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**NSCLC-DREDF WEBINAR**
**THE CALIFORNIA COORDINATED CARE INITIATVE:**
**ADVANCED TRAINING**

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CART Services Provided by:
Christine Slezosky, CBC, CCP, RPR
Home Team Captions
1001 L Street NW, Suite 105
Washington, DC 20001
202-669-4214
855-669-4214 (toll-free)
info@hometeamcaptions.com

HOME TEAM CAPTIONS

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>> We focus on legal advocacy on behalf of low income seniors and people with disabilities. We have three offices: one in Los Angeles, one in Oakland, California, and the other in DC.

With that, I'm going to turn it over to Silvia to introduce DREDF and get started with the rest of today's webinar.

>> Silvia Yee: Hello, everyone. DREDF is founded in 1979. It's actually our 35th Anniversary year. We're proud to be an organization of people with disabilities and parents of children with disabilities. We are a national law and policy center based in Berkeley, California. And our interest is in dedicating, protecting and advancing the civil and human rights of people with disabilities.

I'm going to turn to Amber now to begin our presentation.

>> Amber Cutler: Thanks, Silvia. Thanks, everyone, for participating today. For the first part of the presentation I'm going to go fairly quickly just because it's a review of the Coordinated Care Initiative, and hopefully most of you who are on the line today have already participated or listened to one of our basic presentations.

So today we're going to cover just an overview of the CCI. We're going to take a deeper look at what long-term service and supports going into Managed Care looks like. We're going to take a look at what the benefit package for Cal MediConnect looks like. And then we're going to spend a little less than half of the presentation on consumer protections, especially those Continuity of Care protections under the Coordinated Care Initiative.

Before we get started, I always like to start with a glossary of terms just to make sure we're on the same page.

A Dual Eligible is someone who has both Medicare and Medi-Cal also known as a Medi-Medi. That is one population under the Coordinated Care Initiative that is impacted.

The other population that is impacted is that final bullet point: seniors, persons with disability or SPD. That is an individual who has Medi-Cal only. And the basis for that Medi-Cal eligibility is either age or disability.

Another term that comes up frequently is a Duals-Special Needs Plan or a D-SNP. That is a special type of Medicare Advantage plan that serves Dual Eligible specifically. And there is a specific policy under the Coordinated Care Initiative with regard to people who are enrolled in D-SNP.

Finally, the term Long-Term Support and Services or LTSS, that is an umbrella term under the Coordinated Care Initiative and it encompasses four Medi-Cal programs. So when I'm referring to LTSS or we're talking about LTSS and the Coordinated Care Initiative, we're really talking about In-Home Supportive Services or IHSS, the Community-Based Adult Services program or CBAS, formerly known as Adult Day Healthcare, the Multipurpose Senior Services program, MSSP, and nursing facility care. Those four Medi-Cal-funded programs fall under that umbrella term of LTSS.

So what is the Coordinated Care Initiative? It is three major changes. First is that Medi-Cal -- Medi-Cal Managed Care is mandatory for all Medi-Cal recipients. Basically, you are going to have to be in some sort of Managed Care plan to continue receiving your Medi-Cal benefits.

We saw this start back in 2011 when SPDs, those of Medi-Cal only, were transitioned

into Medi-Cal Managed Care plans. But in that transition back in 2011, there were major populations that were excluded. For example, if you had a share of costs in most counties, you were excluded from Medi-Cal Managed Care. If you lived in a nursing facility, you were excluded from Medi-Cal Managed Care. If you were a Dual Eligible, you did not have to mandatorily enroll in a Medi-Cal Managed Care plan. That will no longer be the case under the CCI. All of those populations are going to have to be in a Managed Care plan to continue receiving their Medi-Cal benefits.

The second major change is that long-term services and supports are becoming part of the Medi-Cal Managed Care benefit package. So, again, back in 2011, when we saw people transitioning into Managed Care, long-term services and supports remained a Fee-for-Service benefit. It was carved out from the benefits that the Managed Care plans had to deliver.

To give an example of LTSS coming into Managed Care under the CCI, it's easiest to look at nursing facilities residents. Today if you're not in the CCI, you're a Medi-Cal only beneficiary, living in the community back in 2011, you had to choose the Managed Care plan. You go into the hospital. You're discharged into a nursing facility.

Today, if you're not under the CCI, once you discharge into that nursing facility, you'd be disenrolled from your Medi-Cal Managed Care plan and put back in Fee-for-Service. Under the CCI, an individual who is in a Medi-Cal Managed Care plan is going to have to choose a nursing facility that is contracted as a provider with their Medi-Cal Managed Care plan and go to a nursing facility that is part of their Medi-Cal Managed Care network.

So it changes the delivery of that nursing facility benefit and an individual's access to nursing facility providers under the CCI. So those are the two first changes where Medi-Cal Managed Care is going to be mandatory and long-term services and supports are going to be integrated into the Medi-Cal Managed Care benefit package.

The third change is Cal MediConnect. That is the integration of Medicare and Medi-Cal into one Managed Care plan. This change is only impacting those who have both Medicare and Medi-Cal. So it's only impacting our Dual Eligibles.

This program is voluntary. You do not have to join it. But keep in mind that if you decide not to join Cal MediConnect, you're still going to have to choose a Medi-Cal Managed Care plan. Medi-Cal Managed Care is a mandatory change.

To reiterate who's impacted by the Coordinated Care Initiative, it's those individuals who have both Medicare and Medi-Cal, are Dual Eligible, they're Medi-Medis, and individuals with Medi-Cal only, SPDs. Individuals who only have Medicare are not going to be impacted by the Coordinated Care Initiative. But these groups of duals and SPDs are going to be affected differently by the Coordinated Care Initiative.

So we have SPDs, those with Medi-Cal only who are already in Medi-Cal Managed Care plans. Most of them had to go into Medi-Cal Managed Care plans starting in 2011. Those individuals are going to see long-term services and supports added to their benefit package. That's the only change they're going to see. They are going to receive a notice from their Medi-Cal Managed Care plan telling them that their plan is now responsible for delivering their IHSS, MSSP, nursing facilities and CBAS benefits. So no choice to be made for that

population. But they're still going to get a notice under the Coordinated Care Initiative.

There are some individuals, some Medi-Cal only recipients, SPDs, who are going to remain exempt from enrolling into Managed Care. There are very few of these individuals. Individuals who live in a veterans home in California, individuals who have other healthcare coverage except in San Mateo and Orange Counties, and individuals who successfully obtain a medical exemption request.

Again, very few people are going to be able to stay out of Medi-Cal Managed Care. If we're talking about duals, most Dual Eligibles are going to be eligible for and subject to what's called passive enrollment into Cal MediConnect. So passive enrollment is if you do nothing, you're going to be automatically enrolled into a Cal MediConnect plan.

So most Dual Eligibles are going to be eligible and subject to passive enrollment into Cal MediConnect. But there are certain Dual Eligibles who can enroll in Cal MediConnect but who are not going to receive any notices.

And finally, there are duals who are excluded from Cal MediConnect. So who are these individuals? So duals who are actually excluded from Cal MediConnect, individuals who have end stage renal disease, who live in certain zip codes in L.A. County, San Bernardino, Riverside, residents of VA home, a resident of an ICF-DD, individuals who do not continuously meet their share of costs, individuals who have other health coverage, and those who are receiving services through a DDS waiver or through a regional center. Those individuals are supposed to be excluded from Cal MediConnect and should not receive notices from the state about the Cal MediConnect program.

I say should not because we do know that a lot of these populations are receiving notices about Cal MediConnect. And if your client is receiving notices and they fall into one of these excluded categories, it's very important that you contact the Cal MediConnect Ombudsman.

And in that right-hand column, those are duals who can participate but who will not be passively enrolled. So individuals who are enrolled in PACE. They would have to disenroll from their PACE program in order to participate in Cal MediConnect. Similarly, individuals enrolled in the AIDS Healthcare Foundation. You'd have to disenroll and then enroll in Cal MediConnect. There are certain zip codes in San Bernardino County not going to receive notices about Cal MediConnect. But if they wanted to join, they could. Individuals enrolled in a waiver, individuals enrolled in Kaiser. And then individuals enrolled in Medicare Advantage plans are not subject to passive enrollment.

And let me break that down a little bit. The state has just recently release a new Medicare Advantage policy for Cal MediConnect. And it's pretty complicated. Go figure. The -- an individual who's enrolled just in a Medicare Advantage plan, so just standard Medicare Advantaged plan -- and there are some duals who are just enrolled in a Medicare Advantage plan. They are not going to be subject to passive enrollment into Cal MediConnect; meaning that they should not receive any notices about Cal MediConnect as long as they're enrolled in that Medicare Advantaged plan before December 31, 2014.

Also, individuals who are enrolled in a D-SNP, so that special type of Medicare Advantage plan that is particular to duals, individuals who are enrolled in a D-SNP that is not

operated by a Cal MediConnect plan. So, for example, the SCAN D-SNP, or the Easy Choice D-SNP. SCAN and Easy Choice are not operating a Cal MediConnect plan. Those individuals who are in Easy Choice or SCAN and any other D-SNP not operated by a Cal MediConnect plan are also not going to be subject to passive enrollment into Cal MediConnect as long as they are in that D-SNP prior to December 31, 2014.

Individuals who are enrolled in a D-SNP that is operated by a Cal MediConnect plan, so, for example, Healthnet or LA Care or Molina, they all operate D-SNP but they are all also Cal MediConnect plans. Individuals enrolled in those D-SNP operated by a Cal MediConnect plan are going to be subject to passive enrollment into Cal MediConnect. And that will be on January 1, 2015.

I know there are probably questions about that, but I'm going to move forward. I'll try to get to those questions when we stop in just a few minutes.

So if an individual is not eligible for Cal MediConnect connect or even if that individual decides they do not want to participate in Cal MediConnect, enrolling a Medi-Cal Managed Care is mandatory. There are very few people who are not going to have to enroll in a Medi-cal Managed Care plan even if they don't want to participate in Cal MediConnect or even if they're not able to participate in Cal MediConnect.

In total there's about 1.2 million people impacted by the Coordinated Care Initiative in some way. On the left-hand side, it's about 575,000 individuals who are going to receive notices about Cal MediConnect who will be subject to passive enrollment into Cal MediConnect. Only 485,000, 486,000 will actually be subject to enrollment I guess in Cal

MediConnect. And that number is always in flux because people become newly Dual Eligible and others pass away. The reason that number is lower is because Los Angeles County has a cap on enrollment. So even though 288,000 duals are eligible, not all could sign up if they wanted to. Only 200,000 can be enrolled in L.A. But still, 288,000 are going to receive notices about passive enrollment into Cal MediConnect.

On the right-hand column, we have individuals who are going to be impacted by the Coordinated Care Initiative because they either have to choose a Medi-Cal plan for the first time so they're either excluded from Cal MediConnect or their SPDs who previously did not have to choose a Medi-Cal plan and now are going to have to. And it also includes those individuals who are already in Medi-Cal plans who are going to see long-term services and supports added to their benefit package.

So about 1.2 million people are going to receive some form of notice about the Coordinated Care Initiative.

As we look at timelines, it gets complicated. I put the link to the most recent timeline on each of these slides just to give everybody a place to look. Cal MediConnect enrollment, it depends on county. So we saw it start in San Mateo County on April 1, Riverside, San Bernardino and San Diego started on May 1, Los Angeles is to go live wits passive enrollment on July 1, and Alameda, Orange, and Santa Clara, and individuals who are involved in a D-SNP are reassigned to a Part D plan are subject to be passively enrolled on January 1.
So we see four major dates with the timelines moving forward with Cal MediConnect.

If we're talking about individuals who are already enrolled in a Medi-Cal plan and

they're having long-term services and supports added to their benefit package, it depends whether you're a dual or SPD. So if you're a dual in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo, those duals saw that notice on their health plan on April 1. If you're in Santa Clara, Santa Clara duals saw that notice July 1 from their health plan or will see that notice on July 1.

If you're someone who has Medi-Cal only and you're already in a Medi-Cal Managed Care plan, you'll see that notice from your health plan in Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara on July 1. And then duals and SPDs in Alameda and Orange County are supposed to see LTSS added to their benefit package on January 1. I have a star on each of these slides because there's a separate timeline which complicates things further.

Finally, there's a start date for those who have to choose a Medi-Cal Managed Care plan. So we're not talking about duals who are eligible for Cal MediConnect and they're going to get Cal MediConnect plans. We're talking about the SPDs who didn't have to choose Medi-Cal plan and now have to or those duals excluded from Cal MediConnect or not subject to passive enrollment in Cal MediConnect who still have to choose a Medi-Cal plan.

So for the most part, most counties are starting on August 1, by birth month, Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara. And then in Alameda we're seeing that happen on January 1. Duals and SPDs in orange and San Mateo County are already in Medi-Cal Managed Care plans. So they don't need to make that choice because they're already in one.

I'm going to go ahead and stop there for questions. Do we have anything in the chat box?

>> Silvia Yee: We don't actually have anything in the chat box, Amber. You can continue if you like.

>> Amber Cutler: Great. Actually, Silvia, it's up to you. Your turn to take over the benefit packages.

>> Silvia Yee: You're right. It went so quickly because you were so smooth, Amber.

Here we are at Medi-Cal Managed Care. So we're stepping away a little bit. We're looking at Medi-Cal Managed Care. I've spoken to a number of individuals over the past couple of years who aren't sure what Managed Care is. Managed Care is when a Managed Care organization delivers your Managed Care healthcare services. So that is pretty well happening for everyone who's an SPD and eligible for Medi-Cal in these counties. Under the CCI, individual Medi-Cal services are provided through Managed Care. And the big difference with the CTI is it isn't just your medical services, your doctor visits, your hospitals, your prescriptions but the long-term services and supports are moving in to Managed Care as Amber said.

In addition, there are two new Medi-Cal benefits that are being added and that have been restored to Medi-Cal in California. There's a new mental health benefit that started January 1 of this year. And the mental health benefit is available to all Medi-Cal recipients and there's a dental benefit that's starting May 1, 2014.

So a couple of things to say about each of them. In terms of the mental health benefit, it's intended to fill something of a gap. There are some individuals who, perhaps, historically

have received some mental health services through their primary care providers. The county -- counties still continue to give specialty mental health benefits. So if you need certain kinds of more what might be considered more serious counseling and therapy and services, drug counseling, rehabilitation services, those are -- those Medi-Cal services are still received through the county.

If you're sort of in this gap, you are interested and want to receive mental health services but don't rise to the level of being provided by the county, and these are the kinds of services such as group counseling, family counseling, some psychological testing, these new benefits are being provided for all Medi-Cal recipients and they are also being delivered through Medi-Cal plans for those who are in the Medi-Cal plan.

The dental service is being restored to Medi-Cal recipients. And it's being delivered through Denti-Cal not through a plan. So even though you are an SPD, you receive -- eligible for Medi-Cal only, you are a member of a Medi-Cal plan, a Managed Care plan, your plan is not necessarily the one. It is not the one that will be delivering or taking care of your dental services for you.

One possible implication for this, which we will have to see how it works out, is how that -- because the plan isn't responsible for coordinating your Denti-Cal, for someone who say needs accessible, non-urgent transportation, will the plan be part of that? For instance, if you -- if there's a company that provides you with your wheelchair user, a company that provides you with your Medi-Cal transportation, accessible van, non-urgent van or a company that takes you to your Medi-Cal appointments, your Medi-Cal doctor appointments, is it also

possible to use that service for your dentist appointments?

In theory, yes. How in practice that works and whether you can phone your Medi-Cal plan for assistance if there's a glitch in the delivery of that transportation service, I think that remains to be seen.

Looking more closely at long-term services and supports. So again, we're talking about a major change, long-term services and supports under Managed Care. This comes across categories, whether you're a dual or an SPD, long-term services and supports are coming into managed care. That is supposed to help with integrating -- it's very complicated to manage someone as an individual who uses these services to manage all your long-term services and supports programs as well as your healthcare. The point -- some of the point of joining a Managed Care plan and being in a plan is that they will help coordinate a variety of different services that you use.

So we already have CBAS that is in the eight counties affected by the CCI. That is already under Managed Care. That transition happened in 2012. And there were some difficulties, some considerable difficulties with that transition. With the CCI the remaining LTSS programs are also going move into Managed Care.

So looking more closely at those programs, IHSS, In-Home Supportive Services is moving into Managed Care. It's a Medi-Cal benefit that allows a beneficiary to remain safely in the home it includes things like chores, house cleaning, shopping, meal preparation, assistance with all of those activities one needs assistance in the home.

The important thing to know about the transition, though, into Managed Care is that

the county will continue to administer the service. So the county will assess the hours the beneficiary needs. The beneficiary will still have the right to hire, fire, and supervise their IHSS workers. What the plan will be responsible for is coordinating and referring to the county. So things should not change for the beneficiary for a few years in terms of IHSS administration.

With regard to MSSP, the Multipurpose Senior Service Program, that's a service provided at a separate outside site that provides social and healthcare management for frail, elderly clients. There are 39 of these sites statewide. And they provide some of the chore assistance that IHSS does along with respite, transportation, meal services, etc.

So until the end of March in 2015 or 19 months after enrollment commences, the plans are required to contract with their MSSP organizations in the eight counties. And that is supposed to help provide a period of continuity so that you can continue with your MSSP provider, the same one you've had before the transition.

After that time period the plan must still provide MSSP services. But they do not necessarily have to contract with the same MSSP providers. So that is a protection that's there for a limited time. We'll see what the plans do after that point, whether they will continue to contract with MSSP providers that have proven themselves or they might consider taking MSSP services or some of them in-house.

And then the other component of LTSS is nursing facility service. So now rather than nursing facilities being paid by the state, the plans will contract with the nursing facilities. As Amber said, they will have a nursing facility network. And the plan they're supposed to provide the rates, that nursing facilities currently receive from Medicare and Medi-Cal.

Now we're turning to look more closely at the Cal MediConnect benefits. These are specific to duals. That will include Medicare Parts A, B, and D, which includes hospital and inpatient stays. Part B is patient. Part D prescription drugs. The Medi-Cal services include all the LTSS services that we just talked about. There is also a vision benefit. One routine eye exam once a year. And $100 towards glasses or contacts every two years.

There is a very specific non-urgent medical transportation benefit. And it comprises of 30 one-way trips per year. And there's also the element of care coordination, which is very much a benefit. Again, for those beneficiaries dual an SPD who have been juggling multiple services, the plan is supposed to help coordinate the variety of medical and LTSS services that one has.

Looking at the next slide, that care coordination that a plan is supposed to provide to a dual is supposed to be a person-centered. It is required to focus on the least restrictive setting. And it is to include a health risk assessment.

Breaking that down a little bit. The idea of person-centered has always been so that the individual, the beneficiary, him or herself, has a say, an equal say, in how their care is administered and how their healthcare is delivered.

When a new member joins a plan, the new member will receive an assessment. And the plans are required to conduct a health risk assessment; that is an in-depth assessment process to identify the primary, acute, the long-term services and supports, behavioral health, all the needs that any member has. Right now that can happen in person. A beneficiary can also choose to do it over the phone. And it can be done in one's home if one requests that.

The new members are going to be divided into either a high-risk or low-risk category. Depending on that is when your assessment has to take place.

The individualized care plan is something that is supposed to be developed for each enrollee that includes the member's goals and preferences. And it's supposed to also incorporate your care team, your social worker's, primary care doctor, nurse, manager, pharmacist, etc., as you wish and as required.

So there have been -- the universal assessment tool continues to be developed. It hasn't been completed yet.

Going on to the next slide. These -- the Care Plan Option services are an interesting aspect of the Cal MediConnect benefit. For the duals who join the Cal MediConnect plans, there is the Care Plan Option. These are home and community-based supports and services. They are like home and community-based supports and services that you already received through LTSS.

The big distinction here is that these are discretionary. The plans get to choose when and how to deliver these additional services, services like tour assistance or meal assistance, including things maybe like home modifications, a wheelchair ramp, other accommodations in your home like shower bars, Meals on Wheels. It remains a little unclear at this time. I think perhaps it remains a little unclear to plans, too, exactly the standards by which these will be provided, how and when, and how changes might be administrative of time.

It's important to note that these optional services cannot be delivered as an exchange in lieu of required Medi-Cal benefits like IHSS. They're supposed to be assessed during the

risk assessment process that duals will get when they enter the plan as a new member.

Finally, the Carved Out Benefits. There are just a couple of benefits that are not included as Cal MediConnect benefits. One are the county-administered specialty Medi-Cal mental health benefits. Those include intensive day treatments, crisis intervention, adult residential treatment services, psychiatric services that are not covered by Medicare. They also include job benefit therapy, day therapy, etc., and also dental benefits.

So the same caveat that was said before about plans assisting with the coordination of dental care services and the other services that one might need such as transportation when one goes to a dentist, that applies here. I think how that actually works out is something we're going to have to watch over time.

Now I'm going to turn it back to Amber.

>> Amber Cutler: Thanks, Silvia. There were only two questions. I think we're going to cover one in the Continuity of Care portion. You somewhat covered the other one in that last slide.

Katheryn had a question about what is the difference between specialty mental health and the new mental health benefits plans are responsible for. I think you saw, Katheryn, some of the examples of what specialty mental health benefits are that are provided by the county. That will continue to be the case. The county will still be responsible for delivering those specialty mental health benefits and paying for those specialty mental health benefits. The Cal MediConnect plans are required to enter into Memorandums of Understandings with the county to help coordinate those benefits. So to the beneficiary it looks like it's just coming from the health plan.

The mental health benefit that was added to the Medi-Cal Managed Care benefit package in January 2014 was the mental health benefit that was -- it didn't rise to the level of a specialty mental health benefit but it wasn't a mental health benefit that the primary care physician was particularly able to do either. So it's really kind of like group therapy or individual counseling and therapy sort of benefit, that in between sort of mental health benefit for people that previously in the Fee-for-Service world was being provided but then when it came into Managed Care, the PCP wasn't able to deliver that benefit and so now the Medi-Cal Managed Care plans are responsible for that new mental health benefit.

I hope that helps.

Ok. So for Cal MediConnect, the Continuity of Care protection. This is one of the major protections that are supposed to be afforded under the Coordinated Care Initiative. So we're going to cover the Cal MediConnect Continuity of Care and then focus on the Medi-Cal Managed Care Continuity of Care.

On the Cal MediConnect Continuity of Care, if certain criteria are met, a beneficiary can continue to see his out-of-network providers for a certain period of time, at six months if it's a Medicare provider and it's 12 months if it's a Medi-Cal provider. Keep in mind that these are the base protections. Plans can actually extend Continuity of Care for longer than the six months or longer than the 12 months.

In fact, San Mateo's health plan has just decided to do 12 months across the board with their Continuity of Care. So these are baseline Continuity of Care protections.

And I also want to point out at the bottom of the slide is a link to the All Plan letter that

addresses Continuity of Care for Cal MediConnect plans so do, if you have any questions, refer to that, that Cal MediConnect All Plan letter, that Dual All Plan letter.

So what are the criteria for Continuity of Care? First of all, there must be an existing relationship with the provider. If the provider is a primary care physician, you have to have seen that primary care physician at least once in the preceding 12 months of plan enrollment for a non-emergency visit in order to establish a preexisting relationship. If that provider is a specialist, you had to have seen that provider at least twice within the 12 months preceding plan enrollment.

It's on the plan to get that evidence of that existing relationship. The plan is supposed to look at the utilization data that CMS and DHCS provided to the plan. In fact, the whole way that people are enrolled into Cal MediConnect is so that they're actually enrolled on the 60-day mark prior to their effective coverage date in order for DHCS and CMS to share the utilization data with the plans so the plans know who the beneficiaries have seen on the first day of coverage so that they can try to maintain Continuity of Care. So the plans are supposed to be looking at that utilization data to establish whether there was an existing relationship.

If the plans can't tell whether there was an existing relationship, they can request documentation from the beneficiary. The beneficiary has to do more than just a test to the prior relationship. They would have to have some form of documentation of seeing that provider previously.

In addition to having that preexisting relationship, the provider must also agree to accept payment from the health plan. This is where I think Continuity of Care falls apart. It’s

upon the provider to agree to the arrangement with the health plan. Granted, most of the health plans on the Medi-Cal side have to pay the same provider rate. And what we're seeing is that on the Medicare side, they are doing this as well, at least with the majority of providers. But a lot of providers are still reluctant to enter into these case-by-case agreements to extend Continuity of Care. So Continuity of Care is a great protection, but it only goes so far as the provider's willingness to enter in that agreement with the health plan.

Finally, the third criteria is that the provider can't have any quality issues that would prevent the health plan from contracting with them.

There are some major exceptions to Continuity of Care. And, Neil, this goes to your question. Nursing facilities a big one. If an individual is residing in a nursing facility at the time of their passive enrollment into Cal MediConnect or the time of their enrollment into Cal MediConnect, and that nursing facility is an out-of-network provider, there is no limitation of being able to stay in the nursing facility on the Cal MediConnect side. They are kind of grandfathered in. They can continue to live in that nursing facility for the length of the demonstration. So even if that nursing facility is not a Cal MediConnect nursing facility provider.

Another major exception is durable medical equipment providers. It goes the opposite way. DME is not covered as a Continuity of Care. So there is no Continuity of Care protection for DME provider. Obviously there's Continuity of Care for the service of DME, but your particular provider, if they are out of network and you're in a Cal MediConnect plan, you're not going to have any Continuity of Care protection to continue seeing that DME provider.

Similarly, that’s the same for ancillary services no Continuity of Care protection. And, of course, there's no Continuity of Care for the Cal MediConnect plan in carved out services because the Cal MediConnect plan isn't responsible for those carved out services. The Cal MediConnect plan can't continue to provide you specialty mental health benefits from the county when it's the county providing those benefits. So carved out services are an exception to the Continuity of Care protections.

IHSS is also an exception, but not in any meaningful way. The reason is Continuity of Care doesn't really apply because the IHSS consumer continues to have the right to hire, fire, and supervise their IHSS provider. So the consumer remains the director of their IHSS services. So Continuity of Care doesn't really apply in that situation.

With regard to prescription drugs, the Part D transition rules apply. So Part D transition rules state that you are permitted to receive one-time fill of a 30-day supply of your prior prescription drug, even if that prescription drug is not on the Cal MediConnect formulary. And that's within the first 90 days of your enrollment into the Cal MediConnect plan. So this is a really important protection because we are seeing a lot of individuals who are being enrolled into the Cal MediConnect plan go into the pharmacy and having some issues. And it has more to do with the pharmacy education. So those individuals need to just talk to their plan, to their care coordinator, who can iron that out with the pharmacy and explain that it doesn't matter that it's not on the Cal MediConnect formulary. They're supposed to get that refill of that prescription drug even if it's not on the formulary.

Other protections under the Continuity of Care protections under Cal MediConnect,

the health plan that has to complete services for acute, serious, chronic, terminal illnesses and other surgeries or procedures that were previously authorized as part of the document of course of treatment. So people have the right to continue to get the services that they were already scheduled to have, particularly if they're -- if they have some serious or acute, chronic -- serious, chronic, or acute issues going on.

There are Continuity of Care periods in Cal MediConnect and what I mean by this is if someone decides that they want to change Cal MediConnect plans, they can get another period of Continuity of Care. But it's very, very limited.

So Continuity of Care does not start over if the beneficiary returns to Fee-for-Service Medicare and then re-enrolls back into Cal MediConnect. So it's really only applying if you're switching Cal MediConnect plans. And it's really only going to apply to providers that were not in either plan. So you can maintain Continuity of Care with the provider who was in either Cal MediConnect plan either that you were previously in or that you switched to. So it's a very limited renewal of a Continuity of Care period, but it's better than nothing.

I think Marcello just asked a question about whether you need a prior -- the Continuity of Care request kind of question. An individual -- like I said, the plan is supposed to provide an assessment within 90 days of enrollment or 45 days if in the high-risk category. That's supposed to identify Continuity of Care issues. And then a beneficiary can make a direct request for Continuity of Care. And the Cal MediConnect plan is supposed to process that request within five working days of the request. The long end of that processing is supposed to be 30 days or within 15 days if the medical condition requires immediate attention.

Obviously we're hoping that the plans are doing this even faster than the 15 days. And certainly faster than the 30 days because what we're seeing most often is that people don't even realize that they're enrolled in Cal MediConnect. And then they realize they are. Maybe they have an appointment the next day or maybe they don't realize it until they've reached their appointment. So it's important that the plans -- [Inaudible] recognize immediate requests for Continuity of Care in order for people to have the least amount of disruption in seeing their doctors.

The ultimate Continuity of Care protection under Cal MediConnect is the beneficiary's right to disenroll from Cal MediConnect. An individual can always disenroll from Cal MediConnect and go back to Fee-for-Service Medicare and seeing their Medicare providers for Fee-for-Service. That disenrollment becomes effective the first day of the next month.

So if someone is not able to continue, like Continuity of Care is not working, their provider doesn't want to enter into a case-by-case agreement or they're having problems establishing their preexisting relationship, or they just want out of Cal MediConnect, they can always disenroll and that effective coverage date will change the first day of the next month.

Keep in mind, though, that someone still has to stay in a Medi-Cal Managed Care plan. They can disenroll from Cal MediConnect but their Medi-Cal has to stay in Managed Care.

However, and this question comes up a lot, what does it mean that their Medi-Cal is now Managed Care? Can they continue to see their Medicare provider? Yes. The Medicare provider will get paid the cost sharing, that 20%, by the Medi-Cal plan. And that Medicare

provider does not need to be part of the Medi-Cal Managed Care plan's network in order to receive that 20%. The Medicare provider would bill Medicare. And we're hoping in most instances it would be automatic that the bill would then go to the Medi-Cal Managed Care plan and the Medi-Cal Managed Care plan would pay out the 20% if the 20% were actually due. And a lot of circumstances the 20% isn't payable because of the rate issues. If it were actually payable, it's the Medi-Cal plan that pays for it.

And some instances, the Medicare provider might have to submit the bill to the Medi-Cal plan directly. But in either case the Medi-Cal plan is responsible for paying that cost sharing.

As we talk about Continuity of Care with regard to just Medi-Cal, so you are someone who has opted out of Cal MediConnect and your Medi-Cal is in the Medi-Cal Managed Care or most often what we're talking about is someone who is an SPD. Who is in a Medi-Cal plan only and all of their health care is delivered and their long-term service and supports are delivered through the Medi-Cal plan.

The Continuity of Care protections look very similar. It's a 12-month Continuity of Care period. An existing relationship is actually the broader standard. You only have to see that provider once within 12 months. Again, the provider must accept the plan reimbursement rate and enter into the contract with the plan, must meet quality of care standards. The same exceptions with the DME and ancillary services. Continuity of Care does not extend to those services.

The major difference is nursing facilities in CBAS providers. If someone decides they

want to opt out of Cal MediConnect, for example, and they're living in a nursing facility. They're going to be in a Medi-Cal Managed Care plan only. That Medi-Cal Managed Care plan does not contract with their nursing facility. That individual can continue to live in that out-of-network nursing facility for 12 months. But remember on the Cal MediConnect side it was for the length of the demonstration. They were basically grandfathered in. But if you opt out of Cal MediConnect, you're only going to get a 12-month Continuity of Care period. We've been advocating that the two standards should be the same and the state has yet to release an all-plan letter on Continuity of Care under the CCI for the Medi-Cal side. So we still have hope that they will match those two Continuity of Care periods and have the broader Continuity of Care standard on the Medi-Cal side as well. But right now as of today, it's just the 12-month Continuity of Care period.

The other protection from Medi-Cal beneficiaries but not Dual Eligibles, just our Medi-Cal only, our SPDs, is the opportunity for medical exemption request. A medical exemption request means to stay out of the Medi-Cal Managed Care all together. These are very difficult to obtain. Again, it's not available to duals. We're only talking about those with Medi-Cal only. It's only available in the plan and geographic managed care counties. It's not available in San Mateo or Orange Counties. And it's limited to individuals who have complex medical conditions like cancer or HIV/AIDS. And you submit a medical exemption request to stay out of Managed Care for a time-limited period, 12 months. And it can get extended but again very difficult to be taken. Those are available to individuals who have Med-Cal only.

I'm going to go ahead and stop there for questions.

>> Silvia Yee: We have one to define ancillary services.

>> Amber Cutler: I'm going to refrain from defining ancillary services. That's because the state hasn't defined it yet. And our hope is that it's defined somewhat narrowly. We don't want it to be too large.

So in my mind, ancillary services are things like maybe a lab or a pharmacy. But it could get bigger. But so far the state hasn't provided a definition of ancillary services.

I'm sorry, Marcello, that I can't answer that more.

Any other questions?

>> Silvia Yee: What happens when a dual beneficiary gets defaulted into a Cal MediConnect plan, he is currently enrolled but decides to opt out. What will happen to his or her prescription drug coverage?

>> Amber Cutler: There's lots of scenarios there. Let’s pretend the person has enrolled in Cal MediConnect and their coverage started. Say it's July 1 you're in L.A. County and enrolled in a Cal MediConnect plan. Your Cal MediConnect plan is now responsible for your prescription drug coverage. They have -- all the Cal MediConnect plans have their own Part D formularies. If you decide that you don't want to be part of the Cal MediConnect plan anymore, you're going to disenroll from Cal MediConnect; you're going stay in Medi-Cal Managed Care but because it's after your effective coverage date in Cal MediConnect, you're going to have to choose a new Part D plan. If you don't choose a new Part D plan, CMS will default you into a Part D plan that meets the low-income benchmark threshold.

If we're talking about someone who is before their effective coverage date in Cal

MediConnect, say 10 days before they're supposed to start Cal MediConnect to opt out of Cal MediConnect, they're going to still be in a Medi-Cal Managed Care plan. When they opt out because it's before their effective coverage date in Cal MediConnect, they will automatically be re-enrolled into their Part D plan that they were in previously.

And then I think a follow-up question is where do you call to re-enroll the PDP? Probably best bet is to call 800-Medicare. Or if you have your Part D plan, you can call your Part D plan that you were previously in and re-enroll that way.

All right, Silvia, back to you.

>> Silvia Yee: Thanks. A few other consumer protections that have very, very important. One is the right to receive materials and services, the consumers have the right to receive materials and services in their own language. And so this looks at language rights, limited English proficiency, for those with English -- limited English proficiency and alternative formats. Alternative formats are -- [Inaudible] blind, visually impaired, communication.

As you can see, the CCI is very complicated. That's been made very clear through this presentation and others. One's right to opt in or opt out or make choices is only as clear as one's understanding of that material. So we think that that's very, very important. And that's an important right for consumers.

In terms of accessibility rights, people with disabilities have the right to gain full and equal access to services. They have an equal right to benefit from care coordination, from healthcare services, etc. And so there is a right to reasonable modifications from the plan and from providers, a right to physical accessibility in provider offices, effective communication.

And the plans are required to receive training on disability discrimination and cultural competency.

Going on to the next slide. If you're having -- whether you are enrolled, whether you're having problems with getting the notices, whether you're having problems with communicating your opt out or opt in decisions, there are local advocates that are there to help individuals. One is the HICAP which is the state organization that's there to help those Medicare recipients. Their number is here on this next slide, the HICAP.

The Health Consumer Alliance is a group of legal services organizations across the state which are there to help healthcare consumers with their individual needs and individual advocacy. And Disability Rights California, there are three -- at least three locations, possibly more, I'm trying to think more quickly, across the state, which can help individuals with accessibility issues and people with disabilities with accessibility and benefits issues, etc.

On the next slide you'll see information for Amber and National Senior Citizens Law Center. There's also information for DREDF. And also the Department of Health Care Services.

So we hope this is helpful to you. If you have more questions about CCI, about your consumer rights, and stories you want to share with us about issues that are happening to you around the CCI, please contact us and let us know.

Thank you.

>> Amber Cutler: And thanks, Silvia. There's two things that I wanted to point out. I forgot to add the contact number for the Cal MediConnect Ombudsman. That number is -- it was an old

slide. Sorry about that. It's 1-855-501-3077.

And the role of the Cal MediConnect Ombudsman is to really help with issues regarding the CCI. So the HICAPs are helping with individual enrollment counseling. The Cal MediConnect Ombudsman can help if someone receives a notice and they shouldn't have, if they're having problems disenrolling, problems having accessing their care under their new Cal MediConnect plan, all of those different kinds of issues. Once they're in the Cal MediConnect plan, having filing appeals and grievances, that's the role of the Ombudsman.

And the second thing I wanted to just say before we signed off is that today, this afternoon, we should be releasing NSCLC and DREDF collaboratively the third version of the advocates guide to the Coordinated Care Initiative. So that will be going out to any individual who signed up for our listserv will receive that announcement later today about that third version of the advocates guide. And if for whatever reason you have the second version, you should throw it away because it is really outdated at this point.

I want to just thank everyone for participating. If you have any questions, feel free to e-mail any of us. Our e-mails are all listed there on the last slide.

>> Silvia Yee: Do we have information about when the chat -- are we going to try to make the chat available?

>> Amber Cutler: I don't know -- I'll just copy and paste it right now. I can add it -- we can put it on our website along with the copy of the PowerPoint presentation and the recording of the PowerPoint presentation and the transcript of the PowerPoint presentation. That will all go up on our website and on DREDF's website, I believe.

Is that right, Silvia?

>> Silvia Yee: Yeah.

Thank you, everyone.

[The webinar ended at 5:02 p.m. eastern time]