CCI Stakeholder Advisory Committee Meeting
Thursday, December 8, 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:

Denny Chan, Justice in Aging
Eileen Koons, Huntington Hospital
Dwayne Broussard, L.A. Care
David Kane, L.A. Neighborhood Legal Services
Deborah Cherry, Alzheimer's Greater Los Angeles
Demetria Saffore, L.A. Care Member at Large
Misty De Lamare, L.A. Care
Gretchen Brickson, L.A. Care
Raffie Barsamian, SynerMed
Maria Lackner, L.A. Care
Bruce Pollack, L.A. Care
Peg Bernardy, Hospital Association of Southern California
Karen Widerynski, California Association of Health Facilities
Garrison Rios, L.A. Care

CCI/Cal MediConnect Program Updates

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

Ms. Brooks reported that there are 114,000 individuals in the Cal MediConnect program, making it the largest demonstration in the country, and that breakouts by county can be found in the monthly dashboard on calduals.org. She also shared that as of today, 16,000 people have been successfully enrolled through the new streamlined enrollment process, which started August 22, 2016, with all plans but one participating. The DHCS is monitoring closely, and they have seen high percentages of individuals who are actually eligible for enrollment.

Regarding MLTSS, Ms. Brooks advised that in November an MLTSS resource guide and choice book was mailed out to people to assist them with the enrollment process. It's anticipated that 63,000 will go out over a 6-8 week period. They are focused on English to start, with non-English going out later.

This will be an ongoing process and as new individuals come into the program.

Ms. Brooks shared the DHCS's efforts the standardize questions on the Health Risk Assessments, specifically questions around referrals for LTSS. There have had ongoing Health Risk Assessment Questions Workgroup meetings, to bring together a group of experts to talk about the questions and come up with the best questions to ensure those referrals are occurring in an appropriate way. There have been 4 meetings so far, and fifth planned later this month. The goal is to create ten set, core questions to be included in the Health Risk Assessment, and they are going to work with health plans to work on standardizing those Health Risk Assessment questions in 2017.

Finally, Ms. Brooks reported that she had no further updates to share regarding the Governor's budget in January 10, 2017.

Q&A

Mr. Kane: I was wondering if you could talk a little bit about the State's efforts to resolve enrollment barriers presented to beneficiaries when they're trying to enroll, both through healthcare options, and also through the streamlined enrollment process.

Ms. Brooks: Can you talk a little bit about what some of those barriers are?

Mr. Kane: At the ombudsman, we regularly have beneficiaries calling us with erroneous healthcare coverage codes appearing in their Medi-Cal eligibility message. We also have people with erroneous aid codes for their Medi-Cal eligibility, sometimes there are also unexplained enrollment into waiver programs that people never were enrolled in. In addition when we escalate these to the designated contacts at the department, they're unable to come back with any message indicating ineligibility, except that this person is ineligible. Just some examples.

Ms. Brooks: We do continue to work on data here at the department with respect to ensuring that our health coverage data is correct. That data is reported to us from the health plans and uploaded into our system. We're working on an updated and improved system for that process so that we can identify people who have other health coverage or don't. A lot of times what happens is that somebody won't have other coverage when they're enrolled into Medi-Cal and they're put into a certain aid code or they're enrolled in a certain way, and they get it after the fact. Or sometimes they have it before, but the data hasn't caught up, so there are some timing issues that do occur, and so those are some examples of things we're looking at fixing in terms of streamlining process to make sure we are able to have the most up to date data available to us when we're working through those different processes.

Mr. Chan: Regarding streamlined enrollment process and the outbound calls that are going out to confirm whether a beneficiary wanted to enroll. Is there a sense of how many people aren't able to be reached through that phone call campaign?

Ms. Brooks: Great question. It's not something I have off the top of my head, I would have to follow up with that. I also wanted to talk a little bit about our new dashboard. We'll be working in the beginning of the year on a new dashboard that will have some streamlined enrollment data on it. That's one of the data points that we will include.

Evaluation of Cal MediConnect

Carrie Graham, Ph.D., MGS, University of California, Berkeley

Dr. Graham shared the results of an evaluation of CCI and Cal MediConnect that her team conducted. The evaluation included 14 focus groups made up of 120 individuals from many varied demographics. It also comprised telephone interviews conducted with 2139 dually eligible beneficiaries. The resulting information gathered offers insight into a multitude of topics, such as how satisfied beneficiaries are with their insurance, the reasons some of them opted out, Cal MediConnect involvement with LTSS, and unmet needs among LTSS duals.

Q&A:

Ms. Saffore: What have you done about the unmet needs of the beneficiaries?

Ms. Wunsch: Maybe that's a good question for L.A. Care to answer.

Dr. Graham: People who've used LTSS or had unmet needs, a lot of them said that the plan hadn't talked to them about that or asked them about that. I am piloting our new survey with Cal MediConnect members and I talked to this woman who couldn't have loved her plan more, she loved her care manager. Her care manager had been in every aspect of her care, helping her with DME, helping her with her specialist. It was incredible what her care manager had done for her. Then we asked if her care manager had talked to her about her IHSS, and she said they hadn't. I haven't seen the new Health Risk Assessment that Sarah was talking about, but it'll be interesting to see if the Health Risk Assessment addresses asking people about their unmet needs for personal care. As far as that goes, all I know is a lot of people aren't being asked about it.

Ms. Wunsch: We're going to have Gretchen answer Demetria's question from the L.A. Care perspective

Ms. Brickson: I'm not going to respond right this second because your question is a perfect segue into the presentation I'm going to be doing in a few minutes about how we actually try to really enhance access to MLTSS services and how they get access to them. So hold on, and we'll get to it.

Mr. Barsamian: Did you look at the correlation between the likelihood of a Health Risk Assessment being completed with some other metrics. Because if all the work, and the village we build to take care of someone's psychosocial/physical needs for Cal MediConnect…. It seems like there's a high percentage where the Health Risk Assessments aren't being completed, mostly because there's not a valid phone number, I could see why some of the scores could be the way they are, especially trying to answer if someone reached out to you. If we don't have a phone number, we can't. I was wondering if there were any parallels with Health Risk Assessments being completed and maybe scored high or low, and not being completed with some of the metrics that you show.

Dr. Graham: Unfortunately that's an area where we didn't have that information. We couldn't get that information from the State because they didn't know who…at the time when we got the names, we couldn't get a variable on had a Health Risk Assessment been completed or not. And then we tried to think of a way to ask beneficiaries had a Health Risk Assessment been completed, and we were practicing it and trying different things, and a lot of times people said yes, but what they were really talking about was their ihss social worker coming out. So we just didn't feel like it was valid. There was no way to find out from the people we interviewed if a Health Risk Assessment had been completed,

so we couldn't make those correlations, unfortunately.

Ms. Cherry: Thank you for the evaluation. I've been reading it over time on the SCAN website. I wonder if you've made any effort to reach the caregivers of people who cannot speak for themselves because there is a significant number of duals who are cognitively impaired for one reason or another, or significantly mentally ill that they cannot speak for themselves.

Dr. Graham: I want to go back to the Health Risk Assessment question: We were able to contact these people. We sent letters to people, and we allowed them to contact us. We would do these surveys through relay communication. We would send them PDFs, so we did a lot to try to make it accessible. Just in terms of trying to contact people, you have to remember that these are people that we were able to contact through a DHCS list, so they probably are people that the health plan could have contacted for a Health Risk Assessment.

To answer your question, yes. If someone could not speak for themselves, we asked for a proxy. It isn't necessarily a caregiver, we don't know that the person is necessarily providing paid help, but it would be a person who helped them make healthcare decisions. Off the top of my head I can't remember the full percentage of the sample that was proxies, but we certainly gave an opportunity for the person to nominate a proxy or we called and they said, "Well, the person can't speak to you," and we say, "Then can we speak to you." And we had a little screener to make sure they were a person who did make healthcare decisions, they were involved enough to be able to answer the survey correctly. Everybody who participated got a ten dollar gift card for participating. Even if a proxy participated, that gift card still went to the beneficiary.

Mr. Chan: It seems like a number of opt-out beneficiaries are reporting either receiving and/or are really satisfied with their care coordination. In thinking about Cal MediConnect and how the care coordination benefit is supposed to set this program apart, I'm wondering if in the course of your interviews with the opt-out beneficiaries, if you get a sense of who those care coordinators are and what exactly they're doing?

Dr. Graham: I don't have it in front of me, but if someone was getting any care coordination, we asked, "Who is your main care coordinator?" I can get back to you with those stats. People who are opting out are getting care coordination, some are getting them from their plans, some are getting it from a community based organization, some are getting it from a specialty office, some have a friend or family member who's doing it. We have those stats, and I could do a follow-up email to the organizers of this. They have the plan for MLTSS, so they certainly are getting some kind of care coordination. I have a question for you: For people who are in L.A. Care, who opted out, how are you providing care coordination for them?

Mr. Pollack: We have 160,000 plus members throughout the health plan who are full duals, who are with us for Medi-Cal only. There are thousands who opted out of Cal MediConnect, but clearly the general structural challenge is that when you talk about care coordination, I don't know who their PCP is. They're getting their medical benefits through Medicare, their behavioral healthcare. We are only responsible, as a Medi-Cal plan for coordinating their long term supports and services, but it's very challenging to endeavor to coordinate that with the other care that they're receiving. I will gladly share that my bias as a managed care idealist, I firmly believe that managed care is preferable to fee for service, firmly believe that being able to coordinate all of the medical, behavioral, and social services is a better model within Cal MediConnect than perhaps disintegrated care that we find with the CCI and the unknown Medicare services. To go back to your study for a moment, we learned about all the challenges with the passive enrollment process, the confusion about the enrollment process and

people learning that were enrolled in Cal MediConnect the first time they tried to use a medical service. Now that the program has been around for a while, my presumption is that the people who are still in Cal MediConnect are the ones who wanted to be there. The opt-outs have opted out, the people who were disenrolled are gone, and the people who we're not maintaining in the program are, perhaps, the ones who are losing their Medi-Cal eligibility. Not that they wanted to leave the program. I'm curious in your study, or maybe as you move forward, if you perceive a difference in the faction of the program with those who enrolled voluntarily as opposed to those who were passively enrolled.

Dr. Graham: We're going to have a whole added section this year asking people if they had originally opted out, and if they've reenrolled. Or if they were in the program and have disenrolled since we talked to them last and ask them why. We're just going to call back the same people. It may be that they lost their Medi-Cal or something like that, so we're going to be looking at that. It's an open ended question, and I'm not sure what the sample size will be, how many people will be making those changes.

The only distinction we have for someone who is passively enrolled…We don't know if they did an active enrollment form, but we do have this weird distinction between people who enrolled and didn't know it. We have these unaware people who didn't know that they were enrolled or didn't know that they were opted out. The distinction between voluntary and involuntary is hard to assess when people were passively enrolled. If you have any ideas for us as to how to assess that, "Did you want to enroll or did you feel forced?" We don't know how to get that information, but if you have ideas….

Mr. Rios: I think this is a really timely conversation about care coordination because we're just rolling out our new model of care with Cal MediConnect. We have a pilot program with one of our high performing PPGs. It's really based on patient-centered care and understanding what the patient's needs are up front, then identifying the right resources for them along a continuum. That's actually a social community need. We have something that we're using to evaluate our PPGs on how they'll work with us and what our goals are around this model of care. And they really align with what Carrie has said regarding care coordination. What we're finding is that the sooner we get in touch when they are enrolled and have them understand what's going to be going on around the Health Risk Assessment, understanding what their score is from the Health Risk Assessment, whether they be low, medium, or high risk, and working with our PPG partners to address their concerns. We take this very seriously because it's a core program, to make sure the people are getting the coordination that they would not have gotten from Medi-Cal and Medicare directly. So we launched that, and it's a local ppg we're working with, and we'll evaluate within the first two months how that's working, but the idea is to make sure we're not losing any type of connection with the member in regards to their needs and resources.

Dr. Graham: I would love to hear more about that program. Maybe you could email me. I think it would be really interesting to look at that in our case study around innovation. If you could email me, I'd love to really talk to you and hear more about that.

Ms. Cherry: There's person-centered care and there's family centered-care. When I talk to people in most healthcare systems right now, the language is changing over to person-centered care, and I think that's really terrific. I think if we're dealing with managed long term services and supports, we have to go a step further. There's a fabulous report I brought a copy of. AARP came out with a study on what's happening in managed long term services and supports with families around the country in the duals pilot.

Mr. Rios: Absolutely, and it's all the words that we use and how we choose to use them. In regards to

our approach, we understand that this integration, it's a circle of influencers that are helping the patient along the continuum, so that if you get to a nursing home or an in-home care situation, the influencers are really driven by family members or advisors, so the circle widens. When we think about patient-centered care, it's what's best for the patient, and if all these other people are involved in making that decision that's really important for us.

Ms. Cherry: A good many of your home-based people are getting their home and community based long term services and supports from their families.

Mr. Rios: When you think about health care coordination, you have to think about it in a broad way because every situation can be presented differently, so it's not one-size-fits-all. That's why we have care plans. The care plan will identify specific needs that that member has that patient B doesn't.

MLTSS Overview

Gretchen Brickson, Senior Director, Managed Long Term Services and Supports (MLTSS)

Ms. Brickson presented information on L.A. Care's MLTSS program, providing statistics around program utilization and demographics, and outlining the ways in which L.A. Care engages with members to determine how best to meet their needs. She also discussed efforts to build and strengthen relationships with MLTSS providers and community partners.

Q&A

Mr. Barsamian: How are "full duals" defined?

Ms. Brickson: The full duals and the partial duals are folks that aren't in Cal MediConnect. They can either be opt-outs or folks who are ineligible for Cal MediConnect. And they also do not have a Medi-Cal SPD Code.

Ms. Widerynski: This isn't reflective of utilization at all. It's just numbers, right?

Ms. Brickson: In June of 2016 we had these many members that were showing an authorization for these particular services.

Ms. Widerynski: Do Cal MediConnect have higher utilization than opt-outs, something like that?

Ms. Brickson: That's not something that I have handy, but it would be something we could look at for you.

Ms. Koons: 70,000 authorizations, so there are duplications right? That's not people. Someone could be receiving more than one thing?

Ms. Brickson: This might be kind of an approximation. We've tried to account for the overlap. The 4970 is our attempt adjust it to get to a unique member count.

Ms. Koons: To link back to something Bruce said, that 70,000….?

Mr. Pollack: Let me just clarify: the 160,000+ CCI members that I was referring to at L.A. Care are beneficiaries that are enrolled both directly in our direct contact line of business as well as our plan

partners. In the statistics you see here, Gretchen is limiting the data to our direct line of business for Medi-Cal, as well as Cal MediConnect, but you're not seeing, I believe, our plan partner data as well. So it's not quite apples and apples.

Ms. Brickson: I have some rough figures on what the direct line population looks like, so if there's a point of comparison, we have 12,903 Cal MediConnect members as of August. 100,529 CCI members. 93,192 Medi-Cal only SPDs. So roughly 207,000. L.A. Care has 2M members, but we are serving a lot of the L.A. Care, CCI, Cal MediConnect, and SPD populations. We have 72,753, so you can see we have a lot of people in MLTSS in that category.

Ms. Koons: I'm a little surprised that IHSS can't provide their findings. They do an assessment.

Ms. Brickson: We do get information about the members ADL impairment that's causing the number of IHSS hours, and we do get a little bit of information about the member, but unlike MSSP and CBAS where you actually get a document that says, "This is the assessment," DPSS doesn't share that with us. Rather than trying to work from partial information, we decided to reach back to the member and look at them. It's very labor-intensive, but it gives us a good connection to the member, and it's one of the ways we're trying to ensure we're addressing unmet needs.

Mr. Pollack: If we had a unified assessment you could use for IHSS, and CBAS, and MSSP, and long-term care, we could do a much better job of coordinating that care.

Ms. Koons: So is it that DPSS in L.A. County doesn't want to share the information with your health plan or all health plans? Or is that state-wide, all CCI counties?

Ms. Cherry: I think it's state-wide, with all plans.

Ms. Brickson: The DPSS does feed information back to us, and we can pick it up in electronic format. It's just not the kind of assessment that we're used to in MSSP or CBAS where you're really looking at the whole person and their needs. IHSS is really looking at whether this person needs homemaker hours, so it's a much more limited kind of approach. The data that gets fed back to us, you're not really getting a comprehensive picture of the individual. That's something that I think would be a really interesting thing to work on, and maybe our need for a universal assessment would help solve that.

Ms. Koons: Isn't the universal assessment stalled?

Ms. Brickson: No, it's under legislative mandate until 2018.

Ms. Premo: It is stalled. There's a debate about who should be doing what. We've had a presentation, and there are two things going on. One of them is IHSS social workers trying to look at physical facts, so the report would be different. Second is that the departments are fighting about who would have control and when and who will give it. There need to be a number of questions asked. One of the groups that's working on this is SCAN; they funded it. They're not happy. So it has been delayed. I would recommend you have one of the folks from SCAN speak here so you can get their perspective.

Mr. Chan: Regarding CPO services, you included transportation, dental, and vision, and I was wondering if you could clarify what kind of services those are. I'm assuming it's outside the medical transportation benefit and the Cal MediConnect benefit.

Ms. Brickson: If someone is eligible for transportation, or are in Cal MediConnect, and have dental or

vision, then we would do that first, but if that's exhausted, we try to go to community resources. Transportation is pretty much what you all know, accessing the usual providers. For dental and vision, I'd have to drill down and get back to you on that.

Mr. Chan: There are so many community-based referrals for free services that you end up having to pay for very few services. It seems to me like this is a great system, but I'm wondering how you follow that person after they've gotten the referral to community service.

Ms. Brickson: Because we're using the Health Risk Assessment as a trigger, we have not set it up that we follow up over time, but we are using a vendor. We're about to transfer to the MSSPs, who are experts in all of this, we have relied on the vendor to let us know if there's an ongoing issue that needs to be addressed.

Mr. Pollack: There needs to be follow up to see whether or not the beneficiary was able to connect with whatever service they need. Through the annual reassessment process, we have the opportunity to evaluate current and ongoing needs.

Ms. Cherry: One plan told me that they have Respite as a CPO**.** It wouldn't necessarily come to your attention from the Health Risk Assessment, but you could get a call from the family letting you know that the caregiver needs help.

Ms. Brickson: We can take a CPO as a referral, so if someone alerts us to that need, we can do that.

Ms. Koons: As an MSSP provider, it's common that when people end up on our waitlist, one of the things they're having trouble with is accessing benefits with their health plan.

Ms. Brickson: I agree, the coordination could be strengthened.

Mr. Pollack: When you screen new people, do you share these potential unmet needs with the health plan even before….

Ms. Koons: Every time. Weekly. But that doesn't mean the need is met.

Mr. Pollack: It helps the health plan to know what it should be doing.

Ms. Lapre: Right now we are redoing all of the MSSP intake forms, so if we identify any unmet needs, or if they need assistance with health plan benefits, we do address that. We try to connect them to services.

Ms. Brickson: This is a great example of how we really do need to partner.

Updates:

- **Medi-Cal Only Duals Member Handbook Changes for 2017**

  Maria Lackner, Director, Medi-Cal Product Administration

  Ms. Lackner shared with the group that the State is developing some model documents that plans must use for 2017 for their Evidence of Coverage, and that L.A. Care is waiting to receive

those model documents in order to proceed. She anticipates that L.A. Care's document will be released sometime in the summer of 2017.

- **Streamlined Enrollment at L.A. Care**

  Dwayne Broussard, Manager, Medicare Enrollment Unit

  Mr. Broussard reported on the new Streamlined enrollment process, which began September 5. Since that time, the Medicare Enrollment Unit has received 521 streamlined enrollments, with about 8% being rejected.

  Mr. Pollack: Aren't you triple checking each beneficiary before you put them through the process?

  Mr. Broussard: Yes, that's correct. We do a cursory check, then the staff checks the MARX system and the AEVS system to verify eligibility. The fact that we're getting that rejection code, for the most part, the rejections happened early on. We have worked some issues out, and its smooth going right now.

Q&A Session/Public Comment

Bobbie Wunsch, Facilitator

Ms. Bernardy: Looking at the minutes from the last meeting regarding the follow-up meetings that I had had in March over the phone, there was supposed to be feedback given to me. I have tried on two occasions. I have tried follow-up emails trying to get this same issue resolved. I have worked on it, Mr. Garcia has tried to follow up, and we haven't gotten a response. If a workflow has been developed and a management team is in place, I have not seen that in practice as an actual asset.

Ms. Wunsch: Thank you for bringing that up. I wonder if a member of the L.A. Care staff could meet with Peg and with Jaime Garcia to work out a process for getting this issue resolved, and can report back at the next meeting.

Ms. Brickson: Why don't I talk with you after the meeting, and we'll try to get the momentum going.

Follow-up Items for the next meeting

Bobbie Wunsch, Facilitator

- Update on the effort to streamline the process of placing members in long term care
- Update on discussion around adding additional consumer voices to the table.
- Introduce Follow-Up Items Grid

Future Meetings

- **Los Angeles CCI All Plan Stakeholder Workgroup**

- January 19, 2017 – Hosted at the California Endowment
- (Hosted by L.A. CAre)

- **L.A. Care CCI Stakeholder Advisory Committee Meetings for 2017**
  - Thursday, April 28, 2017 – Hosted at L.A. Care
  - Thursday, June 22, 2017 – Hosted at L.A. Care
  - Thursday, September 28, 2017 – Hosted at L.A. Care
  - Friday, December 8, 2017 – Hosted at L.A. Care