



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

DATE: JULY 17, 2013

DUALS PLAN LETTER 13-004

TO: CAL MEDICONNECT DEMONSTRATION SITES

SUBJECT: INTERDISCIPLINARY CARE TEAM AND INDIVIDUAL CARE PLAN
REQUIREMENTS FOR MEDICARE-MEDICAID PLANS

PURPOSE:

The purpose of this Duals Plan Letter (DPL) is to clarify requirements for development of the Interdisciplinary Care Team (ICT) and Individual Care Plan (Care Plan) for Medicare-Medicaid Plans (MMPs) that are participating in the Duals Demonstration Project, now known as Cal MediConnect.

This document sets forth requirements which will be coordinated by the MMPs directly and are not applicable to medical care plans established by primary care providers.

BACKGROUND:

In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs) through shifting service delivery away from institutional care to home and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

A component of the CCI is a three-year Duals Demonstration, known as Cal MediConnect. It will be implemented no sooner than January 1, 2014, in the following eight counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Alameda, Santa Clara, and San Mateo and will serve beneficiaries who are both Medi-Cal and Medicare eligible (Duals). Cal MediConnect will combine the full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services into a benefit package delivered through an organized service delivery system administered by participating MMPs. Unless exempted, Duals will be passively enrolled into MMPs, but may choose to opt out.

Cal MediConnect will include coordinated Medicare and Medi-Cal processes including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes.

Cal MediConnect's model of care will include person-centered care coordination supported by ICTs. While all Cal MediConnect members will have the right to request an ICT, not everyone will require or necessitate one. ICTs are established when a member demonstrates a need for one to be created. They are dynamic in nature and thus are not implemented under a fixed structure.

POLICY AND REQUIREMENTS:

A. Individual Care Plan

1. Should a need for a Care Plan be demonstrated by the member, the MMP will develop a plan and engage the member and/or his or her representative(s) in its design. This Care Plan is the responsibility of the MMP and is separate and distinct from the medical care plan which is created, established, and maintained by the member's primary care provider.
 - a. A need for a Care Plan may be identified by the MMP through interactions with the member (e.g. when conducting the Health Risk Assessment [HRA]), stratifying members into lower and higher-risk categories (e.g. through the HRA risk-stratification process), and any other appropriate interactions.
2. The member must have the opportunity to review and sign the Care Plan and any amendments to the Care Plan. The member must be provided a copy of the Care Plan and any amendments to the Care Plan. The Care Plan must be made available in alternative formats and in the member's preferred written or spoken language.
3. Care Plans will include:
 - a. Member goals and preferences.
 - b. Measurable objectives and timetables to meet medical needs, behavioral health, and long term support needs as determined through the assessment process, In-Home Supportive Services (IHSS) assessment results, Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS) records, behavioral

health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate.

- c. Coordination of carved out and linked services, and referral to appropriate community resources and other agencies, when appropriate.

Reassessment and updating of the Care Plan will be conducted at least annually or if a significant change in condition occurs.

B. Interdisciplinary Care Team

The MMP will offer an ICT for a member when a need is demonstrated (or one is requested) and in accordance with the member's functional status, assessed need, and the Care Plan. It will be built around the needs of the member, and will ensure integration of the member's medical care, Long Term Services and Supports (LTSS), and the coordination of behavioral health services. Every member will have the right to request an ICT. Members or their provider may contact the MMP to obtain an ICT and Care Plan. MMPs must include information about the ICT and Care Plan in new member welcome packets.

1. ICT Functions

The ICT will facilitate care management, including assessment, care planning, authorization of services, transitional care issues. It will work closely with members to stabilize medical conditions, increase compliance with Care Plans, maintain functional status, and meet individual member Care Plan goals. ICT functions will include, at a minimum:

- a. Develop and implement a Care Plan with member and/or caregiver participation.
- b. Conduct ICT meetings periodically, including at the member's request.
- c. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site.
- d. Maintain a call line or other mechanism for member inquiries and input, and a process for referring to other agencies, such as LTSS or behavioral health agencies, as appropriate.
- e. Conduct conference calls among the MMP, providers, and member.

- f. Maintain a mechanism for member complaints and grievances. Use secure email, fax, web portals or written correspondence when communicating with members. The ICT must take the member's individual needs (e.g. communication, cognitive, or other barriers) into account when communicating with the member.

2. Composition of the ICT

The ICT must be person-centered, and built around the member's specific preferences and needs including language and culture, which will ensure integration of the member's medical, behavioral health, and LTSS care. The member has the primary decision-making role in identifying his or her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for the member.

- a. The ICT will be led by professionally knowledgeable and credentialed personnel, and at a minimum will be comprised of the following core members:
 - i. Member – the Dual and/or his or her authorized representative.
 - ii. Family and/or caregiver, if approved by the member.
 - iii. Care coordinator – A person employed or contracted by the MMP who is a licensed medical professional or is overseen by a licensed medical professional. The care coordinator is accountable for providing care coordination services, which include 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 Care Plan, participating in the initial assessment, and supporting safe transitions in care for members moving between settings.
 - iv. Primary care provider – A physician or non-physician medical practitioner under the supervision of a physician, who is responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care.

- v. Specialist – If a specialist is serving as the member’s primary care provider, he or she must be part of the ICT.
- b. The ICT will include the aforementioned individuals (care coordinator, family and/or caregiver, primary care provider, specialist). The ICT will also include individuals or providers who are actively involved in the care of the member, if approved by the member, when appropriate:
- i. If receiving IHSS, County IHSS social worker.
 - ii. Hospital discharge planner.
 - iii. Nurse.
 - iv. Social worker.
 - v. Nursing facility representative.
 - vi. Specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists.
 - vii. If receiving IHSS, the IHSS provider if authorized by the member.
 - viii. If participating in CBAS, the CBAS provider.
 - ix. If enrolled in the MSSP waiver program, MSSP coordinator.
 - x. Behavioral health service provider.
 - xi. Other professionals, as appropriate.

For purposes of the ICT, the MMP is not required to compensate any individuals who are not directly employed by, or contracted with, the MMP.

3. Communication with the ICT

- a. The MMP will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and members.

- b. The MMP will have a documented process for coordinating the exchange of information amongst all members of the ICT including when a change in ICT membership occurs.
- c. The MMP will have procedures for notifying the ICT of admission to a hospital (psychiatric or acute) or skilled nursing facility and coordinating a discharge plan.

4. Competencies of the ICT

- a. The MMP will provide training for ICT members and potential ICT members initially and on an annual basis on:
 - i. Person-centered planning processes.
 - ii. Cultural competence.
 - iii. Accessibility and accommodations.
 - iv. Independent living and recovery and wellness principles.
 - v. Information about LTSS programs, eligibility for these services, and program limitations.
- b. The MMP will make training opportunities available to IHSS providers if the member requests that their provider participate.

If you have any questions regarding this DPL, please contact Sarah Brooks at sarah.brooks@dhcs.ca.gov or (916) 552-9373.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Chief
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