OPERATIONAL MEMO

TITLE:	CARE COORDINATION AND CASE MANAGEMENT EXPECTATIONS FOR UTILIZATION MANAGEMENT DENIALS
SUPERSEDES NUMBER:	N/A
EFFECTIVE DATE:	JUNE 5, 2020
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Purpose and Audience:

The purpose of this Operational Memo is to inform Regional Accountable Entities (RAEs), Case Management Agencies (CMAs), and the Utilization Management (UM) Vendor of Department expectations regarding care coordination and case management for Health First Colorado members who received administrative approvals for private duty nursing and long-term home health benefits. These members' benefits were extended to June 30, 2020, but they likely will change effective July 1, 2020.

Information:

There were issues and concerns with denial notices for private duty nursing (PDN) and pediatric long-term home health (LTHH) benefits. As a result, prior authorization requests (PARs) for these benefits have been administratively approved through June 30, 2020 to accommodate the Department's work to revise the denial notices and complete system changes.

The Department is directing RAE care coordinators and CMAs to work together to assist families or guardians who may need to locate and access a more appropriate level of service for their pediatric or the adult members. The Department will issue separate guidance about process changes for case management and care coordination related to this topic.

Consistent with the Department's objective that members received the right care, at the right time, in the right place, the Department has provided each RAE with a list of the home health agencies across the state as well as tools presented at the 2019 August RAE Learning Collaborative related to work flows (attached). Along with a list of home health agencies, intensive case management/care coordination should be provided to families of the members who are receiving service denials or reductions.

RAE Care Coordination and Case Management Agency Process

The home health agency list and a bi-weekly list of members who receive a service denial notice will be sent to each RAE via their RAE Program Specialist. Beginning June 2, 2020, RAE care coordinators shall start the process of meeting with families and requesting service providers to discuss the need for other service options. Families and RAE care coordinators shall discuss how each service applies, the level of support the member needs, and the frequency needed for each service. RAE care coordinators shall assist the family in locating appropriate providers for those services utilizing the home health agency list provided. Those services may still require a PAR and be dependent on review and approval. The RAE shall assist families with the PAR process, as needed.

Members on your bi-weekly lists may wish to appeal service denial decisions. The RAE care coordinators shall assist families by providing accurate and up to date information about how to file an appeal, including the time limits for filing appeals.

For members who are enrolled into an HCBS waiver and have a CMA providing case management, RAE care coordinators should contact the case manager who can assist the individual with determining the level of service required based on their needs and if that service can be provided through the waiver benefits. RAE care coordination staff should work with the CMA case management staff to ensure families are able to access all medically necessary services under the state plan, EPSDT, or the waivers, utilizing the tools provided on work flow to the CMAs and RAEs. CMA case managers shall complete an unscheduled review, if needed, and service plan revision if it is determined additional waiver services can be provided to the member for an assessed need.

For members who are not currently enrolled in an HCBS waiver, but who may be eligible, the RAE care coordinator should work with the member or family to contact their local CMA to make a referral for a long-term care functional needs assessment.

<u>Ongoing expectations</u>

Beginning July 1, 2020, RAEs shall report their progress monthly (no later than 5 calendar days after the end of the month) to the Department and their RAE program specialist. The report will include the RAE's progress assisting the members or their families of the children and youth members with access to other services. This report list will be in the same format as the list provided to them for care coordination and will indicate if the CMA has been included in the plan as well as any referrals for waiver assessments.

RAEs are required to keep the list of home health agencies up to date and share information across RAEs and other case management entities as needed or when requested by the Department or CMA case managers.

Accountable Care Collaborative and RAE Information:

https://www.colorado/gov/pacific/hcpf/accphase2

Long-Term Services and Supports and SEP/CCB Information:

https://www.co.orado.gov/pacific/hcpf/long-term-services-and-supports-programs

https://www.colorado.gov/pacific/hcpf/community-centered-boards

https://www.colorado.gov/pacific/hcpf/single-entry-point-agencies

Attachment(s):

Collaboration Between Regional Accountable Entities (RAEs) and Case Management Agencies (CMAs)

RAE and CMA Collaboration: Scenarios

Case Management Agencies and Regional Accountable Entities Collaboration Learning Collaborative Training

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