L.A. Care HEALTH PLAN

For All of L.A.

L.A. Care Bi-Monthly Health Services Webinar

October 29, 2024

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

LA6514 1124

Agenda

- Greeting / Background
- L.A. Care Utilization Management- Outpatient Updates
- L.A. Care Utilization Management – Inpatient Updates
- Nursing Facility Transition/Diversion NFTD to assisted Living Facilities
- Community Health CalAIM Community Supports
  - Nursing Facility Transition/Diversion Services (NFTD)
  - Community Transition Services (CTS)
  - Personal Care and Homemaker Services (PCHS)
- Social Services
  - Recuperative Care
  - Short-Term Post-Hospitalization Housing (STPHH)
- Community Supports- Housing
- Pharmacy
- Q&A

Ingrid Castelo, Director Utilization Management

- L. A. Care Utilization Management - Outpatient

No Auth Required Process Update

Since Go-Live July 25, 2024, there has been a ***significant reduction in total UM authorization volume! Thank you for your collaboration!***

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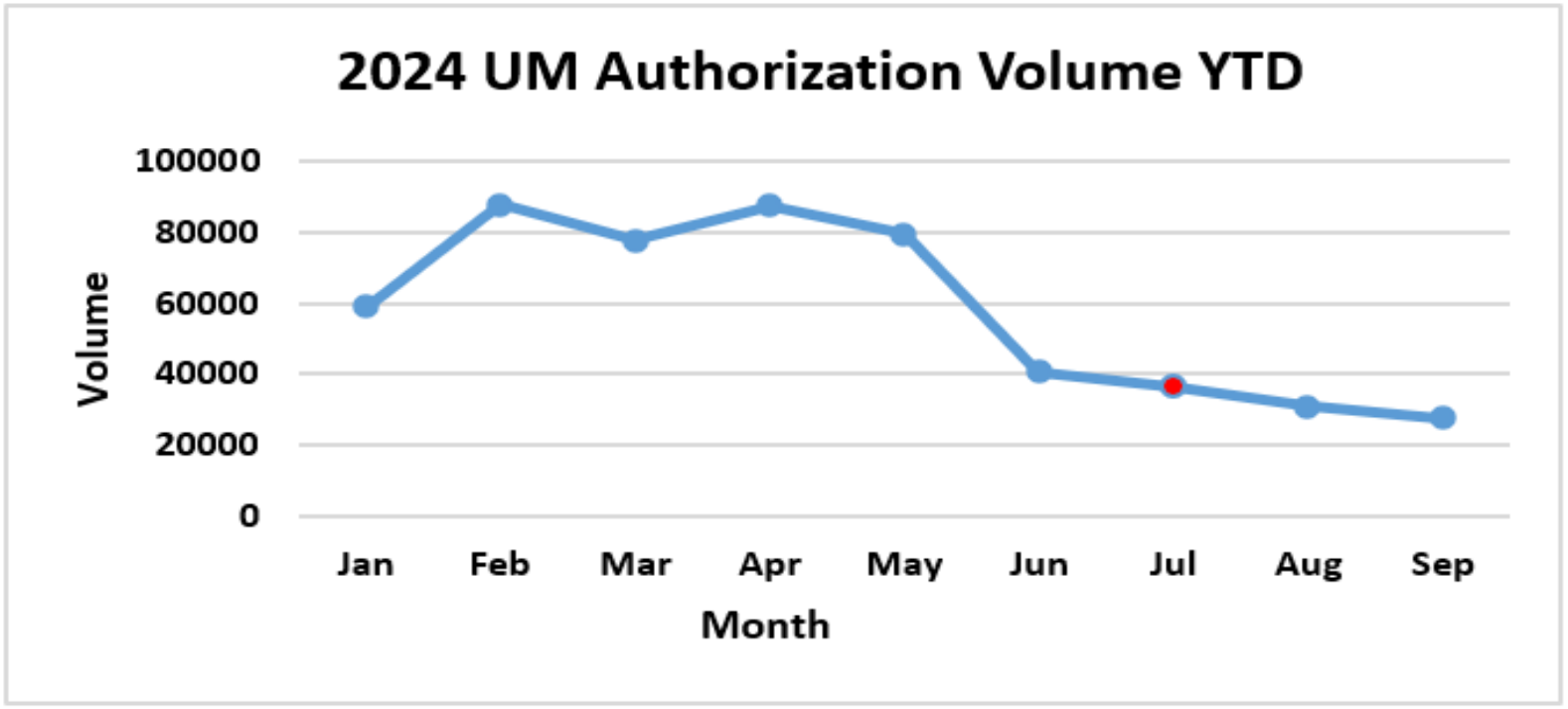
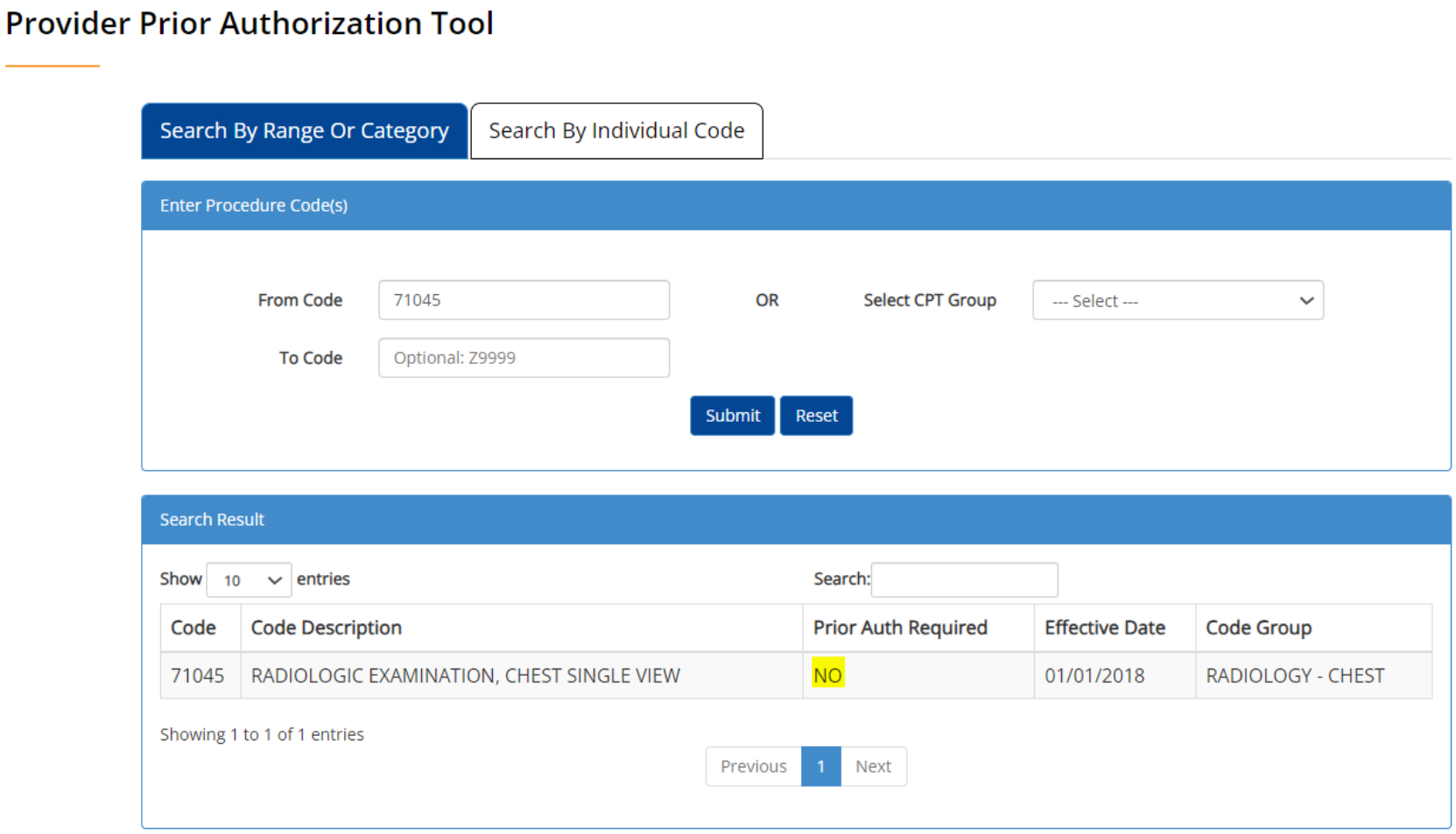


We are receiving approximately ***7,500 auth requests a month for services/items that do not require prior authorization***. This amounts to approximately ***1,000 hours*** of unnecessary manual work.

Streamlining and reducing administrative burden cannot be achieved without your cooperation!

Important Reminders- No Auth Required

Please do not send the UM prior auth request to L.A. Care when the online provider prior authorization tool states an auth is not needed for in-network services. ***An authorization will not be provided.***



Important Reminders- DME and Medical Supplies

To ensure smooth review and processing of the authorization and claim, please ***specify the number of units requested for the 3-month timeframe*** of the auth.

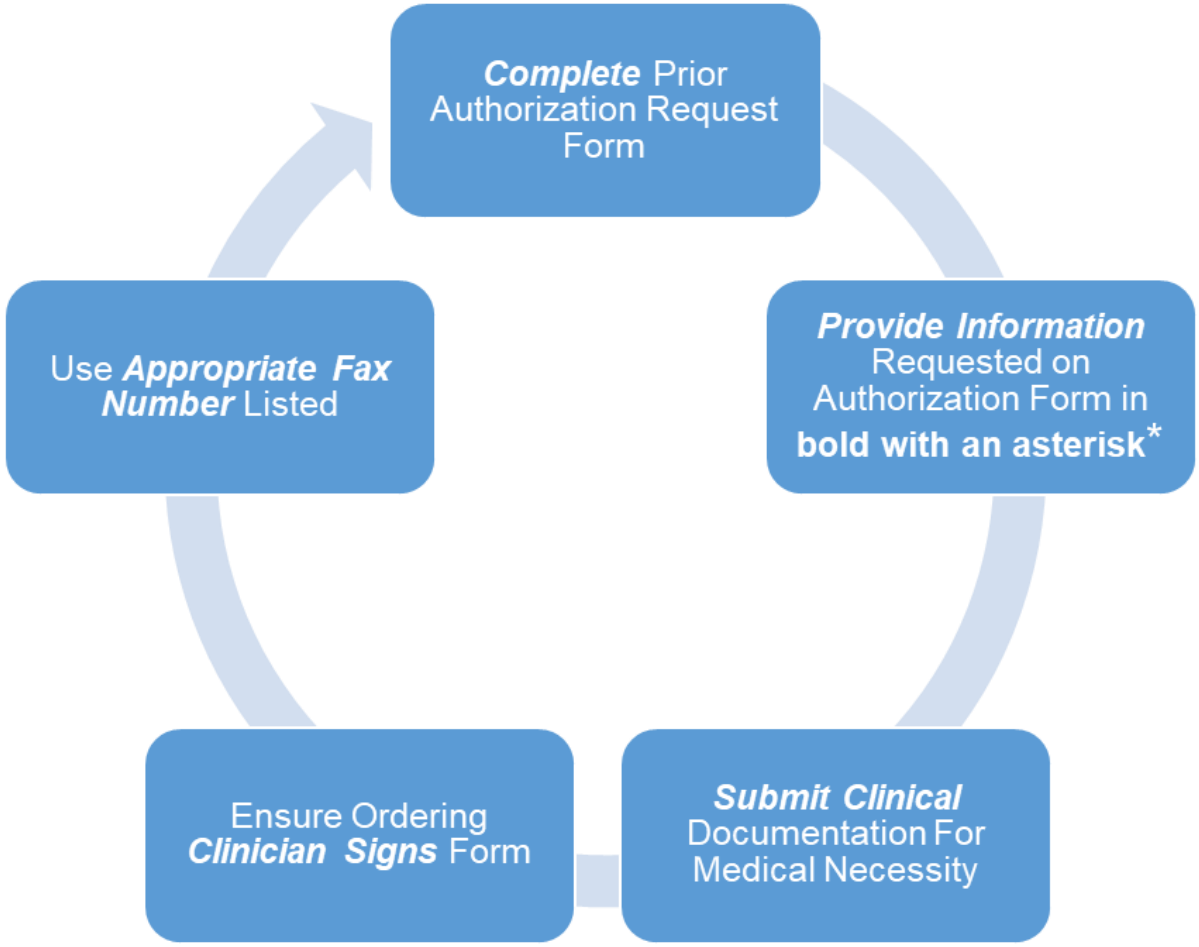
Example: The UM prior auth request is for a standard wheelchair (K0001).

- If Rental: Use RR modifier with 3 units (K0001 x 3 with RR). 1 unit reflects each month.
- If Purchase: Use NU modifier with 1 unit (K0001 x 1 with NU).

Important Reminders- All UM Prior Authorization Requests

To ensure efficient review and processing of the UM prior auth, please complete ALL required fields on the UM request form before submitting it to L.A. Care.

**** Incomplete or missing information (i.e., such as requested provider or procedure codes) and duplicate requests may cause delays.***

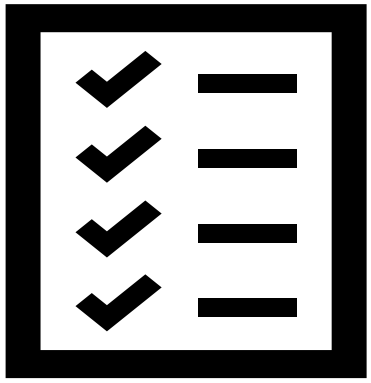


Summary

- ✓ ***Check the Provider Prior Authorization Tool PRIOR to submitting the request:***
  - https://www.lacare.org/providers/provider-prior-authorization-tool
  - If no authorization is required, please do NOT submit to L.A. Care

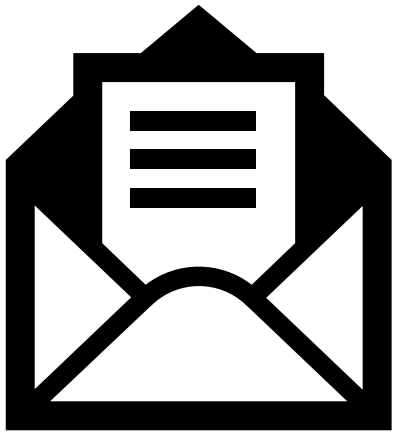
- ✓ ***Specify the number of units requested for the 3-month timeframe of the auth to ensure smooth review and processing of the authorization and claim.***

- ✓***Complete ALL required fields on the UM prior auth request form before submitting it to L.A. Care.***



UM Resources

- Please reach out to your ***Provider Representative*** for concerns or issues.
- ***Contact Utilization Management*** via the general mailbox e-mail address for process inquiries at UM_Operations_Mailbox@lacare.org



Kelly Frost, Director
Utilization Management

L. A. Care Utilization Management - Inpatient

Administrative Day Authorization Requests

*Applies to MCLA Line of Business Only

Form Submission Requirements

1. Use the "Hospital Review Priority Type of Clinical Service Requested" form.
2. Complete the following steps:
    a. Mark "Administrative Days Request.“
    b. Include the Acute Inpatient Reference Number or Document ID number.
    c. Specify the dates of service for which administrative days are requested.
    d. Attach clinical records that support the medical necessity for the requested administrative days.

Form Submission Process

1. Fax the completed form to L.A. Care at (213-438-5063).
2. The UM department will handle the request as part of the retrospective review process.
3. A new Reference number or Document ID number will be generated for the administrative days request.

Eligibility Criteria

1. To qualify for administrative days, the acute inpatient dates of service must have been denied for not meeting medical necessity.
    - If acute inpatient days are approved, the same dates of service cannot also be approved for administrative rates.

Administrative days will not meet criteria for approval if any of the following apply.

1. Lack of timely discharge planning
2. No documentation of placement efforts
3. Social/family issues which delay or prevent placement
4. Patient accepted to nursing facility, but placement/transfer delayed while awaiting legal conservatorship
5. Patient does not require nursing facility level of care.
6. Placements that do not qualify include:
    a. Congregate Living Health Facility
    b. Homeless shelter/Recuperative Care
    c. Respite care center
    d. Board and care facility

Acute Inpatient Care Criteria and Adverse Determination Response Options

We utilize MCG guidelines to assess and review requests for acute inpatient levels of care.

- If an adverse determination is made, our Notice of Action letter will inform the provider that they have the opportunity to request a peer-to-peer discussion with our physician reviewer. This request must be received within seven days of the Notice of Action by calling 213-694-1250, ext. 4277.

- Providers may submit a written appeal by completing the appropriate form or sending a letter to the following address:

  L.A. Care Health Plan
  Member Services Department
  1200 W. 7th St
  Los Angeles, CA 90017
  Fax: 213-438-5748

Inpatient Department Contacts
Main Phone number 213.694.1250

Director Kelly Frost Ext 6329

Email: KFrost@lacare.org

Manager Nicole Ross Ext 6890

Email: NRoss@lacare.org

Inpatient & Provider Dispute Review

Supervisor Audrey Gordon-Henderson Ext 6370

Email: agordon-henderson@lacare.org

Inpatient & Discharge Planning

Supervisor Yvette Taylor Ext 6484

Email: YTaylor@lacare.org

Post Stabilization and Higher Level of Care Transfer

Supervisor Mary P. Herbek Ext 7334

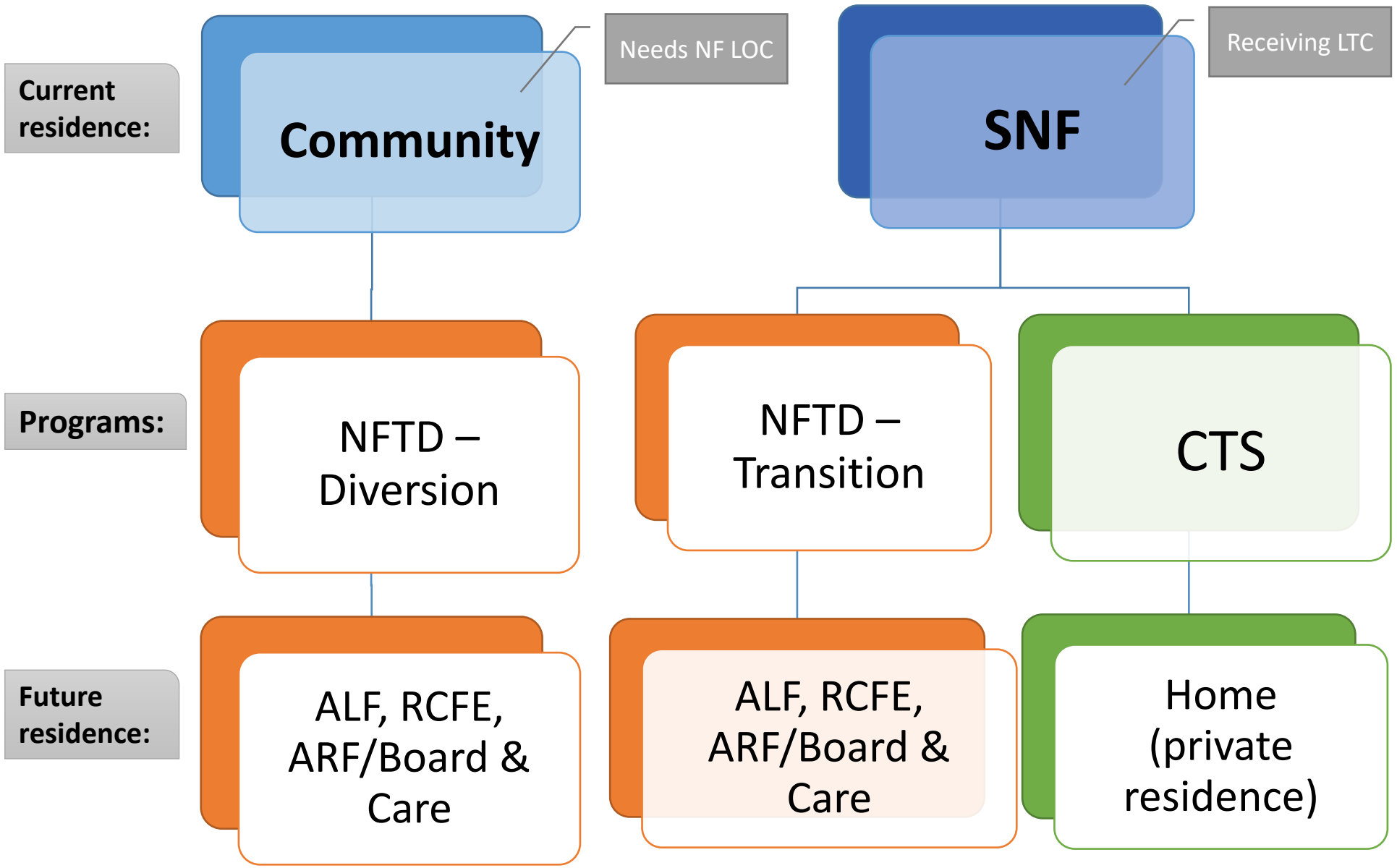
Email: MHerbek@lacare.org

Dawn Knotts, Manager – Skilled Nursing Managed Long Term Services and Supports

- Nursing Facility Transition or Diversion to Assisted Living Facility

Nursing Facility Transition/ Diversion (NFTD) to Assisted Living Facilities

Nursing Facility Services



NFTD to ALF Overview

- ***Effective 1/1/2024*, Nursing Facility Transition/Diversion (NFTD) to:**
  - ASSISTED LIVING FACILITIES (e.g., ALF, RCFE, ARF).

- **NFTD** services assist Members to live in the community and/or avoid institutionalization when possible.

- **TRANSITION:**
  - Facilitate nursing facility transition back into a home-like, community setting

- **DIVERSION:**
  - Prevent skilled nursing admissions for Members with an imminent need for Nursing Facility Level of Care (LOC).
  - Members have a choice of residing in an ALF setting as an alternative to LTC placement when they meet eligibility requirements.

NFTD to ALF : Eligibility Criteria & Restrictions/Limitations

Nursing Facility Transition

- Member has resided in a nursing facility for at least 60 days; AND
- Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; AND
- Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports

Nursing Facility Diversion

- Member is interested in remaining in the community; AND
- Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; AND
- Member must be currently receiving medically necessary nursing facility Level of Care (LOC) or meet the minimum criteria to receive nursing facility LOC service and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary facility LOC services at an Assisted Living Facility (ALF)

NFTD to ALF: Eligibility Criteria & Restrictions/Limitations

Restrictions/Limitations

- Members receiving NFTD to ALF Services are directly responsible for **paying their own living expenses**
- CS Services shall supplement and not supplant services received by the Member through other State, local, or federally-funded programs in accordance with the CalAIM STCs and federal and DHCS guidance

Member Sample: NFTD

Meet Ray

- Ray lives in an apartment on the 3rd floor and is unable to get a unit on a lower level. Lately, he has had a decline in health and is only able to ambulate 5 feet.
- He also has difficulty remembering to take his medications and often skips his medications for days at a time.
- He has done physical therapy at home and had a caregiver, but he still needs 24/7 assistance.
- He does not want to live in a nursing home but feels like this may be his only option. Ray reached out to LAC for assistance.

Program Intervention

- A referral was made for the NFTD program. The NFTD vendor outreached to Ray and discussed alternative options to divert from nursing home placement.
- Vendor assisted Ray in applying for the Assisted Living Waiver (ALW). Once Ray was approved, the vendor helped find an **assisted living facility** and arranged his move.
- He remains in a community setting and gets the appropriate care and monitoring. Ray is able to keep much of his independence while receiving the support he needed.

Anjanette Collaso, Program Manager III
Managed Long Term Services and Supports

- **Community Transition Services**

Community Transition Services (CTS)

CTS Overview

- ***Effective 1/1/2024,*** **Community Transition Services (CTS) to HOME**
- ***CTS*** helps Members to live in the community and avoid further institutionalization:

> - **TRANSITION:** non-recurring set-up expenses for individuals who are trasitioning from a SNF to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

CTS Services and Exclusions

❑ Services Covered under CTS

- ✓ Assessing the Member's housing needs and presenting options.
- ✓ Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- ✓ Communicating with landlord (if applicable) and coordinating the move.
- ✓ Establishing procedures and contacts to retain housing.
- ✓ Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
- ✓ Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

CTS Eligibility

- *Member is currently residing in a Nursing Facility or Medical Respite setting for **at least 60 days**; AND*
- *Member is currently receiving medically necessary Nursing Facility Level of Care services AND*
- *Member is interested in moving back to the community **choosing to transition to a home setting** in lieu of remaining in the Nursing Facility AND*
- *Member is **able to live safely in the community** with appropriate and cost-effective supports AND*
- *Member is willing to **pay for their own living expenses***

Community Transition Services

CTS: Eligibility Criteria & Restrictions/Limitations

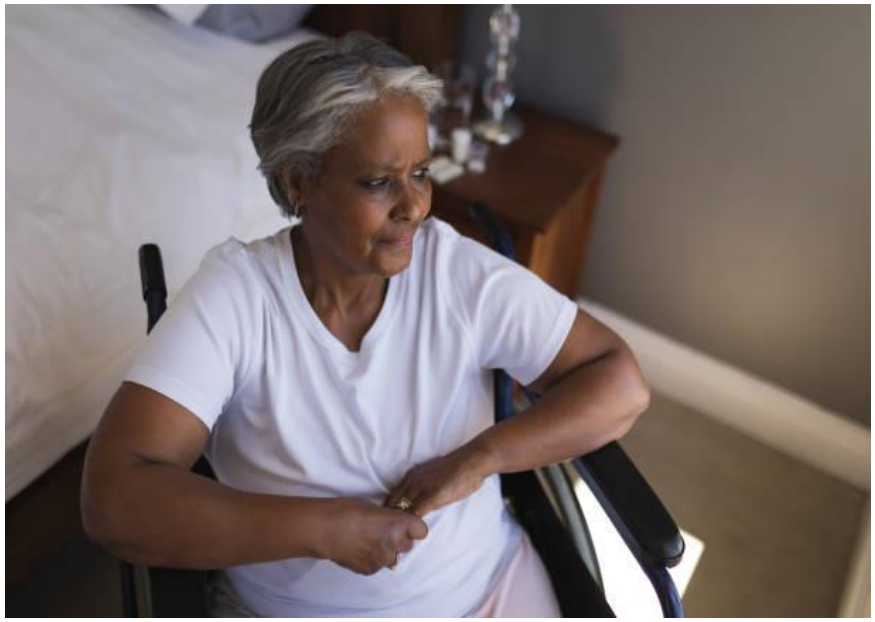
Restrictions/Limitations

- CTS does not include monthly rental or mortgage expense, food, regular utility changes, and/or household appliances or items that are intended for purely diversionary/recreational purposes
- CTS are payable up to a lifetime maximum amount of $7,500.00. The only exception to the Lifetime Maximum is if the Member is compelled to move from a Provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond the Member's control
- CTS must be necessary to ensure the health, welfare and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization

Member Sample: CTS

Meet Ava

- Ava is a 63 years old and has been a long term care (LTC) resident at ABC skilled nursing facility. She had a stroke 5 years ago and has had some physical and occupational therapy; however, she requires extensive assistance with her activities of daily living and medication management.
- She has now regained some of her strength but still needs some assistance with meal preparation and set up for her activities of daily living. She wants to return to her home but will require assistance with her ADL's and IADL's. Ava also utilizes her wheelchair when she goes to appointments and will require some home modifications.
- The Social Worker at the SNF submitted the SAR to LAC for Nursing Facility Transition services.



Program Intervention

- The NFTD vendor reached out to Ava and they created a plan to ensure Ava has all of the necessary resources in place for a safe discharge back to the community.

NFTD and CTS Referrals

NFTD & CTS Process

Submit SAR form to L.A. Care via fax

Request will be reviewed for completeness and clinical review by MLTSS RN for determination and processing

Authorization Letter will be sent to NFTD/CTS Vendor for transition coordination

Vendor will do outreach to SNF CM and/or member

If member meets criteria, Vendor will begin coordination to find placement in **ALF, RCFE, ARF (NFTD) or Home/Private Residence (CTS)**

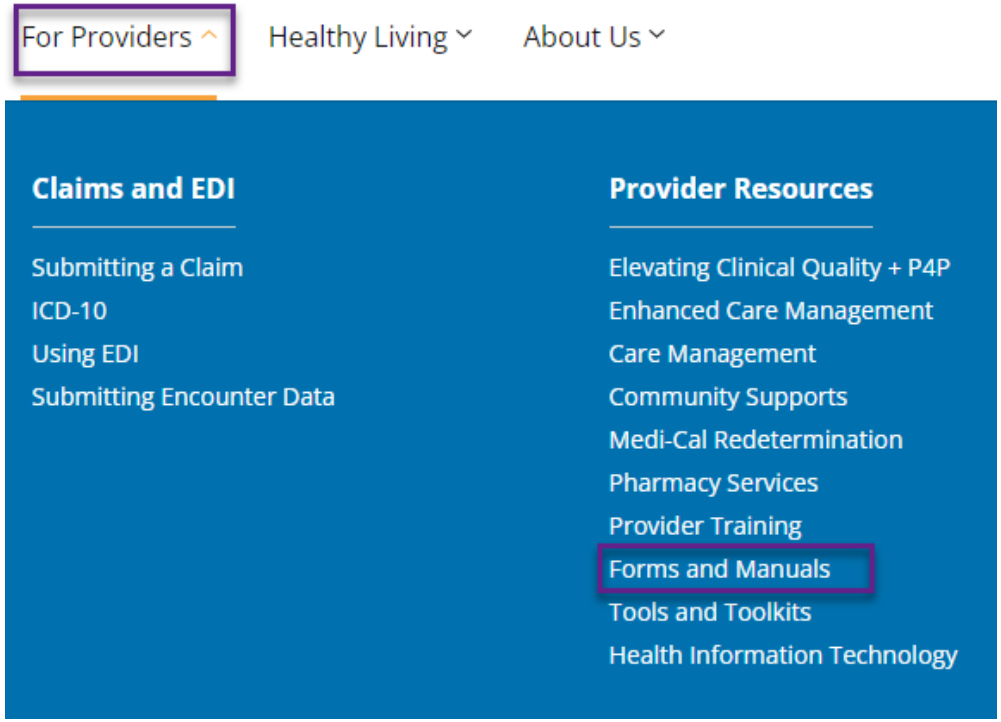
If applicable, SNF to coordinate DC with L.A. Care MLTSS RN

Upon DC, SNF to submit ***MC171*** form to ensure enrollment change to community PPG

NFTD/CTS Referrals

SAR Forms

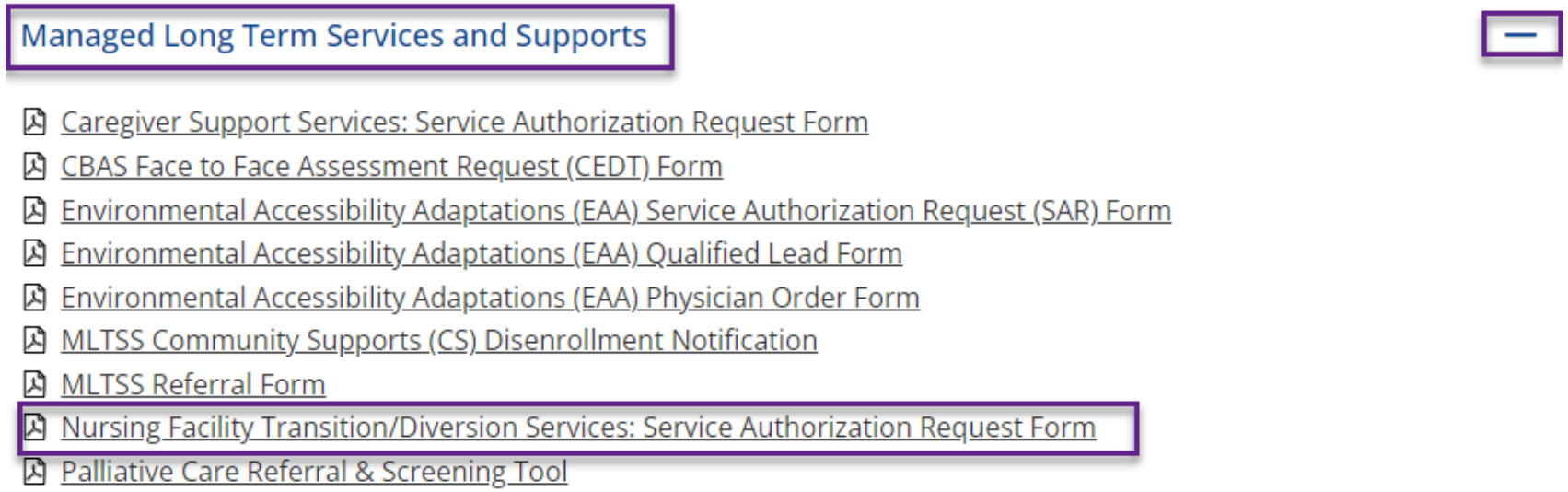
- Complete the SAR Request Form
  - ❑Download from L.A. Care Website: Manuals and Forms | L.A. Care Health Plan (www.lacare.org)
  - ❑Select For Providers menu drop down
  - ❑Select Forms and Manuals library



NFTD/CTS Referrals

SAR Forms Continued…

- ❑Expand Managed Long Term Services and Supports list
- ❑Access the ***Nursing Facility Transition/Diversion Services: Service Authorization Request Form***



CS Housing Updates

Housing CS Overview

L.A. Care HEALTH PLAN®

For All of L.A.

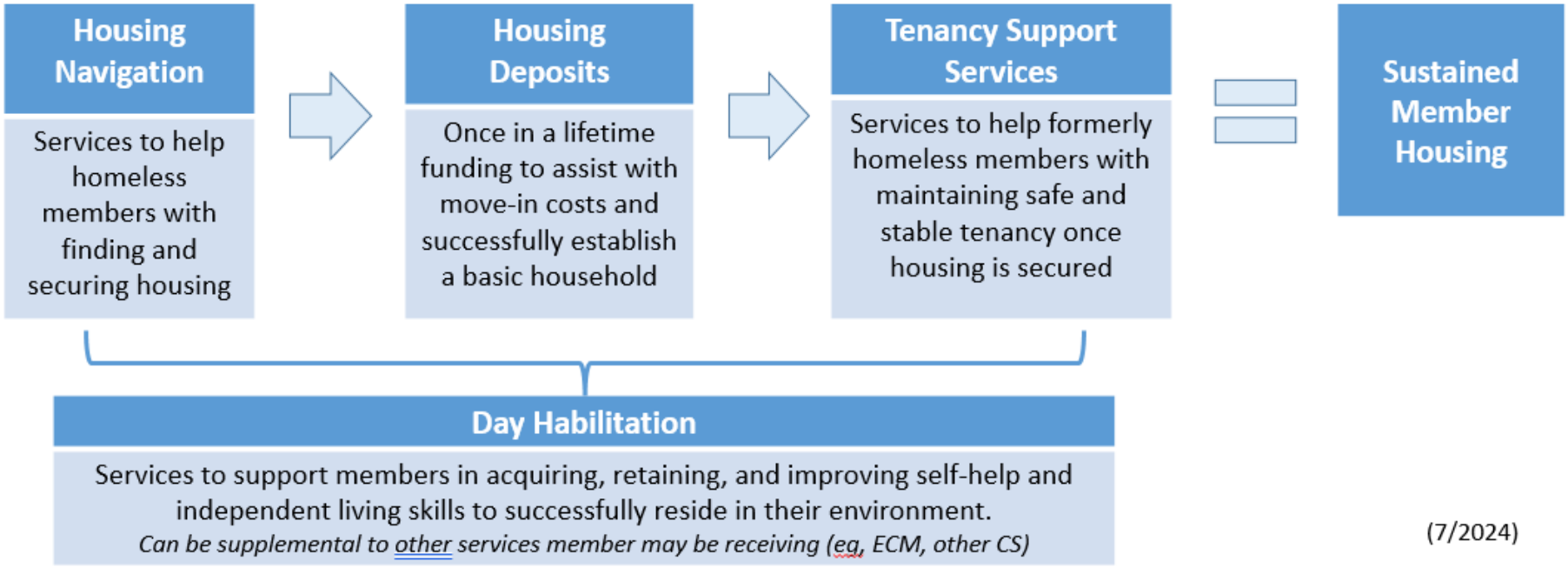
Housing Navigation, Tenancy Sustaining Services, Housing Deposits, and Day Habilitation

October 2024

L.A. Care's Housing Continuum of CS Services

L.A. Care's housing continuum of CS services available to our eligible members includes:

- Housing Navigation
- Tenancy Sustaining Services
- Housing Deposits
- Day Habilitation



(7/2024)

Eligibility:

- Must be an L.A. Care Medi-Cal or DSNP member

CS Housing Trio

L.A. Care offers Members the CS Housing Trio, which includes: Housing Navigation (HN), Tenancy Sustaining Services (TSS), and Housing Deposits (HD)

Housing Navigation: Services to help homeless members find housing

- Services include: Screening and Housing Assessment, Individualized Housing Support Plan (ISP), Locating Housing for Members, Applications and Documentation Assistance, Benefits Advocacy, Identifying and Securing Resources for Housing Expenses, Landlord-Related Services

Housing Deposits: To support members who are moving into permanent housing

- Services include: Assistance with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board

Tenancy Sustaining Services: Services to help formerly homeless members maintain safe and stable tenancy once housing is secured

- Services include: Individualized Housing Support Plan, Housing Retention, Landlord-Related Services, Connection to Community Resources, Benefits Advocacy, Life Skills

Eligibility

- HN/TSS Eligibility
- Housing Deposits & Eligibility

HN/TSS: Referrals and Authorization

1. Eligible Referrals Identified
2. HHSS Authorization Form completed
3. Form submitted to L.A. Care for review

If Approved:

- Member enrolled into HN or TSS for an initial 12-months of service
- Member enrolled with a contracted Provider
- Authorization letter sent to referring agency, assigned provider, and Member

If Denied: Denial letter sent to referring party and Member

Re-Authorization

HN/TSS Re-Authorization provides authorization for an additional 6-months of service for Members determined to require continued support

1. Providers assess Member's continued need and progress
2. Re-Authorization requests must be submitted 30-60 days prior to end of current authorization

HD: Referrals and Authorization

HD Eligibility:

- Member must be enrolled in HN with a Provider also contracted for HD; and
- Member must be in the process of moving into permanent housing; and
- Member is unable to meet requested initial move-in costs/expenses

Request for Funds Form (RFF):

1. Eligible Members Identified
2. HD Request for Funds Form completed and submitted for review, including total funds requested (identified expenses/services)
3. If approved, Member authorized and enrolled into HD for 6-mos
4. Decision letter sent to provider and Member

Revised RFF:

Providers may submit a revised RFF for additional needs identified after initial RFF approval (if not exceed allowable $6,000 total)

Second Round HD: May be considered

Day Habilitation Programs

- Day Habilitation Programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.

- Day Habilitation Program services include, but are not limited to, trainings and support related to:
  - Housing support
  - Independent living skills development
  - Personal skills development
  - Financial management skills development
  - Employment support

- Day Habilitation services may be provided supplemental to other services Member may be receiving, including ECM and Community Supports

More on Day Habilitation & Eligibility

Day Habilitation: Referrals and Authorization

1. Eligible Referrals Identified
2. Day Habilitation Authorization Form completed
3. Form submitted to L.A. Care for review

If Approved:

- Member enrolled into Day Habilitation for an initial 6-months of service
- Member enrolled with a contracted Provider
- Authorization letter sent to referring agency, assigned provider, and Member

If Denied:

- Denial letter sent to referring party and Member

Re-Authorization

Day Habilitation Re-Authorization provides authorization for an additional 6-months of service for Members determined to require continued support

1. Providers assess Member's continued need and progress
2. Re-Authorization requests must be submitted 30-60 days prior to end of current authorization

Pharmacy Updates

Physician Administered Drugs (PADs) Criteria Update

- This is an update for any Physician Administered Drugs (PADs) that are subject to L.A. Care's Utilization Management authorization review (L.A. Care risk).

- Beginning **9/30/24**, Navitus Criteria will be added to the review hierarchy for Physician Administered Drugs. This will be implemented for drugs already requiring medical necessity review.

- Beginning **1/1/25**, specific J-codes will require medical necessity review. These J-codes will be subject to the current review hierarchy including the newly implemented Navitus criteria for PADs. J-codes will be reviewed and added to this list on a quarterly basis with respective criteria. For general inquiries, please reach out to drugcoverage@lacare.org (please refrain from sending PHI).

Q & A