OVERVIEW of the Coordinated Care Initiative

INTRODUCTION

Dual eligible patients – those with both Medicare and Medi-Cal – are among the poorest and sickest insured patients in the country, and are likely to have poor health outcomes and high health care costs. While individual physicians may do an excellent job coordinating care for their dual eligible patients, many dual eligibles do not get the help and support they need. Some physicians and their staff have the training, skills, and capacity to help deal with multiple specialists, behavioral health providers, and community-based resources dual eligible patients need to have a good quality of life. But many physicians feel overwhelmed – as can the patients themselves and their caregivers.

The **Coordinated Care Initiative (CCI)** is a new program designed to help provide that extra support for low-income seniors and people with disabilities in California, including those who are dually eligible for Medicare and Medi-Cal. The CCI is available in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The **Coordinated Care Initiative** grew out of research and pilots conducted in California and other states showing that dual eligible individuals can benefit from better coordination of care.

CAL MEDICONNECT

People eligible for both Medicare and Medi-Cal can now enroll in a new type of health plan, called a Cal MediConnect plan. These plans will provide all Medicare and Medi-Cal benefits, plus additional care coordination, transportation to medical services and vision benefits. Through a Cal MediConnect plan, physicians can participate in an interdisciplinary care team for their patients. This can help doctors ensure their patients get all the care and supports they need to live safely in their homes and avoid unnecessary hospitalizations or stays in a nursing facility.

Participation in Cal MediConnect is voluntary, so people can choose to join or choose to opt out and receive Medicare services as they do today. If someone is eligible for Cal MediConnect and they don't make an affirmative choice to join or not join, they will be automatically enrolled into Cal MediConnect on their coverage date, usually the first day of their birth month. They can choose to disenroll in any month.

ORIGINAL MEDICARE & MEDI-CAL MANAGED CARE

Simultaneously, California is requiring most dual eligibles who do not enroll in a Cal MediConnect plan to enroll in a Medi-Cal managed care plan. These Medi-Cal plans are assuming the role previously performed by the state in the administration of Medi-Cal benefits, including long-term services and supports and Medicare co-pays. Consequently, the Medi-Cal plan will be responsible for any reimbursement physicians previously received from the state for Medicare cost sharing. Physicians need not be contracted with the Medi-Cal plan's network to submit a bill for any Medicare cost sharing the plan will owe under state law. Usually, because of state law the Medi-Cal plan will not be required to pay anything. Also, the Medi-Cal plan should not assign a primary care physician to the patient.

HOW CAL MEDICONNECT SUPPORTS PHYSICIANS AND CARE COORDINATION

A major focus of Cal MediConnect is supporting physicians in the management of complex patients. Cal MediConnect plans will be responsible for conducting a comprehensive Health Risk Assessment (HRA) of all enrollees to assess medical, behavioral health, long-term services and supports, functional and social needs. Physicians can access the HRA results, since this information can help physicians understand their patients' histories and the broad spectrum of needs their patients may have. This HRA will also be the basis for assigning a health plan Care Coordinator to high-need patients, as well as establishing an Interdisciplinary Care Team and an Individualized Care Plan for those patients. Physicians will be able to participate in these care teams, which will provide patients with care coordination support, such as ensuring patients are managing their appointments and prescriptions and receiving the long-term services and supports they need to live independently in their homes and communities. These long-term services and supports include In-Home Supportive Services (IHSS) and Adult Day Health Care (also known as Community-Based Adult Services or CBAS), as well as long-term stays in nursing facilities. This coordination can help relieve the administrative burden some practices feel when helping their patients access care and community-based services.

To ensure that Cal MediConnect plans provide this type of care coordination, the federal and state governments created oversight teams that are closely watching the plans to ensure they are fulfilling their contractual obligations. Care coordination tools such as the HRA and the individualized care plan are a way that the oversight teams, as well as physicians and patients, can hold plans accountable for giving patients the care and support they need.

PATIENTS WHO JOIN CAL MEDICONNECT PLANS

If your patient joins a Cal MediConnect plan, you eventually will have to be in that plan's network in order to continue seeing the patient. If you are not currently in the network, there is a continuity of care period when you can continue to see an existing patient for six months if you and the health plan can work out terms, including payment terms. Payment would be based on 80% of the Medicare fee schedule plus any copays that Medi-Cal is required to pay.

This is in addition to the generally applicable right patients have to request completion of covered services for certain conditions once they join a managed care plan.

PATIENTS CONTINUING IN FEE-FOR-SERVICE ORIGINAL MEDICARE

If dual eligible Medicare patients decline to enroll in a Cal MediConnect plan, or are excluded from joining a Cal MediConnect plan, their Medicare coverage will remain the same as it is today. The patient must join a Medi-Cal plan for their Medi-Cal benefits (i.e., long-term care, Medicare copays) but will not receive physician services through their Medi-Cal plan. They should not be assigned a primary care physician by their Medi-Cal plan. Their Medi-Cal plan does not authorize physician services.

Their physicians should bill for Medicare services exactly as in the past. Even if the patient is enrolled in a Medi-Cal managed care plan, the physician should bill for Medicare services – which include physician and hospital services – exactly as in the past. There is no change in what Medicare will pay for billed charges, generally 80% of the Medicare fee schedule.

It should be noted that no change is made in the rules governing the billing of the 20% co-pay for dual eligible patients. It continues to be **unlawful to bill dual eligible patients.**

In most cases, providers will need to send their "crossover claims" for that 20% co-pay to the patient's Medi-Cal managed care plan, which will pay the physician any amount owed under state Medi-Cal law. In some cases, Medicare will send these crossover claims directly to the Medi-Cal plans.

It should be noted that state law significantly limits Medi-Cal's reimbursement on Medicare claims, and there are few types of services where Medi-Cal owes any reimbursement on Medicare claims.

Physicians do not need to be part of the Medi-Cal plan's network or have a contract with the Medi-Cal plan to have these crossover claims processed and paid if the plan owes anything under state law.