

February 14, 2014

Cal MediConnect: Summary of the Three-Way Contract

Amber Cutler, Staff Attorney
National Senior Citizens Law Center

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

Housekeeping

- Listeners on mute.
- For technical questions and concerns or to ask substantive questions, please use the chat or question feature.
- Slides and recording of the webinar will be available at <http://dualsdemoadvocacy.org/california>

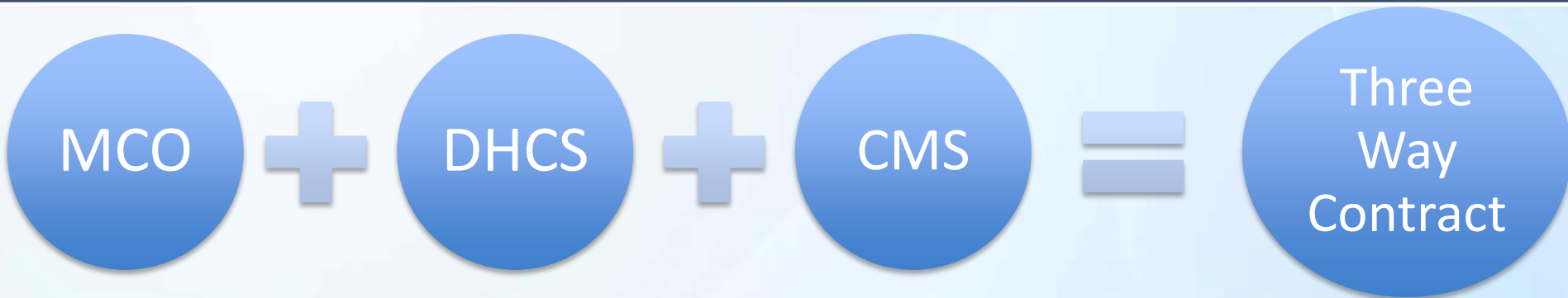
Coordinated Care Initiative

CCI Change	Description	Federal Approval
Mandatory Medi-Cal Managed Care	Duals and previously excluded SPDs must enroll in Medi-Cal Managed Care	Pending
LTSS Integration	LTSS added to Medi-Cal Managed Care plan benefit package	Pending
Cal MediConnect	For duals, integration of Medicare and Medi-Cal benefits into one managed care plan.	Approved

Cal MediConnect Governing Documents

- SB 1008 and SB 1036 (June 2012)
- 1115 Waiver (PENDING)
- MOU between CMS and DHCS (March 2013)
- Three-Way Contract (December 2013)
- CMS Guidance - Medicare Advantage/Part D/Model Notices/Enrollment Guidance
- All Plan Letters
- Other Policy Documents
- MCO Contracts & MOUs

Three-Way Contract



Demonstration Period

Year 1: April 1, 2014 – December 31, 2015

Year 2: January 1, 2016 – December 31, 2016

Year 3: January 1, 2017 – December 31, 2017

Three-Way Contract available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractwithoutSub.pdf>

MCO Compliance

- Applicable federal and state laws
- MOU
- Regulations, Guidance, Waivers
- Medicare Advantage Requirements
- Administrative Bulletins and Plan Letters
- Maintain licensure in compliance with Knox – Keene

Readiness Review

Plans cannot start enrollment until they pass the
Readiness Review

- Network adequacy
- Adequate MCO staffing
- Care Coordination capabilities
- Provider contract templates
- Enrollee services capability
- Internal grievance and appeal polices
- Fraud and Abuse
- Financial solvency
- Information systems

Enrollment

- Enrollment ends 6 months prior to end of Demonstration
- Enrollment is accepted in order of application
- Enrollment will proceed unless restricted by CMS or DHCS
- Enrollment will utilize Intelligent Assignment

Intelligent Assignment

Hierarchical Logic

Match Medical Managed Care Plan

Highest Utilized Provider

If 1 plan, assigned to that plan

If 2 or more: equal distribution

- 90 days prior to start, MCO supply DHCS with list of Network Providers
- MCO must update Network Provider List on quarterly basis with DHCS

Disenrollment

Disenrollment becomes effective the first day of the next month

- Upon Request
- Death
- Change Demo Plan
- Enrollment in Medicare Advantage Plan
- Enrolls in a new Part D plan

Covered Services: Required Benefits

- All Medi-Cal Benefits
 - Except: ICF/MR services; county-administered Medi-Cal specialty Mental Health Services, State and County IHSS activities, Medi-Cal Dental Services
- Long-Term Services and Supports
 - IHSS, MSSP, CBAS, Nursing Facility
- Medicare Part A, B, D

Covered Services: Required Benefits

- Vision Benefit
 - \$0 copay for 1 routine eye exam a year
 - \$100 for eyeglasses or up to \$100.00 for contact lenses every two years
- Non Medical Transportation Benefit
 - 30 one-way trips a year
- Care Coordination

Covered Services: No Cost Sharing

- Cost Sharing is Not Permitted
 - Exceptions
 - Part D co-pays
 - Cannot exceed the amount under the Part D Low Income Subsidy
 - Plans can establish lower cost-sharing for prescription drugs than the maximum allowed
 - Supplemental Dental Benefits

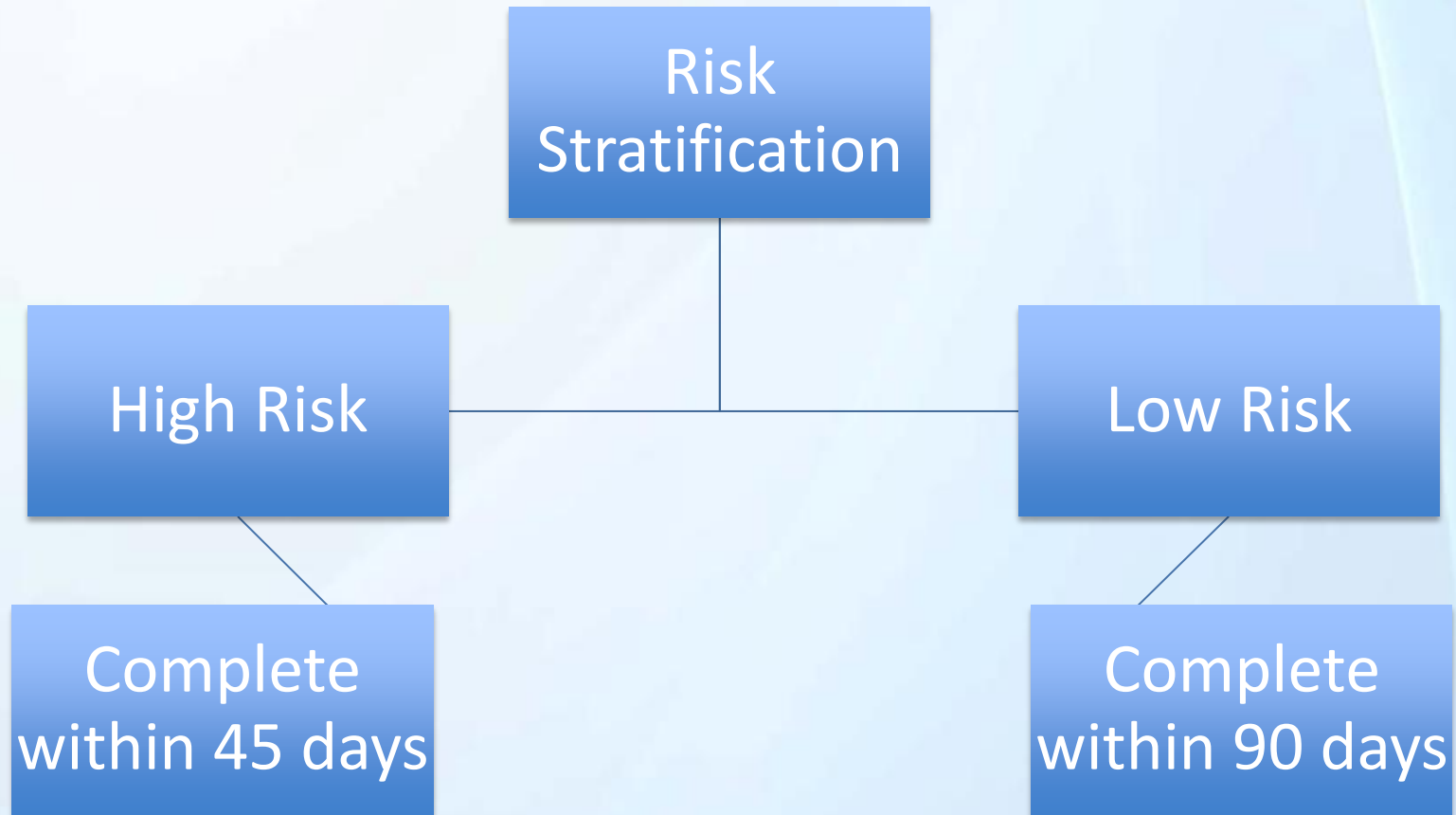
Covered Services: CPO Services

- CPO Services provided in sole discretion of MCO
 - Exempt from appeals procedures
 - MCO must develop procedures to record and address CPO complaints and procedures to report to DHCS
 - May include, but not limited to:
 - Respite Care
 - Additional Personal Care/Chore Services
 - Habilitation
 - Nutritional assessment
 - Home Maintenance
 - Other

Covered Services: Behavioral Health

- MCO must provide behavioral health services covered by Medicare and Medi-Cal
- MCO must provide new mental health benefits (January 1, 2014)
- MOU with county agencies that deliver specialty mental health benefits

Health Risk Assessment



Care Coordination

MCO must offer care coordination and case management to all enrollees

- Coordinate care across continuum: medical, behavioral health, LTSS
- Least Restrictive Setting
- Person-Centered
- IHSS right to self-direct: hire, fire, manage IHSS provider
- Focus on transitions
- Care Coordinator
- Interdisciplinary Care Team (ICT)
- Individual Care Plan (ICP)

Care Coordination

Care Coordinator

- Available to any enrollee who needs or requests one
- Must have appropriate experience and qualifications based on enrollee needs
- Specialty staff in area of dementia and MSSP

ICT

- Offered to any enrollee who needs or requests
- Develop ICP
- Conduct ICT meetings
- Monitor complaints & grievances
- Composition – person-centered
- Member does not have to participate
- MCO must provide training to ICT initial and annually

ICP

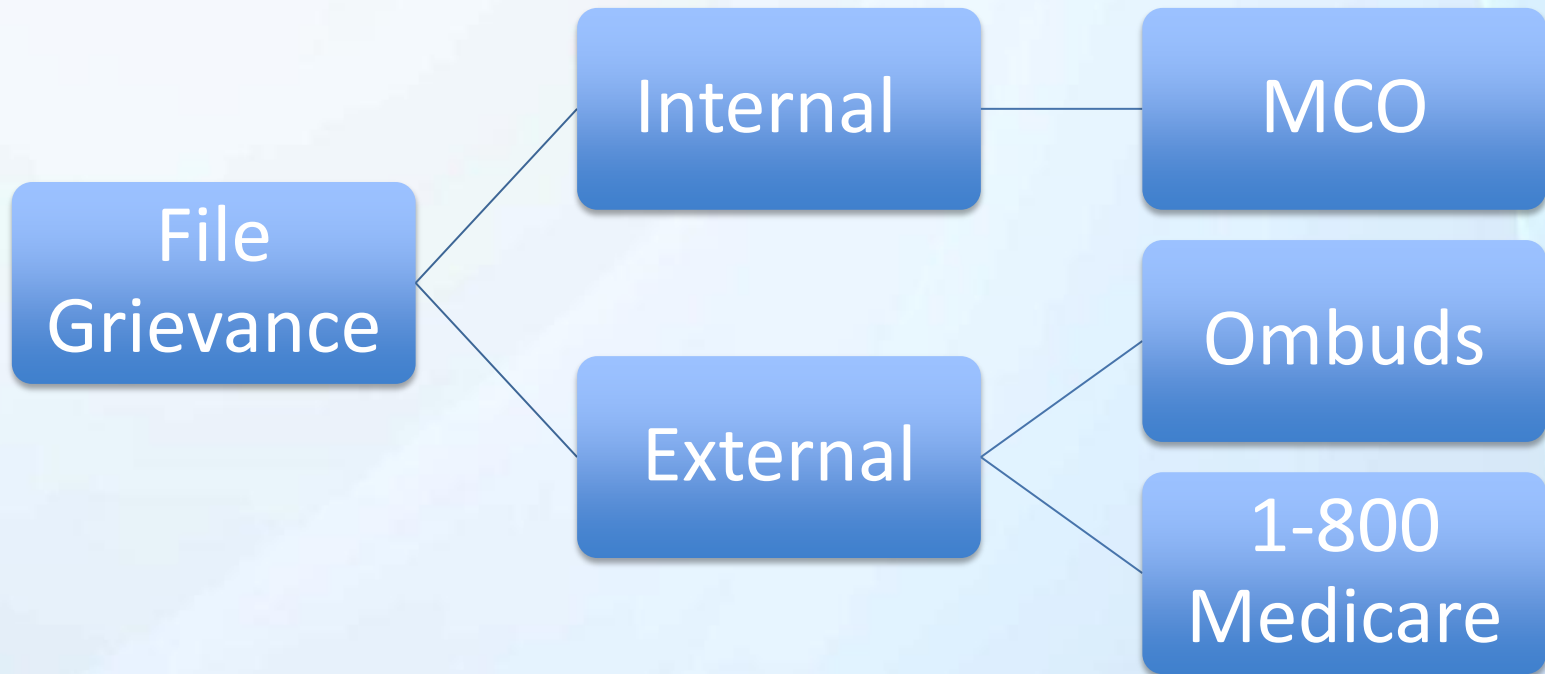
- Reflect enrollee goals and preferences
- Measurable objectives
- Updated annually or upon significant change
- Behavioral Health inclusion

Continuity of Care

MCO must allow enrollees to maintain current providers and service authorizations at time enrollment

- For 6 months for Medicare/12 months for Medi-Cal
- Must have existing relationship
 - PCP – seen once in 12 months prior to enrollment
 - Specialist – seen twice in 12 months prior to enrollment
 - Established through utilization data – if cannot be established, request from enrollee and/or provider
 - Provider must meet quality standards
 - Provider must agree to rates (Medicare Rates and Medi-Cal Rates)
- Enrollees will not have to change Nursing Facilities
- Part D transition rights for prescription drugs
- COC does not apply to DME, medical supplies, transportation, other ancillary services, or carved-out services

Grievances



Appeals

- Integrated Notice of Action
- Aid Paid Pending for both Medicare and Medi-Cal at plan level
- Medicare covered benefits follow Medicare appeals
- Medi-Cal covered benefits follow Medi-Cal appeals
- Overlapping services not discussed

Enrollee Rights

Treated with
dignity & respect

Privacy &
Confidentiality

Copy of medical
records

Discrimination
protections

Right to have all
plan options, rules,
benefits explained

Access to adequate
network to meet
needs

Right to choose
plan and provider
at any time

Right to participate
in Care

Right to HRA

Cultural competent
care

Right to not
participate in Cal
MediConnect

Right to hire, fire,
supervise IHSS
provider

Right to no cost
sharing

Materials in
accessible
materials

Want to know more?

- NSCLC Duals Website
 - Advocate's Guide
 - News
 - Sign up for alerts

<http://dualsdemoadvocacy.org/>
- CCI Advanced Webinar 2/18/14
11:00 a.m.
- Contact us:
 - Amber Cutler – acutler@nsclc.org
- Disability Rights Education & Defense Fund (DREDF)
 - www.dredf.org
- Department of Healthcare Services
 - www.calduals.org