CCI Stakeholder Operational Workgroup

Wednesday, July 30, 2014
1:00 pm – 3:00 pm

The California Endowment

1000 N Alameda St, Los Angeles, CA 90012
Yosemite B

Conference Line: 213-438-5445
Access Code: 999 054 072
WebEx URL: https://conferencing.lacare.org/orion/joinmeeting.do?MK=999054072

AGENDA

1:00 – 1:10 p.m.	**Welcome and Introductions** *Bobbie Wunsch, Facilitator*
1:10 – 1:30 p.m.	**L.A. Care CCI/CMC Update** *Gretchen Brown, Senior Director of Medicare Operations*
1:30 – 2:00 p.m.	**Continuity of Care** *Dr. Trudi Carter, Chief Medical Officer*
2:00 – 2:10 p.m.	**Behavioral Health Update** *Dr. Clayton Chau, Medical Director of Behavioral Health*
2:10 – 2:20 p.m.	**L.A. Care Cal MediConnect Website** *Misty De Lamare, Communications Manager* • www.calmediconnectla.org
2:20 – 2:50 p.m.	**Q&A**
2:50 – 3:00 p.m.	**Future Meetings** *Bobbie Wunsch, Facilitator*

CCI Stakeholder Meeting
Friday, May 9, 2014
1:00 pm – 3:00 pm
Meeting Minutes

Welcome and Introductions
Bobbie Wunsch, Facilitator

L.A. Care CCI/CMC Update
John Wallace, Chief Operating Officer

Mr. Wallace stated that L.A. Care is open for voluntary enrollment through January 2015 for the Cal MediConnect (CMC). L.A. Care has 15 CMC members effective as of May 2014. DHCS has distributed approximately 42,000 voluntary enrollment notices to L.A. County CMC eligibles with October, November and December birth months.

The "crosswalk" population was described as dual eligible members (duals) who are currently with a Medi-Cal managed care plan for their Medi-Cal and have fee for service (FFS) Medicare benefits. Approximately 16,000 of these duals are currently for Medi-Cal with L.A. Care and their Medicare and Medi-Cal will be "crosswalked" or enrolled into the CMC program on July 1, 2014. We are preparing to serve these members, prioritizing member choice and ensuring correct PCP assignment by cross referencing historical Medi-Cal and Medicare encounter and claims data. We will also conduct outreach calls. Approximately, 5,500 Medi-Cal beneficiaries are currently enrolled in a CBAS program. L.A. Care will work cooperatively with the CBAS centers to also ensure L.A. Care honors correct PCP assignment for this population.

L.A. Care contracted with Neighborhood Legal Services (NLS) to deliver unbiased education to community based organizations in regards to CCI/CMC. To date, NLS has delivered 3 presentations to about 100 participants. Attendees have included staff from the following organizations: the County Department of Mental Health, County Department of Public Health, Department of Managed Health Care, social workers, clinic staff, hospital staff and other community based organizations who work with and/or are a trusted source of information for dual eligibles. The next NLS presentation is set to occur on 5/19 at Maternal Health and Child Access from 9 a.m. – 12 p.m.

The following information was provided as resources to stakeholders:

To obtain information about L.A. Care Health Plan or LA Care's Cal MediConnect Program, call L.A. Care Member Services Department at 1-888-522-1298 (TTY: 1-888-212-4460).

The Health Insurance Counseling and Advocacy Program (HICAP) is available to help you understand coverage changes and your options. For more information please contact 1-213-383-4519 (TTY:711)

or 1-800-434-0222.

Health Care Options (HCO) staff can provide information about Cal MediConnect and manage enrollment, disenrollment or opting-out of Cal MediConnect. In addition, they can help with enrollment into managed care for Medi-Cal by calling 1-844-580-7272.

The Cal MediConnect Ombudsman Program assists with beneficiary complaints and troubleshooting with Cal MediConnect issues. You can reach Ombudsman services at 1-800-896-3203. The Health Consumer Center of Neighborhood Legal Services of Los Angeles is serving as the Ombudsman in Los Angeles County.

The Medi-Cal Managed Care Office of the Ombudsman assists with beneficiary complaints and troubleshooting with Medi-Cal/MLTSS issues. They can be reached at 1-888-452-8609.

Member Onboarding
Maribel Ferrer, Senior Director of Member and Medi-Cal Services

Ms. Ferrer discussed enrollment processing and the mission and philosophy of the L.A. Care member outreach, retention, and engagement (MORE) unit. The mission of the unit is “to inform, educate, engage, and empower members and create a positive member experience that translates to increased member satisfaction.” The philosophy was noted as, “going above and beyond the average level of service to make an impact and understand our customers.”

Ms. Ferrer also described the approach in which new member welcome calls are made. The roles of the member service navigators were described as “serving as the bridge of communication among the member, member’s caregivers, providers and health plan services addressing any barriers to accessing care.” L.A. Care’s Family Resource Centers also provide new member orientations for L.A. Care members.

Medical Management Update
Anna Edwards, RNP; Director of Care Management &
Halima Bascus, RN,BSN,PHN; Director of Utilization Management

The Health Risk Assessment (HRA), Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT) were described at length. The requirements in these areas were described as utilizing best clinical outcomes to satisfy the members experience and guaranteeing that L.A. Care adheres to its model of care and CMS requirements.

Continuity of Care (COC) was described as the ability for a member to continue to see their existing providers that are currently managing their health care needs. Members may submit COC request to L. A. Care Member Services in three ways:

- Verbally via a telephone call to L.A. Care Member Services at 888-839-9909.
- In writing/on their own behalf to L.A. Care Health Plan 1055 W. 7th Street, Los Angeles, CA 90017.
- Or in writing/via a provider on behalf of their patient who is an L.A. Care member at L.A. Care Health Plan 1055 W. 7th Street, Los Angeles, CA 90017.

L.A. Care’s mission is to provide access to quality health care for Los Angeles County’s vulnerable

and low income communities, residents; as well as support the safety net required to achieve that purpose. Continuity of Care truly aligns with our mission as it prevents lapses in care, ensuring members have access to services throughout the continuum of their care.

Managed Long Term Services and Supports (MLTSS) Update
Dr. Trudi Carter, Chief Medical Officer
Judy Cua-Razonable, Dir. of Home & Comm. Based Svs & Long Term Svs & Supports &
Beau Hennemann, Long Term Services and Supports Manager

Gretchen Brickson was introduced as L.A. Care's Senior Director of Long Term Services and Supports. Her wealth of knowledge and experience offers great support to the Department and L.A. Care.

Following the introduction, it was explained that, effective April 1, 2014, MLTSS became a health plan benefit for existing L.A. Care Medi-Cal members who are also full duals. Beginning on July 1, 2014, the benefit will be extended to all existing L.A. Care Medi-Cal members regardless of their Medicare status. Beginning on August 1, 2014, duals who are excluded from enrollment in CMC, Medi-Cal only seniors and persons with disabilities (SPD) and partial duals will begin mandatory enrollment into a Medi-Cal managed care plan for their MLTSS benefits. This enrollment will be by birth month. (Please note: since this meeting, DHCS has revised the enrollment date for MSSP recipients. MSSP beneficiaries eligible for Cal MediConnect will be enrolled effective October 1, 2014. Similarly, MSSP recipients receiving services through Medi-Cal managed care or fee for service Medi-Cal and who opt out of Cal MediConnect or are not eligible will be enrolled into a Medi-Cal managed care plan for their MLTSS benefits.

LTSS services stay within the L.A. Care plan level and are not delegated to our preferred provider groups (PPGs).

L.A. Care formed a dedicated LTSS Department to work with individuals, stakeholder groups and agencies to help transition these beneficiaries. Plan partners are responsible for LTSS services. L.A. Care does provide oversight to ensure consistency and L.A. Care is responsible for final outcomes and service delivery.

Members and providers can contact the L.A. Care LTSS department with referrals at 1-855-427-1223 or LTSS@lacare.org. CBAS and LTC services require prior authorization. If a referral does not meet criteria the request it will be referred to the appropriate LTSS team and/or to L.A. Care Case Management (Social Work, Complex Case Management, Disease Case Management).

Q&A
The section below focuses on the Q&A portions that were discussed.

Question 1: How can someone opt out of the Cal MediConnect Program?

Answer: A person can opt out of the Cal MediConnect program by using the Department of Health Care Services' Health Plan Choice Form. In order to do this, the individual should leave Section 3 blank (i.e., not select a CMC plan). By leaving Section 3 blank, the individual is electing not to enroll into the Cal MediConnect program.

However, it is also important to note that, although someone may want to opt out of the Cal MediConnect program, they will still need to enroll into a Medi-Cal managed care plan to receive their MLTSS benefits. This requires making a plan selection in Section 5 on the choice form. You can mail the completed form back in the self-addressed stamped envelope or call Health Care Options (HCO) to make that decision in real time. The number to HCO is 1-844-580-7272.

Question 2: Is there a blank form that we can print from the internet and provide to clients in case they have lost their mailed materials?

Answer: The choice form version that is available on the CalDuals website (www.calduals.org) and in the handouts provided to you today are only samples. The choice forms are pre-coded for each individual eligible for enrollment in the program. Because of this, you cannot print it out, fill it in and mail it back. When the individual receives the choice form in the mail, it is prepopulated with their personal information and a barcode which is unique to every individual. The bar code is specific to each beneficiary because these forms are electronically processed/scanned when they are received by the State. If you have a printed form from the internet, it will not scan.

If you lost your choice form, need a copy or would like to enroll or opt out, it is best to call Health Care Options (HCO) to request a new form and/or make your enrollment decision over the phone with a HCO representative. The number to HCO is 1-844-580-7272.

Question 3: The experience that we have had with helping our participants call this past week as they have begun receiving the blue envelope packet is that HCO does not seem to have accurate information. Our participants are being directed to join Cal MediConnect and these are individuals who simply want to enroll into a managed care plan. The participants are getting confused and frustrated. Can L.A. Care help convey this message to HCO?

Answer: Yes, we will communicate this information to the California Department of Health Care Services.

Question 4: Regarding continuity of care and the historical claims data that will be transmitted to the preferred provider groups (PPGs), will that be done through a secure portal?

Answer: Yes.

Question 5: For those members who are auto-assigned to a PPG, will L.A. Care identify them in a way so that the PPGs can reach out to them immediately? How will that auto-assigned member be identified for eligibility?

Answer: We are developing an indicator to support this need for our PPGs. Today we provide it in an 834 file that goes out to our PPGs and we are exploring the feasibility of placing that indicator on our eligibility lists so the PPG is able to make that determination. There will be an effective date, however, you wouldn't know if it was a beneficiary that came in due to choice or auto-assignment. We are currently working on that piece and will get you an update as soon as one is available.

Question 6: Are the welcome kits and other materials ready and available in all of the threshold languages and other alternative formats? Is the provider directory available in print?

Answer: It is part of our commitment to our members and it is also a regulatory requirement to have welcome kits and other materials available both in translated and alternative formats. We do translate

all of our materials as necessary and provide alternative formats like braille and large print by request. The provider directory is now available. The most up-to-date provider directory is available online at http://www.calmediconnectla.org

Question 7: I have a case where a patient requested disenrollment, but the start month did not go through retroactively as requested. Who or what agency is liable to pay for that service?

Answer: Disenrollment is processed by the state. As long as that member is in our network, L.A. Care would be responsible.

Question 8: How much flexibility do you have in addressing the member's whole needs? The reason why I ask is because a member's social needs, their housing status, etc. can be very complex. If they don't have a place to live or they get kicked out or they are hungry, their care plan is going to be meaningless because they won't really be able to follow that care plan. As much as the Interdisciplinary Care Team sounds to me like an excellent concept, I think that it is really not going be effective at all for those members who are experiencing severe social challenges.

Answer: We will work directly with individual members based on their need and work with them to find appropriate solutions.

Question 9: Is housing status a listed question on the HRA?

Answer: Yes.

Question 10: When does the HRA need to be completed and do all the plans use the same HRA?

Answer: Upon enrollment in the CMC program, the HRA needs to be completed within 45-90 days. There is a risk stratification mechanism that indicates the completion date according to high and low risk. For the high risk beneficiaries, the HRA needs to be completed within 45 calendar days. For individuals at lower risk, the HRA needs to be completed within 90 calendar days. Not all of the health plans are using the same HRA tool, but there are certain indicators within the tool that must be addressed according to CMS regulations. All of the HRA tools need to be approved by CMS.

Question 11: Will CBAS participants who are currently enrolled in a Medi-Cal health plan like LA Care have an HRA conducted again if they choose to enroll in Cal MediConnect and already have a similar tool completed at their CBAS center?

Answer: Yes.

Question 12: The HRA completion rate was explained to be low. What is the rate of completion?

Answer: The average range of completion was between 20-30% for our existing DSNP Medicare population. For CMC, it is still too soon to determine the rate of completion.

Question 13: On what basis is an individualized care plan developed when no HRA is completed?

Answer: Outreach to the member should be completed to perform a clinical assessment and form the ICP from the discussion with the member and the members' goals and preferences. If unable to contact, the care plan can include continued communication with providers to support care needs.

Question 14: There is much confusion about SNFs and the payment with Hospice services. If a hospice is not contracted with you, yet the member has signed up for that particular hospice, how does the SNF get paid?

Answer: Hospice services themselves are not included in the Cal MediConnect program. However, an individual eligible for hospice services would remain in the Cal MediConnect program and L.A. Care would be responsible for all non-hospice services. Any services provided by the hospice provider will be paid for through fee for service Medicare.

Question 15: If ICT is at level of IPA/PPG and needs a Pharmacist on the team, can we engage the Health Plan Pharmacist? If yes, who should we contact?

Answer: Yes, this can be arranged. Contact the Care Management department to request participation in PPG ICT meetings including Pharmacy as a specialist.

Question 16: Does the CBAS referral need to come from an L.A. Care provider? For example, can the Medicare PCP refer on behalf of a patient with Original Medicare + L.A. Care Medi-Cal if the PCP is not contracted with LA Care?

Answer: CBAS referrals should come from the PCP which does not need to be an L.A. Care physician.

Question 17: If an individual chooses to enroll into Cal MediConnect and has multiple providers e.g. eye specialists, ear specialists, cardiologists, podiatrists, as well as a primary care; how will it work if some or all of those providers are not within the health plans network?

Answer: An authorization will be issued to all requested providers as long as the following criteria are met:

- quality
- payment acceptance
- established relationship

The completion of covered services shall not exceed 6 months for Medicare services and 12 months for Medi-Cal services from the effective date of coverage for the newly enrolled member.

Future Meetings
Bobbie Wunsch, Facilitator

The next meeting will be announced in a stakeholder communication via e-mail. The L.A. Care Stakeholder Operational Workgroup meets on a quarterly basis.

Cal MediConnect Resources

L.A. Care HEALTH PLAN

- To obtain information about L.A. Care Health Plan or L.A. Care's Cal MediConnect Program, call the **L.A. Care Member Services Department** at **1-888-522-1298 (TTY: 1-888-212-4460).**
- The **Health Insurance Counseling and Advocacy Program (HICAP)** is available to help you understand coverage changes and your options. For more information please contact **1-213-383-4519 (TTY: 711)** or **1-800-434-0222.**
- **Health Care Options (HCO)** staff can provide information about Cal MediConnect and assist with enrollment, disenrollment or opting-out of Cal MediConnect. In addition, they can help with enrollment into a Medi-Cal health plan by calling **1-844-580-7272.**
- The **Cal MediConnect Ombudsman Program** assists with beneficiary complaints and troubleshooting with Cal MediConnect issues. You can reach Ombudsman services at **1-800-896-3203.** The Health Consumer Center of Neighborhood Legal Services of Los Angeles is serving as the Ombudsman in Los Angeles County.
- The **Medi-Cal Managed Care Office of the Ombudsman** assists with beneficiary complaints and troubleshooting with Medi-Cal/MLTSS issues. The office can be reached at **1-888-452-8609.**

Coordinated Care Initiative

L.A. Care HEALTH PLAN

L.A. Care Health Plan Contact Card

	L.A. Care	
	Cal MediConnect	**Medi-Cal**
Member Services *(Examples: Case Management, benefit inquiries, grievance & appeals)*	888.522.1298 TTY: 1-888-212-4460	888.839.9909 TTY: 1-866-522-2731
Website	www.calmediconnectla.org	www.lacare.org
24-Hour Nurse Line	800.249.3619 TTY: 1-888-212-4460	800.249.3619 TTY: 1-866-735-2929
Pharmacy Line *(formulary available online)*	888.839.9909	888.839.9909
Transportation	866.529.2141	866.529.2141
Language Assistance Services	888.522.1298 TTY: 1-888-212-4460	888.839.9909 TTY: 1-866-522-2731

Disclaimer: This information is for LA County CCI Stakeholder use only. Please refer beneficiaries to the Member Services department for inquiries.

CalMediConnect
Your choice for complete care

Continuing Your Care After You Join a Health Plan

Coordinated Care Initiative Factsheet - February 2014

Your new Cal MediConnect or Medi-Cal health plan is required to make sure your care continues and is not disrupted. Your health plan will work with you and your doctors to make sure you get all the care you need.

You have the right to continue to receive needed services, even if you may no longer be able to receive them from the same provider. Eventually, you must get all your covered services from providers who work with your plan. These are "in-network" providers.

If you have a scheduled treatment and just joined a new health plan, call your new health plan right away. Tell the plan about your treatment so they can work with you to arrange it.

Continuing Care: Your Doctors

If your doctor is not in your plan, you may be able to continue to see them for:

- Medicare services: 6 months
- Medi-Cal services: 12 months

This applies to primary care doctors and specialists, like heart doctors, called cardiologists, or eye doctors, called ophthalmologists.

You must show a relationship with the provider in the 12 months prior to enrolling in the plan:

- Primary Care: one visit over 12 months
- Specialists: two visits over 12 months

In addition, your provider must:

- Be willing to work with the plan;
- Accept payment from the plan; and
- Not be excluded from the plan's network for quality or other concerns.

Eventually, you must get all your covered services from providers who work with your health plan. These are "in-network" providers.

See the box above for steps to continue seeing your "out-of-network" doctors.

How to See Your Out-of-Network Doctor after Joining a Cal MediConnect Plan

You may be able to see an out-of-network doctor after you join the plan.

1. Call your health plan and tell them about your scheduled care. Ask if your doctor is in their network.
2. Tell your doctor that you joined a health plan. If the doctor is not "in-network," you can ask them about joining the plan network.
3. If your doctor is "out-of-network," tell the plan you want to keep seeing your doctor.
4. If you have seen the doctor twice in the last 12 months, the plan must contact your doctor and allow you to keep seeing them. The doctor must agree to work with the health plan.
5. If you are not happy with your plan's response, you can call:
   Cal MediConnect Ombudsman:
   (855) 501-3077 [starts April 1, 2014].

(Turn Over for More Continuity of Care Information)

CalMediConnect
Your choice for complete care

Continuing Your Care After You Join a Health Plan

Continuing Care: Other Providers

You will have to get other non-doctor services through the health plan's network, such as suppliers of medical equipment, medical supplies, and transportation. You will also have to switch to home health or physical therapy providers who are in your plan's network.

Continuing Care: Long-Term Supports and Services (LTSS) Providers

If you're in a nursing home, you have a right to stay in your current nursing home under Cal MediConnect, unless it is excluded from the plan's network for quality or other concerns. Also, you can ask your health plan about getting help to return to the community.

If you're already receiving long-term supports and services (LTSS), you also won't have to change your In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) providers.

Continuing Care: Prescription Drugs

Every health plan has a list of drugs that they will pay for, a list that is called a formulary. Before you enroll in a plan, you should call the plan and see if the drugs you need are included on their formulary. Otherwise you may have to switch drugs. For example, you may need to switch between brand name and generic.

Your Rights as a Health Plan Member:

As a health plan member, you have a right to:

- Be treated with respect and dignity
- Get timely access to services for a health problem or disability
- Be told where, when, and how to get needed services
- Take part in decisions about your care, including the right to refuse treatment
- Be treated by providers who have experience/expertise in your condition
- Have your medical records and treatment kept private
- Get a copy of your medical records
- Continue to have the right to hire, fire, and manage your IHSS provider

You can always change health plans, or switch from Cal MediConnect to original Medicare and a Medi-Cal managed care plan. To make a change, call Health Care Options at 1-800-580-7272 (TTY: 1-800-430-7077.

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: *December 13, 2013*

DUALS PLAN LETTER 13-005
(REVISED)

TO: ALL MEDI-CAL MANAGED CARE PLANS PARTICIPATING IN CAL MEDICONNECT

SUBJECT: CONTINUITY OF CARE

PURPOSE:
The purpose of this Duals Plan Letter (DPL) is to clarify and provide guidance about continuity of care provided by Medicare-Medicaid Plans (MMPs) that are participating in the Duals Demonstration Project, called "Cal MediConnect."

BACKGROUND:
In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities by shifting service delivery away from institutional care to home- and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

A component of the CCI is a Duals Demonstration Project, called "Cal MediConnect." It will be implemented no sooner than April 1, 2014, in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, and San Mateo. Cal MediConnect will serve beneficiaries who are both Medi-Cal and Medicare eligible (dual-eligible beneficiaries), and will combine the full continuum of acute, primary, institutional, and home- and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by an MMP. Dual-eligible beneficiaries will be notified of their right to select a participating plan no fewer than 60 days prior to the effective date of enrollment and will receive a notice regarding implementation of the program 90 days prior. When a beneficiary makes no active choice of a participating plan, he or she will be enrolled into an MMP using a seamless, passive enrollment process; this process provides the opportunity for each beneficiary to make a voluntary choice to enroll or disenroll from the participating plan at any time. A beneficiary who chooses to disenroll will still receive his or her Medi-Cal services from a Medi-Cal managed care health plan.

Continuity of care requirements for Cal MediConnect are defined at Welfare and Institutions (W&I) Code, Section (§) 14182.17. These requirements are also set forth in the Memorandum of Understanding (MOU) between the Centers for Medicare and

Medicaid Services (CMS) and the Department of Health Care Services (DHCS); the MOU establishes the following requirements:

- CMS and DHCS will require each MMP to ensure that each beneficiary continues to have access to medically necessary items, services, and medical and long-term services and supports providers.
- DHCS will require each participating MMP to follow continuity of care requirements established in current law.
- As part of a process to ensure that continuity of care and coordination of care requirements are met, an MMP must perform an assessment process within 90 days of a beneficiary's enrollment in the participating plan.
- Upon beneficiary request, an MMP must allow a beneficiary to maintain his or her current providers and service authorizations at the time of enrollment for:
    - A period up to six months for Medicare services if the criteria are met under W&I Code §14132.275(k)(2)(A).
    - A period of up to 12 months for Medi-Cal services if the criteria are met under W&I Code §14182.17(d)(5)(G).
- Medicare Part D transition rules and rights will continue as provided in current law and regulation for the entire integrated formulary associated with the MMP.

Also consistent with the provisions of the MOU, the following exceptions are allowable:

1. An MMP is not required to provide continuity of care for services not covered by Medi-Cal or Medicare.
2. In addition, the following providers are not eligible for continuity of care: providers of durable medical equipment (DME), transportation, other ancillary services, or carved-out services.
3. An MMP may choose to not provide continuity of care with an out-of-network provider when:
    - The ability to demonstrate an existing relationship between the beneficiary and provider does not occur;
    - The provider is not willing to accept payment from the MMP based on the current Medicare or Medi-Cal fee schedule, as applicable; or
    - The MMP would otherwise exclude the provider from its provider network due to documented quality of care concerns. Under these circumstances, a quality of care issue means an MMP can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MMP beneficiaries.

CAL MEDICONNECT CONTINUITY OF CARE REQUIREMENTS:
An MMP are required to offer continuity of care to all Cal MediConnect beneficiaries who have an existing relationship with a primary or specialty care provider with some exceptions. An existing relationship means a beneficiary has seen an out-of-network primary care provider at least once or a specialty care provider at least twice during the 12 months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit.

All Cal MediConnect beneficiaries with pre-existing provider relationships who make a continuity of care request to an MMP must be given the option to continue treatment for up to six months with an out-of-network Medicare provider and up to 12 months with an out-of-network Medi-Cal provider.

If a beneficiary changes MMPs, the continuity of care period may start over one time. If the beneficiary changes MMPs a second time (or more), the continuity of care period does not start over, meaning that the beneficiary does not have the right to a new six or 12 month period depending on the type of provider. If the beneficiary returns to Fee-for-Service (FFS) Medi-Cal and later reenrolls in Cal MediConnect, the continuity of care period does not start over. If a beneficiary changes MMPs, this continuity of care policy does not extend to in-network providers that the beneficiary accessed through their previous MMP.

<u>MMP Processes</u>
Beneficiaries may make a direct request to an MMP for continuity of care. When this occurs, the MMP must begin to process the request within five working days after receipt of the request. The continuity of care process begins when the MMP determines there is a pre-existing relationship and has entered into an agreement with the provider.

The MMP should determine if a relationship exists through use of data provided by CMS and DHCS to the MMP, such as FFS utilization data from Medicare or Medi-Cal. A beneficiary or his or her provider may also provide information to the MMP that demonstrates a pre-existing relationship with a provider. A beneficiary may not attest to a pre-existing relationship (instead actual documentation must be provided) unless the MMP makes this option available to him or her.

Following identification of a pre-existing relationship, the MMP must determine if the provider is an in-network provider. If the provider is not an in-network provider, the MMP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the beneficiary.

Each beneficiary's continuity of care request must be completed within 30 calendar days from the date the MMP received the request, or *within 15 calendar* days if the beneficiary's medical condition requires more immediate attention*, such as upcoming*

appointments or other pressing care needs. A continuity of care request is considered completed when:

- The beneficiary is informed of his or her right of continued access or if the MMP and the out-of-network FFS provider are unable to agree to a rate,
- The MMP has documented quality of care issues, or
- The MMP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

If an MMP and the out-of-network FFS provider are unable to reach an agreement because they cannot agree to a rate or the MMP has documented quality of care issues with the provider, the MMP will offer the beneficiary an in-network alternative. If the beneficiary does not make a choice, the beneficiary will be assigned to an in-network provider. Beneficiaries maintain the right to pursue an appeal through the Medicare and Medi-Cal processes.

If a provider meets all of the necessary requirements including entering into a contract, letter of agreement, single-case agreement, or other form of relationship with the MMP, the MMP must allow the beneficiary to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the MMP for a shorter timeframe. In this case, the MMP must allow the beneficiary to have access to that provider for the shorter period of time.

At any time, beneficiaries may change their provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the MMP must work with the provider to establish a care plan for the beneficiary.

<u>MMP Extended Continuity of Care Option</u>
MMPs may choose to work with a beneficiary's out-of-network doctor past the six or twelve month continuity of care period, but MMPs is not required to do so.

<u>Beneficiary and Provider Outreach and Education</u>
MMPs must inform beneficiaries of their continuity of care protections and must include information about these protections in their beneficiary information packets and handbooks. This information must include how a beneficiary and provider initiate a continuity of care request with the MMP. These documents must be translated into threshold languages and must be made available in alternative formats, upon request. MMPs must provide training to call center and other staff who come into regular contact with beneficiaries about beneficiary continuity of care protections.

Provider Referral Outside of the MMP Network
An approved out-of-network provider must work with the MMP and its contracted network and cannot refer the beneficiary to another out-of-network provider without authorization from the MMP. In such cases, the MMP will make the referral, if medically necessary and if the MMP does not have an appropriate provider within its network.

Durable Medical Equipment
For DME, MMPs must provide continuity of care for services, but are not obligated to use providers that are determined to have a pre-existing relationship, for the applicable six or twelve months.

Nursing Facilities
A beneficiary who is a long term resident of a nursing facility (NF) prior to enrollment will not be required to change NFs during the duration of the Duals Demonstration Project if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and MMP agree to Medi-Cal rates in accordance with the three-way contract.

EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA LAW:
In addition to the protections set forth above, Cal MediConnect beneficiaries also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with W&I Code §14185(b), MMPs must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the MMP, until the prescribed therapy is no longer prescribed by the contracting physician.

Additional requirements pertaining to continuity of care are set forth in Health and Safety (H&S) Code §1373.96 and require all health plans in California to, at the request of a beneficiary, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under this Section, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment. Health plans must allow for the completion of these services for certain timeframes which are specific to each condition and defined under H&S Code §1373.96.

If you have any questions regarding this DPL, please contact Sarah Brooks, Chief, Program Monitoring and Medical Policy Branch at sarah.brooks@dhcs.ca.gov.

Sincerely,

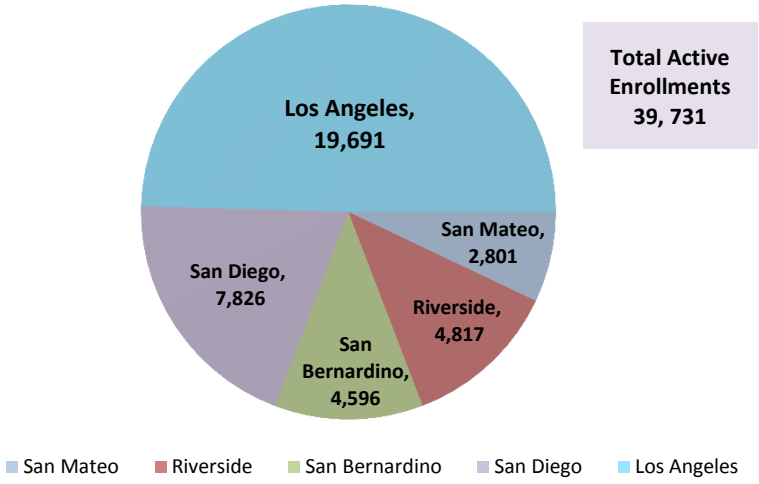
Original Signed by Margaret Tatar

Margaret Tatar, Assistant Deputy Director
Health Care Delivery Systems

Cal MediConnect Monthly Enrollment Dashboard
As of July 1, 2014

Creation Date: 7/15/14

Total Active Enrollments Effective July 1, 2014 by County



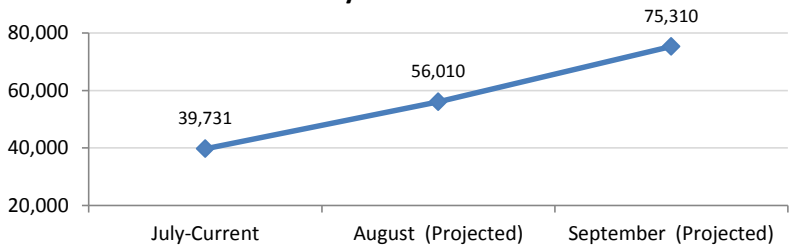
Total Active Enrollments 39, 731

Projected Enrollments - Two Month Look Ahead

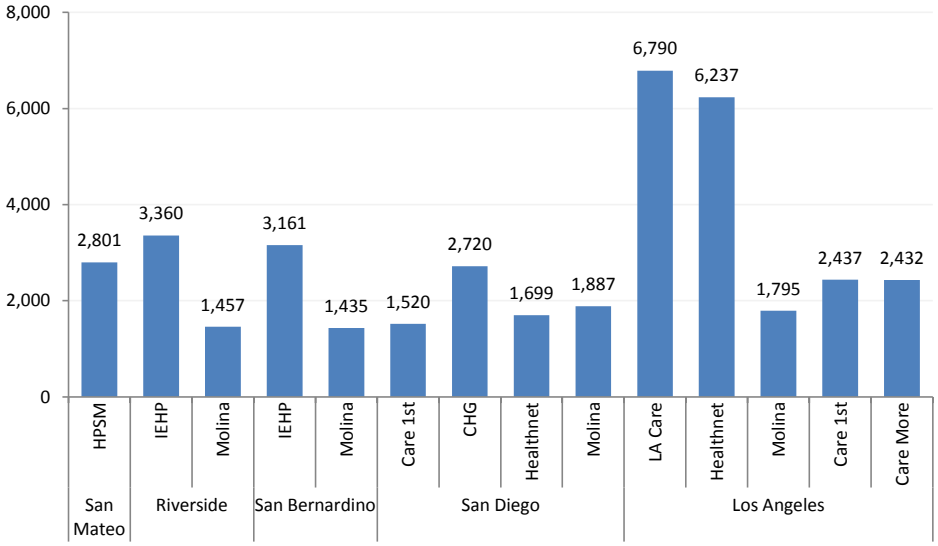
County	Active Enrollments as of 7/1/14	August Pending Enrollments	September Pending Enrollments	Total Projected Enrollments for Sept Month of Eligibility*
San Mateo	2,801	0	0	2,801
Riverside	4,817	1,366	1,539	7,722
San Bernardino	4,596	1,299	1,573	7,468
San Diego	7,826	2,265	2,654	12,745
Los Angeles	19,691	11349	13,534	44,574
Total	**39,731**	**16,279**	**19,300**	**75,310**

* Projected enrollments are based on passive enrollment transactions submitted 60-days prior to the enrollment effective month. Voluntary (Opt-in) enrollment projections are not included in these statistics.

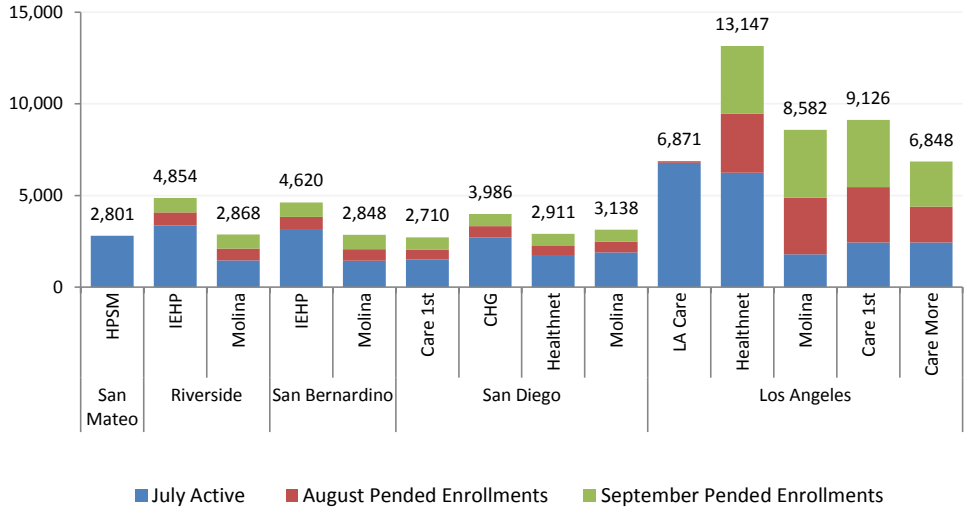
Monthly Enrollment Trend



Total Active Enrollments Effective July 1, 2014 By Plan



Projected Enrollment Estimates for September Month of Eligibility by Plan



Data Sources: MEDS June MOE 2014, pulled on 7/2/14

Cal MediConnect Monthly Enrollment Dashboard
As of July 1, 2014

Creation Date: 7/15/14

DHCS Health Care Options Mailing Schedule[1]

	2014								2015					
Phase --->	1	2	3	4	5	6	7	8	9	10	11	12	13	14
For Coverage Effective Date -->	May 1[2]	Jun 1	Jul 1	Aug 1	Sep 1	Oct 1	Nov 1	Dec 1	Jan 1	Feb 1	Mar 1	Apr 1	May 1	Jun 1
90-day Notice -->	Jan 2 & Feb 3	Feb 26	Mar 28	Apr 28	May 22	Jun 26	Jul 29	Aug 27	Sep 26	Oct 29	Nov 24	Dec 29	Jan 28	Feb 25
90-day notice volume-->	21,805	7,763	53,625	22,927	21,157	22, 263								
60-day Notice -->	Feb 26	Mar 28	Apr 28	May 27	Jun 26	Jul 29	Aug 27	Sep 26	Oct 29	Nov 24	Dec 29	Jan 28	Feb 25	Mar 28
Choice Packet -->	Mar 6 - Mar 11	Mar 31	Apr 30	May 29	June 30	Jul 31	Aug 29	Sep 29	Oct 31	Nov 26	Dec 31	Jan 30	Feb 27	Mar 31
60-day+choice packet volume-->	18,122	6,907	49,046	24,054	20, 193									
30-day Notice-->	Mar 28	Apr 28	May 28	Jun 26	Jul 29	Aug 27	Sep 26	Oct 29	Nov 24	Dec 29	Jan 28	Feb 25	Mar 28	Apr 28
30-day notice volume-->	15,360	5,391	36,644	19, 341										

1. Health Care Options (HCO) Maximus mailings for Riverside, San Bernadino, San Diego and Los Angeles Counties. San Mateo Notices were sent by the Health Plan of SanMateo.
2. Maililngs for May 1, 2014 coverage start date include April and May birth months.

San Mateo Mailing Schedule for April 1 Coverage Effective Date	**90-day**	**60-day**	**30-day**
Mail Date -->	Dec 28	Jan 29	Feb 21
Volume -->	4,547	4,285	3,637

HCO Call Center Statistics June 2014

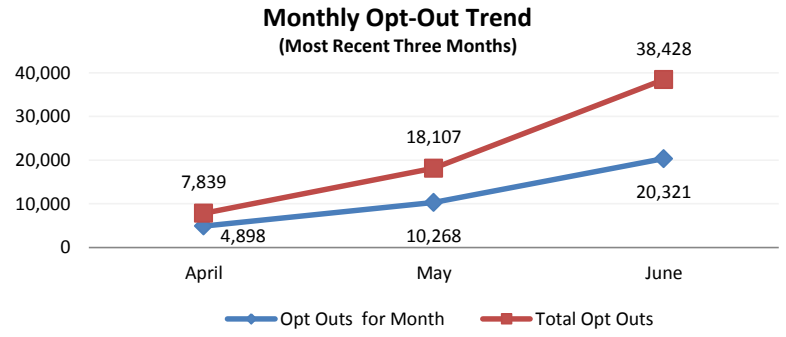
For Week Ending	Total Calls Received[1]	Total Calls Answered	Total Calls Abandoned	Average Abandon Rate	Average Talk Time (Minutes)	Average Wait Time (Minutes)
06/06/14	12,810	10,268	780	6.09%	9.25	1.36
06/13/14	11,555	9,889	521	4.51%	9.52	1.20
06/20/14	9,545	8,783	201	2.11%	9.28	0.65
06/27/14	10,222	8,974	349	3.41%	9.20	0.90
Totals for Month	**44,132**	**37,914**	**1,851**	**4.19%**	**9.31**	**1.03**

1. Total calls received are hits to the call center system. Members may receive assistance in an automated phone tree, therefore are not accounted for in the call answered or abandoned counts.

Opt-out Requests by Month/County[1]

County	Apr	May	June	Totals[2]	% of Passive[3]
San Mateo	36	5	66	1,421	31.25%
San Bernardino	1,186	768	1,302	3,692	26.24%
San Diego	1,724	1,767	2,154	6,375	27.05%
Riverside	1,132	700	1,121	3,414	25.10%
Los Angeles	820	7,028	15,678	23,526	30.94%
Total	**4,898**	**10,268**	**20,321**	**38,428**	**29.15%**

1. Table includes the most recent three-months of opt-out (including voluntary disenrollment) requests.
2. Totals are cummulative opt-outs from the start of the Cal Mediconnect program.
3. The Opt-Out % is applied to 90 day mailings within the county excluding the most current 90 day mailing.



Data Sources: Beneficiary notice schedule: From Maximus and HPSM notice timeline reports
Call Center Statistics: HCO Weekly CCI Call Center Report dated 6/30/14