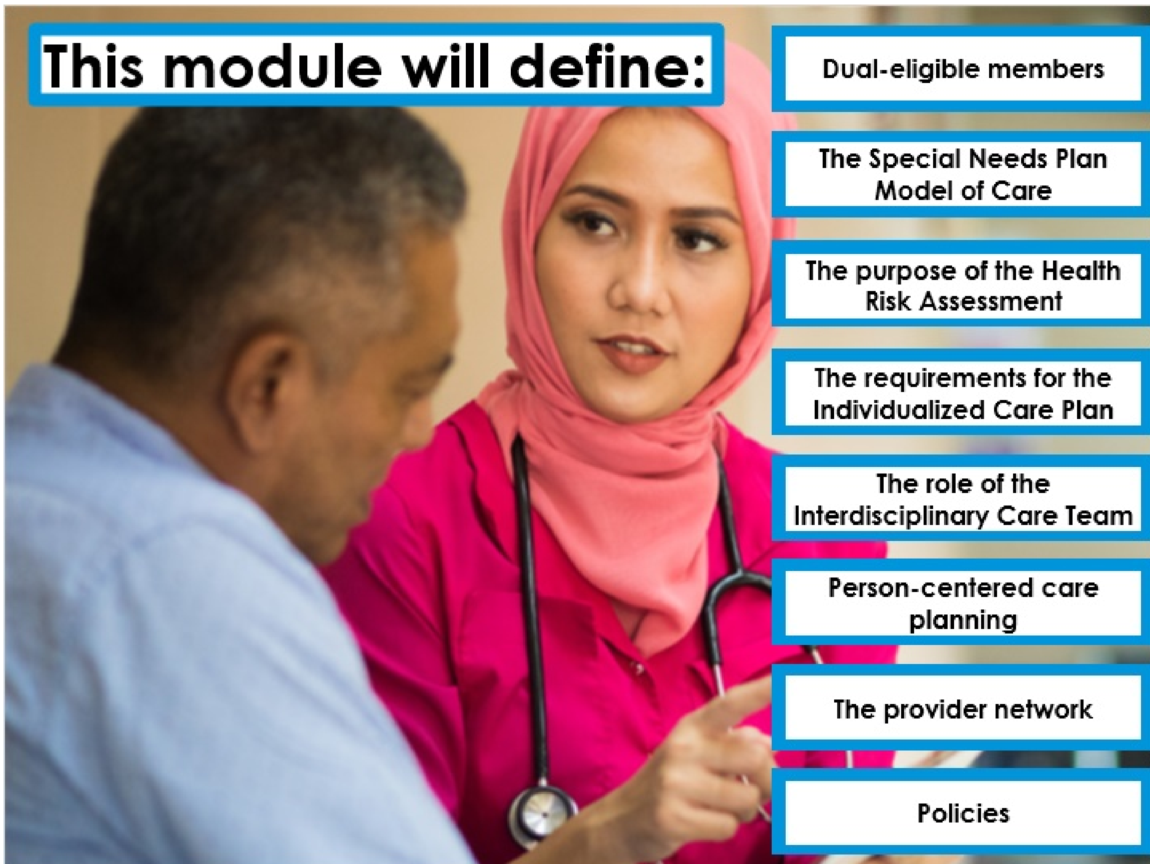
Cal MediConnect and Dual-Eligible Special Needs Plan

Model of Care



Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

Click the plus and minus signs to open and close each question.

Who are dual-eligible members?

What is Cal MediConnect?

What is the Model of Care for Special Needs Plan members?

What is the Model of Care based on?

What are the care coordination roles?

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

Click the plus and minus signs to open and close each question.

Who are dual-eligible members?

Dual-eligible members are eligible for both Medicare and Medi-Cal. They are more likely to have:

- Behavioral, mental, emotional, and social support needs
- Financial barriers to care

- Limitations in daily activities
- Multiple chronic conditions

- Barriers to care access, coordination, and compliance

Each dual-eligible member has a special needs plan to coordinate care.

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

Click the plus and minus signs to open and close each question.

Who are dual-eligible members?

What is Cal MediConnect?

The Blue Shield Promise Cal MediConnect Plan integrates medical care, prescription drugs, behavioral health care, and long-term services and supports for dual-eligible members. The Centers for Medicare & Medicaid Services and the California Department of Health Care Services contract with Blue Shield for these dual-eligible members in Fresno, Los Angeles, Orange, San Bernardino, San Diego, San Joaquin, and Stanislaus counties.

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

Click the plus and minus signs to open and close each question.

Who are dual-eligible members?

What is Cal MediConnect?

What is the model of care for special needs plan members?

The Blue Shield Model of Care for Special Needs Plan members identifies:

- How various demographic factors combine to adversely affect health status
- Special services to meet the needs of the most vulnerable members

- Community partners such as Multipurpose Senior Services Program, the Alzheimer's Association, Area Agency on Aging, and In-Home Support Services to provide specialized resources

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

Click the plus and minus signs to open and close each question.

Who are dual-eligible members?

What is Cal MediConnect?

What is the Model of Care for Special Needs Plan members?

What is the model of care based on?

To build the Model of Care for these members, we perform a population assessment that identifies age, gender, ethnicity, and:

- Prevalence of major diseases and chronic conditions
- Language barriers and health literacy
- Barriers to healthcare services associated with cultural beliefs or socioeconomic status
- The segment of the special needs population who are at the highest risk of poor health outcomes by looking at multiple hospital admissions, high pharmacy utilization, high costs, or a combination of medical, psychosocial, cognitive, and functional challenges

Questions and answers

Here are answers to questions about Cal MediConnect and the dual-eligible special needs plan model of care.

Click the plus and minus signs to open and close each question.

Who are dual-eligible members?

What is Cal MediConnect?

What is the Model of Care for Special Needs Plan members?

What is the Model of Care based on?

What are the care coordination roles?

Blue Shield care coordination roles for the Special Needs Plan Model of Care include contracted or employed staff for:

- Administrative functions such as enrollment, eligibility verification, claims processing, and administrative oversight
- Clinical roles of case managers, social workers, pharmacists, behavioral health providers, and clinical oversight

All staff are trained on the Model of Care upon hire and annually, and Blue Shield has a plan for staff absences to avoid disruption in care.

Who is the primary and secondary payer?

Click each photo to learn more.

Medicare

Medi-Cal

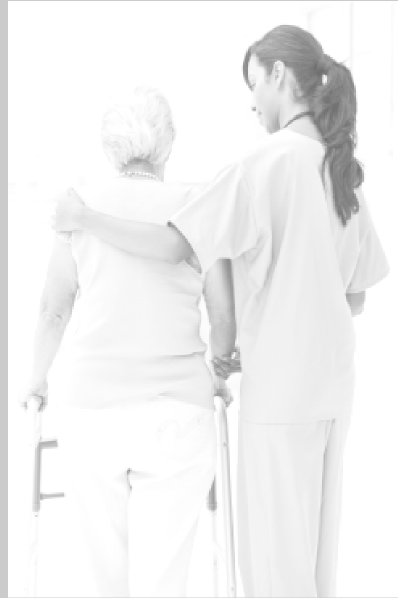
Who is the primary and secondary payer?

Click each photo to learn more.

Medicare is the primary payer and covers the following services:

- Physician
- Hospital
- Short-term skilled nursing facility

Medi-Cal



Who is the primary and secondary payer?

Click each photo to learn more.

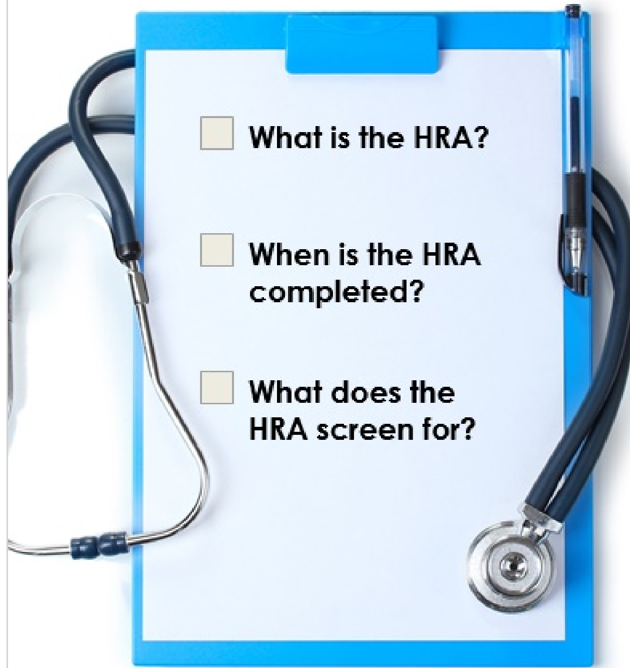
Medicare

Medi-Cal is the secondary payer and covers the following:

- Medicare cost sharing
- Services not covered by Medicare
- Services delivered after Medicare benefits have been exhausted
- Most long-term care costs including longer nursing home stays and home and community-based services that prevent institutionalization

Health Risk Assessment (HRA)

Click each box to learn more about the HRA for special needs plan members in the Blue Shield Promise Cal MediConnect Plan.

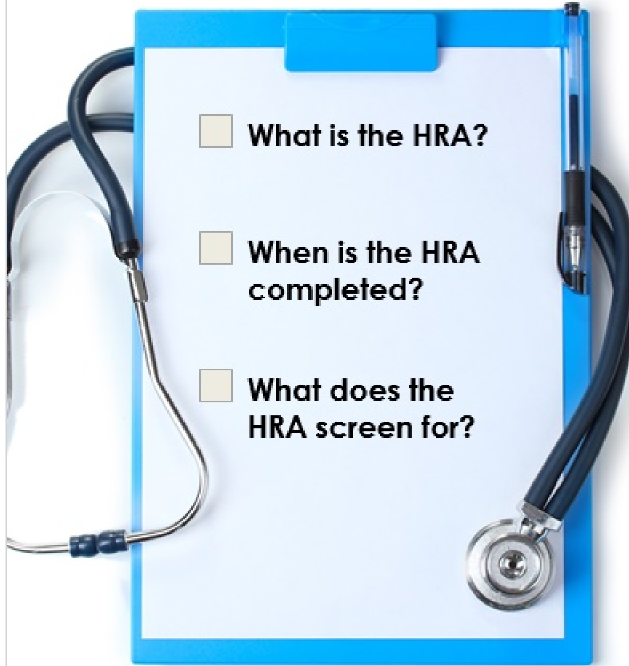


What is the health risk assessment?

The Blue Shield Promise Cal MediConnect Plan attempts to complete health risk assessments for each dual-eligible member to identify medical, psychosocial, cognitive, and functional risks. The assessment is conducted by phone or face-to-face depending on the member's needs or preferences. After multiple attempts are made to directly contact the member, the survey is mailed.

Health Risk Assessment (HRA)

Click each box to learn more about the HRA for special needs plan members in the Blue Shield Promise Cal MediConnect Plan.



When is the health risk assessment completed?

The health risk assessment is completed:

- **Annually**, within 1 year of the last health risk assessment for all members
- Within **90 days** from date of enrollment for lower risk members or for those in a long-term care or nursing facility
- Within **45 days** from date of enrollment for higher risk members

After the Health Risk Assessment is conducted, the member's responses are incorporated into the Individualized Care Plan and communicated to the provider by fax or mail.

Health Risk Assessment (HRA)

Click each box to learn more about the HRA for special needs plan members in the Blue Shield Promise Cal MediConnect Plan.

The health risk assessment screens for:

- Health status including chronic health conditions and health care needs
- Clinical history
- Mental health and cognitive status
- **Activities of daily living and instrumental activities of daily living**
- Medication review
- Cultural and linguistic needs, preferences, or limitations
- Visual preferences or limitations
- Quality of life and life planning activities
- Caregiver support
- Available benefits
- Continuity of care needs
- Fall prevention
- Managed Long-Term Services and Supports, including Home and Community-Based Services

Activities of daily living (ADL) consist of self-care tasks including:

- Bathing and showering
- Personal hygiene and grooming
- Dressing
- Toilet hygiene
- Functional mobility (moving from one place to another)
- Self-feeding

Instrumental activities of daily living (IADL) consist of independent living tasks including:

- Cleaning and maintaining the house
- Managing money
- Moving within the community
- Preparing meals
- Shopping for groceries and necessities
- Taking prescribed medications
- Using the telephone or other forms of communication

Individualized Care Plan (ICP)

Click each tab to learn more.

Overview

Components

In-Home Support Services

Individualized Care Plan overview

- The Individualized Care Plan is developed specifically for each member.
- The member, or their authorized representative, must be given the opportunity to review and sign the Individualized Care Plan or any amendments.
- The Individualized Care Plan must be at a sixth grade reading level, in alternative formats, and in the member's preferred written or spoken language.

Individualized Care Plan (ICP)

Click each tab to learn more.

Overview

Components

In-Home Support Services

Individualized Care Plan required components:

- Name and contact information for the member's primary care physician and any specialists
- Member goals and preferences
- Measurable objectives and timetables for medical and behavioral health services and long-term services and supports
- Time frames for reassessment: at minimum, annually or per current state or federal requirements

Individualized Care Plan (ICP)

Click each tab to learn more.

Overview

Components

In-Home Support Services

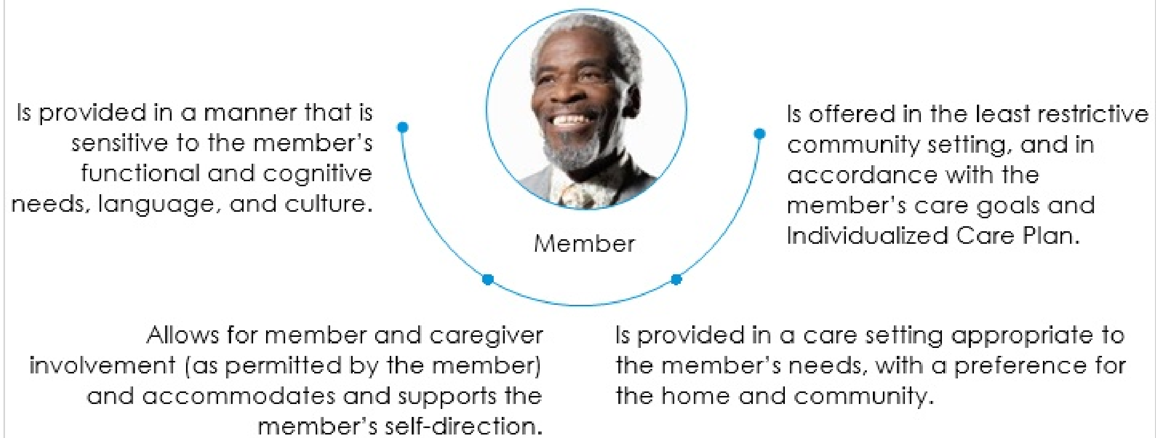
In-Home Support Services

For members receiving In-Home Support Services, the Individualized Care Plan must include:

- Contact information for the county social worker who has responsibility for authorizing and overseeing the member's in-home support services hours
- Contact information for the member's In-Home Support Services worker

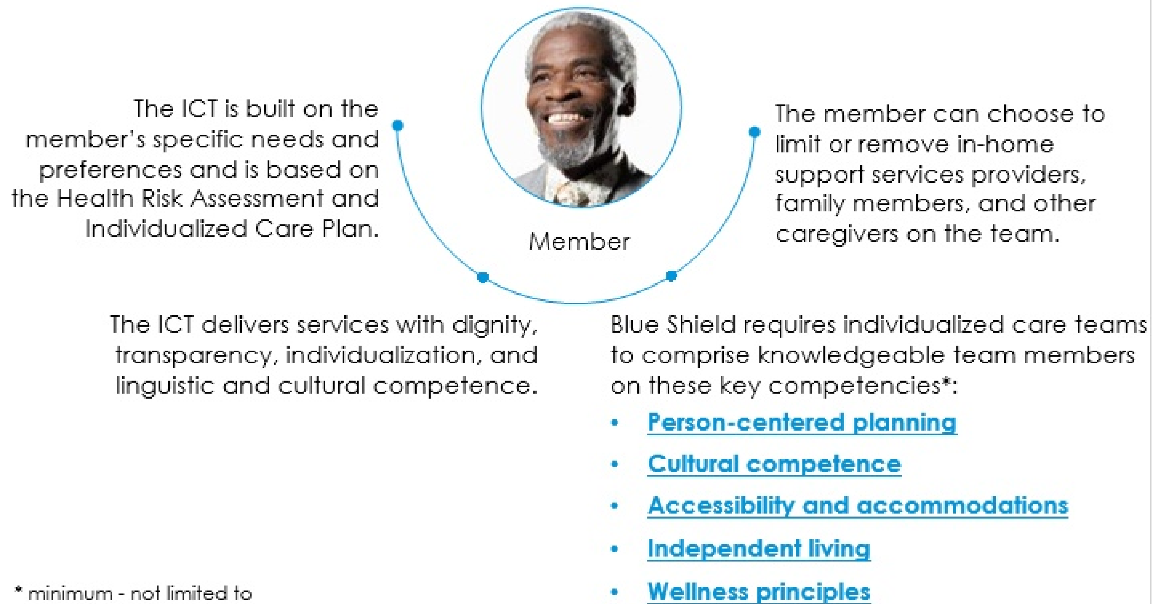
Person-centered care

Blue Shield is committed to the provision of member care that:



The interdisciplinary care team (ICT) is person-centered.

The interdisciplinary care team facilitates care assessment, planning, and management, as well as authorization of services and care transition. Members and caregivers are encouraged to participate. The team typically includes a case manager, social worker, pharmacist, medical director, and treating physician. Others are included based on member needs.



Person-centered planning

Person-centered planning is the member-controlled method of selecting and using services that allows the person maximum control over his or her home and community-based services, including the amount, duration, and scope of services, as well as choice of providers.

Patient-centered planning

- Recognizes the person as the expert
- Includes significant others
- Identifies hopes, interests, preferences, needs, and abilities
- Maximizes community connections

Cultural competence
Cultural competence is the ability to effectively interact with people across cultures. Cultural competence encompasses:
• Developing positive attitudes towards cultural differences
• Gaining knowledge of different cultural practices and world views
• Developing skills for communication and interaction across cultures
Underlying cultural competence are the principles of trust, respect for diversity, equity, fairness, and social justice.

Accessibility and accommodations

The Americans with Disabilities Act and Section 504 of the Rehabilitation Act require that health care providers provide individuals with disabilities full and equal access to their health care services and facilities.

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Click each box to reveal an accommodation.

Communication and auxiliary aids

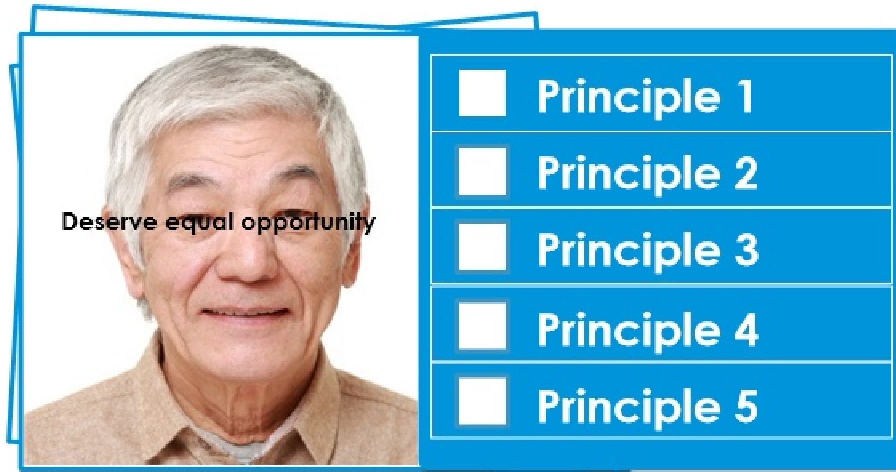
https://www.ada.gov/effective-comm.htm

- Parking spaces
- Curb ramps
- Barrier-free access from parking
- Wide doorways
- Accessibility in public spaces
- Ample, accessible restrooms
- Accessible drinking fountains
- Accessible service counters
- Raised tactile Braille signs
- Accessible exam rooms
- Accessible exam tables
- Accessible weight scales
- Transfer equipment
- Communication and auxiliary aids

Independent living

The independent living philosophy emphasizes that people:

(Click each box to reveal a principle of independent living.)



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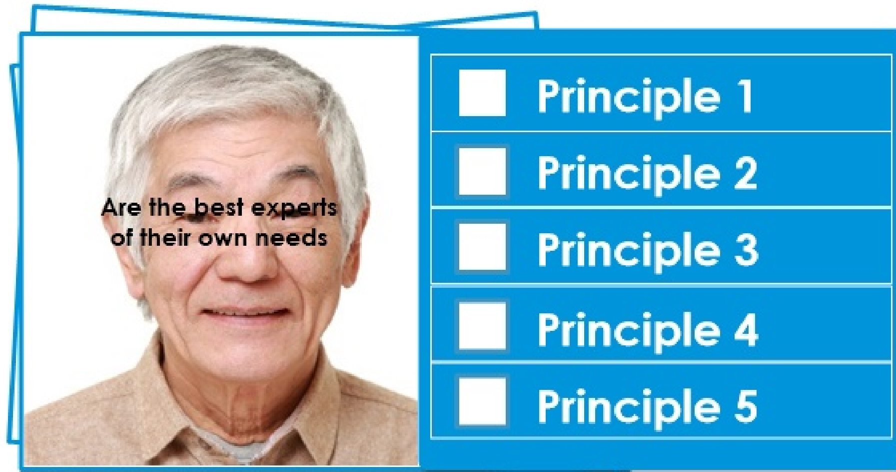

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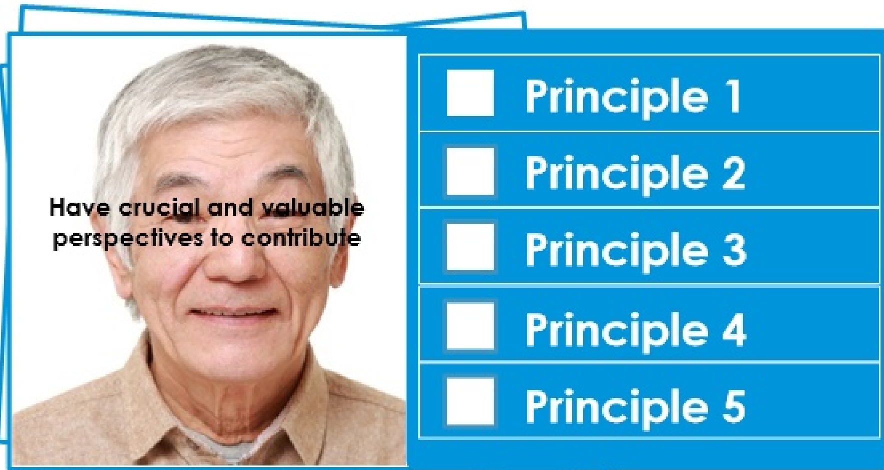

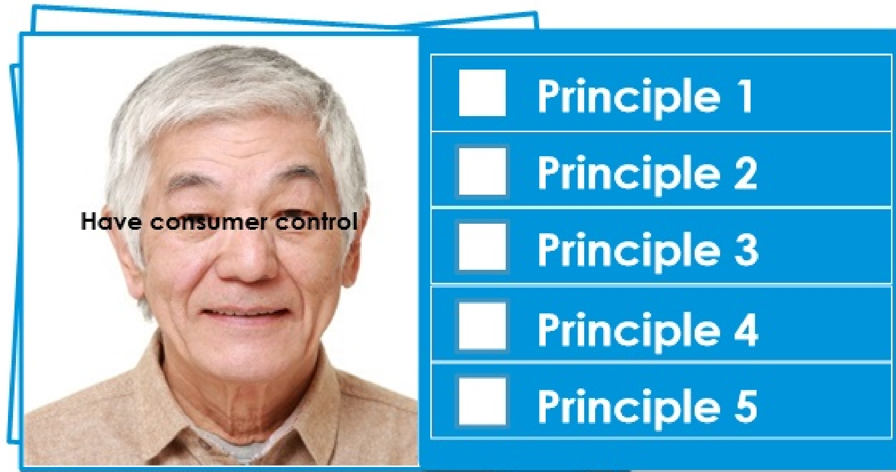
Independent living
The independent living philosophy emphasizes that people:
(Click each box to reveal a principle of independent living.)
Have consumer control
Principle 1
Principle 2
Principle 3
Principle 4
Principle 5

Independent living

The independent living philosophy emphasizes that people:

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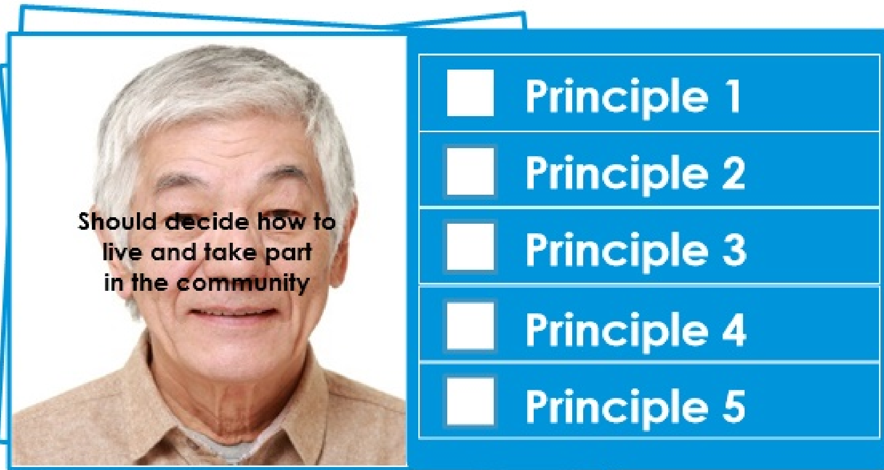


Wellness principles

Click each apple for more information.

Wellness principles

Click each apple for more information.

Physical exercise, good nutrition, stress-management, and social support are important for every one and health promotion activities are critical for people who are prone to a more sedentary lifestyle.

Wellness principles

Click each apple for more information.

Health includes a dynamic balance of physical, social, emotional, spiritual, and intellectual factors.

Wellness principles

Click each apple for more information.

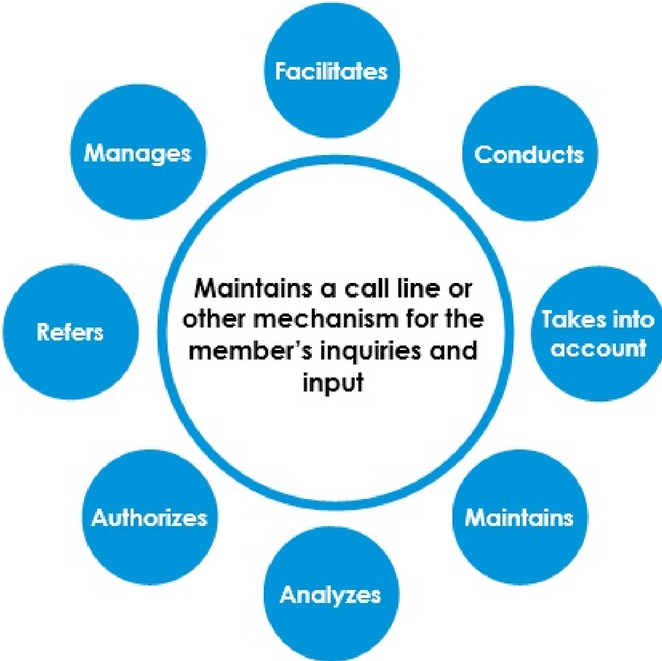
Providers can be of tremendous assistance in helping people select and practice tailored health promotion behaviors to increase their level of well-being.

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Refers
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Facilitates care management and coordination

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Conducts individualized care team meetings periodically and at the member's request
Refers
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Conducts
Takes into account
Maintains
Analyzes
Authorizes
Refers
Manages
Takes member's communication needs into account (cognitive, communicative, or other barriers)


Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Refers
Maintains a call line or other mechanism for the member's inquiries and input
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Refers
Analyzes and incorporates health risk assessment results into the Individualized Care Plan
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Refers
Authorizes services and transitional care
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Refers members to other agencies when needed (e.g., long-term supports and services or behavioral health services)
Refers
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team roles
Click each circle to learn more.
Facilitates
Manages
Conducts
Manages information flow for care delivered outside the primary care site
Refers
Takes into account
Authorizes
Maintains
Analyzes

Interdisciplinary care team participants

Required	Optional*
• Member or authorized representative (whenever possible) • County IHSS social worker (if receiving IHSS) • Medical expert (PCP or specialist) • Care coordinator (case manager, social worker, or behavioral health specialist)	• 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

Interdisciplinary care team communication

Blue Shield facilitates information flow between members, interdisciplinary care team participants, and physicians with:

- Documentation in the care management system and member's Individualized Care Plan
- Regular telephonic communication with member/caregiver and provider
- Written interdisciplinary care team meeting minutes
- A member data dashboard that includes utilization and pharmacy data

*As needed or approved by member

Interdisciplinary care team participants

Required	Optional*
• Member or authorized representative (whenever possible) In-home support services • County IHSS social worker (if receiving IHSS) • Medical expert (PCP or specialist) • Care coordinator (case manager, social worker, or behavioral health specialist)	• 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

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Long-term services and supports

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- A member data dashboard that includes utilization and pharmacy data

*As needed or approved by member

Interdisciplinary care team participants

Required

- Member or authorized representative (whenever possible)
- County IHSS social worker (if receiving IHSS)
- Medical expert (PCP or specialist)
- Care coordinator (case manager, social worker, or behavioral health specialist)

Optional*

- Pharmacist
- Health Educator
- Public Program Coordinator
- Specialized Providers (PT, OT)
- Long-Term Care Provider
- Disease Management Specialist
- LTSS Service Provider (CBAS, MSSP, etc.) Community-based adult services
- County Behavioral Health Providers

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- Written interdisciplinary care team meeting minutes
- A member data dashboard that includes utilization and pharmacy data

*As needed or approved by member

Interdisciplinary care team participants

Required

- Member or authorized representative (whenever possible)
- County IHSS social worker (if receiving IHSS)
- Medical expert (PCP or specialist)
- Care coordinator (case manager, social worker, or behavioral health specialist)

Optional*

- 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

Multipurpose Senior Services Program

Interdisciplinary care team communication

Blue Shield facilitates information flow between members, interdisciplinary care team participants, and physicians with:

- Documentation in the care management system and member's Individualized Care Plan
- Regular telephonic communication with member/caregiver and provider
- Written interdisciplinary care team meeting minutes
- A member data dashboard that includes utilization and pharmacy data

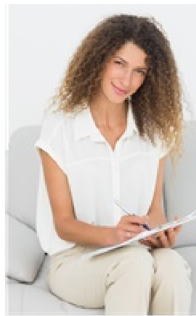
*As needed or approved by member

Provider network

Blue Shield has a specialized network of providers to meet the needs of Special Needs Plan dual-eligible members.

Click each provider to learn about specialties included in the provider network.

Internists, family practitioners, geriatricians, endocrinologists, cardiologists, oncologists, pulmonologists



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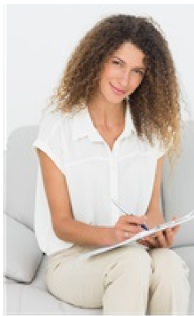
Behavioral health providers



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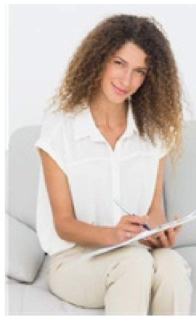
Long-term service and support providers



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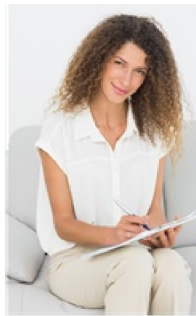
General and subspecialty surgeons



Provider network

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Ancillary health providers such as physical, speech and occupational therapists

Provider network

Blue Shield has a specialized network of providers to meet the needs of Special Needs Plan dual-eligible members.

Click each provider to learn about specialties included in the provider network.

Tertiary care physicians

Provider network information sharing

Blue Shield has integrated communication systems to implement Cal MediConnect and Special Needs Plan care coordination requirements including:

- Care planning and management documentation
- Interdisciplinary team input
- Transitions information
- Assessments
- Waivers and authorizations

Care coordination resources

Cal MediConnect
Click here and scroll for Blue Shield Promise Cal MediConnect information or call **(855) 905-3825** toll free for member, transportation, and care coordination services.

Special Needs Plan
Click here for the Blue Shield website or call the provider line at: **(800) 468-9935**.

Our Customer Care Center is ready to assist with enrollment, eligibility and benefit questions, and connecting members to their Care Navigator.

Other member and provider communications such as newsletters, educational outreach, and provider updates are distributed online or by mail, phone, or fax.

Provider network information sharing

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Coordinates all the member's providers and services

Other member and provider communications such as newsletters, educational outreach, and provider updates are distributed online or by mail, phone, or fax.

Care transition timeline

Blue Shield adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital	SNF	Home	PCP

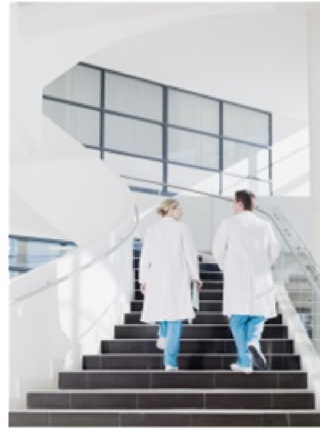
Click on each tab above for timelines.

Care transition timeline

Blue Shield adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital	SNF	Home	PCP

Within one day of notification of an admission to a hospital, a copy of the current Individualized Care Plan is faxed to the hospital.

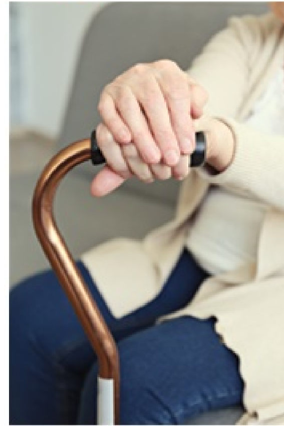


Care transition timeline

Blue Shield adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital | **SNF** | Home | PCP

Within one day of discharge
from a hospital to
a skilled nursing facility (SNF),
the discharge orders/care plan
are faxed to the skilled nursing facility.



Care transition timeline

Blue Shield adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital	SNF	**Home**	PCP

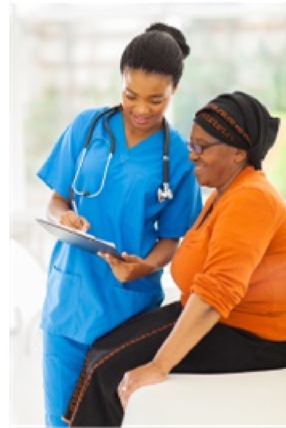
When the member is being transitioned to the usual setting of care (typically the home), the case manager will discuss the discharge plan with the member and/or caregiver. This will be followed within two business days by a phone call to ensure the member is familiar with the appropriate self-management tools and to assist with scheduling a follow-up appointment with the primary care physician.

Care transition timeline

Blue Shield adheres to the following timelines to ensure timely planned and unplanned care transitions for our members:

Hospital	SNF	Home	PCP

The primary care physician (PCP) will be notified by fax within three business days of all care transitions.



Provider network policies and procedures

Click each topic for information.

Policies and procedures

Blue Shield ensures that network providers:

- Comply with special needs plan model of care required training upon joining the network and annually thereafter
- Have active licenses and certifications
- Are part of the member's interdisciplinary care team as needed
- Incorporate relevant clinical information in the member's ICP
- Follow care transition protocols
- Can request exception to clinical practice guidelines for members with complex healthcare needs

Clinical practice guidelines

Compliance

Provider network policies and procedures

Click each topic for information.

Policies and procedures

Clinical practice guidelines

To ensure the use of clinical practice guidelines, Blue Shield:

- Requires medical groups to use evidence-based nationally approved clinical practice guidelines
- Approves all clinical practice guidelines annually
- Communicates approved guidelines to the network via provider communications and the provider website
- Reviews member education materials annually to ensure consistency with approved clinical practice guidelines

Compliance

Provider network policies and procedures

Click each topic for information.

Policies and procedures

Clinical practice guidelines

Compliance

Compliance with approved guidelines is monitored through:

- An annual review of delegated group utilization decisions
- The member appeals process
- Review of patient medication profiles in the **Medication Therapy Management Program**
- Healthcare Effectiveness Data and Information Set (HEDIS) reporting

Quality improvement for the special needs plan model of care

Blue Shield has a quality improvement plan specific to meeting the healthcare needs of model of care members based on specific Healthcare Effectiveness Data and Information Set (HEDIS) health outcome measures and special needs plan member satisfaction surveys. These findings are used to modify the model of care quality improvement plan on an annual basis. Providers and stakeholders may view the quality improvement plan on the **Blue Shield website**.

End