Cal MediConnect
Training for Contracted Network Providers
Summary of Topics

• Overview of:
  • Dementia Awareness
  • Managed Long Term Supports and Services (MLTSS)
  • Continuity of Care
  • Behavioral Health
  • Grievance and Appeals
  • Member Rights
  • Critical Incidents
  • Cultural Competency
  • Disability Awareness
  • Care Coordination
  • Model of Care
  • Interdisciplinary Care Team (ICT)
Dementia Awareness
Dementia Definition and Diagnosis

Dementia is a general term for loss of memory and other mental abilities severe enough to interfere with daily life.

It is caused by physical changes in the brain.

AD under-recognized by providers
- Only 50% of patients receive formal diagnosis
  - Millions unaware they have dementia
  - Lack of documented diagnosis in medical record
- Diagnosis often delayed on average by 6+ years after symptom onset
- Significant impairment in function by time it is recognized
  - Poor timing: diagnosis frequently at time of crises, hospitalization, failure to thrive, urgent need for institutionalization
- Alzheimer’s disease: Most common form of dementia
# Signs and Symptoms

<table>
<thead>
<tr>
<th>Poor judgment/problem solving</th>
<th>Changes in sleep and appetite</th>
<th>Mood/personality/behavior changes</th>
<th>Wandering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deterioration of self care, hygiene</td>
<td>Difficulty performing familiar tasks, functional decline</td>
<td>Memory loss/confusion</td>
<td>Disorientation to time or place</td>
</tr>
<tr>
<td>Getting lost in familiar locations</td>
<td>Impairment in speech/language</td>
<td>Trouble with time/sequence relationships</td>
<td>Diminished insight</td>
</tr>
</tbody>
</table>

Reproduced with permission from ACT on Alzheimer’s
Risk Factors

✓ Age
  • >65 greater likelihood
  • After age 85; 50% increased risk

✓ Family History

✓ Genetic
  • APOE-e3 gene; may be a factor in 20-25% of cases

✗ Myth: Aluminum

Stages of Dementia

1. No impairment
2. Very mild decline
3. Mild decline
4. Moderately severe decline
5. Moderately severe decline
6. Severe decline
7. Very severe decline
Managed Long Term Services and Supports (MLTSS)
What is MLTSS?

• **Managed Long Term Services and Supports** (MLTSS) typically refers to a wide range of services that support people living independently in the community.

• As defined by CCI legislation, MLTSS also includes long-term care services, or services provided in a skilled nursing facility.
MLTSS Delegation Model

- Plan Partners are responsible for MLTSS Medi-Cal benefit
- PPGs will not be delegated for MLTSS services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Delegation</th>
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<tbody>
<tr>
<td>IHSS</td>
<td>L.A. Care MLTSS</td>
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<tr>
<td>MSSP</td>
<td>L.A. Care MLTSS</td>
</tr>
<tr>
<td>CBAS</td>
<td>L.A. Care MLTSS</td>
</tr>
<tr>
<td>Long Term Care (LTC)</td>
<td>L.A. Care MLTSS</td>
</tr>
<tr>
<td>Skilled level of care</td>
<td>PPG level</td>
</tr>
</tbody>
</table>
Care Plan Options (CPO)

• Available to Cal MediConnect members only
• Provides additional services that include:
  • Respite care/provider support
  • Supplemental IHSS-like services
  • Home modification/maintenance
  • Nutritional services
• All available community resources must be exhausted
• Prior authorization and coordination required
Recognizing the Need for MLTSS

Referrals to the MLTSS Department can come from:

- PCP/PPGs
- ICT
- Case Management
- Member Services
- Grievances and Appeals
- Community Based Organizations
- Member Request
Continuity of Care
Basic Cal MediConneet (CMC) Continuity of Care (COC) Requirements

Upon beneficiary request L.A. Care must offer continuity of care (COC) with an Out-of-Network Provider for the following regulatory timeframes:

• Up to 6 months for primary and specialty Medicare services
• Up to 12 months for primary and specialty Medi-Cal Services

Provided all the following circumstances exist:

• Evidence the beneficiary has an existing relationship with the Provider
• Provider has no quality or credentialing issues
• Provider must be willing to accept payment based on the current Medicare or Medi-Cal fee schedule
Additional requirements for CMC COC: Skilled Nursing Facilities

Skilled Nursing Facilities

- **When a new CMC member in a SNF upon enrollment, this serves as an automatic request for CMC COC in the SNF.**
- If a CMC Skilled Nursing Facility (SNF) resident leaves, and then requires a return to a SNF level of care due to medical necessity, the beneficiary has the right to return to the same SNF where he/she previously resided under the Leave of Absence and Bed hold policies
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  - (See DPL 14-002 for more information on these policies), and the continuity of care policies contained in this DPL. The specific requirements on the Leave of Absence, Bed hold, or continuity of care policies will apply depending on which policy is applicable in any given circumstance.
Requesting Continuity of Care

Members, their authorized representative on file with Medi-Cal, or their provider, may make a direct request of Continuity of Care to L. A. Care Member Services:

- Verbally via a telephone call to L.A. Care Member Services at 1-888-522-1298.

- In writing, via members on their own behalf:
  L.A. Care Health Plan Cal MediConnect Program
  1055 W. 7th Street
  Los Angeles, CA 90017

- In writing, via you as a provider on behalf of your patient who is an L.A. Care Cal MediConnect member
  L.A. Care Health Plan Cal MediConnect Program
  1055 W. 7th Street
  Los Angeles, CA 90017

*Per DHCS DPL14-004, no form/document is required to initiate a Continuity of Care request.
Continuity of Care for New Enrollees

Services covered upon new enrollment:

• Medical
• Psychosocial
• Mental and behavioral
• Managed Long-term services and supports (MLTSS)
• Pharmacy

Covered services include acute conditions, serious chronic condition, pregnancy, terminal illness, and authorized surgeries/procedures to occur within 180 days of effective date of coverage.
Continuity of Care – General Criteria

Continuity of Care is provided for Cal MediConnect members if the following criteria are met:

- Evidence of an historical relationship with the provider
- Provider must be willing to accept the plan reimbursement
- No provider quality or credential issue
Required Timeframes for Processing CMC COC Requests

• L.A Care Health Plan must begin processing COC requests within five working days from receipt of the request

• And

• Must complete their responses to each request within
  • 30 calendar days from the date L.A. Care receives it,
  Or
  • within 15 calendar days if the beneficiary’s medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs.
  Or
  • If there is a risk of harm to the beneficiary, the request must be completed in three days.
Requirements for Delegated Entities

• When a beneficiary transitions into L.A. Care, and has an existing relationship with a PCP that is in L.A. Care’s network, as determined through:
  • the HRA process; or
  • review of prior utilization data; or
  • beneficiary request,

• L.A. Care must assign the beneficiary to the PCP, unless the beneficiary chooses a different PCP.

• If L.A. Care contracts with delegated entities, it must assign the beneficiary to a delegated entity that has the beneficiary’s preferred PCP in its network;
Requirements for Delegated Entities (continued)

• When a CMC beneficiary transitions into L.A. Care, and has an existing relationship with a PCP and/or specialist that is in L.A. Care’s network, and he or she wishes to continue to see these providers, L.A. Care must allow the beneficiary to continue treatment with these providers for the continuity of care period.

• This is regardless of whether these providers are, or are not, in the network of the prime PPG to which the beneficiary is assigned, as long as the continuity of care requirements are met.
  • For example, if a beneficiary has an existing relationship with a PCP and a specialist with the assigned PPG #1 PPG #1) as well as a specialist in another PPG in L.A. Care’s network (PPG #2), where both PPGs are delegated entities of L.A. Care, L.A. Care must assign the beneficiary to PPG #1 and allow the beneficiary to continue treatment with both specialists (one in PPG # 1 and another in PPG # 2)
    • The continuity of care agreement for the specialist in PPG #2 would last for up to six months for Medicare services and up to 12 months for Medi-Cal services.
Behavioral Health
The Cal MediConnect Population

• This population has a high prevalence of chronic medical and mental health conditions or disabilities, substance use disorders, social isolation, and poverty.

• Behavioral Health services integration and care coordination are an important care component of Cal MediConnect.

• Behavioral health services do not require referrals
Beacon Health Options

- L.A. Care has partnered with Beacon Health Options for Behavioral health services for Cal MediConnect. Access to behavioral health for all LA Care members and providers is 1-877-344-2858.

- Behavioral Health services include inpatient and outpatient care:
  - Mental health crisis prevention and treatment
  - Substance use disorder diagnosis and treatment
  - Integrated with medical care and services

- For access to carved out specialty services, L.A. Care will partner with Department of Mental Health for specialty mental health services and Department of Public Health/Substance Abuse Prevention & Control for Drug Medi-Cal services.
Contacting Beacon

• L.A. Care staff, contracted practitioners and members may contact Beacon at (877) 344-2858

• Behavioral Health Services do not require referral.
Grievances and Appeals

• Members of Cal MediConnect are adults who are eligible for both Medicare and Medi-Cal benefits.
  • Medicare benefits follow the Medicare grievance and appeal process.
  • Medi-Cal benefits follow the Medi-Cal grievance and appeal process.
  • For “overlapping benefits” the Member may choose either path, but not both.
    • Home Health, DME, Skilled Therapies
Member Rights
Member Rights

• L.A. Care Members have specific rights about information, privacy, participation in their treatment, voicing complaints, choosing a provider, enrollment/disenrollment, and receiving emergency services.

• L.A. Care does not discriminate against enrollees due to:
  o Medical condition
  o Claims experience
  o Receipt of health care
  o Medical history
  o Genetic information
  o Evidence of insurability
  o Disability
Member Rights

• Members have the right to:
  • Receive information about L.A. Care, its services, its practitioners and providers.
  • Privacy and right to be treated with respect, dignity, and courtesy from L.A. Care’s providers and staff.
  • Participate with practitioners with any care their practitioner provides or recommends, discuss all treatment options, and participate in making decisions about their health care, presented in a manner appropriate to the enrollee’s condition(s) and ability to understand.
  • Right to say “no” to treatment.
  • Talk candidly to their practitioner about inappropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Right to decide in advance how they want to be cared for in case they have a life-threatening illness or injury.
What is Balance Billing?

- Balance billing occurs when doctors, ancillary providers or hospitals charge beneficiaries for Medi-Cal and Medicare covered services.

- Charges are usually in the form of co-pays, co-insurance, or deductibles.
Prohibition of Balance Billing

• L.A. Care Members cannot be balance billed

• Federal and State law prohibits billing Members for covered services that are not the responsibility of the Member
  • This prohibition includes co-pays, co-insurance and completion of forms:
    o Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997
    o Title 22 Medical Assistance Program CCR §51002 Beneficiary Billing
    o California Welfare & Institutions Code §14019.4
    o California Health and Safety Code §1379
    o California Health and Safety Code §1262.8
Balance Billing

• L.A. Care members who have both Medi-Cal and Medicare (including Cal MediConnect) should never be charged for services covered under Medi-Cal or Medicare.

• A provider must accept as payment in full whatever amount the provider receives from the health plan, contracted provider group, Medicare or Medi-Cal.
What to Do If a Member is Balance Billed

• If a contracted provider bills a patient in error, the provider must stop immediately upon proof of enrollment!

• Immediately call off any collection efforts that have begun.

• Upon receiving proof of eligibility, debt collection agencies and/or providers also must correct any erroneous information sent to credit reporting agencies.
What to Do if a Member is Balanced Billed, cont.

- Providers who continue billing or collections are subject to:
  - Referral to L.A. Care’s Fraud, Waste and Abuse program
  - Referral to CMS Provider Certification Program
  - Referral to DHCS Medi-Cal Provider Certification Program
Balance Billing Resources and Information

• More information about balance billing is also available in the L.A. Care provider manuals at https://www.lacare.org/providers/provider-resources/provider-manuals

• Also, information about how to process crossover claims can be obtained at the L.A. Care Provider Service Line at 1-866-522-2736 and at http://www.calduals.org/providers/physician-toolkit/
Critical Incidents
LISTENING FOR CRITICAL INCIDENTS

- If your position includes contact with members or with member information, you may become aware of a critical event when:
  - A member tells you
  - A member is admitted for a suicide attempt
  - A caregiver or family member with knowledge of the member’s situation tells you
- Always take a report of a critical event seriously.
REPORTABLE EVENTS
AS DEFINED BY L.A. CARE’S CRITICAL INCIDENT REPORTING/TRACKING POLICY

CRITICAL INCIDENTS

- SUICIDE ATTEMPT
- ABUSE
- INAPPROPRIATE RESTRAINTS OR SECLUSION
- DISAPPEARANCE
- EXPLOITATION
- UNEXPECTED DEATH
- NEGLECT
- SERIOUS LIFE THREATENING EVENT
- SUICIDE ATTEMPT
- ABUSE
- INAPPROPRIATE RESTRAINTS OR SECLUSION
- DISAPPEARANCE
- EXPLOITATION
- UNEXPECTED DEATH
- NEGLECT
- SERIOUS LIFE THREATENING EVENT
WHEN & TO WHOM TO REPORT

REPORT
Critical Incidents must be reported to authorities/reporting agencies

DOCUMENT
Track all reported critical incidents in the CI Report Log

L.A. CARE QI DEPARTMENT
Email to Cl@lacare.org completed CI Report Log
Quarterly
How To Report a Critical Incident?

- PPGS and Subcontractors report on a quarterly basis using the Critical Incident Reporting tool. They will be audited for compliance.
- Providers report a Critical Incident to their respective PPG, who will report it using the tool.

**Reporting Schedule** (Ref: PARTICIPATING PHYSICIAN GROUP SERVICES AGREEMENT EXHIBIT P.2A)

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Quarterly Due Dates:</th>
</tr>
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<tbody>
<tr>
<td>Report Log</td>
<td>1(^{st}) Qtr – May 15</td>
</tr>
<tr>
<td></td>
<td>2(^{nd}) Qtr – Aug 15</td>
</tr>
<tr>
<td></td>
<td>3(^{rd}) Qtr – Nov 15</td>
</tr>
<tr>
<td></td>
<td>4(^{th}) Qtr – Feb 15</td>
</tr>
</tbody>
</table>

CI@lacare.org

L.A. Care Format (Critical Incident Report Tool)
Cultural Competency
Importance of Cultural Competency in Health Care

- To respond to demographic diversity.
- To offer patient centered care.
- To increase member satisfaction.
- To improve quality of services and outcomes.
- To reduce health and healthcare disparities.
- To meet legislative, regulatory and accreditation mandates.

Adapted from: National Center for Cultural Competence, Georgetown University
Culture

Culture is shared values, norms, traditions, customs, history, and beliefs that are held by a group of people.
Cultural Competency

To be culturally competent doesn’t mean you are an authority in the values and beliefs of every culture.

It means you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world.

Okokon O. Udo PhD
Integrative Health and Wellness
Northwestern Health Science University
Cross Cultural Communication Skills

- Have awareness of yourself and knowledge of the other.
- Keep biases in check.
- Ask open-ended questions.
- Listen with empathy.
- Be open to new information.
- Explain your own perceptions and knowledge.
- Accept ambiguities.
- Treat people as individuals.
Language Assistance Services

L.A. Care members have the right to:

• Access no-cost interpreting services 24-hour, 7-days a week, including American Sign Language.

• Receive written Member Informing Materials in their preferred language and format (large print, audio.)

• File complaints and grievances if their cultural or linguistic needs are not met.
Provider’s Responsibilities

- Assess and qualify bilingual staff if they are used as interpreters.
- Document member’s preferred language in the medical record.
- Inform members of the availability of no-cost interpreting services.
- Discourage use of friends and family (especially minors) as interpreters.
- Document member refusal of interpreting services in the medical record.
Tips for Working with Interpreters

• Have a briefing with the interpreter prior to the appointment or call
• Allow extra time for the interpreting session
• Speak in a normal voice, not too fast or too loud
• Talk to the member directly
• Pause for interpreter to interpret
• Be brief and basic
• Avoid acronyms, medical jargon, and technical terms
• Don’t say anything you don’t want the member to hear
More Information on L.A. Care’s C&L Services

Provider Manual
http://www.lacare.org/providers/provider-resources/provider-manuals

C&L Contact
CLStrainings@lacare.org
Disability Awareness
Serving Seniors and People with Disabilities
What is a disability?

Contemporary understanding of disability:

*The interaction of impairment with environmental factors*
Regulations

- The 1990 Americans with Disabilities Act (ADA)
- The 1999 Olmstead Act
- Section 504 of the Rehabilitation Act of 1973
- Section 1557 of Affordable Care Act
Accommodations

• Communication accessibility

• Physical accessibility
### “People First” Language

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Unacceptable-Offensive</th>
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</thead>
<tbody>
<tr>
<td>People with disabilities</td>
<td>The handicapped or disabled</td>
</tr>
<tr>
<td>He has a cognitive disability</td>
<td>He’s mentally retarded</td>
</tr>
<tr>
<td>She has autism</td>
<td>She’s autistic</td>
</tr>
<tr>
<td>He has Down Syndrome</td>
<td>He’s Down’s, a Down’s person, mongoloid</td>
</tr>
<tr>
<td>She is a wheelchair user</td>
<td>She’s confined to/is wheelchair bound</td>
</tr>
<tr>
<td>She is of short stature</td>
<td>She’s a dwarf/midget</td>
</tr>
<tr>
<td>He has a physical disability</td>
<td>He’s quadriplegic/crippled</td>
</tr>
<tr>
<td>People without disabilities</td>
<td>Normal healthy/typical people</td>
</tr>
</tbody>
</table>
Serving Seniors and People with Disabilities

• Use “people first” language
• Treat people with disabilities as individuals
• Don’t make assumptions
• Ask before you help
• Speak directly to a person with a disability
• Respond to requests
More Information

- American with Disabilities Act
  http://www.ada.gov

- Olmstead Act
  http://www.ada.gov/olmstead/olmstead_about.htm

- Council for Disability Awareness
  http://www.disabilitycanhappen.org
Care Coordination
What is Care Coordination

• Case Management services for members with increased needs:
  • Episodic
  • Increased resources
  • Multiple services along the continuum
  • May be accessing MLTSS services
  • Additional designated care coordinator, appropriate specialty providers, and additional service providers.

*The goal is to have seamless service coordination.*

*Primary Care and Specialty Care providers play an important role in Care Coordination.*
Care Coordination Standards

• Five elements of a person-centered approach:
  • Individualized service planning and delivery
  • Participation of the person and, as appropriate, family members and others chosen by the person in service planning and delivery
  • Consideration of the person’s values, culture, traditions, experiences and preferences in the definition of quality
  • Recognition and support of a person’s self-care capabilities
  • Integration of formal and informal supports
Care Coordination Processes

Care coordination addresses:

- Targeted assessment of identified member needs
- Creation of individualized care plan
- Facilitation of identified referrals
- Facilitation of Continuity of Care with non-contracted providers
- Development of short term goals
- Follow up communications
- Discussion of ICP with ICT
L.A. Care’s Model of Care

**Member’s Interdisciplinary Care Team (ICT)**
- Primary Care Provider
- Care Manager
- Social Worker
- Therapists (OT, PT, etc.)
- Medical Specialists
- Pharmacist
- Managed Long-Term Services and Supports Specialist
- Behavioral Health Specialist
- Health Educator

**Member’s Health Care Team**
- Member
- Family and Caregivers

*Each member’s needs will dictate who is on his/her health care team and his/her care management and services.*

**Enhanced Care Management & Services**
- Health Risk Assessment
- Care Planning and Service Coordination
- Transitional Care
- Home-based Care
- Medication Management
- Disease Management
- 24/7 Nurse Advice Line
- Integration of Medical, Behavioral and Long-term Care

**Member & Family**
- Member
- Family and Caregivers
Measurable Goals

• Improving access to essential services, such as medical, mental health, substance use, social services and supports including home and community based services

• Improving access to affordable care

• Assuring appropriate utilization of services

• Improving coordination of care through an identified point of contact

• Improving seamless transitions of care across healthcare settings, providers and health services

• Improving access to preventive health services

• Improving beneficiary health outcomes
Measurable Outcomes

- Performance is measured annually
- Measurable goals may be analyzed more frequently as defined by the measure
- Established by CMS, DHCS or defined by L.A. Care Quality Improvement program
- Measured using the Plan, Do, Study, Act model of improvement
- Corrective Actions Plans and Interventions
- Continuous quality cycle
- Analyzed by multidisciplinary team and approved by appropriate quality committees
- Goals not met – Quality Committees will perform root cause analysis to establish causal relationship for compliance with identified measures
Administrative And Clinical Oversight

Administrative/Clinical Oversight functions are related to the review of:

- Encounter Data for appropriateness and timeliness of services
- Pharmacy Claims
- Utilization Data
- Delivery of health care services and benefits
- Administrative and clinical performance
- Quality improvement activities
- Beneficiaries and providers Satisfaction Survey and Analysis of Results
Health Risk Assessment (HRA)

L.A. Care will maintain an assessment process that will:

- Assess each new enrollee’s risk level and needs based on an interactive process such as telephonic or in-person communication. The HRA can also be mailed.
- Address the care needs and coordinate the Medicare and Medi-Cal benefits across all settings
- Review historical Medicare and Medi-Cal utilization data
- Follow timeframes for reassessment
More About The HRA

Standardized self-reported screening tool conducted with each member upon enrollment.

When the member cannot be reached, L.A. Care follows up with a written form and self-addressed stamped envelope for completion by the member. A follow up call to the member confirms receipt of the mailing.
Who Gets An HRA? And When?

• Initial comprehensive HRA for every enrollee within the first 90 days of enrollment; annual reassessment (HRA) within 12 months of the last HRA or more often based on member needs or change in health status.

• All members are offered face-to-face HRAs if desired

• Timeline
  o High Risk within 45 days of enrollment
  o Low Risk/Community Well or residents in a nursing facility within 90 days of enrollment
Who Conducts An HRA?

• Personnel trained in the use of the assessment instrument

• For higher risk members, knowledgeable and credentialed personnel to review, analyze, identify and stratify health care needs, such as physicians, nurses, social workers, or behavioral health specialist

• Contracted vendor for members residing in long-term settings

• Members may receive the HRA in a face to face setting, but most must choose to be assessed over the phone.
What Does The HRA Assess?

The HRA screens for

- Health status, chronic health conditions/health care needs
- Clinical history
- Mental health and cognitive status Activities of daily living (ADLs)/Instrumental activities of daily living (IADLs)
- Depression
- Medication review
- Cultural and linguistic needs, preferences or limitations
- Evaluate visual and health needs, preferences or limitations
- Quality of Life
- Life planning activities
- Caregiver support
- Available benefits
- Continuity of care needs
- Fall prevention
- Managed Long Term Services and Supports, including HCBS

*This tool, along with other resources, is used to develop the Individualized Care Plan (ICP)*
Additional Uses For The HRA

Coordinate referral as need, such as:

- Managed Long Term Services and Supports
- Home and Community Based Services
- Disease Management Programs
- Behavioral Health Programs
- Substance Use Programs
- Community Transitions
Interdisciplinary Care Team (ICT)
What Is An ICT?

An ICT is a collaborative, multidisciplinary team who:

• Analyzes and incorporates the results of the initial and annual health risk assessment into the care plan.
• Develops a collaborative Individualized Care Plan (ICP) and annually update the member’s ICP.
• Manages the medical, cognitive, psychosocial and functional needs of each member.
• Communicates the ICP to all caregivers for care coordination.
• Coordinates with and facilitates referrals to the appropriate resources, medical, behavioral health or home and community based providers, i.e. MLTSS.
ICT Composition

- Contracted and employed L.A. Care Health Plan’s staff
- Knowledgeable, licensed, and Credentialed individuals, that are involved or closely associated with the care of the member.
- ICT members are selected based on population needs, such as:
  - Clinicians experienced in managing geriatric and/or chronically ill populations
  - Support providers serving vulnerable disadvantaged populations
  - Licensed behavioral health practitioners
  - Staff with expertise in Medicare and Medicaid operations
  - Agreed upon with the member relevant to identified goals of care

NOTE: ICTs can be specific to MLTSS and Behavioral Health services
Who Is On The ICT?

The member is at the center of the care planning process and may choose to include clinical or non-clinical staff and/family or caregivers. **The member may also choose to exclude participants as part of their right to self-direct care.** Possible ICT members include:

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<th>County IHSS Social Worker</th>
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<td>IHSS Provider with approval from member</td>
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<td>Social Worker</td>
<td>Other professional staff in provider network</td>
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<td>Patient Navigator</td>
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The Care Manager (Care Coordinator) is the Team Leader, responsible for organizing the ICT in response to:

- Member or provider requests
- Negative events or needs identified via the Health Risk Assessment (HRA)
- Other previous assessments such as medical, MLTSS (IHSS, CBAS, MSSP), nursing facility and Behavioral Health assessments

The Care Manager assigned to the members’ risk level (High, Moderate or Low) is the responsible lead of the ICT
Who Will Have an ICT?

- New guidance received in the March 9, 2015 DPL 15-001 clarified responsibilities around the ICT (and ICP):
  - Not required unless the member requests or demonstrates the need for an ICT
- L.A. Care developed Care Management expectations that were defined in 1Q 2015 & written into policy & procedure in response to the new guidance in DPL 15-001
- Training on these updates was provided on June 25, 2014
Provider Network

If you have any questions regarding the L.A. Care Cal MediConnect training please contact the Customer Solution Center Provider Services Unit at 1-866-522-2736.
Please take this assessment to complete the training.