DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

CAL MEDICONNECT SURVEY

TECHNICAL ASSISTANCE GUIDE

CONTINUITY OF CARE

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 27, 2015 Technical Assistance Guide renders all other versions obsolete.

CONTINUITY OF CARE REQUIREMENTS

Table of Contents

Requirement CC-001: The Health Plan ensures the coordination of Medicaid-based services within its own provider network and with contracted services. 2

Requirement CC-002: The Health Plan facilitates the Coordination of Medicaid-based services with other services delivered under Cal MediConnect through the Enrollee's assigned primary care physician and/or the interdisciplinary care team. 18

Requirement CC-003: The Health Plan ensures the coordination of Medicaid-based services outside the network consistent with the Plan's obligations under Cal MediConnect. 32

Requirement CC-004: The Health Plan ensures oversight of Continuity of Care activities performed by delegated entities. 38

Requirement CC-001: The Health Plan ensures the coordination of Medicaid-based services within its own provider network and with contracted services.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.5.1. Care Coordination. The Contractor shall offer care coordination and case management services to all Enrollees, as described in WIC Sections 14182.17(d)(4) and 14186(b).

2.5.1.1. Contractor will coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and LTSS.

2.5.1.3. Care coordination will be led by the Care Coordinator with participation by members of the ICT.

2.5.1.7. Contractor will have a process for assigning a Care Coordinator to each Enrollee needing or requesting one. Assignment will be made to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs.

2.5.1.6. Contractor will ensure that care coordination services:

2.5.1.6.1. Reflect a person-centered, outcome-based approach, consistent with the CMS model of care, CFAM-MOU, and DHCS' RFS;

2.5.1.6.2. Maintain an Enrollee's right to self-direct his or her IHSS, in addition to the right to hire, fire, and manage the IHSS provider, as described in WIC, Section 12301.6;

2.5.1.6.3. Follow Enrollee's direction about the level of involvement of his or her caregivers or medical providers;

2.5.1.6.4. Span medical and LTSS systems, including IHSS, with a focus on transitions;

2.5.1.6.5. Reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health services;

2.5.1.6.6. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3;

2.5.1.6.7. Are performed by nurses, social workers, primary care providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan care coordinators, as applicable; and

2.5.1.6.8. Reflect access to appropriate community resources, as defined in WIC Sections 14132.275(f)(7) and 14182.17(d) (4)(G) and (6)(B) and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

2.5.1.10. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.

2.5.1.10.1. Enrollees may choose to refuse any treatment, including case management.

2.5.1.10.2. Basic case management services include:

2.5.1.10.2.1. A review of clinical information from the provider;

2.5.1.10.2.2. Completion of the HRA. (see Section 2.8);

2.5.1.10.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);

2.5.1.10.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS, Behavioral Health, Care Plan Option Services, and for covered and non-covered services;

2.5.1.10.2.5. Direct communication with Enrollee, Enrollee providers, and family;

2.5.1.10.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.10.8); and

2.5.1.10.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services or specialty mental health or Drug Medi-Cal services.

2.5.1.11. Complex Case Management. Contractor will develop methods to identify Enrollees who may benefit from complex case management services, using the risk stratification and HRA results (see sections 2.8.1 and 2.8.2) as well as utilization and clinical data and any other available information across medical, LTSS, and Behavioral Health domains, as well as self and provider referrals.

2.5.1.11.1. Complex case management services will include:

2.5.1.11.1.1. Basic case management services (see Section 2.5.1.10)

2.5.1.11.1.2. Management of acute or chronic illness

2.5.1.11.1.3. Intense coordination of resources to ensure Enrollee maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization when appropriate and possible.

2.5.1.12. Coordination of Care Management. Contractor shall coordinate with external organization(s) for provision of Covered Services (described in Appendix A) as appropriate for the Enrollee (see Sections 2.6 and 2.7).

2.5.1.12.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollee to MSSP organization for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.1.12.2. Contractor shall develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible, in accordance with WIC section 14182.17(d)(4)(H).

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for: 1) CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.2.1 , MSSP for Enrollees who meet the eligibility criteria for MSSP pursuant to WIC, Section 9560; and, 3) IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to WIC, Section 12305.6.

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age 21 or older and derive their Medi-Cal eligibility from the state Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the state and meet "Nursing Facility Level of Care A" (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer's Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.1.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.1.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.1.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on care coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits

between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.1.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.1.9 and 2.8.3.

2.6.1.3. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help pursuant to Article 7 of California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956.).

2.6.1.3.1. Contractor shall maintain Enrollees' right to be the employer, to select, engage, direct, hire, fire, manage, supervise, schedule, and terminate IHSS providers.

2.6.1.3.2. Contractor will coordinate with county agencies to facilitate IHSS participation on the ICT. Contractor will ensure Network Providers coordination with IHSS.

2.6.1.3.3. Contractor and county agencies will develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.1.3.3.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC Section 12301.1 and how that information is coordinated and shared with the ICT.

2.6.1.3.3.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.1.4. Nursing Facilities

2.6.1.4.1. Contractor shall contract with SNFs, as defined in Title 22, CCR, Section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.1.4.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

2.7. Coordinated Primary Care and Behavioral Health

2.7.1. Contractor shall provide Enrollee access to Behavioral Health services covered by Medicare and Medi-Cal with a focus on the Recovery Model (See Covered Services in Appendix A). Coordination of Behavioral Health services financed and administered by county agencies shall include at a minimum the following:

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.7.1.1.1. To determine responsibility for covering Medi-Cal Specialty Mental Health Services, the Contractor and county will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis – one or more of the specified diagnoses; 2) impairment – significant impairment or probability of deterioration of an important area of life functioning; or; 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

2.7.1.1.3. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, the Contractor shall use medical necessity criteria set forth in a DPL to be issued.

2.7.1.2. Contractor will have a Memorandum of Understanding (MOU) with county agencies that finance and administer Behavioral Health services. The MOU must be approved by CMS and DHCS. It will include:

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2) and ICP (see Section 2.9.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;

2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and

2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.

2.7.1.2.2. Administrative coordination: Contractor will clearly delineate administrative responsibilities and provider contracting responsibilities, including:

2.7.1.2.2.1. Point of contacts and communication processes to address administrative coordination;

2.7.1.2.2.2. Process for annual review and evaluation of administrative management programs; and

2.7.1.2.2.3. Process for demonstrating how administrative problem identification and resolution occurs.

2.7.1.2.3. Information exchange: Contractor will develop data sharing mechanisms with the county Behavioral Health agencies, to the greatest extent practicable under state and federal privacy laws, to share accurate and timely information to inform care delivery. It will describe:

2.7.1.2.3.1. Information flow between Contractor and county agencies; and

2.7.1.2.3.2. Processes for exchange of health information.

2.7.1.2.4. **Performance measures:** Contractor is required to report on measures related to Behavioral Health services for which they have direct contracts with providers including Medicare Behavioral Health benefits.

2.7.1.2.4.1. Contractor is required to show evidence of data sharing agreement with county agencies that provide Medi-Cal Behavioral Health services. The data sharing agreements shall provide for the exchange of data in compliance with all applicable state and federal laws.

2.7.1.2.4.2. Shared financial accountability is discussed in Section 4.3.6.4.

2.9.10.10. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers. (see Section 2.9.7.8.).

2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).

All Plan Letter 15-001

This letter clarifies requirements for Interdisciplinary Care Teams (ICT) and Individual Care Plans (Care Plan) for Plans participating in Cal MediConnect.

WIC Section 14182.17(d)(2)

(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:

(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:

(A) Assesses each new Enrollee's risk level and needs by performing a risk assessment process using means such as telephonic, Web-based, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those Enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.

(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.

(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.
(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.
(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.
(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.
(G) Assesses each new Enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.
(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

CMS Model of Care Requirements (See SNP Model of Care (MOC) Summaries)

The MOC is comprised of the following clinical and non-clinical elements:

1. Description of the SNP Population,
2. Care Coordination,
3. SNP Provider Network,
4. MOC Quality Measurement & Performance Improvement.

A minimum score of seventy (70) percent is considered passing and scores of 75 or more qualify the SNP’s MOC for multi-year approval, either two or three years. The MOC summaries are intended to provide a broad overview of each SNP’s MOC and are intended to provide the reader with a general overview of how each SNP addresses beneficiary needs.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- QA Director
- UM Director
- Case Managers
- HRA specialists
- IT specialists
- Members of an ICT
- LTSS specialist
- Behavioral health specialist

DOCUMENTS TO BE REVIEWED

- Plan and/or delegate policies and procedures regarding care coordination and case management.
- Plan and/or delegate policies and procedures on communications and reporting protocols related to coordination of services and oversight of coordination activities.
- Reports or documentation of Plan oversight of coordination activities
- Plan contracts for CBAS.
- Plan policies and procedures for CBAS eligibility.
- Plan contracts for MSSP.
- Plan policies and procedures for informing Cal MediConnect enrollees about MSSP.
- Plan policies and procedures for referring potentially eligible Cal MediConnect enrollees to MSSP providers for eligibility determination.
- Reports or documents supporting that the Plan refers potentially eligible enrollees to MSSP providers for evaluation.
- Plan policies and procedures regarding care coordination with MSSP providers.
- Plan policies and procedures for provision of alternate services for Members placed on the MSSP waiting list
- Memorandum of Understanding between the Plan and the County Agency related to the provision of IHSS.
- Plan policies and procedures for referrals to IHSS.
- Plan policies and procedures regarding care coordination with IHSS.
- Plan contracts with SNFs within and outside the service area.
- Plan policies and procedures on coordination of behavioral health services for Cal MediConnect enrollees.
- Plan medical necessity criteria for behavioral health referrals.

- Plan oversight of medical necessity referrals for contacted provider groups for behavioral health referrals.
- MOU with county agencies that provide behavioral health services.
- Plan evidence of a data sharing agreement with county agencies that provide Medi-Cal behavioral health services.
- Plans policies and procedures for Non-Medical Transportation
- Plans policies and procedures for Non-Emergency Medical Transportation

CC-001 - Key Element 1:

1. The Plan provides basic and complex case management services for Cal MediConnect Enrollees when needed and/ or wanted.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures for basic and complex case management services for Cal MediConnect Enrollees? (§2.5.1.10.; §2.5.1.11.; §2.5.1.11.1.1.; §2.5.1.11.1.2.)			
1.2 Do the Plan policies and procedures for basic and complex case management allow for Cal MediConnect Enrollees to refuse case management? (§2.5.1.10.1.)			
1.3 Does the Plan's description of basic case management services include: a) a review of the clinical information from the provider; b) completion of the HRA; c) creation of the ICP in collaboration with the ICT (as demonstrated by enrollee's needs identified by the Plan) ; d) identification and referral to appropriate providers; e) direct communication with the Cal MediConnect Enrollee and family and providers; f) Enrollee and family education including health lifestyle changes when warranted; and g) coordination of services outside of the Cal MediConnect plan, such as community social services? (§2.5.1.10.2.1.; §2.5.1.10.2.2.; §2.5.1.10.2.3.; §2.5.1.10.2.4.; §2.5.1.10.2.5.; §2.5.1.10.2.6.; §2.5.1.10.2.7.: APL 15-001)			
1.4 Does the Plan have methods to identify Cal MediConnect Enrollees who may benefit from complex case management services? (§2.5.1.11.)			

Assessment Questions	Yes	No	N/A
1.5 Does the Plan's description of complex case management services include: a) basic care management services; b) management of acute and chronic illness; and c) intense coordination of resources to ensure Cal MediConnect Enrollees maintain optimal health or improved functionality or maintains current functionality or prevents/delays functional decline and avoids institutionalization when appropriate? (§2.5.1.11.1.; §2.5.1.11.1.1.; §2.5.1.11.1.2.; §2.5.1.11.1.3.)			
1.6 As part of its provider education, does the Plan include information related to identifying, preventing, and reporting abuse, neglect, exploitation, and critical incidents? (§2.9.10.9.)			
1.7 As part of its provider education, does the Plan provide disability sensitivity training for its Behavioral Health, MSSP and CBAS providers? (§2.9.10.10.)			

CC-001 - Key Element 2:

2. The Plan coordinates Medicaid-based services within its network.

Assessment Questions	Yes	No	N/A
2.1 Does the Plan offer Medicaid-based care coordination and case management services to all Enrollees? (§2.5.1.; §2.5.1.1.1.)			
2.2 Do the Plan policies and procedures specify that care coordination services for Cal MediConnect Enrollees be performed by appropriate nursing, social work, medical, behavioral health, LTSS, and other professionals as applicable? (§2.5.1.6.7.)			
2.3 Do the Plan policies and procedures for Cal MediConnect Enrollees specify that care coordination services will reflect a person-centered, outcome-based approach? (§2.5.1.6.1.; *See also* CMS Model of Care Requirements)			

Assessment Questions	Yes	No	N/A
2.4 Do the Plan policies and procedures for care coordination services for Cal MediConnect follow the Enrollee's direction about the level of involvement of his or her caregivers and/or medical providers? (§2.5.1.6.3.)			
2.5 Do the Plan policies and procedures focus on providing services for Cal MediConnect Enrollees at the least restrictive setting? (§2.5.1.6.8.)			
2.6 Do the Plan policies and procedures for Cal MediConnect Enrollees establish effective linkages of clinical and management systems among network providers and do the linkages include communication protocols among first tier, downstream, and related entities? (§2.5.1.4.; §2.5.1.4.1.)			
2.7 Do the Plan policies and procedures for care coordination services reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health Services? (§2.5.1.6.5.)			
2.8 Does the Plan have policies and procedures to ensure access to, provision of, and payment for contracted Community Based Adult Services (CBAS) to Enrollees who qualify based on the program's criteria? (§2.6.1.1; §2.6.1.1; §2.6.1.1.1 *et seq*)			
2.9 Does the Plan have policies and procedures to ensure access to, provision of, and payment for Multipurpose Senior Services Program services, and ensure that Enrollees who are potentially eligible based on the program's criteria are referred to MSSP for eligibility determination? (§2.6.1.1.; §2.6.1.2. §2.6.1.2.1.)			

Assessment Questions	Yes	No	N/A
2.10 Does the Plan have policies and procedures for coordinating services with contracted MSSP providers to ensure that there is no duplication of services and/ or benefits, and to coordinate Care Management activities, roles and responsibilities at the point of discharge from the MSSP? (§2.6.1.2.2; §2.5.1.12.1.)			
2.11 Does the Plan have policies and procedures to ensure access to, provision of, and payment for contracted In Home Supportive Services to Enrollees who qualify based on the program's criteria? (§2.6.1.)			
2.12. Does the Plan have processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible? (§2.5.1.12.2.)			
2.13 Does the Plan have policies and procedures for coordinating contracted Non-Medical Transportation services? (§2.5.1.1.)			
2.14 Does the Plan have policies and procedures for coordinating contracted Non-Emergency Medical Transportation services? (§2.5.1.1.)			

CC-002 - Key Element 3:

2. The Plan has established procedures for coordinating with external Long Term Services and Supports (LTSS).

Assessment Questions	Yes	No	N/A
3.1 Do the Plan policies and procedures for care coordination services include LTSS systems, including IHSS, with a focus on transition? (§2.5.1.6.4.)			

Assessment Questions	Yes	No	N/A
3.2 Does the Plan have an executed Memorandum of Understanding with county In-Home Supportive Services (IHSS) program agencies? (§2.6.1.3.3)			
3.3 Do the Plan policies and procedures maintain the right of the Cal MediConnect enrollee to be the employer, to select, engage, direct, hire, fire, manage, supervise, schedule, and terminate IHSS providers? (§2.5.1.6.2.; §2.6.1.3.1.)			
3.4 Does the Plan coordinate with county agencies to facilitate IHSS services? (§2.6.1.3.2.)			
3.5 Does the Plan ensure network provider coordination with IHSS? (§2.6.1.3.2.)			
3.6 Does the Plan, along with county agencies, develop and implement detailed processes for coordination and integration of IHSS which includes: a) provision of intake activities and redetermination by IHSS social workers and allocation of IHSS hours and, and how that information is shared with the ICT; and b) framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT? (§2.6.1.3.3; §2.6.1.3.3.1; §2.6.1.3.2.)			
3.7 Does the Plan have contract with Skilled Nursing Facilities (SNFs) in its service area that are licensed by CDPH and certified by DHCS for participation as a SNF in the Medi-Cal Program? (§2.6.1.4.1.)			
3.8 Does the Plan contract with LTSS providers outside of the covered service area whenever the LTSS provider within the Service Area cannot meet the Enrollee's medical needs? (§2.10.2.3.1.)			

Assessment Questions	Yes	No	N/A
3.9 Does the Plan have contracts with qualified SNFs in areas outside of the Plan service area in the event that SNF beds are not available within the Plan service area, corresponding to the Plan's projected need for SNF beds for Cal MediConnect enrollees? (§2.6.1.4.2.)			

CC-001 - Key Element 4:

3. The Plan has established procedures for coordinating Medicaid-based Behavioral Health services.

Assessment Questions	Yes	No	N/A
4.1 Does the Plan provide Cal MediConnect Enrollees access to Behavioral Health services covered by Medicaid/Medi-Cal, with a focus on the recovery model? (§2.7.1.)			
4.2 Does the Plan have policies and procedures to ensure seamless access, coordination and delivery of covered behavioral health services for Cal MediConnect Enrollees who meet the medical necessity criteria? (§2.7.1.1.)			
4.3 Does the Plan use appropriate medical necessity criteria for specialty mental health waiver services for Cal MediConnect Enrollees; (a) Diagnosis; (b) Impairment; or (c) Intervention? (§2.7.1.1.1.)			
4.4 Does the Plan use appropriate medical necessity criteria for Medicaid-based behavioral health services for Cal MediConnect Enrollees? (§2.7.1.1.3.)			
4.6 Does the Plan have a memorandum of understanding (MOU) with county agencies that finance and administer behavioral health services (that is approved by CMS and DHCS)? (§2.7.1.2.)			

Assessment Questions	Yes	No	N/A
4.7 Does the MOU delineate the clinical responsibilities and provider contracting responsibilities for Cal MediConnect Enrollees? (§2.7.1.2.1.; §2.7.1.2.1.1.)			
4.8 Does the MOU set forth a point of contact within the Cal MediConnect Plan and county entity (ies) and the various communications processes to address issues related to clinical coordination? (§2.7.1.2.1.2.)			
4.9 Does the MOU describe a process for resolving disagreements related to clinical decision making, administrative, and policy issues for Cal MediConnect Enrollees? (§2.7.1.2.1.3.)			
4.10 Does the MOU set forth a standardized approach to screening, referral, and linkages and coordination for Medicaid-based mental health and substance abuse services with specified timelines for Cal MediConnect Enrollees? (§2.7.1.2.1.4.)			
4.11 Does the MOU delineate processes for clinical consultation and coordination of ICPs for Cal MediConnect Enrollees? (§2.7.1.2.1.5.)			
4.12 Does the MOU clearly delineate the administrative coordination responsibilities and provider responsibilities for care coordination of Cal MediConnect Enrollees using behavioral health services? (§2.7.1.2.2.)			
4.13 Does the MOU describe points of contact to address administrative coordination, a process for annual review and evaluation of administrative management programs, and a process for demonstrating that administrative problems are identified and resolved? (§2.7.1.2.2.1.; §2.7.1.2.2.2.; §2.7.1.2.2.3.)			
4.15 Does the MOU describe the timely and accurate flow of information between the Plan and county behavioral health agencies and processes for exchange of health information? (§2.7.1.2.3.; §2.7.1.2.3.1.; §2.7.1.2.3.2.)			

Assessment Questions	Yes	No	N/A
4.16 Does the MOU define the performance measures that the Plan is required to report on related to Medicaid-based behavioral health services for Cal MediConnect Enrollees who are under the care of directly contracted providers including Medicare behavioral health benefits? (§2.7.1.2.4.)			
4.17 Does the Plan have evidence of a data sharing agreement with county agencies that provide Medi-Cal Behavioral Health services? (§2.7.1.2.4.1.)			
4.18 Does the Plan have evidence of shared financial accountability with county agencies that provide Medi-Cal Behavioral Health services? (§2.7.1.2.4.2.)			

End of Requirement CC-001: The Health Plan ensures the coordination of Medicaid-based services within its own provider network and with contracted services

Requirement CC-002: The Health Plan facilitates the Coordination of Medicaid-based services with other services delivered under Cal MediConnect through the Enrollee's assigned primary care physician and/or the interdisciplinary care team.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.5.1.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health Services delivered by a county Behavioral Health agency, when applicable.

2.5.1.8.1. Every Enrollee will have access to an ICT if requested.
2.5.1.8.2. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.1.8.3.2 to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual Enrollees care plan goals. ICT functions will include, at a minimum:
2.5.1.8.2.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.1.9 and 2.8.3;
2.5.1.8.2.2. Conduct ICT meetings periodically, including at the Enrollee's discretion;
2.5.1.8.2.3. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;
2.5.1.8.2.4. Maintain a call line or other mechanism for Enrollee inquiries and input , and a process for referring to other agencies, such as LTSS or Behavioral Health agencies, as appropriate;
2.5.1.8.2.5. Conduct conference calls among the Contractor, providers, and Enrollees;
2.5.1.8.2.6. Maintain a mechanism for monitoring Enrollee complaints and grievances ; and
2.5.1.8.2.7. Use secure email, fax, web portals or written correspondence to communicate. The ICT must take the Enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the Enrollee.

2.5.1.8.3. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.1.8.3.1. The ICT will be led by professionally knowledgeable personnel. If the ICT is led by a PCP, the PCP must be credentialed.
2.5.1.8.3.2. ICT will include the Enrollee and/or authorized representative, family and/or caregiver if approved by the Enrollee, PCP (this may be a specialist, if a specialist is serving as the PCP), care coordinator, and may include the following persons, as needed and if applicable:
2.5.1.8.3.2.1. Hospital discharge planner;
2.5.1.8.3.2.2. Nursing facility representative;
2.5.1.8.3.2.3. Social Worker, including the IHSS social worker if IHSS services are provided;
2.5.1.8.3.2.4. Specialized providers, such as pharmacists and physical therapists;
2.5.1.8.3.2.5. If receiving IHSS, the IHSS provider, if authorized by Enrollee;
2.5.1.8.3.2.6. If enrolled in CBAS, the CBAS provider, if authorized by Enrollee;
2.5.1.8.3.2.7. MSSP coordinator;
2.5.1.8.3.2.8. Behavioral Health specialist, which may include, but is not limited to, a specialty mental health provider or a substance use disorder counselor; and
2.5.1.8.3.2.9. Other professionals, as appropriate.

2.5.1.8.4. Communication with ICT. Contractor will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. Contractor will have a documented process for coordinating the exchange of information amongst all ICT members.

2.5.1.8.5. Contractor will have procedures for notifying the ICT of emergency department use, hospital admission (psychiatric or acute) or SNF and coordinating a discharge plan.

2.5.1.8.6. Competencies of ICT. Contractor will provide training for ICT members initially and on an annual basis. Required training topics include:
2.5.1.8.6.1. Person-centered planning processes;
2.5.1.8.6.2. Cultural competence;
2.5.1.8.6.3. Accessibility and accommodations;
2.5.1.8.6.4. Independent living and recovery and wellness principles; and
2.5.1.8.6.5. Information about LTSS programs, eligibility for these services, and program limitations.

2.5.1.8.7. Nothing in this contract shall be construed as requiring the Enrollee to participate on the ICT. The Contractor shall allow the Enrollee to opt-out of the ICT at any time and the ICT shall be able to continue its operations. Enrollees may not be disenrolled for lack of participation on the ICT. Criteria for disenrollment are discussed in Section 2.3.2.3.2.

2.5.1.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will engage Enrollees and/or their representatives in the design of the ICPs. ICPs will include:

2.5.1.9.1. Enrollee goals and preferences;

2.5.1.9.2. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS;

2.5.1.9.3. Timeframes for reassessment and updating of care plan, to be done at least annually or if a significant change in condition occurs;

2.5.1.9.4. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

2.5.1.9.4.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

2.5.1.9.4.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

2.5.1.9.4.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, evidence of creation or adjustment of care goals, as described in the plans' models of care reviewed and approved by the National Committee on Quality Assurance (NCQA)

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2) and ICP (see Section 2.9.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;

2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and

2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.

2.8. Health Risk Assessments, ICP, and Care Coordination

2.8.1. **Risk Stratification.** Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance with DHCS DPL 13-002.

2.8.1.1. Contractor shall use the following data sources to identify an Enrollees' risk level.

2.8.1.1.1. Medicare utilization data, including Medicare Parts A, B, and D.

2.8.1.1.2. Medi-Cal utilization data, including IHSS, MSSP, SNF, and Behavioral Health pharmacy data.
2.8.1.1.3. Results of previously administered assessments.
2.8.1.1.4. Other population- and individual-based tools.

2.8.2. **Health Risk Assessment (HRA).** In accordance with all applicable federal and state laws WIC Section 14182.17(d)(2), the CMS Model of Care requirements, Dual Plan Letter 13-002, Contractor will complete HRAs for all Enrollees.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:

2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;

2.8.2.2.2. Caregivers, Enrollees, and authorized representatives' participation;

2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;

2.8.2.2.4. Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;

2.8.2.2.5. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and

2.8.2.2.5.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.1.11 and 2.5.1.12.

2.8.2.2.5.2. Other elements as are specified in Dual Plan Letter 13-002.

2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.

2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with DHCS Dual Plan Letter 13-002.

2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

2.8.2.6. Reassessments will be conducted at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires.

2.8.2.6.1. When determining the mode for completing reassessment, the Contractor will consider the reason the assessment needs to be updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee.

2.8.2.7. Contractor will regularly use electronic health records and claims data to inform reassessments and to identify Enrollees at high risk, with newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or Behavioral Health referral.

2.8.3. Individualized Care Plan (ICP). An ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.1.9.

2.8.3.1. ICPs will be developed within thirty (30) working days of HRA completion.

Additional Authority:

1. **Duals Plan Letter 13-002**
2. **Duals Plan Letter 14-004**
3. **Duals Plan Letter 15-001**

DOCUMENTS TO BE REVIEWED

- Case management program descriptions regarding care coordination and related policies and procedures, including:
    - Continuity, timeliness and coordination of care between and among providers of Medicaid-based services (including mental health providers, case management staff, etc.);
    - Descriptions of case management services, including basic case management and complex case management, case management staff;
    - Case management team structure and processes;
    - Procedures related to Person-Centered Planning;
- Health Risk Assessments
    - Health Risk Assessment survey
    - Procedures and tools used to complete health risk stratification
    - Policies and procedures regarding the completion of HRAs
    - Policies and procedures regarding follow up on missed HRAs
    - Policies and procedures to ensure arrangement of follow up services identified during the HRA
    - Documents or reports demonstrating Plan oversight of the HRA process, including tracking of timeliness of HRA completion
    - Documents or reports demonstrating Plan oversight of those who do not complete an HRA within specified timeframes, and PCP and Enrollee communications.
    - Documents or reports demonstrating Plan oversight of the HRA re-assessment process, including the requirement to perform reassessments at least annually.

- Plan policies and procedures for care coordination, including assignment and identification of care coordinators.
- Interdisciplinary Care Teams
  - Plan policies and procedures on Interdisciplinary Care Teams
  - Reports or other documentation that the Plan provides oversight of the care coordinator credentials.
  - Reports or other documentation that the Plan provides oversight of the structure and function of the ICT in order to meet all specified requirements.
  - Reports or other documentation that the Plan provides oversight of the annual training of ICT members.
- Individual Care Plan
  - Plan policies and procedures on the development of ICP.
  - Plan policies and procedures for the implementation of ICP, including ICP for Enrollees receiving behavioral health services.
  - Policies demonstrating that the Plan develops the ICP within a 30 day time frame.
  - Policies demonstrating that the Plan ensures that the ICP is updated at least annually.
  - Reports or other documentation that demonstrates that the Plan provides oversight of ICPs where behavioral health services are being received to ensure that the ICP includes all needed information.
- Practitioner and provider manuals
- Member Services Guide
- Notification letter templates to participants requesting transitional care
- Reports on number, type and disposition of transitional care cases
- Delegated entity oversight reports

CC-002 - Key Element 1:

1. The Plan assures that contracting providers schedule and complete Health Risk Assessments (HRA) within the required timeframes.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have procedures to ensure that it completes HRAs for all Enrollees? (§2.8.2.)			
1.2 Does the Plan have procedures to use an approved health risk stratification mechanism or algorithm to identify newly enrolled Cal MediConnect beneficiaries with higher risk and more complex healthcare needs? (§2.5.1.11.; §2.8.1.)			

Assessment Questions	Yes	No	N/A
1.3 Does the Plan's initial health risk stratification for new Cal MediConnect Enrollees use Medi-Cal utilization data (including IHSS, MSSP, SNF, and behavioral health pharmacy data), result of previous assessments, and other population and individual-based tools? (§2.8.1.1.; §2.8.1.1.1.; §2.8.1.1.2.; §2.8.1.1.3.; §2.8.1.1.4.)			
1.4 Does the Plan's HRA process for Cal MediConnect Enrollees appropriately identify referrals to LTSS and home and community-based services? (§2.8.2.2.; §2.8.2.2.1.)			
1.5 Does the Plan's HRA process for Cal MediConnect Enrollees identify the participation of Enrollees, caregivers, and authorized representatives with Enrollee approval? (§2.8.2.2.2.; DPL 13-002.)			
1.6 Does the Plan's HRA process for Cal MediConnect Enrollees identify and/or assess facilitation of timely access to Medicaid-based health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access. (§2.8.2.2.3.)			
1.7 Does the Plan's HRA process for Cal MediConnect Enrollees include the facilitation of communication among the Enrollee's providers, including behavioral health providers as appropriate? (§2.8.2.2.4.)			
1.8 Does the Plan include comprehensive screening for behavioral health as part of the HRA? (§2.7.1.2.1.)			
1.9 Does the Plan's HRA process for Cal MediConnect Enrollees include the identification of Medicaid-based services needed to optimize the health or functional status of the Enrollee? (§2.8.2.2.5.)			

Assessment Questions	Yes	No	N/A
1.10 Does the Plan maintain policies and procedures to administer the HRA within forty-five calendar days of enrollment (for new Enrollees identified to be at higher health risk) or within ninety calendar days of enrollment (for those identified as a lower health risk)? (§2.8.2.3.; §2.8.2.4.)			
1.11 Does the Plan maintain policies and procedures to ensure that it attempts at least five phone calls within the first 30 days (two within ten business days of the Enrollee's coverage date) to offer **high risk Enrollees** the option of an in-person HRA? (Dual Plan Letter 13-002)			
1.12 Does the Plan offer the Enrollee an in-person HRA, and, if the Enrollee refuses, offer the opportunity to complete it by phone or mail? (Dual Plan Letter 13-002)			
1.13 Does the Plan maintain policies and procedures to ensure that if the Plan is unable to complete the HRA by day 30, that it mails the HRA to the **high risk Enrollee** by the next business day? (Dual Plan Letter 13-002)			
1.14 Does the Plan maintain policies and procedures to ensure that after six months, if the Plan is unable to complete the HRA due to a lack of response from the Enrollee, it mails an HRA survey to the **high risk Enrollee**? (Dual Plan Letter 13-002)			
1.15 Does the Plan maintain policies and procedures to ensure that it attempts at least two phone calls within 30 days of the **low risk Enrollee's** coverage date to first offer the Enrollee the option of an in-person HRA? (Dual Plan Letter 13-002)			
1.16 Does the Plan maintain policies and procedures to ensure that if the Plan is unable to complete the HRA by day 30, that it mails the HRA to the **low risk Enrollee** by the next business day? (Dual Plan Letter 13-002)			

Assessment Questions	Yes	No	N/A
1.17 Does the Plan maintain policies and procedures to ensure that a second mailing by next business day of the HRA occurs after 60 days of no response from the **low risk Enrollee**? (Dual Plan Letter 13-002)			
1.18 Does the Plan maintain policies and procedures to ensure that it attempts another phone call to the **low risk Enrollee** within 86 to 90 days if the member has not completed the HRA? (Dual Plan Letter 13-002)			
1.19 Does the Plan maintain policies and procedures to share assessment results with Enrollees, caregivers, authorized representatives (with Enrollee consent), the ICT, and other providers within ten days of completion of the HRA? (Dual Plan Letter 13-002)			
1.20 Does the Plan notify PCPs of enrollment of any new Cal MediConnect Enrollee who has not completed a HRA within the time period and whom Plan has been unable to contact? (§2.8.2.5.; Dual Plan Letter 13-002.)			
1.21 Does the Plan encourage PCPs to conduct outreach to their new Cal MediConnect Enrollees and to schedule visits to complete the HRA? (§2.8.2.5.)			
1.22 Does the Plan require that Medicaid-based providers review the HRA with Cal MediConnect Enrollees at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires? (§2.8.2.6.)			
1.23 When identifying the mode for completing reassessment, does the Plan consider the reason the assessment needs to be updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee? (§2.8.2.6.1.)			

Assessment Questions	Yes	No	N/A
1.24 Does the Plan regularly use electronic health records and claims data to inform reassessments and to identify high risk Enrollees? (§2.8.2.7.)			

CC-002 - Key Element 2:

2. The Plan has established and implemented processes to ensure that care coordinators lead Interdisciplinary Care Teams as required by the three way contract.

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have a process for assigning Care Coordinators to each Cal MediConnect Enrollee needing or requesting one? (§2.5.1.7.)			
2.2 Does the Plan assign Care Coordinators with appropriate expertise and qualifications based upon a Cal MediConnect Enrollee's assigned risk level and individual needs? (§2.5.1.7.)			
2.3 Does the Plan specify that care coordination will be led by the Care Coordinator with participation of the Interdisciplinary Care Team (ICT)? (§2.5.1.3)			
2.4 Does the Plan offer an ICT to each Cal MediConnect Enrollee when the need for one is identified? (§2.5.1.8.)			
2.5 Does the Plan ensure access to an ICT if requested? (§2.5.1.8.1.)			
2.6 Do the Plan's policies ensure that the ICT facilitates care assessment, care planning, authorization of services, and transitional care issues, to meet individual Cal MediConnect Enrollee's care plan goals? (§2.5.1.8.2.)			

Assessment Questions	Yes	No	N/A
2.7 When the need for an Interdisciplinary Care Plan (ICP) is identified, does the Plan ensure that the ICT develop and implement the ICP with Cal MediConnect Enrollee and/or caregiver participation? (§2.5.1.8.2.1.; §2.5.1.6.6.; DPL 15-001)			
2.8 Does the Plan ensure that ICT meetings are conducted on a periodic basis, including at the Cal MediConnect Enrollee's discretion? (§2.5.1.8.2.2.)			
2.9 Does the Plan ensure that the ICT manages communication and information flow regarding referrals transitions, and care delivered outside of the primary care site? (§2.5.1.8.2.3.)			
2.10 Does the Plan ensure that the ICT maintains a call line or other mechanism for Cal MediConnect Enrollee inquiries and input? (§2.5.1.8.2.4.)			
2.11 Does the ICT maintain a process for referring Enrollees to agencies, such as LTSS and/or behavioral health? (§2.5.1.8.2.4.)			
2.12 Does the Plan ensure that the ICT uses secure e-mail, fax, web portals, or written correspondence to communicate? (§2.5.1.8.2.7.)			
2.13 Does the ICT conduct conference calls among the Contractor, providers, and Enrollees? (§2.5.1.8.2.5.)			
2.14 Does the Plan ensure that the ICT maintains a mechanism for monitoring Cal MediConnect Enrollee complaints and grievances? (§2.5.1.8.2.6.)			

Assessment Questions	Yes	No	N/A
2.15 Does the Plan ensure that the ICT takes the Cal MediConnect Enrollee's individual needs into account in communicating with the Enrollee? (§2.5.1.8.2.7.)			
2.16 Does the Plan ensure that the ICT is person-centered, delivering services with transparency and built on the Cal MediConnect Enrollee's specific preferences and needs? (§2.5.1.8.3.)			
2.17 Does the Plan ensure that the ICT takes into consideration the individual needs of the Enrollee, including linguistic and cultural needs? (§2.5.1.8.3.)			
2.18 Does the Plan ensure that the ICT will be led by professionally knowledgeable personnel? If the ICT is led by a PCP, is the PCP credentialed? (§2.5.1.8.3.1.)			
2.19 Does the Plan ensure that in addition to the Cal MediConnect Enrollee (and/or authorized representative, family and/or caregiver if approved by the Enrollee), the ICT includes the PCP, care coordinator, and applicable persons such as hospital discharge planner, nursing facility representative, social worker (including IHSS social worker), specialized providers, IHSS provider, CBAS provider, MSSP coordinator, behavioral health specialist, and other professionals as approved by the member? (§2.5.1.8.3.2.; §2.5.1.8.3.2.1.; §2.5.1.8.3.2.2.; §2.5.1.8.3.2.3.; §2.5.1.8.3.2.5.; §2.5.1.8.3.2.6.; §2.5.1.8.3.2.7.; §2.5.1.8.3.2.8.; §2.5.1.8.3.2.9.)			
2.20 Does the Plan's policies include a documented process for coordinating the communication and exchange of information and services amongst all ICT members, including the Cal MediConnect Enrollee? (Including the integration of LTSS services and the coordination of Behavioral Health Services delivered by a county Behavioral Health agency, when applicable.) (§2.5.1.8.4.; §2.5.1.8.)			

Assessment Questions	Yes	No	N/A
2.21 Does the Plan have policies and procedures for notifying the, hospital admission (including psychiatric), or SNF and coordinating a discharge plan for Cal MediConnect Enrollees? (§2.5.1.8.5.)			
2.22 Does the Plan provide and document adequate training for ICT members initially, and on an annual basis for at the minimum the following required topics: a) Person-centered planning process; b) Cultural competence; c) Accessibility and accommodations; d) Independent living and recovery and wellness principles; and e) Information about LTSS programs, eligibility for these services, and program limitations? (§2.5.1.8.6.; §2.5.1.8.6.1.; §2.5.1.8.6.2.; §2.5.1.8.6.3.; §2.5.1.8.6.4.; §2.5.1.8.6.5.)			
2.23 Does the Plan allow the Enrollee to opt-out of the ICT an any time and still allow the ICT continue its operations? Does the Plan ensure that Enrollees are not disenrolled for lack of participation on the ICT? (§2.5.1.8.7.)			

CC-002 - Key Element 3:

3. The Plan assures that the ICT completes an Individualized Care Plan (ICP) after the Health Risk Assessment process.

Assessment Questions	Yes	No	N/A
3.1 When the need for an ICP is demonstrated, does the Plan ensure that an ICP is developed for each Cal MediConnect Enrollee within 30 working days of Health Risk Assessment (HRA) completion? **(See ICP Worksheet, question 5)** (§2.8.3.1.; DPL 15-001)			
3.2 Do the Plan policies and procedures ensure that the information gathered in the HRA is integrated into the ICP? (§2.8.2.1.; DPL 15-001.)			

Assessment Questions	Yes	No	N/A
3.3 Does the Plan ensure that the ICP is developed with input from the Cal MediConnect Enrollee and/or their approved representative? (§2.5.1.9.; DPL 15-001.)			
3.4 Does the Plan policies and procedures ensure that the ICP reflects Enrollee goals and preferences? (§2.8.3.)			
3.5 Does the Plan policies and procedures ensure that the ICP includes measurable objectives and timetables to meet the Enrollee's Medicaid-based needs? (§2.8.3.; §2.5.1.9.1.; §2.5.1.9.2.)			
3.6 Does the Plan policies and procedures ensure that the ICP includes timeframes for Cal MediConnect Enrollee re-assessment and updating of the ICP on at least an annual basis or sooner, if needed? (§2.8.3; §2.5.1.9.3.)			
3.7 Does the Plan policies and procedures ensure that if the Cal MediConnect Enrollee is receiving behavioral health services, that the ICP will include the name and contact information of the primary behavioral health provider, an attestation that the behavioral health provider and PCP have both reviewed and approved the ICP, and a record of at least one case review meeting that includes the behavioral health provider, the meeting date, names of all participants, and evidence of creation or adjustment of care goals (as described in the plans' models of care reviewed and approved by the NCQA)? (§2.5.1.9.4.; §2.5.1.9.4.1.)			

End of Requirement CC-002: The Health Plan Facilitates the Coordination of Medicaid-based services with other services delivered under Cal MediConnect through the Enrollee's assigned primary care physician and/or the interdisciplinary care team.

Requirement CC-003: The Health Plan ensures the coordination of Medicaid-based services outside the network consistent with the Plan's obligations under Cal MediConnect.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.5.1. Care Coordination. The Contractor shall offer care coordination and case management services to all Enrollees, as described in WIC Sections 14182.17(d)(4) and 14186(b).

2.8.4. Continuity of Care. Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers as described below in accordance to with DHCS Dual Plan Letter.

2.8.4.1. Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

2.8.4.1.1. A period up to six (6) months for Medicare services if all of the following criteria are met under WIC Section 14132.275(l)(2)(A):

2.8.4.1.1.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network primary care provider at least once within the previous twelve (12) months from the date of enrollment and a requested out-of-network specialist at least twice within the previous twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medicare data provided by DHCS or by documentation by the provider or Enrollee;

2.8.4.1.1.2. Provider is willing to accept payment from the Contractor based on the current Medicare fee schedule; and

2.8.4.1.1.3. Contractor would not otherwise exclude the provider from its Provider Network due to documented quality of care concerns or state or federal exclusion requirements.

2.8.4.1.2. A period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under WIC Section 14182.17(d)(5)(G).

2.8.4.1.2.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least twice within the previous twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the state or by documentation from the provider or Enrollee.

2.8.4.1.2.2. Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and
2.8.4.1.2.3. Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or state or federal exclusion requirements.

2.8.4.1.3. Enrollees will not be required to change nursing facilities during the duration of the Demonstration if they resided in the nursing facility prior to enrollment in MediConnect, the facility is licensed by CDPH, meets acceptable quality standards, and the facility and Contractor agree to rates in accordance with Section 2.8.4.1.2.2.

2.8.4.1.4. Sections 2.8.4.1.1 and 2.8.4.1.2 do not apply to IHSS providers or providers of the following: durable medical equipment, medical supplies, transportation, other ancillary services, or carved-out services.
2.8.4.1.5. Contractor must inform Enrollees of their new service providers.
2.8.4.1.6. If an Enrollee receives care from an out-of-network provider, Contractor must advise the Enrollee and provider that they have received care from an out-of-network provider that would not otherwise be covered at an in-network level.

2.8.4.1.10. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period ends, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568.

2.8.4.1.12. If Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is otherwise unable to provide them, as required by 42 C.F.R § 438.206(b)(4).

WIC Section 14182.17(d)(2)
(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:
(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:
(A) Assesses each new enrollee's risk level and needs by performing a risk assessment process using means such as telephonic, Web-based, or in-person

communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.
(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.
(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.
(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.
(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.
(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.
(G) Assesses each new enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.
(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

WIC section 14182.17(d) (5)(G)
(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following: . . .
(5) Ensure that the managed care health plans comply with, at a minimum, and in addition to other statutory and contractual requirements, network adequacy requirements as follows: . . .
(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary and specialty care

services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

CC-003 - Key Element 1:

1. **The Plan has established procedures for providing case management and coordination of care for members who require Medicaid-based services with entities outside the Plan's network.**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a process to cover medically necessary Medicaid-based services in an adequate and timely manner outside of its network if the Plan cannot otherwise provide those services for Cal MediConnect Enrollees within its network? (§2.8.4.1.12.)			
1.2 Do the Plan policies and procedures for Cal MediConnect Enrollees clearly outline all communications and reporting protocols related to coordination of services out of network? (§2.5.1.; WIC Section 14182.17(d)(2).)			
1.3 Does the Plan have a mechanism to notify the Cal MediConnect Enrollee and provider when they receive care from an out-of-network provider that is not otherwise covered at an in-network level? (§2.8.4.1.6.)			

CC-003 - Key Element 2:

2. **The Plan has established procedures for maintaining continuity of care for Enrollees with existing services.**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan ensure that Cal MediConnect Enrollees have continued access to Medicaid-based services in accordance with the DHCS Dual Plan Letters, including 14-004? (§2.8.4.)			

Assessment Questions	Yes	No	N/A
2.2 Does the Plan ensure that new Cal MediConnect Enrollees can maintain their current LTSS providers and service authorizations at the time of enrollment for a period of up to (12) months for Medi-Cal services if all of the applicable criteria are met? (LTSS only) 1. The new Enrollee has seen the requested out-of-network provider at least twice in the previous twelve (12) months from the date of enrollment. (The Plan may verify through Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the state or by documentation from the provider or Enrollee.); 2. The Provider is willing to accept payment from the Plan based on the Plan's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and 3. The Plan would not otherwise exclude the provider due to quality of care concerns or state or federal exclusion requirements. (§2.8.4.1.2.; WIC section 14182.17(d)(5)(G); §2.8.4.1.2.1.; §2.8.4.1.2.2.; §2.8.4.1.2.3.; §2.8.4.1.4.)			
2.3 Does the Plan ensure that Cal MediConnect Enrollees will not be required to change nursing facilities during the duration of the Cal MediConnect Demonstration if they resided in a nursing facility prior to enrollment so long as the facility is licensed by CDPH, meets acceptable quality standards, and the Plan and facility agree to Plan's rate for services offered or applicable Medi-Cal rate, whichever is higher? (§2.8.4.1.3.)			
2.4 Do the Plan's policies and procedures ensure that the Plan informs Cal MediConnect Enrollees of their new service providers? (§2.8.4.1.5.)			
2.5 Does the Plan have a mechanism to notify the Cal MediConnect Enrollee prior to the end of the continuity of care period that the (otherwise unauthorized) service will no longer be authorized? (§2.8.4.1.10.)			

End of Requirement CC-003: The Health Plan ensures the coordination of Medicaid-based services outside the network consistent with the Plan's obligations under Cal MediConnect.

Requirement CC-004: The Health Plan ensures oversight of Continuity of Care activities performed by delegated entities.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.11.8. Delegating Utilization Management Activities

2.11.8.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

Additional Authority:

1. **Duals Plan Letter 14-004**

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM or QI Director

- Director of Compliance or Audits
- Director of delegated entities (or equivalent), if necessary

DOCUMENTS TO BE REVIEWED

- Materials provided by the Plan to the delegate to delineate responsibilities and monitoring activities
- Delegated entity Continuity of Care Program description, policies and procedures, and criteria, as applicable
- Plan audit tool and sample audits of delegated entities
- Delegate Continuity of Care reports
- Minutes of meetings where Plan presents audit findings for delegated entity audit
- Corrective action plans submitted and reviewed as necessary
- Provider service agreement and amendments addenda as applicable

CC-003 - Key Element 1:

1. Delegation Oversight: The Plan has policies and procedures for monitoring Continuity of Care activities performed by its delegated entities.

Assessment Questions	Yes	No	N/A
1.1 Is there a delegation agreement between the Plan and the delegated provider(s) of Continuity of Care Activities that includes, but is not limited to a description of the delegated services, activities and administrative responsibilities? (§2.2.4.)			
1.2 Does the Plan ensure that all delegates conduct care coordination activities within the required timeframe? (§2.2.4.1.; §2.2.4.6.)			
1.3 Does the Plan ensure that delegated entities have policies and processes in place to coordinate care and case management for Cal MediConnect Enrollees across the full continuum of service providers including medical, behavioral health, and LTSS? (§2.2.4.1.)			

Assessment Questions	Yes	No	N/A
1.4 Does the Plan conduct regular oversight of the entities that provide delegated activities to ensure compliance with its established Continuity of Care standards? (§2.2.4.1; §2.2.4.6.)			
1.5 Does the Plan have policies and procedures for monitoring its delegated entities including methodology and frequency of oversight? (§2.2.4.1.)			
1.6 Does the Plan identify areas needing improvement and require improvement when deficiencies with Continuity of Care activities are identified? (§2.2.4.4.)			
1.7 Does the Plan follow up on identified continuity of care deficiencies to ensure that issues have been corrected? (§2.2.4.4.)			

End of Requirement CC-004: The Health Plan ensures oversight of Continuity of Care activities performed by delegated entities.