Questions Gathered from All Plan Stakeholder Meeting		
	Question	**Response**
1.	Can each plan speak to what has been delegated to the Provider Groups? Delegation arrangements from Plans to Participating Physician Groups (PPGs) can differ from plan to plan.	Plans generally contract with networks of physicians to provide healthcare services. These networks are often referred to as Independent Practice Associations, Medical Groups and/or Provider groups. The Provider Groups are generally delegated to provide and authorize services, pay claims and credential their providers. The delegation responsibilities vary by plan and by group. Health plans do not delegate quality management, complaints and grievance management or the handling of member appeals. Provider Groups must pass rigorous pre-contractual audits, ongoing oversight audits, submit compliance reporting regularly and demonstrate ongoing compliance with all plan requirements. Please contact each plan for more specific questions related to delegation.
2.	How are plans preparing for the January enrollment wave?	Although plan preparations differ from plan to plan, all plans are engaging in the following activities in preparation for the January 1, 2015 enrollment wave: • Increasing staffing, both clinical and operational (claims, care coordination, member services, provider relations, etc.) • Ensuring staff is trained, especially on most recent policy changes issued by DHCS • Ensuring adequate training of participating physicians and physician groups (PPGs) • Outreach to community-based organizations, ensuring they are equipped with plan information and contact information • Informed PCP of expected transition (letter to PCP) • The majority of members health plans are already serving through DSNP plans

3.	Concern about cutting the frequency of LA County CCI Meetings.	In addition to Quarterly All Plan Stakeholder meetings in 2015, CMC plans are also hosting operations and consumer focused advisory workgroups. If you are interested in participating please contact your plan representative.
4.	What are the timelines for complying with new Continuity of Care (CoC) Dual Plan Letter (DPL) which stipulates?	All CMC plans are required to implement and abide by the new CoC policy as of September 29, 2014 (DPL 14-004). Plans are communicating these changes to CoC staff as well as PPGs within their networks.
5.	Risk of Harm (plan specific): 1. How is this defined? 2. How are plans processing? 3. Any best practices	While risk of harm is not clearly defined in the State guidelines, continuity of care requests are processed so that the risk of harm is minimized. Generally speaking, plans triage requests to ensure that members with upcoming appointments and other urgent needs are addressed as quickly as possible. Members, physicians and administrative staff all participate in identifying urgent needs and processing the requests quickly to minimize disruption. The Dual Plan letter dated 09/29/0214, revising Continuity of Care, identifies that a continuity of care request must be completed in 3 days if there is a risk of harm to the beneficiary.
6.	COC: Will plans process retroactive requests when date of service is more than 30 days?	All plans will review CoC requests that exceed the 30 day timeframe on a case-by-case basis and determine if retroactivity can be honored. Plans comply with the referenced Dual Plan letter dated 09/29/2014; please contact your specific plan representative for further inquiries.
7.	How are plans (both CMC and Medi-Cal HMO) working to satisfy member requests for transitional fills of supplies, such as incontinence items and diabetes materials?	Plans have processes in place to identify needs and accept requests for services. Authorization turnaround times are adhered to by the plans. Expedited requests are typically processed within 24 to 72 hours and suppliers usually deliver within 24 hours for urgent request and within the week for non-urgent request. Plans are working diligently to satisfy these requests. If you have any issues, please contact

		member services or your health plan stakeholder representative.
8.	How quickly can plans deliver medical supplies to new members through in-plan suppliers?	Plans comply with regulatory requirements for approval and fulfillment of authorizations that meet medical necessity. Expedited requests are typically processed within 24 to 72 hours and suppliers usually deliver within 24 hours for urgent request and within the week for non-urgent request.
9.	Which plans contract with outside agencies to complete Health Risk Assessments (HRAs)?	Care1st/Health Net/LA Care: Yes, we contract with external vendor to assist in HRA completion. CareMore: At this time, CareMore does not contract with outside agencies for HRA's. Molina: Molina has not previously contracted with outside agencies for HRA's. However, we will use a vendor to support the in-person HRA requests of lower risk members for a short-term basis to manage the increased membership effective Jan 1.
10.	How do plans ensure members understand why sub-contractors are contacting them?	Plans are required to ensure that vendors are using CMS-approved script which describes the purpose of the call in a simple to understand and HIPAA compliant manner. Molina: To manage the increased member volume in January, when a lower risk member indicates s/he would like an in-person HRA the Molina staff person will explain about the vendor and make a warm transfer to schedule the in-person assessment.
11.	Are plans meeting the HRA deadlines? Are members receptive?	All plans must abide by HRA timelines and most members are receptive. Challenges include wrong contact information, language barriers, unresponsiveness and refusal to participate. All plans must document and report to CMS and DHCS their varied efforts to reach the CMC population.
12.	For CMC plans who also run D-SNPs, what is the crosswalk share of D-SNP providers that	Network crosswalks between DSNP and CMC programs may differ from plan to plan. Please contact each plan for details. The majority of DNSP primary care physicians and

	participate in the matching CMC networks?	specialists are also participating CMC providers.
13.	How do you complete in-person HRA's when member doesn't speak any of your eight languages?	Outreach efforts for each CMC plan may differ but include in-home visits and use of bilingual staff or interpreter services to ensure member's language needs are met. Sign language interpreters are also used as appropriate.
14.	How do you contact the hearing impaired, the non-communicative member, or cognitive impaired?	Face-to-face encounters are used for members who have cognitively disabilities. TTY or relay services are used for telephonic communication with members who are deaf or hard of hearing. Non-communicative members' designated representatives and/or caregiver may speak on behalf of members. American Sign Language (ASL) or other modes of interpreting (i.e. tactile) are used to support in person communication with deaf or deaf/blind members.
15.	Do you report updated member contact information to Health Care Options (HCO) & CMS when your outreach yields such data?	Plans currently do not have the ability to report updated membership information to DHCS or CMS systems. Plans encourage members contact both DHCS through Health Care Options as well as their local DPSS (Medi-Cal) office to report changes to contact information (address/phone).
16.	What share of high-need members do you reach and complete an HRA for? During what time period?	Allocation of high risk membership can differ from plan to plan but based on program requirements and DPL 13-002, high risk membership must have an HRA completed within 45 days of enrollment into CMC. HRA completion statistics differ from plan to plan; please contact each plan individually for reporting. The plans report activity weekly to the CMS and DHCS Contract Management Team.
17.	Alzheimer's Association, California Southland Chapter welcomes the opportunity to share with health plans the "business case" for providing dementia capable coordinated care and opportunities available to work with health	Health Net/LA Care: CMC Plans have engaged the Alzheimer's Associations for multiple training sessions and more are planned in the future. Care1st: We are working closely with the Alzheimer's Association, California Southland Chapter (AA), on training our Case Managers and Social Workers on ADRDs, and letting our members and their family caregivers know about AA resources, as

	plans to strengthen their systems of care, train their care managers, and provide education to family caregivers.	appropriate. CareMore: We have engaged with the Alzheimer's Association to discuss training opportunities for providing dementia education to caregivers and CareMore clinical staff. Molina: has also connected with Alzheimer's association and are considering additional training opportunities for our clinical staff. Molina has also had Alzheimer's association provide in-services to our staff in multiple Molina offices.
18.	The September 10th All Plan Letter from DHCS asks that Health Risk and Long Term Services and Supports (LTSS) assessments to include, process to identify need for community services. Will the plans be talking to stakeholders as they make these changes? How? What is the timeline for this change?	The plan to include a process to identify a need for community services is not novel and has been implemented prior to the release of this APL. And, while the APL does not outline that plans are required to have stakeholder involvement, stakeholders are engaged, encouraged and do participate in the process. Finally, the State has not outlined a timeline for this change.
19.	How would one identify someone who's a Low Income Subsidy (LIS)-Re-Assignee?	Plans receive information through enrollment transaction files. Please contact the plans' member services department for specific information on coverage issues.