CCI Stakeholder Advisory Committee Meeting
Friday, September 18, 2015
1:00 pm – 3:00 pm
Meeting Minutes

Welcome and Introductions
Bobbie Wunsch, Facilitator
John Baackes, Chief Executive Officer, L.A. Care Health Plan
Maria Lackner, Medicare Product Manager, L.A. Care Health Plan

Ms. Wunsch welcomed the group and asked that both the committee members and their alternates, if in attendance, sit at the table. The committee members introduced themselves. Those in attendance were:

David Kane, Neighborhood Legal Services & LA County CCI Ombudsman Office
Rigo Saborio, Saint Barnibas Senior Services
Aileen Harper, Center for Health Care Rights
Karen Widerynski, California Association of Health Facilities
Jennifer Schlesinger, Alzheimer's Association
Jaime Garcia, Hospital Association of So. California
Eileen Koons, Huntington Hospital
Rus Billimoria, Preferred IPA
Cynthia Banks, Area Agencies on Aging
Todd McClure Cook,Providence Health & Services, California
Teresa M. Hernandez, Huntington Hospital

Absent:
Denny Chan, Justice In Aging
Wayne Sugita, County of Los Angeles Dept. of Public Health
Arturo Nevarez, Southern Ca. Resource Services for Independent Living
Roderick Shaner, L.A. County Dept. of Mental Health
Demetria Saffore, L.A. Care CMC Member

Mr. Baackes greeted the group and spoke about ways in which L.A. Care has grown since the implementation of the Affordable Care Act and the challenges presented by that rapid growth. He touched on an impending restructure as part of the effort to meet the varied needs of the duals population.

Ms. Wunsch gave a brief overview of the new committee and meeting format, introducing the charter for the new Stakeholder Advisory Committee (SAC) and informing the group of upcoming meetings.

Ms. Lackner requested feedback on the SAC charter, encouraging Committee members to take a look

and ask any questions before the charter is finalized.

L.A. Care CCI/CMC Update
Gretchen Brown, Sr. Director, Medicare Product Management, L.A. Care Health Plan
Maria Lackner, Manager of Medicare product Management, L.A. Care Health Plan
Beau Hennemann, Manager of Home and Community Based Services, L.A. Care Health Plan

Enrollment Update
Ms. Brown discussed program enrollment numbers with the group, including State and health plan enrollment trends as well as projected enrollment rates for the rest of the year. She noted that the continued high disenrollment rates are likely the result of passive enrollment earlier in the year. It is hoped that as we become further distant from the end of the passive enrollment phase, and as members learn more about the benefits of an integrated health plan, the enrollment numbers will start to pick up and member retention will improve.

Ms. Lackner spoke briefly about disenrollment trends as revealed by L.A. Care's CMC-approved disenrollment survey and self-reported reasons beneficiaries are providing for opting to disenroll from CMC. She also reviewed some high-level descriptors on L.A Care's CMC member demographics and discussed the initial impacts of the integration of Behavioral Health into managed care.
Mr. Hennemann discussed current enrollment and referrals to L.A. Care's CCI/CMS MLTSS program.

Ms. Lackner shared L.A. Care's onboarding process followed by open dialogue amongst the committee members on recommendations for L.A. Care on how to improve and better refine the member introductory and onboarding process.

Committee members voiced several inquiries in response to the data that was presented and reviewed by L.A. Care. Please see the Q&A section of this meeting summary below.

Future Meetings
Bobbie Wunsch, Facilitator

The following dates are upcoming stakeholder workgroups:

- Los Angeles CCI (All Plan) Stakeholder Workgroup (L.A. Care will host)
  - October 22, 2015 (1 – 3 p.m.)
  - The California Endowment
- L.A. Care CCI Stakeholder Advisory Committee Meeting (Winter Session)
  - December 2, 2015 (1 – 3 p.m.)
  - L.A. Care Health Plan (Headquarters Downtown Los Angeles)

Q&A Between Stakeholder Committee Members and L.A. Care Staff

Q: We didn't get a copy of the Enrollment Trends Slide

A: We'll include it with the summary of the meeting

Q: What, currently, is your disenrollment rate?

A: Approximately 40% to 45% of total membership is enrolled, with the remaining opting out or disenrolled. Our disenrollment rates can fluctuate from month to month, depending on a number of reasons.

Q: If Providers are in the L.A. Care CMC network, aren't they in the Provider Directory? Are members not looking in the directory?

A: L.A. Care's online provider directories are updated regularly. It is L.A. Care's experience that some members seek advice from their PCP or PCP office staff, and if the PCP says they are not contracted with L.A. Care, the member is more likely to opt out or select another plan. We are focusing on educating the provider and the provider's staff, who may not be aware that they are contracted with L.A. Care.

Q: With regards to the provider, is there a different rate for the care they provide under L.A. Care than they would for another contract?

A: (John Baackes) The problem is if the doctor and medical group or IPA [the members] belong to is in a Medicare Advantage plan or dual special needs plan (DSNP), they're probably getting a Medicare reimbursement rate. When the duals program was implemented, because our arrangements with our CMC providers are usually capitated and because the reimbursement for the duals program has built-in savings imposed by State and CMC, the savings have to be passed down to the providers and the capitation payment, in general is lower than the payment they may receive from another Medicare program.

Q: Regarding disenrollment trends/reasons: Do you have a sense of how much this mirrors what other plans are experiencing? Is the state involved in your findings? I know there are a lot of studies being done, but really, beside this dashboard, very little information about what is really going on with enrollment.

A: (Maria Lackner) We have had conversations with other participating health plans, and they have communicated similar anecdotal information from what they've been able to gather conducting disenrollment surveys of their own. We have been participating in collaborative groups with other CMC health plans, not just in LA County, but also throughout the state and having conversations with not only DHCS but also CMS to let them know about this information that we are able to gather. The state is not gathering disenrollment information to our current knowledge. When beneficiaries call, HCO has two different roles, and so we've been encouraging them to collect some of that data so we can compare.

John Baackes: The disenrollments in California have been the highest across the nation. One of the issues is that lack of adoption and endorsement by the doctors. The program would benefit from additional provider and beneficiary education. California is not alone, there are 11 or 12 states doing this, and they've all had the same issue. Basically, the member finds out about the program when they get the letter, which is confusing for most. Most physicians find out about the program when the health plan tells them, so it's a problem.

Q: With regard to the Behavioral Health information presented, is that grand total for L.A.

Care, or are those unique members? And which setting does this represent?

A: They are unduplicated CMC members, and they represent both specialty as well as primary, both outpatient and inpatient.

A lot of these numbers represent what we know about the members. We're doing a really good job in completing the HRAs, but the HRAs are self-reported. This is what's coming up. We are continuing to conduct HRAs, and we're seeing that more and more referrals are occurring, not only to behavioral health, but to the county, and we're trying to connect our members to the right services. We anticipate that these numbers will continue to increase. This is only representative of the primary diagnosis as of the last date of service. This might not reflect the entire population. We'll work with Dr. Chau to develop data that's more reflective of what is going on with our members.

Q: This is not reflective of those who are seeking Medicare coverage, then? This is just Medi-Cal benefits?

A: Yes, because it's the primary.

Q: What constitutes an unreachable individual when conducting the Health Risk Assessment (HRA)?

A: Someone who we may have inaccurate contact information for (i.e. phone number or address). Our Medicare population tends to move a lot or change their residence and they don't always inform the health plan of that change. When we attempt to call them, it's disconnected, or they no longer live there, and then when we try to send them mail, that is also sometimes returned. We have to rely on other ways of contacting them, such as getting their current information from their provider or via a pharmacy visit.

Q: Regarding the DHCS HRA Dashboard-Are these L.A. Care-specific statistics? Then, on the graph, it appears that L.A. Care is at 2%.

A: We have spoken with the state about this chart. They're making edits to the way they're collecting data. Also, L.A. Care data is as of September 2015, whereas the DHCS information that you have in front of you is as of March 2015, so there is a wide difference. Also, in March, L.A. Care had only participated in three months of passive enrollment, so our membership was lower. As for September, our membership was significantly higher due to six months of passive enrollment.

Q: Does it have to be the member that completes the HRA?

A: No, the member can have an authorized representative or if there is a caretaker who can help, as long as the beneficiary provides their consent, the caretaker can assist in completing the HRA on their behalf.

Q: I was just made aware of an interesting issue where the beneficiary's primary language is something other than English, and that individual when receiving written materials that they're not going to act on for whatever reason, they get help from a family member. But the family member doesn't speak the beneficiary's language. Do you have a way of recording who it is that you're going to be working with so that you can be sure to reach out to *that* person in the appropriate language?

A: When we do onboarding for new members, part of what we're looking for is whether or not there is

an authorized representative that will be acting on behalf of the beneficiary, whether it's on file or needs to be on file with the health plan. If there is someone who is an authorized representative, we will work with them to get their information in the system and ensure materials are provided or translated for them.

Q: How does LA care deal with members who can no longer consent? This has been a problem for years, that there is not a good provision for having a recognized decision maker in the absence of the court in the absence of the individual being able to consent. Could any of that explain the HRA, the unreachables?

A: (Maria) I don't know, I can certainly find out. I can see what processes and policies we have. I think it's a great question, and we definitely want to make sure that if there isn't anything in place, we're thinking about it. I'll find out and bring it back to the group.

Q: (Gretchen) Can David from Neighborhood Legal Services weighs in? You've done a lot of work on that.

A: (David Kane) People think we do a lot of work on that, but it's an obstacle that no one has solved yet. The process that used to be in place in nursing homes is now unconstitutional, so as far as options for some people. We haven't solved that at the ombudsman yet, sorry. With the state's enrollment broker, Healthcare Options, if someone wants to make an enrollment decision or change, you can have somebody who knows you call on your behalf if you're without capacity, answer some questions over the phone, and make a one-time enrollment decision on your behalf. That's the best we've got right now.

Q: So if the state hasn't provided the authorized representative in the eligibility file, and the plan does its best to identify that person, and you said it's documented in the records to the health plan, how is that communicated to the providers.

A: The eligibility file and HRA information that is communicated to providers may contain that detail.

Q: Are the CPO providers evaluated on an annual basis?

A: (Beau Hennemann) We haven't because we've only been going for a few months, but that's something we will be looking at.

Q: (Question posed to Committee Members: What additional efforts/strategies can L.A. Care consider for member onboarding?

-and-

How can we collaborate with community stakeholders on member onboarding efforts?

A: (Todd) One way I see we would be able to help and also get knowledge for ourselves would be if you had some sort of PDF element that would be the same thing you tell a member, I know my people are bedside. Once they have them in a bed, they're not going anywhere for a while, so there's a lot of opportunity for them to affirm their options, how to access, what to do that we could help reinforce. We just don't have the knowledge and the information, nor the materials to really get them.

Q: Can you talk about the onboarding process for the opt-out people who remain in L.A. Care for Medi-Cal?

A: The truth is that we've been treating them like our regular Medi-Cal members, and they've been receiving the same information that our Medi-Cal members receive, and that's predominantly the state-required materials and communications. Beau and Henry have been working on how we can enhance the MLTSS beneficiaries, so I think we've had initial conversations and lots of ideas, and we will be vetting that information with you here.

Q: Have you considered during the sessions, partnering the new members? That way they can ask questions of each other and feel like they're part of a group. Older adults like having buddies as they move forward.

A: We haven't used that approach, per se. Our new member orientations are conducted in groups when possible, when it's appropriate for the individuals who are registering. If it's only one person, we're not going to delay their orientation to wait for a group, so we do those one on one.

Q: (Aileen??) I don't have any solutions for you, but I would suggest you think very seriously about looking at the opt-outs and disenrollment from what was your high risk group. There's a correlation there between the high opt-outs and LA Care's current strategies. I think you have to think about who it is that you're losing, and what would work for them 'cause they're never going to find a family resource center, make their way there and hear more about all the things you can do for them, and they're never going to buddy up with someone they don't know. There's too much else going on.

A: N/A

Q: (Cynthia?) It seems from the survey, the correlation with disenrollment is the PCP, right? Then having courtesy calls seems like a good idea, although I kind of feel like it's just another person. If I had a number I could call when I need something, and I'm going to get the same person who knows me, as opposed to a courtesy call that's another phone call I have to take when I don't need it. Do you strategically put those member services people in the PCP's office so they're meeting those folks there.

A. No, the staff making the calls to members calling from LA Care.

Q: I think when you start a new program; you want to have a dedicated line. Can LA Care provide a dedicated line for new members to call when they encounter issues, with staff who are responsive, interested and knowledgeable? This line would be separate from the traditional member services line.

A: We can investigate that option.

Q: I did have a follow-up. Unless I missed it, I'm not seeing any metrics on this, but you have the metrics for enrollment. So I'm wondering if it would be interesting to correlate the metrics of the individuals who had orientation and induction to disenrollment and actually--

A: We actually just asked our analysis team to investigate if there is a correlation. They're going to go back and take a look at the 139 who were registered and the 58 who completed the new member

orientation to find out how many are still enrolled. Hope to be able to Report back any findings at the next meeting.

Q: Automated calls have some proven effectiveness in the hospital settings. Had LA Care considered IVR systems for onboarding calls?

A: We've talked about having onboarding calls be automated, and we hear the same kind of arguments for and against using them. People don't like to receive automated calls or aren't that engaged. If an automated call seems appropriate for the message, we'll explore it.

Q: Are there specific issues that you think are important for this group to explore that are significant to the program, that you'd like to work on in the group, talk about together.

Building and nurturing relationships that may be separate and apart from the CMC program, generally, may also potentially help disenrollment as a symptom of other issues plans are having to work out with providers (i.e. hospitals and hospital physicians).

Karen: Our issue isn't too much different in terms of being a provider. The conversation about getting care for our patients and the service breaks that happened while, and a lot of it has to do with the delegated providers, and who's on first and the providers and hospitals are playing hot potato with the member's needs, and it's just…maybe broken is an exaggeration, but it's not working efficiently. We really need to pay attention to that, to coordinate that care. We've got folks sitting in nursing homes that can't figure out which button to push to make it happen, and that's not right.

Jennifer: We'd like to see more around caregiver identification and engagement and workflow processes and what that looks like in care management practices, as well.

Rico: I'd like to get into more about how community based organizations that are not necessarily traditionally CBAS or MSSP could actually engage in this outreach and addressing the disenrollment and opt-out. I think that community based organizations that are trusted and are deeply rooted can help as partners in figuring out how to go about selecting who we work with.

David: I think L.A. Care is in a unique position to set an example for all Medi-Cal plans in our county about increasing the coordination between Medicare and Medi-Cal, even though you don't have them in a coordinate tie-in. I think if we could make some inroads there, it would be wonderful for your members.

The other thing I want to build on is the provider issues about billing and navigating the delegated entities in our county are trickling down more and more to individual members, and they're experiencing denials of care, they're getting bills, they're being threatened to get kicked out of their facility, and so I think that's something you'll want to be looking at very closely if you're thinking about bullet point number three.

Q: (Bobbie) If you would like to make any recommendations or suggestions about the format of the meeting, the way we're sitting at the meeting, how we prepare you for the meeting…. Is there anything else that you'd like to have in terms of the process we're engaging in, please feel free to say anything right now, but also after you leave the meeting, we really do welcome your thoughts and your feedback.

A: (Cynthia) In our future agendas, if we could have a section on follow-up on questions that were

asked or issues that were raised, to make sure that we have follow-up so there's tracking of above issues.

Bobbie: I have on my list three issues to follow up on: Behavioral Health, one on the authorized reps and others who might be participating in the care of members, and then the issue of the Medi-Cal only onboarding.

Follow-up Items:

- Behavioral Health
- Authorized reps and others who might be participating in the care of members
- Medi-Cal only onboarding