

This toolkit explains the **Coordinated Care Initiative (CCI)**, launched by the state of California for people with both Medicare and Medi-Cal – dual eligibles. The Coordinated Care Initiative includes Cal MediConnect, a health plan that brings together Medicare and Medi-Cal benefits, and mandatory Medi-Cal managed care for people who remain in Original Medicare (fee-for-service) or Medicare Advantage.

WHAT THE CCI MEANS FOR YOU AND YOUR PATIENTS

Whether you participate in a Cal MediConnect plan or only see patients in Original Medicare (fee-for-service) or Medicare Advantage (MA), this toolkit was designed to give physicians like you the information you need to know about these changes and the new choices your patients have for their health care coverage. This toolkit includes:

- Overview: How the Coordinated Care Initiative is changing health care for dual eligible patients.
- Continuity of Care: How to keep seeing your patients if they join a Cal MediConnect plan.
- Care Coordination: How Cal MediConnect plans can help support physicians in coordinating care for patients, including long-term services and supports.
- Billing Processes: How billing works under Cal MediConnect and how to submit crossover claims to Medi-Cal plans for Medicare fee-for-service patients.

The toolkit also includes a sample letter for patients to educate them about the program and important information that will help address questions you may receive from patients.

We expect many people receiving notices about Cal MediConnect will turn to you as a trusted advisor on medical issues. We thank you for helping your patients understand the facts about these changes and correcting any misunderstandings.

More information is available at www.CalDuals.org or www.dhcs.ca.gov.

You can email info@calduals.org with any questions or to request a training for your staff on 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. They are more 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.

Coordinating these services can also place a high burden on physician offices. Cal MediConnect can help connect patients to services and support their physicians.

The Coordinated Care Initiative (CCI) is a program designed to help provide extra support for low-income seniors and people with disabilities in California, including those who are dually eligible for Medicare and Medi-Cal.

Currently, the CCI is available in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The CCI 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 into a Cal MediConnect plan. These plans provide all Medicare and Medi-Cal benefits, plus additional care coordination, vision benefits, and some extra services.

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. People can choose to join Cal MediConnect or they can continue receiving Medicare services as they do today. They can choose to disenroll at any time.

ORIGINAL MEDICARE & MEDI-CAL MANAGED CARE

California also requires 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 copays. Consequently, the Medi-Cal plan will be responsible for any reimbursement physicians previously received from the state for Medicare cost sharing. Physicians do not need to be contracted with the Medi-Cal plan's network to submit a bill for any Medicare cost sharing the plan owes under state law. Usually, because of state law, the Medi-Cal plan will not be required to pay anything. Also, the Medi-Cal plan will not assign a primary care physician to the patient.

Cal MediConnect health plans can support physicians in coordinating care for patients, including long-term services and supports. 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.

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 Health Risk Assessment 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 MEDICCONNECT 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 up to 12 months if you and the 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.

The continuity of care provision 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 ORIGINAL MEDICARE (FEE-FOR-SERVICE) OR MEDICARE ADVANTAGE

If dual eligible patients are not enrolled in a Cal MediConnect plan, their Medicare coverage will remain the same as it is today. Patients 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 patients are enrolled in a Medi-Cal 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, which is 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% copay 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% copay to the patient's Medi-Cal 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.

As a reminder, 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.

Many dual eligibles are living with disabilities and have a right to accessible health care facilities or other assistance accessing services.

Providers are required to make their facilities accessible to people with disabilities under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Additionally, providers must make other accommodations to ensure health services are accessible and that they can communicate effectively with their patients.

ACCESSIBILITY REQUIREMENTS

Under federal and state law, medical care providers must provide individuals with disabilities:

- 1 Full and equal access to their health care services and facilities;
- 2 Reasonable modifications to policies, practices, and procedures when necessary to make health care services accessible; and
- 3 Effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.

PHYSICAL ACCESS

Providers must make their facilities accessible, including their medical equipment and exam rooms. The law requires the development and maintenance of accessible paths of travel, elevators, ramps, doors that open easily, reachable light switches, accessible bathrooms, accessible parking, and signage that can be used by individuals who are blind or have low vision.

Additionally, health care providers must provide accessible equipment, such as exam tables and diagnostic equipment, and use a lift or trained staff as necessary to ensure equal access to medical examinations and tests. Office staff must also schedule the use of accessible rooms, equipment, and trained staff to ensure availability as needed.

REASONABLE MODIFICATIONS

The ADA provides protection from discrimination for people with all types of disabilities, including people with physical, cognitive, communication, and mental health disabilities. Health care providers must make “reasonable modifications in policies, practices and procedures” when necessary to avoid discrimination on the basis of disability, unless the provider can demonstrate that making the modification would “fundamentally alter the nature of the service, program or activity.”

Some examples of reasonable modifications health care providers may need to make to accommodate people with disabilities include:

- Taking extra time to explain a procedure to a patient who has a cognitive disability and might have difficulty understanding;
- Scheduling an appointment at a specific time to accommodate a patient with an anxiety disorder who has difficulty waiting in a crowded waiting room; or
- Allowing patients to be accompanied by service dogs.

EFFECTIVE COMMUNICATION

Under the ADA, health care providers must provide effective communication for patients, family members, and visitors who are blind, visually impaired, deaf, or hard of hearing. Since people who are blind, visually impaired, deaf, or hard of hearing use a variety of ways to communicate, the method that the health care provider must provide will vary depending on the abilities of the individual, his or her preferences for communication, and the complexity, importance, and nature of the communications required.

Communication methods patients may request will vary by their needs and preferences:

- 1 Assistance for the Blind or Visually Impaired:** Readers, taped texts, Braille materials, buying or modifying equipment, and assistance with filling out forms.
- 2 Assistance for the Deaf or Hard of Hearing:** Qualified sign language interpreters, assistive listening devices, note takers, written materials, television decoders, closed caption decoders, and real-time captioning.

Whatever method is used, the person's privacy and independence must be respected.

Note: A health care provider cannot require individuals who are blind, visually impaired, deaf, or hard of hearing to bring someone with them to interpret or facilitate communication, and generally cannot rely on a companion to interpret or facilitate communication. A health care provider cannot charge patients for providing sign language interpreter services or alternative formats. Cal MediConnect plans and Medi-Cal plans will provide sign language interpreter services for members.

PROCEDURES FOR PROVIDING ACCOMMODATIONS

Health care providers must:

- Ensure that individuals are informed of their right to request accommodations;
- Provide individuals with information about the process for requesting accommodations; and
- Provide individuals with information about filing complaints about accommodations with the health plan if the provider is in a plan network, and filing complaints with other entities that oversee disability access laws in the health care context.

There are many tools that can help you assess the accessibility of your office, exam rooms, equipment and communication. For example, see the U.S. Department of Justice publication, "**Access To Medical Care For Individuals With Mobility Disabilities**". In addition, Cal MediConnect plans and Medi-Cal plans have trained clinical staff who survey all primary care and some specialty care offices and make recommendations about how to improve accessibility. Contact your Cal MediConnect or Medi-Cal plan for more information.

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- 1 See the Harris Family Center for Disability and Health Policy's training program at <http://www.hfcdhp.org/training/>; See also http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm
 - 2 More information about physical access requirements is available at: 28 C.F.R. § 35.151 (Title II); 28 C.F.R. Part 36, Subpart D (Title III). Regulations available at: <http://www.ada.gov/reg2.html> and <http://www.ada.gov/reg3a.html>; Cal.Gov't.Code §§ 4450 et seq. See also, <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2010/PL10-016.pdf>; <http://www.ada.gov/rachek.pdf>
 - 3 http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm#accessmedequip
 - 4 *More information is available at* <http://www.afb.org/info/programs-and-services/public-policy-center/ada-checklist-health-care-facilities-and-service-providers/125>; <http://www.ada.gov/hospcombr.htm>.
 - 5 See, e.g., U.S. Department of Health and Human Services Office of Civil Rights (OCR) www.hhs.gov/ocr/civilrights/complaints; United States Department of Justice (DOJ), www.askDOJ@usdoj.gov; California Department of Social Services (CDSS) Civil Rights Bureau (CRB), www.dss.cahwnet.gov/cdssweb/PG49.htm; California Department of Managed Care, <http://www.dmhc.ca.gov/>.

Under the **Coordinated Care Initiative (CCI)**, certain dual eligible beneficiaries who choose not to enroll in Cal MediConnect will still be mandatorily enrolled in Medi-Cal plans for their Medi-Cal benefits, including Medicare cost sharing. This document explains how physicians can bill the Medi-Cal payment portion for dual eligible beneficiaries in Medi-Cal plans.

For more information about how payment works for physicians serving beneficiaries in Medicare and a Medi-Cal plan, please see the physician payment fact sheets available at www.CalDuals.org/providers.

For beneficiaries that are in Medi-Cal plans, Medicare should be billed as usual. Medicare will pay 80 percent of the Medicare fee schedule. The 20 percent copay cannot be billed to dual eligible patients. Instead, these “crossover claims” must go to the patient’s Medi-Cal plan, which will pay any amount owed under state Medi-Cal law. Since 1982, state law has limited Medi-Cal’s reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal’s maximum payment for similar services. Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not pay anything on these crossover claims.

The CMS Coordination of Benefits Agreement (COBA) Program allows crossover claims to go directly to the Medi-Cal plan after the claims have been submitted to Medicare. As most Medi-Cal plans are not yet participating in this automated process, the chart below outlines how Medicare providers should submit their Medi-Cal claims to each plan.

Providers should use the Medi-Cal eligibility verification system to identify a patient’s Medi-Cal plan. Learn more about this system at www.Medi-Cal.ca.gov/Services.asp.

Physicians do not need to be contracted with a Medi-Cal plan’s network to submit a crossover claim.

HEALTH PLAN	CCI COUNTY PARTICIPATION	IF A PROVIDER NEEDS TO SUBMIT A MEDI-CAL CROSSOVER CLAIM, HOW SHOULD THEY DO THAT?
ANTHEM BLUE CROSS Provider Relations: 855-817-5786	Santa Clara	Submit paper claims with Medicare EOB to: Anthem Blue Cross P.O. Box 60007, Los Angeles, CA 90060-0007
CALOPTIMA Provider Relations: 714-246-8600	Orange	CalOptima receives crossover claims automatically from Medicare. Physicians can also submit paper claims to: CalOptima CMC Crossover Claim P.O. Box 11070, Orange, CA 92856
CARE1ST* Provider Relations: 323-889-6638, ext. 3388	Los Angeles, San Diego	Submit paper claims with Medicare EOB to: Care1st Health Plan Mail Stop: CL005 (Claims COB) 601 Potrero Grande Drive, Monterey Park, CA 91755

* On January 1, 2019, Care1st Health Plan’s name is changing to Blue Shield of California Promise Health Plan.

HEALTH PLAN	CCI COUNTY PARTICIPATION	IF A PROVIDER NEEDS TO SUBMIT A MEDI-CAL CROSSOVER CLAIM, HOW SHOULD THEY DO THAT?
COMMUNITY HEALTH GROUP Provider Relations: 619-422-0422	San Diego	Submit paper claims to: Community Health Group Claims Payment 2420 Fenton street, Suite 100 Chula Vista CA 91914
HEALTH NET Provider Relations: 800-675-6110	San Diego and Los Angeles	Submit paper claims with Medicare EOB to: Health Net Medi-Cal Claims P.O. Box 14598, Lexington, KY 40512 Health Net Medicare Claims P.O. Box 14703, Lexington, KY 40512 Other Crossover Claims Procedures: If a crossover claim is submitted where the member has Health Net coverage for Medicare and for Medi-Cal, the claim is routed internally for processing.
HEALTH PLAN OF SAN MATEO Provider Relations: 650-616-2106	San Mateo	Submit paper claims with Medicare EOB to: HPSM 701 Gateway Blvd., Ste 400 South San Francisco, CA 94080
INLAND EMPIRE HEALTH PLAN Provider Relations: 909-890-2054	Riverside, San Bernardino	Submit paper claims with Medicare EOB to: Inland Empire Health Plan P.O. Box 4259, Rancho Cucamonga, CA 91729-4259
L.A. CARE HEALTH PLAN Provider Relations: 213-694-1250 ext. 4719	Los Angeles	Submit paper claims with Medicare EOB to: L.A. Care Claims Department P.O. Box 811580 Los Angeles, CA 90081
MOLINA Provider Relations: 888-665-4621	Riverside, San Bernardino, San Diego, and Los Angeles	Submit paper claims to: P.O. Box 22702, Long Beach, CA 90801 Electronic claims: Send EDI to: P.O. Box 22807, Long Beach, CA 90801 Electronic EDI Submission: EDI Vendor: EMDEON Emdeon Payer ID: 38333
SANTA CLARA FAMILY HEALTH PLAN Provider Relations: 408-376-2000	Santa Clara	Submit paper claims with Medicare EOB to: SCFHP P.O. Box 18640, San Jose, CA 95158 Electronic claims: Providers can electronically submit their claims as HIPAA compliant X12 837 5010 P/I transactions to our clearinghouse—Office Ally. Providers must attach the Medicare EOB or RA to allow SCFHP to coordinate benefits under Medi-Cal.



California's **Coordinated Care Initiative**
www.CalDuals.org | info@calduals.org

Date
Patient Name
Address
City, CA ZIP

Dear (Type patient's name here):

Cal MediConnect is a type of health care plan that will combine your medical, mental health, and long-term services and supports into one health plan. Cal MediConnect plans will help you coordinate your care and your Medicare and Medi-Cal services. This will help you, your doctors, and caregivers work together to get you the care you need and help you live a healthy life.

If you are eligible for Cal MediConnect, you can make a choice about how you want to receive your Medicare and Medi-Cal benefits. Joining Cal MediConnect is your choice. If you do not want to join a Cal MediConnect plan, you can keep your Medicare the way it is now. You will have to choose a Medi-Cal plan for your Medi-Cal benefits. You will not lose your Medicare or Medi-Cal benefits no matter what you choose. Joining a health plan does not cost you anything.

As your doctor, I want to make sure you have the information you need to understand your options and make the best choice for you. I am part of Cal MediConnect so whether or not you join, I can still be your doctor.

You can also contact my office at (XXX) XXX-XXXX to find out which Cal MediConnect plans we accept.

Sincerely,

(Type your name here), M.D.
Enclosure

Find a customizable electronic version at: <http://www.calduals.org/physician-toolkit/>

DUAL ELIGIBLE Patient Insurance Status and Where Physicians Bill for Services

PATIENT MEDICARE & MEDI-CAL STATUS	PHYSICIAN CONTRACTED WITH HEALTH PLAN		PHYSICIAN NOT CONTRACTED WITH HEALTH PLAN		AMOUNT PAYABLE
	MEDICARE PHYSICIAN SERVICE CLAIM	MEDI-CAL WRAP/ COPAYMENT CROSSOVER CLAIM	MEDICARE PHYSICIAN SERVICE CLAIM	MEDI-CAL WRAP/ COPAYMENT CROSSOVER CLAIM	
Original/fee-for-service (FFS) Medicare FFS Medi-Cal	Not Applicable		Bill Medicare directly	Medi-Cal will automatically receive and process claims	Medicare: 80% of Medicare fee schedule Medi-Cal: Amount allowable under state law
Original Medicare (FFS) Medi-Cal managed care plan	Not Applicable		Bill Medicare directly	Bill Medi-Cal managed care plan (no contract required)	Medicare: 80% of Medicare fee schedule Medi-Cal: Amount allowable under state law
Medicare Advantage (MA) plan FFS Medi-Cal	Bill Medicare Advantage plan	Bill Medi-Cal directly	Bill MA plan (only for continuity of care or emergency services)	Bill Medi-Cal directly	Medicare: Refer to health plan contract terms Medi-Cal: Amount allowable under state law
Medicare Advantage (MA) plan Medi-Cal managed care plan	Bill Medicare Advantage plan	Bill Medi-Cal managed care plan	Bill MA plan (only for continuity of care or emergency services)	Bill Medi-Cal managed care plan (no contract required)	Medicare: Refer to health plan contract terms Medi-Cal: Amount allowable under state law
Cal MediConnect (combined Medicare and Medi-Cal)	Bill Cal MediConnect plan		Bill Cal MediConnect plan (only for continuity of care or emergency services)		Medicare: Refer to health plan contract terms Medi-Cal: Refer to health plan contract terms
Program of All-inclusive Care for the Elderly (PACE)	Bill PACE plan		Bill PACE plan (only for continuity of care or emergency services)		Medicare: Refer to health plan contract terms Medi-Cal: Refer to health plan contract terms

The Coordinated Care Initiative (CCI) is designed to help provide 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 type of coordinated plan called a Cal MediConnect plan. These plans are 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 Interdisciplinary Care Team to develop and track an Individualized Care Plan. All beneficiaries are 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 are offered a Health Risk Assessment. Prior to the assessment, Cal MediConnect plans 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 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 the patient needs and to identify existing gaps in care or continuity of care needs. Health Risk Assessments identify an enrollee's primary, acute, long-term services and supports (LTSS), behavioral health, and functional needs.

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

Cal MediConnect plans 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 play a key role in the Interdisciplinary Care Team (ICT). The ICT provides 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;
- Engaging the enrollee in their care plan.

The Health Risk Assessment results 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 the enrollee, the primary care provider, and 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 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); and
- Supporting safe transitions in care for members moving between settings.

The care coordinator is 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 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.

WHEN MEDICARE & MEDI-CAL BENEFITS ARE SEPARATE

For patients who choose to keep their Medicare and Medi-Cal separate, physicians will need to continue to bill Medicare and Medi-Cal separately. Physicians can never balance bill dual eligible patients.

- Claims for Medicare-covered services will go to the Medicare Advantage plan or directly to Medicare for FFS patients.
- Claims for Medi-Cal covered services and Medicare coinsurance and copays should be sent to the Medi-Cal plan. Physicians do not need to be part of the Medi-Cal plan's network to have these crossover claims processed and paid.

PAYMENT FOR MEDICARE PHYSICIAN SERVICES PROVIDED TO DUAL ELIGIBLES

Physician services for dual eligibles are the responsibility of Medicare, not Medi-Cal. It is a Medicare benefit paid primarily under the Medicare fee schedule. For most physician services in Original Medicare (fee-for-service), physicians receive 80 percent of the Medicare fee schedule.

Medi-Cal is responsible for services and supports not covered under Medicare, including Medicare cost sharing, as well as some long-term care, durable medical equipment, and other services and supports. The only role Medi-Cal managed care plans have with respect to physician services for dual eligibles who remain in Original Medicare (fee-for-service) is to adjudicate the payment of crossover claims for any Medicare cost sharing owed under California state law.

WHEN MEDICARE & MEDI-CAL BENEFITS ARE COMBINED: CAL MEDICONNECT OR PACE

Cal MediConnect - Patients enrolled in Cal MediConnect generally need to receive all their physician services from providers in the Cal MediConnect plan network. Physicians who are part of a Cal MediConnect plan's network no longer need to bill Medicare or Medi-Cal for Cal MediConnect enrollees' care. They will receive all payments directly from the Cal MediConnect health plan or the plan's delegate (IPA or medical group). This simplifies billing processes for physicians. Some physicians may receive monthly capitation payments, and some may bill fee-for-service, depending on the arrangement they have with the Cal MediConnect plan or its delegate. These processes are similar to processes used by Medicare Advantage plans.

Physicians who are not part of a Cal MediConnect plan's network may, under certain circumstances and for a limited period of time, be able to continue to provide services to their patients under Cal MediConnect continuity of care guidelines. See the continuity of care fact sheet in this toolkit for more information.

PACE - Patients enrolled in a Program of All-inclusive Care for the Elderly (PACE), another option given to certain high-need persons living in areas served by a PACE program, need to receive physician services from providers in the PACE plan's network, and providers must contract with the PACE plan for all Medicare and Medi-Cal payments.

Medicare Advantage Plans or D-SNPs - Patients enrolled in a **Medicare Advantage** plan or **Medicare Advantage Dual Special Needs Plan (D-SNP)** must receive their physician services from providers who are in that plan's network of providers. For Medicare-covered services, physicians may receive a capitation from the Medicare Advantage plan or its delegate (IPA or medical group) or may bill fee-for-service depending on their contract.

Medicare Fee-For-Service - Cal MediConnect, PACE and other Medicare managed care plans are voluntary. Dual eligible patients may choose instead to receive their Medicare services from Original Medicare (fee-for-service). Billing and payment to Medicare for services for these patients will be the same as it has been in the past, even though dual eligible patients now have to be enrolled in a Medi-Cal plan. Medicare should be billed and will pay 80 percent of the Medicare fee schedule. **By law, the 20 percent copay cannot be billed to dual eligible patients.**¹

Role of Medi-Cal Plans - Physicians treating dual eligible patients enrolled in a Medi-Cal plan (but not enrolled in Cal MediConnect or PACE) will need to send their "crossover claims" for the 20 percent copay to the patient's Medi-Cal plan, which will pay the physician any amount owed under state law. In some cases, Medicare will send these crossover claims automatically and directly to the Medi-Cal plans. **Physicians do not need to be part of the Medi-Cal plan's network to have these crossover claims processed and paid.**

It should be noted, however, that state law limits Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum allowed for similar services.² Essentially, this means that if the Medi-Cal rate is 80% or less of the Medicare rate for the service rendered, Medi-Cal will not reimburse anything on these crossover claims.

This is true under fee-for-service Medi-Cal and has been state law for over 30 years. If the Medi-Cal rate is higher, providers will receive the payment. For example, in 2014 many primary care providers received Medi-Cal reimbursement as Medi-Cal payments for primary care services in certain circumstances have been raised to 100 percent of Medicare under the Affordable Care Act.

Since Medi-Cal reimbursements are generally lower than Medicare reimbursements, there are few types of services where Medi-Cal owes any reimbursement on Medicare claims.

1 Welfare and Institutions Code, Section 14019.4. (a): "A provider of health care services ... shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient...."

2 Welfare and Institutions Code, Section 14109.5: "Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services."

The **Coordinated Care Initiative (CCI)** is an effort by California and the federal government to integrate the delivery of medical, behavioral, and long-term services and supports for persons eligible for both Medicare and Medi-Cal (i.e., dual eligibles).

Most dual eligibles in seven counties will be eligible to enroll in a type of coordinated plan, called a Cal MediConnect plan. These plans are responsible for administering the benefits under both programs.

Participation in Cal MediConnect is voluntary, so people can choose to join or choose to continue receiving Medicare services as they do today. They can choose to disenroll at any time.

If your dual eligible patients decide not to join a Cal MediConnect plan, they can continue to see you as a Medicare fee-for-service (FFS) physician. However, California is requiring most dual eligibles who do not enroll in a Cal MediConnect plan to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits, including long-term services and supports.

The state has received reports of a common but dangerous misunderstanding: patients who decide they want to continue in Original Medicare are being told they may not continue to see their existing physicians if they are enrolled in a Medi-Cal plan. This is plainly false. Patients remaining with Original Medicare (fee-for-service) may continue to see their current physicians even if they join a Medi-Cal plan. Medicare physicians do not need to be contracted with Medi-Cal plans to see dual eligible patients. This misunderstanding prevents the patient's effort to be treated by the physician and causes the physician to lose that patient, based on false information. See below for billing instructions.

FINANCIAL RESPONSIBILITY FOR PHYSICIAN SERVICES

Physician services provided to dual eligibles are the financial responsibility of Medicare, not Medi-Cal. It is a Medicare benefit paid primarily under the Medicare fee schedule. For most physician services, the rate physicians receive is 80 percent of the Medicare fee schedule.

Medi-Cal has responsibility for services and supports not covered under Medicare, including Medicare cost sharing, as well as some long-term care, durable medical equipment, incontinence supplies, and other services and supports. The only role Medi-Cal managed care plans have with respect to physician services for dual eligibles is to adjudicate the payment of crossover claims for any Medicare cost sharing owed under California state law.

BILLING FOR ORIGINAL MEDICARE (FEE-FOR-SERVICE)

If dual eligible Medicare patients decline to enroll in a Cal MediConnect plan, or are excluded from joining a Cal MediConnect plan, 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 exactly as in the past. There is no change in what Original Medicare (fee-for-service) will pay for billed charges, generally 80 percent of the Medicare fee schedule.

It should be noted that **no change** is made in the rules governing the billing of the 20 percent copay for dual eligible patients. It continues to be **unlawful to bill dual eligible patients**.¹ Instead, that claim for the 20 percent copay should be sent to the patient's Medi-Cal plan – this is known as a "crossover claim."

BILLING CROSSOVER CLAIMS

In most cases, providers will need to send their “crossover claims” for the 20 percent copay to the patient’s Medi-Cal plan, which will pay the physician any amount owed under state Medi-Cal law. In some limited cases, Medicare will send these crossover claims automatically and directly to the Medi-Cal plans. **Physicians do not need to be part of the Medi-Cal plan’s network to have these crossover claims processed and paid.** Please refer to the “How Medi-Cal Plans Process Crossover Claims” document in this toolkit for a chart outlining how Medi-Cal plans will process crossover claims.

As a reminder, **no change** is made in the rules governing how much the Medi-Cal plans will pay on these claims for Medicare services to dual eligibles. Since 1982, state law has limited Medi-Cal’s reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal’s maximum payment for similar services.² Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not reimburse anything on these crossover claims. If the Medi-Cal rate is higher, providers will receive the payment. For example, in 2014 many primary care providers received Medi-Cal reimbursement, as Medi-Cal payments for primary care services in certain circumstances have been raised to 100 percent of Medicare under the Affordable Care Act.

However, since Medi-Cal reimbursement rates are generally lower than Medicare rates (80 percent of the Medicare fee schedule), it is anticipated that **there are few types of services where Medi-Cal owes any reimbursement on Medicare claims.** Again, this is not the result of the **Coordinated Care Initiative.** This has been the law in California for over 30 years.



- 1 Welfare and Institutions Code, Section 14019.4. (a): “A provider of health care services ... shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient....”
- 2 Welfare and Institutions Code, Section 14109.5: “Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services.”

The **Coordinated Care Initiative (CCI)** is an effort by California and the federal government to integrate the delivery of medical, behavioral, and long-term services and supports for persons eligible for both Medicare and Medi-Cal (i.e., dual eligibles).

CALIFORNIA'S CCI CONSISTS OF TWO PARTS:

1 Cal MediConnect

Most dual eligibles are eligible to enroll in this coordinated plan that is responsible for administering the benefits under both Medicare and Medi-Cal. A major focus of Cal MediConnect is supporting physicians in the management of complex patients. Participation is voluntary and dual eligibles can disenroll at any time.

2 Managed Long-Term Services and Supports (MLTSS)

California is also requiring most dual eligibles who do not enroll in a Cal MediConnect plan to enroll in a Medi-Cal managed care plan for their Medi-Cal benefits, including long-term services and supports (LTSS). A dual eligible who does not enroll in Cal MediConnect will continue to receive their Medicare as they do currently, through either a Medicare Advantage plan or Original Medicare (fee-for-service), but most Medi-Cal benefits will be administered by a Medi-Cal managed care plan. Enrollment in a Medi-Cal plan will not interfere with Medicare services or payment, which includes hospitalizations and physician services.

CONTRACTING WITH CAL MEDICONNECT PLANS

If your patient joins a Cal MediConnect plan and you are in the plan network, your patient may request to continue seeing you by contacting the health plan's Member Services. If your patient joins a Cal MediConnect plan and you want to join the plan's network, see instructions below for how to contact the plan. Please note that most health plans contract with IPAs and medical groups. Physicians may have to contract with those groups in order to join the health plan network. Each plan can provide a list of its Cal MediConnect contracted IPAs and medical groups upon request.

If your patient joins a Cal MediConnect plan and you remain out-of-network, **continuity of care** allows you to **continue seeing your patient for up to 12 months**, if you and the plan agree to terms. Please see the continuity of care fact sheet in this toolkit for details on this process. After the continuity of care period, you likely will have to contract with the Cal MediConnect plan to continue seeing your patient.

If your patient is in Original Medicare (fee-for-service) or a Medicare Advantage plan and joins a Medi-Cal plan, you may continue seeing that patient as usual. You do not need to contract with the Medi-Cal plan to continue seeing your patient.

For more information about continuity of care and other payment issues, visit www.CalDuals.org/providers.

TO JOIN A CAL MEDICONNECT NETWORK

Below are the Cal MediConnect plans in each county participating in the **Coordinated Care Initiative**. To find out more about how to join the network of Cal MediConnect plans in your county, please refer to the provider-specific resources below.

COUNTY	HEALTH PLAN NAME	PROVIDER SERVICES CONTACT INFORMATION
LOS ANGELES	Care1st*	323-889-6638, ext. 3388 http://bit.ly/care1stprov
	CareMore**	888-291-1358 http://bit.ly/caremoreprov
	Health Net	855-464-3571 Participating provider website http://bit.ly/healthnet-part-prov Non-participating provider website http://bit.ly/non-part-prov
	L.A. Care	866-522-2736 http://bit.ly/lacare_prov
	Molina Health Plan	888-665-4621, http://bit.ly/molinapro
ORANGE	CalOptima	714-246-8600, http://bit.ly/caloptima-prov
RIVERSIDE / SAN BERNARDINO	Inland Empire Health Plan	909-890-2054, http://bit.ly/iehp-prov
	Molina Health Plan	888-665-4621, http://bit.ly/molinapro
SAN DIEGO	Care1st*	323-889-6638, ext. 3388 http://bit.ly/care1stprov
	Community Health Group	619-422-0422, http://bit.ly/chgsd_prov
	Health Net	855-464-3572 Participating provider website http://bit.ly/healthnet-part-prov Non-participating provider website http://bit.ly/non-part-prov
	Molina Health Plan	888-665-4621, http://bit.ly/molinapro
SAN MATEO	Health Plan of San Mateo	650-616-2106, http://bit.ly/hpsm-prov
SANTA CLARA	Santa Clara Family Health Plan	408-376-2000, http://bit.ly/scfhp-prov
	Anthem Blue Cross	855-817-5786 http://bit.ly/anthem_prov

*On January 1, 2019, Care1st Health Plan's name is changing to Blue Shield of California Promise Health Plan.

**On January 1, 2019, CareMore Health Plan's name is changing to Anthem Blue Cross.

CONTINUITY OF CARE PROTECTIONS

After enrolling, dual eligible patients in a Cal MediConnect plan are eventually required to receive all covered services from physicians and other providers who are part of the plan's network. However, enrollees in a Cal MediConnect plan have continuity of care rights – the right to temporarily continue seeing an existing physician outside the Cal MediConnect network for a specified period following enrollment.

In addition to the generally applicable ability to request completion of covered services for certain conditions¹, enrollees may be able to continue to receive Medicare-covered services from an existing primary or specialty care physician with whom they have an existing relationship for up to 12 months.

CONDITIONS FOR CONTINUITY OF CARE

All of the following conditions must be met in order for a Cal MediConnect enrollee to receive continuity of care from an out-of-network physician:

- The enrollee, their authorized representative, or their physician may request continuity of care from the Cal MediConnect plan.
- The plan must validate that the enrollee had a pre-existing relationship with the physician(s) prior to enrollment in Cal MediConnect. To demonstrate this relationship with a physician, the enrollee must have seen the physician at least once in the 12 months preceding enrollment. Plans must review Medicare claims data to validate this relationship before requesting evidence from the enrollee or physician.
- The out-of-network physician must be willing to accept the Cal MediConnect plan rate or the applicable Medicare or Medi-Cal rate, whichever is higher, and agree to receive payment from the plan. This is typically 80 percent of the Medicare fee schedule, plus any copayments owed under state law.
- The physician must enter into some type of simple agreement with the health plan and agree to follow the plan's utilization management rules.
- The physician is not excluded from the plan's network due to quality of care issues or failure to meet federal or state requirements.

STEPS FOR PROCESSING CONTINUITY OF CARE REQUESTS

Cal MediConnect plans must attempt to determine if there are continuity of care needs during the Health Risk Assessment process that takes place soon after enrollment. Alternatively, enrollees, their authorized representatives or their physicians can make requests using the following steps:

- 1 The enrollee advises the physician that s/he has enrolled in a Cal MediConnect plan and determines whether or not the physician is part of the plan's network. OR: The physician, upon checking the enrollee's eligibility, advises the enrollee that s/he is enrolled in a Cal MediConnect plan and informs the enrollee whether or not the physician is part of the plan's network.

¹ Acute or serious chronic conditions, pregnancy, terminal illness, care of newborn child from birth to 36 months, or performance of surgery or other procedure authorized by the plan as part of a documented course of treatment. (California Health and Safety Code, Section 1373.96)

2 If the physician is not part of the plan's network, the enrollee, their representative, or the physician contacts the Cal MediConnect plan and tells the plan that they want to continue treatment based on the pre-existing relationship.

- Plans must allow continuity of care requests by phone.
- It is the plan's responsibility to first attempt to validate the pre-existing relationship through Medicare claims data before requesting evidence from the enrollee or provider.

3 The Cal MediConnect plan works with the physician and makes a good faith effort to determine:

- Whether the physician will accept the higher of the Medicare or plan rate for services, and
- Whether there are quality issues that would prevent the physician from being eligible to participate with the plan for this enrollee.

If an agreement is reached between the Cal MediConnect plan and the physician, the enrollee can continue receiving Medicare services from the physician for up to 12 months. At the discretion of the Cal MediConnect plan, this continuity of care period may be extended.

