Duals Demonstration Care Coordination Principles Summary, 2013

June 10, 2021

The following summarizes initial care coordination principles developed in the Cal MediConnect (CMC) program in 2013 and codified in statute through Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012). As DHCS and stakeholders consider the care coordination model in future integrated products, the following can serve as context and reference.

Care Coordination Principles (2013)

1. Plans will provide care coordination services to all Members, as needed, in accordance with the Member's individual preferences, and in a way that meets the needs of Members with disabilities. Plans may offer additional services beyond those required by Medicare and Medi-Cal at the Plan's discretion (SB 1008).
2. Plans' care coordination services will reflect:
    a. A person-centered, outcome-based approach, consistent with the CMS model of care and Medicare requirements and guidance (D-SNP).
    b. A Member's right to self-direct the provision of long-terms services and supports (SB 1008).
    c. A Member's right to determine the appropriate involvement of his or her health care and LTSS providers and caregivers (SB 1008).
3. Plans will coordinate the Member's care across the full continuum of service providers, including medical, behavioral, and LTSS. This includes facilitating access appropriate community-based resources and monitoring skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between facilities and the community.
4. Care coordination will be performed by nurses, social workers, primary care providers, and, if appropriate, other medical or long-term services and supports professionals, and health plan care coordinators.
5. Care coordination will include, at a minimum, the following steps within the prescribed timeframes:
    a. A **health assessment process** that includes an initial risk stratification and health risk assessment survey, which looks at both health and functional status.
    b. The development of **Individual Care Plans (ICP)** that comply with Medicare and Medi-Cal continuity of care provisions.
    c. Access to **Interdisciplinary Care Teams (ICT),** as appropriate and as requested.
    d. Ongoing **care management** that includes basic and complex case management, and, when appropriate, conducted by nurses, social workers, the Member's PCP, if appropriate, and other medical professionals, in accordance with state and federal law (SB 1008).