CCI Stakeholder Advisory Committee Meeting
Thursday, June 9, 2016
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:

Demetria Saffore, L.A. Care Member at Large
Aileen Harper, Health Care Rights
Denny Chan, Justice in Aging
Eileen Koons, Huntington Hospital
Rina Cruz, L.A. Care
Maria Lackner, L.A. Care
Bruce Pollack, L.A. Care
Donna Harris, California Association of Health Facilities
David Kane, L.A. Neighborhood Legal Services
Garrison Rios, L.A. Care
Gretchen Brickson, L.A. Care
Rigo Saborio, St. Barnabas Senior Center/Los Angeles Aging Advocacy Coalition
Clayton Chau, L.A. Care
Cynthia Banks, Department of Community Senior Services for L.A. County
Judy Cua-Razonable, L.A. Care.

CCI/Cal Medi-Connect Program Updates
Sarah Brooks, Executive Director, Department of Health Care Services (DHCS)

Ms. Brooks gave an update on the CCI comprehensive strategy, the DHCS will be aligning Medicare and Medi-Cal, as well as making a number of changes related to LTSS and the Health Plans referral process for LTSS services. In addition, they are looking to standardize Health Risk Assessment questions, and will be putting together a workgroup to walk through feedback they've received from the Health Plans. Ms. Brooks also shared that they are moving forward with the operationalization of

MLTSS enrollment, and streamlined enrollment, which should go live in July or August.

Q&A

Ms. Harper: The department is looking at July/August as target months for going live with regard to plan participation in the enrollment process. Will there be any formal notification either publicly to the community or to Medi-Cal beneficiaries who are specifically in these plans?

Ms. Brooks: Yes, when we have an official effective date we will provide notification to the public. There'll be a testing period prior to actually going live with the health plans, and so I expect that once we engage in the testing period, we will let the public know, and following that, when we have a confirmed effective date, we'll advise stakeholder advocates and other interested parties, as well.

Ms. Wunsch: Could you just describe for us what the DHCS is envisioning for the role of the health plans in this effort?

Ms. Brooks: The health plans will do the same as they do today in terms of providing information to the beneficiaries about the program. If somebody expressed and interest, they will take that information down, and they will forward it to Health Care Options, who actually does that enrollment. Then, with beneficiary protections in place at the state level, there are follow up phone calls to beneficiaries to confirm that they actually did want to be enrolled in the program. We'll be monitoring that process closely.

Mr. Pollack: An observation around your efforts to standardize the HRA questions, particularly related to LTSS, there's another objective down the road to come up with a standardized assessment for CBAS, IHSS, and hopefully if we come up with one set of questions that we know we need to ask the beneficiaries, maybe we can take advantage of that to expedite the development of that standardized assessment.

Ms. Brooks: I think that's a great comment. The DHCS continues to engage with the Department of Aging and Department of Social Services in the creation of the universal assessment tool that you're referencing. We have actually sent for comment these questions to make sure that we are continuing that conversation. I do think it is a good segue into utilizing those questions for that purpose, potentially.

Mr. Kane: I was wondering if it's still the case with the beneficiary protections during the streamlined enrollment period that a beneficiary will still be enrolled in Cal Medi-Connect even if the state is unsuccessful in reaching the beneficiary by phone or is unable to verify that the letter reaches the beneficiary's address.

Ms. Brooks: It is true that if we are not able to reach a beneficiary, they will continue their enrollment in the program, but as you know, beneficiaries can disenroll at any time. It is a voluntary program. That ties back to part of the monitoring that we'll be doing as well, We are not going to just call one time. We call five times, different times of the day to really make an effort to reach them.

L.A. Care Medicare Operations: Introduction and Organization Structure
Garrison Rios, Executive Director, Cal MediConnect

Mr. Rios introduced himself, speaking about his background in Health Care. He then shared his

assessment of the challenges that Cal MediConnect has faced thus far, and highlighted strategies for overcoming them, including a focus on Member Enrollment, Provider Engagement, and Provider/Pharmacy Directory. He spoke about plans to streamline the method of enrolling and communicating to the enrollees, of educating both beneficiaries and providers about our product and strengthening the lines of communication between all parties, as well as improved assessment of beneficiaries' needs in order to provide a better experience for our members.

Q&A:

Mr. Chan: You talked about tinkering with the onboarding process of the member. I'm wondering, from the beneficiaries' point of view, what changes have you instituted that look different if they were to join Cal Medi-Connect now? How is that operationally different than before?

Mr. Rios: As part of the Cal Medi-Connect product there is an Annual Wellness Exam. Through the Health Risk Assessment process, what we're trying to do that's different is actually do a face-to-face assessment so that some of these member's needs are more up front. That's a new process that they would not have experienced before. Now we're bringing it in-house so that we're face-to-face with the members, rather than them showing up at an emergency room or urgent care. We expect to do that upfront in the first two months of their membership. We're going out proactively to try to do that.

Mr. Pollack Part of what we're doing is rationalizing all of the touch points, coordinating them and making it more welcoming for the member without appearing to be imposing.

Mr. Rios: We're being very careful about overcalling and over communicating. We're trying to link all these teams—and they're all cross-functional teams—identifying what happens with the welcome call, what happens with clinical so that there's more coordinated effort, the member isn't getting five or six phone calls and thinking, "What is going on here, why am I getting all these calls?" This is just launching, too.

Mr. Chan: I have two more questions:

1) About the marketing efforts, I'm wondering if you've seen an uptick in voluntary enrollment as a result and how that's compared to prior to the campaign.

2) With respect to meeting providers and one-on-one meetings with providers, how does that work when you have both directly contracted providers and those that are part of delegated groups?

Mr. Rios: We have seen an uptick in enrollment. We are currently averaging about 300 – 350 voluntary enrollments per month, which has been an increase over the prior period. We also just received an email from a gentleman in CMS, who actually acknowledged to John Bacckes that they've noticed an increase in enrollment at L.A. Care. Can I say it's directly related to the campaign? I don't know. I think what is going to do is create brand awareness. Regina's team is working specifically with the providers and going out and doing education to the providers and their staff about the Cal Medi-Connect product, and helping to increase that knowledge. I think that's helping.

With regards to provider engagement, there is an organization of how they're going out and meeting with the providers, and it's based on score card data.

Mr. Pollack: L.A. Care has ventured into some direct provider contracting in the Antelope Valley. Today we have approximately 200 Medi-Cal members only with those direct contracts, and that

network is not yet providing any services to the duals demonstration pilot. Our other provider group arrangements are all with some delegated entities, which have all kinds of models. They have employed positions, they have IPA positions, etc.

Ms. Saffore: About the continuity of care, if there is continuity of care for 12 months, what happens after the 12 months?

Ms. Lackner: During that 12 month period, you'll continue to see your provider. If that provider is out of the network, we, the plan, are allowed to honor that relationship, to maintain that care with that provider. After the 12 month period, if the health plan has been unable to negotiate a contracting effort with that provider, if they're unable to come into our network, either through a relationship with L.A. Care, or through a relationship with one of our contracted provider groups, then we will be working with you to help you select a provider that is within our network.

Ms. Wunsch: Bruce, you mentioned the provider score card that you're working on with the delegated entities on. Is that going to become a public document?

Mr. Pollack: I'm going to have to get back to you on that.

Medi-Cal Only Duals Initiative: Updates
Maria Lackner, Director, Medi-Cal Product Administration

Ms. Lackner addressed recent efforts to streamline and improve communications to dual-eligible members who are with L.A. Care for Medi-Cal only. She mentioned that a meeting had been held between a handful of L.A. Care staff, as well as several members of the Stakeholder Advisory Committee wherein a lot of great feedback had been received. As a result, a streamlined Evidence of Coverage is underway, as well as updates to the full-scope Medi-Cal materials. Ms. Lackner added that efforts are currently being made to identify additional areas to further develop, and that she hopes to have more to report on that at the next Stakeholder Advisory Committee meeting.

Updates: Meeting with Peg Bernardy, Representative for the Hospital Association of Southern California (HASC)
Judy Cua-Razonable, Director, MLTSS

Ms. Cua-Razonable provided the Committee with updates from the March 10 meeting with Hospital Association of Southern California. She reported that in an effort to streamline the process of placing members in long term care, a workflow had been developed, along with L.A. Care's Utilization Management team so there is now one point of contact for hospitals and for PPGs.

Q&A

Ms. Koons: Very often the skilled nursing facility comes into in play because other things can't happen rapidly enough, but they might still be options. Are you helping to hand off? Who is it that makes sure there's some kind of follow-up on what could happen, just not in the rapid timeframe of a hospital discharge?

Ms. Cua-Razonable: If the member is in the hospital, then usually the quarterback for that member's care is really the hospital folks. If they need assistance, they'll coordinate with us, and we'll collaborate with each other. But if there's a member who goes through, say, a skilled nursing facility, and their skilled level of care, or even short-term/long-term care, then long term care nurse specialists will follow up and make sure that we're working on the transition. We also track to see if the member has been in the hospital or skilled nursing facility for 90 days because if they're eligible for a CCT referral, then we will activate that as soon as the member becomes eligible.

Ms. Harper: At the last meeting we brought up two issues relating to problems that our agency was seeing with regard to discharge of Cal Medi-Connect or L.A. Medi-Cal duals who were needing to transfer to skilled nursing facility. I think what we're seeing is more a situation where the person that needs to use the skilled nursing facility benefit, and what's causing the problems with transition are potentially a couple of things. 1) The patient is perceived by the facility as too high maintenance, needs too much. On a ventilator…. They have multiple issues and are too complicated; or 2) The patient is younger and/or has mental health issues. So what, specifically, are you guys doing in terms of those?

Ms. Cua-Razonable: Those are the very complicated, complex cases. We could throw in the homeless part in there, too. A lot of times they're younger, they have mental health issues, and they also are homeless. Those are the ones that are really, really a challenge. Speaking to some of the health plans with which we share best practices, everyone is having challenges with placing those members. If the member is homeless, a lot of times the facilities don't want to take those members because there is really no long-term discharge plan. So things are going to take longer for us to facilitate. We do have a social services department over here, and we have a housing and transportation specialist that we will connect the member to. However, the unfortunate thing is it doesn't happen right away, it does take time. Even if we expedite the request to the specific agency. So for those cases, we work on them on a case-by-case basis. We use every relationship we have out there, and every possible solution or alternative that we can get.

Ms. Cua-Razonable: The other issue with our LFC that we're trying to do on our end identify which centers specialize in which service area, so if we have a facility that is really good at working with wounds are not afraid to work with members with complex wound care, we would flag that in the system so that we know exactly who to go to rather than calling the 400 skilled nursing facilities in the la area, we at least know where to put our efforts.

Ms. Brickson: we're trying to build partnerships with the CA community transition programs that help the money follows the person program in CA. So that if there are individuals who could actually transition out of a nursing home after 90 days, we have a place to refer them. Independence at Home, Caring Connections…and there's several others, they all do that kind of work, and we're trying to develop a relationship with them on that.

Ms. Koons: I have been in a position of trying to discharge people from a hospital setting, very complex, and it can drag on for days, weeks, months. Where I start to wince is the thought of that one facility in 4081 square miles of a county and the 85-year-old in that one facility and they live all the

way across the county, and their wife is never going to see them again. I'm wondering about the social connectedness aspect of any of this. Is L.A. Care prepared to help connect wife and husband? Is there some kind of attention to that? I heard some pretty dramatic stories, not necessarily L.A. Care-related, about people being relocated very far away from where they call home. Wondering what your thoughts are on that.

Ms. Cua-Razonable: Definitely for us, especially if it's going to be long term, and they have family members in the vicinity, we will look in that specific area. However, if this is a very difficult case, and in order to help the hospital transition the member, if we have a taker that's a few miles farther away, if the family and the patient agree, we will facilitate the transfer. But we will continue to work with that member to see if we can move them closer. The difficult part of that is that you don't want to keep the member in the hospital because they're so close to infections, and also from a facility standpoint, you don't want to take up an acute bed for somebody who's in your ER that might actually need the acute bed.

Cindy (Synermed): Is there even an option to bed lease with these facilities at the skilled level?

Ms. Cua-Razonable: That's something I can take back to the team. Our senior leadership and our contracting needs to explore as an option. Just from my experience – I came from Healthcare Partners and from Kaiser, where we lease beds for specific higher functioning skilled nursing facilities, they still can refuse those members their bed lease. They can always say that this is something that the services required, their facility cannot provide. When they use those terms, we cannot force the facilities to take the member.

Ms. Brickson: One of the things that helps us is actually knowing if there's a particular case where there's a struggle, so Judy and her team are experts at all this, so if you do have something that's specific to L.A. Care Members, we'd really love to hear from you. If you know someone is being placed far away from their husband or there's a homeless person who's not making it into a nursing home, be sure to let Judy know about that.

L.A. Care Homeless Health Programs and Initiatives

Dr. Clayton Chau, Medical Director, Behavioral Health

Dr. Chau addressed the growing issue of homelessness in L.A. County, and the difficulties inherent in adequately serving that population, highlighting efforts to better identify and address the medical and behavioral health needs. He also shared the feedback that was gathered at Homeless Community Listening Sessions and outlined the goals of L.A. Care's Homeless Health Coordinating council.

Q&A

Ms. Banks: In your work with the county homeless initiative, has there been any conversation about referral after they are medically well, to move them to homelessness to sustainability?

Dr. Chau: We make referrals to the home for health initiative. Something on the stove right now is we tried to identify the individual from the Medi-Cal expansion population and see if they meet the criteria to qualify for SSI to help them. That's one way to help people gain some funding so they have a better opportunity at housing.

Ms. Banks: As part of the strategy is to look at employment and training. I would suggest that we look at moving individuals to sustainability, that we embrace the whole strategy for homelessness and make those referrals, as well.

Dr. Chau: Maria (Senior Director for Safety Net Initiative) and I have a tall order. We just got an order from our COO to create a program that's looking at providing care for our homeless population, and that's something that we're going to look at. Number one piece of outreach that we don't do very well currently is to engage providers who specialize in treating the homeless and assign members to go to those providers. In other words, our usual member assignment would have to change in order to meet the care, and then providers, as you know, most of the homeless providers who do the day to day care really do not have to schedule an appointment. In our planning scheme, we will engage members who are homeless for the project.

Ms. Wunsch: Can you remind us, you've estimated about 12,000 homeless members?

Dr. Chau: At least.

Ms. Wunsch: Can you tell us how many in CCI or Cal Medi-Connect?

Dr. Chau: A few hundred.

Ms. Koons: This data, I haven't really tried to absorb all of it, but there's a lot of data coming out on homelessness and poverty, obviously, but particularly the ones that have piqued my interest are the rise of homelessness of older individuals, age 50 and older. On one hand we're talking about strategies to help people get jobs and training and that sort of things. I would imagine those issues are off the table when you're dealing with an older population.
Dr. Chau: One of the populations that we're paying attention to is the frail elderly. We have a workgroup working on the frail elderly now. We're going to come up with a model of care for the frail elderly, and one of the criteria that we will be looking at is the elderly who are homeless. And nobody really knows, or maybe we don't want to speak to the fact that many of our homeless individuals are actually the elderly and the approach you use for someone who is young and who is homeless is completely inappropriate for someone who is older. 70 and older. At that time, the goal isn't to go back into the workforce. Most of us by age 70 or older, that's not something we want to do. So the approach for someone who is older and homeless is very different, and we're not going to lump them into the same population of homeless.

Jessica Jew (Safety Net Initiatives Project Manager, L.A. Care):. Our Safety Net Initiatives group has been meeting with providers and connecting them with MLTSS department to make those connections, setting IHSS hours and making sure that providers are understanding all the different resources that L.A. Care can provide to make sure that older adults that may be experiencing homelessness get the services they need.

Dr. Chau: One thing I want to make very clear is that we do know that Medi-Cal dollars are not to pay for a home. We need to make that clear because we've had members in the community that say, "Can you give me dollars for a home." Medi-Cal dollars is medical care, not housing. There's a misconception out there that L.A. Care does this. No, L.A. Care collaborates and partners with other groups in the community to do the housing piece.

Mr. Mahler: Have you guys done a survey for the Antelope Valley? We've got a lot of homeless in the Antelope Valley that are needing services like that. Have you guys gone out there to check them out?

Dr. Chau: As we showed on the map, Antelope Valley has homeless, but fortunately it's not one of the largest homeless populations; in fact I think it's one of the lowest. So yes, when you create a model of

care for the homeless, the hope is to spread.

Ms. Premo: I have two comments. One has to do with the discussion about nursing homes and about the different kinds of care. We keep talking about what we don't have and it doesn't exist and we can't find it in the existing system. Why aren't we adding new models so we have it? As long as we look at the existing system and say, "Oh gosh, we can't find anything," we won't find anything.

My second comment is that I'm a little concerned about the way in which the committee is constituted. I love the committee, and I love what you've done, and I've sat here since the first time. I see a lot of my advocates, friends that I know. I don't see a deaf person, I don't see a person who uses a wheelchair who has the background. I believe there should be some vision, because this committee's doing great work, of the people who actually have to figure out how they're going to get from A to B, but have work in a professional position and do what they do. Not just the advocates for us, the advocates *of* us, and I don't see that.

Ms. Wunsch: Donna, anything you want to add in terms of the facilities and their ability to accept very complicated individuals like we've been talking about?

Donna Harris: It is a struggle, and from the nursing home end of it, we struggle, as well. It's a difficult population to provide for, to care for, to place once they no longer need to be in the skilled nursing center and then find a location for them to go, a safe discharge. We struggle with that, as well. I made lots of notes when we went through the difficult placement piece because we live that. We get the call from the hospital, and they're difficult to place, but we as an industry have to deal with the safety of those residents, make sure we can care for them well, appropriately, and make sure that we have a safe place to discharge them. I really liked the comment on maybe we look at developing a different kind of setting that could more appropriately care for certain situations that we have.

Dr. Chau: Like I've mentioned, we've worked with a faculty and helped develop a model of care for individuals with severe illness. We live in the Medicare Medi-Cal space that is heavily regulated. It's not as easy as inventing a different kind of facility, that has to go through the approval process that L.A. Care has no control of.

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Mr. Saborio: As a representative of St. Barnabas Senior Services, we are part of a network of senior centers throughout the city and also work very closely with senior services throughout the county, and we are experiencing at the senior center level an increasing engagement with the homeless, older adult population. Over 90% of the population we serve in general, not the homeless, in general, they're Duals. I see a natural opportunity to work together beyond the traditional MLTSS providers, but the senior center network. I'd like to get feedback in terms of any work that you're doing, thoughts about that….

Dr. Chau: You just got yourself an invitation to my workgroup.

Q&A Session/Public Comment

Bobbie Wunsch, Facilitator

Mr. Chan: I would love it if at the next meeting we could do a deeper dive on LTSS referrals processes and what those numbers look like thus far. I think the state in releasing the dashboard gave us a snapshot across all plans and across all counties, but it would be great to know process-wise and numbers-wise how LA care is performing both with respect to the duals and Cal Medi-Connect and those who've opted out.

Ms. Wunsch: Maybe can combine with that the summary of the beneficiary study that UC Berkeley has done in which the biggest area of opportunity is LTSS and the lack of knowledge on the beneficiaries' part about LTSS and the program. So we could do that together, that would be a good combination.

Mr. Kane: I have a process suggestion. I think we're missing some of our "to-do" items from previous meetings. They're buried in the meeting minutes, and I would like to have them pulled out of the minutes and displayed in some sort of chart. I'm happy to share my notes from previous meetings, if that helps.

Follow-up Items for the next meeting

Bobbie Wunsch, Facilitator

- Garrison Rios on how Cal Medi-Connect business strategy is unfolding
- Maria regarding member handbook changes for 2017
- Main topic will be LTSS Referral process and the outcomes of that
- Talk with L.A. Care staff about adding additional consumer voices to the table. Report back.

Future Meetings

- Los Angeles CCI All Plan Stakeholder Workgroup
  - July 20, 2016 – Hosted at the Braille Institute in Los Angeles
  - (Hosted by CareMore)

- L.A. Care CCI Stakeholder Advisory Committee Meeting
  - September 16, 2016 – Hosted at L.A. Care
  - December 8, 2016 – Hosted at L.A. Care