L.A. COUNTY COORDINATED CARE INITIATIVE (CCI)
Stakeholder Workgroup
MEETING MINUTES

Wednesday, January 28, 2015; 1-3 p.m.
Oldtimers Foundation
3355 East Gage Ave., Huntington Park, CA 90255
Facilitator: Pamela Mokler, Care1st Health Plan

Call-In: 1-877-336-1829 Code: 2849488#

TIME	TOPIC	PRESENTER
1:09 – 1:20 p.m.	**Welcome/Introductions** • Meeting was called to order at 1:09 p.m. by Pamela Mokler and introductions were made by the health plan representatives and the stakeholders in the room. Participants via phone and WebEx were acknowledged and welcomed. • Pam stated that questions would be taken at the end of the presentations. • Pam gave a brief introduction about the importance of housing for homeless and individuals transitioning out of SNFs/NFs, and reported that most of the Plans are, or in the process of working with nonprofit organizations that serve the chronically homeless. • There are 2 initiatives at the State level: ✓ 1115 Waiver Workgroup to make recommendations for funding for an 1115 Medicaid Waiver that would focus on housing ✓ Health Homes AB 361 for chronically homeless high utilizers.	**Pamela Mokler** *VP of Long Term Services & Supports, Care1st Health Plan*
1:20 – 2:00 p.m.	**Housing & Chronically Homeless High Utilizers**  CSH Presentation - LA CCI Stakeholder m • Susan Lee gave a presentation on the Corporation for Supportive Housing's 10th Decile Project for chronically homeless high utilizers. • Susan gave a summary of CSH's mission which focuses on advancing supportive housing solutions that: ✓ Improves the lives of vulnerable people ✓ Maximizes public resources ✓ Builds strong, healthy communities	**Susan Lee** *Senior Program Manager, Corporation for Supportive Housing*

	• CSH is headquartered in New York City, with staff in more than 20 locations throughout the country. • In LA, the Economic Roundtable did some research starting in 2009 on the "10th Decile" – the most expensive 10% of homeless persons that account for 56% of all public and hospital costs for homeless adults. • Currently, CSH works with 14 hospitals, 8 homeless service providers and 6 FQHCs on the FUSE Project. • The 10th decile model for health care delivery focuses on housing case management services and permanent supportive housing. • The housing retention rate after one year for 10th decile clients is 91%, and studies of the project show a 79% decrease in actual hospital costs per client per year. • CSH's 10th Decile Project uses a triple aim alignment, which includes improving quality of care, reducing costs and improving health outcomes. • ACA Requirements of Health Home Option: ✓ Must have two chronic conditions ✓ The Health Home must be comprised of a team of primary, behavioral health, and social service providers ✓ For the first two years of implementation, the Federal Government will pay 90% of the costs and the State will pay 10% ✓ Six required services • AB 361 is the Health Homes bill that was signed in October 2013. • CSH held a Home Health Charrette Planning process in LA in 2014 to gather recommendations for the Health Homes program. • CSH has also been selected to be the TA Provider for the Housing Workgroup for the new 1115 Waiver. PATH LA CCI Stakeholder Presenta • Katie Hill & Jeremy Sidell from PATH gave a presentation. PATH's mission is to end homelessness for individuals, families and communities. • PATH has 22 locations throughout southern California and they have been providing comprehensive supportive services, strategic outreach,	**Katie Hill** *Chief Operating Officer, PATH* **Jeremy Sidell** *Chief Development and Communications Officer, PATH*

	permanent housing and interim housing for 30 years. • The majority of PATH's work is done in LA County, but they provide services from the border up to San Luis Obispo and Fresno. • Two years ago, PATH set a goal to serve 3,000 individuals by 2015. As of the 1st of the year, they were able to house 3,767 people. • PATH currently has seven completed, permanent housing buildings, three more in construction and 12 to come. • Service providers are changing the way they deliver services. These paradigm shifts include: ✓ Strategic Outreach ✓ Housing First ✓ Rapid Re-Housing ✓ Permanent Supportive Housing ✓ Coordinated Entry Systems • PATH focuses on chronic homelessness. They provide integrated services, utilize individualized approaches, and provide a full continuum of resources to help people move into and stay in permanent housing. • Community engagement is essential – every community is different and partnerships are critical to ending homelessness. • Major elements of PATH's integrated services include: ✓ Strategic Street Outreach ✓ Assertive Community Treatment ✓ System Navigation ✓ Employment Assistance ✓ Housing Location and Placement ✓ Housing Retention • PATH also has interim housing (i.e. short term housing). They have 346 beds across Southern California (LA & SD Counties). • PATH has 385 site-based permanent housing units and over 1,500 scattered site units.	
2:00 – 2:09 p.m.	**State Update on January Enrollment** • Ryan MacDonald gave a brief recap of the Provider Summit and provided the State update on January enrollment. • Highlights: ✓ Over 400 individuals in attendance ✓ Detailed report and summary to come; still a lot of work to be	**Ryan MacDonald** *Communications and Outreach, Harbage Consulting*

	done ✓ Communication is an area in need of improvement ✓ How can we better focus on transitions and how can the Plans better support the providers in serving patients through these transitions? ✓ Delegation can complicate issues regarding CCI ✓ Complications with billing and revenue codes • January Enrollment Update: ✓ There was a large transition of enrollees into Cal Mediconnect in January ✓ Approximately 122,908 enrollees as of January 1, 2015 ✓ Approximately 56,240 enrollees in LA County ✓ Feedback from the January transition has been relatively positive • Next "challenge" will be to focus on the completion of the HRAs; the State is currently working with CMS and the Plans on how to coordinate these efforts • The State will be providing an update on how HRA completions are going in the coming month • Opt out information has been provided on the Cal Duals website: http://www.calduals.org/enrollment-data/ • As of January 1, 2015, approximately 40% of eligible participants have enrolled into CMC Plans. This number varies by county with approximately 32% in Los Angeles County. • IHSS consumer participation is much lower than the average beneficiaries enrolling into the program. Approximately 26% overall, 39% if Los Angeles County is excluded. • The State is continuing to work with CMS and Plan partners to understand and review the data around opt out rates. • Disenrollment rates have been relatively low. Most beneficiaries seem to be staying with the Plans once they have enrolled; 12% disenrollment rate overall – 10% disenrollment rate if Los Angeles County is excluded. **<u>Stakeholder Question</u>: How many enrollees have the Plans not yet been able to connect with or find?**	

	<u>Response (Ryan MacDonald)</u>: The State is currently working on collecting data about this and other statistics that Stakeholders are interested in and hope to be able to provide this information soon.	
2:09 – 2:17 p.m.	**Consumer Update on January Enrollment** • David Kane provided an update on the January enrollment from the consumer perspective (i.e. call data, trends & case examples for January). • General call estimates for January are around 850-900 calls to the Ombuds Program from Duals, which constitutes about 73-75% of the total call volume at the Health Consumer Center. • Call volume for January has been fairly consistent with what the Center has seen, even with the large CMC transition. • The Ombudsman is still addressing the following issues: ✓ Education of providers, consumers, pharmacies, Plans, hospitals, etc., are still a huge obstacle ✓ Pharmacies do not understand how to bill for the Part B deductible ✓ Many CMC members do not receive their enrollment materials and cards in time by the first of the month ✓ Providers are still refusing to honor continuity of care ✓ Education to the IPAs and Hospitals about CMC is still a big issue and lack of education has caused many problems with beneficiaries accessing the services they need ✓ Transportation issues (*beneficiaries do not know how to identify their rides and they are being dropped off at the curb*) ✓ IPAs & PPGs handling continuity of care – need to educate members about this ✓ Issues/conflict between the Meds and Medicare systems	**David Kane** *Staff Attorney, Neighborhood Legal Services*
2:17 – 3:05 p.m.	**Cal MediConnect Health Plan Representatives – January Enrollment Q&A** • Jamie Ueoka led the Health Plan panel/Q&A session with a brief summary from each of the Plans on their perspective of the January transition. • Care1st Perspective (Jamie Ueoka): ✓ Plan reporting requirements increased with regards to CMC and the January transition ✓ Call Center and Pharmacy departments were closely monitoring	**Jamie Ueoka** *Vice President, Program Development Medicare-Medicaid Plans, Care1st Health Plan*

	activity during the transition ✓ Around January 5th Care1st experienced a spike in activity due to the newly enrolled MAPDs and the CMC transition ✓ Care1st worked diligently internally and with external providers and partners to ensure that all transitions were handled as smoothly as possible • Molina Perspective (Yunkyung Kim): ✓ Similar experience to Care1st ✓ Call volume spiked, stabilized and then spiked again around the 3rd week of the month ✓ Approximately half of the members that transitioned in January were former DSNP members ✓ There was a lot of outreach done to these individuals prior to this transition ✓ Transition was fairly smooth ✓ Took approximately 2 weeks to "clean up" data systems ✓ In preparation for the volume, Molina outsourced a portion of their HRAs for the month of January ✓ Still dealing with many of the same issues as last year (outreach, education, locating members) • Health Net Perspective (Martha Smith): ✓ CMC membership for the month of January saw an additional 14,000 members – approximately 9,000 of which were previously in the DSNP Plan with the remaining 5,000 being new enrollees ✓ Increased efforts to ensure that the transitions went smoothly, especially for the new members ✓ Increased oversight • L.A. Care Perspective (Maria Lackner): ✓ Approximately 50% of membership in January was comprised of former DSNP members ✓ Increased education to members and providers on the new transitions ✓ Increased monitoring of the call centers and pharmacy activity • CareMore Perspective (Joyce Furlough): ✓ 50% of January enrollment were already existing members ✓ 1,500 DSNP members – approximately 1,000 were cross-walked over	

	✓ Second wave of DSNPs to transition over in May ✓ Confusion from members over the letters they were receiving from the State and confusion about the connection between CMC and CareMore **<u>Q&A</u>** **<u>Stakeholder Question</u>: Are any of the Plans thinking about honoring Continuity of Care beyond the required 6 month period?** **<u>Response (from Panel)</u>:** This would have to be examined on a case by case basis and would depend on the needs/situation/treatment of the member. **<u>Response (Molina)</u>:** During this time we would work on bring the provider into the Plan's network. **<u>Stakeholder Question</u>: Are you doing the full HRA for the cross-walked DSNP members?** **<u>Response (from Panel)</u>:** Yes, the Plans are currently completing HRAs for the DSNP members, but some of the Plans are leveraging existing information, if/when possible. **<u>Stakeholder Comment</u>: Advocates might benefit from having a clearer understanding of how the delegated model works. Can the Plans share more about how delegation works (i.e. who they delegate to, what services are delegated, etc.).** **<u>Response</u>:** The delegation process is different for each Plan but this topic will be added to the agenda for the next Stakeholder Meeting. **<u>Stakeholder Question</u>: What is the general success rate for completion of HRAs for new enrollees?** **<u>Response (Health Net)</u>:** Generally speaking, reaching out to the members	

	to complete the HRAs has been a challenging process and the success rate is probably around 50%. This will also vary based on the acuity of the member and based on the method of outreach (i.e. face-to-face, telephonically or via mail). Locating members and engaging them has been difficult, but the goal is to connect with them once they show up in the system and try to connect with them once they register on the Plan's radar. **<u>Response (LA Care)</u>:** State data does not capture what the Plans are doing after the required timeframes. The Plans have a commitment to ensure that they are able to capture the information and are engaging with the providers to assist with getting the HRAs completed. **<u>Response (CareMore)</u>:** CareMore has been trying to come up with alternative ways to complete the HRAs since they have encountered many of the same struggles the other Plans have been facing. CareMore had a strong bias to complete face-to-face HRAs. However, they have had to shift to telephonic methods since the F2F methods were not yielding much success. **<u>Stakeholder Question</u>: How are the Plans handling the COC transitions for members who are approaching the end of their coverage period?** **<u>Response (from Panel)</u>:** We have not seen much of this happening and have not heard of any issues or concerns about this yet but the Plans will look into this and report back to the group. **<u>Stakeholder Question</u>: Are the Plans being paid by the State for each passively enrolled member, regardless of whether or not they are able to locate the member? Does the Plan continue to get paid (and for how long) if they can't find the member?** **<u>Response (from Panel)</u>:** Regardless of whether or not the HRA is completed, the beneficiary still has complete access to all of their CMC benefits and services; it is their right to decline completion of the HRA but	

	they will still have access to all of their services. The Plans are responsible for the full scope of the member's care until they decide they want to disenroll with the Plan. **<u>Stakeholder Question</u>: What is your completion rate for the HRAs, to date, and what is currently being done with the data/Care Plans?** **<u>Response (Molina)</u>:** Use the HRA data is used to develop the Care Plans which are then shared with the Care Teams. Completion rates vary by month and for the members that the Plan is able to locate, the completion rate is good. We are also getting better at finding members to complete the HRAs. **<u>Response (Health Net)</u>:** When we receive the Historical Claims Data, we create an initial Care Plan and then we use the additional data from the HRA to add to the Care Plans. Care Plans are also shared with the PCPs, ICTs, the delegated medical groups and anyone else involved in the member's care. **<u>Response (Care1st)</u>:** The HRA is only one way of gathering information about the member. The Plan is continually using other data points and feedback to assist with managing and coordinating care and services for the member. **<u>Stakeholder Question</u>: Did the DSNP members that became eligible for CMC in January get information from the Plans about the opportunity to join CMC or did they only receive information from the State?** **<u>Response (from Panel)</u>:** The DNSP members received the standard 90, 60 & 30 day letters from the State but the Plans conducted extensive outreach through calls and letters to members as well. **<u>Stakeholder Question</u>: With regard to the high IHSS opt-out rate, can the Plan offer extra personal care hours through the Plan's optional benefits to persuade IHSS members to remain with the Plan? Is this**	

	something that may be useful for the Plans to consider? **<u>Response (Care1st)</u>:** Extra personal care hours is not a benefit. They are considered Care Plan Options that the Plans can use at their discretion on a case-by-case basis. **<u>Response (LA Care)</u>:** The Plans are trying to look at this from a patient-centered approach and are continually looking at all the elements in terms of the member's care. The Plans are looking at whether the member is accessing the services that they are eligible for and are committed to working collaboratively with the State and County DPSS to determine if the beneficiary could benefit from additional care, but this is determined on a case by case basis. Additionally, the Plans will look at what other services the member currently has at their disposal to determine the best course of action for the member. **<u>Response (Health Net)</u>:** The Plans are also looking at the member's unmet needs and continually working to advocate on behalf of the member in this regard.	
3:05 - 3: 07 p.m.	**Closing Remarks** ➢ **Approve December 17, 2014 Meeting Minutes** o Minutes Approved ➢ **Next Meeting: TBD (Sometime in April 2015)** o Location: TBD o Facilitated by CareMore o Time: 1:00 p.m. – 3:00 p.m. ➢ **Meeting was adjourned at 3:07 p.m.**	**Pamela Mokler** *VP of Long Term Services & Supports, Care1st Health Plan*