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

September 17, 2014; 1-3p.m.
Cathedral of Our Lady of the Angels
555 West Temple Street, Los Angeles, CA 90012
Conference Rooms 6, 7 & 8
Facilitator: Joyce Furlough

Telephone Dial-In:
1) Call 1-866-513-8896
2) Enter Participant Code: 982 414 2190#

TIME	TOPIC	PRESENTER
1:05 – 1:20 p.m.	**Welcome & Introductions** • Meeting was called to order at 1:05 p.m. by Joyce Furlough. • Joyce stated based on feedback, there will be less topics and more time for discussion. Today's focused topic will be Continuity of Care (COC). • Introductions were made by the health plan representatives and the stakeholders in the room.	**Joyce Furlough** *Vice President, Member Engagement* CareMore
1:20 – 1:41 p.m.	**Cal MediConnect Continuity of Care Overview (COC)** Final LA County_All Plan Presentation 09_ • Joyce introduced James Tea to discuss COC at CareMore. • COC from the member's perspective, there are 3 conditions that must be met: o 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 o The physician must meet quality of care standards. o The out-of-network physician must accept the Cal MediConnect plan rate = current Medicare/Medi-Cal fee schedule, as applicable. • COC from the health plan's perspective, a member's request is completed when:	**James Tea** *Director, Network Operations* *CareMore* **LaShaunta Harris** *Care Manager* *CareMore*

	o Member request COC through their selected/assigned health plan. o 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. o Health plan will notify both member and provider of COC approval/denial. o 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. o 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. o Health plan makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days. • For nursing facility residents, COC allows them to remain in their current facility. • 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. • Recent state policy COC updates: o Providers can now request Continuity of Care while complying with plan UM policies. o Continuity of Care can be requested by phone. o Plans cannot request unnecessary information, or require members to complete a request form. o Request must be processed within 3 days if there is risk of harm to the member. o Plans must actively try to determine continuity of care needs as part of HRA process. o Providers or members can now request continuity of care after service delivery. o Beneficiaries must be notified that Continuity of Care is time-limited. • Hilary Haycock from Harbage Consulting stated that the 90 days definition for long-term nursing home residents will be dropped per the revised COC Dual Plan Letter. • James stated CareMore's COC stats to date: 1,817 COC requests received, 1,474 approved, and 178 denied. Of the 178 denied, there were 0 health plan denials, 160 provider denials, and 18 other	

	denials. • Top things to remember about COC: o COC is an option for members to continue with their existing providers as they transition into the Cal MediConnect Plan. o COC approval is based on 3 components: ▪ Member has an established relationship with the provider. ▪ Provider agrees to Cal MediConnect Plan current Medicare/Medi-Cal rates. ▪ Provider meets professional and quality of care standards. o Members and Providers will receive notification of approval or denial within 30 days of COC submission. o Nursing Home members can remain in their facility. **Real Stories** • James Tea introduced LaShaunta Harris to discuss a real COC story at CareMore in which the member's mother felt that the COC process, the home health care services authorization, and healthy start appointment made her feel that she made the right choice in selecting CareMore for her son. **Healthy Start (Health Risk Assessment)** • Joyce Furlough discussed further CareMore's COC stats to date. There were 160 providers who declined to contract with CareMore to provide COC to their patients. CareMore views the COC process as an opportunity to expand our network and to reach out to new providers. • Joyce stated that the Healthy Start appointment helps CareMore get to know our new members and find out about their health care needs. During the appointment, CareMore: o Confirms medical equipment needs o Assists with medicine refills or renewals o Continues access to current in-home or community based services o Completes health risk assessment o Discusses what is most important to the member about the member's health o Identifies who needs to be on the member's personal care team	

	o Determines health management programs that would be right for the member's health needs. • The challenge is how to reach these members to conduct the health risk assessment. CareMore utilizes multiple means, e.g., phone, in person, get out in the community, etc. Joyce stated CareMore's strategy is conducting more HRAs face-to-face. For those stakeholders who have clients, health plans need to be innovative to reach clients/new members to provide care and inform members about COC to ease the transition to care.	
1:41 – 1:55 p.m.	**Ombudsman Program Update** • Joyce introduced Hilary Haycock who stated that the revised COC policy is not yet final or public. The state COC update call yesterday has the same information that was presented by James today. • Hilary stated that the COC changes James discussed are not in effect yet. The current policy is still in force. • The final revised Dual Plan Letter should be public in next week or so and then plans have 30 days to implement. • Hilary pointed out that not all stakeholders and their clients understand the enrollment wave. For example, there will be approximately 100,000 beneficiaries enrolled all in January 2015. This number includes Santa Clara coming online, people with January birthdays, Cal MediConnect DSNP crosswalk, and beneficiaries who would need a different Medicare Part D plan. A lot of people will be receiving new notices Sept 29, e.g., 90 day notices. They're all not just January birthdays. • English versions of the revised Cal MediConnect notices are now posted in CalDuals.org. The notices make it clear what happens if the beneficiary does nothing and the notices are now more consistent with each other. Definitions are now included in the form, not in a separate book. The state is working closely with the Ombudsman to help beneficiaries know their choice, COC options, and increase information flow between the Ombudsman and the state. • Ombudsman statistics: In Aug there were 2,500 calls re CMC in CA which lasted 7 minutes. In LA, there were 950 calls in Aug. • Joyce said the meeting minutes will be attached with the new form. Health Care Options Choice Form.pdf	**Hilary Haycock** *Harbage Consulting*

1:55 – 2:45 p.m.	**Stakeholder Discussion & Open Forum** • Joyce introduced Jane Ogle **<u>Stakeholder Question</u>: Please tell us more about the 160 physicians who refused COC with CareMore. Was it a perception of the paperwork burden?** **<u>Response (Joyce Furlough):</u>** Joyce stated the providers did not want to participate with CMC. Joyce stated that educating the providers to better understand the implications. A COC request is one request per member. Providers are not obligated to become a contracted health plan provider. **<u>Stakeholder Comment</u>: Providers have a feeling that saying no would cause the member to opt out of CMC.** **<u>Response (Jane Ogle):</u> What is the paper work burden?** **<u>Stakeholder Response</u>:** The provider need only sign a paper saying they will accept Medi-Cal/Medicare rates. **<u>Stakeholder Comment:</u>** What is the state doing about providers saying that members will be billed for the 20% Medicare reimbursement, etc? This is a problem for all health plans. Billing systems are not sophisticated enough to differentiate the 20%, it's against the law. **<u>Response (Jane Ogle):</u>** We are working with CMS to work with the providers who are doing this. **<u>Stakeholder Comment:</u>** Cedars and UCLA are the big offenders. **<u>Response (Hilary Haycock):</u>** Said the state is looking at opt out rates and looking into different ways to slice and dice the data. **<u>Stakeholder Question:</u>** Do bed hold requests on the member's behalf require an authorized representative form? **<u>Response (Hilary Haycock):</u>** An authorized representative form needs to be signed by the member. The authorization form is very strict. Current policy is to act on behalf of the member, the authorized representative form must be on file. To call Health Care Options, the form or a conservatorship needs to be on file. **<u>Stakeholder Question:</u>** Is the diabetic testing issue addressed by each plan in house?	**Jane Ogle** *Former Deputy Director, Dept. of Health Care Services*

	Response (David Nolan): It has been addressed and he will talk to the stakeholder after the meeting. **Stakeholder Question:** Diabetic strips requests are receiving a lot of denials. If a patient has been using the same meter for years, why is he/she being required to use the plan's meter first? Some plans use consumer meters vs meter for multiple use. Then the plan will require the facility to use 6 different meters vs the institution's meter that works. **Response (Joyce Furlough):** Plans will get together to work towards a single solution. **Stakeholder Comment:** This issue was brought up last month and no solution yet. **Stakeholder Comment:** This is a big issue. There are many residents who are affected and there are many benefits to using a professional meter. Stakeholder is requesting a name from each plan with whom to work. **Stakeholder Question:** Oftentimes the #1 reason why beneficiaries call is regarding COC. Stakeholder wants to know about the CareMore negotiations with the medical groups and IPAs. What's the harm about extending the COC beyond 30 days (retro COC) when they have already received the capitation for that member? Providers may receive their denial from CMS 45 days later, 15 days beyond the plan's retro COC policy. There are huge delays by the plans in addressing COC. **Response (Joyce Furlough):** COC requests are mostly from non-contracted providers. **Response (HeathNet):** HealthNet's process is that all requests are funneled into one phone #. They get assigned and the plan reaches out to the IPA point of contact. If there is no response, the escalation process is initiated. **Response (LA Care):** LA Care has a dedicated COC unit. If the group doesn't address COC timely, then the issue is escalated and the plan takes out capitation from the group. **Stakeholder Comment:** Each group runs reach COC differently. Some delegate to IPA and some do not. Stakeholder is requesting a document with how each plan is doing it to help advocates. Same with HRAs. There's confusion because some plans delegate HRA and members don't connect that. At the end of the day, who's accountable? The buck stops with the health plan.	

	Stakeholder Comment: When a member disenrolls from CMC, they still need to pick a Part D plan for their drugs. If longer than 30 days, they'll be assigned to a Part D plan that might not be the same Part D plan as before. If before 30 days, then they'll get the same Part D plan. **Response (Hilary Haycock & Jane Ogle):** Medicare Limited Income NET program address this. Any patients who have problems with this can call 1-800-Medicare. **Response (LA Care):** Physicians do not want to accept 100% of Medicare. The easy out is for them to request members to opt-out. At LA Care, if the provider doesn't respond, they'll deduct money out of their capitation. **Stakeholder Question:** How do plans feel about extending the 30 day retro COC policy? Some providers are checking plan status and some aren't. Why can't the plan extend that beyond 30 days? **Response (Jane Ogle):** There's an obligation on the provider's part to check eligibility. The bigger issue here is how do we make non-contracted providers aware of CMC? **Response (LA Care):** LA Care pays beyond 30 days, but just Medi-Cal rates. The problem being when providers want more than Medi-Cal rates. **Stakeholder Question:** What about a media campaign to reach providers? **Response (Jane Ogle):** Face-to-face education is best. There has been very little provider participation in webinars. Very large outreach to providers and it will continue. There is no budget for print media. **Stakeholder Question:** What is the enrollment strategy for MSSP? Birth month or Oct 1? Members hear a lot of different things when they call Health Care Options and the Ombudsman. People with other health coverage don't know they're not invited to CMC and MLTSS. **Response (Jane Ogle):** Cal MediConnect eligibility is for people with Parts A and B and Medi-Cal, not for people with other health coverage. **Response (Hilary Haycock):** Many of the individual cases of MSSP issues are because the person is not otherwise eligible.	

2:45 p.m.	**Wrap Up** • **Next Meeting: October 15, 2014** • **2015 Meeting Frequency/Location** • Susi Rodriguez-Shapiro said next meeting will be hosted by Molina. • For the rest of the year, the meeting dates are Nov 12 and Dec 17. • Now that we are implemented, we are going to move away from monthly meetings towards to quarterly meetings. One reason being is that every health plan has monthly consumer advisory committees. • Looking for new venues, open for ideas ADA accessible, free parking, etc. • Request for topics for Oct meeting. Put on white card and Molina will receive.	**Susi Rodriquez-Shapiro** *Director, Community Engagement, CareMore*