MEDI-CAL PROVIDER EDUCATION

SUBJECT: Long-Term Services and Support

PURPOSE: To provide guidelines for referring members who qualify for Long-Term Services and Support

DEFINITION: Long Term Services and Supports (LTSS) help elderly individuals and/or individuals with disabilities with their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in the homes and communities, but also in facility-based settings such as nursing facilities.

These services are defined as follows:

- Multipurpose Senior Services Program (MSSP)
- In Home Support Services (IHSS)
- Community-Based Adult Services (CBAS)

PROCEDURE:

I. **Multipurpose Senior Services Program (MSSP):** helps frail, elderly Medi-Cal members remain in their homes and avoid admission into hospitals or nursing homes

Eligibility requirements

- Be certifiable for placement in a nursing facility (member would otherwise be in a nursing facility)

- Be age 65 or older

- Receive Medi-Cal under an appropriate aid code (1D, 2D, 6D, 1E, 2E, 6E, 1X, 1Y, 10, 14, 16, 18, 1H, 20, 24, 26, 28, 60, 64, 66, 68, 6H)

- Not have a Medi-Cal share of cost

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- Be able to be served within MSSP's cost limitations
- Be appropriate for care management services

Referral Process

If a member and or PCP fines that a member will benefit from MSSP services,

- Member/Provider/family member calls MSSP by county to speak with MSSP Intake Coordinator and provide Medi-Cal ID number with issued date, Social Security number, Date of Birth, patient's symptoms, and PCP information.
- Depend on each county – Patient may be put on waiting list and an intake coordinator will advise the member of the approximate wait time.
- MSSP Social worker/case manager will contact the member for phone assessment, schedule for home visit assessment, and will enroll member on the same day for home visit.
- Member needs to contact the assigned county of MSSP case manager/social worker to follow up on the status of the request
- Member will be notified by the MSSP social worker of the approval or denial.

II. **In-Home Supportive services (IHSS):** The objective of the IHSS program is to allow eligible individuals to live safely at home in the least restrictive living environment.

Eligibility Requirements

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- Be disabled, blind or age 65 years or older
- Be unable to live at home safely without help
- Meet the program's financial need requirements
- Member is able to self-direct their care – choose to hire, train, supervise, and if necessary fire the personal assistant.

Referral Process

If a member and or PCP fines that a member may benefit from IHSS services,

- Provider or member contacts Department of Social Services (DPSS) who will transfer requester to the IHSS Intake Unit. See references for IHSS website links.
- Member can also visit their local County Social Services agency to verify eligibility and begin the application process.
- The Personal Assistance Service Council (PASC) assists members with finding homecare workers and provides other support services for IHSS members. They can be reached at **(877) 565-4477**.
- When the application is received by the IHSS county office, the request will be entered into CMIPS database, and will be assigned to a social worker.
    - The IHSS Dept. will mail out Health Certification Form to member to fill out by the doctor
    - The application form must be returned back to the county prior to the authorization of services or the application process cannot continue until the physician has completed it.
- If the member fits Medi-Cal eligibility, an assigned social worker will contact the patient to schedule a home visit to perform face-to-face "needs assessment" to determine member's eligibility and need for IHSS, and number of hours that the county will authorize.
    - Member will be notified for approval with number of hours per month or denial with reason.

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- If patient does not have full scope or Medi-Cal eligibility, patient is referred to county Medi-Cal staff for Medi-Cal eligibility determination.
- If approved for IHSS, member must hire someone to perform the authorized services. Member may contact the assigned worker to determine the IHSS hourly rate in member's county.
- If denied by IHSS, patient is referred to community resources.

  ***For IHSS and MSSP, If the member in question is a Molina Medi-Cal member : Provider can contact Molina Case Management Department at (800) 526-8196, ext.127604 or by email to MHCCaseManagement@MolinaHealthCare.com to make a referral and request assistance in referring the member for MSSP and other community resources.

  ***If the member is an Anthem Medi-Cal member: Provider must call Anthem LTSS Dept. at (855) 871-4899 or contact by email: LTSSProviders@anthem.com to refer the member.

III.   Community based Adult Services (CBAS):

CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CBAS services include: an individual assessment; professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; a meal; nutritional counseling; and transportation to and from the participant's residence and the CBAS center.

Eligibility requirement

- Must be enrolled in the Medi-Cal program with the Health Plan

- Must be at least 18 years of age or older, or a senior or person with disabilities (SPD)

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- Meet certain nursing facility level A requirements

- Have brain injuries or chronic mental health conditions

- Have Alzheimer's disease or other dementia

- Have mild cognitive impairment

- Have a developmental disability

Referral Process

a. **Health Net**

- CBAS center admission coordinator needs to submit an authorization with History & Physical from PCP office by fax to **818-479-0473** (Health Net Partners in Care Foundation **888-370-6777**).
- Assigned case manager needs to call member to schedule for face-to-face interview/assessment at the CBAS center within the 14 days.
- After conducted the interview at the center, the case manager will either send the approval to the CBAS center with notification as well or notify the center or member regarding the denial.
- Whole process is between the CBAS center and the assigned case manager.

b. **CalOptima and LA Care**
- Patient can visit the local CBAS center, schedule a tour with that center, and go through eligibility process with admission department at the center.
- CBAS center needs to fill out a Benefit Inquiry form for the patient and the center needs to fax it back to REGAL so as to verify eligibility, the social worker, will then call the patient for phone assessment.
- The case will be forwarded to the nurse case manager/social worker to visit the selected CBAS center for assessment with member.

c. **Molina**
- Provider needs to submit a referral to Molina or fax the referral request form for

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the CBA to Molina.   <u>Complete & fax CBAS Request</u> for Services Form to: **(866) 811-4804.**

- Member can refer themselves to local CBAS center and the admission coordinator at center needs to submit an authorization request along with needed medical record to Molina's Utilization Management Dept.
- Utilization Management Dept. will review the case to see if member is eligible and determine how many day/hours per week the member qualifies for.
- Case Manager will contact the member/requesting provider/the CBAS center for the status or request for further information needed.
- Once patient is approved for CBAS, Molina will send patient a list of places that patient can go for CBAS (if patient never picked one).
- For more information or if you have any questions, <u>please call Molina Utilization Management Department at: **(800) 526-8196** or Member Services Department at **(888) 665-4621**</u>.

d. Anthem Blue Cross
- To begin the referral process, please contact Anthem's Member Services Dept.
- CBAS providers must obtain an authorization from Anthem.
- Patient can visit the local CBAS center, schedule a tour with that center, go through eligibility process with admission department at the center, and CBAS will follow up with Anthem for authorization.
- Request is must come from the center instead of PCP office so PCP must provide CBA locations to member.
- CBAS center will submit 3 days assessment to evaluate the member – submit a referral to Anthem (turnaround time usually 1 week).
- After the 3 days assessment is approved by Anthem, CBAS center will notify member to come in to evaluate member's needs based on diagnosis and the number of days patient needs per week.
- CBAS center will send a 2nd authorization request with the IPC – Individual Plan of Care, back to Anthem CBAS unit for case manager to determine patient's eligibility based on the IPC the number of days per week will be determined.

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- Once the authorization is approved, the nurse from Anthem will come to the CBAS center to interview the patient (face-to-face assessment) and enroll the patient to that CBAS center officially.

***Provider may also submit and authorization with REGAL to refer member for coordination of services. PCP can fill out the online authorization form located at **www.regalmed.com** under the provider section with their **Regal Express Access**

References

MSSP County List - http://www.aging.ca.gov/ProgramsProviders/MSSP/Contacts/

MSSP Overview - http://www.aging.ca.gov/ProgramsProviders/MSSP/Program_Overview.aspx

IHSS Overview - http://www.cdss.ca.gov/agedblinddisabled/pg1296.htm

IHSS County List - http://www.cdss.ca.gov/agedblinddisabled/PG1785.htm

CBAS Providers - http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/CBAS_Providers/Default.aspx

CBAS Information - http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/

LA CARE LTSS – (213) 694-1250, ext.5422 or email to ltss@lacare.org

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