



## You Are Part of Our Community

Our platform connects providers, patients, caregivers and health plans.

# Cal MediConnect FAQs

### What is Cal MediConnect?

The Cal MediConnect Program is a voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term services and supports through a single organized delivery system.

### What is Managed Medi-Cal Long-Term Supports and Services (MLTSS)?

LTSS include a range of home and community-based services such as IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) in addition to care in nursing facility services when needed.

### Where is Cal MediConnect Available?

The program is available in eight counties: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside and San Bernardino.

### What is the goal of Cal MediConnect?

The Cal MediConnect program aims to improve care coordination for dual eligible beneficiaries and drive high quality care that helps people stay healthy and in their homes for as long as possible. Additionally, shifting services out of institutional settings and into the home and community will help create a patient-centered health care system that is more sustainable.

### Who are dual eligible beneficiaries?

Dual eligible beneficiaries are people who qualify for both public health insurance programs, Medicare and Medi-Cal. In California, as many as seven in ten dual eligible beneficiaries are age 65 and older, and most are women. Approximately one in three are younger people with disabilities.

### How many Dual Eligible beneficiaries live in California?

California has about 1.1 million of these beneficiaries. Of these, about 456,000 are estimated to be eligible for enrollment into the Cal MediConnect program, including a 200,000 enrollment cap in Los Angeles.

### How will Cal MediConnect coordinate care?

Cal MediConnect plans will give providers information and resources to support care coordination:

#### Health Risk Assessments (HRAs)

- Primary, acute, LTSS, behavioral health and functional needs

#### Interdisciplinary Care Teams

- Beneficiary, plan care coordinator and key providers

#### Individualized Care Plans

- Care teams will develop and implement ICPs

#### Plan Care Coordinators

- Facilitates communication between plans, providers and beneficiaries

## How can I stay informed?

Additional Resources:

HICAP: 213-383-4519

Hotline: 1-800-434-0222

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