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DISABILITY RIGHTS EDUCATION AND DEFENSE FUND (DREDF)

Webinar

COORDINATED CARE INITIATIVE (CCI)
ADVANCED I: BENEFIT PACKAGE AND CONSUMER PROTECTION

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>> Amber Cutler: This is Amber. I'm just doing a sound check. Mary Lou, Silvia, Jenni, can you hear me?

>> I can hear you.

>> Amber Cutler: Silvia, I can. Great. We're going to start in a couple minutes to make sure everybody has the opportunity to sign on. And if you have any issues or questions, you can type those into the chat function and we will try to respond to you. Thank you.

>> Amber Cutler: Hi! Welcome to today's webinar. This is the Coordinated Care Initiative advanced one. We're going to talk about benefit package and consumer protection. This is advanced training, so we're going to get more into the Coordinated Care Initiative. If you haven't participated in the basics training, this may be a little more advanced and you might have questions that we will not be going over during this presentation. So I encourage you to go back and look into our basics presentation, which is available on our website.

Just some housekeeping matters. In order to turn on the closed captioning function, you'll want to hit Ctrl + F8. This will turn closed captioning on, which is available during the presentation. Also, participants, you are going to be on mute during the presentation, but I encourage you to ask questions through the chat function, which is available. And we will be stopping periodically throughout the presentation to answer questions we get through the chat function. So, again, we really encourage you to ask questions throughout the presentation. And finally, a copy of the PowerPoint is available on our website, and I think the link is available in the chat box. Jenni has posted that link for you guys.

So my name is Amber Cutler, and I am a staff attorney with the National Senior Citizens Law Center. And we focus on providing advocacy to low-income seniors, particularly in areas of public benefit programs like Social Security, Medicare and Medicaid. And I'm going to introduce Silvia. Silvia, you

want to jump on?

>> Silvia Yee: Hi, Amber. Thanks for introducing me. I'm with the Disability Rights Education~&~Defense Fund, which was founded in 1979 by people with disabilities and parents of children with disabilities. We are a national law and policy center based in Berkeley, California.

>> Amber Cutler: Thanks, Silvia, California.

>> Amber Cutler: Silvia and I will take turns and stop for questions. All right. Let's get started.

So today's discussion, we're going to do a really quick overview of the Coordinated Care Initiative, just to make sure everybody is on the same page. Then we're going to go into depth with regard to the integration of long-term services and supports under the Coordinated Care Initiative. We're going to discuss the benefit package offered under Cal MediConnect and we're going to discuss the consumer protections that are available under the Coordinated Care Initiative.

So let's get started with a glossary. We've got here Dual Eligible, and that's an individual who has both Medicare and Medi-Cal benefits. We refer to them as a medi-medi. I would like to contrast with the last one on the slide, which is a senior or person with disabilities, SPD, that is a person with Medi-Cal only. Their basis for eligibility for Medi-Cal is age or disability. So that is a totally separate population from the Dual Eligible population, which has both Medicare and Medi-Cal. Both populations are impacted by the Coordinated Care Initiative and implemented in different ways. The dual Special Needs Plan has a red arrow, that is a special Medicare advantage plan targeted specifically at those who are dually eligible for Medicare and Medi-Cal. And finally Long Term Support and Services. Under the Coordinated Care Initiative that refers to four basic Medi-Cal programs, the in-home support services or IHSS, community based services, the multi-purposes senior services programs and nursing home facility care. So those for Medi-Cal benefit programs fell under the umbrella of long-term services and support. When referring to LTSS, I'm referring to those

four benefit programs.

The Coordinated Care Initiative is set to begin on April 1st, 2014. The first notices will be going out on January 1st. Notices go out 90 days in advance. That's only 27 days from today. So we're going to be seeing these first notices drop very soon, if everything remains on track, which is department of healthcare services has indicated that it will. What is the Coordinated Care Initiative? It encompasses three major changes. First is the mandatory enrollment of all Medi-Cal beneficiaries into a Managed Care Plan for the Medi-Cal benefit. Back in 2011 we saw SPDs, Medi-Cal only having to mandatorily enroll in a managed plan for Medi-Cal benefits. At that time there were major populations excluded from having to enroll for Medi-Cal. For example, Dual Eligibles were excluded. I'm stopping there. I'm sorry, I'm going to pause. I see we're having problems with the sound. We have two people having issues with sound.

Silvia, can you hear me okay? Mary Lou?

>> I can hear you, Amber. I'm going to see if we can figure out what is going on.

>> Amber Cutler: I encourage those who are having a problem with sound to run the audio wizard. And to do that, you want to go up to the tools box at the top of the Blackboard screen and hit "audio." There's a drop-down menu under audio. Go to audio setup wizard and that should help you adjust your sound in order to hear me better.

And I'm going to take just a second and type that into the chat box as well.

Sorry for the technical difficulties.

Okay. So change number one is all Medi-Cal beneficiaries are going into a Managed Care Plan for Medi-Cal benefit. Dual Eligibles, individuals with share costs. It includes people living in nursing facilities. Basically if you have Medi-Cal, you're going to have to join a Managed Care Plan for your Medi-Cal benefit. Very few exceptions. Change number 2 is the integration of long-term services

and supports into the managed care benefit package. So back in 2011 when we saw seniors and persons with disabilities SPDs moving into managed care for Medi-Cal benefit, long-term services and supports were carved out, meaning they were delivered through the Fee-for-Service system. That will no longer be the case. IHSS, and nursing facility benefits are all coming into managed care. Meaning that the Managed Care Plan will be responsible for delivering those benefits where before they were not. To give you an example, if you have someone right now, an SPD with Medi-Cal only, you are in a Managed Care Plan for your Medi-Cal benefit living out in the community. If you have to go into a nursing facility, you go into the nursing facility and you have to disenroll from your Managed Care Plan and you go back into Fee-for-Service. That nursing facility care is taken care of through Fee-for-Service. Under the Coordinated Care Initiative that will no longer be the case. Instead you have to go into a nursing facility that is in your Managed Care Plan's network. This is how we're seeing LTSS integrated into the Medi-Cal benefit package. So second major change happening under the Coordinated Care Initiative. And the eight CCI counties. Third final change is the integration of Medicare and Medi-Cal into one Managed Care Plan. And this is impacting Dual Eligibles only. This new program is called Cal MediConnect. We're seeing Medicare and Medi-Cal coming into one Managed Care Plan with one card, Dual Eligibles will receive both sets of benefit through one Managed Care Plan. So we have those three major changes happening under the Coordinated Care Initiative.

To give you guys a visualization of how this looks, right now we are in a Fee-for-Service world where is senior or person with a disability goes to see a provider that accepts their Medicare or their Medi-Cal card or both. Then that provider bills the Department of Health Care Services or Medicare for the service they provided. For example, if you got an x-ray through the provider, the provider would bill DHCS or Medicare for the service. That's the Fee-for-Service role. We're moving from that

system into managed care, where we have a senior or person with disability who is a member of the health plan. That health plan receives a rate from the Department of Health Care Services and Medicare to provide services to the member to. The health plan contracts with a network and the senior or person with disabilities must go through the health plan's network. We know that sometimes a senior person with disability going into a health plan will no longer be able to see a provider they previously saw because that provider is not in the health plan's network.

To emphasize who is impacted by the Coordinated Care Initiative, it is the individuals with Medi-Cal and Medicare, Dual Eligibles, and then the individuals with Medi-Cal only or seniors or persons with disabilities, SPDs. An individual who only has Medicare is not impacted by the Coordinated Care Initiative.

Those different groups, those SPDs and duals are impacted differently under the Coordinated Care Initiative. So I'm going to go through the bullet points fairly quickly and then the next slide I'll go into a little more detail. So an SPD, that is someone with Medi-Cal only, who is already in a Managed Care Plan, already in the community, in a Managed Care Plan, now they're going to get a notice telling them that their long-term services and supports are going to be delivered through their Managed Care Plan. So that's the only notice they're going to get. They're going to be told that their LTSS is going to be delivered by their Managed Care Plan. Then there are SPDs who remain exempt from managed care. So those are individuals who live in a veterans home, for example, or have other private health insurance, or those SPDs who obtain a successful Medical Exemption Request or what we call a MER. So there's very few exceptions going into Medi-Cal Managed Care, but there are a few but very difficult to get that exception, that Medical Exemption Request. Then there are Dual Eligibles, both Medicare and Medi-Cal. Most Dual Eligibles will be passively enrolled into Cal MediConnect. When they get a notice, if they don't choose a Cal MediConnect plan or choose not to

participate in Cal MediConnect, do nothing, in other words, they automatically will be enrolled into a Cal MediConnect plan. That's most. Most are subjected to that process. But there are Dual Eligibles who can enroll in Cal MediConnect but won't be passively enrolled, they won't get notices about Cal MediConnect and won't be subject to the passive enrollment process. Then there are Dual Eligibles who cannot participate in Cal MediConnect at all. Not only will they not receive notices but if they wanted to participate they can't. To go through those, just kind of quickly, there's a chart, and the advocates guide, the National Senior Citizens Law Center and DREDF put together, I think it begins on page 17, a chart outlining the exceptions and exclusions, but this is kind of a quick breakdown. Those duals that are absolutely excluded from Cal MediConnect, meaning they cannot participate, even if they wanted to are those with end stage renal disease, orange county and San Mateo. Beneficiaries who reside in San Bernardino zip codes and LA County, that's that Catalina County. Those who live in Catalina are not going to be able to purchase in Cal MediConnect. Residents of VA hall, those who do not have a share of costs they regularly meet, other health insurance or those receiving services through a DDS waiver or regional center disability center. So those individuals cannot participate in Cal MediConnect regardless if they want to. They cannot participate. However, most of those populations are going to have to choose a Managed Care Plan for their Medi-Cal benefit. So even though they can't participate in Cal MediConnect, they still have to go into the Managed Care Plan for their Medi-Cal benefit. Then there are Dual Eligibles who can participate in Cal MediConnect but will not receive notices and not subject to that passive enrollment process. So individuals who are enrolled in the PACE program, the program all inclusive care for elderly, they are not going to receive a notice about Cal MediConnect, not subject to passive enrollment, however, if they wish to participate in Cal MediConnect, they would have to disenroll from PACE. The same goes for those in foundation waiver. Individuals who live in certain zip codes in San Bernardino

County, they will not be subject to passive enrollment. They will receive a notice. They are the only population in the whole list that will receive a notice about the program but they will not be subject to passive enrollment. Individuals enrolled in Kaiser will not be subject to passive enrollment and not receive notices. Individuals enrolled in the home and community based behaviors, like the hospital waiver or in-home operations waiver, they're not going to get notices about Cal MediConnect. If they want to participate they have to disenroll from their waiver to participate. Finally, those individuals who are enrolled in a Medicare advantage plan in 2014 will not be subject to passive enrollment into Cal MediConnect, meaning they won't get notices, but they will have to join a Medi-Cal Managed Care plan. Again, all of these people in these categories have to go into a Managed Care Plan for their Medi-Cal benefit. So those won't get notices about Cal MediConnect. They are going to get notices telling them they have to go into a Managed Care Plan for Medi-Cal benefit and if they want to participate in Cal MediConnect, they have to disenroll into the plan they're in to enroll in Cal MediConnect.

Just to make that all clear, a slide to bring it all home is that Medi-Cal Managed Care is pretty much mandatory for everyone. Very few exceptions. So even if you have a Dual Eligible who decides they do not want to participate in Cal MediConnect, isn't able to participate in Cal MediConnect, or is not subject to passive enrollment into Cal MediConnect, they are still going to have to choose a Managed Care Plan for their Medi-Cal benefit. The Medicare side is voluntary, the Medi-Cal side is mandatory. In total, this impacts about a million beneficiaries in the eight CCI counties. Just to make it clear that the Coordinated Care Initiative is taking place in the eight CCI counties. This breaks it down into notices and those only get notices about having to join a Managed Care Plan for their Medi-Cal benefit. So about 418,000 individuals are going to receive notices telling them they are going to have to make a choice if they want to participate in Cal MediConnect, they don't want to participate in Cal

MediConnect, or if they do nothing, they're automatically enrolled into a Cal MediConnect program. 418,000 people are going to receive notices to that effect. And Los Angeles County there's a cap on the number who can be enrolled into Cal MediConnect. It's 200,000. But yet 223,000 in LA County are going to receive notices. The cap, in fact, 200,000 people enrolled in Cal MediConnect in Los Angeles County. Then a waiting list initiated for individuals who want to participate but are over that 200,000 cap. Just to point this out, though, the department of healthcare services does not believe that 200,000 people will enroll into Cal MediConnect in LA County. They do not think they will reach that cap. In addition to those that are going to receive notices about Cal MediConnect, there's 592,000 people who are going to receive a notice about Medi-Cal Managed Care. Those are individuals who are going to be told they need to choose a Managed Care Plan for Medi-Cal or they are individuals who are going to see long-term services supports integrated into Managed Care Plan. So there's 592,000 individuals will receive notice about managed care. So that entire population impacted by the Coordinated Care Initiative totals about a million individuals.

And I'm going to go ahead, Silvia, and stop there for questions. Is there any questions that came up?

>> Silvia Yee: I think you answered one of them as you were going, and there's another they thought I would check with you as well. When you mentioned that HIV AIDS individuals will not be passively enrolled, you meant those who are enrolled in the AIDS waiver program, correct?

>> Amber Cutler: That is correct, those in the AIDS waiver that will not be subject to passive enrollment. Those individuals with HIV/AIDS -- might want to double check in the chart, but I'm pretty sure those with the diagnosis of HIV/AIDS can at any time disenroll from managed care. So they'll be subject to passive enrollment into Cal MediConnect and Medi-Cal Managed Care, those individuals are able to disenroll at any time, so even on the Medi-Cal Managed Care side, which is mandatory, they can disenroll because of their diagnosis.

>> Silvia Yee: I think that's my understanding too. I will check on that and write back as well.

>> Amber Cutler: Okay, perfect.

So what is going on with Medi-Cal Managed Care? So basically we've got two programs, the Medi-Cal program and the Medicare program. We're seeing with managed care on the Medi-Cal side, we have medical already pretty much in managed care -- I'm talking about hospitals and doctor visits, individuals who have Medi-Cal are in managed care unless they were a dual. So that's already in managed care. Now we're also seeing LTSS going into managed care. On the medical side, though, there are some new Medi-Cal benefits I want to make everyone aware of first of all, simple is being restored to all Medi-Cal beneficiaries, starting in May 2014. And so this isn't just Medi-Cal beneficiaries of the CCI counties, all Medi-Cal beneficiaries are going to get dental back. And that dental benefit will be delivered through Denta-Cal. So managed care plans aren't actually responsible for dental benefit. That benefit will be carved out. Managed care plans are not going to receive anything in their rate to provide dental. Instead individuals who receive dental benefits through Denta-Cal. They are going to get it back starting May 2014. There is a new benefit that managed care plans will be responsible for.this new mental health benefit is a benefit that fills the gap. So in the mental health world, there are mental health benefits that Medi-Cal pays for and Medicare pays for and when they rise to a certain level under Medi-Cal, they become what are considered specialty mental health benefits. And there are special requirements for them to be considered -- like the need for specialty mental health benefits. And those specialty mental health benefits are provided by the county and paid for by the county mental health system. So Medi-Cal beneficiaries receive the specialty mental health services through the county. That will continue to be the case under Medi-Cal Managed Care and continue to be the case under Cal MediConnect. The new mental health benefit fills the gap between specialty mental health and what a primary care

physician can do. So basically mental health services that rise above what a primary care physician can provide but don't meet the level of specialty mental health benefits. So it includes things like group counseling and family counseling and individual counseling, psychological testing, some psychological consulting. This new mental health benefit will be delivered by the Managed Care Plan. So the Managed Care Plans will be responsible for giving this benefit to the beneficiary. Then if mental health needs rise to the specialty mental health level, then the county would be responsible for delivering those county specialty mental health benefits. So those are the kind of two new benefits that are coming to Medi-Cal beneficiaries overall. The mental health benefit is all Medi-Cal beneficiaries, not just the CCI counties. We're actually seeing the Medi-Cal benefit package kind of expand. On another note about mental health benefits is that under the county specialty mental health benefits that's also increasing, so the county is going to be giving a new substance abuse benefit and that will roll out on January 1st, 2014 just like the new mental health benefit that the new Managed Care Plans are responsible for. We're seeing an expansion of benefits for beneficiaries. On the long-term services and supports side, we've seen that one of the major changes under the Coordinated Care Initiative is the movement of all Medi-Cal beneficiaries into a Managed Care Plan for Medi-Cal benefit regardless if they're a senior or person with disability with Medi-Cal only or dual eligible with both Medi-Cal and Medicare. They're going to have to be in a Managed Care Plan for Medi-Cal, whether that's just a Medi-Cal managed plan or Cal MediConnect. The second major change is that we're moving the Long Term Support and Services programs into the managed care programs. Back in 2012 we saw CBAS, Community Based Adult Services program, formerly known as adult day care moved into managed care. So the Managed Care Plans are already responsible for that benefit. Now we're seeing IHSS, MSP and nursing facility care also moved to managed care. And depending on the type of program or depending if it's IHSS or nursing care facility, those look

different as they move into managed care. So IHSS, in-home supportive services is a Medi-Cal benefit and intended to allow a beneficiary to allow safely in the home rather than going into a nursing facility or other institution and some of the services provided under IHSS include house cleaning, shopping, meal preparation, laundry, personal care services, accompanying to medical appointments, things like that. It is county administered and then the beneficiary has the right to hire, fire and supervise their provider. That will continue to be the case as IHSS moves into managed care. To the beneficiary, how IHSS looks is not supposed to change. I say "not supposed to change" because that's what we've been told and how we understand it, but we won't actually know until it rolls out. It's supposed to look the same to the beneficiary as in managed care. The Managed Care Plan will be responsible for coordinating the benefit and making sure that the beneficiary has been assessed a need for IHSS. Still the county who is responsible for assessing the hours and the providers still are the beneficiaries that have the right to hire, fire and supervise. That's IHSS moving to managed care. Then we have the multipurpose senior program which is a site-based service that provides social and healthcare management for the frail, elderly clients. These are individuals who are certifiable for nursing home placement but who wish to remain in the community. Certain eligibility requirements, and there are 38MSSP states stayed wide, and the services include housing assistant, respite and transportation and social services. MSSP moving into managed care, at the outset won't look that different because for the first 19 months after enrollment commences for the CCI, the managed care plans are required to contract with all of the MMSP organizations and the eight CCI counties, and the MMSP providers will receive the same rate they currently receive.

After that first 19 months, plans will continue to have to provide MMSP services but they will no longer be required to contract with the MMSP providers. So we could see in the future that they take the MMSP in-house rather than contracting with current MMSP providers. We don't know if it will happen

but it could since they're no longer required to contract with them after the 19 month period. Then finally we have nursing facility care moving into managed care as well. So this looks pretty different because right now you can go to any nursing facility that has Medi-Cal. Now managed care plans are going to have to contract with nursing facilities and those nursing facilities will have to become part of the plan network. So that looks very different than nursing facilities placement now and the ability to access nursing facilities right now. So we could see major changes with regard to nursing facility care where before you know, a nursing facility might have five or six people who are in some sort of Managed Care Plan in the nursing facility. Now we're going to see nursing facilities having like 95% of their residents in some sort of Managed Care Plan. So that looks very different than it does today. So what about home and community based service waivers. We talked about the waiver program, but what about our in-home operations waiver, nursing facility acute hospital waiver, assisted living waiver? Those waivers, individuals who are enrolled in those waivers will have to join a Medi-Cal Managed Care plan. And then the beneficiary will remain in that waiver program but the health plan will be responsible for coordinating services with the waiver providers. So if you have someone or are someone who is in an a waiver today, you are going to get a notice telling you you have to join a Managed Care Plan for your Medi-Cal benefit. And that's a pretty big change. Individuals in those waivers, though, are not going to get notices about Cal MediConnect and they can only participate in Cal MediConnect if they disenroll from their waiver. If they are on a waiver waiting list, meaning they haven't being accepted to a waiver and sitting on the waiver list, those individuals will receive notices about Cal MediConnect and will be subject to the passive enrollment process. Once they're enrolled in Cal MediConnect and they actually get into the waiver they can disenroll from Cal MediConnect and go into the waiver. So Silvia, I'm going to go ahead and stop there for questions.

>> Silvia Yee: Okay. Actually, I do not have specific questions for this segment. So you have been

incredibly clear.

>> Amber Cutler: Thank you, Silvia. Great. I encourage people, if you have any questions whatsoever, type them in the chat function and we will try to answer them during the session. So I'm going to hand it over to Silvia now.

>> Silvia Yee: Thanks, Amber. I anticipate far more questions coming now. We're going to be looking in a little more detail at the Cal MediConnect benefits, what is it, what the plan will actually offer and supposed to offer to those who pick up and join the plan. So there is on the Medicare side, there is Medicare parts A, B and D. So that's hospital and patient stays, part B, outpatient care, your general primary care provider, specialists, et cetera, clinics, treatment facilities. Part D is prescription drugs. That's all included. On the Medi-Cal side, all required Medi-Cal benefits. That includes the ones that Amber discussed earlier, IHSS, MMSP, CBAS and nursing home facility care. Also, there are some new managed Medi-Cal benefits. One is that the new mental health benefit that Amber outlined. Another is dental care, preventative and emergency, as of May 2014. And those two are good benefits to have in there. I'm going to highlight a key difference between them, however. The new mental health benefit is sort of administered within the plan, and the more serious mental health benefits are a carve-out, but even though there are more serious mental health benefits are carved out and administrated by the county, the plan has an obligation to help coordinate. So an individual who is a plan member may be receiving services from the county, but the plan is supposed to know about those benefits and help to coordinate the administration of those benefits and the care team will accept responsibility for coordination. The dental benefit is going to be administered through Denta-Cal and also a carve-out but the plan does not have explicit responsibility for dental services under Medi-Cal with the rest of Medi-Cal benefits. So I think that may -- I think we'll have to see how that actually plays out, and it could be a particular concern to individuals who -- individuals with

developmental disabilities or other disabilities that require sedation, for example. And when they have dental services. So that going to dentist is not simply a matter of going to a dentist but has to be provided with anesthesia and possibly in a hospital or surgical facility. That seems to me is something that actually people with disabilities have often encountered, coordination problems with that regard. So I think it's unfortunate that plans, who in some ways could be in an ideal position to provide that kind of coordination and support will not, it seems, be involved with a new dental benefit. Also included are vision, same thing, preventative and emergency. And transportation, which is a very specific -- I believe it's 30 trips in a year for non-medical purposes. And we're not -- I'm not entirely sure what the non-medical purposes are or whether that's strictly enforced, how that might or might not interact, let's say, for a member who, for example, is having problems with -- you know, the general Medi-Cal transportation, isn't getting accessible transportation for non-emergency appointments, can that individual actually then use the other transportation benefit, the 30 trips, that are supposed to be for non-medical purposes, because that's a guaranteed benefit, 30 trips. However, for someone who has many appointments, the 30 trips benefit will run out quite quickly. And another key benefit is care coordination, which is one of the main reasons behind the instigation of the Cal MediConnect plan. Care coordination is something the plans will provide, and looking at the next slide will help explain why clarification may be necessary. This is an interesting -- primarily a graphic, an interesting look at all the different sources of money that go towards a Dual Eligible's benefits. So there are different agencies involved. The federal government, state government, counties, and also many, many different programs, different sources of funding are Medicare, Medi-Cal, which in itself is a blended state and federal program. Miscellaneous federal funding sources, the older Americans act is a source of funding, state entitlement can be a source, Social Security and private pay insurance can be another. And you get a sense of the complexity of how

many services can be involved. Meal programs, senior centers and day care are under one source of funding. Transit, mental health services, housing, Section 8, a whole different source of funding. Primary care physicians, specialists, home health, labs, that's Medicare funding. Primary care physicians, specialists, that can be Medi-Cal for those in Medi-Cal only. You can see there are all these little different compartments. And, you know, you can imagine someone, an individual, trying to rest on a bed of pins, and it reminds me a little bit of that. That the hope and benefit of care coordination through a plan is all of these different funding sources and programs will be blended together so that in a plan, the plan will take care of, knowing where all the funding sources come from. And will instead be able to focus on the needs -- just overall needs of the person who is a member.

So looking at the next slide of care coordination, Cal MediConnect benefits, the care coordination is, these are the principles that are supposed to govern Cal MediConnect care coordination benefits. They are supposed to be person-centered. They are supposed to focus on the least restrictive setting, which is also comes from a Supreme Court decision concerning the rights of people with disabilities to receive services in the least restrictive setting, not just a less restrictive setting. It will include a health risk assessment that will look at the overall needs of the person with the disability and should not just be medical but also social and home community based care. There's an individualized care plan. Let me go into the subjects a little more detail.

When a member first enters our plan, the plans are required to conduct a health risk assessment, and it's supposed to be an in-depth assessment process to identify the primary, acute, the long-term services and supports, health and functional needs. There is a right to an in-person assessment. So it doesn't have to be something that is done over the phone unless a member chooses to have that. And many plans are actually offering to go to an individual's home, because an individual's home can

also provide information about the degree of assistance someone may need in the home. However, again, that is purely the choice of the member. This health assessment is supposed to identify the member as high risk or low risk. There's a particular algorithm that they use, and also included is the new member's Medi-Cal and Medicare utilization data. So those who are assessed as being at high risk are supposed to get this health risk assessment within 45 days, while those at low risk will get the health risk assessment within 90 days. The individualized care plan, which is another benefit is one that is supposed to be developed for each enrollee, and it is specifically supposed to include that member's goals and preferences, objectives and also a timetable to meet that person's medical, behavioral and long-term needs. Going back again to this is supposed to be a person-centered process. The interdisciplinary care team is supposed to include the primary care provider in the plan, nurse managers, social workers, pharmacists and it can include also an individual's IHSS, workers as determined by the employer. So it, again, should be at the member's choice. There is also a universal assessment tool that is being developed. And stakeholder readings are actually going on right now. This is a pretty vital process. Even though at this point I'm not entirely sure how the universal assessment process that is to be developed is actually going to interact with current assessments, such as the IHSS assessment, that is being determined by the county right now. I think that, like many other questions, is to be determined.

Let's look briefly at the care plan option services. And this is -- these are services available only under Cal MediConnect. They are not officially available to seniors or people with disabilities who are already in managed care. What they are is the potential for a member going into a plan to get additional home community based service. So essentially IHSS, like supports and services, chores, assistance in the home, reading of documents to those with visual impairment, that's not something covered under IHSS right now. Those kind of things that will help an individual stay independent in

the community, maybe home modifications. And these are attractive because they can make the difference between someone being able to stay safely in the community or taking risks in order to do so. However, these are options, exactly as they are called. They are discretionary at the plan's discretion. So they are given in addition to, not instead of, those benefits that are already inquired. That's an important thing. They can't be a bargaining point. You can't be trading services, and the plan can't try to trade services. And the need for them is supposed to be assessed during the health risk assessment that the plan takes. Because they are optional and only at discretion of the plan, they -- if some extra hours are granted to a member and then the plan reduces them, the appeal of that reduction goes through the plan. It doesn't go through the state because they're not state-mandated services. There's not a right to them. There's a right to be considered for them. But not an actual right.

And we will just look at the next slide and stop after that for questions. So it's important to think about -- whoops!

If I leaf it on the arrow, it clicks ahead.

Cal MediConnect benefits, the carved-out benefits. We spoke a little about this earlier already. So there are some benefits that are not administered by the plan. Those that are county administered and financed and specifically one of the most important ones is the specialty Medi-Cal mental health benefits. For example, this includes intensive day treatment, portions of the inpatient psychiatric services not covered by Medicare, day rehabilitation, crisis intervention, adult residential treatment services. Also in this carve-out are example of Medi-Cal drug benefits, methadone therapy, day care rehabilitation and other treatments for narcotic dependence. So those are not administered by the plan, but as I mentioned, the plan is still responsible for coordinating these services for a member and for the beneficiary. So from the beneficiary's point of view, it should not feel like there's any

difference. You should not be having interrupted continuity of care with your county provider, for example, or any facility that you are going to through county care. And also there shouldn't be any indication that the services are actually being provided by county incentive plan. For the member, if you have a problem with your mental health benefits, you should be able to go to the plan and have them work with you to figure it out. You cannot be told, oh, that's being delivered by the county, you have to work it out with them. And once again, this is not the case for the Denta-Cal benefits, for the dental benefits. Okay, are there any questions after this?

>> Amber Cutler: No, Silvia, not a single question. Well, I answered one, but otherwise not a single question. So I guess we'll move forward. Again, I encourage people, if you have questions, just type them in. You can always email Silvia or I after the presentation as well and we'd be happy to answer any questions that you want to ask during that time.

So we thought we would cover some of the consumer protections that are under the Coordinated Care Initiative. And I think one of the major consumer protections is the right to continuity of care. What exactly is continuity of care? That is the ability to continue to see a provider that is not in the plan's network. So an out-of-network provider. That right to see a certain provider has certain requirements, things that have to be met in order to continue seeing that provider. First of all, the period of time you can continue to see a provider differs depending on the type of benefit. If it's a Medicare benefit or Medicare provider, that will only last for six months. Continuity of care for six months. If it is a Medi-Cal benefit or provider, it's 12 months. So we have two different standards already. And then there has to be an existing relationship. And the definition of existing relationship differs depending on what type of provider. So if it's a primary care physician, in order to demonstrate an existing relationship, you must have seen that provider once within the previous 12 months of enrollment in the health plan. If it's a specialist, you have to have seen the specialist twice within 12

months of enrollment. We have two different standards there. Nursing facilities are excluded. This is a big win that we recently obtained as advocates. On November 27th, the Department of Health Care Services finalized an all plan letter outlining continuity of care for Cal MediConnect. That is available on the website under the all plan letters, and addressing continuity of care for Cal MediConnect. What they said is regarding nursing facilities, if someone is residing in a nursing facility at time of enrollment in Cal MediConnect they can continue to reside in the facility for length of demonstration, which is three years, and there is no time that they have to have lived in the nursing facility and that means that -- this only applies in the instances of where the nursing facility is not in the plan network. For example, LA County, you know, we have someone who gets passively enrolled residing in a nursing facility and they have not contacted with Health Net. That individual reside negative the nursing facility will be able to continue living the nursing facility without fear of continuity or disruption of care because that nursing facility is not in the plan's network for the length of the demonstration. That nursing facility does have to enter into an individual contract with Health Net and they have to accept Health Net plan, the rates, Medi-Cal and Medicare rates and have to be a licensed nursing facility under the rules, but otherwise it's allows people living in nursing facilities to stay there without any disruption, which is fantastic. That leads into to other requirements you have to have in order to exercise continuity of care rights. The provider has to meet quality of care standards and the continuity of care and they have to be able to accept the rates from Medicare and Medi-Cal, the plan rate, whichever is the higher. So all of those requirements have to be met. So if you have someone who requests this continuity of care protection, the health plan has to honor that continuity of care request and enter into an individual contract with that out-of-network provider for the length of time depending on the type of service. It's important to note that continuity of care does not extend to durable medical equipment providers, however, it does extend to durable medical equipment

services. So continuity of care applies to the service that you're getting, the D&A services but not necessarily that D&E provider. It does not apply to other ancillary service. With regard to prescription drugs, the health plans have to follow part D transition roles. This means they have to at least the Medicare covered prescription provide for one-time fill, 30-day supply even if it's not part of the plan, if it's a Medi-Cal covered drug, which there's a few that Medi-Cal covers instead of Medicare, if you're dual, then the plan must allow the beneficiary to continue use of that prescription drug until the doctor makes the determination that the prescribed therapy is no longer needed and they find some sort of substitute for that prescription drug coverage. So those are the prescription drug continuity of care protection. I think the ultimate continuity care protection under Cal MediConnect is the right to disenroll from Cal MediConnect. You can disenroll from Cal MediConnect at any time for any reason. They can change plans at any time. This allows someone to, if they were paying a Fee-for-Service doctor through Medicare, which it would be because Medicare is a primary payer, then they can decide to disenroll and then go back to Fee-for-Service and continue seeing Medicare provider Fee-for-Service. So on the Medicare side they have this really strong ability to continue seeing their doctor through the disenrollment process. It's important to remember they have to stay in managed care on the Medi-Cal side but as a Dual, what you're accessing through the Medi-Cal side of managed care is that the Managed Care Plan for Medi-Cal benefits is paying the rap, that 20% that Medicare doesn't pay, so the plan takes the place of the state in that regard. And then the Managed Care Plan for Medi-Cal, it really comes into play when it's Long Term Support and Services. So that's the nursing facility, IHSS and MMSP with regard to providers that are primary care physicians, specialists, all of those are Medicare providers, so you can always disenroll and see the providers Fee-for-Service. So then I think, Silvia, I'll turn it over to you for description of continuity of care on the Medi-Cal side.

>> Silvia Yee: Sure. Amber, we have one question too. I'll give that to you. The question was: Can the independent Cal MediConnect help consumers appeal CPOs within the plan?

>> Amber Cutler: Absolutely. So the independent program is the state of California receives funding in order to create an ombudsman service to help those individuals who get enrolled in Cal MediConnect. And so I think any issue or problem arising out of enrollment or problems with Cal MediConnect would be something that the Cal MediConnect office and program will handle.

>> Silvia Yee: Thanks, Amber. I think that was it for the questions. So going on with the Medi-Cal Managed Care consumer protections. Not the dual protections, just applying to the Medi-Cal population. And so whatever described as the ultimate consumer protection and I agree, being able to disenroll is not available for the most part to Medi-Cal Managed Care enrollees. This is mandatory. You will be enrolled for your Long Term Support and Services. And for your medical care as well, if you are Medi-Cal only. The consumer protection you do have, or one of them, is 12 months continuity of care. You can continue to see your current providers and obtain service authorizations and fee services that are supposed to occur within 180 days of enrollment. Surgeries and examinations can be set up pretty far, so that you continue to be able to keep those. You are supposed to have an existing relationship with the provider, so you should have seen the provider at least twice within 12 months of your date of plan enrollment. My recollection is that if you actually have the scheduled surgery, for example, and you may not have seen that provider, I think that continuity of care does apply to that.

So also the provider must accept plan reimbursement rate or the Medi-Cal rate. The provider must meet quality of care standards. And those are all reasonable requirements. Unfortunately, continuity of care only applies to certain kinds of providers. It does not extend to durable medical equipment to medical supplies, transportation or other ancillary services. And this will prove and has proven to be

an issue for those who have complex rehabilitation needs. By that I mean individuals who use wheelchairs and have very particular musculoskeletal requirements and use devices that basically perform the functions that their body and spine cannot perform. These are very, very customized services and it's very unfortunate that durable medical equipment providers cannot count for continuity of care. Prescription drugs must be refilled until the provider is informed and a new plan is agreed upon by the provider that is appropriate. So that is a good continuity of care protection. Moving on in absence of time, the Medi-Cal Managed Care also offers by regulation something called the Medical Exemption Request, which Amber mentioned earlier. It's only available in two plans, tore geographic managed care counties, like Sacramento. So like San Mateo, it's not available. What it does is it avoids enrollment and allows someone to avoid enrollment in managed care entirely for a certain amount of time up to a year. And it has to be applied for in conjunction with your provider. So you can't as an individual just apply for it on your own. And it's available to individuals with certain complex medical conditions, such as cancer, and sort of a catch-all complex medical condition, but it has over the last couple of years been very, very difficult to get. It's administered by Health Care Options, but the state has a team of medical staff that reviews the -- reviews the application. And there have been issues of it with how difficult it has been to get managed care exemptions even for people who, let's say, have longstanding -- long-time relationships with very specialized clinics and don't feel strongly. They can't get the same degree of complex care within a plan. So I'll leave it there. And just a catch-all for other additional consumer protections. That can be very useful for individuals. One is the right to receive materials and services in their own language and also in alternative formats. And I believe strongly this should extend to someone who has both those needs, for example, someone who speaks Russian or Chinese and is visually impaired. They should be able to get their language in a large font print. Also with accessibility rights. There is a right to reasonable

modifications to enable people with disabilities to gain full and equal access to have services, services in the plan provider network and all the services that you should get under Medi-Cal or Medicare. Physical accessibility is required. I actually think this is to a level of undue burden giving ta we're talking about public programs where federal and state funds are flowing through to provide them and the plans. Plans are required to receive training on disability discrimination and cultural competency and this has been happening. And also information about provider offices, accessibility provider offices, physical accessibility, is supposed to be available in plan directories.

So I think that as advocates we have some concerns about how this is actually monitored and enforced, but the consumer protections do exist and it's important for beneficiaries, for members and their advocates to know that they are there.

And I'll just stop there to ask if there are any additional questions?

>> Amber Cutler: There are no additional questions. Silvia, I think we did a fantastic job.

>> Silvia Yee: Well, we've lulled people into a sense of --

>> Amber Cutler: Or put everyone to sleep.

>> Silvia Yee: Right.

>> Amber Cutler: So here is information for local advocates assistance, and as soon as we have the independent ombudsman office up and running, which is supposed to happen by April 1st, that would be an additional source for assistance for consumers, so there's the HICAP, which will be listed on the notices and the Health Consumer Alliance and Disability Rights California. And then sheer information about our two organizations. You can find links and alerts on the web pages. Our next CCI basics presentation is taking place on December 17th at 3:00. If you have questions, feel free to contact either Silvia or I at our email address. And I really appreciate everyone participating and if you have questions, email us. Thanks!

Thank you, Silvia!

>> Silvia Yee: Thanks, everyone. Thank you, Amber!

[Conclusion of webinar program]