Cal MediConnect (CMC) Model of Care 2018

A Comprehensive Annual Training for Health Net Providers and Associates

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Health Net®

Learning Objectives

By the end of this training, participants will be able to:

1. Describe Duals Population

2. List two goals of the Cal MediConnect Model of Care

3. Define the Interdisciplinary Care Team (ICT) and the three required disciplines

4. Describe enrollee participation in the development of the individualized Care Plan and Interdisciplinary Care Team

5. Name two added benefits for Cal MediConnect enrollees

6. Identify two processes that improve coordination of Care Transitions

7. Give three examples of data collected to evaluate Cal MediConnect plans as part of the Cal MediConnect Quality Improvement program

Presentation Overview

This Annual CMC Model of Care Training will cover:

- Cal MediConnect General Information

- Goals of the Model of Care (MOC)

  - Coordination of Medicare and Medi-Cal

  - Person Centered Care

  - Culturally Responsive Care

    - Accessibility and Accommodations

- Roles and Responsibilities

- Interdisciplinary Care Team

- Provider Network and Integrated Communications

Presentation Overview (cont.)

- Additional Benefits
- Case Management
    - Health Risk Assessments
    - Individualized Care Plan
    - Care Transitions
    - Long Term Services and Supports (LTSS)
        - In Home Supportive Services (IHSS)
        - Community Based Adult Services (CBAS)
        - Multipurpose Senior Services Program (MSSP)
        - Long Term Care (LTC)
- Behavioral Health
- Quality Improvement Program

Cal MediConnect General Background

Cal MediConnect – in a nutshell

What
- Mandatory enrollment into a Medi-Cal health plan
- Mandatory transition of Medi-Cal Long Term Services and Supports (LTSS) to Medi-Cal health plans
- A voluntary demonstration for individuals covered by both Medicare and Med-Cal (Dual Eligible)

Who
- Dual eligibles (including 21+, excluding partial duals, developmentally disabled, certain 1915 (c) waiver participants, etc.)
- Medi-Cal only (Seniors & Persons with Disabilities and other applicable aid codes)

Where
- 7 counties: Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara, and Orange (Alameda County is no longer participating)

When
- Passive enrollment in 2014
- Streamlined enrollment is currently allowed

Why
- Improve the coordination of care across the spectrum (physical, behavioral and social services)
- Improve quality of care and service

Dual Eligible Background

- Over 1.2 million Medi-Cal beneficiaries are enrolled in both Medicare and Medi-Cal in California and are referred to as dual eligibles.

- Beneficiaries are more likely to have:
  - A behavioral health disorder
  - Limitations in activities of daily living, and
  - Multiple chronic conditions like:
    - Asthma/Chronic Obstructive Pulmonary Disease (COPD)
    - Diabetes
    - Hypertension
    - Congestive Heart Failure

- Few beneficiaries are served by coordinated care models and even fewer are in integrated models that align Medicare and Medi-Cal.
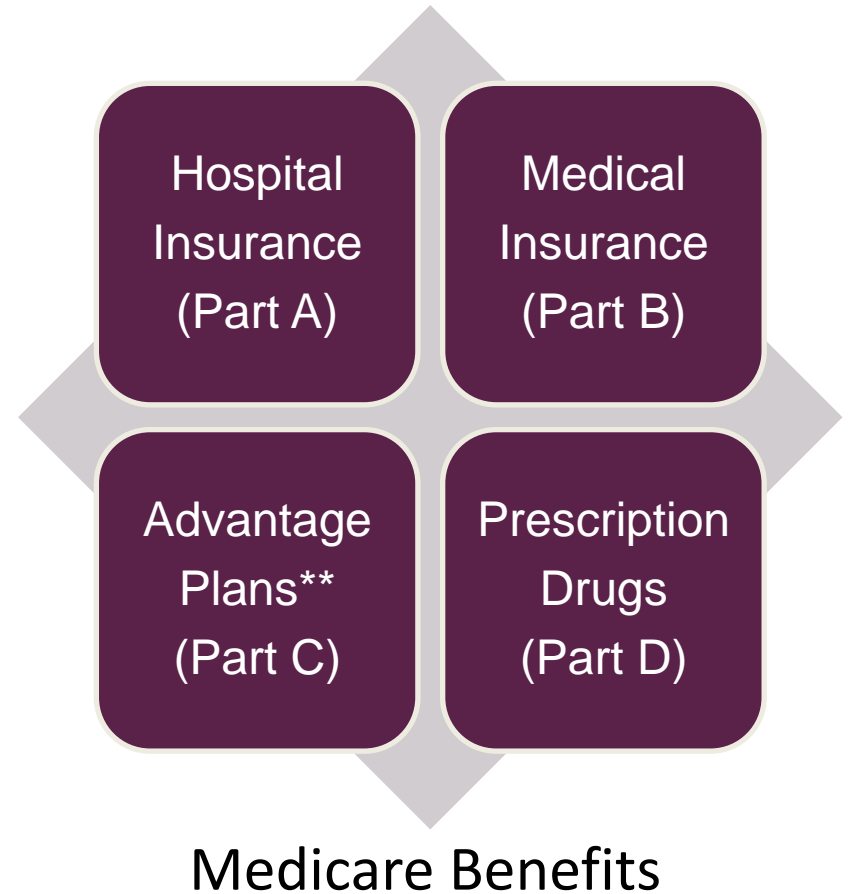
Dual Eligible Background (cont.)

- Medicare is the primary payer for dual eligibles and covers health services, such as physician and hospital services and short-term skilled nursing.

- Medi-Cal is the secondary payer and typically covers Medicare cost sharing and services not covered by Medicare, as well as services delivered after Medicare benefits have been exhausted.

- Most long term care costs are paid for by Medi-Cal including longer nursing home stays and home and community based services designed to prevent institutionalization.

Cal MediConnect Categories

At Health Net, there are 3 categories that Dual Eligible members may fall into:

Full Duals	Enrollee will have both Medicare (Parts A/B and be eligible for Part D) and Medi-Cal
Partial Duals	Enrollee has Medi-Cal and Medicare A **or** B (does not qualify for CMC)
Opt-Out	Enrollee who is Full Dual eligible, but who elects not to participate in the demonstration (opts out of Cal MediConnect, but is still enrolled for Medi-Cal Managed Care)

Hospital Insurance (Part A)

Medical Insurance (Part B)

Advantage Plans** (Part C)

Prescription Drugs (Part D)

Medicare Benefits

**Medicare Advantage plans are also known as Medicare Part C, which are Medicare-approved private health insurance plans for people enrolled in Medicare Part A and Part B.

Cal MediConnect Model of Care

Includes:

- Specialized Provider Network

- Integrated Communication Systems

- Additional Benefits

- Case Management for All enrollees

- Annual Health Risk Assessments

- Individualized Care Plan for each enrollee

- Interdisciplinary Care Team to Coordinate Care

- Management of Care Transitions

- Coordination of Medicare And Medicaid Benefits

- Least Restrictive Care Settings via Long Term Services and Supports (LTSS)

- Quality Improvement Program

Background:

- 58 year old enrollee with cognitive disabilities and a behavioral health diagnosis

- Current medical problems include: Chronic Obstructive Pulmonary Disease (COPD), obesity, and hypertension

- Enrollee resides in a Board and Care facility without appropriate support system

- Hospitalized twice for COPD during the past 4 months as a result of non-adherence with treatment plan

- Enrollee has not seen Primary Care Physician in over a year, but has seen Psychiatrist

- Enrollee's continued residence at the facility is at risk due to the enrollee's inability to comply with the treatment plan

Hypothetical Case Scenario (cont.)

Examples will be given throughout the training help illustrate how this model will be delivered

Interventions:

The Case Manager, who is a member of the interdisciplinary care team (ICT) will have a discussion with the enrollee and will arrange for the following:

1. Behavioral health, primary care, and pulmonology appointments
2. Transportation to all medical appointments
3. Medication reconciliation by a pharmacist
4. Nutritional counseling
5. Advance Directives
6. Additional community resources for support

Hypothetical Case Study (cont.)

An Integrated Care Plan (ICP) will be developed based on these interventions, and may include Home Health Care or services if the enrollee's behavioral health disorder does not interfere.

Goals: The goals would be to:

1. Establish an Integrated Care Plan that would stabilize the enrollee's acute medical condition

2. Establish a behavioral health treatment plan

3. Assist enrollee's ability to maintain residence at the Board and Care Facility

4. Establish ICT team makeup and receive approval from enrollee

Goals of the Cal MediConnect Model of Care

Goals of Cal MediConnect

As established in a partnership between the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS), the primary goal is to improve health outcomes by:

1. Improving access to essential services such as medical, mental health, Long Term Services and Supports(LTSS), and social services.

2. Increasing access to affordable care by optimizing utilization of home and community-based services (HCBS).

3. Providing coordination of care through an identified point of contact and medical home.

4. Creating seamless transitions of care across health care settings, providers and HCBS.

5. Preserving and enhancing the ability of consumers to self-direct their care and enable Dual Eligible enrollees to remain in their homes and communities.

Goals of Cal MediConnect (cont.)

- Through Case Management, Health Net strives to support the enrollee's desire to self direct care, help the enrollee regain optimum health and improve functional capability in the right setting and most cost effective manner.

- Health Net will measure outcomes to monitor goals using metrics collected through:
  - Healthcare Effectiveness Data and Information Set®
    (HEDIS®)
  - Consumer Assessment of Healthcare Providers
    and Systems® (CAHPS®)
  - HRAs, audits/data validation, appeals and grievances, and
    utilization.

Coordination of Medicare and Medi-Cal

The goals of coordination of Medicare and Medicaid benefits for enrollees are to:

- Inform enrollees of benefits offered by both programs

- Ensure a seamless coordination between medical, behavioral and LTSS benefits

- Inform enrollees on how to maintain Medi-Cal eligibility

- Reduce duplicative services and their fragmented delivery while improving upon our enrollees' care and health outcomes

- Increase/maintain enrollees' access to staff that has knowledge of both programs

- Maintain clear communication regarding claims and cost-sharing from both programs

- Inform enrollees of rights to pursue appeals and grievances through both programs

- Assist enrollees in accessing providers that accept Medicare and Medicaid

Person Centered Care

Participating Plans shall ensure that all medically necessary covered benefits and services provided to enrollees include these components:

- Care is provided in a manner that is sensitive to the beneficiary's:
  - functional and cognitive needs,
  - language and culture,

- Allows for involvement of the beneficiary and caregivers (as permitted by the beneficiary)

- Care should accommodate and support member's self-direction

- Services should be provided in a care setting appropriate to the beneficiary's needs, with a preference for the home and the community

- Care is offered in the least restrictive community setting, and in accordance with the enrollee's wishes and Individual Care Plan

Enrollee Centered Model of Care

- Enrollee is informed of and consents to Case Management.

- Enrollee participates in development of the Care Plan.

- Enrollee agrees to the goals and interventions of the Care Plan.

- Enrollee is informed of Interdisciplinary Care Team (ICT) members, agrees with the team makeup, and is aware of meetings the team initiates.

- Enrollee either participates in the ICT meeting or provides input through the Case Manager and is informed of the outcomes.

Culturally Responsive Services and Policy

Federal and state regulations, and national guidelines are in place to ensure that healthcare services being provided in a non discriminatory manner and that they recognize the needs of our diverse membership.

Some examples include:

- Title VI of the 1964 Civil Rights Act
- Americans with Disabilities Act
- Affordable Care Act Section 1557
- DHCS All Plan Letters and Policy Letters
- Office of Minority Health Culturally and Linguistically Appropriate Standards
- National Committee for Quality Assurance Multicultural Healthcare Distinction

Accessibility and Accommodations

- Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.

- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language interpreters, captioning and assisted listening devices.

Benefits of Culturally Responsive Communication and Services

- Helps to ensure equal access to appropriate health care services

- Improves health outcomes by improving the quality of care

- Reduces healthcare costs by decreasing unwanted procedures

- Decreases malpractice risk

- Increases member and provider engagement and satisfaction

- Ensures compliance with state and federal regulations

Using Professionally Trained Interpreters

When Enrollees are stressed by illness, communication in their preferred language can improve understanding. Being prepared to use an interpreter when needed will help.

Remember… remain patient. In some languages, it may take longer to explain a word or concept.

- Hold a brief introductory discussion with the interpreter
  - Introduce yourself and give a brief nature of the call/visit
  - Reassure the enrollee about your confidentiality practices

- Be prepared to pace your discussion with the enrollee to allow time for interpretation

- Avoid interrupting during interpretation

- Interpreters must be professionally trained
  - Providers cannot ask an enrollee to bring an interpreter but members can give permission to another adult to provide interpretation.
  - Minors can **only** be used in cases of emergency and serious threat to the member's care.

Clear Communication through Effective use of an Interpreter

Use the Teach Back method even during an interpreted visit. It will give you confidence that your patient understood your message.

- Speak directly to the enrollee, not the interpreter

- Speak in the first person

- Speak in a normal voice, try not to speak fast or too loudly

- Speak in concise sentences

- Interpreters are trained in medical terminology; however, interpretation will be more smooth if you avoid acronyms, medical jargon and technical terms

- Be aware of the cultural context of your body language

For more in-depth Culturally Competency trainings, please contact Health Net's Cultural Competency Department at Cultural & Linguistics Services
Cultural.and.linguistic.services@healthnet.com

Roles and Responsibilities

Roles and Responsibilities

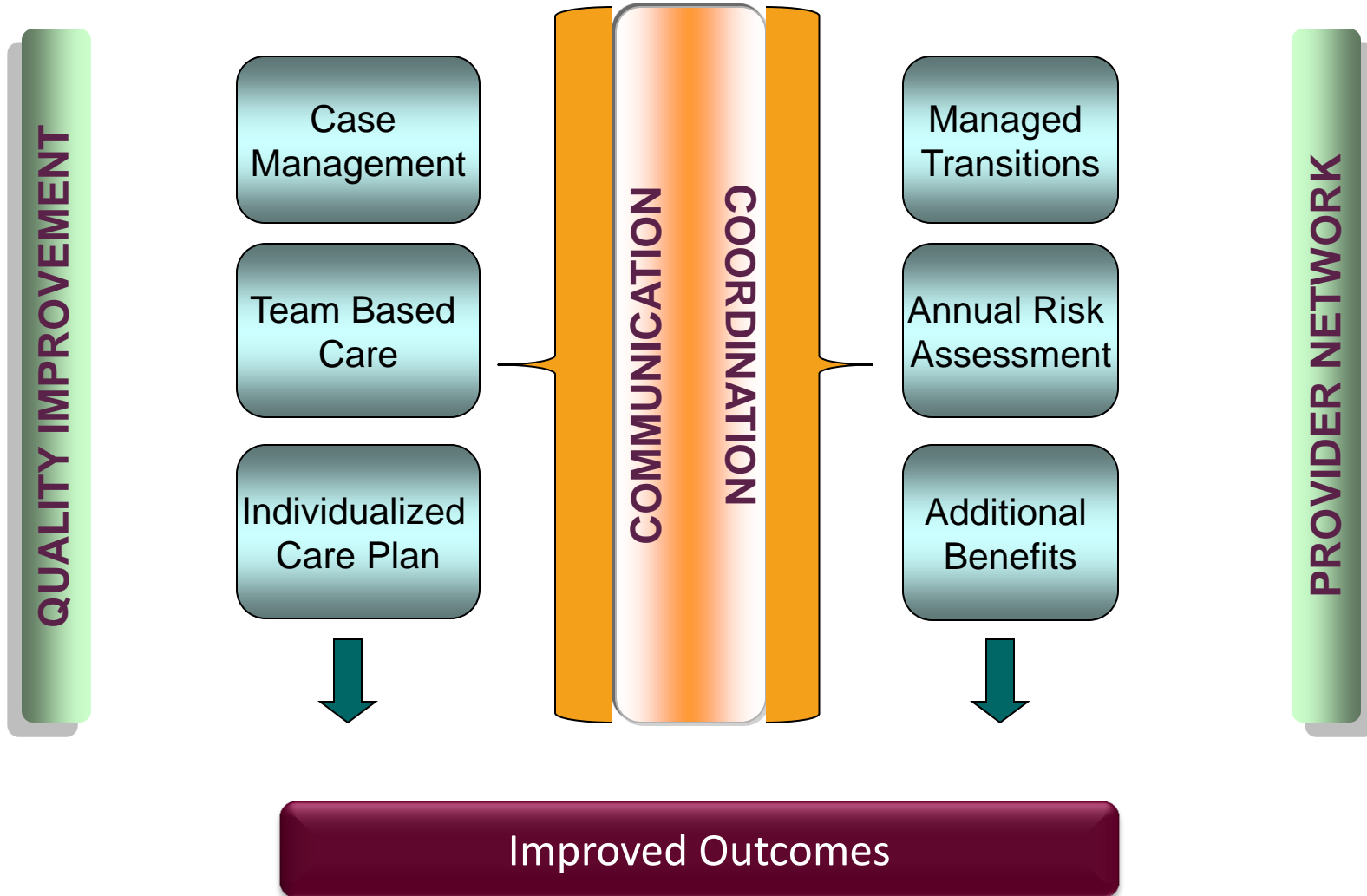| Role/Responsibilities	Position
Coordinate care management	Case Manager, Behavioral Health Case Manager, provider
Advocate, inform, and educate enrollees on services and benefits	Case Manager, Enrollee Service Associate, Provider, Behavioral health Case Manager, Care Coordinator, Public Program Coordinator
Identify and facilitate access to community resources	Case Manager, Behavioral Health Case Manager, Provider, Care Coordinators, Public Program Coordinator
Triage care needs	Case Manager, Behavioral Health Case Manager, provider
Facilitate HRA	Case Manager, Behavioral Health Case Manager, Enrollee Service Associate, Survey Vendor, Care Coordinator, Public Program Coordinator
Evaluate and analyze responses to HRA and assign enrollees according to risk level	Data Analysis, Case Manager, Behavioral Health Case Manager
Facilitate implementation of Care Plan	Case Manager, Behavioral Health Case Manager, Provider

Roles and Responsibilities (cont.)

Roles/Responsibilities	Position
Educate enrollees in disease and behavioral health self-management	Case Managers, Behavioral Health Case Managers, Disease Management Specialist, Provider, Health Educator
Consult on pharmacy issues	Pharmacist
Authorize or facilitate access to services	Provider, Pre-authorization Specialist, Concurrent Review Nurse, Case Manager, Behavioral Health Case Manager, Care Coordinator, Public Program Coordinator
Obtain consultation and diagnostic reports	Case Manager, Pre-authorization Specialist, Concurrent Review Specialist, Behavioral Health Case Manager, Provider
Facilitate translation services	Director and Manager of Cultural and Linguistics Services, enrollee Service Associate, Case Manager, Behavioral Health Case Manager, Provider
Facilitate transportation, dental, vision and other add-on services	Case Manager, Behavioral Health Case Manager, Provider, Care Coordinator, Public Program Coordinator

Roles and Responsibilities (cont.)

Role/Responsibilities	Position
Provide Medical and Mental Health Care	Provider
Counsel on Substance Abuse and rehab strategies	Behavioral Health Provider, Behavioral Health Case Manager, Social Worker
Coordinate Social Services	Case Manager, Behavioral Health Case Manager, Social Worker, Provider, Care Coordinator, Public Program Coordinator
Conduct medication reviews	Pharmacist, Provider
Conduct onsite or telephonic concurrent review of enrollees admitted to hospitals, rehabilitation units, or skilled nursing facilities. The review monitors medical necessity, levels of care, and evaluates alternatives to inpatient care. This team facilitates discharge planning and coordinates care transitions to promote continuity and coordination of care in conjunction with the provider, enrollee, and enrollee's family to ensure a timely and safe discharge.	Health Net Nurses and Medical Directors, and Delegated Partners
Facilitate care transitions related to behavioral health services including: facility admissions, facility admission diversions, discharge to home or other living arrangement, and step down to alternate clinical care setting (i.e., residential treatment, Partial hospital, Intensive Outpatient Treatment).	Behavioral Health Provider, Plan Behavioral Health Case Manager, County Behavioral Health Case Manager, Social Worker

Cal MediConnect Coordinated Model of Care

QUALITY IMPROVEMENT

Case Management

Team Based Care

Individualized Care Plan

COMMUNICATION

COORDINATION

Managed Transitions

Annual Risk Assessment

Additional Benefits

PROVIDER NETWORK

Improved Outcomes

Interdisciplinary Care Teams (ICT)

Interdisciplinary Care Team (ICT)

- The ICT will be offered to all Dual Eligible enrollees and when requested by the:
  - Enrollee
  - Enrollee's authorized representative, or the
  - Family member and/or caregiver

- The ICT will coordinate the care for CMC enrollees to address the medical, cognitive, psychosocial, and functional needs.

- The ICT is responsible for overseeing, coordinating, and evaluating the care delivery to enrollees.

- The ICT meets regularly to review the needs of the enrollee.

Interdisciplinary Care Team (cont.)

Required Team Members

- Enrollee or authorized representative (whenever possible)

- If receiving IHSS, the County IHSS Social Worker

- Medical Expert (i.e. PCP or Specialist)

- Care Coordinator (i.e. Case Manager, Social Worker, Behavioral Health Specialist

Optional Team Members*

- Pharmacist

- Health Educator

- Public Program Coordinator

- Specialized Providers (PT, OT)

- Long Term Care Provider

- Disease Management Specialist

- LTSS Service Provider (CBAS, MSSP, etc.)

- County Behavioral Health Providers

*As needed or approved by Enrollee

Interdisciplinary Care Team (cont.)

The role of the ICT is to:

- Facilitate care management, analyze and incorporate the results of the initial and annual HRA into the Care Plan, authorization of services and transitional care.

- Conduct ICT meetings periodically and at the enrollee's request.

- Manage communication and information flow regarding referrals' transitions and care delivered outside the primary care site.

- Maintain a call line or other mechanism for the enrollee's inquiries and input.

- Maintain a process for referring the enrollee to other agencies, such as LTSS or behavioral health agencies, as appropriate.

- Use secure email, fax, web portals or written communication when communicating with enrollees.

- When communicating with the enrollee, the ICT must take his or her needs (e.g. communication, cognitive, or other barriers) into account.

Person Centered ICT

- The ICT will be person-centered: built on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

- The enrollee can choose to limit or disallow altogether the role of IHSS providers, family members and other caregivers on the team.

- Participating Plans will require that each ICT has a composite of members that are knowledgeable on key competencies including, but not limited to:

  - person-centered planning processes
  - cultural competence
  - accessibility and accommodations
  - independent living and recovery, and
  - wellness principles

Provider Network and Integrated Communications

Specialized Provider Network

- Health Net maintains a comprehensive network of Primary Care Providers, facilities, specialists, behavioral health care providers, social service providers, community agencies and ancillary services to meet the needs of CMC enrollees with complex social and medical needs.

- Health Net will coordinate with IHSS, MSSP and other HCBS programs as necessary to meet the needs of CMC enrollees in assisting them with their goal to remain independent in their homes.

- Health Net provides the full CMC Model of Care with team based internal case management when it is not provided by the enrollee's primary care provider and medical group.

- Delegated medical groups must demonstrate capability to meet the team based care requirements in providing the CMC Model of Care for their enrollees. The Delegation Oversight team monitors delegated medical groups to ensure they meet the CMC Model of Care requirements.

Integrated Communications

- Health Net has integrated and extensive communication systems necessary to implement the CMC care coordination requirements:

- The Electronic Medical Management System integrates documentation of case management, care planning, input from the interdisciplinary team, transitions, assessments, waivers and authorizations for non-delegated enrollees.

- The Customer Call Center is staffed with associates trained to assist with enrollment, eligibility and coordination of benefit issues or questions, and can connect them to their Case Manager (CM).

- The Provider Portal securely communicates Health Risk Assessment results and new enrollee information to CMC delegated medical groups.

- The Member Portal provides enrollee access to online education, programs and the ability to create a personal health record.

- Enrollee and Provider Communications such as enrollee newsletters, educational outreach, Provider Updates and Provider Online news may be distributed by mail, phone, fax or online.

Additional Benefits

Added Benefits

A combined Medicare/Medi-Cal benefit package, enhanced with additional value-added benefits and services, will be offered as a means of helping CMC enrollees meet their specialized health care needs.

- **Decision Power/Disease Management** – *whole person approach to wellness with comprehensive educational and interactive health materials and a focus on chronic diseases.*

- **Medication Therapy Management** – *a pharmacist reviews medications annually and communicates with enrollee and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues.*

- **Complex Case Management** - *case management services available for enrollees experiencing catastrophic or end-of life diagnosis.*

- **Transportation** – *for medically related trips including a family or caregiver if needed.*

- **Vision and lower costs for items such as Diabetic Monitoring supplies and Oxygen** – *these benefits vary by region and type of Dual plan.*

Pharmacy and Medicare Part D

No Balance Billing: No enrollee may be balance billed by any provider for any reason for covered services

Health Net (HN) will continue to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D

- HN is permitted to charge co-pays for drugs and pharmacy products (including both those covered by both Medicare Part D and Medi-Cal) to individuals currently eligible to make such payments.

- Co-pays charged must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy or Medi-Cal cost-sharing rules.

- HN may elect to reduce this cost sharing for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence.

Decision Power Disease Management

Health Net's comprehensive disease management program focuses on the following co-morbid chronic conditions:

- Heart Failure (CHF)

- Coronary Artery Disease (CAD)

- Diabetes

Additional components of the program can include:

- Biometric monitoring devices and reporting

- Care Alerts for enrollees and providers when gaps in care or treatment are identified

- Preventive health reminders on the enrollee portal

- Tobacco Cessation
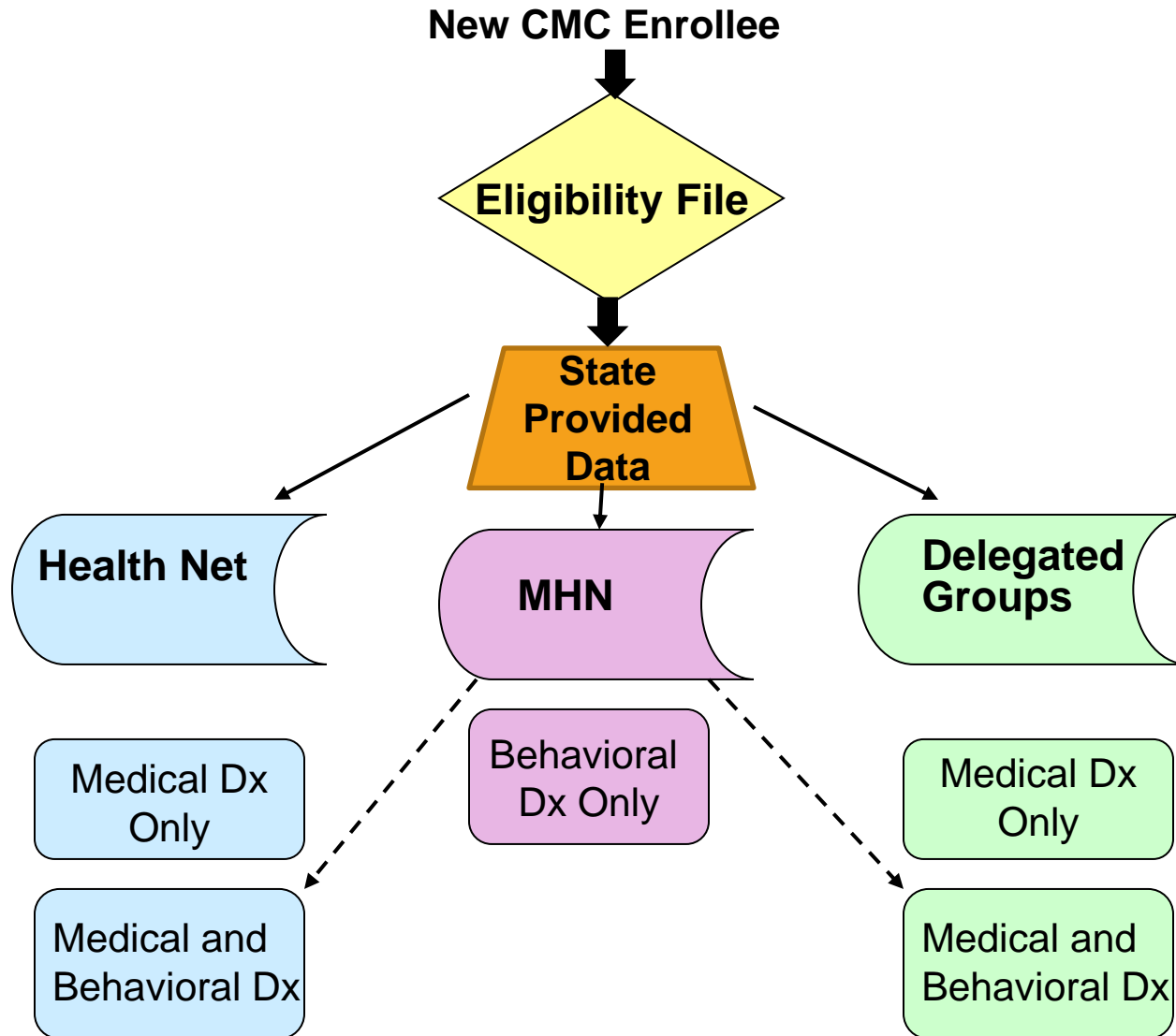
- 24/7 telephonic access to a nurse

Case Management

Case Management Services

- All CMC enrollees are eligible for case management, must have an individualized care plan developed and an ICT.

- Enrollees may opt out of active case management but remain assigned to a Case Manager who continues to contact the enrollee especially if there is a change in health status.

- Enrollees are stratified according to their risk profile to focus resources on the most vulnerable.

- Enrollees who are stratified based on data as high risk behavioral health will receive case management from MHN, Health Net's Behavioral Health provider.

- The Health Net, MHN or delegated medical group Case Manager coordinates the enrollee's Interdisciplinary Care Team (ICT).

Cal MediConnect Case Management Flowchart

New CMC Enrollee

Eligibility File

State Provided Data

- Health Net
  - Medical Dx Only
  - Medical and Behavioral Dx
- MHN
  - Behavioral Dx Only
- Delegated Groups
  - Medical Dx Only
  - Medical and Behavioral Dx

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Case Management Process

The Case Manager:

- Performs an assessment of medical, psychosocial, cognitive and functional status

- Develops a comprehensive individualized care plan

- Identifies barriers to goals and strategies to address

- Provides personalized education for optimal wellness

- Encourages preventive care such as flu vaccines and mammograms

- Reviews and educates on medication regimen

- Promotes appropriate utilization of benefits

- Assists enrollee to access community resources

- Assists caregiver when enrollee is unable to participate

- Provides a single point of contact during Care Transitions

Health Risk Assessment (HRA)

HRA calls are made by our vendor, Optum, with access to interpreter services or by HN associates in CM, whichever occurs first.

- A Health Risk Assessment is conducted on each enrollee to identify medical, psychosocial, cognitive and functional risks.

- Health Net attempts to complete the initial HRA telephonically:
  - within 45 days for higher risk enrollees from date of enrollment
  - within 90 days for lower risk enrollees or if an enrollee is in a nursing facility
  - annually within 1 year of the last HRA for all enrollees

- Multiple attempts are made to contact the enrollee and the survey is mailed if unable to reach them telephonically.

- The enrollee's responses to the HRA are incorporated into the enrollee's care plan and communicated to the provider via provider portal or by mail.

Individualized Care Plan (ICP) Requirements

- The Case Manager will regularly engage enrollees and/or their representatives in the design, reassessment and updates of the ICPs.

- If an enrollee refuses to be involved in ICP development, the Case Manager must seek to re-visit the refusal at least at the time of reassessment, or if the enrollee's PCP or any specialist changes.

- ICPs will include the name and contact information for the enrollees current, assigned care coordinator. Enrollee services numbers may be used only if the number will transfer the enrollee to her/his assigned care coordinator.

ICP Requirements (cont.)

The ICPs will include:

- The name and contact information for the enrollee's PCP and any specialists.

- A complete, current list of the enrollee's medications.

- Enrollee goals and preferences.

- Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS

ICP Requirements (cont.)

- ICPs will include timeframes for reassessment and updating of care plan, to be done at least annually or if a significant change in condition occurs.

- If the enrollee is receiving Behavioral Health services, the ICP will also include:
  - The name and contact information of the primary county or county-contracted Behavioral Health provider;
  - Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and
  - Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, evidence of creation or adjustment of care goals, as described in the plans' models of care reviewed and approved by the National Committee on Quality Assurance (NCQA).

ICP Requirements (cont.)

- If the enrollee is receiving IHSS, the ICP will also include:
  - The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and
  - The name and contact information for the IHSS worker.

- Dual-eligible beneficiaries or their authorized representative must have the opportunity to review and sign the Care Plan and any of its amendments. MMPs must provide dual-eligible beneficiaries with copies of the Care Plan and any of its amendments.

- The care plan must be made available to the beneficiary at a 6th grade level, in alternative formats, and in the beneficiary's preferred written or spoken language.

- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate.

Care Plan Goals - SMART

When documenting a member's care plan goal(s), please use the **SMART** approach:

- **Specific**: clear with target result to be achieved

- **Measurable**: includes quantifiable criteria of how the result will be measured such as quantity, frequency and time period

- **Achievable:** realistic, clinically appropriate, and credible (Case Manager, Medical Director, enrollee or provider is confident that he/she has the ability to attain the goal)

- **Results-oriented/Realistic**: stated in terms of an outcome that must be achieved and requires focused interventions and effort

- **Time Bound:** includes specific deadline by which the goal must be achieved that focuses attention and effort on achieving the goal results

- In order to build the **Individualized Care Plan** and coordinate care effectively, the Case Manager will need various documents and data sets.

- Health Net provides PPGs these tools/documents through the **Health Net Provider Portal.**

- The **Member Profile** should be available for almost every member, and will be one of the first documents available on new members.

- The two HRA documents MUST be incorporated into the ICP upon completion, **even if the ICP has already been initiated.**

Health Net Provider Portal

Behavioral Health Care Plan
- Available when MHN is primary CM
- Updated as needed, as frequently as daily

Member Profile
- One time historical claims summary to facilitate transition & coordination
- Only available first 180 days

HRA Q&A
- HRA questions and Answers
- Recommended Care Level included at top
- Updated at least annually

Physician HRA Summary Report
- One page summary of risk flags the PCP should be aware of
- Updated at least annually

MSSP Care Plan & Assessment
- Actual MSSP care plan for members in MSSP
- Will show most current, up to a year

CBAS Care Plan
- Actual CBAS care plan for members receiving CBAS services
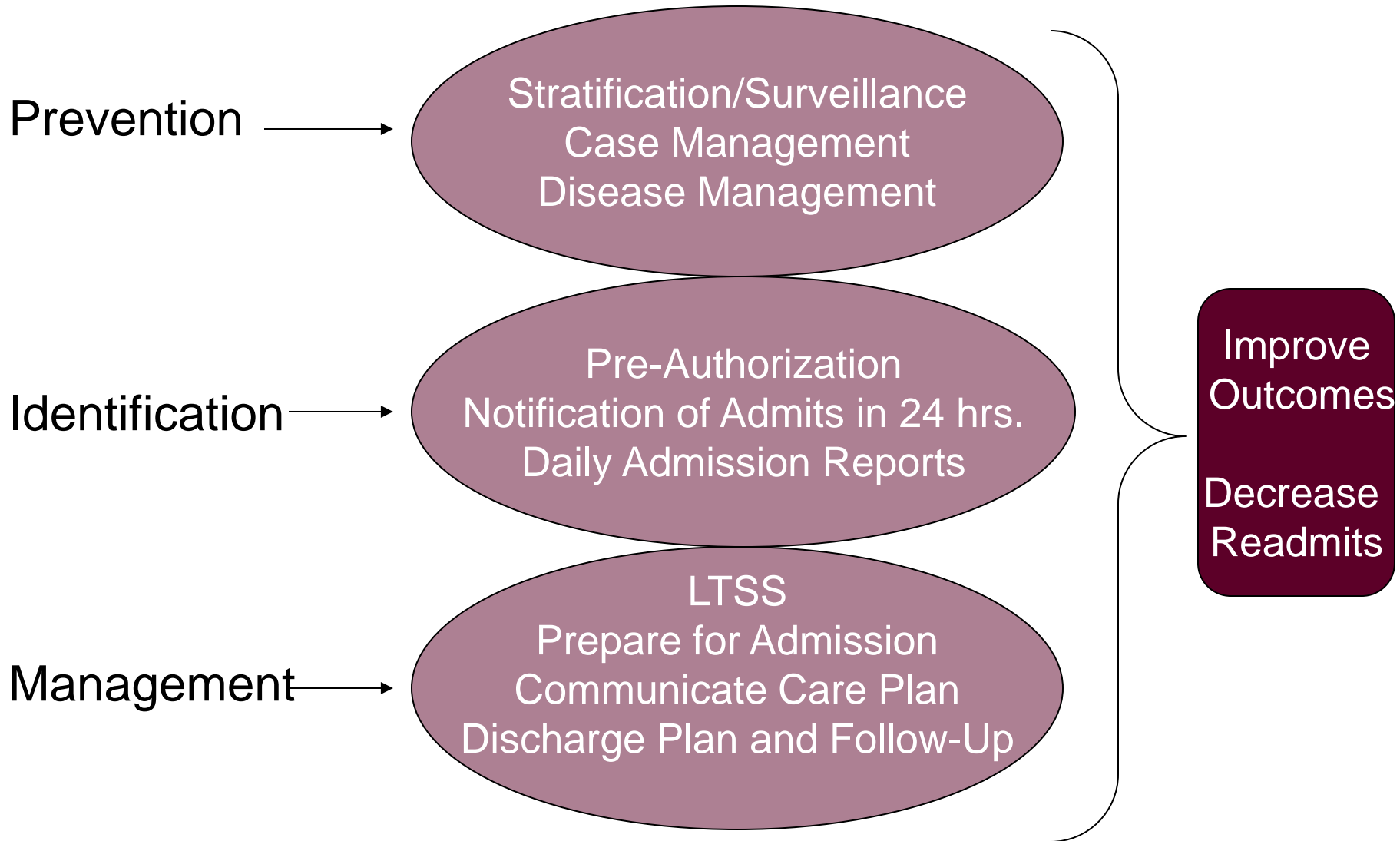- Will show most current, up to a year

IHSS Data/ Assessment Info
- Will include caregiver info, functional status, &authorized services
- Updated annually for members receiving IHSS

Management of Care Transitions

- Enrollees are at increased risk of adverse outcomes when there is a transition from one care setting to another such as admission or discharge from a hospital, skilled nursing, rehabilitation center or home health.

- Enrollees experiencing or at-risk of an inpatient transition are identified (via pre-authorization, facility notification, surveillance).

- Inpatient stays (acute, SNF, rehab) are monitored including the establishment of the Care Plan by the physician in 1 business day of admission.

- When the enrollee is discharged home, the Case Manager conducts post-discharge calls in 2 business days of notification to review changes to Care Plan, assist with discharge needs, review medications and encourage follow-up care with provider.

Care Transitions

Prevention → Stratification/Surveillance
Case Management
Disease Management

Identification → Pre-Authorization
Notification of Admits in 24 hrs.
Daily Admission Reports

Management → LTSS
Prepare for Admission
Communicate Care Plan
Discharge Plan and Follow-Up

Improve Outcomes

Decrease Readmits

Olmstead Decision

In the Olmstead decision the court upheld that public entities must provide community-based services to persons with disabilities when:

- such services are appropriate;
- the affected persons do not oppose community-based treatment; and
- community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments."

- "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life."
- "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

For more information on the Olmstead Decision, please visit the ADA web site http://www.ada.gov/olmstead/

Integration of Long Term Services and Supports (LTSS)

LTSS will be incorporated into the care plan to support the independence of the enrollee in their homes and community. LTSS is to include the Medi-Cal State Plan benefits and services for the enrollee including:

- In-Home Supportive Services (IHSS)

- Community Based Adult Services (CBAS)

- Multipurpose Senior Services Program (MSSP)

- Long Term Care Placement (LTC)
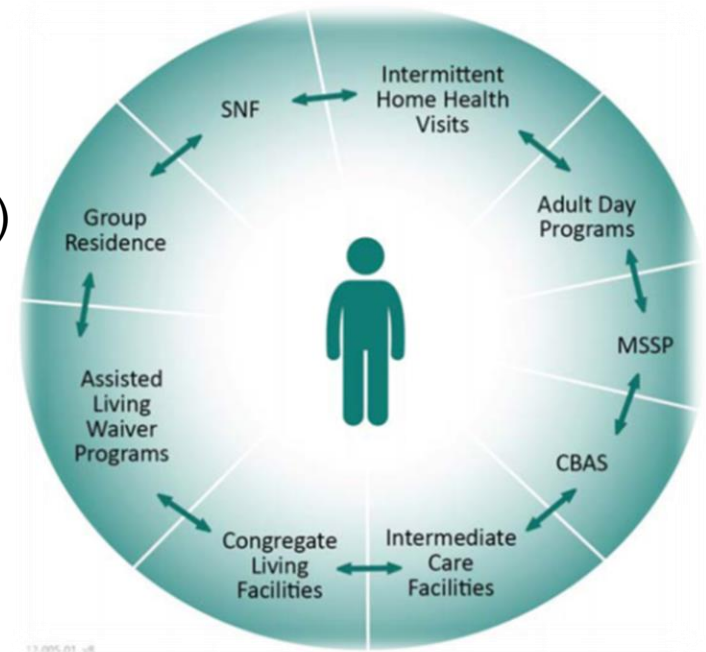
In Home Supportive Services (IHSS)

IHSS performs a critical role in the lives of many CMC enrollees. The core tenet of this program includes:

- Caregiver services that are enrollee directed, which means they have the rights to hire, fire, schedule, and supervise their IHSS care provider.
- Reliance upon Health Net's ability to improve upon the IHSS system, while ensuring we do not fracture the system and disrupt enrollees' abilities to receive needed IHSS services.
- Health Net will develop and utilize care coordination practices with County's Department of Social Services (DPSS) IHSS Social Workers and staff.
- IHSS consumers will participate in the development of their Care Plan, and select who else participates in their planning of care.
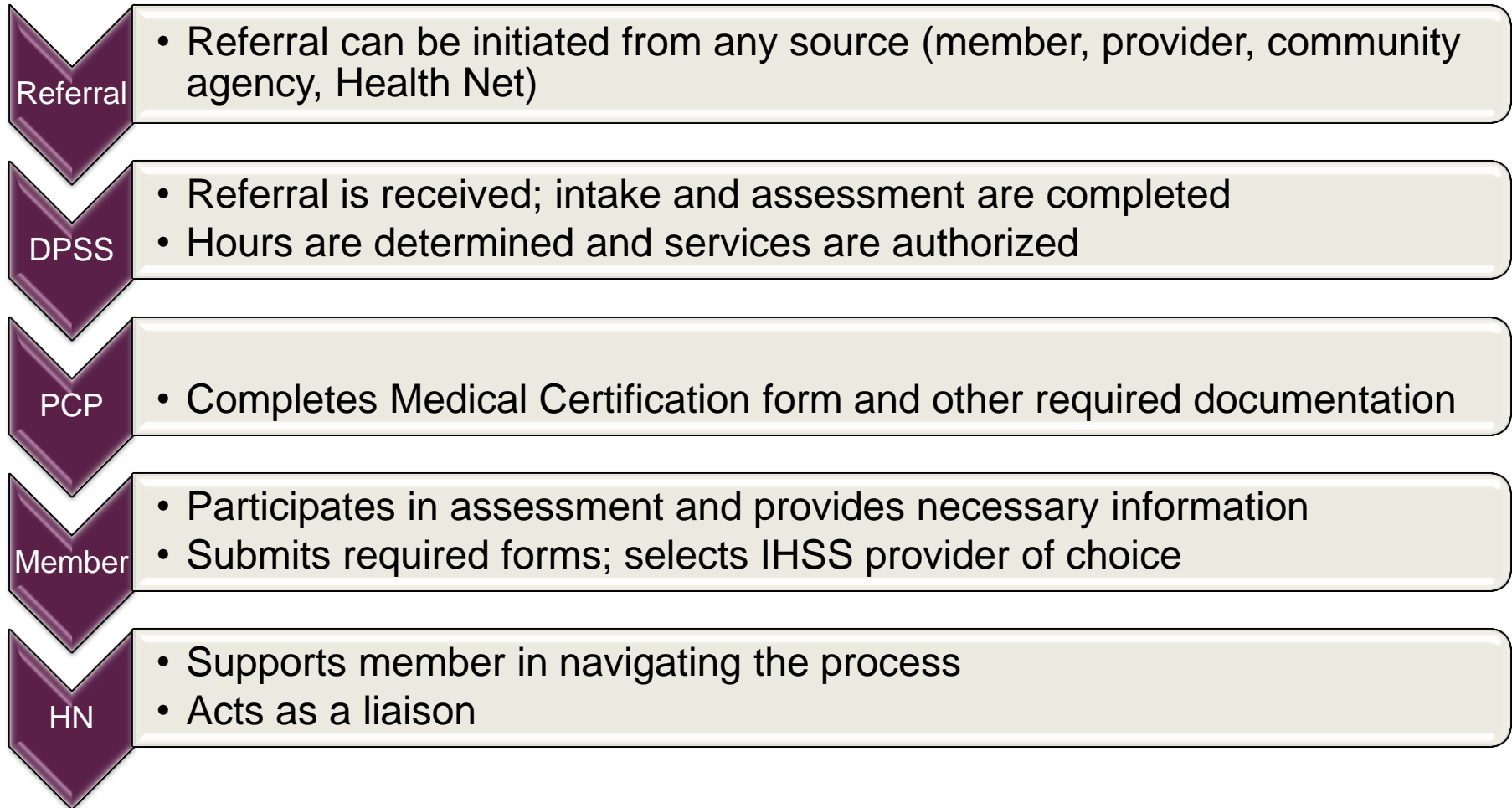
In Home Supportive Services (cont.)

- In order to qualify for IHSS, the enrollee must:

- Be an older adult (65) years of age or older, or

- Be legally blind, or disabled;

- Meet income requirements for the Supplemental Security Program/State Supplementary Program;

- Reside in California, and

- Be a U.S. citizen or legal resident living the enrollee's own home

IHSS Application Process

Health Net does not determine need for IHSS services, approve initial nor authorize increase of hours

Referral
- Referral can be initiated from any source (member, provider, community agency, Health Net)

DPSS
- Referral is received; intake and assessment are completed
- Hours are determined and services are authorized

PCP
- Completes Medical Certification form and other required documentation

Member
- Participates in assessment and provides necessary information
- Submits required forms; selects IHSS provider of choice

HN
- Supports member in navigating the process
- Acts as a liaison

Community Based Adult Services (CBAS)

- In lieu of placement in a SNF, Health Net's ICT identifies enrollees who may benefit from CBAS programs, formerly known as Adult Day Healthcare Centers.

- In order for Medi-Cal to pay for CBAS services, Medi-Cal beneficiaries must be enrolled in a Medi-Cal Managed Care plan.

- These services are provided by a multi-disciplinary team in licensed community based centers and may be authorized for up to five days a week.

Community Based Adult Services (CBAS-cont.)

Enrollees must be over age 18 and meet certain health criteria in order to receive CBAS services.

Allows at-risk seniors and people with disabilities to stay in their own homes and receive routine, facility-based care.

CBAS services can include:

- Professional nursing services

- Physical, occupational, and speech therapies

- Mental health services

- Therapeutic activities

- Social Services

- Personal care, meals, and nutritional counseling

- Rides to and from your home

- …and additional services

Multipurpose Senior Services Programs (MSSP)

The MSSP provides intensive Case Management, social and health care management services for frail older adult Medi-Cal enrollees who are certified or certifiable for placement in a nursing facility but who wish to remain at home.

MSSP recipients must meet the following criteria:

1. Be an older adult (65 years of age or older)

2. Live within an MSSP site's geographic service area

3. Be eligible for Medi-Cal

4. Be certified for nursing home placement

Multipurpose Senior Services Program (MSSP – cont.)

Health Net will work with the Area Agency on Aging (AAA) and local MSSPs to explore options to expand capacity of the intensive care coordination

Services provided by Multipurpose Senior Services Programs can include, but are not limited to:

1. Care management
2. Personal care assistance (primarily via IHSS)
3. Environmental adaptations (ex: ramps, grab bars, Personal Emergency Response System (PERS), etc.)
4. Minor home repairs
5. Money management
6. Protective supervision

Long Term Care Services (LTC)

- For enrollees residing in a LTC facility, a care coordination conference will occur with the enrollee, the enrollee's family and facility providers to develop a person-centered Care Plan for enrollees.

- The ICT develops a person-centered Care Plan based on a review of the enrollee-specific HRA for enrollees in long-term facilities.

  - The enrollee's desire and ability to return to a home, or to a non-institutional housing environment, utilizing home- and community-based services will be assessed with the goal of returning the enrollee to independent living whenever reasonably possible.

- Health Net will contract with credentialed SNF and LTC facilities to ensure enrollees have adequate access to qualified LTC facilities.

LTSS Program: Audit Elements

Audit Element Name	Audit Element Description (from PDAT)	Examples of Evidence Auditors will Look for
Referrals to LTSS	There is evidence of assessment of need and timely referral to LTSS or appropriate home- and community-based services, such as BH, IHSS, CBAS, MSSP, Connect the Needs, personal care services, and nutrition programs.	Members demonstrating LTSS need: - PPG educated member on LTSS programs (documented in ICP) - If member agreed to LTSS, PPG made LTSS referral - PPG referred members with significant LTSS need to Connect the Needs program through Health Net's HELP team.
ICP Inclusion of Assessments	In addition to the HRA, use the information gathered from the assessments of the member (such as CBAS Assessment/ Care Plan, MSSP Assessment, IHSS Assessment, SNF Assessment, Connect the Needs Care Plan, County BH Treatment Plan) and previously-administered assessment of the enrollee in developing the ICP.	- PPG accessed the Provider Portal for LTSS assessments or care plans available. If none, document portal was accessed. -PPG incorporated any assessment result into ICP and/or worked with LTSS provider coordinate services and document in ICP. - If no "other assessments" available on the portal, PPG attempted to obtain (e.g. from member's physician if member was established) - If member is LTC, PPG attempted to retrieve the MDS or other assessments from facility.

Skilled Nursing Facilities (SNF)

Many beneficiaries may have gone from acute care settings to nursing homes without adequate, appropriate community-based services being offered.

- Upon enrollment, Health Net's contracted LTC provider and certain medical groups will work with CMC enrollees living in a nursing home to determine if less restrictive living arrangements are wanted or feasible.

- Building upon Health Net's recent experience with the California Seniors & Persons with Disabilities (SPDs) expansion, a more comprehensive approach has been developed to integrate the entire continuum of available services through the development of person-centered care management plans.

- Health Net's contracted LTC provider and certain medical group's Case Managers will review all enrollees placed in SNFs and those at risk for placement to help keep them independent and in their homes.

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Background

- Ms. Atkins is an 83 y.o., African American CMC member with COPD, hypertension, and diabetes.

- Ms. Atkins has lived alone since her husband passed away 8 years ago. She has an adult daughter that resides out of the area who visits occasionally, and has good but intermittent support from her church members.

- Ms. Atkins was recently hospitalized after falling out of bed and fracturing her rib when trying to answer the phone. She was able to call 911, and the paramedics found her lying on the floor between the bed and the wall.

Interventions

- While in the hospital, Ms. Atkins' CMC Case Manager (CM) contacted Health Net's Public Programs Department for assistance in obtaining In Home Supportive Services (IHSS), as it had become clear that she needed more assistance than admitted during recent visits to her PCP.

- Public Programs submitted a referral to IHSS, requesting an expedited status, and the social worker from IHSS visited Ms. Atkins in the hospital to determine if she qualified for the program. Ms. Atkins was preliminarily approved for services, and the CM worked with Ms. Atkins to identify a caregiver – Ms. Atkins' great niece.

- A Care Plan was carefully developed by the Case Manager that included a referral to a Home Health Agency for an evaluation by the RN, PT, and ancillary services, medication education and monitoring, and a home safety evaluation. Transportation to physician visits, as well as a discussion with the member regarding Advance Care Planning and long term care plan options for safety and care needs are also included in the care plan.

- The IHSS social worker conducted a home visit, completed the assessment, and determined Ms. Atkins qualified for 80 hours of IHSS per month, which allowed her to safely remain at home.

- Ms. Atkin's church friends still plan to visit frequently and take the member on outings and to church services. The member is satisfied with the current level of support which ensures her safety, medical, and social needs.

- The Case Manager will meet regularly with Ms. Atkins to update and adjust the Care Plan as needed to anticipate the member's changing needs.

Hypothetical Case Scenario (cont.)

Goal:

- The ongoing needs of the member will be continually assessed to ensure that the long-term care setting is appropriate to the member's needs and to the member's chronic or deteriorating health conditions.

- The CMC Case Manager will continue to evaluate the member's situation to proactively address any health care conditions that may be expected to arise.

For specific LTSS referrals, questions or trainings, please contact Health Net's Public Programs department at (800) 526-1898

Behavioral Health Services

Behavioral Health

If the enrollee is at risk for behavioral health disorders, Health Net's subsidiary, Managed Health Network, Inc. (MHN) will lead the ICT and coordinate the enrollee's treatment.

- The delivery of behavioral health services to enrollees will be provided through an integrated network of private, contracted behavioral health specialists and county mental health and substance abuse programs.

- Through the combined efforts of these delivery systems, Health Net will provide comprehensive behavioral health services for CMC enrollees to ensure the development of a comprehensive, person-centered Care Plan.

Behavioral Health Identification

If the enrollee has been diagnosed with the following diagnosis/reason(s), a referral to the behavioral health specialist will be done

- Eating Disorder admitted to medical unit

- Catastrophic Illness requiring behavioral health support

- Needs behavioral health follow-up on discharge from medical admission

- Complicated detox requiring medical admission

- Difficult placement due to behavioral health problems

- Medical Admit with transfer to psychiatric unit

- Referrals for post discharge substance abuse treatment while still at medical facility

- Pain management with substance abuse issues

- Frequent ER visits for behavioral health diagnoses

- Dementia with acute exacerbation of behavioral / psychological symptoms

Behavioral Health (cont.)

- If the enrollee's Health Risk Assessment identifies high risk behavioral health needs for any identified enrollee, the Interdisciplinary Care Team (ICT) will include behavioral health specialists who work in partnership with the enrollee and the team.

- The ICT will provide support to remove access to care barriers by assisting the enrollees to make appointments and to provide transportation assistance when needed.

Behavioral Health (cont.)

ICT coordination will also include the following directives:

- Improve access to care by evaluating provider network adequacy, appointment availability statistics and enrollee satisfaction.

- Improve continuity of care and services by coordinating with county behavioral health resources, including:
  - Community-based organizations, and the full range of providers throughout Health Net's system of care

- Develop a comprehensive behavioral health assessment for any identified enrollee conducted by the behavioral health specialist who is a enrollee of the ICT.

Quality Improvement

Measurable Goals
Evaluation of Performance
Communicate Progress towards Goals

Quality Improvement Program

Health Plans offering Duals must conduct a Quality Improvement program to monitor health outcomes and implementation of the Model of Care (MOC) by:

- Identifying and defining measurable Model of Care goals and collecting data to evaluate annually if measurable goals are met.
- Collecting Cal MediConnect specific quality withhold and HEDIS® measures.
- Conducting a Quality Improvement Project (QIP) annually that focuses on improving a clinical or service aspect that is relevant to the CMC population.
    - Effective Prevention of Diabetes will be the focus in 2018
- Providing a Chronic Care Improvement Program (CCIP) that identifies eligible members, intervenes to improve disease management and evaluates program effectiveness (Adherence to Cardiovascular Medications).
- Communicating goal outcomes to stakeholders.

Quality Improvement Program (cont.)

Additional monitoring of health outcomes and implementation of the MOC include:

- Collecting results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) to evaluate member/caregiver experience of care including Long Term Services and Supports (LTSS).

- Evaluating results of the Health Outcome Survey which measures member's physical and mental health status and if their provider evaluated physical activity, fall risk management and urinary incontinence.

- Conducting required state specific Performance Improvement Project (PIP) that focuses on two measures:
    1. Members with an ICP completed
    2. Members with documented discussions of care goals

Data Collection (cont.)

Data are collected, analyzed, and evaluated from multiple domains of care to monitor performance and identify areas for improvement:

- Health Outcomes

- Access to Care

- Improved Health Status

- Health Risk Assessment

- Implementation Of MOC

- Delivery of Extra Services

- LTSS

- Implementation of Care Plan

- Continuum of Care

- Provider Network

- Integrated Communications

Cal MediConnect Quality Withhold and/or HEDIS Measures

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|	
Colorectal Cancer Screening	Antidepressant Medication Management
Spirometry Testing for COPD Pharmacotherapy	Management of COPD Exacerbations
Persistence of Beta Blockers after Heart Attack	Medication Reconciliation Post Discharge
Adult BMI Assessment	Care for Older Adults
Use of High Risk Medications in the Elderly	Comprehensive Diabetes Care
Breast Cancer Screening	Statin Therapy for Patients with Cardiovascular Disease
Reducing the Risk of Falling	Potentially Harmful Drug Disease Interactions
Adults' Access to Preventive/Ambulatory Health Services	**Plan All Cause Readmission***
Follow up After Hospitalization for Mental Illness*	**Medication Adherence for Diabetes Medications***
Annual Flu Vaccine*	**Controlling High Blood Pressure***

*Quality Withhold Measure

Health Net EFT Overview: Data Exchange

Health Net sends PPGs the same data via SFTP that PPGs can access in the Provider Portal. Additionally, Health Net sends PPGs supplemental reporting tools intended to support various aspects of performance. This is also how PPGs receive their **Case Management Logs.**
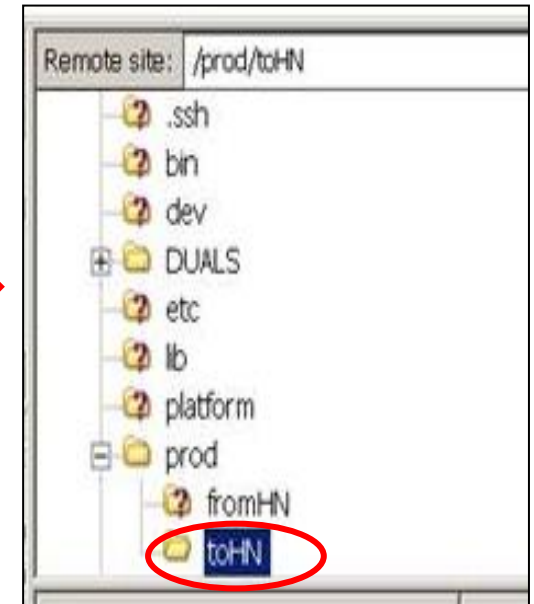
1. Health Net posts files into "OUTBOX" folder
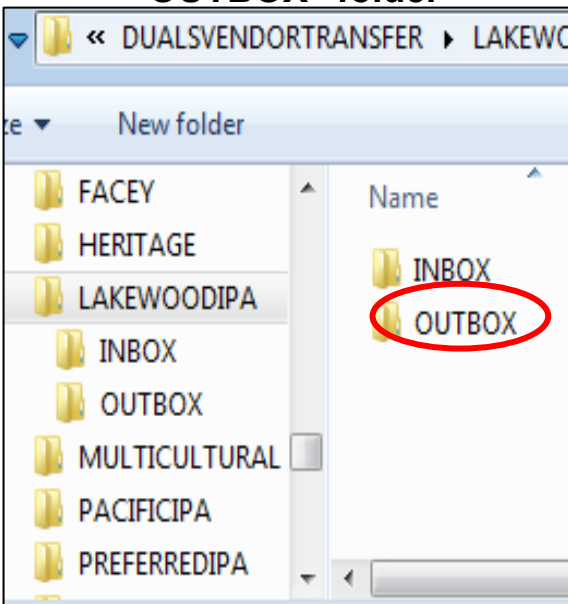
2. PPG Retrieves Files from "from HN" folder
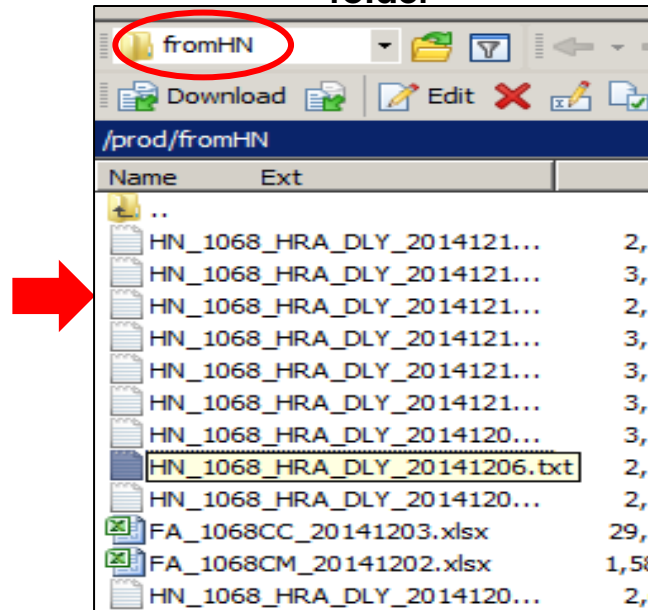
3. PPG submits completed CM Log to HN via the "to HN" folder

Health Net EFT Overview: Case Management Log Transfer

Case Management Logs:

- At the beginning of each month, a list of members assigned to each PPG are submitted to delegates via SFTP. The logs include member identifiers and outbound compliance data, such as HRA dates.

- PPGs perform required case management functions for mutual members according to MOC, contractual and regulatory requirements.

- Case Management Logs are populated by PPGs with data that represents the case management activities completed with their assigned members each month.

- Using the SFTP as a two-way data exchange process, PPGs then submit their completed logs to Health Net by the 25th of each month.

- Health Net aggregates this data and uses it to report on internal operational measures, required regulatory reporting and PPG Performance Programs.

Case Management Data Submissions

Required Documentation for Members with Care Goal Discussions:

- PPGs are required to submit all ICPs (both initial and revised ICPs).

- Documentation **must also include information to substantiate conversations that occurred between members and their case managers** regarding the care goals form these initial or revised ICPs.

  - If a care goal discussion is made clear in the content of the ICP, no additional documentation is required.

  - If care goal discussions are not contained within the member's ICP, this should be submitted as a screenshot of the member's case notes.

  - If no care goal discussions took place, <u>no documentation is required for that date.</u>

  - If care goal discussions take place later in the year (for example, if contact information is received months after the care plan was actually created), PPGs should submit that documentation once the conversation occurs.

Case Management Data Submissions (cont.)

Required Documentation for ICP Compliance:

- Case Managers are required to reach out to members a minimum of three times, on separate days, to create or revise their ICP within 90 days/3 full months of the member's enrollment date.

- PPGs are required to submit documentation of all outreach attempts to members for the purpose of creating or revising the ICP during this timeframe.

- This will most likely be a screenshot of the member's case notes or call log from their file in the PPG's case management system.

Quality Withhold Program

- In the event Health Net does earn back the withheld funds by meeting the QWH benchmarks, PPGs are eligible to receive their contracted portion of the withhold based on their performance against 3 out of the 4 metrics most heavily influenced by PPG performance:

1. Members w/ a documented discussion of a care goal
2. Members w/ at least one care team contact
3. Reduction in Readmissions
4. Annual Flu Vaccine

Quality Withhold Program

QWH Metric	What HN is Looking For	Data Source
Members with a documented care goal discussion	Evidence that newly enrolled members had a discussion of their care goals w/the care manager Note – Was also a QWH metric in 2015	Monthly case management log
Members enrolled for 6 or more months who had at least one case manager or other care team contact.	Evidence that members had at lease one contact w/ their care manager or other ICT member Note - Was also a QWH metric in 2015	Monthly case management log
Annual Flu Vaccine	Evidence that member has a care goal around receiving their flu vaccine, evidence of a discussion of that care goal in the member's care plan; and reasonable flu vaccine interventions and progress against those interventions evidenced in quarterly UM/QI work plan	Audit score from quarterly File Review audits

In Conclusion

- Cal MediConnect combines Medicare and Medi-Cal benefits into a single program, and offers additional benefits in order to support the members in accessing services and living as independently as possible.

- Health Plans offering Cal MediConnect make it easier in managing and coordinating the members' various health needs.

- For the benefit of our members, collaboration is key…Health Net is here to help.

Health Net's Resources

- Health Net's Public Programs Department
  - For LTSS referrals Help_Referral@healthnet.com or (866) 922-0783 (fax)
  - For LTSS questions and requests for specific trainings (800) 526-1898

- Health Net's Cultural & Linguistics Services
  - For specific information about translations and Cultural Competency trainings contact Cultural.and.linguistic.services@healthnet.com

- Health Net's Cal MediConnect Provider Services Center
  - Telephone requests: (855) 464-3571 (Los Angeles County)
  - Email: Provider_Services@HealthNet.com

Additional Resources

- Cal Duals – for information about Medicare and Medi-Cal integration through the Coordinated Care Initiative (CCI) including CMC, MLTSS
  - www.calduals.org

- California Advance Directive forms in various languages
  - PREPARE for your Care (written in simplified format) https://prepareforyourcare.org/advance-directive-state/ca
  - National Library of Medicine/Medline Plus - http://www.nlm.nih.gov/medlineplus/languages/advancedirectives.html

- California POLST forms (Physician Orders for Life Sustaining Treatment)
  - http://capolst.org/polst-for-healthcare-providers/forms/

- Office of Minority Health "Think Cultural Health"
  - Cultural competency training for providers: https://cccm.thinkculturalhealth.hhs.gov/

References

http://www.calduals.org/background/ca_duals_demo/

HN Connect Duals Site:
https://hnc.healthnet.com/documents/departments/duals_demonstration/program_requirements/dhcs_plan_letters

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2017/DPL17-001.pdf

http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCI_Healthplan-Quality-Compliance_Report.pdf

CMS.gov
Centers for Medicare & Medicaid Services

Thank You

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