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

Wednesday, March 26, 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: 1-888-584-2113 Code: 229-738-8378

TIME	TOPIC	PRESENTER
1:05 – 1:20 p.m.	**Welcome/Introductions** • Meeting was called to order at 1:005 p.m. by Pamela Mokler and introductions were made by stakeholders and health plan representatives in the room and on the telephone.	**Pamela Mokler** *Vice President, Long-Term Services & Supports, Care1st*
1:20 – 1:23 p.m.	**Approval of February 27, 2014 Meeting Minutes** • Raffie Barsamian referred to the email distribution of the draft minutes from the previous meeting and asked if there were any corrections. • No corrections were made. Raffie noted corrections could be sent via email to carol.x.hartoonians@healthnet.com. • Raffie stated if there are no objections, the minutes will be approved as written.	**Raffie Barsamian** *Manager, Public Programs, Health Net*
1:23 – 1:26 p.m.	**L.A. County Coordinated Care Initiative (CCI) Stakeholder Workgroup Charter Review** L.A. County CCI Stakeholder Workgro • The discussion and review of the L.A. County CCI Stakeholder Workgroup Charter was conducted by Beau, Raffie, and Pamela. • Key points of the Charter were listed: ➢ Purpose of this Workgroup is to provide a forum where the five L.A. County CCI health plans can collaboratively work with advocates, stakeholders, and Community Based Organizations during the development, implementation, and operations of the CCI and Cal MediConnect. ➢ Workgroup will promote information sharing and provide an opportunity for the participating health plans and advisory committee to give feedback on the CCI and Cal MediConnect.	**Beau Hennemann** *Manager, In-Home Supportive Services, L.A. Care* **Raffie Barsamian** *Manager, Public Programs, Health Net*

	➢ Understand that this is a collaborative meeting – plan specific information and issues will not be addressed or discussed here. ➢ Recognize that all the participating health plans do have the responsibility to take in feedback and respond accordingly. Also recognize that some concerns are beyond the plans' control. ➢ Active participation by stakeholders is encouraged and essential in developing agenda topics and for incorporating stakeholder expertise in planning for the CCI. ➢ Five prime health plans will take turns, hosting and paying for each stakeholder workgroup. • Pamela explained that Care1st is hosting today, and CareMore will be facilitating next month's meeting. ❖ **<u>Stakeholder Comment</u>: With regard to membership, stakeholders would prefer that representatives from the Department of Health Care Services (DHCS) attend and listen to feedback, not consultants.** ❖ <u>Response (Pamela Mokler)</u>: Stakeholders' comments and concerns from the last meeting were heard and taken into consideration while planning for today's meeting. As a result, we are fortunate to have Margaret Tatar from DHCS here as one of our keynote speakers.	
1:26 – 1:52 p.m.	**Department of Health Care Services Update** • Margaret stated that the promise of Cal MediConnect is about collaborations and working together to serve a very vulnerable population. • She announced the three areas of topics for her discussion, as the following: 1) California's section 1115 Waiver Amendment 2) Announcement – Coordinated Care Initiative (CCI) Changes 3) L.A. Enrollment Timeline & Strategy Changes • CCI is comprised of three parts: the Duals Demonstration, we are calling Cal MediConnect; the Managed Medi-Cal Long-Term Services and Supports (MLTSS); and lastly, the inclusion of duals into plans to receive Long-Term Services and Supports (LTSS). **1) California's section 1115 Waiver Amendment:** ▪ Margaret announced that on March 19, 2014, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to California's section 1115 Waiver (Bridge to Reform) which authorizes the DHCS to begin coverage under CCI, no sooner than April 1, 2014. ▪ She noted that the Wavier is available on the CalDuals.org website and encouraged stakeholders to participate on the State's monthly	**Margaret Tatar** *Assistant Deputy Director, Health Care Delivery Systems, Department of Health Care Services*

stakeholder call for a walk through of the amendment.

- DHCS will conduct a stakeholder call to discuss these updates and answer questions. This call will be held on Wednesday, April 2 from 11am-12pm.

2) Announcement – Coordinated Care Initiative (CCI) Changes

- DHCS made an announcement via email on 03.25.2014 regarding modifications to enrollment timeline and strategy for CCI and Cal MediConnect.
- The State has taken a very measured and incremental approach on the implementation process to ensure success.
- DHCS has adjusted the enrollment dates for subpopulations in order to increase consumer clarity, prevent the need for multiple transitions in a single year, ensure sufficient time for noticing of fee-for-service (FFS) populations, and ensuring plan readiness.
- Announcement was made based on input from advocates and stakeholders who stated that it would be problematic and confusing for beneficiaries to receive two notices at the same time.
    - A) DHCS decided to align the Cal MediConnect and MLTSS enrollment strategies to start enrollment into Cal MediConnect first.
        - Now, if a beneficiary is eligible for Cal MediConnect, he/she will receive a notice about Cal MediConnect. If he/she decides to opt out of Cal MediConnect, then the beneficiary will receive a notice about MLTSS.
        - Beneficiaries who are in Medi-Cal FFS will not transition to MLTSS ahead of their Cal MediConnect passive enrollment date. This will reduce the number of plan choices a beneficiary will need to make, and reduce confusion.
    - B) DHCS announced that it will not start MLTSS enrollment for Medi-Cal FFS populations (non-duals or duals excluded from Cal MediConnect) until August 2014. The previous enrollment schedule was to have the population begin in July.
        - The MLTSS transition for FFS population was adjusted to start in August to ensure that the MLTSS 90 day notices have had appropriate quality reviews.
    - C) Enrollment in Alameda and Orange Counties was adjusted until no sooner than January 2015 for all aspects of CCI to allow more time to achieve plan readiness.

3) L.A. Enrollment Timeline & Strategy Changes

- Enrollment rules are laid out in the MOU. LA County has a three month voluntary enrollment period starting April 1, 2014.

	▪ The plans who will be able to accept voluntary enrollments in April will be Health Net and L.A. Care. ▪ Passive enrollment into Care1st, CareMore, Health Net, or Molina will begin July 1, 2014. L.A. Care will be eligible to begin receiving passive enrollment, once L.A. Care improves its Medicare quality rating. ▪ The State is working with advocates and partners at CMS on the voluntary enrollment notices. ▪ DHCS wants to ensure that the timing of the notices being sent to beneficiaries makes sense. ▪ DHCS continues to solicit feedback on notices and on communication efforts with beneficiaries. Also, the state looks forward to holding focus groups with beneficiaries. ▪ The State has received a lot of feedback recently in regards to making sure communication materials and notices are available in accessible formats and reaches beneficiaries. • Margaret concluded by stating that she would be joining this stakeholder group again as well as with other groups in L.A. County to provide more information on CCI and answer questions. • Pamela requested that participants hold all questions until the speakers have finished presenting. • She explained that at our last meeting, there were many questions about continuity of care; as a result, Amber Cutler was asked to join and present on the topic.	
1:52 – 2:28 p.m.	**Update on Communications and Outreach Workgroup & Continuity of Care Presentation** NSCLC - CCI_Continuity of Ca • Amber gave a presentation on Continuity of Care (COC) for Cal MediConnect and Medi-Cal managed care. • If certain criteria are met, a Cal MediConnect plan must allow a beneficiary to maintain his/her current out-of-network providers and service authorizations at the time of enrollment for a period of six months for Medicare and twelve months for Medi-Cal. o This is only the baseline; plans can provide extended continuity of care. • Plans must have a dedicated liaison to coordinate continuity of care. **<u>Cal MediConnect: Continuity of Care</u>** ➢ **Cal MediConnect COC Criteria:** 1) Existing relationship with the Provider ▪ Must see **PCP** provider at least **once in 12 months** preceding enrollment in plan. ▪ Must see **specialist** at least **twice in 12 months** preceding	**Amber Cutler** *Staff Attorney, National Senior Citizen Law Center (NSCLC)*

enrollment in plan.
    - Plan must first use utilization data provided by CMS and DHCS to determine pre-existing relationship.
    - If relationship cannot be established through data, then plan can ask beneficiary to provide documentation of the relationship.
2) Provider must accept payment and enter into agreement with plan.
    - During SPD transition, we saw a lot of disruptions in care despite the COC provisions because providers are not required to accept the COC terms. Providers may find that the process is cumbersome and time-consuming and choose to not accept the terms.
3) Provider must not have documented quality of care concerns.

➢ **Cal MediConnect COC Exceptions**
- COC does not apply to nursing facilities, durable medical equipment (DME), transportation, ancillary services, carved-out services, or IHSS.
    - A beneficiary residing in a nursing facility prior to enrollment will not be required to change the nursing facility during the demonstration.
    - An individual does not need to make any request to continue to see an IHSS provider.
    - County will remain responsible for background check of IHSS providers and hours.

❖ **<u>Stakeholder Question</u>: Do the same COC provisions apply for beneficiaries enrolling in Medi-Cal managed care?**

❖ <u>Response (Amber Cutler)</u>: No, the COC provisions for Medi-Cal managed care beneficiaries are slightly different and will be covered later on in this presentation.

❖ **<u>Stakeholder Question</u>: Can you elaborate on the carved-out services that are not covered under COC?**

❖ <u>Response (Amber Cutler)</u>: Carved-out services, such as specialty mental health and dental benefits, will continue to be provided by the county. Therefore, if the county decides to switch a provider, the health plans will not have a say or be able to offer COC for the member to continue seeing the county provider.

➢ **Cal MediConnect COC Prescription Drugs**
- Part D rules apply – one time fill of- a 30-day supply unless a lesser amount is prescribed – of any ongoing medication within the first 90 days of plan enrollment, even if the drug is not on the plan's formulary or is subject to utilization controls.

- Residents in institutions get further protections.
- Part D rules apply to both Medi-Cal and Medicare covered drugs.

➢ **Cal MediConnect COC Other Protections**

- Plans must complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, and surgeries or other procedures previously authorized as part of documented course of treatment.

➢ **Cal MediConnect COC Periods**

- If a beneficiary changes plans, the COC period can start over one time.
  - COC does not start over if the beneficiary returns to FFS Medicare and later reenrolls in Cal MediConnect.
  - When a beneficiary changes a plan, COC does not extend to the previous plan's in-network providers.

- Cal MediConnect COC request must be completed within 30 calendar days of request or within 15 if medical condition requires immediate attention.
- COC requires a lot of provider education, as well as, trust on the provider side that he/she will get paid although not in plan's network.
- The overall protection for Cal MediConnect is that the beneficiary can disenroll at any time. Disenrollment will be effective the first day of the next month.

<u>Medi-Cal Manged Care: Continuity of Care</u>

➢ **Medi-Cal Managed Care COC Criteria:**

1) Existing relationship with the Provider
   - Must see PCP provider at least once in 12 months preceding enrollment in plan.
2) Provider must accept plan reimbursement rate or Medi-Cal rate.
3) Provider must not have documented quality of care concerns.

➢ **Medi-Cal Managed Care COC Exceptions**

- COC does not apply to durable medical equipment (DME), transportation, ancillary services, carved-out services, or IHSS.
  - Nursing facility and CBAS providers are 12 months or until a service plan is completed and agreed upon by beneficiary or resolved through an appeal.
  - If beneficiary opts out of Cal MediConnect and is only enrolled in Medi-Cal managed care, then he/she may need to change nursing facilities.
  - An individual does not need to make any request to continue to see an IHSS provider.
  - County will remain responsible for background check of

	IHSS providers and hours. ❖ **<u>Stakeholder Question</u>: What is the status of Aid Paid Pending?** ❖ <u>Response (Amber Cutler)</u>: Aid Paid Pending is approved for both Medicare and Medi-Cal. • Medical Exemption Requests (MER) for SPDs/Medi-Cal only beneficiaries acts to avoid enrollment in managed care entirely for a 12 month period. ❖ **<u>Stakeholder Comment</u>: One of the COC provisions stated was the ability for beneficiaries to opt out of Cal MediConnect; however, the notices/choice forms we have seen do not clearly explain how a beneficiary can opt out of Cal MediConnect. Advocates are requesting for the State to provide clear directions and communications about beneficiaries' choices to allow for beneficiaries to make informed decisions about their health care.** ❖ <u>Response (Margaret Tatar)</u>: Comments and feedback received about the draft materials are very much appreciated. The State has heard loud and clear that the choice forms are confusing and difficult to understand. DHCS has responded with a willingness to alter the notices to meet some of the concerns. Generally, we host calls, provide draft materials, and solicit feedback. The feedback is then compiled, analyzed, and used to make changes. We are hearing that the changes made are not enough and that we need to further improve the choice forms. State officials are working with our federal partners to make modifications to the forms and to conduct focus groups/beneficiary testing. We will follow up and provide further information once we have more details. In regards to a previous comment about the State's presence at meetings like this, as I mentioned in the beginning, we value our consultants' efforts to provide information and engage in outreach, but we also heard clearly that our presence and participation is needed here. ❖ <u>Additional Comment (Amber Cutler)</u>: DHCS has committed that the draft choice forms we have seen will get corrected and will go through beneficiary testing as soon as possible. ❖ **<u>Comment (Margaret Tatar)</u>: In regards to a previous comment about the State's presence at meetings like this, as I mentioned in the beginning, we value our consultants' efforts to provide information and engage in outreach, but we also heard clearly that our presence and participation is needed here.**	

2:28 – 3:25 p.m.	**Open Forum – Q&As** ❖ **<u>Stakeholder Question</u>: What will happen to dual eligible beneficiaries who currently have a share of cost (SOC)?** ❖ <u>Response (Amber Cutler)</u>: Individuals who were previously excluded from enrolling in Medi-Cal managed care due to SOC will continue to have a SOC and be enrolled in Medi-Cal managed care in August 2014. ❖ **<u>Stakeholder Question</u>: What will happen to dual eligible individuals who are not eligible to join Cal MediConnect, but they are scheduled to be enrolled in a Medi-Cal managed care plan?** ❖ <u>Response (Amber Cutler)</u>: Beneficiaries receiving home-and-community-based waiver services, such as the HIV/AIDS program, will not be passively enrolled in Cal MediConnect, but they will need to avoid enrollment in Medi-Cal managed care by opting out through the MER process. They do not need to meet the criteria for MER, just need to complete the MER application. ❖ **<u>Stakeholder Question</u>: Could you walk us through the MLTSS enrollment?** ❖ <u>Response (Margaret Tatar)</u>: We are currently working on an enrollment chart that walks through the beginning of enrollment in each county, by population. This chart should be completed and uploaded to the CalDuals.org site by next week. CCI-enrollment-by-County-4.2.14.pdf ❖ **<u>Stakeholder Question</u>: There is a large population of individuals in skilled nursing facilities (SNFs) and regional center clients who lack the capacity to make decisions about their health care and do not have a responsible party. Who will be responsible for making these decisions for this population? Currently, in similar situations, we hold bioethics and interdisciplinary team (IDT) meetings to discuss these patients' care options and make decisions in their best interest. Our concern is that if a SNF believes it is in the patient's best interest to opt out of Cal MediConnect, we do not want it to seem like the SNF is being self-serving.** ❖ <u>Response (Margaret Tatar)</u>: What percent of the population would you say fall under this category?	**Pamela Mokler** *Vice President, Long-Term Services & Supports, Care1st*

	❖ Stakeholder Response: 10-20% ❖ Stakeholder Comment: In regards to the SNF residents who are unable to make decisions, I would suggest consulting with your facility's legal representatives and sending a letter to the State to request a Hold Harmless Agreement letter. ❖ **Stakeholder Question: Does the State have a public relations policy on disseminating information via media/television about Cal MediConnect and Medi-Cal managed care enrollments. What are the mechanisms that are being used to inform people about the health care changes that will be occurring?** ❖ Response (Margaret Tatar): There is a Communications and Outreach Workgroup and a communications plan that has been developed by the State's consultants - Harbage. ❖ **Stakeholder Question: We discussed COC issues but did not discuss access to care issues. We are concerned about individuals ending up in hospitals because of not having access to care. From an operational and planning standpoint, do we have enough providers?** ❖ Response (Margaret Tatar): The health plans participating in the CCI are subject to a number of reviews and audits – CMS audits, DHCS and Department of Managed Health Care (DMHC) oversight and plan readiness review. Plans had to go through the rigorous readiness review process to ensure that the networks were in place for the needs of this population. ❖ Comment (Amber Cutler): Since there are questions and concerns about disruptions in care and access to care issues, it may be beneficial to discuss the appeals and grievances process at a future meeting. • Raffie requested that the participants on the phone send an email to carol.x.hartoonians@healthnet.com for attendance purposes.	
3:25 p.m.	**Next Steps/Wrap Up** ➢ **Next Meeting: Thursday, April 24, 2014** ○ Location: Los Angeles Cathedral ○ Time: 1:00 p.m. – 3:00 p.m.	**Pamela Mokler** *Vice President, Long-Term Services & Supports, Care1st*