CCI Stakeholder Advisory Committee Meeting
Friday, April 28, 2017
1:00 pm – 3:00 pm
Meeting Minutes

Welcome and Introductions
Bobbie Wunsch, Facilitator

Ms. Wunsch began by asking the committee members to introduce themselves. Those in attendance and seated at the table were:

Amber Christ, Justice in Aging
Deborah Cherry, Alzheimer's Greater Los Angeles
Raffie Barsamian, SynerMed
John Kotick, St. Barnabas Sr. Services
Eileen Harper, Center for Healthcare Rights
Maria Lackner, L.A. Care
Misty De Lamare, L.A. Care
Bruce Pollack, L.A. Care
Hanan Obeidi, L.A. Care
Dwayne Broussard, L.A. Care
Erika Estrada, L.A. Care
Nairi Varteressian, L.A. Care
Francisco Oaxaca, L.A. Care
Mariah Walton, L.A. Care
Denise Colomé, L.A. Care
Deaka McClain, L.A. Care Member

Approval of the Minutes
Bobbie Wunsch, Facilitator
Ms. Wunsch drew attention to the minutes from the previous meeting, held December 8, 2016, and gave the committee an opportunity to ask questions, inviting them to make any changes, if they felt it necessary.

DHCS CCI/Cal MediConnect Program Updates
Hilary Haycock, Harbage Consulting

Ms. Haycock talked about some of the work that is being done to help make sure that CMC is sustainable and that it's working and serving its members, including creating strategies to ensure members are receiving sufficient LTSS services, and looking at how plans can work with members experiencing homelessness. She also gave updates on enrollment, provider outreach, and the two months of deeming. Lastly, she introduced the newly relaunched calduals.org, which has been revamped to be more consumer friendly.
Q&A

Ms. Cherry: Would it be possible sometime to hear a summary of what happens with the dementia informational bulletin from CMS, how the plans are responding to it, and how it might be moving things forward or not? It would be great to hear that kind of summary.

Ms. Haycock: I think the state and CMS are still working through the data provided by the plans. It's still a work in progress, but as it gels, I will make sure we're keeping plans in the loop.

Ms. Wunsch: Deborah had asked if we could put the informational bulletin on the agenda for this meeting, so we will do that for the June meeting and ask Deborah to lead that conversation. Hilary, if DHCS is ready by then with any comments, that would be great, but if not, we'll have an educational discussion here among the members [of this committee] and be ready for whenever DHCS is ready.

Ms. Christ I have two questions for Hilary, and then some questions for L.A. Care that came out of that update.

First, you said the two-months deeming period was largely in place for L.A. County, and I was hoping you could specify what you meant by "largely in place."

Ms. Haycock: As far as I understand, all of the L.A. County plans have implemented. I haven't talked to the department about this specifically lately, but I think there was one plan in Northern California that is still working on implementing.

Mr. Pollack: We can confirm that it is in place at L.A. Care, and has been as of April 1. Hilary, as you may know, this has all been done over the phone, and the health plans are rather insistent with DHCS and CMS, can you please confirm *in writing* that this is in fact the process that we are following? But it is in place today.

Ms. Haycock: Thank you for working with us. I have shared similar sentiments.

Ms. Christ: We agree that it would be great to have in the contracts and maybe in the plan letter some guidance, but we understand the challenges there.

The other question I had has to do with the performance dashboard, and the revamped performance dashboard. I was wondering if you had a launch date in mind.

Ms. Haycock: I don't want to make promises I can't keep. We have made some really great progress on it.

Ms. Christ: For L.A. Care: For the notices that are going out on a rolling basis to newly eligible Medi-Cal beneficiaries, or new duals, I was wondering if you have a sense of how many that is a month. Also, what proportion of those are going into CMC, versus Medi-Cal only, or MLTSS plan?

Mr. Pollack: I'll answer a somewhat related question. As you may recall, notices were issued in the November/December timeframe for remaining fee for service CCI members regarding passive enrollment into a Medi-Cal managed care plan. They were also given the opportunity to select a CMC plan. The passive enrollment was supposed to be completed in February. It kind of trickled in through March. Among L.A. Care and our plan partners, we saw about 15,000 beneficiaries who were passively enrolled in our health plan for their Medi-Cal benefits. We were delighted to see more than 1,000 beneficiaries in the same timeframe, who completed their choice forms and joined L.A. Care for CMC. It's hard for us to see on the eligible file we get from the state who's new to Medicare versus who's new to Medi-Cal because they've now aged in. I don't have

that statistic. I'll commit to looking for it.

Ms. Christ: Regarding streamlined enrollment, now you have all these new members coming into your MLTSS plan, and I was wondering what is the outreach strategy and schedule for those people. You don't want to immediately contact them and ask them to join. But then I'm wondering, what kind of schedule do you have in order to do that outreach? I know you want to use that streamlined enrollment process, but not have too many touches.

Mr. Pollack: It's a measured, targeted, and multiple step approach. We don't do this for all new Medi-Cal members, but we do some outreach to those who may have been confused. We welcome them to L.A. Care as a new Medi-Cal beneficiary, and make sure there aren't any unanswered questions about services they may have been receiving on a fee for service basis that they are now going to need to work through the health plan to receive. In April the State provided us with historical fee for service claims for Medicare and Medi-Cal for open treatment authorizations for the new members, and we are evaluating it in order to identify any potential gaps, as well as to identify any new duals who might coincidentally be receiving their medical benefits from a physician who is a member of our CMC network. They're going to get a call, an outreach letter, and promotional materials. We are also working with our network physicians, and our CMC groups so that doctors can encourage patients to join.

Ms. Christ: Regarding the nursing facility plans, I was wondering if you were going to share that plan. What is that going to look like in terms of engagement with stakeholders and just releasing that plan generally so we get an idea of what kind of best practices you're employing to improve those outcomes?

Mr. Pollack: I'll commit to respond to that in a future agenda. We welcomed Dr. Richard Seidman, our new Chief Medical Officer this week—this is something he can address.

Ms. Haycock: Amber, I will tell you that Martin is working with CMS. We'll put a high-level summary document together, so we'll have that out.

Ms. Wunsch: We'll make a note to see if we can have that on the next agenda in June.

Ms. Cherry: This is just something to think about, but there are some evidence-based programs that seem to decrease hospital readmissions. Like the Coleman model with the dimension overlay, the Bridges model. These are randomized, controlled trials that show that these kind of interventions that are heavily care management-centric could reduce your readmissions and improve care.

Mr. Pollack: There's always been some general focus on concerns and specific monitoring of 30-day readmissions, and I'm going to talk a little later on in the program today about something we're doing to try to avoid unnecessary ER visits and hospitalizations.

Ms. Harper: Right now, in terms of folks who are newly Medi-Cal or newly dual eligible, do you have a rough idea of what is the timetable before those folks are assigned to a Medi-Cal plan in L.A. County? For example, let's say we have a Medicare eligible beneficiary who becomes Medi-Cal eligible in April. I assume they are getting info on how to select their MLTSS plan. If they do nothing, what is the timetable before they would be assigned to a plan?

Ms. Haycock: I don't know exactly when they become eligible. There is always a period when they're in fee for

service. I think that when they get the packet from DHCS, which they send out as soon as they get the eligibility files from the county. We tend to say the process runs about 45 days. It depends on when in the month they receive the packet. I'd be happy to try to nail that down more specifically and follow up with you.

Ms. Harper: Do you have an idea of the number of people each month that are entering into MLTSS plans in L.A. county?

Ms. Haycock: I have not been able to get that number from the department, but I will let you know if we do.

Ms. Lackner: Hilary, I'm not sure if the healthcare options process for new members is similar to CMC, but it's my understanding that there is a default date on the member communication, when they would be defaulted into a health plan. Can you confirm that?

Ms. Haycock: Yes, I believe so.

Ms. Lackner: So, Eileen, does that answer your question?

Ms. Harper: Most don't even know if they got a packet, so if you reference the date on the packet….

Mr. Pollack: Generally, there would be something like 60-day notices, so if someone has an effective coverage on May 1st, Hilary, do they get a notice saying they're eligible, or do they get a notice in February saying, "You're *going* to be eligible?" That might be for an age-in situation where someone is on Medi-Cal and becomes Medicare eligible.

Ms. Haycock: The way this ongoing MLTSS enrollment is going is with folks that are entering Medi-Cal, the department is still trying to work through some data issues around getting notification from CMS about folks entering Medicare in time to be able to adequately notify them. This is around part D rules and things like that. The folks who are receiving these notices from DHCS are already on Medicare and they are gaining Medi-Cal. It's more like the situation Eileen brought up. I will find out how long it takes to get their packet. I have confirmed that the packet that comes, there's a resource guide that explains what CMC is, that explains that they'll be defaulted into MLTSS, that they have the option to go into PACE. And then there is the choice booklet that goes with it that does have a date by which folks can understand they can choose a plan any time before that time, but if they do not, they will be defaulted. It tells them, as well, what day the plan would be active. I'm happy to send a link so that folks can read that language, if that's helpful. I feel like the packet hits folks at least 45 days ahead of time. I will confirm that and follow up with Eileen.

Development of the Medi-Cal Evidence of Coverage (EOC) DHCS Model Documents
Maria Lackner, Director, Medi-Cal Product Administration

Ms. Lackner gave an update on the work that is currently being done by DHCS on the Evidence of Coverage model documents.

Q&A:

Ms. Christ: I agree with everything you said, particularly concerns that the EOC was very tailored for an SPD and took very little variation in terms of CCI counties or duals, so we, too, urged the state to adopt separate templates. It's good to hear that L.A. Care is pushing for that and will continue to do that in the future.

Mr. Pollack: I appreciate your support on that. I also want to be open with this group: as we've talked with the state, there's an expectation that with the mega rule coming into effect on July 1st, that new model documents will be mailed to all our Medi-Cal beneficiaries annually on July 1st. Given the practicalities of the timing, that we won't have the model documents until mid-May, and that we'll then complete our variable language and submit it for review, and then go to a threshold language translation, printing, and distribution, it is unlikely we'll meet a July 1st mail date, but we'll do the best we can.

Ms. Wunsch: We'll have an update on that in our June meeting; we'll put it on the agenda.

L.A. Care's Plan to Increase Accessibility

Hanan Obeidi, Director, Medi-Cal Administration, SPD/CCI

Ms. Obeidi discussed L.A. Care's short term and long term plans to increase members' accessibility in clinic exam rooms around the county.

Q&A

Ms. Harper: You said about $15,000 is allocated. Do you have a sense of the amount of equipment you need to meet the demand? Are we just talking about exam tables? Or are you talking about other types of changes?

Ms. Obeidi: Let me clarify: We are hoping to fund up to 15 grantees, organizations, and that would roughly be up to $350,000 for this grant cycle. What would that include? It's hard to say. It's largely for accessible equipment. I'd have to ask Lisa Kodmur. Perhaps she has a better idea of how much some of the equipment may cost. It varies between $4,000 and $8,000.

Ms. Kodmur: The grantees were told that in their proposals they could request either height adjustable exam tables, which are about $5,000 each, or platform style weight scales for people who can't step onto a regular scale because of balance or because they might be a wheelchair user. They were also told they could order other types of adaptive equipment or even minor modifications to their clinics. These are all Federally Qualified Health Centers that had to apply. Each request is slightly different, based on the need expressed by that clinic, and then once the applications have been reviewed and the first round of selections have been made, L.A. Care will also send consultants to each site to help them really understand from an expert what accessibility means, what type of equipment would be best for them to purchase based on their space, and their needs, and their population, how to use that equipment, how to make sure the patients who need it get tracked into that exam room, all these things that L.A. Care has learned from running these types of grant initiatives in the past. This will be the third time the organization has funded this type of equipment, and these types of grants for clinics and for the safety net.

Mr. Kotick: In terms of accessibility, have you done an assessment of accessibility needs of all your providers? Not just clinics, but individual providers, as well. Also, what programs will you have to assist individual doctors or medical groups in the acquisition of exam tables, and are you also looking at facility accessibility in terms of the width of doorways, ramping, etc.?

Ms. Fernandez: We do a Physical Accessibility Review Survey (PARS Assessment) for all of our PCPs in our network for Medi-Cal and CMC. That is infused with the FSR assignments, so whichever plan is assigned to a particular PCP site, they will also do a PARS assessment for that site location. We also do PARS assessments on our high volume specialists, which is run by encounter data that we do on an annual basis for both our SPD population and our CMC population. We submit that report to DHCS on an annual basis. We do CBASs, SNFs,

urgent cares, non-hospital-based radiology centers, and high volume behavioral health providers, and dialysis. Those are the ancillary services we do at this time. I know there are a lot more out there, but that hasn't been identified as high volume at this point. L.A. Care can do a PARS assessment on any of our providers.

Meeting Attendee: Do you do pharmacies?

Ms. Fernandez: No, not pharmacies.

Mr. Kotick: Accessibility equipment is one piece of the puzzle. The second piece of the puzzle is the training of the facility staff on the use of the equipment. Could you also comment on the work to actually train provider staff and provide that education on an ongoing basis so that new staff coming to the facility will know how to actually use the accessible equipment?

Ms. Obeidi: We do offer provider training, especially when PPGs and providers sign on, and there are toolkits to help providers with that type of training on information and awareness. We hope to expound upon that in the future, the point you're raising is about ongoing training and education, so as there is office or facility turnover, new staff would have that level of understanding on an ongoing basis, that's part of our mid-term plan, to ensure that all the training is updated in that facility and that staff are aware of all the updates and info they need to know to help members.

Mr. Pollack: Keep in mind, with L.A. Care's delegated model, we can help develop training material, but we will have to delegate to the PPG the responsibility for the ongoing training of their staff.

Ms. Christ: Regarding grants and opening it up to safety net providers, I think that's great, and safety net providers should get that funding. I was thinking about duals and the disability community itself usually has Medicare, and they're not as likely to use the FQHCs. So they aren't getting the accessible providers and so the grants aren't going to the providers who are more likely to be serving that population.

Ms. Obeidi: That is a good point. Generally speaking, our community benefits provide grants to the safety net, not just a PPG or private provider. We are looking into that, but at this point it is mainly for safety net providers.

Introduction to New CCI SAC member

Bobbie Wunsch, Facilitator

Ms. Wunsch introduced Deaka McClain, welcoming her to the CCI Stakeholder Advisory Committee and invited her to tell the group a little bit about herself.

L.A. Care's Work in FSR Workgroups

Dulce Fernandez, Senior Manager, Facility Site Review, L.A. Care

Ms. Fernandez spoke about the Facility Site Review Workgroups and the collaboration with our plan partners for the PARS assessments.

Mr. Kotick: We've been talking about the ability to provide accessible equipment to community health centers and providers. Is there any discussion on the state level of incentivizing, either by payment or reimbursement to providers to add accessible equipment to their practices?

Ms. Haycock: Not that I'm aware of. I doubt it. If I'm wrong about that, I will let Bobbie know. I think the department is very focused on gathering data about what accessibility exists, and more specifically where it exists, and make that data available to beneficiaries.

Ms. McClain: Something that came up at ECAP about accessibility, we're happy we're at this point right now, but as we all know, it needs to go a little further, to the state level, the federal level, to add this component to the ADA. Would it start at the state level to have this conversation? We shouldn't even be sitting here discussing this; it should be automatic according to the Americans with Disabilities Act.

Ms. Haycock: I'm not sure about it being automatic. I think the ADA has really clear requirements around accessibility and the department is working on a number of workgroups to help make sure that folks with specific needs have better information so they can identify providers that can meet those needs. At the recent L.A. Stakeholder meeting there were some really compelling personal stories about the difficulties that those who live with a disability face in trying to access healthcare. I think that any time they experience that type of a hiccup—And I say hiccup, but it's not a hiccup; it's an extreme disruption to spend all your time trying to arrange transport to get to a doctor's office, and then not be able to be accommodated. To have to go without receiving screenings because you cannot identify a facility that can accommodate you. That clearly is a challenge, and as I said, the department is working really hard with these workgroups to try to help ensure that folks have the information that they need so they can identify and access the providers that can meet their needs. This is something the department is committed to working on.

To give you a sense of who I am, nice to meet you, I'm a guest of today's meeting. My name is Hilary Haycock. I work with Harbage Consulting, and we are supporting the department's implementation of the CMC program and CCI. So we are helping on the policy side, trying to think of ways that we can help make the program work better, and we have a team of outreach coordinators who are in the CCI counties, including Los Angeles, who are doing on-the-ground outreach to beneficiaries and providers.

Ms. McClain: Thank you very much, and I just want to add: I understand about the ADA, and I understand how it's supposed to help people with disabilities, but I'm irritated with a specific issue. When I've done my research -- if anyone in the room who knows what I'm talking about can help me out, that would be great – There's nowhere in the ADA pertaining to medical facilities where it is mandated under the ADA that they have to have accessibility tables or equipment. That's the part that I'm trying to angle and ask what can be done for us to start the conversation so that we can get it to the federal level to put that in that. We shouldn't be sitting here having this discussion because it should already have been in there.

Ms. Wunsch: Deaka, Amber is another advocate. Perhaps she has some perspective on this.

Ms. McClain: Thank you. Hilary, I apologize, I'm very passionate about this.

Ms. Christ: The ADA talks about having to provide accessibility for people with disabilities, but as to the specifics, that you have accessible exam tables, it's to the extent that it can be accommodated. So you can't require buildings and all of those things. I agree that in order for…. At the federal level we're probably not going to get changes to the ADA. I do think at the CA state level, and it's happened before here, that we have stronger accessibility and disability protections, so I think we can continue pushing in there. Also, Disability Rights California and Disability Rights Education and Defense Fund, those two advocacy organizations in CA are really active on that front. To your point, I agree, we are how many years post-ADA, and we are still having conversations about whether you can get into a doctor's office. So I think there's a lot that we need to continue to do. I like these conversations here at L.A. Care, it's good to hear that they're committing to that. But as much as we can push, we should be pushing. To that point, we had a major Stakeholder meeting recently. Accessibility was on the agenda, and Hilary brought up really compelling stories how people couldn't

get access to their providers, and PASC, the Personal Assistant Services Counsel would love to do a tele-town hall with the Plans about accessibility so maybe a higher level, talking about the ADA, California state-specifics and then what the Plans are doing to increase accessibility for individuals. Doing that would be really helpful because it reaches IHSS assessments and our caregivers.

Ms. Wunsch: Deaka, thanks for jumping in. This is exactly what we were hoping for, and now we don't have to worry because we know you're not shy.

Updates:

CLTCEC Grant

Bruce Pollack, Executive Director, Medi-Cal, SPD, CCI, L.A. Care

Mr. Pollack discussed the California Long Term Care Education Center grant, which will provide training for IHSS workers who are caring for L.A. Care members.

Q&A

Ms. Cherry: I applaud you all for doing this training. Do you know if they are going to use the same curriculum for you that they used in the CMMI Innovation run?

Mr. Pollack: We cherry-picked the curriculum. We thought, "What's really best-targeted for our population?" We're going to be using about two thirds of the curriculum. There's no new material in particular that will be included in the curriculum other than a module that will focus on our model of care, and a little bit more about care coordination in a managed care setting.

Ms. Cherry: When I think of that, I have some familiarity with their original curriculum, and I think they did a great job with that project. What I would say is if you're going to do this, in essence, I think 65% of homecare workers are family members.

Mr. Pollack: 70% in L.A. County.

Ms. Cherry: A large number of the seniors in this program have dementia. I would hope that you kept the part that was on dementia. I would love you guys to encourage them to work with us as they seek trainers because Alzheimer's Greater Los Angeles is a recognized expert in providing this kind of training, just on the dementia part of their curriculum. And we like working with them.

Mr. Pollack: I'll check on the dementia module in the curriculum. We know that 70% of the home care workers are family members, and that 60% of the workers have at most a high school education. So there's really a lot of thought and effort going into tailoring the population for the educational level of the person who is receiving the training. We have to be sure that we have the consent both of the worker and the member to participate because it's not just a classroom training for an individual provider, it's inviting the member into the classroom, too, so there is hands-on training for the beneficiary an the provider in the classroom.

Ms. Cherry: Because of CMC and because of the requirements around literacy level, we have developed materials that we can provide to CLTCEC to educate workers at about a sixth grade level on management of different challenging behaviors with dementia, such as wandering, combativeness and things like that. So they may not think to ask for that, and we have it accessible to them, and if you have any way to encourage them to work with us and use our materials, we'd love it.

Mr. Kotick: There's been an issue that's been percolating over the last five or six months in the IHSS community, and that's the issue of payment. Workers are not getting paid in a timely manner. As a result, their clients are losing their caregivers. I know that 70% are family members. Those family members also need to get paid on time. In the threads and the discussions and the material I've been reading, there are issues of workers sometimes not getting paid for multiple weeks or months after they start working for a client. It would be great if you could keep your ears open for that issue among your membership. Deaka may have picked up on that issue.

Ms. McClain: It has been brought up in my circle about the time sheet, as far as more accessibility, especially for visually impaired clients or people that are blind, they're trusting their worker to be honest, but they're having to sign it, and, and they can't see. I know that's in the works to try to work on making that better; I'm just hoping that we're continuing that conversation. I don't know how new this is, but they've gone and changed it, and it seems to be difficult in how they look and how to fill them out. That has been a running problem.

Also, I want to add to the curriculum, is there anything about domestic violence, abuse? That is an ongoing conversation. I'm willing to help with that, as far as research or help with training, if need be. That's also my area. My biggest beef with that part is when you talk about domestic violence upon seniors and people with disabilities, it always comes up about the caregiver, how they abuse them. I'm here to say that yes, that's an issue. But not everybody has a caregiver. They do have wives and husbands, and they are a vulnerable population. There needs to be a continual conversation to help them protect themselves, and they don't have to feel vulnerable when it comes to domestic violence.

Ms. Wunsch: John, I'm sure L.A. Care staff will keep their ears open on that issue, whatever influence they may have. Deaka, we'll ask Bruce to follow up on the issue of family violence in the curriculum and how that's being addressed and report back at the next meeting. It may be that at one of our future meetings we can have Corinne come and talk about the program, so everyone can know as much as a couple of you do.

Action Item Log
Maria Lackner, Director, Medi-Cal Product Administration

Ms. Lackner took a few minutes to review the issues on the Action Item Log.

Q&A

Meeting Attendee: On the crossover claims question, that was asked back in March 2016, but now the mega reg will require that of all Medi-Cal plans, and I can't remember when that implementation date is. That might be next year. I'm wondering if that's expedited your process in getting this taken care of.

Ms. Lackner: The provision in the mega reg goes into effect July 1, but there is some latitude for the State to provide more specific date for plans. I can tell you that we are working internally on policies and procedures around this piece, as a result of the mega reg, and we had already begun working on it, so we anticipate that we'll be able to meet this expectation by the time the State pulls the trigger for this.

Ms. Harper: The crossover claim will certainly happen if it's a Medicare fee for service person, but what if it's an MA plan? So let's say there's some other MA plan, will the crossover claim process work in that instance

where it will go through the MA plan as primary and then to you as secondary?

Ms. Lackner: That's the intent. It would as any other coordination of benefit process.

Ms. Harper: But how would that occur? Something has to be generated on the MA plan level. What's going to generate that?

Mr. Pollack: Based on our eligibility files from the State, we'll know if someone is a full dual or a partial dual. We'll know if there is other coverage available, and what Medicare coverage they have. So when we receive a claim from wherever we receive it, if we know that there is a Medicare payable portion of that benefit, then we're going to suspend the claim or we're sure we receive the explanation of payment from the primary Medicare provider.

Ms. Harper: If it's a capitated model, how would that get generated?

Mr. Pollack: If it's capitated mode, and the service is fully capitated, then there should be no Medi-Cal payment.

Ms. Harper: What level in the plan is going to generate that claim?

Mr. Pollack: Even in an MA model, if there's a Medi-Cal payable portion from a hospitalization or some other benefit, if it gets to us, we'll pay the Medi-Cal payable piece. The other point I was going to make was that there may be some members of an MA plan, beneficiaries that have available to them Medi-Cal only benefits that they'll get as CCI members, such as CBAS, there is no Medicare payable portion of that, so that doesn't generate a crossover claim.

Ms. McClain: On number 4, the date seems kind of old. I was wondering why this is still open. Does this include Medi-Cal? Let me use an example: As of right now, you have transportation, and if you have a dental appointment, then the transportation won't be provided from L.A. Care to go to the dentist office?

Ms. Lackner: Under CMC, where CPO services are a benefit or a service provided, there are additional transportation, as well as dental and vision benefits, above and beyond what are offered by Medi-cal. As long as it's a covered benefit under CMC, then transportation will be offered.

Ms. McClain: So why is it still open?

Ms. Lackner: We're still in the process of gathering information on the non-dental-covered benefits.

Ms. McClain: So we're trying to find a way to include them?

Ms. Lackner: We're waiting for guidance from the State as to how to handle this.

Ms. Harper: One other issue we're also seeing, and I think we have and some discussion relating to the CMC dental benefit and its relation to the Medi-Cal dental benefit. I think the MA plans also have other optional benefits. For example, one thing we're seeing now is with the hearing aid benefit. Frequently there are copayments on the MA hearing aid benefit. How does that detail with Medi-Cal plan cost sharing? It's obviously an optional benefit, so it's not a Medicare-covered benefit, but it is a Medi-Cal covered benefit. Have

you guys gotten any direction for DHCS on those types of issues?

Mr. Pollack: I'm not aware of any specific guidance on that. Having had direct involvement in L.A. Care's recent core system conversion and system upgrades, I'm quite comfortable to know that, given the claim, that Medi-Cal would pay, knowing what the Medicare portion of payable was.

Ms. Harper: In this case, it's not a Medicare-covered benefit; it's an optional benefit under the plan. Hearing aids are not Medicare-covered.

Mr. Pollack: But there is something covered under Medi-cal. It gets harder to process when it wasn't a Medi-Cal provider that ordered the hearing aid.

Ms. Harper: In the cases we have right now, they are Medi-Cal providers.

Mr. Pollack: Then that should make it simpler in terms of the claim being processed. If you're aware of a specific payment issue for an L.A. Care member, I'll gladly follow up and make sure it gets reimbursed. I'm concerned, as well, in the broader issue and that all these get paid properly.

Meeting Attendee: Eileen, is it possible that it's incumbent on those MA plans to refer these members to their Medi-Cal plan for Medi-Cal covered services instead of ordering them something that they then are going to have a copay for out of their own pocket.

Ms. Harper: That's not really accurate because, remember, Medi-Cal is the payer of last resort, so if you have something covered by your MA plan, that comes first. So if you have a hearing aid benefit in your MA plan, you should use that first before you use your Medi-Cal.

Mr. Pollack: We do have similar challenges with DME, in particular certain wheelchair payments, and some is covered by Medicare. In that case often it's the Medi-Cal provider that didn't order the service, but we work though those.

Ms. Christ: It happens a lot in dental, too. It shouldn't happen in CMC, which I think is the benefit of CMC, but if you're in an MA plan that has supplemental dental, it will overlap with what you have in Denti-Cal, and my guess is that those individuals are paying for services that would have been covered under Denti-Cal, which is not accurate. The MA plan is responsible, technically, fiscally because they're being improperly billed, they're balance billed, but that's an education component. Is there a way to improve also, from the Medi-Cal side, that education? It's a problem with the supplemental benefits.

Ms. Harper: I brought up the issue, not so much that I expect L.A. Care to resolve it, but I think that this warrants discussion in terms of DHCS and CMS in terms of getting some guidance on it.

Ms. Lackner: Unfortunately, what you see is the member ends up being caught in the middle because they have a copayment that they were misinformed or misdirected, that their Medi-Cal plan would pay. We can pay, but if the MA plan is saying that they're covering it with a copay, then that's making the assumption the Medi-Cal plan is going to pay the copay.

Ms. Christ: That's on vision, not dental. It's Denti-Cal. That's carved out, which makes it even more complicated.

Mr. Pollack: I'm proud to represent L.A. Care nationally on the Board of the National Managed Long-term Supports and Services Health Plan Association, along with other health plans nationally, including Molina. We're all advocating for more integrated Medicare/Medicaid benefits. This is so much simpler to administer when there aren't separate plans. We want to make it more seamless for the beneficiary. A number of national associations are really trying to advocate for more care coordination and integration.

Mr. Barsamian: I think hearing aids, for several years now, have been a balanced billing issue, too. You can go to a local hearing aid store, and that provider or store owner doesn't always know they can bill Medi-Cal, and they end up giving the beneficiary the bill. Then they're stuck with it, and they end up paying for it because they don't know that they have an option. This is a much larger question, not easily resolved.

Regarding Item #4, CPO services are beyond just dental, vision, and transportation, right? So the question of, let's say, home modification, if it's not covered under CMC, then you go to a community resource, but that community resource isn't available or doesn't have capacity, then from my understanding, the health plan has the option to pay for it, under CPO, to provide that home modification.

Ms. Lackner: That is correct.

Mr. Barsamian: I didn't see that referred to here. It seemed like it was more transportation, dental, and vision-specific, but it does include home modification.

Ms. Lackner: I think, at the time, of the meeting, these were the three examples that were spoken of, so we made an effort to answer the three that were discussed at the meeting, and not go into the whole list of CPO services. You're right, there are more services, including home modification. If it's warranted by the member, the plan will look to community resources first. If those are not available, then the plan steps in.

Ms. Cherry: I believe that Gretchen Brickson was also speaking of respite at that meeting. I wouldn't want it to be left off the list.

Ms. Lackner: That's another reason why it's still open. I'll make sure we add home modification and respite to this piece, and next meeting we'll add any additional commentary around those two services.

Q&A Session/Public Comment
Bobbie Wunsch, Facilitator

Ms. Ballew: I want to let you know that you just got two for the price of one. Deaka and I run side by side with a lot of opinions, and we're not shy about speaking up about a lot of issues. I'm thrilled today with what I heard because everything you tapped on today, we've been pushing and trying to encourage the ECAC and getting things up to the Board of Governors, to the people who have the power to address these issues. We're the ones who are on the front lines who are listening to the people who have these problems, so both of us really try to do what we can to assist in helping the people we go back to and live with. Neighbors and family members. We want to be able to answer those questions correctly and not have it drag on and on and on. I'm thrilled. Thank you.

Ms. Lackner: Really quickly, going back to the action item log, Item #1, we were requesting the committee to let us know if this is still something that you would like to see as a future agenda item. Brenda Primo who attended one of our last meetings suggested maybe having SCAN foundation at our next meeting to discuss the

Universal HRA assessment. Is that still something that's of interest to the stakeholder committee members to have as part of an upcoming agenda?

Ms. Cherry: It seems to me that it may have moved away from SCAN and gone over to the Department of Health Care Services. It might be something that would be more appropriate for Hilary to address. I wouldn't mind hearing how it ends up because by then it will be finalized.

Ms. Lackner: What we can commit to doing in order to close this item out, we can reach out to our DHCS contact for our contact, and have them provide us the state update on this piece at our next meeting. If that's okay with the committee.

Misty De Lamare: I wanted to propose a future agenda topic. One of the things I would love to present to this group on is our CCI Councils. I know that we are probably all aware that these exist. Deaka and Wilma are on those councils, but it's kind of the counterpart to this group, and so we would love to share with you information about the CCI Councils and how we use them to collect feedback and ensure that our members' voices are heard.

Future L.A. Care CCI Stakeholder Advisory Committee Meeting
June 22, 2017