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 certain physicians 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 we know dual eligible patients need to have a good quality of life. But many physicians do not, and feel overwhelmed – as can the patients themselves and their caregivers.

The **Coordinated Care Initiative** (CCI) is 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, and their physicians. Under the CCI, most dual eligibles can enroll in a new type of coordinated plan called a Cal MediConnect plan. These plans will be responsible for administering the benefits under both Medicare and Medi-Cal.

A key feature of Cal MediConnect is identifying high-risk enrollees who need a high degree of care coordination and assembling an appropriate care team to develop and track an Individualized Care Plan. All beneficiaries will be offered a Health Risk Assessment (see below) and subsequent care coordination, but these processes are designed particularly to help high-need beneficiaries.

HEALTH RISK ASSESSMENT

All people enrolled in a Cal MediConnect plan will be offered a Health Risk Assessment. Prior to the assessment, Cal MediConnect plans will stratify enrollees into high- and low-risk categories based on analysis of Medicare and Medi-Cal claims data and past health care utilization. Enrollees identified as high-risk, e.g., have had recent emergency room visits or hospitalizations or have certain diagnoses, will be contacted for an assessment within 45 days of enrollment into the plan. All other enrollees will be contacted within 90 days.

Cal MediConnect Health Risk Assessments are performed using plan-specific survey tools approved by the Centers for Medicare and Medicaid Services and the California Department of Health Care Services. Each plan has developed its own assessment tool, but all assessments must include some standard topics. Some plans will use vendors to conduct the assessments, while others will conduct the assessments themselves or through their delegates, including medical groups.

The assessments may be conducted in person, by phone, or by mail, depending on the enrollee's needs and preferences. The assessment is designed to determine what health care and social supports are needed and to identify existing gaps in care or continuity of care needs. Health Risk Assessments will identify an enrollee's primary, acute, long-term services and supports (LTSS), behavioral health and functional needs.

The results of the assessment will be shared with the enrollee and their health care providers. In some cases, you may automatically receive the results for your patients.

Cal MediConnect plans will reassess enrollees at least annually or sooner if the enrollee's condition changes, although a physician or the enrollee may request a reassessment earlier by contacting the Cal MediConnect plan.

INTERDISCIPLINARY CARE TEAM

As a physician, you have a key role to play in the Interdisciplinary Care Team (ICT). The ICT will provide the infrastructure for receiving and sharing information about your patients and makes it easier for your patients to get the various services and treatments they need.

The primary functions of the ICT are:

- Assessing the enrollee's health status and needs, on an ongoing basis
- Care planning
- Facilitating and coordinating delivery of services
- Facilitating transitions between institutions and the community
- Facilitating enrollee engagement in their care plan

The Health Risk Assessment results will help identify who serves on each enrollee's ICT, which is built around an enrollee's specific needs and preferences. The core team members will be (1) the enrollee, (2) the primary care provider, and (3) the enrollee's Cal MediConnect plan Care Coordinator.

Depending on the enrollee's desires and circumstances, the ICT may also include specialty physicians, a hospital discharge planner, nursing facility representative, physical therapist, social worker, personal care services provider, family member, and relevant social and supportive service providers.

Members of an ICT will have access to important information about enrollees. They will be notified of key events including changes in an enrollee's health status or level of care (including hospital admission or nursing facility placement) and updates to an enrollee's care or discharge plan.

The enrollee always has the option to decline an ICT or to appoint an agent to represent them on the ICT.

CARE COORDINATORS

Cal MediConnect plans will provide enrollees with Care Coordinators. These coordinators will either be licensed medical professionals or overseen by a licensed medical professional. Care Coordinators do not replace the important role of physicians in directing care for patients, but can help provide the care management support and smooth flow of information that can reduce administrative burdens for physicians' offices.

Coordinators will be accountable for providing care coordination services, including:

- Assessing appropriate referrals and timely two-way transmission of useful member information;
- Obtaining reliable and timely information about services other than those provided by the primary care provider;
- Assisting in the development and maintenance of the Individualized Care Plan (see below);
- Supporting safe transitions in care for members moving between settings.

The Care Coordinator will be a key point of contact for the enrollee and their providers about care coordination. Cal MediConnect enrollees may decline care coordination.

INDIVIDUALIZED CARE PLAN

Physicians can help develop an Individualized Care Plan (ICP) for their patients as a member of the Interdisciplinary Care Team (ICT). The plan must reflect the enrollee's specific goals, needs, and preferences, identifying what services and supports an enrollee needs, how the ICT will help the enrollee access those services and supports, and will include measurable objectives and timelines to meet an enrollee's needs.

Cal MediConnect plans will use the outcomes from the Health Risk Assessment to determine which enrollees need an ICP, although enrollees or their providers can always request an ICP be developed. Enrollees can decline a care plan. Enrollees, their authorized representatives and their providers may request a copy of the care plan by contacting the Cal MediConnect plan.