Los Angeles County Coordinated Care Initiative (CCI)
Stakeholder Workgroup Meeting

Thursday, September 17, 2014

1:00 P.M. – 3:00 P.M.

Cathedral of Our Lady of the Angels

Welcome and Introductions
CareMore Cal MediConnect Plan

Joyce Furlough
Vice President, Duals Program, CareMore

Cal MediConnect Continuity of Care (COC) Overview

James Tea
Director, Network Operations, Duals Program, CareMore

Intro: Continuing care after joining a health plan:

- In addition to the Continuity of Care coverage you receive today for medical necessity, you may enjoy added COC benefits to continue with your existing provider.
- Your new Cal MediConnect or Medi-Cal health plan will work to ensure that your care continues and is not disrupted.
- Your health plan will work with you and your doctors to ensure you get all the care you need.
- If you have a scheduled treatment and just joined a new health plan, call your new health plan right away. Tell the health plan about your treatment so they can work with you.
- Members have the right to continue services with existing Primary Care Provider or Specialist. Cal MediConnect continuity of care provisions do not apply to Durable Medical Equipment (DME), medical supplies, transportation, or other ancillary services.

Cal MediConnect Requirement for Continuity of Care (COC):

Once the member, his/her authorized representative or provider has requested the continuity of care from the Cal MediConnect plan, the following three conditions must be met:

1. The plan must find a pre-existing relationship with the physician(s) prior to enrollment which demonstrates a relationship:
    - Primary care physician, at least once in the 12 months preceding enrollment
    - Specialist, at least twice in this 12-month period
2. The physician must meet quality of care standards.
3. The out-of-network physician must accept the Cal MediConnect plan rate = current Medicare/Medi-Cal fee schedule, as applicable.

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How to see out-of-network doctor after joining a Cal MediConnect plan

- You may be able to see an out-of-network provider for up to six months (Medicare) or 12 months (Medi-Cal) after you join the plan.
- Tell your doctor or provider that you joined a health plan. You can ask them if they have joined or might consider joining the health plan's network.
- Call your health plan and tell them about your scheduled care. Ask if your doctor is in their network.
- If your doctor or provider is "out-of-network," tell the plan you want to keep seeing your doctor.
- The plan will contact your doctor and allow you to keep seeing that doctor for up to the respective Medicare/Medi-Cal time period if the doctor agrees to the terms.

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The Continuity of Care (COC) Process for the Health Plan:

A member's request is completed when:

- Member request COC through their selected/assigned health plan.
- Health plan will complete the evaluation of a member's continuity of care request within 30 days, or within 15 days if the member's medical condition requires more immediate attention, or sooner if medically warranted.
- Health plan will notify both member and provider of COC approval/denial.
- When the COC period is over, and the provider did not contract with the health plan, the member will transition to a provider within the health plan's network.
- Health plan will engage with the member and physician before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.
- Health plan makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Additional Continuity of Care Requirements:

Continuity of Care for Long-Term Resident of Nursing Homes

- Cal MediConnect members residing in nursing homes will not have to change nursing homes even if their nursing home is not in the health plan's contracted network unless there are quality concerns during the period of the demonstration.
- A "long term resident" is defined as having continuous residence, including approved bed hold days, of greater than 90 days.

Continuity of Care for other Benefits/Services

- Members receiving LTSS will not have to change their services for In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), or Multipurpose Senior Services Program (MSSP) providers.
- Will receive existing Medicare Part D prescription drug continuity of care, including a supply of up to 30 days of any existing prescription. After that, members must switch to drugs on the formulary, which may require switching between brand names and generic.
- Must use providers in network for other non-physician specific services through the health plan's network, such as suppliers of medical equipment, medical supplies, transportation, or other ancillary services.

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Recent state policy updates:

Requesting Continuity of Care

- Providers can now request Continuity of Care while complying with plan UM policies.
- Continuity of Care can be requested by phone.
- Plans cannot request unnecessary information, or require members to complete a request form.
- Request must be processed within 3 days if there is risk of harm to the member.
- Plans must actively try to determine continuity of care needs as part of HRA process.

Retroactive Continuity of Care

- Providers or members can now request continuity of care after service delivery.
- Request must come within 20 business days of first service following enrollment.
- Allows patients to see providers while plan processes request.

Beneficiaries must be notified that Continuity of Care is time-limited

- Notification must include duration of continuity of care, process for transition following that period, and the member's right to choose different in-network providers.
- Within 30-days of request approval, and 30-days prior to end of continuity of care period.

CareMore's COC stats to date (includes provider-based and medical necessity COC)	1,817
Total Approved	1,474
Total Denied • Health Plan denial • Provider denial • Other	178 0 160 18

Closing: Top things to remember about Continuity of Care (COC):

- COC is an option for members to continue with their existing providers as they transition into the Cal MediConnect Plan.
- COC approval is based on 3 components:
  - Member has an established relationship with the provider.
  - Provider agrees to Cal MediConnect Plan current Medicare/MediCal rates.
  - Provider meets professional and quality of care standards.
- Members and Providers will receive notification of approval or denial within 30 days of COC submission.
- Nursing Home members can remain in their facility

Real Stories

LaShaunta Harris,
Care Manager, Duals Program,
CareMore

Real Stories

- Mr. S is an under 65 year old new CareMore Cal MediConnect member effective 9/1/2014. He has **an authorized representative** (his mother) to assist in coordinating his many medical needs.
- The member's mother was concerned about how her son would continue to receive treatment ordered from previous providers. She **called CareMore Member Services** and was immediately **connected to the assigned Care Manager** to assist in getting Mr. S what he needed to continue his care.
- The Care Manager spoke to the treating physician to learn more about the member and his needs. A **continuity of care request was initiated** which allowed the member's existing physician to continue care.
- Mr. S was also receiving home health care services. The home health care agency happened to be a contracted provider, so the agency agreed to continue services without having a paper authorization. A verbal authorization was all that was needed to support this transition and the member received services in a timely manner.
- The Care Manager took the **opportunity to education** the mother about CareMore and assisted in scheduling a Healthy Start appointment for her son.

The mother said ***"This makes me feel a sense of comfort and warmth knowing that I made the right choice in selecting CareMore for my son."***

CareMore Healthy Start

Healthy Start appointment helps us get to know our new members and find out about their health care needs. We will:

- Confirm medical equipment needs
- Assist with medicine refills or renewals
- Continue access to current in-home or community based services
- Complete health risk assessment
- Discuss what is most important to you about your health
- Identify who needs to be on your personal care team
- Determine health management programs that would be right for your health needs.

After a Healthy Start appointment, CareMore gives the member a personal care plan. The care plan list the services and programs needed to achieve the member's health goals.

Cal MediConnect Ombuds Program Update

New Choice Form

Hilary Haycock
Director of Strategic Outreach and Communication,
Harbage Consulting

Stakeholder Discussion and Open Forum

Jane Ogle
Former Deputy Director, Health Care Delivery Systems, DHCS

Wrap Up

Susi Rodriguez Shapiro
Director, Community Engagement, CareMore

Wrap Up

- Next Meeting: October 15, 2014
- 2015 Meeting Frequency/Location