Hospital Case Managers – Cal MediConnect Tool Kit

Background
Cal MediConnect promotes coordinated health care delivery to seniors and people with disabilities who are dually eligible for both Medicare and Medi-Cal, sometimes referred to as "dual eligible beneficiaries."

Cal MediConnect health plans coordinate medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system. All of a patient's Medicare and Medi-Cal benefits are included in one health plan.

The goal is to drive high quality care that helps people stay healthy and in their homes for as long as possible. By shifting services out of institutional settings and into the home and community, Cal MediConnect is creating a person-centered health care system that is sustainable.

Case Managers and Cal MediConnect

Case management standards and Cal MediConnect policies are closely aligned.

Cal MediConnect plans are a resource to help you help your patients to successfully navigate care transitions, particularly around care decision making and discharge planning.

Steps to ensure coordination with your patient's Cal MediConnect health plan:

- ✓ Call your patient's Cal MediConnect Health Plan as soon as they are admitted.
- ✓ Speak with your patient's Care Coordinator or a provider relations representative and ask about having a role in the beneficiary's Interdisciplinary Care Team (ICT).
- ✓ If you are having issues coordinating with the health plan, call the Cal MediConnect Ombudsman for assistance at # 1-855-501-3077.

Cal MediConnect patients are a unique population with special considerations.

This tool kit will explain the process for coordinating care with their Cal MediConnect health plan and cover common questions regarding:

- Admitting a Cal MediConnect Patient
- Requesting Authorizations from Cal MediConnect Health Plans
- Billing Cal MediConnect Health Plans
- Care Coordination for Cal MediConnect Patients
- Discharge Planning for Cal MediConnect Patients
- Further Resources for You
- Cal MediConnect Health Plan Contact Sheet

Admitting a Cal MediConnect Patient

Step 1: Contact the patient's Cal MediConnect health plan as soon as the patient comes into the hospital—before admitting the patient.

- Contact numbers for the patient's health plan are located on their Cal MediConnect health plan insurance card.
- Some plans have hospitalists placed in each contracted hospital that should be informed when a patient from their health plan comes into the hospital.
- If you cannot find a specific person to call, refer to the attached Cal MediConnect Health Plan contact sheet.
- The plan contact will work with you to:
    - Determine where authorizations and claims should be sent.
    - Identify the person who you should work with to coordinate the patient's care. In some cases this may be the patient's assigned care coordinator, but not always.

Step 2: Work with your Cal MediConnect health plan contact to:

- Learn more about the patient's individualized care plan (ICP) and care goals.
    - If the patient does not already have an ICP, their admission may trigger the plan to work with you and the patient to develop one, starting with conducting a Health Risk Assessment (HRA). An HRA is an assessment tool that identifies primary, acute, long-term services and supports, behavioral health, and functional needs.
    - Identify if your patient has specific needs such as cognitive or functional impairment(s) that may influence care.
- If the patient already has an HRA, you can work with your plan contact to update the HRA based on the patient's admission.
- Connect with the patient's interdisciplinary care team (ICT), if they have one, to ensure that you are using the resources included in the patient's Cal MediConnect health plan to best coordinate the patient's care.
    - Identify if your patient has a family member and/or other informal caregiver who assists with care and decision making.
- Begin thinking about potential discharge and transition issues, including possible long term services and supports or nursing facility needs.

IMPORTANT:

You must contact the patient's Cal MediConnect health plan prior to any elective admissions.

You must contact the patient's Cal MediConnect health plan within 24 hours of emergency admissions.

The sooner you identify and contact your patient's Cal MediConnect health plan, the sooner you can access the care coordination supports available through Cal MediConnect.

Cal MediConnect beneficiaries maintain the right to access the full range of benefits available under traditional Medicare and Medi-Cal, in addition to the care coordination benefits they receive as members of a Cal MediConnect health plan.

Requesting Authorizations from Cal MediConnect Health Plans

Cal MediConnect Health Plan Responsibilities:

- Offer urgent care appointments that require authorization within 96 hours of request.
- Cover emergency services without prior authorization.
- Follow written policy and procedures for initial and continuing authorizations.
- Ensure that an authorized care coordinator is available 24 hours a day.
- Make authorization decisions based on the opinion of a health care professional with clinical expertise in treating the patient's condition.
- Provide the decision to deny services – and the reason for doing so – to the patient and/or caregiver in writing.

Tip: To streamline the authorization process for Cal MediConnect patients, you can set up trainings for your staff with provider representatives at each Cal MediConnect health plan in your county. The Cal MediConnect health plans should be able to work with you to clarify their authorizations policies and procedures to make the process easier to navigate.

Authorization Time Frames

- For standard authorizations: authorization decisions must be made within **5 working days** from receipt of necessary information to make a decision. If the health plan request more information, it has **14 calendar days** to render a decision (unless granted up to 14 day extension).
- The decision must be made in **72 hours** if the situation is urgent and a delay would jeopardize a patient's life.
- Retrospective review must occur within **30 calendar days.**
- Authorization for non-formulary Part D pharmaceuticals must occur within **24 hours.**
- Concurrent review of authorization for treatment already in place must occur within **5 business days.**

Note: The Cal MediConnect health plan may require that you provide sufficient clinical information on the patient within 24 hours to enable them to make the authorization decision.

Authorizations from Cal MediConnect Health Plan Delegates

1. Some Cal MediConnect health plans may have delegated responsibility to authorize and pay for hospital care to a medical group or IPA, known as the plan delegate. In this case you may need to request authorization from the plan delegate.
2. You should be able to get clear guidance from the Cal MediConnect health plan provider representatives about how to request authorizations.
3. Plan delegates must follow the same rules as plans.

Troubleshooting

What if I can't figure out who I need to request authorization from?

- The patient's Cal MediConnect insurance card has all relevant contact information on it.
- If you cannot access the patient's card, call the Cal MediConnect health plan to request more information. The plan's provider relations representatives will be able to provide you with guidance.

What if I can't get the Cal MediConnect health plan representative on the phone?

- If the general provider relations department number is insufficient, please see the Cal MediConnect Contact Sheet attached to this tool kit (also available at CalDuals.org).

How can I help the patient to appeal a denied authorization?

- Call the patient's health plan or plan delegate to learn about the appeals process.
- You can also call the Cal MediConnect Ombudsman for help in beginning the appeals process – more details and contact information can be found on the "Resources" page of this tool kit.

Billing Cal MediConnect Health Plans

One of the goals of Cal MediConnect is to streamline billing for providers.

When billing for patients who are enrolled in a Cal MediConnect health plan, providers should only have to submit the claims to one entity rather than navigating both the Medicare and Medi-Cal billing processes.

Delegated Hospital Risk

If the Cal MediConnect health plan has delegated hospital risk, you can submit hospital claims to the delegated entity, and they will adjudicate both the Medicare and Medi-Cal parts of the claim.

Knowing Who to Bill

You should be able to get clear guidance from Cal MediConnect plan provider representatives about how to submit claims.

The patient's Cal MediConnect Insurance care includes billing information.

In no instance should you bill the patient.

Care Coordination for Cal MediConnect Patients

Coordinated transitions in and out of the hospital are essential to the patient's overall health.

Cal MediConnect is designed to support patients and providers with care coordination.

Fully understanding the unique process of care coordination offered by Cal MediConnect health plans is key to working together with your patient's health plan for the best possible outcome.

The following resources are available to each Cal MediConnect patient:

- Health Risk Assessment (HRA)
- Care Coordinator
- Interdisciplinary Care Team (ICT)
- Individualized Care Plan (ICP)

Health Risk Assessments (HRAs)

- An HRA is an assessment tool which identifies primary, acute, long-term services and supports, and behavioral health and functional needs.
- An HRA serves as a starting point for the development of the ICP.
- Requirements:
  - Must be completed by the Cal MediConnect health plan within 45 days for higher risk beneficiaries and 90 days for lower risk beneficiaries,
  - Cal MediConnect health plans must be reassess patients annually, and
  - ICPs must be developed within 30 working days of HRA competition.
- Through HRA and ICT discussions, beneficiaries will be identified as potentially eligible for LTSS services, including Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and In Home Supportive Services (IHSS).
- The HRA may be conducted by the Cal MediConnect health plan, the delegate, or a vendor.

HRAs as a resource for you:

- You can request an HRA from the Cal MediConnect health plan to better understand a patient's overall health and functional assessment.
- If the patient has an HRA, work with the health plan to update it based on the patient's admission.
- It is possible your patient does not have an HRA completed either because the patient was unresponsive after the health plan attempted to contact them or because the patient did not want to participate in an HRA. By notifying the health plan of the patient's admission, you can trigger an assessment and help coordinate your patient's care.

Care Coordinators

- Cal MediConnect members should all have access to a dedicated care coordinator upon request or if deemed necessary by the Cal MediConnect health plan.
  - Care Coordinators are accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information, obtaining reliable and timely information about services other than those provided by the PCP, and supporting safe transitions in care for patients moving between settings.
- For higher needs patients, that care coordinator will often be a nurse or social worker who has been following their care over time through the care plan and care team.

Care Coordinators as a resource for you:

- Cal MediConnect care coordinators should be a resource for hospital case managers.

- The provider relations representative at the patient's health plan should be your first point of contact. They will direct you to the right person to work with in order to ensure that you are using all of the resources the plan has available to coordinate the patient's care.
- Some Cal MediConnect health plans have delegated care coordination – a plan representative should be able to direct you to the appropriate care coordinator for your patient.

Interdisciplinary Care Teams (ICTs)

- The ICT works with the patient to develop, implement, and maintain the ICP. The purpose of the ICT is to ensure the integration of the patient's medical, LTSS, and behavioral health services when applicable.
- The ICT is composed of:
    - The patient's primary care provider, the patient's care coordinator, and other provider's at the discretion of the patient.
    - The ICT can also include: hospital discharge planner, nursing facility representative, social worker, IHSS provider, CBAS provider, MSSP coordinator, family members or other caregivers, and other professionals as appropriate.
- The health plan must offer an ICT for each beneficiary upon request or if the health plan deems it necessary.
- The ICT is responsible for facilitating all care management including: care planning, authorization of services, transitional care issues, coordination with providers, and meeting the patient's care plan goals.

ICTs as a resource for you:

- If a Cal MediConnect member is admitted to your hospital, you should coordinate care with your patient's ICT.
- The patient's care coordinator is the point of contact for the ICT. You should contact the care coordinator, if applicable, to update the ICT on the patient's condition.
- You do not need the patient's permission to be on the ICT - while the patient is in the hospital, their hospital providers are a critical part of their care team.

Individualized Care Plan

- Cal MediConnect health plans are required to provide an ICP to enrolled beneficiaries who have demonstrated need, which is usually identified in the HRA process.
- Care Plans may range from something as basic as the need to get annual flu shots for low risk patients to very complex plans regarding managing chronic conditions and quality of life issues for higher-risk patients.

ICPs as a resource for you:

- Ask to see the patient's ICP to help inform care in the hospital as well as to inform discharge planning.
- Request to have the ICP updated based on a change in the patient's health status.

Keep in mind:

Before, during, and after a patient's admission to your hospital, you can contact the patient's Cal MediConnect health plan to learn more about these resources. You can also ask to be part of the patient's ICT, and provide the ICT with updates on the patient that may impact the ICP. In situations where the health plans delegate case management responsibility to an IPA or Medical Group, it is important for you to establish a relationship with the delegate to connect with the Care Coordinator and ICT.

Discharge Planning for Cal MediConnect Patients

As case managers, you understand that a successful discharge plan places the patient at the center and makes them and their caregiver(s) full partners in the planning process. Including the patient and the patient's caregiver, if applicable, in discharge planning increases patient safety and improves patient health outcomes.

Your patient's Cal MediConnect health plan should be a resource to you in ensuring that patients experience a safe and coordinated discharge from the hospital back to their community or into a nursing facility.

You can partner with your patient's Cal MediConnect health plan when they are admitted and at each step in the discharge planning process to ensure a coordinated and patient-centered discharge plan.

- **Cal MediConnect is designed to help members live in the most appropriate setting**
    - The health plans have the tools necessary to help move patients out of the hospital and either back into the community or into an appropriate long-term care facility.
    - This can include identifying the best place for the patient– whether that is in a Skilled Nursing Facility (SNF), a SNF alternative, or the community—and providing appropriate services, in the form of IHSS hours or other long term services and supports to keep the patient at home.

- **Cal MediConnect health plans and the patient's care coordinator can help you to:**
    - Work with the patient to identify their goals following discharge.
    - Ensure that the patient has access to all necessary medications and that follow-up appointments have been scheduled.
    - Provide patients transitioning back into the community access to supports and services upon discharge, including: LTSS, durable medical equipment (DME), and transportation.
    - Identify the most appropriate and accessible in-network facility to meet the patient's need, for patients requiring more services and supports.
    - Coordinate the discharge plan as a part of the patient's ICT and ICP.

Note: The plan or plan delegate are responsible for continuing coordinating the beneficiary's care after discharge.

Cal MediConnect Resources

Your first point of contact should always be the patient's Cal MediConnect health plan.

For Complaints and Appeals

- Your first point of contact should always be the patient's Cal MediConnect health plan. Health plans have internal appeals and grievance procedures.
- If a patient cannot resolve their complaint with their health plan, the next step is to call the Ombudsman: Cal MediConnect Ombudsman: 855-501-3077.
- For Medicare benefits and services, you can use the usual Medicare appeals process.

About the Cal MediConnect Ombudsman:

The Cal MediConnect Ombudsman are independent from the Department of Health Care Services, ensuring that there is a third-party assisting enrollees and providing feedback to DHCS on the Cal MediConnect program.

Cal MediConnect Ombudsman # 855-501-3077
Hours of operation: Monday-Friday 9 AM to 5 PM.

What do they do?

The Cal MediConnect Ombudsman offer consumer protection for all Cal MediConnect enrollees, ensuring that individual issues can be addressed. These services are in addition to existing appeals and grievances processes.

Specific functions of the Cal MediConnect Ombudsman are to:

- Provide ombudsman services to individuals enrolled in Cal MediConnect plans
- Empower enrollees and their families
- Investigate and resolve enrollee problems/complaints with Cal MediConnect plans
- Monitor ombuds efforts and track problems, complaints, and trends

Additional Resources

- **HICAP** (1-888-580-7272) – the Health Insurance Counseling & Advocacy Program (HICAP) helps beneficiaries understand their choices under CCI and make changes to their health plan, including choosing a different Cal MediConnect health plan, a different Medi-Cal health plan, or to opt out of Cal MediConnect.
- **Medicare** (1-800-MEDICARE) – for questions about Medicare benefits and services.
- **APL 14.010 – Care Coordination Requirements for Managed Long-Term Services and Supports:** http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-010.pdf
- **DPL 15.001 – Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans**: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL15-001.pdf
- **DPL 13.002 – Health Risk Assessment and Risk Stratification Requirements for Dual Demonstration Plans Under the CCI:** http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-002.pdf

For More Information

- Web: Calduals.org
- Email: info@calduals.org
- Twitter: @CalDuals
- Outreach: Email info@caduals.org or complete the online request form

Resource: CCI All Plan and Duals Plan Letters

Dual Plan Letter 15-001, Supersedes Dual Plan Letter 13-004: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans

This DPL clarifies requirements for ICTs and ICPs for Medicare-Medicaid Plans (health plans) participating in Cal MediConnect.

Care Plan

If a dual eligible beneficiary demonstrates a need for a care plan, Cal MediConnect health plans are required to work with the beneficiary to develop a plan. The health plans can determine the need for a care plan in the following ways: 1) through interactions with dual-eligible beneficiaries, 2) when stratifying beneficiaries into lower and higher-risk categories and 3) during any other appropriate interactions.

The care plan (and any amendments to it) must be signed off by the beneficiary or the beneficiary's authorized representative and be made available to the beneficiary in all alternative formats and in a beneficiary's written or spoken language.

The plan must include:

- The beneficiary's goals, preferences, choices, and abilities.
- Measurable objectives and timetables to meet all needs determined through the HRA.
- Coordination or carved-out and linked services and referral to appropriate community resources and other agencies, when appropriate.

Cal MediConnect health plans must reassess and update care plans at least annually or if a significant change in a beneficiary's condition occurs.

Interdisciplinary Care Team

Cal MediConnect plans are required to offer ICTs to dual-eligible beneficiaries when a need is demonstrated, or if a dual-eligible beneficiary or an authorized representative requests one. ICTs must be comprised of professionals appropriate for the needs, preferences, and abilities of the beneficiary and ensure the integration of the beneficiary's medical care and LTSS.

The ICT must:

- Facilitate care management, including HRA, care planning, authorization of services, and transitional care issues.
- Develop and implement a care plan in participation with the beneficiary and/or caregiver.
- Conduct ICT meetings periodically and at the beneficiary's request.
- Manage communication and information flow regarding referrals, care transitions, and care delivered outside of the primary care site.
- Maintain a call line or other mechanism for the beneficiary's inquiries and input.
- Maintain a process for referring the beneficiary to other agencies, such as LTSS or behavioral health agencies, as appropriate.
- Maintain a mechanism for beneficiary complaints and grievances.
- Use secure email, etc., when communicating with the beneficiary, the must take his or her needs.

Duals Plan Letter 13-002: Health Risk Assessment and Risk Stratification Requirements for Dual Demonstration Plans Under the Coordinated Care Initiative

Health Risk Assessments—General

Cal MediConnect health plans are required to complete an HRA for each enrollee to identify primary, acute, long-term services and supports, behavioral health, and functional needs. The HRA is the basis for developing the beneficiary's

individual care plan (ICP) and can be completed in person, by telephone, or by mail, depending upon the beneficary's preference.

HRA Timeframes

For high risk enrollees (as identified by a risk stratification mechanism or algorithm using claims data) the HRA must be completed within 45 days of enrollment. For enrollees in nursing facilities or those identified as lower risk, the HRA must be completed within 90 days. If a Cal MediConnect health plan does not complete an HRA in the allotted timeframe, the plan must have documentation demonstrating unsuccessful attempts to complete the HRA.

After the HRA

For enrollees who are high risk, the HRA leads to the assignment of the MCP's care managers or Interdisciplinary Care Teams (ICTs) and more in depth and comprehensive care planning and coordination
HRA enrollment dashboard: http://www.calduals.org/wp-content/uploads/2015/11/CMC-November-Enrollment-Dashboard.pdf

All Plan Letter 14-010: Care Coordination Requirements for Managed Long-Term Services and Supports

This APL applies to the following populations:

- Full benefit dual-eligibles who opt out of Cal MediConnect,
- Full benefit dual-eligibles who are ineligible for Cal MediConnect due to exclusion criteria and partial benefit dual-eligibles, and
- Medi-Cal only members who are full scope Medi-Cal SPDs over age 21.

Policy

Managed Care Plans (MCPs) must establish a risk-stratification mechanism to stratify newly enrolled beneficiaries into high or low-risk groups. The following services are considered high-risk indicators and must be included in the risk-stratification mechanism:

- IHSS authorized for greater than or equal to 195 hours per month;
- CBAS; and/or
- MSSP

Health Risk Assessments

MCPs are not required to complete HRAs for Cal MediConnect opt-outs, full benefit dual eligibles excluded from Cal MediConnect, or partial duals but are required to follow existing HRA requirements for Medi-Cal only SPD members as set forth in PL 14-005.

Long-Term Services and Supports Assessment review

MCPs must retain and compile a copy of each assessment conducted on the member's behalf through IHSS, MSSP, CBAS, or the SNF and must review these assessments to determine if any further coordination of services for the member is appropriate

Individual Care Plan

MCPs are required to establish and ICP for newly enrolled and reassessed Medi-Cal only SPD members meeting high-risk criteria, when appropriate

Interdisciplinary Care Teams

MCPs are required to offer ICTs to all Medi-Cal only SPD members who are high-risk or request one, when a need is demonstrated and in accordance with the member's functional status, assessed need, and the ICP.

Cal MediConnect Health Plans

Los Angeles County

Plan Name	Phone Number	TTY	Online
Care1st Cal MediConnect	1-855-905-3825	711	https://www.care1st.com/ca/calmediconnect/
CareMore Cal MediConnect	1-888-350-3447	711	http://duals.caremore.com/
Health Net Cal MediConnect	1-888-788-5395	711	https://www.healthnet.com/portal/shopping/content/iwc/shopping/medicare/duals/duals_introduction.action
L.A. Care Cal MediConnect	1-888-522-1298	1-888-212-4460	http://www.calmediconnectla.org/
Molina Dual Options	1-855-665-4627	711	http://www.molinahealthcare.com/members/ca/en-US/hp/duals

Orange County

Plan Name	Phone Number	TTY
OneCare Connect	1-855-705-8823	1-800-735-2929

Riverside County

Plan Name	Phone Number	TTY	Online
IEHP DualChoice	1-877-273-4347	1-800-718-4347	https://ww3.iehp.org/en/members/plans/cal-mediconnect/
Molina Dual Options	1-855-665-4627	711	http://www.molinahealthcare.com/members/ca/en-US/hp/duals

San Bernardino County

Plan Name	Phone Number	TTY	Online
IEHP DualChoice	1-877-273-4347	1-800-718-4347	https://ww3.iehp.org/en/members/plans/cal-mediconnect/
Molina Dual Options	1-855-665-4627	711	http://www.molinahealthcare.com/members/ca/en-US/hp/duals

San Diego County

Plan Name	Phone Number	TTY	Online
Care1st Cal MediConnect	1-855-905-3825	711	https://www.care1st.com/ca/calmediconnect/
CommuniCare Advantage	1-800-224-7766	1-800-735-2929	http://chgsd.com/mediconnect.aspx
Health Net Cal MediConnect	1-888-788-5805	711	https://www.healthnet.com/portal/shopping/content/iwc/shopping/medicare/duals/duals_introduction.action
Molina Dual Options	1-855-665-4627	711	http://www.molinahealthcare.com/members/common/en-us/pages/duals.aspx

Santa Clara County

Plan Name	Phone Number	TTY	Online
Anthem Blue Cross	1-855-817-5785	711	http://64.60.187.54/
Santa Clara Family Health Plan	1-877-723-4795	1-800-735-2929	http://www.scfhp.com/

San Mateo County

Plan Name	Phone Number	TTY
CareAdvantage CMC	1-866-880-0606	711