

Cal MediConnect Hospital Case Manager Tool Kit

Cal MediConnect is a type of health plan that promotes coordinated health care delivery to seniors and people with disabilities who are dually eligible for both Medicare and Medi-Cal, sometimes referred to as “dual eligible beneficiaries” or “Medi-Medis.”

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

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



Case Managers and Cal MediConnect

Case management standards and Cal MediConnect policies are closely aligned.

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

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

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

Cal MediConnect patients are a unique population with special considerations. This tool kit will explain the process for coordinating care with their Cal MediConnect health plan and cover common questions regarding:

- Admitting a Cal MediConnect Patient (Page 2)
- Requesting Authorizations from Cal MediConnect Health Plans (Page 3)
- Billing Cal MediConnect Health Plans (Page 4)
- Care Coordination for Cal MediConnect Patients (Pages 5-6)
- Discharge Planning for Cal MediConnect Patients (Page 7)
- Considerations for Patients with Cognitive Impairment (Page 8-9)
- Further Resources for You (Pages 10-13)
- Cal MediConnect Health Plan Contact Sheet (Page 14)

Admitting a Cal MediConnect Patient

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

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

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

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

Key Points: Admitting Cal MediConnect Patients

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

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

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

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

Requesting Authorizations from Cal MediConnect Health Plans

Cal MediConnect Health Plan Responsibilities

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

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

Authorization Time Frames

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

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

Authorizations from Cal MediConnect Health Plan Delegates

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

Troubleshooting: Cal MediConnect Authorizations

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

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

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

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

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

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

Billing Cal MediConnect Health Plans

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

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

Delegated Hospital Risk

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

Knowing Who to Bill

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

The patient's Cal MediConnect insurance card includes billing information.

In no instance should you bill the patient.

Care Coordination for Cal MediConnect Patients

Care Coordination Under Cal MediConnect

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

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

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

The following resources are available to each Cal MediConnect patient:

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

Health Risk Assessments (HRAs)

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

HRAs as a resource for you:

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

Care Coordinators

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

Care Coordinators as a resource for you:

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

Interdisciplinary Care Teams (ICTs)

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

ICTs as a resource for you:

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

Individualized Care Plan

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

ICPs as a resource for you:

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

Keep in Mind: Care Coordination and Cal MediConnect

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

Discharge Planning for Cal MediConnect Patients

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

Your patient's Cal MediConnect health plan is responsible for ensuring a patient receives all needed medical supports and services through post-discharge and the transition into the community or a nursing facility.

Partner with your patient's Cal MediConnect health plan when the patient is admitted and at each step in the discharge planning process to ensure a coordinated, safe, and patient-centered discharge plan.

Cal MediConnect is designed to discharge beneficiaries to the most appropriate level of care.

- Health plans must facilitate transitioning patients to the most appropriate setting of care, based on their medical, behavioral, and social needs and preferences within 72 hours— whether that is in a Skilled Nursing Facility (SNF), a SNF alternative, or the community.
- Under continuity of care rights, patients have the right to return to their long-term SNF if it is safe to do so.
- Upon discharge, patients have access to all medically necessary Medicare and Medi-Cal benefits, including inpatient rehabilitation facilities, long-term care hospitals, partial-hospitalization, nursing facilities, and home- and community-based services and supports.

Cal MediConnect health plans and the patient's Care Coordinator can help you:

- Document pre-admission or baseline health status of your patient.
- Work with the patient and patient's caregiver(s) to identify goals following discharge.
- Ensure that the patient and the patient's caregiver(s) have all necessary medications and that follow-up appointments have been scheduled.
- Set up supports and services for patients transitioning back into the community, including: LTSS, IHSS hours, durable medical equipment (DME), and transportation.
- Identify the most appropriate and accessible in-network facility to meet the patient's needs, for patients requiring more services and supports.
- Coordinate the discharge plan as a part of the patient's ICT and ICP.

For more information, see Dual Plan Letter 16-003: Discharge Planning for Cal MediConnect

- <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-003.pdf>

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

Patients with Cognitive Impairment: Considerations for Admissions and Discharge

Caring for Cal MediConnect Patients with Cognitive Impairment

Patients with cognitive impairment are often high-risk patients because as the disease progresses, they are unable to manage self-care such as following care protocols and discharge instructions. Accounting for cognitive impairment in Cal MediConnect patients will improve your ability to work with the patient's Cal MediConnect health plan to deliver quality care from admission through discharge.

Examples of how cognitive impairment may directly impact care include:

- Patients cannot accurately provide medical history and/or manage current treatments/prescriptions
- Confusion in the hospital setting leading to safety concerns (for patient and/or staff)
- Poor management of co-existing conditions during hospitalization and once discharged
- Difficulty in taking medications correctly once discharged
- Inability to make and follow through with post-discharge doctors' appointments, lab tests, etc.

Identifying and Engaging Your Patient's Family and Informal Caregivers

Family and other caregivers are crucial partners in delivering quality care for those with cognitive impairment and/or dementia. Not only can they provide assistance in the hospital and at home, but they can also help navigate the entire continuum of care from admissions to post-discharge. While some patients receive support just from family members and informal caregivers, others may receive support through the In-Home Supportive Services (IHSS) Program, which pays for services to help keep people in their homes.

Identifying a family member or caregiver upon a patient's admission to the hospital is crucial. California legislation mandates that hospitals provide each admitted patient with the opportunity to identify one unpaid family caregiver who may assist in post-hospital care and then record the caregiver's information in the patient's medical record. If a caregiver has been identified, he/she must be notified of the patient's discharge or transfer to another facility as soon as possible, but at a minimum, upon issuance of a discharge order by the attending physician.

Provider Responsibilities

In caring for those with dementia and/or cognitive impairments, providers have the following responsibilities:

- Identify patients who may have cognitive impairment taking into consideration that:
 - Many people with cognitive impairment will not provide accurate self-reports of cognitive issues.
 - Many people with dementia have never received a formal diagnosis from their health care provider.
- Consider differential diagnoses. Dementia and delirium may be confused, especially in a hospital setting.
- Identify and engage a family or other caregiver.
 - Document the primary family or informal caregiver in the medical record, including relationship to patient and contact information.
 - Share this crucial information with the Cal MediConnect health plan and provider group.
 - Encourage the family or informal caregiver to actively participate in post-discharge care planning with the Interdisciplinary Care Team and care coordinator provided through your patient's Cal MediConnect health plan.
- Upon discharge from the hospital, ensure that the family receives dementia-specific care transitions support and information.
 - Assess the caregiver's needs for family or social supports when they return home with the cognitively impaired individual.

- In coordination with the beneficiary's designated Cal MediConnect plan care coordinator, connect families and individuals to community-based organizations that specialize in cognitive impairment support and resources.
- Provide families with dementia-specific information and necessary instructions, including care transitions resources that focus on people with cognitive impairment.

**For more information on dementia-specific care transitions, visit www.alzgia.org/professionals.
Free Care Transitions Notebooks for families will be available soon in multiple languages.**

Cal MediConnect Resources

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

For Complaints and Appeals

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

About the Cal MediConnect Ombudsman:

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

What do they do?

The Cal MediConnect Ombudsman offer consumer protection for all Cal MediConnect enrollees, ensuring that individual issues can be addressed. These services are in addition to existing appeals and grievances processes. The program is specifically designed to empower enrollees and their families and investigate and resolve issues/complaints with Cal MediConnect plans.

Cal MediConnect Ombudsman: 855-501-3077

Hours of operation: Monday-Friday 9 AM to 5 PM

Additional Resources

- **HICAP** (1-888-580-7272) – the Health Insurance Counseling & Advocacy Program (HICAP) helps beneficiaries understand their choices under CCI and make changes to their health plan, including choosing a different Cal MediConnect health plan, a different Medi-Cal health plan, or to opt out of Cal MediConnect.
- **Medicare** (1-800-MEDICARE) – for questions about Medicare benefits and services.

For More Information

- Web: Calduals.org
- Email: info@calduals.org
- Twitter: [@CalDuals](https://twitter.com/CalDuals)
- Outreach: Email info@calduals.org or complete the online request [form](#) on calduals.org.

Resource: CCI All Plan and Duals Plan Letters

The California Department of Health Care Services (DHCS) communicates with health plans regarding interpretations and changes in policy and how to implement these changes through letters released to the health plans. All Plan Letters (APLs) are sent to all Medicaid health plans, and Dual Plan letters (DPLs) are only sent to the health plans participating in Cal MediConnect.

Dual Plan Letter 16-003: Discharge Planning for Cal MediConnect

- <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-003.pdf>

This DPL clarifies the responsibilities of Cal MediConnect plans to ensure a patient receives all needed medical supports and services through post-discharge and the transition into the community, including:

- Documentation of pre-admission or baseline status;
- Set-up of post-discharge services, including medical care, medications, DME, and LTSS;
- Care coordination, including with caregivers and between the hospital and plan care coordinator; and
- Information for follow-up appointments.

Cal MediConnect plans must ensure patients are discharged to the most appropriate level of care, and that their community-based care meets their medical and social needs.

- Patients have access to all medically necessary Medicare and Medi-Cal benefits, including inpatient rehabilitation facilities, long-term care hospitals, partial-hospitalization, nursing facilities, and home- and community-based services and supports.
- Patients have the right to return to their long-term SNF under continuity of care rights if it is safe to do so.
- Plans must place patients in a SNF within 72 hours or coordinate with hospitals to facilitate discharge as soon as possible to the most appropriate level of care based on medical necessity.

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

- <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL15-001.pdf>

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

Care Plan

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

The care plan (and any amendments to it) must be signed by the enrollee or the enrollee's authorized representative and be made available to the enrollee in his/her preferred written or spoken language and all alternative formats.

The care plan must include:

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

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

Interdisciplinary Care Team

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

The ICT must:

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

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

- <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-002.pdf>

Health Risk Assessments—General

Cal MediConnect health plans are required to complete an HRA for each enrollee to identify primary, acute, long-term services and supports, behavioral health, and functional needs. The HRA is the basis for developing the enrollee's ICP and can be completed in-person, by telephone, or by mail, depending on the enrollee's preference.

HRA Timeframes

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

After the HRA

For enrollees who are high-risk, the HRA leads to the assignment of the managed care plan's (MCP) Care Coordinator or ICT and more in-depth and comprehensive care planning and coordination.

To view data on Cal MediConnect health plan's HRA completion rates, visit calduals.org or click [here](#).

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

- <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-010.pdf>

This APL applies to the following populations:

- Full benefit dual-eligibles who opt out of Cal MediConnect;

- Full benefit dual-eligibles who are ineligible for Cal MediConnect due to exclusion criteria and partial benefit dual-eligibles; and
- Medi-Cal only members who are full scope Medi-Cal Seniors and Persons with Disabilities over age 21.

Policy

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

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

Health Risk Assessments

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

Long-Term Services and Supports Assessment review

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

Individual Care Plan

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

Interdisciplinary Care Teams

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

Cal MediConnect Health Plans

Los Angeles County			
Plan Name	Phone Number	TTY	Online
Anthem Blue Cross Cal MediConnect	1-888-350-3447	711	https://lacountyduals.anthem.com/
Blue Shield of California Promise Health Plan	1-855-905-3825	711	https://www.blueshieldca.com/promise/calmediconnect/index.asp
Health Net Cal MediConnect	1-855-464-3571	711	https://mmp.healthnetcalifornia.com/mmp.html
L.A. Care Cal MediConnect	1-888-522-1298	1-888-212-4460	http://www.calmediconnectla.org/
Molina Dual Options	1-855-665-4627	711	http://www.molinahealthcare.com/members/ca/en-US/hp/duals
Orange County			
OneCare Connect	1-855-705-8823	1-800-735-2929	https://www.caloptima.org/en/ForMembers/OneCareConnect.aspx
Riverside County			
IEHP DualChoice	1-877-273-4347	1-800-718-4347	https://ww3.iehp.org/en/members/plans/cal-mediconnect/
Molina Dual Options	1-855-665-4627	711	http://www.molinahealthcare.com/members/ca/en-US/hp/duals
San Bernardino County			
IEHP DualChoice	1-877-273-4347	1-800-718-4347	ww3.iehp.org/en/members/plans/cal-mediconnect/
Molina Dual Options	1-855-665-4627	711	www.molinahealthcare.com/members/ca/en-US/hp/duals
San Diego County			
Blue Shield of California Promise Health Plan	1-855-905-3825	711	https://www.blueshieldca.com/promise/calmediconnect/index.asp
CommuniCare Advantage	1-888-244-4430	1-855-266-4584	https://www.chgsd.com/chg-plans/cmc
Health Net Cal MediConnect	1-855-464-3572	711	https://mmp.healthnetcalifornia.com/mmp.html
Molina Dual Options	1-855-665-4627	711	www.molinahealthcare.com/members/common/en-us/pages/duals.aspx
Santa Clara County			
Anthem Blue Cross Cal MediConnect	1-855-817-5785	711	https://mss.anthem.com/cammp/Pages/aboutus.aspx
Santa Clara Family Health Plan	1-877-723-4795	1-800-735-2929	https://www.scfhp.com/healthcareplans/calmediconnect
San Mateo County			
CareAdvantage Cal MediConnect	1-866-880-0606	711	https://www.hpsm.org/member/careadvantage-2019