of disruption and provide an environment of positive Member outcomes. Key principles in the care transition protocol include:

1. Notification of care transition;
2. Communication of relevant information to the receiving setting;
3. Providing Member/Caregiver with a central point of contact;
4. Assessing for change in Member needs post-transition;
5. Collaborating with the system of care, Primary Care Provider (PCP), Specialty care, other Interdisciplinary Care Team (ICT) participants to develop a safe discharge plan;
6. Facilitating relevant discharge information to the PCP, from the system of care and/or IEHP/IPA;
7. Educating Member/Caregiver on expectations, warning signs and who to contact for questions;
8. Arranging appointments and services;
9. Medication reconciliation; and
10. IEHP or IPA will follow up with Member within three (3) business days post-discharge from hospital or skilled nursing facility. IEHP or IPA will continue to follow-up with Member for at least thirty (30) days post-transition.

B. IEHP or the IPA facilitate safe transitions by conducting the following tasks and monitoring system performance.

1. For planned transitions from Members' usual setting of care to a hospital and transactions from the hospital to the next setting, IEHP or the IPA identify that a planned transition is going to happen.
    a. IEHP, IPA or sending facility will ensure the plan of care is shared with the receiving setting (e.g., hospitals or skilled nursing facilities) which includes, but not limited to reasons for admission, medical problems list, and medication regimen.
    b. All planned transitions require prior authorization by IEHP or the IPA.
2. For planned and unplanned transitions from any setting to any other setting, IEHP or the IPA will:
    a. Communicate with the Member and/or Member caregiver about the care transition process within 1-2 business days, not to exceed three (3) business days post-notification of hospital or skilled nursing facility admission;
    b. Communicate with the Member and/or Member's caregiver about changes to the Member's health status and plan of care, and to provide the Member or caregiver with a central point of contact within 1-2 business days, not to exceed three (3) business days of notification of a hospital or skilled nursing facility admission;
    c. Assess Member's need for all environmental adaptations, equipment, and/or technology (i.e., walker with seat, shower chair, or ramp for wheelchair) needed for a successful care setting transition or any other adaptive equipment or technology necessary for a successful transition back to their usual setting;
    d. Discuss options available to the Member such as sub-acute, skilled nursing or acute rehabilitation, after discharge from acute setting, when skilled level of care cannot be provided in Member's usual setting and assist with scheduling appointments or needed educational activities; and
    e. Notify the Members' PCP to inform of the admission and discharge.
3. For all transitions, IEHP or the IPA will conduct an analysis of the organization's aggregate performance on the above aspects of managing transitions on at least a quarterly basis.
4. IEHP or the IPA will ensure collaboration among internal departments and send updated Member information as needed.
5. IEHP or the IPA will collaborate with IEHP's Pharmaceutical Services department to assist with medication reconciliation and medication management and ensure that the medication list is included on the plan of care.

6. IEHP or the IPA will collaborate with external partners, including but not limited to Hospitals and Skilled Nursing Facilities, to discuss and explore interventions for care coordination and to share the plan of care from one transition to the next.
7. IEHP or IPA will follow up with Member within three (3) business days post-discharge from hospital or skilled nursing facility. IEHP or IPA will continue to follow-up with Member for at least thirty (30) days post-transition.

C. IEHP has a designated team to serve as liaisons for the Long-Term Services and Supports (LTSS) Provider community to help facilitate Member care transitions. These individuals are trained to identify and understand LTSS, including home and community-based services and long-term care, including payment and coverage rules.[1]

Identifying Unplanned Transitions

A. IEHP or the IPA will identify unplanned transitions within its network by:
   1. Reviewing reports and clinical documentation of hospital admissions within one (1) business day of admission notification;
   2. Reviewing reports and clinical documentation of admissions to long-term care facilities within one (1) business day of admission notification; and
   3. Reviewing aggregate performance on identifying unplanned transitions through the following reports on at least a quarterly basis: bed days/1000, admits/1000, Average Length of Stay (ALOS), emergency room (ER) visits/1000.
      a. This will be reported to the IEHP or IPA Utilization Management (UM) Subcommittee on at least a quarterly basis, and will be reflected on the IEHP Utilization and/or Care Management (CM) Annual Industry Collaboration Effort (ICE) Evaluation.

Reducing Transitions

A. IEHP or the IPA will minimize unplanned transitions and work to maintain Members in the least restrictive setting possible. The UM and CM Department will:
   1. Analyze data at least monthly, to identify individual Members at risk;
   2. Coordinate services for Members at high risk of having a transition with the UM and Pharmaceutical Services staff; and
   3. Educate Members and/or Member caregivers during follow-ups regarding transitions, risks and red flags, as well as how to prevent unplanned transitions.

[1] Department of Health Care Services (DHCS), CalAIM Dual Eligible Special Needs Plans (DSNP) Policy Guide, December 2021

12. COORDINATION OF CARE

A. Care Management Requirements
7. Transition of Care

Monitoring & Oversight

A. IPAs must submit the following reports to IEHP by their due date, regardless if it falls on a holiday or weekend (see Attachment, "Medicare Provider Reporting Requirements Schedule" found on the IEHP website):[2]

1. Care Transitions Log – This monthly report will include all TOC activity for the previous month (See Attachment, "Care Transitions Cases Log" found on the IEHP website[3]).
2. UM Workplan Update – Using the UM ICE Evaluation template, the IPAs will provide a summary analysis of the transitions during the reporting period.

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[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] https://www.iehp.org/en/providers/provider-resources?target=forms

12. COORDINATION OF CARE

B. Multipurpose Senior Services Program

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs ensure access to and provision of Multipurpose Senior Services Program (MSSP) for Members who meet the following eligibility criteria:[1]

1. Medi-Cal Members who, but for the provision of such services, would require the Nursing Facility level of care;
2. Age 65 or older;
3. Able to be served within MSSP's cost limitations; and
4. Appropriate for care management services.

PURPOSE:

A. To promote identification and coordination of care for Members requiring services through the MSSP.

B. To ensure and support care coordination between IEHP and County agencies regarding Members' access to appropriate MSSP resources and to focus on providing services in the least restrictive setting.

PROCEDURES:

MSSP Services

A. Long-Term Services and Supports (LTSS) includes a wide variety of services and supports that help eligible Members meet their daily needs for assistance and improve the quality of their lives. The MSSP program was approved under the federal Medicaid Home and Community-Based Services (HCBS), 1915(c) Waiver to provide HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement. MSSP services include:[2]

1. Case Management;
2. Personal Care and Chore Services;
3. Respite Care (in-home and out-of-home);
4. Environmental Accessibility Adaptations;
5. Housing Assistance/Minor Home Repair, etc.;

[1] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Multipurpose Senior Services Program (MSSP)"
[2] Ibid.

6. Non-medical transportation;
7. Personal Emergency Response System /Communication Device;
8. Adult Day Care;
9. Protective Supervision;
10. Meal Services – Congregate/Home Delivered;
11. Social Reassurance/Therapeutic Counseling;
12. Money Management; and
13. Communication Services (such as translation/interpretation).

Identification of MSSP Cases

A. The Member's IPA performs care management activities and is responsible for assisting the PCP with the identification and referral of Members to MSSP.

B. IEHP and its IPAs engage in outreach and case finding efforts to identify Members with potential MSSP program needs.

Referral of MSSP Cases

A. Referral and/or data sources may include but are not limited to the following:
   1. IEHP and/or IPA;
   2. Member and/or caregiver;
   3. PCP and/or Specialist;
   4. Member of Interdisciplinary Care Team (ICT);
   5. Medicare and/or Medi-Cal or Health Plan utilization data;
   6. Health Risk Assessments;
   7. In-Home Supportive Services Provider; or
   8. Community agency representative.

B. Referrals for MSSP can be received through the following mechanisms:
   1. Member and/or caregiver may self-refer by calling MSSP, IEHP or their IPA.
   2. Providers, IPAs, care managers, and community representatives can submit the Care Management (CM) Referral form requesting IEHP assistance to refer the Member to MSSP. The CM Referral form can be found on the IEHP website[3], or on the secure IEHP Provider web portal.

C. IEHP's Behavioral Health and Care Management (BH & CM) Team submits the referral to

[3] https://www.iehp.org/en/providers/provider-resources?target=forms

the appropriate MSSP county agency on behalf of the IPA and communicates the referral outcome to IPA staff.

D. The MSSP county agency is responsible for all assessments and reassessments associated with authorizations of MSSP services.

IEHP, IPA and Provider Responsibilities

A. IPA Care Manager assists the PCP with completing their MSSP referral through IEHP and follow up.

B. County MSSP agencies establish and maintain a waitlist of individuals referred to MSSP. After the Member is placed on the MSSP waitlist, the appropriate county MSSP agency provides IEHP with a list of Members on the waitlist. IEHP's BH & CM Team shares the Member's status with the Member's IPA.

C. The IPA continues to provide care management services to Members placed on a county MSSP waitlist, including but not limited to coordinating available services and providing follow-up for Members.

D. Members not accepted into MSSP continue to receive medical care and care management services through their IPA and PCP.

E. Members authorized for MSSP services continue to receive medical services from IEHP.

F. IEHP or the IPA Care Manager coordinates and works collaboratively with MSSP county case managers on care coordination activities surrounding the MSSP Member including, but not limited to:

1. Coordination of benefits between IEHP and MSSP county case manager to avoid duplication of services; and
2. Coordination of care management activities particularly at the point of discharge from the MSSP.

Interdisciplinary Care Team (ICT) Case Conference

A. Members shall have access to an ICT case conference upon request or when there is a change in the care plan or significant change in the Member's health status. Members and/or their caregivers can also request an ICT case conference at any time by calling their IPA.

B. MSSP County Case Managers and PCPs may call an ICT case conference at any time to discuss the Member's needs by calling Provider Call Center at (909) 890-2054. IEHP and its IPAs ensure the ability to facilitate and support a case conference.

C. The IPA facilitates and supports an ICT to coordinate the delivery of services and benefits as needed for each Member.

D. The IPA Care Manager notifies the MSSP County Case Manager regarding the Member's scheduled ICT meeting and invites them to participate in the case conference.

12. COORDINATION OF CARE

B. Multipurpose Senior Services Program

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12. COORDINATION OF CARE

C. Organ Transplant

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. The following major organ transplants are covered by IEHP DualChoice. Primary Care Providers (PCPs) and IPAs must provide all medically necessary health care services for IEHP DualChoice Members to determine whether a major organ transplant may be indicated, and to refer all potential adult major organ transplant candidates to a Medicare-approved Transplant Center.

1. Bone Marrow
2. Corneal;
3. Heart;
4. Heart/Lung combined
5. Lung;
6. Liver;
7. Combined Liver and Kidney
8. Combined Liver and Small Bowel
9. Liver/Intestinal
10. Kidney
11. Small Bowel
12. Intestinal
13. Simultaneous Kidney and Pancreas
14. Pancreas
15. Stem Cell; and
16. Autologous Islet Cell

PROCEDURES:

Provider Responsibilities

A. The PCP or Specialist is responsible for the initial diagnostic work-up prior to a referral to a Medicare-approved Transplant Center. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second surgical opinions, or hospital admissions must follow the IPA's prior authorization referral procedures.

IEHP and IPA Responsibilities

12. COORDINATION OF CARE

C. Organ Transplant

A. The authorization and/or financial responsibility may vary per the Division of Financial Responsibility (DOFR).

B. The IPA is responsible for facilitating all necessary services for potential organ transplants and, providing care management support to ensure optimal results.

C. Each category of organ transplants may have specific criteria and exclusions. IEHP and its Delegated IPAs shall utilize the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations to determine medical necessity benefit coverage issues to make all utilization decisions.

D. The referral process is as follows:

[Note: If IEHP is financially responsible for both professional and facility organ transplant services, then IEHP shall be responsible for arranging and coordinating transplant services.]

1. IEHP or the IPA contacts the contracted Center of Excellence for Transplantation (COE) for the specific organ transplant. IEHP or IPA Care Manager (CM) shall coordinate all needed services with the chosen Transplant Center.
2. The IPA may consult with the IEHP Medical Director to review medical necessity criteria and to assist in directing diagnostic, therapeutic and/or specialty referrals, as indicated.
3. IEHP or the IPA Care Manager coordinates all aspects of the referral, including providing to the Transplant Center all medical information (diagnostic tests, specialty physician notes, etc.) relevant to the particular major organ transplant criteria. IEHP or the IPAs Care Manager coordinates all referrals and assures that the Member makes all appointments.
4. If the Member is deemed a suitable candidate by the chosen Transplant Center, the Center will place the Member on the transplant waiting list.
5. Once a Member has been determined to be an appropriate surgical candidate for the organ transplant, the Transplant Center will submit a request for authorization to IEHP or IPA for approval. Decisions for these referrals are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (see "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[1]). See Policy 25E1, "Utilization Management - Delegation and Monitoring."

C. If a Member is not accepted into a transplant program, the Member's assigned PCP, IPA, and Specialists continue to provide all necessary care, including care management services, as needed.

[1] https://www.iehp.org/en/providers?target=forms

12. COORDINATION OF CARE

C. Organ Transplant

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12. COORDINATION OF CARE

D. Behavioral Health

1. Behavioral Health Services

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) and other health care Providers are required to provide behavioral health and/or substance use services within their scope of practice.[1,2]

B. IEHP is responsible for outpatient mental health services to Members with impairment(s) resulting from a mental disorder.

PROCEDURES:

Covered Benefits

A. Inpatient services are available, when medically necessary, for the treatment of an acute phase of a behavioral health condition at a participating Hospital.

B. IEHP does not impose Quantitative or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[3]

C. IEHP provides access to the following services, as medically necessary, when provided by network PCPs, Specialists, or other licensed mental health professionals within their scope of practice. See Policy 14D, "Pre-Service Referral Authorization Process."

1. Individual mental health evaluation and treatment (no authorization is required for initial evaluation for therapy and psychiatry);
2. Group psychotherapy;
3. Psychological testing;
4. Outpatient services for the purpose of monitoring medication therapy;
5. Substance use services as it relates to Opioid Treatment Programs and Behavioral Health hospital-based programs (Please refer to Policy 12D2, "Behavioral Health - Substance Use Treatment Services");
6. Outpatient laboratory tests and prescription medications, drugs, supplies, and supplements;
7. Psychiatric consultations; and

[1] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 03/12/18
[2] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Mental Health Services, 12/14/20
[3] Title 42 Code of Federal Regulations (CFR) §§ 438.900, 438.910(d)

8. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT).

D. IEHP will coordinate pre-existing behavioral health services financed and administered by the County Mental Health Plans to ensure the Member receives medically necessary services.

Identification/Diagnosis

A. PCPs and other health care Providers are responsible for identifying Members with behavioral health conditions that require referral to behavioral health specialists for treatment and triage according to the level of urgency. Identification of these Members can occur during routine visits.

B. PCPs and BH Providers are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.[4,5]

Treatment

A. IEHP ensures culturally competent care for persons with severe mental illness and substance use disorders in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community.

B. Certain behavioral health conditions beyond the PCP's scope of practice require treatment by a BH Provider. In these cases, the PCP can directly refer the Member to a BH Provider for an initial assessment without prior authorization.

C. Treatment may include the provision of appropriate psychotropic medications, as well as acute crisis intervention.[6,7]

D. Members referred for behavioral health services remain enrolled in IEHP and IEHP, its IPAs and Providers remain responsible for all necessary physical health care.[8,9]

E. IEHP BH Providers provide medically necessary behavioral health interventions.

Referral Process

A. IEHP processes all requests for BH or Substance Use Disorder (SUD) services in compliance with State and Federal regulatory requirements, including requirements for parity in mental health and substance use disorder benefits.[10,11] See Policy 12D2, "Behavioral Health –

[4] MOU between IEHP and RUHS-BH, 03/12/18
[5] MOU between IEHP and SBDBH, 12/14/20
[6] MOU between IEHP and RUHS-BH, 03/12/18
[7] MOU between IEHP and SBDBH, 12/14/20
[8] MOU between IEHP and RUHS-BH, 03/12/18
[9] MOU between IEHP and SBDHB, 12/14/20
[10] 42 CFR § 438.910(d)
[11] California Health and Safety Code (Health & Saf. Code) § 1367.01

Substance Use Treatment Services" for more information about substance use services and referrals.

B. IEHP's Behavioral Health and Care Management (BH & CM) Department can assist in the referral process for all Members. Members may be directed to IEHP BH & CM Department through the following avenues:

IEHP BH & CM Department Contact Information:

Monday-Friday 8:00am-5:00pm
Provider Relations Team: (909) 890-2054
Member Line: (877) 273-4347
24 Hour Fax: (909) 890-5763

Members may be identified through several sources, which include, but are not limited to:

1. Member or their representative;
2. PCPs and other Providers;
3. County agencies;
4. IPAs; and
5. IEHP Departments

C. IEHP will process requests for BH services. Determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

1. Expedited/Urgent Referrals
    a. In the event an IEHP DualChoice Member needs urgent access to non-specialty mental health services and is NOT experiencing a behavioral health crisis or psychiatric emergency, the Provider can call, fax, or send an electronic referral through the secure IEHP Provider portal.
    b. If a Member presents with a life-threatening psychiatric emergency or behavioral health crisis (e.g., Member is a danger to self or others, is making threats of violence) the Provider must follow their own emergency protocol (e.g., call 911). See Policies 14C, "Emergency Services" and 9A, "Access Standards" for more information on behavioral health crisis or psychiatric emergencies.
2. Standard or Non-Emergent Referrals
    a. PCPs and Specialists, with the assistance of the IPA care management staff as needed, are responsible for referring Members to the IEHP BH & CM Department.

D. IEHP will provide continuity of care in accordance to applicable regulatory requirements. See Policy 12A5, "Care Management Requirements – Continuity of Care."

Care Management

A. PCPs and BH Providers are responsible for maintaining communication with treating Providers, assigned IPAs and/or IEHP BH & CM Department to coordinate the Member's care.

B. For IEHP DualChoice Members receiving their behavioral health or specialty mental health treatment through either the Riverside or San Bernardino County Behavioral Health Department, IEHP assists in coordinating the Member's care with County and the IPA.

C. IPAs are expected to case manage Members' care in collaboration with their PCP, County BH Provider, and LTSS Provider, as appropriate. See Policy 12A3, "Care Management Requirements – Individualized Care Plan."

Medications

A. IEHP is responsible for payment of anti-depressant medications, anxiolytics, hypnotics, anti-bipolar medications, and other psychotropic medications (see the IEHP Medicare Formulary).

B. IEHP also covers medications, as noted above, when prescribed by County providers for Members. County Providers are responsible for providing any additional information requested by IEHP.

C. IEHP Providers are responsible for writing prescriptions for medications that are medically necessary and providing any additional information required by IEHP to obtain a particular medication (e.g., Prescription Drug Prior Authorization (RxPA) information).

D. Out-of-network physicians prescribing medications for Members must provide any additional information requested by IEHP.

Releasing Member Information

A. IEHP Providers must release medical information and behavioral health, or substance use treatment records upon request by the IEHP BH & CM Department for coordination of care when IEHP is the payer of services. Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records".

B. Providers may use their own Release of Information (ROI) form or use IEHP's Authorization for Use or Disclosure of Protected Health Information Form (see Attachments, "Authorization for Use or Disclosure of Patient Health Information - English" and "Authorization for Use or Disclosure of Protected Health Information - Spanish" found on the IEHP website[12]).

Reporting and BH Web Forms

[12] https://www.iehp.org/en/providers/provider-resources?target=forms

12. COORDINATION OF CARE

D. Behavioral Health

1. Behavioral Health Services

A. PCPs, IPAs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests and review reports.

B. PCPs must inform IEHP of Members identified to have significant or complex behavioral health conditions using the BH web forms on the secure IEHP Provider portal.

C. PCPs and BH Providers refer Members to IEHP for behavioral health services using the BH web form on the secure IEHP Provider portal.

D. BH Providers must submit the "Coordination of Care Treatment Plan" through the secure IEHP Provider portal as follows:

1. Prior to the expiration date of the authorization, request continued services, when medically necessary
2. When a Member no longer needs medically necessary services, the Member discharges from treatment, and/or when treatment is terminated for any reason; and
3. Provide results of a second opinion three (3) business days after the second opinion was performed. See Policy 14B, "Second Opinions" for more information.

E. IPAs, PCPs and BH Providers can access BH web forms on the secure IEHP Provider portal. Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider Call Center at (909) 890-2054 or emailing providerservices@iehp.org.

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12. COORDINATION OF CARE

D. Behavioral Health
2. Substance Use Treatment Services

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP, its IPAs, and Providers identify Members requiring substance use disorder treatment services and arrange for their referral to the County Behavioral Health Department for substance use treatment, or other community resources.

PROCEDURES:

Identification/Diagnosis

A. Provision or arrangement of medically necessary care for acute medical conditions related to substance use, such as delirium tremens or gastrointestinal hemorrhage, is the responsibility of the Primary Care Provider (PCP) or the Specialist.

B. PCPs must complete the initial health assessment (IHA) for all new Members within one hundred twenty (120) calendar days of their enrollment. An IHA includes a review of pertinent health related behaviors including smoking, alcohol and drug use, exercise, etc. as well as the Staying Healthy Assessment (SHA) through which the PCP can identify alcohol misuse. Subsequent contact with the Member provides PCPs the opportunity to evaluate the Member's health and screen for substance use problems. See Policies 10C, "Initial Health Assessment," 10B, "Adult Preventive Services" and 15G, "Individual Health Education Behavioral Assessment/Staying Healthy Assessment" for more information on alcohol and drug screening, assessment, brief interventions and referral to treatment.

C. Members with substance use problems may also be identified through:

1. Utilization Management (UM) activities;
2. Care Management (CM) activities;
3. Provider referrals; and
4. Pharmacy utilization management activities.

Treatment

A. IEHP does not impose Quantitative or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[1]

B. PCPs are responsible for all necessary physical and mental health care for Members with substance use problems within their scope of practice. Depending on the specific substance use problem and the health status of the Member, services may include:

[1] Title 42 Code of Federal Regulations (CFR) § 438.900 *et seq*.

1. Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT);
2. Limited or comprehensive physical exam with appropriate diagnostic testing to rule out associated medical conditions (e.g., hepatitis, endocarditis);
3. Mental status exam with appropriate treatment or referral for any actual or potential associated psychiatric conditions; or
4. Referral to specialty Providers for evaluation as necessary.

C. The PCP must discuss recommendations for treatment with the Member, develop a treatment plan, and/or as appropriate, refer them to an acute detoxification or outpatient treatment program.

Referral Process

A. PCPs, IPAs and BH Providers are responsible for referring Members with substance use problems to an appropriate treatment program.

B. IEHP's Behavioral Health & Care Management (BH & CM) Department can assist in facilitating referrals to substance use programs for all Members.[2,3] BH & CM can assist with facilitating referrals to the appropriate County Substance Abuse Service Agency's referral unit, as necessary.

1. IEHP BH & CM Department contact information:

   Monday-Friday 8:00am-5:00pm
   Provider Line: (909) 890-2054
   Member Line: (877) 440-4347
   Fax Number: (909) 890-5763

2. Expedited/ Urgent Referrals

   a. Any IEHP DualChoice Member requiring an expedited referral for a non-emergent substance use problem may be referred to the IEHP BH & CM Department.

   b. Any Member presenting with acute withdrawal symptoms requiring medical detoxification, should be referred to a contracted Hospital emergency department as soon as possible. After hours assistance in locating a contracted Hospital emergency department is available by calling the Nurse Advice Line at (888) 244-4347.

3. Standard or Non-Emergent Referrals

   a. PCPs and/or Specialists are responsible for referring IEHP DualChoice Members

[2] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 03/12/18
[3] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Mental Health Services, 12/14/20

with non-emergent substance use conditions to the IEHP BH & CM Department.

C. Members may also self-refer to the appropriate county programs using the contact information below.

1. **Riverside County Residents:**
   Substance Use Community Access, Referral, Evaluation, and Support
   800-499-3008

2. **San Bernardino County Residents:**
   Substance Abuse Referral Service
   800-968-2636

D. IEHP BH & CM Department coordinates with the County Substance Abuse Service Agency to refer Members to available treatment outside of the Plan's service area, when substance use treatment services are not available within its service area.

Covered Benefits

A. Inpatient services include hospitalization for alcoholism or other drug (AOD) use as medically necessary. Inpatient services are available for medical detoxification, when medically necessary and are coordinated with IEHP's Utilization Management Department.

B. IEHP provides access to Opioid Treatment Programs (OTP) through approved Substance Abuse and Mental Health Services Administration (SAMHSA) and Medicare-certified programs.

C. Members may self-refer to Community Based Organizations (CBOs) for care and assistance on a self-pay basis.

Case Management

A. IEHP BH & CM Department can assist the PCP with the referral process, follow up with Members referred for substance use treatment, and facilitate the Member's transition back into the primary care setting. IPA Care Managers continue to case manage Members before, during, and after referral and/or treatment.

B. PCPs, IPAs, and BH Providers are responsible for maintaining communication with substance use Providers to coordinate the Member's care.

C. Members referred for substance use treatment remain enrolled in IEHP and the assigned PCP, Provider, and IPA remain responsible for all necessary physical health care.

D. The IEHP BH & CM Department is available to assist the PCP, IPA Care Manager, or both in assessing or managing complex cases.

Releasing Member Information

A. PCPs and BH Providers must maintain procedures to ensure appropriate records processing to prevent breach of confidentiality. Refer to Policy 7B, "Information Disclosure and

Confidentiality of Medical Records," for information pertaining to the release of medical records.

B. IEHP Providers must release medical information and behavioral health or substance use treatment records upon request by the IEHP BH & CM Department for coordination of care when IEHP is the payer of services. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records."

C. Whenever a Release of Information is considered, all Providers shall adhere to confidentiality requirements.[4]

Reporting and Web Forms

A. PCPs, IPAs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests and review reports.

B. IPAs, PCPs and BH Providers can refer Members to IEHP or the appropriate county programs for substance use services using IEHP's BH web forms on the secure IEHP Provider portal when the Member is in agreement with the referral.

C. IPAs, PCPs and BH Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider Call Center at (909) 890-2054 or emailing providerservices@iehp.org.

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[4] 42 CFR § 431.306.

12. COORDINATION OF CARE

E. In-Home Supportive Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members eligible for In-Home Supportive Services (IHSS).

POLICY:

A. Long-Term Services and Supports (LTSS) includes a wide variety of services and supports that help eligible Members meet their daily needs for assistance and improve the quality of their lives. IHSS is an LTSS provided over an extended period, predominantly in the Member's home and community.

B. In-Home Supportive Services (IHSS) is provided in accordance with the eligibility determination performed by the County IHSS office. IHSS is a county-administered program with a foundation in consumer self-direction of care.[1]

C. IEHP and its IPAs maintain the consumer-directed model for IHSS Members, which allows Members to self-direct their care by being able to hire, fire, and manage their caregivers.[2]

PROCEDURES:

IHSS Eligibility Criteria

A. IEHP and its IPAs coordinate care and ensure referral to IHSS of Members who meet the eligibility criteria of being aged, blind or disabled persons who are unable to perform activities of daily living (ADLs) and cannot remain safely in their own homes without help.[3] In addition, Members requesting IHSS must meet these following eligibility criteria:[4]

   1. Live at home or a home of Member's own choosing; and
   2. At risk of institutionalization in long-term care facility.

B. An IHSS Member may be eligible to a maximum of two hundred eighty-three (283) hours per month.[5,6]

Identification and Referral of IHSS Cases

A. IEHP and its IPAs proactively identify Members with potential case management or IHSS program needs. Referral sources may include, but are not limited to the following:

   1. IEHP and its IPAs;

[1] California Welfare and Institutions Code (Welf. & Inst. Code), §12300
[2] CA Welf. & Inst. Code, § 12301.6 (c)
[3] CA Welf. & Inst. Code, § 12300
[4] http://www.cdss.ca.gov/In-Home-Supportive-Services.
[5] CA Welf. & Inst. Code, § 12300
[6] CA Welf. & Inst. Code, § 14132.95

2. Interdisciplinary Care Team (ICT);
3. Health assessments (e.g., Health Risk Assessment);
4. Care plan intervention;
5. Internal IEHP departments (e.g., Behavioral Health & Care Management (BH & CM), Member Services Department, Utilization Management, Provider Services, Pharmacy);
6. External Providers (e.g., Community-Based Adult Services (CBAS), Community-Based Organizations, Multipurpose Senior Services Program (MSSP), Independent Living Centers, Primary Care Providers (PCP), Hospitals, and Skilled Nursing Facilities);
7. Member and/or authorized representative; or
8. Member's caregiver.

B. IHSS accepts referrals from any entity including, but not limited to IEHP, IPAs, Hospital Care Managers, Providers, Members and/or their caregiver. Members who may benefit from IHSS are referred to the appropriate IHSS Central Intake Office.

1. Riverside County IHSS Hotline:
   a. Telephone number: (888) 960-4477
   b. Apply online at https://riversideihss.org/
2. San Bernardino County IHSS Hotline:
   a. Telephone number: (877) 800-4544
   b. Facsimile referral form: (909) 948-6560

C. It is the responsibility of the Member's PCP to complete the required IHSS Health Certification form. The PCP cannot charge or bill the Member for this service. See Policy 18L, "Providers Charging Members." The Member's IPA assists Members in obtaining IHSS Health Care Certification Form SOC 873, if not submitted by Member in a timely manner.

D. The appropriate County IHSS county office of IHSS hours.[7] Based on the assessment findings, the County Social Worker determines IHSS hours and services. The County Social Worker will send the Notice of Action (NOA) to the Member following their service eligibility determination.[8] The NOA will describe Member's right to a State Fair Hearing process should the Member disagree with the number of determined hours or the denial of the IHSS request.

[7] CA Welf. & Inst. Code, § 14186
[8] CA Welf. & Inst. Code § 12300.2

12. COORDINATION OF CARE

E. In-Home Supportive Services

Care Management and Care Coordination

A. IEHP and its IPAs coordinate with county IHSS agencies to facilitate IHSS participation on the ICT by inviting the Member's IHSS Social Worker to the ICT case conferences and ensures network Providers' coordination with IHSS.

B. IEHP's ICT and IPAs review Member's health care needs (i.e. HRA results, Fee-For-Service data, IEHP encounter data, Member/caregiver report, etc.) and provides recommendations regarding coordinating care with IHSS and/or additional programs to meet the Member's medical, behavioral, and social needs, allowing the Member to remain independent in the community.

C. The Member's IPA CM staff coordinate care and make referrals to IHSS county programs when needs are identified, such as Members who are at risk for out-of-home placement. The Member's IPA:

1. Ensures Members do not receive duplicative services through Enhanced Care Management (ECM), Community Supports, and other services;
2. Tracks all Members receiving IHSS and continues coordinating services with the IHSS until IHSS determines that IHSS is no longer needed for the Member;
3. Outreaches and coordinates with IHSS for any Members identified by the Department of Health Care Services (DHCS) as receiving IHSS;
4. Upon identifying Members as receiving, referred to, or approved for IHSS, conducts a reassessment of Members' Risk tier.
5. Continues to provide basic population health management (care coordination) of all medically necessary services while Members receive IHSS; and
6. Adheres to a Member's determination about the appropriate involvement of his or her medical Providers and caregivers, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), which includes obtaining expressed consent from the Member of authorized representative to include the IHSS Provider in Member's care coordination planning.

D. IEHP shares with the IPA through the secure IEHP Provider web portal, IHSS information, including IHSS hour allocations, as well as make this available to the Member's ICT.

E. IHSS County Social Worker, PCP or IHSS Provider may request an interdisciplinary care team (ICT) case conference at any time to discuss the Member's needs by calling the IEHP Provider Relations at (909) 890-2054.

1. IEHP and its IPAs conduct ICT, interdisciplinary case conferences to coordinate the delivery of services and benefits as needed for each Member.
2. IEHP and its IPAs determine which Members need an ICT based on medical need, although every Member shall have access to an ICC, if requested.

3. Members can also request an ICT at any time by calling IEHP Member Services at (800) 440-4347.

F. Members are advised to call IHSS or Public Authority to obtain emergency back-up services if their IHSS Provider does not arrive to provide assistance with authorized activities of daily living services:

1. Riverside County IHSS Public Authority: (800) 915-1777
2. San Bernardino County IHSS Public Authority: (866) 985-6322

Complaints, Grievances, and Appeals

A. IEHP Members have a right to register grievances and appeals with the State of California about the determination of authorized IHSS service hours by following the State Fair Hearing process.[9] Members are provided the following information:

1. The California Department of Social Services (CDSS) accepts formal complaint submissions in writing or by telephone.
   a. California Department of Social Services
      Public Inquiry and Response
      P.O. Box 944243, MS 9-17-37
      Sacramento, CA 94244-2430
   b. Phone 1-800-952-5253 (TDD 1-800-952-8349)
2. Members may also be directed to speak with a representative of their county Department of Public Social Services (for Riverside County residents) or the Department of Aging and Adult Services (for San Bernardino County residents) for assistance with the State Fair Hearing process.
3. IEHP does not adjudicate appeals from county decisions about IHSS services.
4. It is the responsibility of IEHP to report IHSS grievance resolutions to the state of California.
5. IEHP complies with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS.

IEHP Staff Training and Orientation Responsibilities

A. IEHP conducts annual trainings to educate health plan staff on IHSS as part of a LTSS option including:[10]

1. IHSS program overview;

[9] CA Welf. & Inst. Code, § 10950
[10] Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, Section I. Care Coordination Requirements

2. Referral Process;
3. Eligibility and Assessment Criteria; and
4. Program Services Available to Members

B. IEHP trains IEHP personnel at least annually regarding the health plan's covered services and policies and procedures to access services and coordinate care.

C. IEHP trains personnel of IHSS organizations regarding IEHP's covered services and policies and procedures to access services and coordinate care.[11,12]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2017	
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[11] Memorandum of Understanding (MOU) between IEHP and Riverside County In-Home Supportive Services Public Authority (PA)
[12] MOU between IEHP and San Bernardino County In-Home Supportive Services Public Authority (PA)

12. COORDINATION OF CARE

F. Community-Based Adult Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Community-Based Adult Services (CBAS) are covered benefits under IEHP that are available to Medi-Cal beneficiaries, including dual-eligible Members. IEHP is responsible for authorization and payment of CBAS services.

B. The CBAS program provides services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities who are at risk of needing institutional care. The intent of CBAS is to restore or maintain optimal capacity for self-care, delay or prevent inappropriate undesirable institutionalization, and engage the Member and/or caregiver, Primary Care Provider (PCP), and the community in working toward maintaining Member's independence.

PURPOSE:

A. To identify and coordinate care for Members requiring services at contracted CBAS centers.

B. To ensure Member access to CBAS equivalent services in all areas where a CBAS center is not available.

PROCEDURES:

CBAS Services

A. CBAS centers offer a package of health, therapeutic and social services in a community-based day care program.
   1. Core services include:[1]
      a. Professional Nursing services;
      b. Social services;
      c. Personal care services;
      d. Therapeutic activities; and
      e. Meal services (one (1) meal offered per day).
   2. Additional services, if specified in the Member's Individualized Plan of Care (IPC), include:[2]
      a. Physical therapy;

[1] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[2] Ibid.

b. Occupational therapy;

c. Speech therapy;

d. Psychiatric and psychosocial services;

e. Registered dietician services;

f. Social services; and

g. Transportation to/from CBAS center to Member's place of residence.

B. Each CBAS center shall have a multidisciplinary team of health professionals who conduct a comprehensive assessment of each potential participant to determine and plan services needed to meet the individual's specific health and social needs.

C. Members have the right to select a CBAS center of their choosing, as per appropriate California Department of Health Care Services (DHCS) guidelines.

D. IEHP will reimburse CBAS centers the daily rate for eligible Members who attend four (4) hours or more in any given day at the CBAS center.[3]

E. The Member's assigned PCP remains responsible for providing primary care and all necessary referrals for specialty services, diagnostic testing and other services.

Identification of CBAS Cases

A. Members who would benefit from CBAS services may be identified by multiple sources and will include those with the following conditions:

1. Serious and/or complex medical conditions requiring rehabilitative services;

2. Physical or psychiatric disability that limits the performance of activities of daily living but do not require twenty-four (24) hour institutional care;

3. Present level of functioning would either be maintained or improved if receiving preventative services; and/or

4. High potential for further impairment and probable need for institutional care if additional services are not received.

B. IEHP's determination of eligibility for CBAS may be requested by Members, caregivers, PCPs, Specialists, nursing facilities, hospitals, Community-Based Organizations (CBO), CBAS Providers, or other Providers assisting with Member's care.

C. Members who would benefit from CBAS may be identified through any of the following:

1. Routine or other office visits to the PCP or Specialist, including by other office, clinic, hospital, or nursing facility staff;

[3] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation, 06/05/14

2. Evaluation of requested specialty referrals, including requests for rehabilitation services or Members with significant illness requiring multiple specialty referrals;
3. The discharge planning process, concurrent case review or referral;
4. Grievances or other Member contacts;
5. Calls to IEHP or CBAS centers by Member or on behalf of a Member that needs assistance; and
6. Health Risk Assessments (HRA).

Eligibility Criteria for CBAS

A. IEHP will make CBAS eligibility determination in accordance with regulatory requirements.

B. In order to be considered for the CBAS Program, the Member must be 18 years of age or older and have one (1) or more of these conditions:
   1. Organic/Acquired or Traumatic Brain Injury and/or Chronic Mental Health condition.
   2. Alzheimer's Disease or other Dementia Stage 5, 6, or 7;
   3. Mild Cognitive Impairment, including moderate Alzheimer's (Stage 4);
   4. Significant chronic medical illness; and/or
   5. Developmental disability; and
   6. In addition to which, the Member shall need assistance or supervision with either:
      a. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
      b. One (1) need from the above and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

CBAS Referral Process

A. If the IPA or PCP receives a request for CBAS services or identifies a potential CBAS candidate, the IPA or PCP shall forward the request immediately to the IEHP Utilization Management (UM) Department through the secure IEHP Provider web portal or by fax at (909) 890-5751 for processing.

B. The PCP is responsible for the submission of a current history and physical and proof of negative Tuberculosis (TB) test results to the CBAS center.

C. The IPA's Care Manager assists the PCP with completion of the referral, telephonic monitoring of potentially eligible Members, monitoring the status of Members, facilitating any needed transfer of medical records, and coordinating any necessary specialty services for Members.

D. IEHP is available for assistance with eligibility questions, coordination of care and other questions regarding CBAS center services.

CBAS Authorization Process

A. CBAS authorization requests must include the signature of the Member's PCP or Care Manager.

B. Authorization is valid for six (6) months. IEHP requires CBAS centers to submit a Member's IPC with the authorization extension request at least every six (6) months. [4]

C. Routine New Cases

1. Upon receipt of the request for CBAS, the IEHP UM Department will forward the authorization request to IEHP CBAS Team for completion of the DHCS-Approved CBAS Eligibility Determination Tool (CEDT) face-to-face assessment. IEHP must not deny, defer, or reduce a requested level of CBAS for a Member without a face-to face review.

    a. For Members in a hospital or skilled nursing facility, whose discharge plan includes CBAS, or Members facing imminent and serious threat to their health, a face-to-face assessment may not need to be performed.[5]

    b. For all other Members, the face-to-face evaluation will be done within thirty (30) calendar days of the authorization request.

2. CBAS centers will perform a multidisciplinary team assessment and then submit prior authorization requests with the Member's IPC and recommended Level of Service (LOS) to IEHP UM Department.

3. Following review of Member's IPC and recommended LOS with CBAS RN, IEHP UM Medical Director determines CBAS LOS approval within five (5) business days.

D. Expedited New Cases

1. Upon receipt of the expedited authorization request from UM, the IEHP CBAS RN will conduct the face-to-face assessment by using CEDT.

2. Approval or denial of CBAS eligibility will be sent to the CBAS center within seventy-two (72) hours of the receipt of the request.[6,7]

3. CBAS centers will perform multi-disciplinary team assessment and then submit prior authorization requests with Member's IPC and recommended LOS to IEHP UM Department.

4. Following review of Member's IPC and recommended LOS with CBAS RN the IEHP UM Medical Director determines CBAS LOS approval in accordance with regulatory

[5] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[6] California Health and Safety Code (Health & Saf. Code), § 1367.01
[7] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation, 06/05/14

requirements.[8]

E. Existing Cases

1. Six (6) months from the original CBAS approval date, CBAS centers will re-assess Member and send prior authorization request including IPC with LOS recommendation to IEHP UM Department.

F. Members that are referred for CBAS by their PCP or IPA, as part of a care plan, must be care managed by the IPA to assure coordination of care until the Member is approved for CBAS services.

G. Once the Member has been approved for CBAS services, the IEHP CBAS staff will coordinate services with the respective IPA, as needed.

H. Members are notified in writing of their CBAS assessment determination within two (2) business days of the decision.

I. Members not accepted into the CBAS Program will continue to receive medical care through their PCP and their IPA and should be referred for other appropriate services as needed.

CBAS Unbundled Services

A. If there are no CBAS centers or if there is a lack in capacity at CBAS centers in the Member's local area and the Member qualifies for CBAS services, IEHP will preauthorize "equivalent" unbundled services. These unbundled CBAS services are the health plan's financial responsibility. These services include:

1. Professional Nursing Services;
2. Nutrition;
3. Physical Therapy;
4. Occupational Therapy;
5. Speech and Language Pathology Services;
6. Non-Emergency Medical Transportation (NEMT) and Non- Medical Transportation (NMT) only between the Member's home and the CBAS unbundled service Provider; and
7. Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services.

B. In addition to the requirements for unbundled CBAS, IEHP will coordinate care for unbundled CBAS services, based on the assessed needs of the Member that is eligible for CBAS, that are not covered services. These include:

1. Personal Care Services;

[8] CA Health & Saf. Code, § 1367.01

2. Social Services;
3. Physical and Occupational Maintenance Therapy;
4. Meals;
5. Mental Health Services; and
6. SUD Services

CBAS Emergency Remote Services

A. Effective October 1, 2022, IEHP will cover emergency remove services (ERS) as a mode of service delivery if the Member meets all ERS criteria and all required ERS policy and procedures are followed. The CBAS center, in consultation with IEHP, may determine the need for ERS in these unique circumstances:
   1. Public emergencies, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, tuberculosis, Norovirus, etc.
   2. Personal emergencies, such as serious illness or injury or crises, or care transitions, such as to or from a nursing facility, hospital, and home.

B. The CBAS center must support the rapid response to the Member's needs, when they are restricted or prevented from receiving services at the center.
   1. The CBAS center must ensure that emergencies resulting in ERS are assessed initially by the CBAS center's RN and social worker, with care plans modified as needed by the full CBAS multidisciplinary team.[9]
   2. When need for ERS is appropriately assessed and determined, the CBAS center must complete and fax the CBAS ERS Initiation Form (CEIF) form to IEHP's Utilization Management department at (909) 890-5751 for review and confirmation.[10]
   3. To support rapid response to the Member's needs, the CBAS center must not wait for notification from IEHP.
   4. On a monthly basis, IEHP will provide CBAS centers a list of Members identified to be receiving ERS based on review of CEIF submissions.

C. The provision of ERS supports and services is temporary and time-limited, and specifically either:[11]
   1. Short-Term – The Member may receive ERS for an emergency occurrence for up to three

[9] DHCS All Plan Letter (APL) 22-020 Supersedes APL 20-007, "Community-Based Adult Services Emergency Remote Services"
[10] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Emergency_Remote_Services/
[11] DHCS APL 22-020

(3) consecutive months; and

2. Beyond Three (3) Consecutive Months – ERS for an emergency occurrence may not exceed three (3) consecutive months, either within or crossing over an authorized period, without assessment and review of possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the Member's care plan.

In both of the above, IEHP and the CBAS center must coordinate to ensure that the duration of ERS is appropriate. IEHP will reach out to Members receiving ERS telephonically to verify that service and supports needs are being met during the duration of ERS.

D. CBAS centers and IEHP may consider the following to determine initial need for and/or duration of ERS. Should there be any concerns regarding the appropriateness of ERS, IEHP and the CBAS center must collaboratively agree on the method of providing ERS.[12]

1. Medical necessity – services and supports are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain;
2. Hospitalization – whether the Member has been hospitalized related to an injury or illness and is returning home but not yet to the CBAS center;
3. Restrictions set form by the Members primary or personal health care provider due to recent illness or injury;
4. Member's overall health condition;
5. Extent to which other services or supports meet the Member's needs during the emergency; and
6. Personal crises such as sudden loss of caregiver or housing that threaten the Member's health, safety and welfare.

E. Within 30 days of discharge from CBAS, IEHP must review and retain a copy of the Member's discharge plan from the CBAS center. IEHP must review the discharge plan to determine if the Member needs further coordination of care or services. When there are unmet needs due to the discharge from CBAS, IEHP must ensure the Member's needs are met through other covered non-CBAS services and that these needs are updated appropriately in the Member's care plan.[13]

[12] DHCS APL 22-020
[13] Ibid.

12. COORDINATION OF CARE

F. Community-Based Adult Services

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

12. COORDINATION OF CARE

G. Vision Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Vision services, including lenses and frames for IEHP DualChoice Members are covered directly by IEHP.

B. Comprehensive eye examinations for IEHP DualChoice Members are a benefit on an annual basis.

C. Vision Providers are required to obtain prior authorizations for all routine vision benefits.

PROCEDURES:

Primary Care and Specialty Referrals

A. Primary Care Providers (PCPs) are expected to schedule and provide an initial preventive physical exam within 12 months of enrollment for all IEHP DualChoice Members. A component of the initial preventive physical exam requires vision screening of the eyes to determine the presence of eye disease or potential refractive errors. The PCP must advise the Member of findings and encourage the Member to seek vision services when appropriate. Refer to Policy 10A, "Initial Preventive Physical Exam."

B. The PCP must continue to observe Members for vision conditions and advise Members to seek vision services as applicable.

Access to Vision Providers

A. PCPs are responsible for referring Members to an IEHP Vision Provider if non-medical vision conditions are noted during the visits or if the Member has Diabetes and is being referred for a Dilated Retinal Exam (DRE).

B. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.

Vision Providers for IEHP DualChoice Members

A. A Vision Provider list is included in the IEHP Provider Directory or can be obtained online at www.iehp.org. To receive assistance with referrals, the Vision Provider may call the IEHP PCC at (909) 890-2054. Members may contact IEHP Member Services at (800) 440-4347 or (877) 273-4347 to obtain assistance.

Vision Benefits for IEHP DualChoice Members

A. IEHP DualChoice Members are limited to one (1) comprehensive eye examination with refraction, including dilation when medically indicated, in a 12-month period unless more frequent examinations are determined to be medically necessary.

1. All routine vision benefits require prior authorizations.
2. Providers are strongly encouraged to obtain referrals through **IEHP's Vision Referral Request** online at www.iehp.org. Provider may also obtain authorization through the PCC at (909) 890-2054.
3. Before ordering services Providers must verify eligibility through IEHP's Online Eligibility Verification System at www.iehp.org. When ordering medically necessary absorptive lenses, medical justification must be provided. IEHP designated contract optical lab order forms are available online at www.iehp.org.
4. Eyeglass frames are covered up to $350 and 100% for lenses with fitting and refraction every 12 months. Eyeglass frames provided to Members must be of good quality with the manufacturer or American distributor's name or identification clearly stamped on the frame. Only frames that Providers supply to the general public may be given to Members.
5. The maximum allowance for contact lenses is $350 every 12 months in lieu of lenses and frames. Contact lens fitting is separately reimbursable.

B. Providers must use the following IEHP designated contracted optical laboratories when ordering lens materials. IEHP Providers must use the IEHP Lab Order Form (See Attachment, "IEHP Lab Order Form" found on the IEHP website[1]) when ordering materials from the IEHP designated contract lab.

Express Lens Lab

17150 Newhope St., Suite 305
Fountain Valley, CA 92708-4251
(714) 545-1024 Phone
(714) 556-2026 Fax

Unique Optical

43990 Golf Center Pkwy, Suite B2
Indio, CA 92203
(760) 391-9100 Phone
(760) 391-9101 Fax

C. Members diagnosed with diabetes are entitled to an annual Dilated Retinal Examination (DRE). Vision Providers are required to coordinate care with the Member's PCP by notifying the PCP in writing of the results of the DRE.

1. Prior to rendering services, Provider is required to obtain a referral through IEHP's Vision Referral Request online at www.iehp.org or through the PCC at (909) 890-2054.
2. For the purpose of benefit availability, annual shall mean once per calendar year but no less than nine (9) months since the last DRE.

1 https://www.iehp.org/en/providers/provider-resources?target=forms

3. DRE may be performed on the same day as a comprehensive examination if the Member is eligible for the periodic routine eye examination.
4. Vision Providers are required to coordinate care with the Member's PCP by notifying the Member's PCP in writing of the results of the DRE, utilizing the IEHP PCP Vision Report Form (See Attachment, "PCP Vision Report Form" found on the IEHP website[2]).

D. The IEHP Therapeutic Pharmaceutical Agents (TPA) Program allows IEHP credentialed and TPA certified providers to perform specific services for Members without a referral from the Members' PCPs. In addition to performing TPA services an optometrist with TPG or TLG certification can diagnose and treat primary open angle glaucoma in patients over the age of 18 years old. IEHP follows Medicare guidelines for authorization requirements.

1. Any IEHP Vision Provider may provide TPA services to Members if the following minimum criteria are met:
   a. Provider is an ophthalmologist that participates in IEHP's vision program.
   b. Provider is credentialed by IEHP.
   c. Optometrists must be TPA, TPL, TPG or TLG certified as verified by the California Board of Optometry.
   d. Provider must be contracted by IEHP to provide those services.
   e. Symptoms and conditions covered under the Program are consistent with Section 3041 of the Business and Professions Code and Section 3051.75 of the Title 5 California Code of Regulations.[3,4]
   f. All Members with confirmed chronic conditions must be referred to their PCP however Vision Providers with TPG and/or TLG certification can treat glaucoma.
2. Additional equipment that is required in order to provide TPA services includes:
   a. Binocular Indirect Ophthalmoscope
   b. Condensing Lens
   c. Automated Threshold Field Analyzer
   d. Goldman Applanation Tonometer
3. Prior to rendering services, Providers are required to obtain a referral in accordance to Medicare guidelines through IEHP's Vision Referral Request online at www.iehp.org or through the PCC at (909) 890-2054.
4. TPA services may not be performed on the same day as a comprehensive examination or Diabetic Retinal Examination (DRE).

[2] https://www.iehp.org/en/providers/provider-resources?target=forms

[3] California Business and Professions Code (Bus. & Prof. Code) §3041
[4] Title 5 California Code of Regulation (CCR) §3051.75

5. TPA Providers are required to notify the Member's PCP that medical services have been provided within two (2) working days of rendering services. Providers must complete the PCP Vision Report form (See Attachment, "PCP Vision Report Form" found on the IEHP website[5]).
6. A legible copy of the PCP Vision Report form must be sent to the Member's assigned PCP.
   a. The Member's assigned PCP information can be found on the eligibility page of the secure Provider portal.
7. The PCP Vision Report form must be completed in its entirety and include:
   a. Patient's presenting symptoms.
   b. Diagnosis description.
   c. ICD code(s).
   d. Procedure(s) and/or treatment performed.
   e. If applicable, the name and type (form) of medication prescribed.
   f. Provider's signature.
   g. Date of the next follow-up appointment, if indicated, in "Next Visit" otherwise specify N/A (not applicable).
8. Claims for TPA, TPG and TLG services can be submitted through **IEHP's Claims Entry** form on the IEHP's Provider Portal at www.iehp.org or on a CMS 1500 Health Insurance Claim Form and must include all information necessary to process the claim for payment.
   a. Under the TPA Program, IEHP performs retrospective review on all non-authorized services. Claims are also reviewed for unbundling and inappropriate use of codes. Claims with unbundled services, or where two (2) or more lower level codes are billed on the same date of service without substantiated documentation, result in lower reimbursement.
   b. Members cannot be billed for any covered service, including services that have been denied as a result of improper billing.
9. Prescription Medications
   a. All prescription medications prescribed to IEHP Members must adhere to IEHP's formulary. Providers wishing to prescribe non-formulary medication must first submit a Prescription Drug Prior Authorization (Rx PA) Request form for approval.
   b. TPA Providers must use Prescription Drug Rx PA Request forms for the following:
      1) Medication or dosage not included in the IEHP formulary.

[5] https://www.iehp.org/en/providers/provider-resources?target=forms

2) Code 1 medications used for treatment of conditions or criteria other than those specified by their restrictions.

3) Branded medications when generic is available.

4) Prescriptions for formulary medications that do not comply with Dose/Duration/or Quantity guidelines (as outlined in the IEHP formulary at www.iehp.org under Pharmaceutical Services page).

5) The RxPA form is available on the IEHP web portal at https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-rx-pa-universal-form/.

c. A Member currently taking medication that has been deleted from IEHP's formulary may continue to receive the medication, if prescribed.

d. All completed Prescription Drug Rx PA Requests will be reviewed within 24 hours for approval or denial.

E. IEHP PCPs continue to provide all necessary health care services to Members even if the Member has been referred to a Vision Provider for services.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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12. COORDINATION OF CARE

G. Vision Services

1. Vision Exception Request

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. All non-routine benefits require prior authorization utilizing the Vision Exception Request (VER) form. Vision Provider must submit a completed VER form to obtain prior authorization.

B. All VERs must contain information that supports the medical necessity of a non-routine benefit.

C. All requests are reviewed and acted on based on the type of request submitted:

1. Routine (Non-urgent) Pre-Service: Decision within fourteen (14) calendar days of receipt of all information reasonably necessary to render a decision.
2. Expedited Authorization (Pre-Service): Decision within seventy-two (72) hours of receipt of the request.
3. Post-Service / Retrospective Review: Decision within thirty (14) calendar days from receipt or request.

PROCEDURES:

A. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (909) 890-2054.

B. VER forms are used for the following:

1. Second eye examination within twelve (12) months covered when signs or symptoms indicate a need and documentation substantiates the need for a second exam.
2. Single Vision Lenses in -lieu of Bifocals – Two (2) pairs of single vision glasses, one for near vision and one for distance vision are covered when one (1) of the following exists:
   a. Sufficient evidence that a Member cannot wear bifocal lenses.
   b. Member is currently using two (2) pairs of glasses.
   c. New presbyopes must have failed with bifocals first.
3. Replacement of lost, broken or damaged appliances may be covered when accompanied by a written statement signed by the Member that includes:
   a. The circumstances of the loss or destruction;
   b. The steps taken to recover the lost item; and
   c. Certification that the loss, breakage, or damage was beyond the Member's control.

4. Other Covered Items – VER Required:

   a. Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes and prosthetic sclera shells are covered when medically indicated. A brief justification must be provided when prescribing or dispensing the covered item.

C. When a VER is determined necessary, Vision Providers have two (2) working days from the determination to submit the VER and all supporting documentation.

D. IEHP reviews and responds to all VERs submitted as:

1. Routine (Non-Urgent) Pre-Service within five (14) calendar days.
2. Expedited (Pre-Service) within seventy-two (72) hours; and
3. Post-Service / Retrospective within thirty (14) calendar days from receipt or request.

E. IEHP reviews the VER, verifies eligibility, benefit availability and previous utilization and either approves, modifies, or denies the request. All decisions are communicated to the Provider via a "Non-PHI fax" form.

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12. COORDINATION OF CARE

G. Vision Services
2. Vision Provider Referral

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP Vision Providers are required to provide evaluation and management services within their scope of practice to Members with known or suspected diseases and conditions of the eye and visual system. [1]

B. Vision Providers caring for IEHP DualChoice Members that require further diagnosis and treatment beyond the scope of practice of the Vision Provider must refer the Member to the appropriate health care Provider, as follows:

1. IEHP DualChoice Members with a known or suspected pathology of the eye, or any of its appendages, may be referred directly by the Vision Provider to an Ophthalmologist by submitting a referral request to the Member's IPA.
2. IEHP DualChoice Members with a known or suspected medical condition that may be systemic or neurological in nature shall be referred to the Member's Primary Care Provider (PCP) for appropriate coordination of care.
3. Vision Providers may also call the IEHP Provider Call Center (PCC) at (909) 890-2054 for assistance regarding information on Member's IPA contact assignment for referral submission.

PROCEDURES:

Identification/Diagnosis

A. Vision Providers are responsible for identifying Members with any pathological ocular health condition that requires treatment. Identification of these Members can occur during any visit for acute or chronic conditions.

B. Members presenting with complex or mixed symptoms or conditions that make the diagnosis uncertain or that may indicate a systemic etiology must be referred to the Member's PCP for assessment, diagnosis, and/or treatment. If the Vision Provider determines that an ophthalmologist consultation and/or treatment is warranted, the Vision Provider can submit a referral directly to a Member's IPA.

D. Vision Providers are responsible for treating Members with ocular conditions within their scope of practice. Treatment includes the provision of appropriate optical devices and the use of topical ophthalmic pharmaceutical agents, as indicated. Typical ocular health conditions

[1] California Business and Professions Code (Bus. & Prof. Code) § 3041

within the scope of practice of Vision Providers, depending on their level of certification and legal authority include, but are not limited to:

1. Refractive and motility disorders of the human eyes
2. Ocular infections
3. Ocular inflammations and allergies
4. Ocular trauma and superficial foreign bodies
5. Primary open angle glaucoma
6. Nothing in this section shall be construed to grant privileges to the optometric Vision Provider beyond the scope set forth in the statutes and regulations of the Optometry Code.[2,]

E. Scope and limitations to IEHP DualChoice Vision Benefit: IEHP DualChoice Members are entitled to one (1) routine comprehensive eye examination every twelve (12) months through their Medicare coverage. If medically indicated, a pair of lenses every twenty-four (24) months. Eyeglass frames are covered up to $350 every 12 months. Contact Lenses are covered up to $350 every 12 months in lieu of frames and lenses. When indicated, medical evaluation and management services of certain eye conditions are available to the Member through an IEHP Vision Provider. Treatment of any eye condition shall be limited to acute conditions. The long-term treatment of chronic medical conditions of the eyes shall be managed and coordinated by the Member's PCP.

Referral to PCP

A. Vision Providers shall complete a PCP Vision Report (See Attachment, "PCP Vision Report Form" found on the IEHP website[3]) to report examination findings and/or treatment provided during an active ocular condition that require further evaluation or follow up by Member's PCP.

1. To ensure Member's continuity of care, Vision Providers are required to notify the Member's PCP if medical services have been provided within two (2) days of rendering service.

Referral to Ophthalmologist

A. Vision Providers, with the assistance of IPA Utilization Management (UM) staff, are responsible for referring IEHP DualChoice Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

[2] CA Bus. & Prof. Code § 3041
[3] https://www.iehp.org/en/providers/provider-resources?target=forms

B. PCPs are also responsible for referring Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

C. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the ophthalmologist specialty Provider through phone calls, transfer of medical records, and other specialty referrals as indicated.

D. Vision Providers shall prepare a written request for referral on the standardized Ophthalmologist Referral Request Form at www.iehp.org (See Attachment, "Ophthalmologist Referral Form" found on the IEHP website[4]) and submit the completed referral to the Member's assigned IPA within 24 hours of the encounter with the Member. Vision Providers may indicate desired ophthalmological sub-specialty by selecting: General Ophthalmology or Retinal Specialist.

E. IPA UM staff are responsible for faxing back a copy of the completed referral form including the specific ophthalmologist selected back to the Vision Provider.

F. Vision Providers may also call the IEHP PCC at (909) 890-2054 and/or Medical Director for advice or consultation regarding Member ocular health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

Medications

A. IEHP covers medically necessary medications for the treatment of ocular disease as listed in the IEHP formulary.

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4 https://www.iehp.org/en/providers/provider-resources?target=forms