CCI Stakeholder Advisory Committee Meeting
Thursday, March 10, 2016
1:00 pm – 3:00 pm
Meeting Minutes

Welcome and Introductions
Bobbie Wunsch, Facilitator

Ms. Wunsch asked the committee members and other participants to introduce themselves. In attendance and seated at the table were:

Demetria Saffore, L.A. Care CMC at Large Member
Aileen Harper, Health Care Rights
Denny Chan, Justice in Aging
Eileen Koons, Huntington Hospital
Peg Bernardy, White Memorial
Karen Widerynski, California Association of Health Facilities
David Kane, L.A. Neighborhood Legal Services
Jennifer Schlesinger, Alzheimer's Greater Los Angeles
Marie Mercado, L.A. Care
Gretchen Brown, L.A. Care
Maria Lackner, L.A. Care
Bruce Pollack, L.A. Care
Beau Hennemann, L.A. Care
Gretchen Brickson. L.A. Care
Nai Kasick, L.A. Care

Audience members in attendance were:

Fred Munoz with Harbage
Amanda Steele, SEIU
Marjory, Brenda Premo's driver
Raffi Barsamian, Synermed
Brenda Premo
Esther Sefilyan, Partners in Care
Teresa Hernandez, Huntington Hospital
Russell Mahler, L.A. Care RCAC Member
Jaime Garcia, Hospital Association of Southern California

Cindy Dizon, LTC Network Manager
Catherine Knox, Regal Medical
Elise Pomerantz, Regal Medical
Elizabeth Norris-Walczak, County of L.A. Public Health

CCI/CMC Program Updates: Governors Proposed Budget

Sarah Brooks, Executive Director, Health Care Delivery Systems
Department of Health Care Services (DHCS)

Ms. Brooks discussed the State budget and its potential impact on the Coordinated Care Initiative, as well as the newly approved MCO tax. She also talked about recent surveys and case studies conducted by the Scan Foundation of Cal MediConnect beneficiaries. In addition, she gave a brief report on current enrollment in the Cal MediConnect program and touched on upcoming enrollment strategies to not only retain current beneficiaries, but to bring new enrollees to the program.

Ms. Brooks then introduced the new "Cal MediConnect Quality" dashboard which reports data on health risk assessments, appeals by determination, hospital discharges, LTSS utilization, and case management. Additional information will be added as it becomes available.

Finally, Ms. Brooks discussed tool kits for providers and beneficiaries, some have been posted to calduals.org, as well a toolkit for LTSS that is being sent through beneficiary testing.

Q&A

Ms. Harper: Is the DHCS looking at any changes to increase Cal MediConnect enrollment for 2016?

Ms. Brooks: We are going to roll out an enrollment strategy in the very near future, likely in the next few weeks to a month that will be focused on both maintaining individuals in the program, looking at the options for individuals who may lose coverage for a short period of time, how do we maintain those individuals on the program. But also looking at what are the supports that we can provide to our health plans with relationship to doing outreach and enrolling individuals and looking at other ways that we can increase the enrollment by looking at eligible populations that may not currently be enrolled Ms. Bernardy: What is happening in regards to those individuals that are homeless and their discharge plans?

Ms. Brooks: Part of the intent of CMC is to provide wrap around services for individuals and identify resources and referral opportunities for individuals. In particular, someone whose homeless, where we can be referring individuals to receive services.
Ms. Bernardy, is there a plan for recuperative care for beneficiaries who cannot be accepted in SNF's because they have no discharge plans?

Ms. Brooks: I would need to do a little more research to see what the discussion has been around that but would also like a bit more information from you on examples. Everybody should have a discharge plan.
Ms. Bernardy: When you have a homeless patient, even if they need SNF placement, our experience and many of my colleagues' experience is that if they're going to return to the street, the SNF does not consider that a discharge plan, and they will not accept the patient on the front end. So they're not getting the care that they need.

Ms. Brooks: And have you reached out to the health plans to talk with them specifically about that?

Ms. Bernardy: Quite a few of them, yes.

Ms. Koons: Our agency has difficulty with discharge plans when it involves a younger Medicare beneficiary who is dual eligible who has severe mental health issues. If they need SNF under Medicare, it's going to be very difficult to place the patient.

Ms. Wunsch: Gretchen or Maria, do you want to comment from L.A. Care's point of view? Ms. Lackner: These are really great questions, and I know that we've been hearing about some of them in past meetings. I know we do have discharge plans for different populations, not only within CMC, but also within CCI, and I want to make sure we get the right folks in the room to share with you what that looks like. So if it's okay with the group, we can either follow up with the committee in writing following this meeting, with some additional information, or we can set up an ad hoc meeting to get some of this information to you before our next meeting.

Ms. Wunsch: I think also it might be worth putting the issue of working with homeless individuals on our agenda so the whole group can hear the broad continuum of work that you're doing, and what the members around the table are doing also.

Ms. Brown: I think that's a really good idea. I know that we are working on a lot of issues around behavioral health. I think there's a lot going on in terms of LTSS for the homeless population, so I think that's the best thing we could do, unless Gretchen or Beau have anything they can add.

Mr. Hennemann: I think it's best that we bring a couple other people into the next meeting and put it on the agenda.

Ms. Widerynski: Ms. Brooks, can you speak to the managed care provider data network improvement project? Any thoughts on how this will impact providers, and then is it going to directly change our reporting?

Ms. Brooks: the managed care provider file project is being implemented on the Medi-Cal managed care side as opposed to CMC. Currently, health plans are required to report their network to us monthly, but we do receive multiple different files from them. The provider file would consolidate all of those different reporting templates into one monthly file. It would require the plans to report through what's called a 274 transaction format, so it essentially allows them to upload their network information to our system. We are not imposing any requirement specifically in relationship to providers, but how the health plans determine that they need to collect the information from the providers would be determined by the individual health plan.;

Mr. Chan: Regarding the new enrollment strategy you're unleashing within the month, to what extent will there be stakeholder feedback? What's the process for that?

Ms. Brooks: We'll be releasing it, and there will be some components of it that will need stakeholder feedback, and that will be part of the larger rollout that we do.

December 2, 2015 Meeting Follow Up
Rina Cruz, Medicare Operations

Ms. Cruz addressed a previous question regarding language availability for enrollees who wish to sign up for new member orientation. Because specialists at the Family Resource Centers where the orientations are conducted only speak English or Spanish, if a new member requires a different language, then the representative will arrange, through the Plan, to have a translator on hand to help them with the orientation. The orientations are normally scheduled ahead of time, and one of the questions asked of the member is which language would they like to receive their orientation in.

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Medi-Cal Only Duals Initiative: Update

Beau Hennemann, Sr. Manager, Home and Community Based Services
Maria Lackner, Sr. Manager, Medicare Product Management

Mr. Hennemann addressed previously asked questions about the types of communication that L.A. Care has been sending to the CCI members who have opted out of Cal MediConnect. He spoke of a new packet of information, currently in the works, that would explain to beneficiaries what benefits they are receiving from L.A. Care Health Plan, as well as how they can access various services.L.A. Care has also been working with regulators on the development of the information packet in hopes that it would streamline the pending approval process.

Q&A

Mr. Kane: What are you doing to address the needs of this same population that is separate from reviving member-facing material. Is that part of your duals initiative at all?

Mr. Hennemann: This particular project focuses on those member materials being sent out, but we are doing several different things to provide services to this group of members.

Mr. Kane: Generally speaking, I didn't know if transportation would be covered in this section. I would also be curious to know about that All-Plan Letter (APL 14-010) and what is done with risk stratification MLTSS data that comes in, how L.A. Care might creatively go about using that.

Mr. Hennemann: The State's All-Plan letter, 14-010, which is Care Coordination for LTSS services for members outside of Cal MediConnect. It focuses on two groups of people: duals who are Medi-Cal only and Duals who are not part of CMC because they've opted out or they're partial Duals or were ineligible for one reason or another. For the Medi-Cal-Only population, what the APL says is, "You really have to do the same type of stuff that you do for Cal MediConnect." Once that was implemented, we had to go back and change some of the questions in our HRA for Medi-Cal, our MCD population, look at the initial risk stratification mechanism and make sure it was incorporating MLTSS services into that, make sure that our case management process was built so that it's identifying needs for the MLTSS risk coordination mechanism. We'd already done that for CMC, so it was really just duplicating services.

For the opt-out population, the requirements are a little bit different because we don't have the Medicare piece. We really only have the members for their LTSS and their other Medi-Cal benefits, and what we're required to do is do a separate risk stratification for this population. To do some additional care coordination, to gather up all the assessment documentation from the MLTSS services that they're receiving, review that documentation, and identify if there are other needs that need to be met, and there some reporting requirements attached to it.

We've made a lot of progress implementing several things so far: For example, the risk stratification for this group is occurring monthly This is a fairly high risk population, especially if they're getting MSSP or over 195 hours monthly. Everybody else is likely to score at low-risk. We've also built a tool to help us with reviewing the IHSS data. Really that is the more complex one

IHSS is more complicated because of the size of the program, as well as the scope of what the IHSS workers do. We have built a tool to help us mine the IHSS assessment data provided to the plans.. The process built is relatively new, but we're starting to look at the IHSS data on a monthly basis and put together processes so that we can work with our members and work with the other individuals who are touching the members to identify that distinction.

Mr. Chan: On the question of MLTSS, I think the state did a great job of releasing some data on the number of people using LTSS services in CMC It would help better understand how the plan is coordinating MLTSS services for the dual opt-outs.

Ms. Koons: Perhaps you could give some examples of other strategies that you're doing to reach out to duals in terms of making sure they have access to these benefits that are not MLTSS.

Mr. Hennemann: There are other efforts around coordination, especially when working with MSSP and our CBAS providers. There is coordination that happens between us and the DME providers as well as the transportation providers.

Ms. Lackner: Since our last meeting I reported some extensive work in terms of reviewing our administration of the transportation benefit. Our transportation vendor is Logisticare. Those efforts continue. We are in constant conversation with DHCS looking at how we are administering our transportation policy internally, not because we needed to, but because we wanted to engage them to make sure that we're working collaboratively on these changes. Nothing has changed in terms of how we're administering our transportation benefit under CCI Medi-Cal and/or CMC to date. I want to make that clear. We're meeting once a week and we are making sure that we're covering every single possible scenario, every single type of transportation case. We will be reaching out to some of you offline and asking you to help us provide feedback to some of the member and provider communications around transportation.– Thank you again for working with our team, particularly Heidi, to report any issues you have encountered with our beneficiaries--, but also to identify issues that are occurring, not only with L.A. Care, but with the other health plans. Both our Chief Medical Officer as well as our Executive Directors are heavily involved in the process.

Ms. Koons: To what extent are the partner plans involved in this?

Ms. Lackner: The partner plans are also part of the conversation. The Chief Medical Officer is driving every single conversation with our plan partners. The plan partners, for those of you who don't know, are the contractors under our Medi-Cal line of business, including Anthem, Kaiser, and Care1st. They are a part of the conversations in terms of what they are doing with the administration of their transportation policy, and we will be hoping to align with them. There's an effort to try to standardize it, but there are some limitations to it. We're hoping to minimize those limitations.

Mr. Kane: Have you gotten any instructions from DHCS or CMS to address transportation, and if so, what did they tell you?

Ms. Lackner: We haven't received directives, necessarily, from CMS. They are more interested in ensuring whether or not our transportation benefits have changed since 2015 and as of now they have not. .

Mr. Kane: Do you have anything to share on the automatic crossover claims for this population?

Ms. Lackner: That is still a work in progress. We can commit to bringing you an update on where we are with that our next meeting.

Balance Billing – Outreach and Education
Maria Lackner, Sr. Manager Medicare Product Management

Ms. Lackner updated the group on steps that L.A. Care has taken to educate both beneficiaries and providers regarding the prohibition of balance billing, including hosting a series of provider webinars, and offering direct provider training. She also asked the committee for their suggestions for how to motivate providers to take the information seriously.

Mr. Kane: One thing that is controversial, but is absolutely true, is that there is a large group of licensed attorneys monitoring the issue of balanced billing across the state.. They should know we're watching to protect the interest of consumers. That's something providers should consider.

Ms. Lackner: It's also important to note that while the majority of our outreach has been to providers, we are making an effort to help educate our members on their right not to be balance billed, and part of that is educating members on what is balance billing.LA Care developed and released a member mailing on balance billing. Further, LA Care members c=will hear an on-hold message regarding balance billing whenever they call our member services line and are placed on hold. Information on if you've received a bill from you provider, and you weren't supposed to, call us immediately. Do not pay it. "Do not pay it" is the phrase used in our member communications. It means "contact us immediately, and we will work with your provider to ensure that that bill is rescinded or we will pay for it. Our goal is to make sure the member is pulled from the middle and that [they] don't have to pay.

Ms. Koons: That document you mentioned, did it go out to specific members or specific plan lines?

Ms. Lackner: The first mailing went out to CMC members, and I need to verify when it's going out to our CCI duals Ultimately we want to make sure it gets out everywhere. We are also working with CMS. It's too late for 2016, but for 2017 because our Cal MediConnect evidence of coverage does have some language regarding balance billing and because it's CMS's template language, we're hoping to work with them to augment that language to include it in the member pamphlet, as well as make it a little more prominent for beneficiaries, and if not, develop a piece that we can add with those member materials.

Part of our communication to our in network providers and part of what we're hoping will help motivate them to take this training is that we are required under our contract with CMS and DHCS to report balance billing activity to both CMS and DHCS, and we have been doing that.

Ms. Koons: How do you incentivize or disincentivize certain behaviors. They(beneficiaries) don't want to lose that provider, and so it's this culture of compliance with what that person is asking them to do Ms. Lackner: For Medi-Cal another issue is that there are beneficiaries who may have a share of cost, and we want to make sure that beneficiaries as well as providers understand that there are some exceptions to when you can and cannot bill a patient under managed care. There are a lot of nuances that make this really complicated, and we of course, are trying our best to hit it from different directions. The ID card, I think, is something that in the future we can consider. It would require CMS and DHCS to approve. More importantly, ensuring that our members know their own rights, and they understand when they can and cannot be charged for a service when they see a medical provider. We've got some work to do on that.

Ms. Saffore; You know how the doctors have posters in their offices about scheduled vaccines? Well, if you add that to the patient's bill of rights and put it on a poster, and have the poster at the doctor's office.

Ms. Lackner: That's a great idea.

Another issue we've encountered is providers saying, "I don't have to take training on balance billing because I don't do billing, I have a contracted vendor who does my billing," or "I have an administrator who does my billing for me." We have to meet with those providers and let them know that they're ultimately responsible for any billing that occurs in their name. When a member calls about a bill, their name is attached to the bill, not the person in the billing department, so when we report them to CMS, their name is the one that gets reported.

Mr. Chan: Members might not be the most ready or want to report the behavior, in particular because they want to preserve that relationship with the doctor. I'm wondering in the mailings that are going out to members and you're creating your strategy, how is LA Care preserving the very delicate balance between ensuring people don't get billed, and that their rights are protected, versus continuing to maintain access to providers they've had really great relationships with.

Ms. Lackner: That's a great point and something we've discussed internally. You are correct, it is a balance and one of the things we were trying to do is really motivate the member to let us know if they're billed and get that message out and not tie it to "your doctor shouldn't have" or "Your doctor this" as opposed to "these are the services that are covered. If you ever get billed for these services, send us the bill." that, in turn, helps us understand where these bills are coming from. That's one approach that we're taking. Ultimately we want to always ensure that the member understands their rights, we are informing providers that we are doing work with the members. We are educating the members on this, so we're hoping that will also motivate the providers as well.

Ms. Koons: Does that mean that you are going to pay a bill if somebody submits it to you?

Ms. Lackner: We are responsible for paying it if they have paid it.

Ms. Koons: So that's a way they can get reimbursed.

Ms. Lackner: We encourage them to file a grievance, to go through our grievance and appeals process, and they will be reimbursed.

Ms. Koons: Is this, like, a month-long evidentiary hearing downtown….?

Ms. Lackner: No.

Ms. Koons: Just submit it any way you can.

Ms. Lackner: They are asked to contact member services and/or initiate our grievance process. Because we are monitoring this really closely, our goal is to ensure the member obtains resolution as soon as possible.LA Care will reconcile with the provider on the back end, if necessary.

Mr. Kane: If it's taking longer than 30 days, please call your local Ombudsman.

Cultural and Linguistics

Marie Mercado, Manager, Culture and Linguistics Services, Cultural Linguistics

Ms. Mercado reported on L.A. Care's Cultural and Linguistics program, touching on the many different services that are provided in order to ensure that the language needs of our members are being met as well as ensure appropriate and culturally linguistic are being provided to our members.

Q&A

Ms. Kasick: We're trying to encourage our members to schedule or call in for the appointment where they need an interpreter because we actually work with agencies that hire independent consultants who are interpreters. Sometimes when L.A. Care is contacted the night before, and someone says, "I'm sorry, I have an appointment, sorry I forgot to call in advance," it's hard for the vendors to find someone right away. We rely on a pool of available interpreters. Especially for the ASL community. There is a very small percentage of qualified and certified American Sign Language interpreters available.

Ms. Kasick: I would recommend for members to call in advance. There's just a better chance they're going to get an interpreter. Oftentimes an individual has a preferred interpreter.

Ms. Koons: You said encourage the member to call in advance. Is that how it's accessed? The member is the one identifying that they need this, and then setting it up?

Ms. Mercado: It can be both. We do receive requests from providers, as well, and we do ask the providers that they do give us advanced notice. We do get more requests from members, actually, than from providers. We do get a high number of provider requests, but usually with big facilities.

Ms. Kasick: We want the members to be making the call. That way they're relying on themselves, not on the providers A lot of our educational videos, for instance, let members know that they have the right to have an interpreter, that they can request it. So we try to encourage members to be that voice.

Ms. Mercado: We have fulfilled requests for members when case managers have requested on the member's behalf. That's something that can happen
Mr. Chen:

How does delegation to match beneficiaries with providers, if at all, happen? For example, if they're Spanish speaking, and there's a provider in your network, but they're not in the right PPG, are we defining network adequacy in that respect sort of at the plan level or at the delegated level?

Related to when you know the person you're matching up with a PCP doesn't speak the same language, are they getting special touches with the process there, with making sure they know that they have the right to an interpreter

Mr. Pollack: We look in the provider directory, and the provider's listed not only by the languages spoken by the provider, but languages spoken in the office. So we're making our best efforts to ensure we have accurate information about the network, languages about the provider and the staff, and the assignee.

Q&A with Members of the Audience

Mr. Barsamian: We've been dealing with balance billing since 2012 with CBAS. The problem with the FFS world outside of your network, you have health plans in L.A. County and across the state. So I think where the communication needs to happen is either at the state level with vendors or Harbage. It's difficult to find where the FFS doctors are, but they all have privileges at some hospitals somewhere. I think communicating through the hospitals to their own contracted physicians in FFS, every hospital has a provider liaison that works with doctors in getting the word out that way. Even getting 30% of the FFS in LA county is a large chunk of the problem.

Future Meetings

- All Plan Meeting (hosted by Blue Shield/Care1st)
  - April 20, 2016 (1 – 3 p.m.)

- L.A. Care CCI Stakeholder Advisory Committee Meeting
  - June 9, 2016 (1 – 3 p.m.)