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Disability Rights Education and Defense Fund
National Senior Citizens Law Center

Webcast:

Coordinated Care Initiative (CCI)
ADVANCED I: Benefit Package and Consumer Protections

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ROUGH DRAFT TRANSCRIPT
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>> Amber Cutler: Hi. Thank you for joining us today for our presentation on the coordinated care initiative. This is the Advanced 1. We're going to discuss the benefit package and consumer protections.

Just as some preliminary matters, you can answer questions -- or ask questions throughout the presentation. You can just use the chat function. We will try to answer your questions throughout the presentation, but if we're not able to get to them we'll try to respond after the presentation. We'll also be stopping periodically through the presentation to answer some of the questions we are seeing.

In order to turn closed captioning on, especially if you are having issues with audio, please hit control F8. There is closed captioning. You can follow along that way as well.

This presentation is being put on by the National Senior Citizens Law Center. My name is Amber Cutler, I am a staff attorney here at the Los Angeles office of the National Senior Citizens Law Center. We also have offices in Oakland and in Washington, DC. This presentation is also being co-hosted by DREDF and Silvia Yee will be presenting certain portions of this presentation. Silvia, do you want to say hi?

>> Silvia Yee: Hello!

>> Amber Cutler: All right. We're going to go ahead and get started, since we have a lot to cover today. Again, if you are having problems with your audio, please do follow along with the closed captioning so that you are able to participate in the presentation. I apologize for any technical glitches that we're having today.

Today's discussion we're going to cover very briefly just the Coordinated Care Initiative overall.

I'm going to assume, since you're participating in this presentation and it's an advanced, that you already know a good deal about the Coordinated Care Initiative. We're really going to focus on what long-term services and supports are being integrated into managed care under the Coordinated Care Initiative, then we're going to go into depth on what benefits are provided under the Coordinated Care Initiative and specifically Cal MediConnect. Then we're going to discuss the consumer protections available under the Coordinated Care Initiative.

Before we dive too far in, I want to start with a specific glossary of terms. Just to make sure we're all on the same page with regard to all of these different terms I'll be throwing around. The first is dual-eligible. That's an individual that has both Medicare and Medi-Cal benefits, also known as a medi-medi. Compare that to the last bullet, seniors and persons with disabilities, or SPD, that's an individual with Medi-Cal only. When I say SPDs, I'm discussing someone with Medi-Cal only, they do not have Medicare. The reason they have Medi-Cal is because of age or they've been found disabled.

A Dual Special Needs Plan is a Medicare advantaged plan, particularly focused on individuals who are dual-eligible in their needs. Then I want to point you to long-term supports and services, or LTSS. This has a very specific meaning under the Coordinated Care Initiative. It refers to four programs. The first is the in-home supportive services, or IHSS, community-based adult services, or CBAS, formerly known as adult day healthcare, the Multipurpose Senior Services Program, MSSP and nursing facility. When I talk about LTSS, I'm really referring to those four programs, those four Medi-Cal programs.

OK. So the first major thing that's changed, probably, since last time you participated in a

Coordinated Care Initiative webinar is that the date of start is now April 1, 2014. Again, this is just a proposed start date. No sooner than this date, and it is possible that that date may move again. With an April 1 start date, however, that means the first notices would go out on January 1, 90 days in advance.

Just yesterday, the state released the new notices for stakeholders to review and comment on Cal Medi-Cal site. If you're interested in seeing those notices, I encourage you to visit the website. They are soliciting comments and feedback and those comments and feedback are due by next Friday. So it's a very short turnaround. If you want to find out, participate, very, very soon.

Just to stay on the same page -- sorry, we're having audio issues. Is that better? I'm sorry, we're having audio issues. It sounds very staticy. Still bad?

>> Silvia Yee: Yeah, still bad.

>> Amber Cutler: OK. Let me try to switch my headsets real quick. I'll be very, very fast. Hold on.

[Pausing]

>> Amber Cutler: Is that better?

>> Silvia Yee: Yes, it's better.

>> Amber Cutler: Thank you, Silvia. OK, must have been the headset.

All right, the Coordinated Care Initiative, it encompasses three major changes. That's going to be the mandatory enrollments of pretty much everybody into Medi-Cal Managed Care in the eight coordinated care initiative counties. Back in 2011, when we saw the transition of seniors and persons with disabilities into managed care there were entire populations that were left out of that transition, including individuals with share of costs, individuals living in nursing facilities, and individuals who

were duly eligible, that will no longer be the case under the Coordinated Care Initiative. All of those populations are going to have to join a managed care plan for their Medi-Cal.

The second major change under the Coordinated Care Initiative will be the integration of long-term services and supports into the Medi-Cal Managed Care benefit package. This means that before there were major services carved out of managed care, so nursing facility care or IHSS, and we just saw CBAS in 2012 go into managed care. Now all of the LTSS programs that used to be in fee-for-service Medi-Cal will be integrated into the managed care package for the Medi-Cal benefit, or for the managed care plan.

So, for example, if we had someone today who is living in the community and they're in FPB, Medi-Cal only, managed care right now for their Medi-Cal benefit, if they go into a nursing facility, they would stay, be disenrolled from managed care plan and their nursing facility care would be paid for fee for service.

Under the Coordinated Care Initiative that would not occur. Instead, the person would go into a nursing facility and could only go into a nursing facility that was in their plan network. The nursing facility would have to contract with the managed care plan, and that person would have to go into a nursing facility that was within the managed care plan's network. That's the integration of LTSS into the Medi-Cal Managed Care benefit package. That's change number 2.

Change number 3 is the integration of Medicare and Medi-Cal into one managed care benefit package. Also known as Cal MediConnect. This only impacts dual-eligible beneficiaries. The first two changes could impact both SPDs and dual-eligibles. The third change, integration of Medicare-Medi-Cal into one managed care package only impacts dual-eligible beneficiaries.

So what the coordinated care initiative is doing, it's moving individuals, or moving from a system of fee for service into a system of more managed care. So where previously we had a senior or person with a disability who could go see any provider that would accept their Medicare Medi-Cal card, then -- for example, if you had an x-ray, you see a provider that accepted your Medi-Cal or Medicare card, then that provider bills the HCS or Medicare for that particular service.

We're moving away from that system into a system of managed care, where we have a senior or person with a disability who is in a health plan, they're a member of the health plan, and the health plan receives one rate from the state or from Medicare, or from both, to provide that senior or person with a disability care, then the health plan contracts with different providers. We all know that sometimes when an individual wants to see a provider they were previously seeing, they will no longer be able to see them, because they're not within the health plan's network. The providers have to be in the health plan's network in order for the individual member to see them.

We're moving into that system of care.

So just to reiterate, I want to make sure everybody understands that understand the Coordinated Care Initiative duals and seniors or persons with disabilities are impacted. Only dual-eligibles, or those who are medi-medi or Medi-Cal only or SPDs. Individuals who have Medicare only had not impacted by the Coordinated Care Initiative. Again, those with Medicare only are not going to be impacted by the Coordinated Care Initiative.

But these different groups, who are impacted by the Coordinated Care Initiative, are impacted differently. For example, a senior or person with a disability or an individual with Medi-Cal only, that individual who is already in managed care for their Medi-Cal benefit isn't going to see much change.

What they're going to see is their long-term services and supports are now part of their benefits package. That person is going to get a notice that says your benefit, your Medi-Cal is not changing, we're just letting you know that now your long-term services and supports are provided by your managed care plan.

Then there's a second group of SPDs that will continue to remain exempt from enrollment into managed care for their Medi-Cal benefit. These are people who, for example, have other private health insurance or individuals who successfully obtain a medical exemption request.

So those people will stay out of managed care for their Medi-Cal benefit.

Then we have dual-eligibles. A lot of them will be passively enrolled into Cal Medi-Cal, and that means that when they get a notice and if they don't do anything, either opt out of cal Medi-Cal or choose a Cal MediConnect plan, they're automatically enrolled into a Cal MediConnect plan. A lot of dual-eligibles are impacted in that way.

Then there are a lot of dual-eligibles that can enroll in Cal MediConnect but won't be subject to passive enrollment. There are dual-eligibles that can't participate in Cal MediConnect at all, they're not allowed to participate in Cal MediConnect, but they're still going to have to join a managed care plan for their Medi-Cal benefit.

This slide breaks down those groups. What duals are actually excluded from participating in Cal MediConnect and then which duals can participate in Cal MediConnect, but will not be passively enrolled. I'm not going through each of these, and there are a lot of exceptions, I will point you to page 17 of our advocate's guide, where we have a pullout table where these are spelled out in detail. There. There is a major population of individuals who will not be subject to passive enrollment into

Cal MediConnect that changed. Those are individuals in Medicare Advantage. If you're in Medicare Advantage in 2014, you are not going to get notices about Cal MediConnect. That includes if you're enrolled in a D-SNP or C-SNP. You won't get a notice of the integration of the benefits.

However, you are still going to have to enroll in a Medi-Cal Managed Care plan. So even if a dual, who is not eligible for Cal MediConnect or decides they don't want to participate in Cal MediConnect, or they're not subject to passive enrollment in Cal MediConnect, that dual is still going to have to joined a managed care plan for their Medi-Cal benefit. Almost all individuals, whether in SPD or dual, living in the eight coordinated care initiative counties, have to go into a managed care plan for their Medi-Cal benefit. Even if they decide they do not want to participate in Cal MediConnect.

That means 1 million individuals will be impacted by the Coordinated Care Initiative in the eight CCI counties. On the Cal MediConnect side, the number of people subject to actual passive enrollment, meaning they get notices about Cal MediConnect and if they do nothing they'll be automatically placed in Cal MediConnect plan, is approximately 418,000 individuals. The number of people who can be enrolled in Cal MediConnect is about 400,000. That's because in Los Angeles County there's a 200,000 cap.

Then there's an additional 592,000 individuals who either cannot participate in Cal MediConnect, are not subject to passive enrollment in Cal MediConnect. These are the individuals, their SPDs have LTSS added to their managed care benefit package. 592,000 of these individuals are going to get notices telling them that they still have to join a managed care plan for their Medi-Cal benefit. In total, we see about 1 million people getting notices about the Coordinated Care Initiative.

I'm going to stop there for questions. I do encourage people to put their questions into the chat box. Looks like we don't really have that many substantive questions.

I did have someone ask me what a C-SNP and D-SNP are. At the beginning of the presentation, one of the very first slides includes a glossary just to allow people to go back to that. A D-SNP and C-SNP are special needs plans, a type of Medicare advantaged plan targeted at specific populations. So a D-SNP is targeted at duals. So they're just a type of Medicare Advantage plan.

You don't think we have any other questions right now. I do see that people are still having a hard time with the sound. Again, I encourage you, I apologize, to take advantage of the closed captioning. Hopefully, Steve is able to hear me well enough to catch up, catch what I'm saying and to provide the closed captioning during the presentation.

I'm going to go ahead and move on from here, and I think some questions that have just come in will be answered as I move forward right now.

So like I said, we're moving into a system of more managed care. We had already seen in 2011 SPDs have gone into managed care for their medical benefits. So for their hospital visits, their doctor visits. Now we're also going to see long-term services and supports moving into managed care. But we're also seeing, as we're moving all of this into managed care, there are some new benefits entering into managed care, and those two main benefits coming in 2014, which are Medi-Cal benefits, and will be available to all Medi-Cal beneficiaries, not just those living in the CCI counties, but all Medi-Cal beneficiaries, include the dental benefit, which is being restored. It was previously cut. Now it's being restored as a Medi-Cal benefit, starting in May of 2014. And then there's a new mental health benefit that is going to be a managed care plan benefit. So the managed

care plans are going to have to provide this benefit. That benefit is a benefit that does not rise to the level of being provided by the county as a specialty mental health benefit, but it is something that a primary care physician wouldn't be capable of providing. It is in between specialty mental health and what a primary care physician can provide. It includes things like group counseling, family counseling, individual counseling and some psychological testing. That will also be rolling out for all Medi-Cal beneficiaries beginning in January of 2014.

Then we have the long-term services and supports moving into managed care. So we're seeing some more benefits on the medical side moving into managed care for Medi-Cal. Then we're seeing these long-term service and supports that are Medi-Cal programs also moving into managed care. We saw CBAS in 2012 move into managed care with some issues, and we're still advocating on behalf of some of those issues that have happened as CBAS moved into managed care.

Under the Coordinated Care Initiative we're going to see IHSS, MSSP and nursing facility care also move into managed care. So if we start with IHSS, or in-home supportive services, that is a Medi-Cal benefit that allows a beneficiary to remain safely in the home rather than going into a nursing facility or other institution.

The services provided by an IHSS provider include housecleaning or shopping, meal preparation, laundry, personal care services, medical appointment accompaniment. There's a whole list of services that IHSS providers give to the beneficiary.

It is county administered, and individuals are assessed by county for the hours of IHSS that they need. So now that program is moving into managed care. So what does that look like? For the most part, we don't, as we are -- as it is explained to us, IHSS as a program will not look that different

to a beneficiary. It is still going to be provided through the county. The county social workers are still responsible for assessing need. It the beneficiary is still going to have the right to hire, fire and supervise their IHSS provider.

The plan, however, the managed care plan, will be responsible for coordinating that benefit and ensuring that people who actually need it, they determine it's needed, will actually get to the county to make sure they receive that benefit.

How that is working is that the managed care plans are required to sign a memorandum of understanding or an agreement with the county to make sure that they can work together to deliver this IHSS benefit to the beneficiary.

So that's IHSS. Then MSSP, multipurpose senior service program, is a benefit that provides social and healthcare management at a site. It's for older adults who are frail, who are typically certifiable for a nursing home placement but want to remain living in the community. There are certain eligibility requirement that the beneficiary has to meet, but the program provides comprehensive care and management services. I think right now there are 38 or 39 MSSP sites statewide, and the services include housing assistance, chore and personal assistance, respite, meal services and social services.

So now MSSP is moving into managed care, what does this mean? So until basically the managed care plans are required to continue -- are required to contract with every single MSSP site for the first 19 months of the coordinated care initiative. So the MSSP sites will still be providing the services. The managed care plans have to contract with all of the MSSP sites.

After 19 months the managed care plans no longer have to contract with the MSSP sites. The

managed care plans still have to provide the benefits under the requirement for the plan, they still have to provide the MSSP benefits, but they no longer have to contract with the MSSP sites.

In other words, a managed care plan could decide to bring MSSP in-house. We don't know if that will happen, but it could, since they are no longer required to contract with the MSSP sites.

Finally, we have nursing facility care moving into managed care. Before I said if right now if you're living in the community, you're in managed care, you have to go into a nursing facility, you're going to be disenrolled. Under the CCI you no longer are disenrolled. You have to be in a managed care plan to get your nursing facility care, which means the plans are going to contract with different nursing facilities to build their network of facilities. No longer will nursing facilities be paid fee for service in the eight CCI counties for the Medi-Cal benefit. Instead, they'll enter into contracts with managed care plans and receive a rate that is the same as the Medi-Cal and Medicare rate they currently receive from the managed care plan. All four of those long-term services and supports are moving into managed care, about you in different ways. Each is impacted differently. In the future, the programs may change as well, depending on, for example, the MSSP example is that the plans could decide to take MSSP in-house.

We're seeing a very different way of all of these programs moving into managed care.

I think someone had this question, what about people who are in home and community-based service waivers?

So HCBS waivers, those include the in-home operation waiver, the nursing facility acute hospital waiver, and assisted living waiver, all of those waivers, the housing CCI impacts them is basically if you're in a waiver right now, you cannot participate in Cal MediConnect. The only way you

can participate in Cal MediConnect is if you disenroll from the waiver, then join Cal MediConnect. However, a person who is actually in a waiver right now has to still join a managed care plan for their Medi-Cal benefit.

That really won't have an impact how they receive their waiver services. Even though they're in a managed care plan for their Medi-Cal, the plan just has the responsibility of coordinating service with the waiver providers. The same waiver providers are going to provide the waiver benefits as they are provided today. But the individual will have to be in a Medi-Cal Managed Care plan. So individuals, again, in an HCBS waiver, other than MSSP, have to join a Medi-Cal Managed Care plan, but they will not be impacted by Cal MediConnect. They will not receive notices about Cal MediConnect. They will only receive notices telling them that they have to join a Medi-Cal Managed Care plan.

Those on waiting lists for a waiver will receive notices about Cal MediConnect, and if they can stay -- they can go into Cal MediConnect and stay on the waiver waiting list. If they get into the waiver, they can disenroll from Cal MediConnect, but they would be in a managed care plan for their Medi-Cal benefit.

I'll stop there for questions. Silvia, did you see any good ones?

>> Silvia Yee: Amber, there was one, Katie asked: Do you know if the Medi-Cal managed care organizations will have network adequacy or nursing facilities starting in April 2014?

>> Amber Cutler: Yeah, that's a good question. Part of the plan readiness for Cal MediConnect, at least for Cal MediConnect, they have to meet certain network adequacy readiness standards. So part of that would have to be contracting and having sufficient numbers of nursing facilities within their

network.

Now, I don't know exactly what that means. I don't know how many nursing facilities that means. I've been in conversations where we know that nursing facilities right now, there aren't enough of them to meet the need of the people needing the services of nursing facilities. I do know that some plans are deciding not to contract with all of the nursing facilities in their region, while other plans have decided that they're just going to try to contract with every nursing facility. So we're seeing it differ from plan to plan, but the goal is, under the readiness standards, that both DHCS and CMS have in place, they should have a certain network in place that is adequate to meet the need of the population.

Silvia, anything you want to add to that?

>> Silvia Yee: No, I don't think so. It's true, it's hard to go into the details. I don't think they're available, the details of what nursing facility network adequacy means. It's not -- a third party entity is reviewing the plans. It's not information that's available, let's say, on the website. It's hard to being clear on what that means.

>> Amber Cutler: That's true. All right, Silvia, you're up.

>> Silvia Yee: OK. Thanks, Amber. Well, all this discussion about the Cal MediConnect, joining Cal MediConnect, who has to join, let's actually look at what Cal MediConnect is supposed to provide to dual-eligibles.

So the managed care organizations involved in Cal MediConnect are supposed to provide Medicare A, B and D. So Medicare part A is hospital and inpatient stays. Part B is outpatient, including primary care and all specialist providers. Part D is prescription drugs. That is all supposed

to transfer over and go through managed care.

Medi-Cal services that are included in Cal MediConnect are all the Medi-Cal general services, the new mental health benefit is supposed to be included, dental coverage, which is now going to be statewide under Medi-Cal is included as of May 2014, and all of the long-term services and supports that Amber went through in an earlier slide, the in-home supportive services, community-based adult services, nursing facility services and MSSP.

The additional services, there are a few extra benefits, you can say, that Cal MediConnect is supposed to provide that are not a part of general Medi-Cal in the state. One of those is vision, vision services preventive, restorative and emergency vision services. And transportation, nonemergency medical transportation, to doctors' appointments, to different treatments.

We have noted before that the memorandum of understanding indicates that plans can have a limit on this transportation, but I don't think -- Amber, please correct me if I'm wrong -- I don't think we have details yet on what that limit is going to look like, whether it's going to be a trips per month or per year or a total distance limit, and I don't think we have really an idea what happens when that limit is reached.

I'm also not entirely sure this is going to be something left up to the discretion of individual plans. So it's one thing to note if you or your client has -- if nonemergency medical transportation is important to you or to your client, and your client actually has a choice of plan, then it's important to ask the plan what is your policy? Do you have a policy yet? What is your policy around nonemergency medical transportation? Would I reach the limit? What happens then? See what your plans say about this, because it will have an impact on your choice of plans.

Also, the additional benefit from Cal MediConnect is care coordination, and that's going to be addressed more on the next slide.

So care coordination is important to many people with disabilities. It's hard to juggle all of those services, long-term services and supports, medical needs, it's hard to juggle that when a chronic condition flares up, when there's a need to enter hospital, etc. Life is complicated, and care coordination is valuable.

The care coordination that is supposed to be provided in Cal MediConnect is supposed to meet certain criteria, and one of those is it is supposed to be person-centered, it is supposed to focus on the least restrictive setting, and it includes a health risk assessment.

So plans are required to conduct a health risk assessment when the member enters a plan, and it is described as an in-depth assessment process to identify the member's various needs, their primary needs, their acute needs, long-term supports and services, specialty care needs, behavioral health and functional needs.

Every member has a right to this assessment in person. I know some plans are offering to come to a member's home, which can actually be quite beneficial, because it can provide a more effective assessment when the assessor can see a home environment and the interaction with the home environment, for a plan actually thinking of providing home modifications or helping with the possibility around the home or assessing the possibility of providing additional in-home support needs and hours, that glimpse into how a person functions in his or her own home is important.

At the same time, I think some people can feel uncomfortable with having a stranger come into their home. So an individual, any member, can choose to be assessed by phone. There is an

algorithm, a formula that helps a plan figure out whether a member is high risk or low risk, and this algorithm also takes into consideration all of the Medicare and Medi-Cal utilization data of the member, as well as a current assessment and any other assessments on record for the person.

So if a member is assessed as high risk, then they're supposed to have their assessment within 45 days. So enrollees at increased risk or having adverse health outcome are supposed to be assessed within 45 days. Others at lower risk or in a nursing facility are supposed to be assessed within 90 days.

Care coordination also has an individualized care plan component. That's supposed to be a plan developed for each enrollee, and it includes that member's goals and preferences, their measurable objectives, and time tables to meet the member's medical, behavioral and long-term needs.

Finally, the interdisciplinary care team, and this is one of the promised benefits of Cal MediConnect, a team that is working on your behalf is supposed to include your primary care provider, nurse manager, social worker, pharmacist, etc., all of the different healthcare and long-term service and support providers who are in your life, or in your client's life.

It can include the individual's IHSS care providers. It is up to the individual whether that is the case. It should be up to the individual, because the individual member is the employer.

There's also -- I'm going to check whether I want to go on. Well, let's go back for a second.

In terms of the assessment, there is a universal assessment tool that is being developed right now, and actually the State Department of Social Services is holding meetings, along with DHCS, a workgroup on this. That tool is not going to be completed yet, prior to the start of the Cal

MediConnect.

Again, Amber can clarify this if there is more current information, but I don't think there is yet clarity on how the universal assessment tool is going to interact with something like the initial, the plan's risk assessment or other assessments currently in use, such as the assessment for IHSS hours, which is going to continue to be administered and used by county IHSS agencies.

So there are some open questions around all of this still, things that are being developed, moving pieces that are still moving. I just want to alert you to some of those.

Now, finally, we're looking at the care plan option services, and these are -- there is now finally a policy available on the Cal duals website, Calduals.org. This involves home and community-based based-like supports and services that are discretionary. It's up to the plan to offer them, to make them available and to continue to make them available. These are services such as personal care hours above and beyond what a member already receives through IHSS, services that may include home modifications like a wheelchair ramp or other home accommodations, Meals on Wheels, that kind of service.

It remains unclear at this time what exactly plans are going to make available and the policies that they're going to have in place to make these services available. Some of these can be quite critical to various people with disabilities and to various members. Because it's discretionary and not required, they're not subject to a state formal appeal process. It's a discretionary plan benefit.

So if a benefit is offered, and then it is changed or reduced a challenge to that change or reduction is through the plan's internal plan appeal process, not a state formal appeal process.

It's important to note that these optional, these care plan option services cannot be offered

instead of required benefits. So if someone has IHSS hours, those are their assessed IHSS hours. It can't be sort of traded away for other care plan option services.

The assessment for these optional services will be during the care plan -- the plan's risk assessment. These are -- one thing to note is how this relates to waiver services, and because some of you have already asked questions about those on home and community-based waiver services.

For those who are on the service waivers, their home and community -- the breadth, the scope of the home and community-based services are right. They have a right to those billed services.

Those kinds of services, for someone not in a home and community-based service waiver, but in the Cal MediConnect, are not a right in the same way. They are discretionary. And that is something to remember, especially if you have a client who is in a waiver and actually thinking that there may be benefits to Cal MediConnect. It may be so, but it's an important thing to note that some of the benefits they're receiving as a right under the waiver will not be a right under Cal MediConnect.

OK. And the next slide. The Carved Out Benefits. There still are some benefits that are not going to be administered through the Cal MediConnect plans. So these include the county administered and financed specialty Medi-Cal mental health benefits. There are examples on the slide: intensive day treatment, a portion of inpatient psychiatric services, day rehabilitation, crisis intervention, and adult residential treatment services.

Also the Medi-Cal drug benefits, such as methadone therapy or day care rehabilitation.

Note that while the plans are not paying for or delivering these carved out services, the plans are still responsible for coordinating services for the beneficiary. On the level of the beneficiary there shouldn't be any indication that there has been this change, but I will raise just the point that

ultimately I think time will tell how this will actually work, who will bear final responsibility for resolving coordination issues that may arise.

So if, for example, there is some communication or payment issue that arises between the county and DHCS, the department, is the member supposed to go to the plan for assistance, and is it the plan that has the responsibility to investigate and resolve the problem? I think that is something that we don't know yet. We don't know how it will work yet.

I'm going to stop here for a moment and see if there are any questions.

>> Amber Cutler: I think there have been a few questions about benefits overall. I do want to share with you guys what I do know about the transportation benefit, and I apologize for not updating the slide accordingly.

Joan Ogle, from the Department of Health Care Services, indicated that the transportation benefit is like a taxi benefit. It will be something that you might use to go to a dentist appointment or to the pharmacy. She has unofficially, there has been no policy released to date, said that the benefit most likely will be capped at 30 rides per year, one-way trips, which is just over one round-trip a month. That is how the transportation benefit has been described informally. That policy hasn't been released.

That is a required benefit. All of the health plans will have to provide that benefit, no matter what.

We had a question about can plans provide different benefits. And the answer is yes. They have to provide all of the required benefits that Silvia went through, but the CPO services is where the plans can have the discretion to provide a whole range of benefits, and each plan can provide

different benefits.

We had a question about how do we know what those services will be? We don't. I think it's important that when notices go out and the plan, the actual plan books that show what benefits the plans are offering, that beneficiaries are going to have to really look at some of those CPO services to see if those are beneficial to them. They're not just going to look, oh, I have to consider these are some of the new benefits I'm getting under Cal MediConnect no matter what, but are any of these CPO services beneficial to me?

It may rain in LA, LA Care may have a very different set of benefits they're offering compared to a Health Net here in LA County.

So I think I answered a few questions in there.

We had a question about the care plan team, and we don't know a lot yet about the interdisciplinary care team. The DHCS put out a final all-plan letter on the composition of the care team, and it does state in the all-plan letter that the team does have to meet periodically.

I'm going to put on the chat the website for those all-plan letters, if you want to take a look at them to determine what that policy is that DHCS put out for the plan. There is some guidance on who has to be members of the care team, who are mandatory members, who are discretionary members, what the purpose of the care team is, and then some requirements around the actual care plan and the drafting of the care plan. So I will put that up.

I think that's about it.

>> Silvia Yee: Thanks, Amber.

>> Amber Cutler: Go ahead, Silvia.

>> Silvia Yee: There was a question whether a plan could offer more transportation than the minimum 30 trips. I answered on the chat, but it's true there is nothing to stop a plan from offering more than the minimum required anything. Yes. I think the answer is yes. An individual plan could choose to go beyond that. But they wouldn't necessarily be made to maintain more than that, if they started out with a policy of giving more.

>> Amber Cutler: I think you're absolutely right, Silvia. I think plans might want to offer benefits that are way beyond possibly what they're required to provide. I think that will probably hinge a lot on what rates they receive, and I think as a general update, I'll kind of say this quickly, is that the rates are very much still in contention, and plans so far do not think that the rates are adequate or sufficient to provide the benefits that the plans need to provide.

So I think the extent of whatever benefits they provide in addition to those required benefits will probably rest on what they receive as a rate.

All right, for the sake of time I'm going to go ahead and move forward. I will try to answer questions in the chat as well, as we move forward.

As for consumer protections within the Coordinated Care Initiative, I think the major one is the idea of continuity of care, which is the right to continue seeing a provider that you currently have in order to minimize disruption during the transition into whatever new healthcare delivery system you're going into, whether that's Medi-Cal Managed Care or Cal MediConnect.

The continuity of care provision for Cal MediConnect are outlined in the memorandum of understanding DHCS signed with CMS in March. The requirement to continue seeing your current providers and maintaining current service authorization differ whether the provider is Medicare or

Medi-Cal provider. If a Medicare provider, the continuity of care provision is 6 months. If Medi-Cal, 12 months.

There are certain requirements in order to continue to see those providers. You must have an existing relationship with the provider. That is defined as having seen the provider at least twice in the 12-month period. That 12-month period is measured from the date of the request to continue seeing that provider.

We're going -- I'm going to discuss the continuity of care protection on the Cal MediConnect side. Silvia will discuss it on the Medi-Cal managed side. The two continuity of care protections differ. Where the Cal MediConnect continuity of care provision is actually less generous than on the Medi-Cal Managed Care side. You will see that discrepancy as we describe them.

You must see that provider at least twice within the 12 months from the date of the request if you want to continue seeing that provider. Then the provider must accept the planned reimbursement rate or Medicare or Medi-Cal rate, and the provider must meet certain quality of care standards.

The continuity of care is limited. It doesn't apply or extent to durable medical equipment or medical supplies, transportation vendors, or other ancillary services.

There is a limitation on who and what kind of providers that continuity of care protection applies to.

Then there's also the continuity of care with regard to prescription drugs, and under Cal MediConnect, the continuity of care protection follows the Part D plan rules. It will allow for a one-time fill of a one 30-day supply, even if that prescription drug is not in the healthcare plan's

formulary.

I think, though, the ultimate continuity of care protection within Cal MediConnect is your ability to disenroll from Cal MediConnect at any time. For any reason.

This means that if you are having a problem continuing to see your Medicare doctor, you can just disenroll from Cal MediConnect and go back into fee for service Medicare or join a Medicare Advantage plan. You even have the right to choose a PACE plan. All of those options remain open to you on the Medicare side. So if you are having an issue with seeing a Medicare provider, then you can just disenroll, and it becomes effective the first day of the next month.

With the caveat that you're still going to have to stay in managed care for your Medi-Cal benefit. That shouldn't matter too much to a Medicare beneficiary because most of the providers they're seeing are going to be primary Medicare paid. Those are providers they want to continue seeing are those they were seeing under Medicare previously. I think the ultimate continuity of care protection under Cal MediConnect is that ability to disenroll.

All right, Silvia.

>> Silvia Yee: OK. Thanks, Amber. Looking at Medi-Cal Managed Care and the continuity of care protection, there are similarities. You can keep seeing your current providers and maintain service authorizations and receive services that are supposed to occur within six months of enrollment.

All of the seniors and people with disabilities who are now enrolled in managed care and who may not have been enrolled before, but are now required to be enrolled under the CCI.

The thing about must have an existing relationship, I actually think that under the 1115 waiver that authorized the initial mandatory enrollment of seniors and people with disabilities into managed

care that it's a little more generous here than having seen the provider at least twice within 12 months.

Sometimes I believe that for those in Medi-Cal Managed Care if before you enrolled, if you had a protection, if you had an appointment, sorry, and had waited a long time, and gotten an appointment to see like a hard-to-see specialist, for example, in Medi-Cal, and you have that standing appointment, my understanding is that you can continue to keep that appointment, even if you had not seen that provider twice before in the prior year. Like you had surgery scheduled with a specialist for some particular condition. So that's something I actually will need to clarify, make sure of. I believe that is one element, one way in this Medi-Cal managed care is more generous than Cal MediConnect.

Again, the provider must accept plan reimbursement and Medi-Cal rate and meet quality of care standards.

The continuity of care does not extend to durable medical equipment, medical supplies, transportation or other ancillary services. This is especially a hardship for those with rehabilitation needs and we'll continue to advocate on that front. And prescription drugs must be refilled until the provider is informed and a new plan is agreed upon by the provider that is appropriate.

Here is -- here I'm going to discuss briefly the medical exemption request. This is a right that is available to those who have Medi-Cal Managed Care. The medical exemption request is actually a longstanding mechanism. It was available before 2012, which is when all of the -- and 2011. It's been around for a long time actually. It's designed to enable someone who has a complex medical condition to continue to see their fee-for-service providers, even though they're supposed to be

subject to mandatory managed care enrollment. It's something that a Medicare beneficiary, who is supposed to enroll in a plan, you have to -- there's a particular form that you and your provider have to work on. You fill it out together. You submit it to the Healthcare Options, which is an enrollment broker that the Department of Healthcare uses, then you wait for a determination by the Department of Healthcare.

Healthcare Option's not supposed to make the decision. The Department of Managed Healthcare says that it has medical personnel, nurses and providers who review the application just to grant or not grant the medical exemption request. If the medical exemption request is granted, you can avoid enrollment altogether in managed care for a certain amount of time, up to a year. Then close to the end of that time, if you're still in need of the special -- that special care, you still have the complex medical condition, you can apply for another medical exemption request.

There is some controversy, some disagreement between advocates in the department over how the MER works. I don't really have time right now to go into all of the details, but just to say there is some disagreement over that. The department has said quite strongly that it feels that an MER will not be granted until the applicant establishes that they would actually be harmed deleteriously by going into managed care.

As I said, there's a disagreement right now over how the statute and the regulations on this read.

Some other consumer protections that are important to note. There is a right to receive -- this is for all of the components of the CCI -- there is a right to receive materials and services in one's own language. That includes the limited English proficiency languages, threshold languages in California,

and alternate formats, such as Braille, electronic formats or large font print.

And accessibility rights include reasonable modifications to enable people with disabilities to gainful and equal access to services. The plans are required to receive training on disability discrimination and cultural competency.

So as a new member, you phone them, you say "I need a provider who has a height adjustable table. I need a provider who I know I can go into their waiting room, turn around in my wheelchair. I need a provider who will serve me and understand that I need a sign language interpreter," etc., the plan member services and plan should understand what you're talking about and be able to respond appropriately.

The plan itself, its own headquarters, its offices need to be physically accessible. Here we're saying that physical accessibility where readily achievable. I think there is some argument that that should be a higher standard, that they need to provide physical accessibility, unless undue burden not to do so. Because we're talking here about federal funds that are going through Medicare and Medicaid funds through the organizations and providers. So that higher standard is achievable.

Here is “Local advocates can help individuals.” The last two slides are those kinds of resource slides. The HICAP, which has a lot of expertise around Medicare, the Health Consumer Alliance in California, and Disability Rights California are all good resources.

I just wanted to check whether there are any questions on what I went whether there are questions on what I went through in the previous slides.

>> Amber Cutler: I don't see anything, Silvia.

>> Silvia Yee: OK. The very last slide is “If you want to know more,” if your curiosity has been whetted, you can't wait to know more, that's true for all of us, here are some additional resources for you.

>> Amber Cutler: I want to point out that we're having another Coordinated Care Initiatives Basics Training on October 21. If anyone on the line wants their staff to participate, they can register on the Duals Demo Advocacy website.

All of our e-mails are here. If you had questions that were not answered, e-mail us for clarification. We do apologize for the sound issues. Hopefully we got them straightened out. If not, you can access the transcript which will be available on our website.

So thank you. Thank you, Silvia.

>> Silvia Yee: Thank you, Amber.

[Webinar ended at 4:04 p.m. Pacific Time.]