Community Care Alliance of Illinois

POLICY AND PROCEDURE

Policy Number: HCM 020	Approval Authority: G.R. Alexander
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Subject: Care Management

Policy: It is the policy of Community Care Alliance of Illinois to have a process that outlines how clinicians oversee and coordinate care for enrollees

Scope: This procedure applies to all Community Care Alliance of Illinois lines of business covered. This procedure describes the care management processes of assignment, assessment, individualized care planning, coordination, monitoring, reassessment and ongoing evaluation as well as care coordinator supervision and orientation.

Definitions:

Authorized Representative- Individual authorized to discuss a member's personal health.

BEAM- Illinois Department on Aging's Benefits, Eligibility, Assistance and Monitoring (BEAM) unit that responds to request for determination of eligibility on MCO participants needling HCBS waiver services.

Care Coordinator-Is the Nurse Coordinator or LTSS Coordinator that is part of the Interdisciplinary Care Team (ICT) and is employed by CCAI.

Care Coordination Organizations-Are organizations that provide case management for HCBS Waivers under DoA or DHS-DRS Home Services Program. CCO's may include Care Coordination Units (CCUs), Coordinated Care Alliance (CCA), El Valor, Aids Foundation of Chicago, Pioneer Center, and RAMP.

Clinical Care Management System (CCMS)-A structured electronic assessment and management application that includes authorization tools, a documentation system as well as assessment tools that identify issues and barriers to effective member self-management and adherence to the member's goals of care and clinical treatment plan. The Clinical Care Management System was developed using evidence-based clinical guidelines, nationally recognized clinical guidelines, e.g. InterQual Level of Care Criteria, American Diabetes Association, National Heat Lung and Blood Institute and others were utilized in developing the documentation platform. The system includes automated features to guide care coordinators through assessments and includes prompts and reminders for follow up. Time of encounter, date and user name is automatically entered by the Clinical Care Management System. This system

supports the case managers and others in capturing member-centered assessments and information. All care management activities and documentation are to be recorded in the Clinical Care Management System.

Comprehensive Health Risk Assessment (HRA)-Specific tools used to evaluate the Enrollee by assessing medical, psychological, functional, Environmental, financial, and social support needs of the Enrollee . HRAs are used to screen members for care management and to risk stratify the members in order to best and timely meet their needs.

DHS-DRS-Is the Department of Human Services-Division of Rehabilitation Services that oversees the Home Services Program that includes: HIV/AIDS, Brain Injury (BI), and Persons with Disability Waivers.

Health Risk Survey *It* is a survey that the CCAI builds upon and incorporates the best of currently-available screening tools. It is a "universal design" instrument, offering a framework that is holistic, easy-to-use, intuitive, and flexible for use in multiple specialized populations.

Home and Community-Based Services (HCBS) Waivers-are 1915 c waivers that include: Aging/Elderly, HIV/AIDS, Brain Injury, Persons with Disabilities, and Supportive Living Facility (SLF) waivers.

Interdisciplinary Care Team (ICT)- The ICT is designed to ensure that beneficiaries needs are identified and managed by an appropriately composed team. Composition of the ICT is aligned with the health risk status of the Enrollees. There will be three levels of ICTs based on the health risk of the beneficiary, and composition will vary at each level. Essential members of all levels of ICT will be the member if feasible, the PCP, Care Coordinator (RN/nurse), and a Home and Community Based Services Coordinator (HCBS) who is a social worker. Other members will participate on the ICT as needed and may include specialists as identified, medical director health educators, customer service representatives, provider network staff, clinical pharmacist, dietician, and long-term care facility care management staff.

Passive Participation- The enrollee who has either declined active case management but will accept educational mailings or a member whom CCAI is unable to contact to enroll in the case management.

Physician Certification-Is a required authorization to receive clinical services under the HCBS waivers which include: PT, OT, Speech Therapy, etc.

Plan of Care (POC)-The individualized POC is developed based on the assessed or perceived needs of the individual or their caregiver using a variety of assessment tools or processes. The POC will include prioritized short and long term goals, specific services and benefits to be provided with measurable outcomes. The POC is developed as feasible with the PCP, member and their caregiver as well as the other health care professionals. The POC and other care planning records are maintained per HIPPA and other professional standards. The POC is available to the PCP, ICT and other health care professionals. The POC is documented in the CCMS. Within the POC, the care management activities are tracked, reflecting progress over time, such as interventions identified, goals met and /or modified.

Primary Care Provider (PCP)- *M*eans a Provider, including a Physician, Nurse Practitioner, Women's Health Practitioner, who within the Provider's scope of practice and in accordance with State

certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned members.

Service Plan Coordinator-Part of the ICT and will develop a service plan and coordinate services that are outlined in the service plan within CCAI's required timeframes. The Service Plan Coordinator is subcontracted with CCAI and is employed by the Community-Based Organization.

Supportive Living Facility (SLF)- means a residential apartment-style (assisted living) setting in Illinois that is (i) certified by the Department to provide or coordinate flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for Residents to move within or from the setting to accommodate changing needs and preferences; (ii) has an organizational mission, service programs and physical environment designed to maximize Residents' dignity, autonomy, privacy and independence; (iii) encourages family and community involvement; and, (iv) administered by HFS under the Supportive Living Program HCBS Waiver.

Procedure:

1. Enrollees are identified for care coordination through a variety of sources, including but not limited to:
    - State enrollment report
    - Self-Referrals
    - Claims
    - Inpatient utilization/notification
    - ER utilization/notification
    - Provider Referrals
    - Administrative data
    - Contractor Personnel
    - Referral from the behavioral health vendor
    - Community Organizations
    - Results of the DON
    - Families and Caregivers

2. All new enrollees will receive an initial health risk survey in their welcome packets.
    - 2.1 Every attempt will be made to complete the initial health risk survey within sixty (60) days of new enrollee's enrollment in the plan.
    - 2.2 Subsequent phone call attempts will be made to new enrollees that do not return the health risk survey by mail within thirty (30) days of initial mailing.
    - 2.3 There will be a total of three (3) attempts to contact each enrollee.
    - 2.4 Enrollees with incorrect or disconnected phones and enrollees that do not call back after messages left on their voice mail will be mailed a letter or Enrollee Services will contact CCA to assist on completing the initial health risk surveys for enrollees who we cannot locate or that need additional assistance completing the initial health risk survey.

2.5 Once the initial health risk survey is completed either by fax, mail, face-to-face, or by telephone, Enrollee Services will enter into CCMS.

2.6 Based on the responses on the initial health risk survey, the enrollee will be stratified as follows:
- High: risk score of 10 or greater
- Medium: risk score of 5-9
- Low: risk score of 4 or less

2.7 A care coordinator is then assigned to every enrollee at the time of his/her enrollment.

2.8 All enrollees select a Primary Care Provider (PCP) upon enrollment.

Comprehensive Health Risk Assessment

3. The Care Coordinator (nurse or LTSS) will complete a comprehensive Health Risk Assessment (HRA) either by phone or face-to-face with the enrollee and/or designated representative.

3.1 Three attempts will be made by the assigned care coordinator via telephone to the enrollee/designee.

3.2 The care coordinators will use best efforts to complete a comprehensive health risk assessment and develop an individualized care plan within the following timeframes:

3.2.1 High Risk: within ninety (90) days

3.2.2 Moderate Risk: within ninety (90) days

3.2.3 Low Risk: within one-hundred and eighty (180) days

3.2.4 For enrollees receiving HCBS waiver services or residing in the Nursing Facilities as of the date that the services in service package II become covered services, a **face-to-face assessment** within the one-hundred and eighty (180)-day transition period is required.

3.2.5 For enrollee eligible for HCBS services or transitioning to Nursing Facilities. A face-to-face assessment within ninety (90) days after enrollment is required.

3.3 If the phone is disconnected or if there is no response to any of the messages left by the care coordinator, the care coordinator will send out a "no contact" letter to the enrollee.

3.4 The enrollee will be assigned the "passive participation" status if no response from the enrollee and/or designee and send educational materials.

3.5 If the member is willing to participate in the case management program, a verbal consent will be obtained and documented in CCMS.

3.6 If the enrollee is not willing to participate in any of the programs, the care coordinator will send "opt out" letter to the enrollee and the PCP.

3.7 Based on the comprehensive HRA findings, the care coordinator further stratifies the enrollee to one of the following stratification categories:
- Tier one: High Risk
- Tier two: Medium Risk
- Tier three: Low Risk

3.8 The comprehensive HRA assessment is shared with the ICT via email or fax and team meetings at the Anchor Health Homes. It is also contained in CCMS.

3.9 The comprehensive HRA assessment is reviewed as often as needed based on enrollee's acuity of needs and with every change in enrollee's condition.

3.10 For members in acute, skilled nursing and/or long term care facilities, part of the comprehensive assessment may be obtained from the facility.

3.11 If an enrollee is being treated and/or admitted at the Anchor Health Home, the initial health risk survey and the comprehensive assessment may be completed by the care coordinator at the same time.

3.12 An individualized plan of care is developed by the care coordinator (nurse or LTSS) using the results of the comprehensive HRA for all enrollees and goals of care are identified.

3.13 The care coordinator coordinates the care and services enrollee in conjunction with the PCP.

3.14 Communication with families, member and/or responsible parties is completed in accordance with the HIPAA privacy and confidentiality policies and procedures.

3.15 The care coordinator reviews clinical status for all reported changes in condition and will follow-up with member until condition change has returned to baseline or new baseline is established.

3.16 The care coordinator will also monitor changes in member's health status in order to identify that a planned transition of care is going to occur.

3.17 When planned or unplanned transitions of care occur, the member, PCP, and ICT are involved and developed the appropriate POC.

3.18 Post hospitalization, the care coordinator will update care plan accordingly.

3.19 If an enrollee is homebound, or has significant mobility limitations, enrollees will be able to request home visits by our Interdisciplinary Care Team including nurse practitioners or Physicians to support the Enrollee's ability to live as independently as possible in the community.

Service Plan Development for HCBS Waivers

4.1 The following process will be followed to develop a service plan for Enrollees in the Elderly/ Aging, HIV/AIDS, Brain Injury, and Persons with Disability Waiver:

4.1.1 Enrollee's service plan will be developed **within 15 days** from the date the Care Coordinator receives notification that the Enrollee is determined eligible for waiver services.

4.1.2 For Enrollees that do not have an existing service plan the following process will be followed:

4.1.3 Upon completion of the comprehensive HRA and development of the care plan, the Care Coordinator will determine that a member is eligible for services and contact BEAM for Enrollees under the Aging Waiver or contact DHS Local Department of Rehabilitation (DRS) Office under the HIV/AIDS, Brain Injury, and Persons with Disability Waivers to request a Determination of Eligibility (DOE).

4.1.4 Care Coordinator will receive and review the Determination of Need (DON) and MCO form that was completed by either the Care Coordination Unit (CCU) or DHS-DRS counselor.

4.1.5 When the Enrollee is not eligible for Waiver Services, based on the Determination of need, the Care Coordinator will seek alternative community resources. For Enrollees sixty year of age or older, the Care Coordinator will contact the Area Agency on Aging for

Title III services after discussing the Determination of Need DON with the CCU care coordinator or DRS counselor. ***See section below***
" Referrals for non-waiver services ".

4.1.6 When Enrollee is determined eligible for Waivers Services, the Care Coordinator will contact a care coordination organization that is subcontracted with CCAI **within 72 hours** from notification of eligibility.

4.1.7 The Care Coordinator will send the Service Plan Coordinator a copy of the Comprehensive HRA, care plan, determination of need (DON) and case notes.

4.1.8 The Service Plan Coordinator from the community-based organization will make a Home Visit to complete the service plan **within 7 calendar days** from notification from CCAI Care Coordinator.

4.1.9 During the home visit, the Service Plan Coordinator will complete a Client Agreement, Plan of Care, CCP Consent Form, Physician's Statement (if required), and a Provider Selection Form based on the Enrollee's determination of need and within the Service Cost Maximum defined by DoA or DHS-DRS.

4.1.10 The Service Plan Coordinator will also explain the services the Enrollee will receive and review with the Enrollee "Your Rights and Responsibility" form.

4.1.11 The Service Plan will be signed by the Enrollee or Enrollee's representative and Service Plan Coordinator that includes the Enrollee's Right to choose a LTSS Provider or if the enrollee does not express a choice, the Service Plan Coordinator will choose a provider on a rotation basis. ***See Policy CCAI HCM_ 039for procedure on assigning a LTSS Provider.*** A copy of the service plan and "Your Rights and Responsibility" form will be given to the Enrollee.

4.1.12 All enrollee's receiving Homemaker Services or a Personal Assistant (PA) will have an Enrollee a contingency or back-up plan. ***See Policy CCAI_HCM 038 for procedure on developing a back-up plan.***

4.1.13 The Service Plan Coordinator will contact by phone the CCAI assigned Care Coordinator **within 48 hours** to share results of the service plan and authorize waiver services, discuss any issues or concerns observed in the home. This will be followed by transmission of any documentation of the service plan.

4.1.14 When a physician certification is needed, the CCAI Care Coordinator will work with the Service Plan Coordinator to obtain the physician approval by the Enrollee's PCP or Specialist.

4.1.15 Service Plan Coordinator will email or fax service plan to the assigned CCAI Care Coordinator.

4.1.16 At this time, the CCAI Care Coordinator will update the Comprehensive HRA care plan.

4.1.17 Service Plan Coordinator will make referrals and coordinate services in the service plan **within 48 hours** by contacting LTSS Providers that are certified with the State or locating a PA by contacting a Center of Independent Living within the Enrollees service area for Enrollees who do not have a PA.

4.1.18 The LTSS Provider will have **15 days** to implement services.

4.1.19 When the Enrollee under the Brain Injury, HIV/AIDS, or Persons with Disability waivers chooses a PA, the Service Plan Coordinator will provide and/or assist the Enrollee with the personal assistance forms and handbook.

4.1.20 The Service Plan Coordinator will also inform the Enrollee that the personal assistance forms must be completed before the PA can begin services.

4.1.21 The CCAI Coordinator will contact the Enrollee to monitor services and to make sure that services are in place.

4.1.22 The CCAI Coordinator will generate a letter in CCMS **16 days after** the Service Plan was signed to notify the enrollee that a Service Plan Coordinator will be making a monitoring visit within the required timeframes outlined below in section (Minimum Required Timeframes) from the time the Service Plan is signed.

4.1.23 At the time the Care Coordinator is checking if services have been implemented as indicated in the service plan, the CCAI Coordinator will conduct the POSM Survey by phone with the Enrollee in CCMS. When necessary and with Enrollee's input, the POSM will be conducted in person with the Enrollee. POSM Survey will be conducted during initial and redetermination of eligibility.

4.1.24 The Service Plan Coordinator will contact the Enrollee as outlined below under the section, (Minimum Required Contacts). At this time Service Plan Coordinator that is conducting the monitoring visit needs to review and update (if necessary) the service plan and communicate all actions and results to the Care Coordinator assigned to the Enrollee. The Care Coordinator is responsible for making sure that monitoring visits are met on time by the Service Plan Coordinator

4.1.25 When an Enrollee expresses dissatisfaction with a LTSS Provider within reasonable cause as mentioned in the "Your Rights and Responsibilities" brochure, the CCAI Coordinator will contact the Service Plan Coordinator to request a transfer of providers.

4.1.26 The CCAI Care Coordinator will monitor the process, by calling the enrollee or by a contact, face-to-face, that required monitoring has been conducted for all waivers.

4.1.27 The CCAI Care Coordinator will educate the Enrollee regarding Abuse, Neglect, and Exploitation and where to report these at the time of reassessment and updating of the CCAI care plan. ***See policy CCAI_HCM026*** for detailed process on reporting procedures.

4.1.28 It is the responsibility of the CCAI Care Coordinator to monitor and verify by contacting the Enrollee and updating the care plan in CCMS per the required reassessment timeframes, that a redetermination is completed by the CCUs or DHS-DRS counselors within the following timeframes:

- 4.1.28.1 Aging Waiver: at least annually
- 4.1.28.2 Persons with Disability: at least annually
- 4.1.28.3 Brain Injury Waiver: Every 6 months
- 4.1.28.4 HIV/AIDS Waiver: Every 6 months

4.1.29 When an Enrollee needs a redetermination of eligibility due to a change in the Enrollee's status, the CCAI Care Coordinator will contact BEAM for the Aging Waiver and DHS-DRS for HIV/AIDS, Brain Injury, and Persons with Disability Waiver to conduct a redetermination.

4.1.30 The CCAI Care Coordinator will review the redetermination of need CCUs or DHS-DRS and contact the Service Plan Coordinator to develop the service plan and to update the care plan.

4.2 **Referrals for Non-Waiver Services**

4.2.1 The CCAI Care Coordinator will contact the appropriate Area Agency on Aging (AAA) office within 72 hours after the assessment and care plan are completed, to determine the referral procedures for Title III services such as Home Delivered Meals, Caregiver Support Program, Chore Services, etc. in each planning service area (PSA).

4.2.2 Once the procedure is obtained from the local AAA, the CCAI Care Coordinator will contact the Title III provider.

4.2.3 The CCAI Care Coordinator will provide the Title III provider with all referral data such as the Enrollee's ADL's, IADL's, nutritional risk, and demographics that were collected at the time the Comprehensive HRA was completed.

4.3 The following process will be followed for Enrollees needing **Supportive Living Facility Waiver Services:**

4.3.1 After completion of the Comprehensive HRA and care plan, the Care Coordinator will determine if the Enrollee is in need of SLF services.

4.3.2 The Care Coordinator will contact BEAM to request a Prescreen.

4.3.3 The Care Coordinator will review the results of the prescreen and contact the SLF chosen by the enrollee.

4.3.4 IF the Enrollee does not express a choice of a SLF, the Care Coordinator will choose a SLF on a rotation basis. ***See Policy CCAI HCM_039 for procedure on assigning a LTSS Provider.***

4.3.5 The SLF will complete the required assessments and service plan for the enrollee. The following assessments and service plan is completed by the registered nurse employed by the SLF:

4.3.5.1 Standardized Interview is required prior to admission to make sure the SLF can meet the resident's needs.

4.3.5.2 Initial Assessment and Service Plan is due within 24 hours of admission and must be reviewed by a registered nurse.

4.3.5.3 The Resident Assessment Instrument (RAI) is due within 7-14 days of admission and annually thereafter. The RAI must be revised each time a significant change in condition occurs.

4.3.5.4 Resident Service Plan (RSP) is due within 7 days of the completion of the RAI. The RSP must also be updated to reflect any significant change in condition, refusal of services or change in services, whether based on need or resident preference.

4.3.5.5 Quarterly Assessment is due every every 92nd day. The RSP should be updated at this time, if necessary.

4.3.6 The Care Coordinator will contact the Enrollee as outlined below under the section, (Minimum Required Contacts) for monitoring.

4.3.7 The Care Coordinator will be responsible for explaining and mailing to the Enrollee or the Enrollee's Representative the brochure, "The Resident's Rights for Persons Residing in Supportive Living Facilities" brochure.

4.3.8 The CCAI Care Coordinator will monitor the process and ensure that required monitoring contact for this waiver is conducted on time, by calling the Enrollee and conducting Comprehensive HRA based on their risk stratification mentioned in section 5 below under section (Reassessment).

4.3.9 The CCAI Care Coordinator will educate the Enrollee regarding Abuse, Neglect, and Exploitation and where to report at the time of reassessment. ***See policy CCAI_HCM026*** for detailed process on reporting procedures.

4.3.10 **Involuntary Discharge** Process:

4.3.10.1 If an Enrollee and/or the Care Coordinator receive an involuntary discharge notification from a SLF, the Care Coordinator will discuss with the SLF to the reason for involuntary discharge of the Enrollee.

4.3.10.2 After discussion with the SLF regarding involuntary discharge. The Care Coordinator will assist the Enrollee or Enrollee's representative through the appeal process if the Enrollee chooses to appeal the discharge notice through the Department's Fair Hearings unit.

4.3.10.3. When the appeal is for a 30 day notice, the Enrollee may remain in the facility pending the hearing outcome.

4.3.10.4 When the Enrollee is admitted to a nursing home, the Enrollee is automatically discharged from the SLF. The involuntary discharge process does not apply and the SLF may choose to hold the apartment (fee determined by the SLF).

4.3.10.5 The Care Coordinator will be responsible for locating alternative housing with the Enrollee or a different SLF.

4.3.10.6 The Care Coordinator will document all actions in CCMS.

4.4 **180-day transition period** for Enrollees on HCBS Waivers

4.4.1 Enrollees that have an existing Service Plan in place on the date that such services become Covered Services, the Care Coordinators will use the existing service plan.

4.4.2 The Care Coordinator will update or make changes to the service plan, only with the Enrollee's consent and only after completion of a face-to-face comprehensive HRA

4.4.3 ***See Transition of Care Policy CCAI_HCM034 for detailed procedure.***

4.5 The following process will be followed for Enrollees under a HCBS Waiver who disenroll with CCAI

4.5.1 CCAI will forward to the BEAM unit or DHS-DRS the Enrollee's Service Plan within fifteen (15) days after notification of disenrollment.

4.6 Minimum Required Contacts

4.6.1 The CCAI Care Coordinator and Service Plan Coordinator will monitor the service plan by following the minimum required contacts outlined below.

4.6.1.1 **Enrollees who are Elderly Waiver**: The Service Plan Coordinator will make a face-to-face contact with the enrollee not less often than once every ninety (90) days.

4.6.1.3 **Persons with Brain Injury**: The Care Coordinator shall have contact with the enrollee not less often than one (1) time per month.

4.6.1.4 **Enrollees with HIV/AIDS:** The Care Coordinator shall contact the enrollee not fewer than three (3) times per month, and not fewer than one (1) of those contacts shall be face-to- face in the enrollee's home.

4.6.1.5 **Enrollees with Disabilities:** The Service Plan Coordinator will make a face-to-face contact with the enrollee not less often than once every ninety (90) days.

4.6.1.6 **Supportive Living Program:** The Care Coordinator shall contact the enrollee no less often than one (1) time per year.

4.6.1.7 Service Plan Coordinator is responsible for sending the case notes and service plan to the Care Coordinator after each contact. CCAI Care Coordinator will review all documentation and scan into CCMS.

4.6.1.7.1 Service plans and case notes are due within 5 days from the date the service plan is signed

4.6.1.7.2 Case notes only are due within 48 hours from the date of contact or the event.

5.0 Comprehensive HRA/Care Plan Reassessments

5.1 Upon change in health status/risk level re-assessments will be completed as necessary and the enrollees' care plan will be updated.

5.2 The CCAI care plan will be reviewed as follows:

5.2.1 High Risk: at least every thirty (30) days,

5.2.2 Moderate Risk: at least every ninety (90) days,

5.2.3 Low Risk: at least yearly,

5.2.4 At minimum, a yearly re-assessment for each enrollee is required.

5.2.5 For Enrollees receiving HCBS Waiver services or residing in NFs, a **face-to-face** reassessment will be conducted each time there are significant changes in Enrollee's condition or if Enrollee requests a reassessment.

6. All activities will be documented in CCMS and maintained in accordance with HIPAA standards in industry practices.

Exceptions: none

Change History: 6/18 – changes to match new contract, and Care Coordination Plan