THURSDAY, JUNE 20, 2013

1:00 – 2:10 P.M.

NSCLC-DREDF Webinar

“THE CALIFORNIA COORDINATED CARE INITIATIVE:
WHAT ADVOCATES NEED TO KNOW – BASICS”

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I'm doing a sound check. Would people on the line just type in the chat box just to make sure that you can hear me. Great. Perfect.

AMBER CUTLER: This is Amber. We are having some technical difficulties. So I'm going to wait a couple more minutes before we get started. And if you're having problems with your audio, if it's going in and out, we also have closed captioning available. If you hit Control F8, closed captioning will pop up on your screen in the right-hand corner. You just want to make sure that "Tammy" is selected.

Hi, Mary Lou. You're back? Mary Lou, can you hear me?

All right. I'm going to go ahead and get started.

My name is Amber Cutler. I'm an attorney with the National Senior Citizens Law Center. And I will be co-presenting today with Silvia Yee from DREDF. We're a technical assistance backup center. We provide services mostly for seniors dealing with benefit programs like Social Security, SSI, Medicare and Medicaid. DREDF is also a technical assistance and backup center that focused on disabilities, civil rights and providing individual benefit assistance to individuals with disabilities. So as a preliminary matter, I just want to make sure, this is a new platform that we're using, and so there are a few glitches, and so you might see some announcements and things pop up on your screen, letting you know how to use the platform. I mentioned before that if you want closed captioning, if you're having problems with your audio, you can hit Control F8, and I believe Silvia just announced that to the group, and we will also be providing a plain text version of this PowerPoint presentation, which will be available on both the NSCLC Web site and the DREDF Web site. If you have questions during the presentation, you can type them in the chat box. Anna rich with NSCLC will be...
responding to some of those questions throughout the presentation by chat, and we will also be stopping periodically throughout the presentation to respond to some of those questions. And if we don't get to all of your questions, we will try to respond individually to all of you. And with that, I'm going to go ahead and get started. So today, we're here to talk about the Coordinated Care Initiative, and this is a basics presentation. So we're going to focus on the what, when, where, why and who of the Coordinated Care Initiative. So this is a basics training. So for some of you, this may be incredibly basic. For others, it may be the first time that you're hearing it, so just keep that in mind when we're going through the presentation.

So, in a nutshell, the Coordinated Care Initiative is a new state program that changes the delivery of Medi-Cal long-term services and supports, and Medicare to dual eligibles and seniors and persons with disabilities living in eight California counties which is set to begin on January 1st, 2014, aimed at coordinating care and reducing healthcare spending. So that's sort of the Coordinated Care Initiative in a nutshell. We're going to go through each of those in a lot more detail. But this is sort of a road map of where we're going to go with the presentation. As you can see, January 1st, 2014 has a little asterisk by it. That's because that date has moved several times, and it's still subject to move, so just keep that in mind. It's no sooner than January 1st, 2014 when the Coordinated Care Initiative is set to begin. So it could be January 1st or it could be much later, or it could be not at all.

Before we get too far into things, I wanted to provide you guys with a glossary. There's a lot of acronyms and phrases we throw around when we're talking about the Coordinated Care Initiative, so I'm going to focus on, a lot of these are somewhat self-
explanatory for you guys. Dual eligible is someone who has both Medicare and Medi-Cal, but the two I want to focus on today are particular long-term support and services, or LTSS, which is a very specific term under, has a very specific definition under the Coordinated Care Initiative. It encompasses four services, and those are in-home supportive services, or IHSS, community-based adult services, or CBAS, which is formerly Adult Bay Healthcare. The multipurpose senior services program, or MSSP, and nursing facility care. So those fall under that big umbrella term of LTSS. So when we're talking about LTSS, we're talking about those services.

And the other program I want you guys to focus on today is seniors and persons with disabilities, or SPDs. It refers to individuals who have Medi-Cal only. So not individuals who have Medicare, but only who have Medi-Cal benefits, and they have those Medi-Cal benefits either because they're aged or because they have a disability, so that's the reason why they're on Medi-Cal. So those are SPDs. So the coordinated care initiative encompasses three major changes, and if there's one slide I want you guys to pay attention to, it is this slide right here, because this is really what the coordinated care initiative is.

And so the very first change is mandatory enrollment into Medi-Cal managed care. If you guys remember, back in 2011, the State of California began moving SPDs, or those with Medi-Cal only, into managed care for their Medi-Cal benefits, but there were major groups of people who were excluded from being enrolled into Medi-Cal managed care, and that included individuals with share of costs, individuals living in nursing facilities, individuals who are duals, with both Medicare and Medi-Cal, did not have to go into managed care for their Medi-Cal benefit. That changes under the coordinated care
initiative. Now all of those groups are going to have to go into managed care to receive their Medi-Cal benefit. So that's the first major change.

The second major change is the integration of those long-term supports and services, and to the Medi-Cal benefit package. So when I was talking about LTSS before, the IHSS and MSSP and nursing facility care, all of those were not previously part of the Medi-Cal benefit package. Now all of them are going to be part of the Medi-Cal benefit package. CBAS went into the Medi-Cal managed care benefit package last year, but now all LTSS will fall under the Medi-Cal benefit package. And to give you an example of that, say you've had someone, or someone right now, who is living out in the community, who has Medi-Cal only, so an SPD. That person is a managed care to receive their Medi-Cal benefit. If they get admitted into a nursing home, that person would stay in managed care for I think it's 30 days, but then they would have to disenroll from managed care, and then Medi-Cal would pay for their nursing facility care fee for service. That changes under the coordinated care initiative. Instead of going to fee for service Medi-Cal, the person would be in managed care, and the plan would pay for their nursing facility care. So that's the second major change, the integration of those long-term supports and services into the Medi-Cal benefit package.

The third change is the most discussed change, the change that everyone's hearing everything about, and that's the integration of Medicare and Medi-Cal into one managed care plan. And that's called Cal MediConnect, and that was federally approved back in march of this year when there was a memorandum of understanding between the federal government and the State of California. It's called -- also called the dual administration or the dual demo. And again that's the integration of someone's
Medicare and Medi-Cal benefits into one benefit package with one card, and so it's only impacting individuals who are dual, so those people with both Medicare and Medi-Cal benefits. As you can see, the first two changes have not received federal approval yet. The State of California has to submit this thing called a waiver to the federal government in order to get approval of those changes. And there's no reason to believe that it's not going to happen. It just hasn't happened yet. Whereas Cal MediConnect received federal approval with the -- those are the three main things happening with the coordinated care initiative.

So to give you an idea of what things look like, currently this is how the system looks. There's a lot of people who receive Medi-Cal that are in fee for service. For example, dual eligibles are receiving their Medi-Cal through fee for service, but there are also a lot of people receiving their Medi-Cal benefits through managed care. There's over 200,000 people who transitioned into managed care -- SPDs who transited into Medicare for their Medi-Cal benefits, so it's kind of both ways right now. For LTSS, it's mostly -- most people are receiving their LTSS through fee for service right now, except for CBAS. And then Medicare, you see the default is that most people go into fee for service for their Medicare benefits, but there are also a lot of people who are in managed care for their Medicare benefit. A Medicare advantage plan or a D Smith is a managed care plan for Medicare, so you see both.

Under the new system under the coordinated care initiative, all of those benefits will move into managed care. That's the point of the Coordinated Care Initiative, to get all benefits moved into a managed care plan. I have behavioral health on both sides has a little asterisk because behavioral health right now, there are certain behavioral health
services that are provided by the county, and paid for by the county. That will continue to be the case. That's the case now and it will continue to be the case under the managed care system. The only difference is that the healthcare plans are supposed to coordinate with the counties to make sure that the beneficiary receives those benefits. But the payments and the distribution of those services will still come through the county.

So this is a little bit -- this is actually an interactive slide, so on this platform, we can't do that, so that's kind of confusing. But an individual before, a senior or person with a disability, used to be able to go and see whatever provider they wanted to see. So they would see provider A, B and C. And those providers would be paid for by the Department of Healthcare Services or Medicare or both. Under managed care, what happens is a senior or a person with a disability goes into a health plan, and that health plan is paid for -- a rate from the Department of Healthcare Services, or Medicare, to provide care to the senior or person with disabilities, and then that health plan contracts with certain providers. And only can the senior or person with disabilities see providers that are within the health plan's network. And sometimes the provider is outside of the network, so the senior or person with disability can no longer see that provider under a managed care health plan. So those are the major changes that are occurring to this system as it looks today.

So just to recap, the individuals who are impacted by the Coordinated Care Initiative are individuals with both Medi-Cal and Medicare, known as dual eligibles, and then individuals with Medi-Cal only, or SPDs. Individuals who have Medicare only, so they do not have Medi-Cal, will not be impacted by the Coordinated Care Initiative. So just to
reiterate, individuals with Medicare only will not be impacted by the Coordinated Care Initiative. This impacts Medi-Cal only beneficiaries and those beneficiaries with both Medi-Cal and Medicare.

And these groups of people, these duals and these individuals with Medi-Cal only are going to be affected differently. So, for example, there are SPDs, those with Medi-Cal only, that are already required to be enrolled in Medi-Cal managed care, so they moved over to managed care last year. The difference for them is that now their LTSS benefits are going to be in their Medi-Cal managed care benefit package so those people are going to get a notice saying your LTSS -- nothing's really changing but your LTSS is going to be part of your Medi-Cal benefit package right now, starting soon. So that's the change they're going to see. Then there's certain SPDs that will remain exempt from mandatory enrollment in Medi-Cal managed care. There are very few of these people. People with other health insurance, people who successfully get a medical exemption request, individuals living in a veterans home, so they're affected differently.

Then we have dual eligibles who will be passively enrolled into Cal MediConnect, so into that integrated Medicare and Medi-Cal package. Those people, and most duals will be subject to that passive enrollment, but then there are duals that can enroll in Cal MediConnect but won't be subject to passive enrollment, and those will be people who are enrolled in Kaiser or waiver, and then there are dual eligibles that can't enroll in Cal MediConnect at all, and those are individuals in certain zip codes who receive services through regional centers, people diagnosed with end stage renal disease in certain circumstances.
I'm not going to go through all of the different exceptions because it's beyond the scope of this presentation. But I just want to point out that there are a lot of them, and this is just to highlight the complexity of the coordinated care initiative and how it affects so many different beneficiaries in very different ways. So I'm going to go ahead and stop there for questions. Anna, if you want to --

>> Sure. We actually don't have any unanswered questions right now. So for those of you who do have questions, you can use the chat feature and we'll pause again a little bit later and see if there are any unanswered questions to bring to Amber or Silvia.

>> AMBER CUTLER: Yeah, I think I have -- yeah, I'm going to just show this last slide before I hand it over to Silvia.

The coordinated care initiative will probably impact about a little over a million beneficiaries. As it is today, right now, there's about 527,000 beneficiaries that will receive a notice about Cal MediConnect for that integrated Cal Medicare package, and then there's about 483,000 additional beneficiaries that will receive noticed about either LTSS being integrated into their benefit package or being told that they have to enroll into Medi-Cal managed care. As you can see, for Cal MediConnect in Los Angeles county, there's a 200,000 cap on enrollment so what this means is that in Los Angeles county, although 271,000 beneficiaries will be subject to passive enrollment into Cal MediConnect and will receive notices about Cal MediConnect, only 200,000 can enroll in to Cal MediConnect. And they put that cap, or we've been told that they put that cap in place because Los Angeles county is so large, so they wanted to limit the demonstration by numbers. So with that, I'm going to go ahead and hand it over to Silvia.
SILVIA YEE: Thank you, Amber. Great job. And hello, everyone. I'm going to talk a little more -- focus a little bit more on Cal MediConnect specifically. So again, Cal MediConnect -- I'm going to share with you my tiny little trick for figuring out Cal MediConnect and how it is distinguished from the CCI. The overall project with the three parts is the Coordinated Care Initiative. Cal MediConnect is just about the duals, and connect always connects two things. So when you see Cal MediConnect, there are always two things involved. It's intended to combine Medicare and Medi-Cal services, two things. For those who are eligible for two things, who are eligible for Medicare and Medi-Cal, so this distinguishes it from the larger coordinated care initiative. And again, that Cal MediConnect is intended to integrate Medi-Cal services and Medicare services under one capitated rate. The plans will be paid one rate to provide you with both kinds of services and you will have one card as a member of a plan.

So going on to the next slide, just to let you know, so how it will work, enrollment is going to be a very specific -- the first issue to really address, and how enrollment in Cal MediConnect works is that it will be through passive enrollment. That means that as a dual, as a dual eligible person, you will receive a notice that informs you about Cal MediConnect. So from that point, you have three options. The first option, just to remind you again, if you do nothing, if you get this notice and you decide I don't want anything to do with it, I'm just going to sit tight, what that means is that you will be in the club unless you actively tell the Department of Healthcare Services that you don't want to join Cal MediConnect. You will be joined to it. So that's an important thing to remember.
So of those three choices, if you get this notice and you say hey, there are some things here that are really interesting to me. I'm interested in being a member of this and you want to join Cal MediConnect, you can actively do that and when you do that, you can then choose the health plan that you want to be in.

Your choice in most of the counties, you do get a choice. In two of the counties, in the San Mateo and in Orange County, there's one plan. If you want to be part of Cal MediConnect, you will join that one plan. In the other counties, you will have a choice of at least two plans. So your second option, if you decided, okay, I think I do not want to join. I want to keep things the way they are, then you have to actively opt out. You take action. You send back your form saying I don't want to be involved in this. And once you've done that, you can stay in what you have now. You can stay in fee for service in Medicare, finding your own providers and keeping your own providers that you have now. You could join -- you could choose a Medi-Cal plan for yourself, just the Medi-Cal part, or you can join a Medicare advantage -- or you could be in a Medicare advantage plan. So you can opt out and sort of keep things the way they are as far as your Medicare services.

And if you -- again, if you do nothing, you will be enrolled in Cal MediConnect, and a plan will be chosen for you by the department. So they will do that. It's important to remember that you can disenroll if you find that I didn't mean to join, I've been joined and I don't like it here, you can disenroll. And also -- yeah, so that's good and we'll go on to the next one. The next slide, looking at just Medi-Cal managed care.

This is distinguished from Medicare. So as a dual, in Cal MediConnect, you have options as far as your Medicare services. As far as your Medi-Cal services, you do not
have those options. If you want to receive Medi-Cal services, which includes home and community-based services such as IHSS, and other long-term services and supports, you have to join a Medi-Cal managed care plan.

So as an example, if you are in a nursing home, and previously you were not part of a -- you didn't have to join a Medi-Cal managed care plan, now you do. If you want to continue staying in that -- receiving your long-term services and supports. As Amber mentioned earlier, there are very few exceptions. You can apply for a medical exemption request and try to be exempted from Medi-Cal managed care, but the process is difficult and it can be lengthy. Also, the medical exemptions request is only available to reserve continuity with your medical providers and not with, let's say, an ancillary provider, like a wheelchair provider and a specialist.

In terms of the -- going back to Cal MediConnect, your actual benefits. So the plans are required to provide you with your Medicare services, A, B and D or hospital services, your physician services, your pharmaceutical services. They are supposed to provide you with the Medi-Cal services, including long-term services and supports, and what that means, which Amber went over earlier, they're also supposed to provide you with dental and vision benefits. This is preventative dental and vision, and also transportation services, non-emergency transportation services.

They also -- this is supposed to be the benefit of a plan -- will provide you with care coordination to the agree that you want it.

There is also the middle part of the slide, the care plan options services, and these are services that specialize additional extra IHSS hours, or some of the services that are available under a home and community-based services waiver. The kinds of services
such as environmental accessibility adaptations, changes to your home to help you continue to use it when you have mobility disability. Community transition services, or personal emergency response systems, private duty services. Those are the private duty nursing. Those are the kinds of additional services that a plan can provide, but is not required to provide. And also, looking at again specialty mental health services and behavioral health, drug Medi-Cal benefits, those will be provided outside of the plan. The plan is also supposed to be coordinating all those services.

Looking at the next slide. Oh, yes.

>> Silvia, did we want to stop there for questions?

>> Silvia Yee: Oh, yes. Sure. Of course. Are there any questions?

>> Well, one question that we've had a couple of times relates to on a practical matter, how does it work if you want to -- if you opt out of Cal MediConnect and stay in fee for service Medicare, but you're in a Cal managed care plan, you know, who pays for the claims in that situation?

>> Silvia Yee: That's -- the money is going to flow a different way. But you should still remain -- well, actually, if you're in fee for service Medicare and you stayed in that, then the department should continue to pay for --

>> Right. Because Medicare is still the primary payor, right?

>> Yes.

>> Silvia Yee: And practically speaking, you should not be receiving -- that should not change. You should not be receiving extra bills, additional co-pays. I mean, that is not supposed to change, and if you're wondering who is actually paying for your Medicare provider when you stay in fee for service Medicare, that should be the department. That
should be going through the plan if you opt out of Cal MediConnect. For your Medi-Cal services, however, that will be going through the plan because that's what's happened.

>> So it really depends on whether it's a Medicare service or a Medi-Cal service, right?

>> SILVIA YEE: Right.

>> Question? Hello? Hello? Can you hear me?

>> SILVIA YEE: Yes.

>> We can hear you. We're not supposed to.

>> In the middle of the slide, it says the optional services, HCBS waiver services, extra IHSS, is a nursing facility, acute hospital, the NFHH waivers, is that an example? And my other question is that means in every county, the plans can choose to cover those or not. And then I guess my last question is Alameda county --

[Inaudible].

>> AMBER CUTLER: I can answer that question. This is Amber. Yeah, the care plan services are entirely optional and so that does mean that the plans can choose to provide services that are like waiver-like services. So, like, the waivers that you did mention. But they do not have to provide those services. So it's just -- and then the plan, different plans could offer different care plan services. It's entirely up to the plan. But feasible, the plans could offer waiver services that the plans -- that the state couldn't provide before because there wasn't the -- I'm getting feedback. The waiver packs -- go ahead, Silvia.

>> SILVIA YEE: If you could put your phone on mute if you're not one of the presenters, and if you have a question, submit it through the chat button. We probably
won’t be able to get to all of them, but we’ll follow up with you afterwards if we can’t answer it within the presentation.

>> SIlVIA YEE: Thanks, Anna. Also, just to make a distinction here. As an option, the plan has the option to provide home and community-based services with a waiver-like services to people who don’t already have them. But when someone is currently right now on a home and community-based service waiver, yes, they have to join a plan for their Medi-Cal services, but their home and community-based services waivers are not optional for them. They are supposed to continue to get those services because they are already on a home and community-based services waiver. A plan can’t suddenly decide, oh, yes, now you’re with us and we’ve decided that your personal home emergency system and your private nursing care and these other services that you get with the waiver, they’re optional and we’re covering them. That’s not an option. And I just wanted to make that clear.

>> We should probably move on with the rest of the presentation, but those of you who have questions should submit them through the chat function, and we'll either address them in the presentation, or afterwards, if we don't have time. Thank you.

>> Anna? Amber? Our chat functions are disabled, so we're unable to chat with you.

>> Well, thank you for letting us know that.

>> Okay. Here we go. All right. You're welcome. This is Susan. Thank you.

>> We are getting some chat. I think that maybe what you need to do is submit a chat -- a question directly to me or to Amber. That seems to be working.

>> AMBER CUTLER: And just double click on our name to do that.

>> SIlVIA YEE: Right. You can direct your chat questions, actually.
>> AMBER CUTLER: All right, Silvia, I will move to the next slide for you.

>> SILVIA YEE: Okay. Thanks. So again, the CCI, Coordinated Care Initiative, will be implemented in eight counties. And two of those counties, it's -- there is only one option. One plan. But in the rest of the counties, there are different Cal MediConnect plans that are available. So this slide looks through some of them. And, let's see, San Diego actually has four plans to choose from if a dual decides not to opt out of Cal MediConnect. And the other five counties have at least two options each.

There was an additional wrinkle in L.A. County because one of the two plans there -- L.A. is a dual-plan county. There are two plans, L.A. Care and Health Net, but L.A. Care actually subcontracts with additional plans such as Caremore, which is out of Athens Blue Cross, Care First and Kaiser. And Kaiser has that little asterisk because it has sort of a special status under the contract with Medicare and Medicaid, that currently if you are a dual or actually if you're a Medi-Cal only. If you were currently a member of Kaiser, you will not be subject to passive enrollment so that if you were a dual and you do nothing and you get a Cal MediConnect notice, you presumably get to just stay where you are. You're not going to be taken out of Kaiser and put into another Cal MediConnect plan.

So it actually makes the status of Kaiser -- how available they are as a subcontracted plan to people who are not currently members of Kaiser, that's a little uncertain at this point.

So now I'm going to turn it over to Amber to discuss time lines.

>> AMBER CUTLER: Anna, do you -- are there any major questions about the health plan that came in?
Well, one question that's related to the health plan is whether or not, because there's that cap that was discussed earlier for enrollment into the Los Angeles Cal MediConnect, whether you're recommending that people sign up for that earlier, or wait in order to make it into the cap.

AMBER CUTLER: Let me just start off by saying that the State of California does not believe that the cap is going to be reached so there isn't really this crazy like influx of people trying to get into Cal MediConnect. They really don't think that the cap will be reached. And whether to enroll into Cal MediConnect is a very beneficiary-specific choice. So when a dual eligible receives the notice if they're eligible for Cal MediConnect, they'll want to take that notice, and think about it. Think about the pros and the cons of joining a Cal MediConnect plan. It shouldn't be whether they're going to get in or not because of the cap. That shouldn't be the consideration. It should be more of a consideration of whether their providers are in their network, and whether they want some of those additional benefits that might be available under the Cal MediConnect plan. They should determine whether it's best for them, and that cap shouldn't act as a -- to speed up enrollment, because that shouldn't be the factor that people should be considering. Did that answer the question? Anna, do you have anything to add to that?

No. I think that's a great answer. One more question about Cal Optima in particular. Someone had the comment and question that Cal Optima is kind of an umbrella group for different plans. Do you know if Cal Optima is putting together a separate plan for Cal MediConnect or will it continue to use several different plans under the Cal Optima umbrella for Cal MediConnect?
>> AMBER CUTLER: That's a good question. And to be honest, I don't know a ton about how Cal MediConnect is going to be -- or Cal Optima is going to be organized. So it's clear in Los Angeles, like L.A. Care is subcontracting with Caremore, Care First and Kaiser and that each of those subcontracted plans will be entirely responsible for the same benefits that L.A. Care is responsible for as the primary plan. They will provide all benefits. That's what we're told. Cal Optima, my understanding is that Cal Optima is the primary plan. Now, they may contract with different provider groups and physician groups underneath that, but that ultimately, Cal Optima will be responsible for providing the plan benefits. Again, though, we don't have a lot of details about how that will actually look on the ground. And whether technically they're not supposed to be able to subcontract out the risk or the benefits in such a way that they wouldn't ultimately be responsible for the actual plan and administering the plan. But again, more details to come on that. I don't have a ton of details on Cal Optima.

>> I'll just add quickly, if you're concerned about a very specific service, or a specific provider or something like that, the best thing would be to really directly contact Cal Optima and give them the specific question you have.

>> AMBER CUTLER: All right. So when is the Coordinated Care Initiative supposed to begin? Well, this time line has moved quite a few times. It's supposed to be now no sooner than January 1st, 2014, which would mean that the first notice would go out in October because notices are supposed to go out 90 days in advance. Like I said, the time line has moved quite a bit, and so that no sooner than January 1st. It could start January 1st or it could start much later. Also, I'm not going to go very much into this, but you guys may have heard that in the may revise with the governor's budget, there was
new legislation about the Coordinated Care Initiative that the senate has passed. Basically take those three changes that are happening under the Coordinated Care Initiative. Previously those three changes had to happen together and move together, so if Cal MediConnect was set to begin on January 1st, so would mandatory enrollment into Medi-Cal and integration of the Medi-Cal benefit into the Medi-Cal benefit package. Those would all have to happen on January 1st. Well, the new legislation allows those three things to move separately. So we're under the impression that everything would start on the same date but it's possible that those three things could start on very different dates now. So I'm not going to go into any more detail about that but just be aware that the date could change and the date could be different for each of the components of the Coordinated Care Initiative.

So the enrollment process and timing varies by county. So we've created this chart and there are a lot of question marks because the time lines moved. So our understanding of it hasn't been clarified to date, but there are some things we do know, that passive enrollment is supposed to begin on January 1st, and most of the counties. Los Angeles County is supposed to have a voluntary enrollment period of three months, and what does that mean? It means that people will get notices and have the option to enroll in Cal MediConnect versus that passive enrollment where, if they did nothing, they would just be enrolled. In L.A. county they're being given this three-month period where they can opt in and if they do nothing, nothing will happen. But then, they will get notices about massive enrollment following that voluntary enrollment period. That's supposed to work to slow down enrollment in Los Angeles county. It's supposed to act to allow there to be a gradual increase into the plans and up -- in L.A. county.
that people, under the passive enrollment scheme, so if you're being passively enrolled, the way that that would happen, for the most part, is by birthday. So you would -- if your birthday was in April, you would be enrolled into the plan in April.

But there are exceptions to that, of course, and these are some major exceptions. There are duals who are already enrolled in Medicare Advantage. They may have a very different passive enrollment date. Duals already enrolled in MSSP will have a different enrollment date. Duals who are already enrolled in Medi-Cal managed care in Alameda and Santa Clara, they are also enrolled. So many of these may go in on different dates than by the birth date passive enrollment schemes.

So if we're looking at passive enrollment and we're looking at birth date, for the most part, enrollment, what you see is a 90/60/30-day notice and then you're enrolled. So if you're scheduled to be enrolled into Cal MediConnect in January, you would receive a notice in October, then November, then December and be enrolled in January. Like I said, if you had an April date of birth, you would get a notice on January, and then February and then March and then be enrolled on April 1st.

What do the notices look like?

>>> The 90-day notice is somewhat just informational. It tells the individual that there's this change happening, that they're going to have to make a choice about their healthcare. They can opt out at that time, or they can decide to opt in at that time. And it's just more informational. The 60-day notice really has the meat of the information that the beneficiaries are going to receive. It's going to include the notice, which is already going to have a default plan on it. It's going to include a choice packet, which will explain to beneficiaries what this choice is all about, what changes are happening,
and then there's going to be a health plan guide telling them about the health plans in their county, what sort of benefits they're offering, and there will be a provider directory saying which providers are in which health plans' networks, so that's when people are really going to get that information and they're going to really need to take that information and discuss it with their family members or their trusted providers in the community, their health and community-based services providers, you know, whoever to figure out what they want to do for their own choice. And then they're going to get that final notice 30 days prior to enrollment telling them that if they don't do anything, they're going to be enrolled into X plan on X date. If they've already chosen a plan, that plan will be listed. And then if they've already opted out, then they won't get that notice. So those are the three notices that people will receive.

I'm going to stop there for questions. Anna, any questions about that?

>> Sure. One question was if you could talk a little bit about the effect of passive enrollment, and particularly how will passive enrollment, will it -- will people who get re-assigned into a Medicare part D plan, how will that -- will that affect their enrollment in Cal MediConnect?

>> AMBER CUTLER: Yes. Well, it's supposed to. Under the memorandum of understanding, individuals who were reassigned to a part D plan in 2013, or who are subject to reassignment in 2014, are all supposed to go into -- be passively enrolled into Cal MediConnect on the same day, which was going to be January 1st. But like I said, there are a lot of changes happening right now around all of the -- particularly all around the Medicare side of things, so that that could change. It could be January 1st of 2014.
It could be January 1st of 2015, I don't know. But technically, yes, those individuals are supposed to all go in on the same day, and that day was supposed to be January 1st.

>> Thanks. And then a couple questions relating to if a dual eligible decides to opt out of Cal MediConnect, how is that going to work? Are they still going to get a notice about the enrollment into Medi-Cal managed care?

>> AMBER CUTLER: They will, yes. That's a fantastic question. Yes, so basically what will happen is that when someone opts out, so say they get their -- well, let's say -- there are two ways, I guess. They could opt out before they even get a passive enrollment notice or they can opt out after they've already gotten a passive enrollment notice. They're still going to get additional notices telling them that they have to choose a Medi-Cal managed care plan, and they will look very similar to their notices before because most likely it's going to be the same health plan that they're going to have to choose from. So that's going to cause some confusion for beneficiaries, so they're going to say wait a second, I opted out of Cal MediConnect. Why am I getting these notices again telling me I have to join this plan? But they're going to get those notices because no matter what they're probably going to have to join a managed care plan for their Medi-Cal benefit.

>> Great. Thanks, Amber.

>> AMBER CUTLER: All right. Silvia, on to you.

>> SILVIA YEE: Back to me. You know, I just wanted to stick in one short thing here. I think I've seen the question before. Some people have asked, I don't even use my Medi-Cal benefits now. Why do I need to join a managed care plan? Why don't I just stick with Medicare? But Medi-Cal can assist with the premiums and the other -- the
co-pays that you may get under Medicare, and you may need Medi-Cal benefits in the future. Some of the home and community-based services, et cetera. So there is a reason to join a plan for your Medi-Cal benefits, even if you feel like you don't really use them or need them as of right now. So going on to the slide, and clearly this is a very, very involved project that's complicated. It affects the lives of thousands and thousands of Californians, and it also is a very, very big job for the department of healthcare services.

So why is it happening? There have been a number of goals given a number of reasons, and one of them is to improve access to care. Historically it has been very difficult for those who are duly eligible to coordinate Medicare and Medi-Cal services. There are distinct billing and appeal and authorization processes and it's hell. And for someone who has multiple providers, long-term service providers, as well as medical providers, and complicated treatments and schedules, it can be a benefit to have some assistance in care coordination. So one of the goals is to improve access to care. And to promote consent as well as promote independence in the community. So those are all good goals. To provide the right care at the right time at the right place is an excellent goal, and there is, as well, the goal of cost savings for the state and federal government.

The projection from the Web site, WWW.duals.org is for 171.1 savings from the coordinated care initiative.

So that's also something else to know. This hasn't been an overnight transition. California first submitted a letter of interest in the duals project back in November of 2011, and the state submitted an actual proposal in May of 2012. It took, actually, quite a while for the federal government to look at that proposal. A lot of negotiations, some
of which we know, some of which we don't, between the federal government and the state to result in a memorandum of understanding in March of this year, and there is still a long way to go. There is the L.A. enrollment process is being worked out. There are readiness reviews of the plans and a very important part, the actual contract, and a three-way contract with the plans and the state and the federal government will enter. So all of these dreams are ongoing and what's not on this chart is also a parallel process of -- a stakeholder process that's been going on, as well as a legislative process. Things happening at the California legislature that impact on this. So it's not finished. It started a while ago. And it's complicated enough that it needs all this time and arguably more.

Going on to the next slide. Should your client enroll in Cal MediConnect? And I think this is something we've really been trying to emphasize. This is an individual choice. And it needs to be an individualized choice. It needs to be something that every beneficiary needs to think through. What is important to me? What are the services that are important to me? What kind of continuity is important to me? What do I need assistance with? What am I doing okay without? Here's some factors when you consider whether to make your decision to enroll in Cal MediConnect or not.

One of the things is do the plans have networks that include your current medical providers. And this is a very, very key one, and if the plans do, which one? Is it only one of the plans have it? And that's something to talk to your provider about. I mean, are you? Ask your doctor. Ask your specialist. Are you contracted with a managed care plan? Which one. Consider whether your plan has a strong relationship with social services providers. And this is particularly in important with regard to the
Medi-Cal -- the Medi-Cal services, and especially your home and community-based services. This is -- you know, talk to your -- if you use an agency in the community, if you are a CBAS client, ask. Ask your provider, your current provider, has the plan -- has the plan just talked to you about entering a contract? About maintaining relationships with you so that I can continue coming to see you when I'm a member of the Medi-Cal managed care plan.

Consider whether you have a course of treatment that should not be interrupted. Whether you're in the middle of surgery or planned surgery or some other kind of treatment, this is a very important relationship, of course, with those who are -- who have HIV or AIDS, that's something you would need to think through.

How important are the additional benefits of preventive dental and vision and transportation, to you or to your client? I mean, transportation is a really critical one for a lot of people. Getting to and from treatments and appointments. So this is a pretty substantial benefit that plans are required to provide now.

One other thing to note, though, is that as of May 2014, adult dental is now going to be restored to Medi-Cal as a Medi-Cal benefit for preventive care and dentures. So if your thought is that, hmmm, if I go into Cal MediConnect, then I'll get dental, whereas if I had stayed in service I wouldn't. So that's something for you to think through there.

And finally, will joining a plan improve or meet your care coordination needs, and those can be very substantial. I've talked to someone who has mentioned how difficult it was when she had to go into a hospital for an unplanned stay, how difficult it was to keep all the balls going on her care provider, her IHSS service provider had no employment for that period. Her rent in her home, other things that were going on in her life were sort of
at a standstill because she's the one who is responsible for all of her care coordination, for keeping all the balls in the air. Now, if a plan can offer you assistance with that, is that a point that you should consider? Going on to the next slide, what to watch out for. And these are good things to watch out for. If you join a Cal MediConnect plan, the potential to care coordination. Also, getting one card. And that can be a big thing when you have a lot of people who have a lot of other cards to handle. I'll make the point that if you join and you have a -- the card should be available to you in alternative format, if you need the number in large font or sent to you in some other way so that you can actually access the number without being able to read the tiny print on the little card, that's supposed to be provided by a plan. Additional required benefits, like the potential ones, with additional IHSS hours, those are, you know -- oh, I'm sorry. There are additional required benefits from the Cal MediConnect plan and also possible optional ones that you should consider.

And finally the assessments and care plans. There is Cal MediConnect should be offering you a robust and complete assessment, and a care plan that is effective for you that considers your needs and your goals and your desires. You know, it's impossible not to preface this with a should, this should all happen. Since it hasn't actually happened yet -- no one can guarantee that it will, but there are clearly attempts being made to make sure that what is supposed to happen is going to happen. So going on to what to watch out for that's not so good. The timing is going to be a real issue. This is a whole bunch of changes are happening in healthcare, nationally and in the state, not just the Coordinated Care Initiative. The changes are happening. Expansion is happening -- rural expansion is happening. There are cuts in IHSS services, open
enrollment in Medicare. So this is a scene of moving parts. So that the timing of the Coordinated Care Initiative puts a lot of pressure on the department, puts a lot of pressure on the advocates as well as the agencies that you might go to for advice and assistance and in that kind of atmosphere, it's easy for there to be confusion and mistakes, both at the level of the enrollment agency, which is Healthcare Option and also at the level of the department and even at the provider level. There could be disruptions in your access to providers. While your own current provider may be part of a managed care network right now, that's not a guarantee. That relationship will continue or will be good for all time. There can be disruptions in care, in your care treatment, and in critical things like your pharmaceuticals. Managed care organizations have a formulary. There are prescriptions and kinds of prescriptions, and -- that they prefer, and that are allowed, so that's something to watch as well. And other issues, network adequacy. If you have a very rare specialist, that's something to really think about.

So looking at the next slide of what can you do? Well, you can try to influence program development. There have been stakeholder meetings. The department has had phone meetings. The department has also had some in person meetings and you can talk to your plan and this is an important one. Try to talk to both plans. See how they treat you. See how if they're trying to form a relationship, see if you can form a relationship, and these legislative advocacy, and for this, there are groups out there who are advocating on very specific issues, and to work with the group, that either the one that already exists, or to try to form one of people who have like-minded interests, we'll give you more clout politically and in your advocacy.
As an advocate, be prepared to provide counsel. And also critically important, report problems as a beneficiary or as an advocate. The problems you hear of, the problems you are encountering, let someone know about them so they can be brought up and raised as issues. And one more thing, even if you are not a professional advocate, the fact is you may have friends. Well, hopefully we all have friends, but you have people you know who they want to compare. You get these notices, you want to talk, you know, everyone talks to one another, and just to be careful here, because the details matter. The county in which you live will affect your choices. Your own status. Are you a Medi-Cal only while your friend is a dual eligible? That matters. So just to be aware that the choice may differ from the choices that your friend is talking to you about.

And just going to go on to this last slide, just to summarize. The coordinated care initiative overall is -- it's a new state law, and it's going to change the delivery of Medi-Cal services, long-term supports and services and Medicare for many, many people, for people who are dual eligible, for seniors and persons with disabilities who are living in the eight counties that we've talked about. This is going to be very, very significant, and right now, at least, it's aimed to begin January 1st, 2014. The goals, to coordinate care, which is great, and also to save money, which -- which ultimately, you want as well. It would be great to save money. It just -- our fear and our concern is always that money can't be saved at the expense of care or coordinating care. So are there any questions at this point?
We've pretty much answered most of the questions that are available. There's one issue that has come up a bunch of times, which is how would enrollment in Cal MediConnect or enrollment in Medi-Cal managed care affect co-pays for duals?

AMBER CUTLER: This is Amber. I can answer that question. It shouldn't change co-pays whatsoever. The Medi-Cal managed care plan would be responsible for paying those Medicare co-pays if they actually exist. Just as fee for service, Medi-Cal pays them today. The managed care plan would just be responsible for moving forward.

And I've talked to, here in Los Angeles county, I've talked to L.A. Care about that because they have a number of duals who are already in their managed care for Medi-Cal benefits, and they've already taken that responsibility on and had the systems in place to pay those co-pays. So it shouldn't change that system overall. It just becomes the plan paying the co-pays rather than the fee for service Medi-Cal paying those co-pays.

And then one remaining question that's outstanding is what about other care plans, and the ones that are mentioned here, not ones I'm familiar with, but maybe Silvia or Amber is, like Central, Easy Choice, United or CBAS, how do they fit into all of this?

AMBER CUTLER: Easy Choice is, I believe, a DSNP here in L.A. County. I'm not familiar with the others. Silvia, are you?

SILVIA YEE: By United, do they mean United Healthcare? Yes.

AMBER CUTLER: I'm assuming that they're talking about the -- DSNPS are special needs plans under Medicare for dual eligible beneficiaries, and that policy is somewhat in flux right now. It was that individuals who were in DSNPS were going to be subject to passive enrollment into Cal MediConnect, just like anybody else, just like any other
So if they were in Easy Choice DSNP, for example, they would get notices about passive enrollment into Cal MediConnect and they would have to either opt out and stay in easy choice or do nothing and join a Cal MediConnect plan, they could do so. But my understanding is that that is changing and that individuals who are currently in a DSNP will not be subject to passive enrollment. But that could change. I'm just throwing it out there. So it's possible that those individuals may not even get notices about Cal MediConnect.

But it is important to note that those individuals will still have to join a managed care plan for their Medi-Cal benefit. So even though they might not receive enrollment notices about Cal MediConnect, they will still receive notices about enrolling into Cal managed care Medicare. And even if they're not subject to passive enrollment, that doesn't mean that they can't join Cal MediConnect, it just means that they have to disenroll from what they're currently in to join the Cal MediConnect plan. So with all that said, again, it's up in the air, so there is nothing definitive about that policy. So just be aware that people who are in those plans, it's up in the air. As soon as we have more details, we will provide those details. Any other questions, Anna?

>> One more, and then we'll wrap it up.

>> I have a question. Will the individuals be able to look at a medication formulary before they enroll?

>> Yes. That will be part of that 60-day notice package.

>> Okay. Thank you.

>> And one more question that came in on the chat. How does this affect those who are moving from one of the non CCI counties into a CCI county?
>> AMBER CUTLER: It's all about timing, I guess. If someone moved in to a CCI county, and we're talking about the Medi-Cal managed care side, basically those people would have to join a Medi-Cal managed care plan is my understanding of it. For Cal MediConnect it's not so clear how that will work, how individuals moving into the county or individuals who become newly eligible, for example, who maybe just got their Medicare benefits after this all started, how they will be enrolled. That entire sort of transition from county to county, or individuals becoming newly eligible, that hasn't all been ironed out yet. So I wish I had a more definitive response for you. But it's sort of up in the air still.

>> SILVIA YEE: Yeah, I have to agree. I think if you were moving in -- you couldn't count, let's say your birthday is in March and then you moved in in June, the thing is you're going to have to start looking for providers. You know, it would be interesting. I don't know what would happen. If you moved to another county and you wanted to keep the providers that you had in the old county, yeah, that's com reply -- I'm not sure what would happen. If you were looking for new providers, the new county that you were moving to, then I think it would come up then that you would have to be joining, you know, mandatory Medi-Cal plan for sure, and it would raise the issue of whether you have to join the coordinated care initiative at that point or have the choice to.

>> AMBER CUTLER: Right. And there are all sort of continuity of care issues that go along with that and how you'll get to see your old providers, there's just a lot of that policy that hasn't been ironed out yet.

All right. Well, I want to thank everyone for participating. If we for some reason didn't get to one of your questions during the presentation, we will try to follow up with you
after this. And I want to highlight that we will be providing these trainings moving forward. This is a basics training, and our next basics training is scheduled for July 10th. And then we're going to have our first advanced training, which will get into some more of the details on July 23rd. NSCLC and DREDF, we are also putting out an advocates guide that goes into a lot of these details in a lot more depth and we hope to have that out by the end of this month, so just keep your eye out on our list serves for those materials.

And again, I want to emphasize that the Coordinated Care Initiative, like Silvia said, it's more of like this moving pieces, moving target. Things are constantly changing, and so we're trying to stay on top of that so that we can convey that to all of you moving forward. And again, thank you, and thank you, Silvia, for presenting with us today, and take care.

>> SILVIA YEE: Thank you.

(Webinar concluded.)