CCI Stakeholder Meeting
Wednesday, October 23, 2014
1:00 pm – 3:00 pm
Meeting Minutes

Welcome and Introductions
Bobbie Wunsch, Facilitator

Ms. Wunsch welcomed stakeholders and walked them through the handout materials including the agenda. She mentioned that this meeting will be assisted by an operator on the phone to support with the queue of questions from those on the telephone. It was described that the PowerPoint was made available to the audience and those participants who have dialed in.

Ms. Wunsch introduced John Wallace.

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

Low Performing Icon (LPI)
Mr. Wallace first announced that CMS has officially released L.A. Care's 2015 Medicare Star Ratings. L.A. Care successfully made improvements by achieving a 3.5 star rating for Part D (Prescription Drug Coverage) and a 3.0 star rating for Part C (Hospital and Medical Coverage). This eliminated the Low Performing Icon, and allows for L.A. Care to participate in passive enrollment under the Cal MediConnect (CMC) program beginning January 1, 2015.

L.A. Care continued to receive voluntary enrollees throughout the fourth quarter and managed the crosswalk population of current CMC eligible Medi-Cal members into Cal MediConnect.

D-SNP Termination
Mr. Wallace explained that L.A. Care notified CMS that it will not renew its contract for the D-SNP product for Contract Year (CY) 2015. He also stated that L.A. Care will continue to operate the D-SNP through December 31, 2014. This allows L.A. Care to fully focus on making the Cal MediConnect program a success.

John Wallace identified that the majority of L.A. Care's current Medicare D-SNP members will transition to the L.A. Care Cal MediConnect Plan on January 1, 2015. L.A. Care expects to receive between 10,000 - 14,000 Cal MediConnect members in January. These members will be a combination of our Medicare D-SNP crossover membership and our first passively enrolled members (eligible beneficiaries with a January birth month and LIS Part D Reassignees). These numbers are subject to change based upon state projections and other contributing factors, like opt out rates.

The remaining DSNP members who are not eligible for Cal MediConnect will be able to continue with L.A. Care for their Medi-Cal coverage, while enrolling in another Medicare plan or joining Medicare Fee-for Service. L.A. Care D-SNP termination notices were mailed out and were received by members on October 2, 2014. L.A. Care is working collaboratively with State and Federal regulators as well as community advocates and stakeholders to ensure members

are aware of the change and their options. We are also working with non-CMC health plans to help provide support and information on coordinating Medi-Cal services for these dual eligibles.

L.A. Care CCI/CMC January 2015 Readiness

Cal MediConnect Provider Network

L.A. Care's Provider Network Operations department launched "phase two" of their outreach to add new provider groups to our Cal MediConnect provider network. The emphasis is on adding many of the Medicare D-SNP provider groups to ensure that the highest proportion possible of our current Medicare D-SNP members will keep their current primary care physician when they transition to Cal MediConnect.

Robust Provider Groups, Hospital and Ancillary Networks Developed:

- Over 200 SNF's contracted for skilled and long term care, with additional contracts forthcoming
- Extensive provider relations training and implementation planning
- Focused provider data system configuration efforts

Contracted Providers	Provider Groups	Hospitals	Ancillaries
Cal MediConnect **Network as of 10/1/15*	21	57	698

Cedars-Sinai

In order to continue to improve member access to high quality care, contracts with Cedars-Sinai providers and hospital have been executed. The Cedars-Sinai Managed Care Network will be available to L.A. Care CMC members effective September 1, through L.A. Care.

L.A. Care's Audit Results

L.A. Care underwent and extensive Medicare D-SNP Program audit in early 2014. As a result, L.A. Care has submitted and CMS has accepted corrective responses to audit findings. As of today, L.A. Care stands with an overall program score of 94%.

Balance Billing

Wendy Magnacca, Claims Director

Ms. Magnacca informed the group that all claims must be received within 365 calendar days from the service date unless your contract specifies differently. Health plans and delegates have 30 calendar days to process claims. Contracted providers have 365 calendar days from the claim processing date to dispute a payment or denial.

The following contact information was also provided:

Paper claims mailing address

L.A. Care Health Plan
Attn: Claims Department
P.O. box 811580
Los Angeles, CA 90081

Provider dispute mailing address

*The provider dispute form can be found at www.lacare.org
L.A. Care Health Plan
Attn: Appeals and PDR Unit
P.O. box 811610
Los Angeles, CA 90081

Claims inquiry telephone number

- 1-866-LACARE6
- 1-866-522-2736
    - Select number two (2) when prompted

CMC claims are adjudicated following the Coordination of Benefits rules which determine the order of payment responsibility. Both Medicare and Medi-Cal are processed by L.A. Care or delegates:

- **Medicare Primary:** covered benefits are paid and member liability deducted if applicable. Medicare non-covered services will be denied and processed under the Medi-Cal coverage.
- **Medi-Cal Secondary:** Medi-Cal rules and benefits are applied:
    - If Medicare covers the service and Medi-Cal does not, the claim will be processed and paid under Medicare. Any member liability will not be paid under the Medi-Cal coverage.
    - If Medicare does not cover the service and Medi-Cal does, the claim will be processed and denied under Medicare. Claim will then be processed under Medi-Cal applying Medi-Cal guidelines and benefits.
    - If Medicare and Medi-Cal both cover the services, the claim will be processed under Medicare first then processed under Medi-Cal. Medi-Cal will cover any member liability deducted from the Medicare payment.

Dual coverage claims are adjudicated following the Coordination of Benefits rules which determine the order of payment responsibility.

When Medicare coverage is with a different health plan other than L.A Care or delegates:

- **Medicare Primary:** Claim processed by prime carrier health plan:
    - If the service provided is a covered service under Medicare, L.A. Care will require the Explanation Medicare Benefits to adjudicate the claim under the Medi-Cal coverage. Medi-Cal will cover any member liability deducted from the Medicare payment.
    - If the service is not covered under Medicare, L.A. Care will not require the Explanation Medicare Benefits to adjudicate the claim under the Medi-Cal coverage. The claim will then be processed under Medi-Cal applying Medi-Cal guidelines and benefits.

Glucose Meters
Bianca Eyherabide, Director of Provider Contracting

Ms. Eyherabide conveyed that blood glucose monitors are covered as per L.A. Care's pharmacy benefits and as of this meeting L.A. Care covers the precision extra reader and test strips for individual blood glucose monitoring. L.A. Care is able to provide free meters along with reimbursement through our pharmacy benefit manager for test strips and lancets.

L.A. Care is aware that SNFs are accustomed to utilizing "house meters". "House meters" are intended for facilities or institutional use on multiple occasions. We are aware of the operational impact of this issue and are currently evaluating and researching it to determine the best way to address it.

Ms. Eyherabide concluded that, as soon as we have an update, we will inform this group and the providers that this impacts.

Bed Hold Authorizations
Judy Cua-Razonable, Director of MLTSS

Ms. Cua-Razonable described the regulations that encompass bed hold (BH) authorizations. The requirements were extracted from the State of California Medi-Cal Website.

Bed Hold General Requirements

- The day of departure is counted as one day or BH.
- A facility will hold the bed vacant during BH.
- A BH is ordered by a licensed physician.
- A recipient's return from BH must not be followed by discharge within 24 hours.
- A BH must terminate on a recipient's date of death.
- A facility claim must identify the inclusive dates of leave.
- When a recipient residing in a nursing facility is admitted to an acute care hospital or under skilled level of care, providers must bill BH days.

Reimbursement for BH days is subject to the following:

- The BH is limited to a maximum of seven days per hospitalization.
- The attending physician must order the acute hospitalization.
- The facility must hold a bed vacant when requested by the attending physician, unless the attending physician notifies the Skilled Nursing Facility (SNF) that the recipient requires more than seven days of hospital care.
- **Note:** The facility cannot hold a bed after seven days. Claims submitted for BH for more than seven days will be denied.

Billing Limitations: Statutory and Regulatory Authorities

Welfare and Institutions Code (W&I Code), Section 14019(a) states: "Any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payer who provides a contractual or legal entitlement to health care services."

California Code of Regulations (CCR), Section 51470(d) states: "A provider shall not bill or submit a claim to the depart of a fiscal intermediary for Medi-Cal covered benefits provided to a Medi-Cal beneficiary:

- for which the provider has received and retained payment."

CCR, Section 51458.1(a) states: "The Department shall recover overpayment to providers including, but not limited to, payments determined to be:

- In excess of program payment ceilings or allowable costs…
- (9) For Medi-Cal covered services already paid for by the beneficiary, but not yet refunded, or for services already reimbursed by the Department or other coverage…
- (13) In violation of any other Medi-Cal regulation where overpayment has occurred."

Provider Reimbursement Manual (HCFA Publication 15-1), Section 2105.3 states: "Providers are permitted to enter into reserved bed agreements, as long as the terms of that agreement do not violate provisions of the statute and regulations which govern provider agreements which

- Prohibit a provider from charging the beneficiary or other party for covered services…"

The Delegated Model
Jasmine Young, Director of Provider Relations

Ms. Young defined delegation as occurring when the organization gives another entity the authority to carry out a function that it would otherwise perform. This authority includes the right to decide what to do and how to do it, within the parameters stipulated by regulators, program standards and agreed on by the organization.

Ms. Young described that NCQA requires a delegation agreement which is a mutual agreement between the delegating organization and its delegate that is performing specific functions related to its own and NCQA standards. She also mentioned that NCQA requires oversight and monitoring which the organization must oversee to ensure that the delegate is properly performing the functions. The organization may reclaim the responsibility for delegated functions at any time.

Health Plans may choose to share administrative responsibilities and the responsibilities of providing care to members. If a Health Plan chooses to share responsibilities, regulatory agencies such as CMS, DMHC, DHCS as well as accrediting bodies (NCQA and URAC), define expectations regarding delegation and the Health Plan's responsibility for structured oversight of the selected vendor. In general a health plan delegates the authority to perform services, and the health plan retains the responsibility to ensure that the services are performed in compliance with all regulatory requirements and accrediting standards.

Ms. Young concluded that delegates are required to undergo a pre-contractual audit prior to performing a delegated activity. If you have provider relations training inquiries, please call (213) 694-1250 ext. 4719 or send an e-mail to providerrelations@lacare.org. The fax number is (213) 438-5032.

Future Meetings

Bobbie Wunsch, Facilitator

- L.A. CCI Stakeholder Workgroup 11/12/14 at the Cathedral

Questions and Answers

Q: For those DSNP members who are eligible for CMC, will they be automatically converted to CMC?

A: The vast majority of our current D-SNP members will transition from the D-SNP into Cal MediConnect on January 1, 2015, unless they actively make a choice to transition instead to original Medicare or a Medicare Advantage Plan for their Medicare. They will still need to enroll in a Medi-Cal Managed Care Plan for their Medi-Cal benefits

Q: What do your January 2015 enrollment projections look like and how many of those are D-SNP members?

A: L.A. Care will receive passive enrollment in January 2015. We are currently estimating that 10,000 – 14,000 Cal MediConnect members will be enrolled in the L.A. Care Cal MediConnect program in January 2015. This includes the 6,700 members that are currently in our D-SNP today, passive enrollment and choice.

Q: Is the L.A. Care contract with Cedars-Sinai for Cal MediConnect new?

A: Yes, L.A. Care is pleased that we have a contract in place with Cedars-Sinai Managed Care Network effective since mid-August of 2014.

Q: How will people get assigned to L.A. Care or Health Net or another plan? Is there some type of formula?

A: Yes, there is a formula. The way the process works for passive enrollment is through member prior affiliation. First, the State looks retroactively at historical Medi-Cal and Medicare claims data over a six month period. Secondly, they identify their Medicare primary care physician (PCP) or regular source of care if they do not have a PCP. Then there are the ones that are called pure auto assignment. These are people that do not have a prior affiliation or their PCP is in more than one L.A. County CMC health plan network or not in either one of those networks. These beneficiaries will be

automatically assigned to a health plan.

Q: Is UCLA participating in the Cal MediConnect program?

A: L.A. Care currently has a contract with UCLA for tertiary services for Cal MediConnect. We are working with them to finalize additional contracts with them for medical group and hospital services for our L.A. Care lines of business.

Q: How does a Cal MediConnect member get assigned to a PCP?

A: L.A. Care uses historical claims data to identify which primary care physician (PCP) the member has visited most within the last year. This physician is then assigned to the member who is enrolled in Cal MediConnect.

Q: What if the member has seen multiple doctors in multiple networks or their Medi-Cal was with one plan and their Medicare was with another plan? How would PCP assignment work then?

A: We manage that PCP assignment very closely. If the member has two separate health plans, our member services department will reach out to the member, inform them of the situation and encourage them to select their preferred physician under his/her participating contracted medical group.

Q: I am an MSSP provider and we have some clients who have opted out of CMC because they want to keep their Medicare as is because they want to keep their current provider. If the provider is not part of the L.A. Care network, but their Medi-Cal is with L.A. Care, does that interfere with services? An example of that could be incontinence supplies, which is a Medi-Cal benefit.

A: No, this should not impact the members' care. A referral simply needs to be made to L.A. Care so that the incontinence supplies can be authorized. If it is a service that is not covered by Medicare, then we would have to have the authorization for the service to be rendered and then we would pick up the cost based on the Medi-Cal benefit.

Q: Is the provider community informed of the coordination of benefits for duals that have opted out and only have the Medi-Cal for the health plan? Where do they bill for the coordination of benefits?

A: Yes, L.A. Care is working actively to implement processes and communicate with non-CMC participating health plans on how to coordinate Medi-Cal services for their dual members who have L.A. Care for Medi-Cal. Additionally, L.A. Care has developed and conducts targeted training for fee-for-service Medicare providers. The purpose of this training is to help educate them on the Cal MediConnect program, including how to bill. We also utilize the materials that have been provided to us by the State as part of their provider toolkit. These are available at http://www.calduals.org/physician-toolkit/

Q: What is L.A. Care doing about providers who have no affiliation with L.A. Care? I am referring to those providers who are actually denying care to patients. These providers do not want to be affiliated with managed care plans. What are your plans for reaching out to those kinds of providers that have no previous relationship with L.A. Care?

A: One reason we are outreaching and collaborating with our contracted hospitals is because we know that there are unaffiliated providers who don't work with any managed care plans. The work is around outreaching to the network that is not contracted, not only with L.A. Care, but with no other managed care plans.

Q: What if an L.A. Care CMC member wants to go see their doctor and their doctor is not part of L.A. Care's network? Who is processing that out-of-network authorization for that doctor?

A: If the member has been seeing this primary care provider for the last six months and recently joined Cal MediConnect, L.A. Care and the assigned IPA would be responsible for arranging that coordination of care with that physician.

Q: If I have an issue with a delegated group who should I speak with?

A: Please call our Provider Relations line at (213) 694-1250 ext.4719 or send an e-mail to ProviderRelations@lacare.org

Q: What are the challenges or successes you have encountered working with the IPAs and guaranteeing continuity of care?

A: As with any new program, a key challenge is building effective processes to ensure services are provided smoothly and all parties are well-informed of the new program requirements. L.A. Care takes continuity of care very seriously and devotes significant efforts to continuously improving this process.