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

Wednesday, August 20, 2014; 1-3 p.m.
Cathedral of Our Lady of the Angels
555 West Temple Street, Los Angeles, CA 90012
Conference Rooms 6, 7 & 8
Facilitator: Pamela Mokler

Call-In: 1-888-363-4734 Code: 1944970#

TIME	TOPIC	PRESENTER
1:10 – 1:27 p.m.	**Welcome/Introductions** • Meeting was called to order at 1:10 p.m. by Pamela Mokler and introductions were made by the health plan representatives and the stakeholders in the room. • Pam stated that participants on the telephone would be given the opportunity to participate and give their feedback during the Q&A portion of the meeting. • Pam introduced Melanie Bella from CMS who gave a welcome greeting and stated that she was here along with her colleagues from D.C. to observe and collect feedback from attendees on their insights and perspectives on how the demonstration is going in California.	**Pamela Mokler** *VP of Long Term Services & Supports, Care1st Health Plan* **Melanie Bella** Director, Medicare-Medicaid Coordination Office, *CMS*
1:27 – 2:08 p.m.	**CMC Care Coordination Overview** LA Stakeholder Presentation 08 20 1⁴ • Susan Bell presented an overview of the care coordination process for a new Cal MediConnect member, through the Care1st perspective. • Outreach begins with a welcome call from the Member Services team. • This is followed by the Health Risk Assessment (HRA) which is conducted face-to-face, telephonically or by mail. • Next, the care navigator contacts the member to discuss the care plan that is generated from the HRA. • Following that is training to the delegated groups and IPAs. • The HRA is the starting point in working with the member and the tool is approved by both DHCS and CMS.	**Susan Bell** *Director of the Coordinated Care Initiative, Care1st Health Plan*

	• The HRA is also used to help identify members for specific programs and interventions (like case management, disease management, behavioral health, social services & LTSS). • The HRA does not replace the care plan or interaction with a physician. • After HRAs are completed, the care navigators and care managers conduct outreach to the members that have individualized care plans, taking into consideration any urgent needs that have been identified. • 3 attempts are made to contact each member. • Once the member has been contacted, the care navigator will help to coordinate services for the member, facilitating referrals to case management, LTSS, Social Services and Behavioral Health services, and working with the member's IPA to coordinate Durable Medical Equipment (DME) and Home Health Services. • Continuity of Care is primarily delegated to the provider groups. • Continuity of Care is the most frequent care coordination request. • Per the Dual Plan Letter (DPL) Continuity of Care is a request for a member to remain with their out-of-network provider for a period of six (6) months for Medicare and a period of twelve (12) months for Medi-Cal. • Criteria for Continuity of Care includes the following: ▪ Must have an existing relationship with the provider (can be identified through the historical claims data that is provided to the Plans) ▪ Must have seen their PCP provider at least once in the past 12 months proceeding enrollment into the Plan for a non-emergency visit ▪ Must have seen their specialist at least twice in the past 12 months proceeding enrollment into the Plan for a non-emergency visit • Susan then gave an example of how Care1st processes Continuity of Care cases. **<u>Stakeholder Question</u>: Are Continuity of Care requests coming through the Health Plans or the IPAs?** **<u>Response (Susan Bell)</u>:** The majority of the member requests are currently coming to the Health Plans, mainly because that is where the	

	members are directing their calls at this time. However, as time goes on, more of the request will likely filter to the IPAs as well. **<u>Stakeholder Question</u>: What is the average amount of time from when a person first files a Continuity of Care request to when they receive an answer?** **<u>Response (Susan Bell)</u>:** According to the DPL, Plans have 5 business days to identify if there is a valid Continuity of Care case; if the member meets the requirements for Continuity of Care. After that, the plan has 15 days for urgent requests (for example if a member is in treatment or has an upcoming appointment), and 30 days for non-urgent requests. The reason for this is because the Plans need to have time to contract with the providers. **<u>Stakeholder Comment</u>: I've made this comment before but, for the benefit of our CMS partners I'll say it again, and this is not about the Care1st process specifically but rather a system feedback, I think it would have been better if the Continuity of Care provisions included that the provider does not have to take the new "contracted rate" to provide continuity of care, because if the provider wanted to work with the Plan, I assume they would have just joined the network and to me, Continuity of Care would be to allow them to continue at the rate that they were getting before.** **<u>Response (Susan Bell)</u>:** We do give them Medicare rates. They are not required to contract with us as part of our network, they are only required to sign an agreement stating that they will accept Medicare rates. **<u>Stakeholder Response</u>:** That was not clarified. **<u>Stakeholder Question</u>: How is Continuity of Care screened for during the HRA and member welcome calls? Does the member have to request it or are there certain questions that the care navigator uses to verify?**	

	<u>Response (Susan Bell)</u>: The HRA does not have a specific question that addresses Continuity of Care, but upon review of the care plans and through speaking with the members the care navigators and care managers may come upon cases in which Continuity of Care may be needed. **<u>Response (CareMore)</u>:** We do offer Continuity of Care questions so that we can start developing the care plan. Based on the data that the Plans are getting back from the State, we are able to get some of that information even before making the calls so that we can proactively start the process. **<u>Stakeholder Question</u>: I wanted to know what level of comprehension the HRA is at, especially with regards to those who are deaf/hard of hearing or have developmental delays/disabilities and how the HRA is catered to those groups?** **<u>Response (Susan Bell)</u>:** Those types of assessments would need to be done fact-to-face. **<u>Response (Melanie Bella)</u>:** There are requirements that the HRA be provided in a manner appropriate to the specific needs of the beneficiary. **<u>Response (Care1st)</u>:** When we come across a situation that requires cultural sensitivity and individual needs, we do offer the face-to-face assessment. We have the availability of translators and other experts in those areas to assist us. **<u>Stakeholder Question</u>: I am interested in this topic of Plan calls. If a person is deaf and the phone rings, you will never get an answer and if they are low language, they will not read their mail or they may have someone read it to them but not understand what it means. Is there a way that the Plans are getting information about the nature of the disability? What is it that the Plans do when they have a member that is hard of hearing, for example? Do the Plans get information about the disability so that they can respond to it? Because you can't call someone back if they do not know how to use**	

	assistive listening devices or they do not know how to use their phone to call for an interpreter, and the Plan cannot arrange for these services if they do not know that a person is deaf. **Response (Susan Bell):** The only information that we have at the time when we are calling a member back on the HRA, is the HRA itself. We do have the member's responses so if they self-identify as speaking a certain language or having a hearing deficit, then we can be proactive and have an interpreter on the line or do whatever is necessary to be as accessible as possible. **Stakeholder Response:** On a similar note, with regards to people with dementia, I am seeing a lot of red flags in your process. Many of these folks are going to be coming to the Plans without a diagnosis, so even if the HRA asks questions about medications related to memory loss, if the member states that they are not taking any, the HRA would not capture this piece of information. Also, if the member is not able to fill out the HRA or answer the phone, how is the Plan going to capture this information? Have you thought about the process of how you can identify these folks early on and how you can bring in the caregivers so that you can get accurate information and then create care plans appropriately? **Response (HealthNet):** The fact that we get historical claims data before the member enrolls has been extremely helpful. In the historical claims data, the Plans are able to view prior prescriptions, physicians that the member has seen, DME records, diagnostic records. This information is then used to risk-stratify the population so that the case managers who conduct the HRAs have the benefit of having access to this information so that if there is someone who is diagnosed or risk-stratified as having dementia, the outreach can be catered to take this into account. This is why the historical claims data has been so valuable to the Plans. **Response (Care1st):** On the member assignment to the Primary Care Physician (PCP), every effort is made, if that physician is in our network, to maintain the member-physician relationship. Also, we work very closely with the PCPs, sending them the HRAs (if they have been	

	successfully completed) and the individualized care plans. Thus far, they have been proactive in collaborating with the Plan and we have been working very hard to maintain those relationships. **<u>Response (Molina)</u>:** Although we do get the historical claims data on our members, there can be a challenge with the aid codes. For example, those with an ABD aid code (Aged, Blind, Disabled) are not given an identifier for their specific type of disability. It might identify blind, but it does not identify depth and it does not identify any type of physical disabilities that the member might have. This is why it is important when the Plan does reach out during the welcome call that they ask if there is anything that the member needs right away or if they have a doctor's visits that the Plan is able to assist and coordinate. This is a process that has been implemented. Additionally, the Plans do ask before the HRA is conducted if the member wants to do a face-to-face interview. Although challenges do exist, there are ways that the Plan is able address them or accommodate for them. **<u>Stakeholder Response</u>:** About 50% of people who have Alzheimer's disease do not actually have a diagnosis and for about half of those individuals, there is no indication of the disease in their medical records. So even though we are getting the historical claims data, which is very helpful, there are still gaps and some of these individuals may be falling through them so we may need to give more consideration as to how we capture information about them. **<u>Stakeholder Question</u>: With regards to choice and Continuity of Care, where can the beneficiary go to easily see what each Plan has to offer in order to make a more informed decision, without having to call an 800 number in order to find out if their physician is contracted with each of the Plans? How can I make an honest decision about my healthcare and view what each Plan has to offer with regards to physicians, DME and other formularies, etc. to meet my needs?** **<u>Response (Susan Bell)</u>:** All of this information should be available on the Plans' websites.	

	<u>Response (Jane Ogle)</u>: A lot of time has been spent on how to educate beneficiaries on what their choices are. HICAP has received a grant which has allowed them to spend time to train their volunteers on this information. We try to direct people, when they want to make a choice about plans, to either Medicare Plan Finder or HICAP because HCO is not helpful in helping beneficiaries choose a Plan but rather they help assist them with opting in or out of Plans. HICAP has the ability in each of the counties to help people work through the choices. The process is complicated and in my experience with the town halls, almost an hour is dedicated to answering questions about which Plan should beneficiaries choose and how should they go about choosing these Plans. For this reason, sending them to a trusted advisor like a physician or family member or HICAP, as the institutional, professional advisor that is funded by the State and Federal Government, is likely the best choice. **<u>Stakeholder Question</u>: Where are the HRAs performed? Are they ever done in the patient's home?** **<u>Response (Susan Bell)</u>:** Yes, the patient does have the option of having a face-to-face assessment, which can be done at the home, or telephonically or by mail. **<u>Response (Care1st)</u>:** We also have gerontology specialists & nurse practitioners that go to the Skilled Nursing and Long Term Care facilities as well. **<u>Stakeholder Question</u>: What is your success rate with actually making contact with the clients for the HRA?** **<u>Response (Care1st)</u>:** We are currently aggregating the data. It is still early in the enrollment process so we do not have concrete numbers at this time but we are hoping to be able to share this data soon. • Susan continued with the presentation, discussing the delegated model	

	at Care1st and the extensive training that has been done for the delegated groups and IPAs. • Typical items that are reviewed with the IPAs include: ▪ HRAs ▪ Continuity of Care ▪ Care Coordination and Case Management ▪ LTSS ▪ Institutional ▪ Behavioral Health ▪ Data and Reporting Requirements **<u>Stakeholder Comment</u>: We are having trouble in the nursing facilities, when a patient is discharged from a hospital, with the Plans and the medical groups not allowing the patient to come back to the same facility even though they should be allowed to return under Continuity of Care. There seems to be an issue there.** **<u>Response (Care1st)</u>:** We are currently addressing this issue and are fully engaged in the Continuity of Care requirements. We understand that when a member leaves a facility and goes to an acute setting he/she should be allowed to return as the facility is their home/residence. We are working on this with the IPAs on a case-by-case basis. We have been doing a lot of training with them and we plan to conduct numerous question and answer sessions, along with the long term care facilities, to help facilitate this process and better educate them. As the Health Plan, we are ultimately responsible for the oversight and we do understand that these individuals have to go back the facility that is their residence. Unfortunately there have been some misunderstandings, but we are working on this with the IPAs. **<u>Stakeholder Question</u>: Could you talk more about what the IPA's role is in Care Coordination?** **<u>Response (Care1st)</u>:** Under the delegated model, they are prime in coordinating the professional specialty and primary care services for the members. They hold the contracts with our specialty and primary care	

	network physicians so they are very familiar with the managed care model and have been doing this for many years. We were very selective with our medical groups and IPAs that are participating in this program, and as far as Continuity of Care goes, the Plan is the gatekeeper. If a member calls in, we transition them over to the IPAs and many are already familiar with this process as they have been working with the SPD and Medi-Cal populations since 2011. They have to follow the requirements in the DPL. The only thing that would prevent a Continuity of Care request from being fulfilled on behalf of the member is if the provider is not willing to work with the rates or if there is a quality of care concern.	
2:08 – 2:11 p.m.	**Communication Workgroup Report** • Denny Chan provided an update on upcoming meetings and activities for the Communication Workgroup. • The LA Communication Workgroup is led by the NSCLC and consists of the Los Angeles Health Plans, stakeholders and Harbage Consulting, and they work collaboratively to strategize on outreach and education efforts surrounding the CCI in LA County. • The next meeting is on August 21st from 3 – 5pm at St. Barnabas. The meeting is open everyone. • Next, Denny provided an update on various active projects: ▪ A smaller subgroup is working on outreach to different ethnic communities. They have started by breaking down each of the Medi-Cal threshold languages and are trying to identify the key community contacts in all of those different groups with the goal being to conduct outreach to them and see what concerns or questions they have about the CCI, as well as to find out what type of education they could use. ▪ IHSS consumer outreach – The group has been brainstorming ways to parallel what was done in San Diego with the IHSS consumers. In LA County, the group is looking to do a similar project that will link the mailings to a phone bank tele-form, as opposed to conducting a tele-town hall. This would allow people to call into the phone bank to have their questions answered. • The active projects will be discussed further during the August 21st meeting.	**Denny Chan** *Staff Attorney, National Senior Citizens Law Center (NSCLC)*

	• Other items to be discussed during the August 21st meeting include: ▪ PSA outreach ▪ Ombuds updates	
2:11 – 2:12 p.m.	**Approve July 16, 2014 Meeting Minutes** • Pamela Mokler referred to the distributed draft minutes from the previous meeting and asked if there were any corrections. • No corrections were made. Workgroup approved the minutes as written.	**Pamela Mokler** *VP of Long Term Services & Supports, Care1st Health Plan*
2:12 – 2:59 p.m.	**Open Forum** LA CCI Stakeholder Meeting Feedback Fo • Eddy Moreno began the open forum by presenting the questions that were submitted on the Feedback Forms, which will be used to document stakeholder questions and topics of interest moving forward. **<u>Stakeholder Feedback</u>: We could not find the numbers of people passively enrolled in Cal MediConnect on the dashboard. Why was this information not included and how do we get these numbers?** **<u>Response</u>:** Right now the dashboard only shows the total active enrollment (meaning individuals that are actually in a Cal MediConnect Plan). Will take this request back to DHCS to see if they will consider adding to the dashboard to have it reflect those who are passively enrolled as well as those who have opted in. **<u>Stakeholder Feedback</u>: I understand that there are people with certain kinds of healthcare coverage that will not be contacted with a blue envelope, even though they are duals. I believe that this includes people covered by Kaiser and SCAN. Is this true? Are there other kinds of coverage in which the duals are not contacted for a Cal MediConnect choice? I understand as well that even though the duals are not contacted, they are still able to choose a Cal MediConnect Plan whenever they want. Is that also true?**	**Eddy Moreno** *Director of the Community Outreach & Education, Care1st Health Plan*

	Response: There are a number of different dual eligible beneficiaries who are not going to be eligible for Cal MediConnect passive enrollment. There is a participating populations chart on the Cal Duals website which we can share with the Plans to pass on to the group. Those who are not eligible for Cal MediConnect passive enrollment, which includes individuals from Kaiser, will not receive a blue envelope with the Cal MediConnect notices. However, if/when they become eligible for MLTSS, they will receive the blue envelope with the MLTSS notices. There are also two additional groups that will not receive the Cal MediConnect notices: individuals who will not be eligible for either Cal MediConnect or MLTSS and individuals who will not be passively enrolled into Cal MediConnect but can choose to join a Cal MediConnect Plan if they want.  CCI-Participating-Populations_June2014.p **Stakeholder Response:** I wanted to say that I looked on the Cal Duals site about a week ago for the operation chart. I'm not sure if it is an old document but I searched for about and I could never find it. My suggestion is that it should be on the front page of the website, always available, as it is a go-to document for stakeholders. **Response:** I would like to issue a blanket apology for the Cal Duals search function. It is being worked on and will hopefully be more user-friendly in the future. The document should be located on the CCI Fact Sheets page. **Stakeholder Feedback: What extra benefits are provided to people who choose a Cal MediConnect Plan or stay with fee-for-service Medicare? Specifically, what are the additional vision, dental, and transportation benefits? Also, I have heard that Managed Care Plans can provide MLTSS-like services such as respite care, provider support, supplemental IHSS-like services, home modification/maintenance and nutritional services. Is this true?** **Response:** Yes, this is true. There are many benefits to joining a Cal MediConnect Plan, that you would receive over fee-for-service Medicare	

	which includes: ▪ $100 vision benefit for frames and lenses ▪ 30 one-way trips (like taxi vouchers) for things like doctor visits or to pick up prescriptions ▪ Care Coordination benefit which includes the HRA, Care Plan, Care Manager ▪ Supplemental dental benefit* The Plans are also able to offer Care Plan Options (CPOs). These are <u>not</u> additional benefits nor are they covered benefits, they are types of services that the Plan may provide to the member to help them stay in the home like grab bars or additional hours of personal care. CPOs are authorized by the Plan and are provided at the Plan's discretion. **<u>Response (Care1st)</u>:** We want to clarify that these are not benefits and that the appeals and grievances process does not apply to CPOs. Up until now, the Plans have only been able to offer services that have been approved by CMS and the State so it is exciting to know that the Plans now have the opportunity to offer these additional services. However, CPOs are provided on a case-by-case basis and they are not a requirement. *Stakeholders would like to hear more about the supplemental dental benefits from each of the Plans at the next Stakeholder meeting. **<u>Stakeholder Question</u>: Do the Plans have any kind of standardized criteria or benchmark (with regards to optional services and benefits) that would let someone know if they qualify for an optional service/benefit? Additionally, how will I know: 1) that I am being assessed with the same level of needs across each of the Plans, and 2) that I will have access to those same optional benefits across the board?** **<u>Response (Jane Ogle)</u>:** The idea was to have the Plans be motivated in the way that they are being reimbursed to maintain the beneficiary at the lowest level of care in their community by having all of the necessary benefits at their disposal to help them stay there. Ultimately, it is to everyone's benefit for the beneficiary to stay at the lowest level of care. Upon review of the care plans, we begin to determine how well these	

	interventions are being implemented on an individual basis. CMS also reviewed each of the Plans' model of care so there should be some level of consistency between them as there was a standard set forth that they were required to meet. Additionally, the Ombuds program was established to ensure that the Plans are maintaining these standards. **Response (Care1st):** All of the Plans have contracted with Home and Community Based Providers and the Plans are able to make referrals to the Area Agencies on Agencies, as well, to ensure that the members get the services they need. **Stakeholder Response:** There are additional programs that the Plans need to know about that could be a useful resource to the Plans such as the CCT Program and the Older Blind Program. Conversations need to happen with these types of programs in order to integrate these funds with Plan funds to better support the beneficiaries. It is important to think about, not just what we do and what funds we have, but what is out in the community and available and how can we work together to create partnerships that allow the funding to be shared and better coordinated. **Response (Care1st):** The Plans are working on ways to leverage existing dollars and are working hard to coordinate resources to better serve our members. **Stakeholder Question: When is the new choice form going to be available for us to see and when will it be sent to the consumers?** **Response:** Hopefully the choice form will be available for viewing by the end of the week. As soon as it is available in PDF format, it will be sent out. **Stakeholder Comment: We have been having a lot of problems with Continuity of Care issues. For example, we have patients who are not getting the services they need and their appointments are getting cancelled and even phone calls to the Plans do not seem to get these issues resolved. I also do not understand how hospitals like Cedar Sinai and UCLA do not have contracts in place with the Plans. It seems like there may be a serious gap somewhere if people are not**	

	getting their critical care needs taken care of. Another problem we are noticing is that individuals with visual and hearing disabilities are not getting the information they need in the appropriate formats and that is something that also needs to be addressed. **Response (Jane Ogle):** With the CBAS transition 2 years ago, there were issues with contracting with Cedars and UCLA. Due to various policy decisions among both entities, it has been difficult for the Plans to contract with them which has caused issues. I have not heard of that many issues with folks in Cal MediConnect having issues with getting Continuity of Care and if you are seeing these issues you should be contacting the Ombudsman as they are in charge of reporting these issues to CMS. **Stakeholder Response:** If there is not a POA in place, the Ombuds will not cooperate. In general, we have not been seeing a lot of good results with the Ombuds program. **Stakeholder Question: Is there any update on the status of the lawsuit or hearing that took place on August 1st?** **Response:** DHCS policy is to not comment on the lawsuit but the motion was denied. **Stakeholder Feedback: Access to obtaining Durable Medical Equipment (DME) in relation to Continuity of Care services?** **Response:** DME is not included in the COC policy. You will need to go through the Cal MediConnect Plan's network to get your DME. **Stakeholder Feedback: Suggestion to include the delegated IPAs, medical groups and hospitals to be part of the stakeholder process.** **Response (Care1st):** Each Plan is responsible for training the IPAs on the Cal MediConnect process and we have been doing a lot of trainings with them. **Response (HealthNet):** A number of the IPAs and medical groups that	

	are contracted with the Plans do listen in and participate via call-in and we do have some representation from them in the room today. **<u>Stakeholder Comments</u>: When we call for authorizations at the beginning of the month, patients are not being loaded into the IPA's and medical group's systems until the 8th or 9th day of the month and that is a problem. Also, claims are being denied due to issues with aid codes and DME for LTC patients is an issue, especially with regards to meters for diabetic patients.** **<u>Stakeholder Question</u>: Is there any update on the status on the policy decision regarding capacity that was discussed last month?** **<u>Response</u>:** Tomorrow we will be releasing a Continuity of Care letter update that will start to address some of those issues.	
2:59 - 3: 00 p.m.	**Next Steps/Wrap Up** ➢ **Next Meeting: Wednesday, September 17th, 2014** ○ Location: Los Angeles Cathedral ○ Facilitated by CareMore ○ Time: 1:00 p.m. – 3:00 p.m. ➢ Meeting was adjourned at 3:00 p.m.	**Pamela Mokler** *VP of Long Term Services & Supports, Care1st Health Plan*