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**CIC ADVANCED 1:**

**BENEFIT PACKAGE AND CONSUMER PROTECTIONS**

**AND BENEFIT PACKAGE SUMMARY**

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>> Silvia Yee: Good morning, everyone. Great to have you with us in the webinar. I want to begin with a few directions how to obtain closed captioning. It's available in your media viewer. You can see in the slide also that accompanies me as I go. The media viewer is in the upper right corner of your screen. If you press on it, or if you click on it, you can get the media viewer panel will pop up on the right, and you can see that you will start to get a transcript. At the bottom right of your screen.

If you want to maximize that viewing space for your captions, in very, very small print, on the very bottom right corner of your screen, there's a show/hide header, and if you hit the hide header it will get rid of some extra text concerning the event that will allow the media viewer window to be bigger.

It's possible, as you go through, if you open the chat window or other panels on the right, the media viewer window with the captions may collapse. So if that happens, you can just click the media viewer icon again to bring back the closed captions.

Also, as you're going, if something odd happens, type a question in the chat box or type the issue in the chat box and one of us will get back to you.

OK. I've had a very kind person let me know that on Macs the direction I gave about media viewer, the media viewer icon, it's on the upper right of your screen for those with desk tops, desktop computers. On a Mac it's on the lower right of your screen. If you're using a Mac, you have to adjust the directions. Thank you. I'm going to hand over to my co‑panelist Amber Cutler to begin the actual webinar and the presentation.

>> Amber Cutler: Thank you, Silvia. Can you hear me?

>> Silvia Yee: Yes.

>> Amber Cutler: OK. Great. All right, so today's presentation is a collaboration between Justice in Aging, formerly the National Senior Citizens Law Center, and Disability Rights Education and Defense Fund. Today, we're going to cover the Coordinated Care Initiative and specifically what we call an advanced presentation, where we're going to cover in more detail the benefit package and consumer protections. Hopefully, most of you in attendance today have listened to the basics training, so you'll have a pretty good understanding of the CCI. This goes a bit more into depth about the program.

Justice in Aging is a nonprofit. We have offices in Washington, DC, Los Angeles and Oakland. I'm based out of the Los Angeles office. We focus primarily on the public benefits program that impacts seniors and persons with disabilities with low income. So we focus on the Medicare program, the Medicaid program here in California, the Medi‑Cal program and Supplemental Security Income.

Silvia, do you want to say a little about DREDF?

>> Silvia Yee: Sure. DREDF has been around since 1979. We're founded by people with disabilities and parents of children with disabilities. Also on our board. We focus on law and policy that is of concern to persons with disabilities. We're based in Berkeley, California, and our interest is in protecting and advancing civil and human rights of people with disabilities.

>> Amber Cutler: Great. So just an outline of today's discussion, we're going to do a brief overview of the Coordinated Care Initiative, to get us all on the same page. We'll talk about the integration of long‑term services and supports. We'll go into more detail about what the benefit package looks like, particularly for Cal MediConnect, then end with a preview of the major consumer protections under the Coordinated Care Initiative.

Before we start off, I always like to start with a glossary to make sure we're all on the same page with regard to definitions. The first definition is a dual‑eligible, or dual, medi‑medi, that is someone who has both Medicare and Medi‑Cal health insurance coverage. That is one population that is impacted by the Coordinated Care Initiative. The other population impacted by the Coordinated Care Initiative is the very last bullet, the seniors and persons with disabilities or SPDs. These are individuals who have Medi‑Cal only coverage. They don't have Medicare. Medi‑Cal only. The basis for eligibility for that Medi‑Cal is either age or a finding of disability.

Another term I like to define is a Dual Special Needs Plan or D‑SNAP. That is a special kind of Medicare Advantage plan. That is one of those plans if you have Medicare, Part C, you can buy into a private HMO or PPO plan for Medicare. Under that umbrella of Medicare Advantage plans are Dual Special Needs Plan. They're a special type of Medicare Advantage plan targeted specific at dual‑eligibles. So they're no‑cost and they're supposed to provide some different coordinated benefits that are particular to the needs of dual‑eligibles. Individuals enrolled in these dual special needs plans are impacted differently under the CCI than individuals who are not enrolled in these types of health plans.

Finally, I like to define long‑term services and supports, or LTSS. Under the CCI that has a very specific meaning. Generally, you can speak about LTSS very broadly, but under the CCI it encompasses four Medi‑Cal, primarily Medi‑Cal funded programs. So it's the in‑home supportive services program, IHSS, that's where you have a provider, usually a friend or family member, who comes in and helps with activities of daily living. The current has the right to hire, fire and supervise that IHSS provider. Then the community based adult services program, formerly known as adult day healthcare. This is where individuals go to sites and receive a range of services, socialization, nutrition, nursing services. The goal of those CBAS centers is to help someone continue living in the community, rather than going into an institutional setting like a nursing facility.

Then there's the Multipurpose Senior Services Program, MSSP, this is an intense case management program available to individuals 65 or over. Again, aimed at keeping people out of nursing communities and living in the community and it's pretty limited in the sense it's a waiver program. So there are only so many slots available to individuals. But it's incredible in case management keeping people living at home.

Finally, nursing facility benefit. These four primarily Medi‑Cal funded benefits fall under that umbrella term of LTSS. When discussing LTSS, we're really talking about those four covered benefits.

All right. So if there are any problems with the sound, do let me know. I don't know what is causing it. It might be our phone systems. But I will try to slow down a little bit and make sure I repeat myself in the event that I am breaking up.

To review what the Coordinated Care Initiative is, it encompasses three major changes. The first is that pretty much if you have Medi‑Cal you're going to have to be in a managed care plan to continue receiving your Medi‑Cal benefits. This started back in 2011, when we saw individuals who only had Medi‑Cal or SPDs. They were mandatorily transferred or transitioned into managed care plans. But in that transition there were major carve‑outs. For example, if you were living in a nursing facility, you did not need to be in a Medi‑Cal managed care plan. If you had a share of cost, you did not need to be in a Medi‑Cal managed care plan. If you were duly eligible, you had both Medicare and Medi‑Cal, you did not have to be in a Medi‑Cal plan.

Under the CCI, that changes. If you have Medi‑Cal you're going to have to join a managed care plan of some sort to continue receiving that Medi‑Cal benefit. Very few exceptions to that.

The second major change is that the plans, the managed care plans, are now going to become responsible for the long‑term services and supports. So CBAS and IHSS and MSSP and most notably nursing facilities are all benefits that you no the managed care plans are responsible for. To give a really concrete example, I like to talk about the nursing facility benefit. It looks the most different moving into managed care. CBAS went in already in 2012. IHSS is going to look pretty much the same to consumers of IHSS. And MSSP at this moment looks the same. But nursing facility looks pretty different. In the past, prior to the CCI, if you were someone living in the community, you were in a Medi‑Cal plan, you went to the hospital and you were discharged to a nursing facility, you were then disenrolled from your Medi‑Cal plan and puppet back in fee for service. You could go to any nursing facility that accepted Medi‑Cal.

Under the CCI, you're in a plan, living in the community, you go to the hospital, you're going to be discharged to a facility. Now you have to choose a nursing facility within your health plan's network. Now it needs to be a network provider, a nursing facility is now part of the providers that you have to see are part of your plan. Just like your primary care physician or specialist, you have to pick a nursing facility that is within your health plan's provider network. That looks very, very different than it used to look prior to the CCI.

The third major change, and the one we hear the most about, is the Cal MediConnect program. This is the new type of health plan that combines someone's Medicare and Medi‑Cal benefits into one health plan. So one health plan is delivering both sets of benefits, both the Medicare benefit and the Medi‑Cal benefit. Including those long‑term services and supports.

This is a voluntary program, meaning you don't have to join the Cal MediConnect plan. It's only available dual to dual‑eligibles. Even if you don't participate in Cal MediConnect, you are still going to have to be in a managed care plan for your Medi‑Cal benefit. That is mandatory.

All right. So again, to reiterate who is impacted, it's individual who have both Medicare and Medi‑Cal, are dual‑eligibles or medi‑medis, and those are Medi‑Cal only, seniors and persons with disabilities or SPDs. Individuals who only have Medicare are not impacted by the CCI.

Hold on just a second. So exactly who is impacted? Actually, Silvia, were you going to take over here?

>> Silvia Yee: Sure, am better. Let me take myself off mute.

>> Amber Cutler: I can't remember, I'm sorry, where the break was.

>> Silvia Yee: I think it was a little later. If you want, I can take over here.

>> Amber Cutler: No, no, I'll go ahead. I just forgot the slide breakdown.   
[Laughter]  
Sorry.

>> Silvia Yee: OK. I think the break, I hear a lot of breaking up, so I'll put myself on mute, maybe that will help hopefully.

>> Amber Cutler: OK.

[Audio is breaking up]  
When it comes to Cal MediConnect, it gets a lot more complicated. So if you have a dual who is excluded from Cal MediConnect, so meaning they pretty much can't participate even if they wanted to, that includes people who have end stage renal disease, so ESRD, who require dialysis. Of course, there's an exception to that if you live in San Mateo or Orange County, that does not apply. If you reside in certain zip codes within LA County, Riverside and San Bernardino, you can't participate. If you're a resident of a VA home, if you're a resident of an ICF‑DD [indiscernible]

[Audio is breaking up]  
You also have some private health insurance through your former employer, you're excluded from Cal MediConnect. Or you're in a DDF waiver or receiving services from a regional center or [indiscernible].

I've marked there in the column with the double star those individuals who are entirely excluded from the CCI. So for example, if you're a resident of an ICF‑DD you shouldn't get any notices about the CCI. Cal MediConnect or otherwise. The rest of the groups are individuals who should not [indiscernible] but will get notices about [indiscernible]

[Audio continues to break up]

>> Silvia Yee: Amber? I think that the breaking up has been just escalating for just over this last slide. So I think we're going to ask you to phone in again. It might be just a bad connection. I'll finish up this slide. Does that work?

>> Amber Cutler: Yes. That works.

>> Silvia Yee: Thank you. OK. Sorry, everyone, for that. We just get ‑‑ I guess we all have to live with a bad connection for a bit.

I'm going to go on from where Amber stopped. I know that it was hard to get what she ‑‑ that first part about duals excluded from Cal MediConnect. We can, if any of you would like us to go over that again, please you can put that suggestion in the chat box. There are also this list is also detailed in other places as quell. We can provide that information.

In terms of the CCI and who is impacted, there are a number of dual‑eligibles who can participate, choose to do so but have to actively do so. They will not be passively enrolled. If they do nothing, they will not be enrolled. That includes those already enrolled in the PACE, program in the Aids Healthcare Foundation waiver. There are individuals in certain zip codes, in San Bernardino county, and these are primarily rural areas, and they will also not be passively enrolled. Then there are a number of individuals, those already enrolled in Kaiser or those who are in a D‑SNP plan with a health plan that is not involved in Cal MediConnect, those who are in the Medicare Advantage plan, then there are also other various specialized, special needs plans that you will not be passively enrolled.

Also, if you're already an individual who is in a nursing facility waiver, any of the home and community‑based service waivers or the HIV/AIDS waivers, assisted living waivers, you will not be passively enrolled. You are, in fact, supposed to be receiving integrated services now under the waiver. So that's one of the rationales for not being passively enrolled in another program.

If Amber is back, I'll go on to the next page and let Amber continue.

>> Amber Cutler: I am here. Is that better?

>> Silvia Yee: Yes.

>> Amber Cutler: Yay! OK. All right. So with this really complicated group of people, some are excluded, some not excluded, some should get one set of notices versus a different set of notices, does the Department of Health Care Services has set up an e‑mail address when people receive the wrong notices, that you can e‑mail to this e‑mail address and let them know. So there are instructions here on what type of information should be provided. You're not supposed to send personal, private health information. They'll send you a secure e‑mail back to provide that information. Then if you're not the person's representative, they may not give you case specifics moving forward, but the goal of this e‑mail address was in order to help fix the problem when wrong populations were receiving wrong notices. So I do recommend that people use this e‑mail address for that problem.

Then just to keep in mind, again, that even individuals who do not receive notices about Cal MediConnect, most likely are going to receive notices telling them they have to enroll in a Medi‑Cal plan. That is pretty much mandatory for everyone except for a few populations. So you're going to find yourself as a dual, you might be in fee for service for your Medicare, but your Medi‑Cal plan is going to be responsible for your Medi‑Cal services.

All right, Silvia, I do think it's time that we switch over. But I would like to stop there to make sure there aren't any questions. I don't see any.

>> Silvia Yee: I don't think there were any.

>> Amber Cutler: No.

>> Silvia Yee: Someone, there is one attendee who put up there permission to speak button on, but I'm not sure if that ‑‑ we'll wait a little bit. I'm not sure if that was actually a real question or not. We'll just continue a little bit. How about that?

Let's look a little bit more at the actual benefit packages. Looking first at Medi‑Cal managed care. So Medi‑Cal managed care does now have these two components. It includes the medical care, the kind of care we often associate with a health plan, going to doctors' offices, hospital care, etc., and now it also includes long‑term services and supports, which is this new very large change. That's now included in Medi‑Cal managed care.

Medi‑Cal has always been a primary source of long‑term services and supports. Medicaid is essentially the provider of home and community based services and long‑term services in the country, but now it's also included under the auspices of managed care, and that's the big change.

There are a couple of additional Medi‑Cal benefit changes in the last two years that will be very interesting to the Medi‑Cal beneficiaries and their advocates. On January 1, 2014, there was a new mental health benefit that was announced which is now available to all Medi‑Cal recipients, and it's a Medi‑Cal benefit that is delivered through Medi‑Cal plans. There is now a differentiation between the levels of mental health care that may be needed, the kind, what Medi‑Cal plans are supposed to deliver now is mental health care of a less, I guess you could see it as a less serious order. They will provide group therapies or any kinds of therapies, mental health assessment testings, that kind of thing. So that's now available through Medi‑Cal plans.

There's now also a Medi‑Cal dental benefit that started on May 1, 2014. So that is a basic Medi‑Cal benefit that will ‑‑ for dental health. This is actually not delivered through Medi‑Cal plans. It's a carveout. The dental benefit is delivered through Denti‑Cal. The health plans do not have a primary responsible for delivering that, though they should at least be open to coordinating with dentists where that's necessary, let's say for someone who needs anesthesia with their dentistry.

So going on and looking a little more closely at long‑term services and supports and managed care, Amber spoke about these briefly at the beginning, but we'll look at them in a little more detail. The four programs now under the flag of managed care are the community‑based adult services. These are homes and programs where often seniors and people with disabilities, people who are Medi‑Cal can go during the day, where they receive some healthcare, if that's necessary. It's a place where they receive services and supports during the daytime, but only the daytime. Then they go back to their own home.

Also there's in‑home supported services, which is a very critical component of long‑term services and supports. It allows seniors and people with disabilities who need assistance with daily living to remain in their homes. It's a program that has been developed and is very dear to the hearts of many in the disability community and many individuals in California, because of the way that it allows people with disabilities to actually have control over the provider who helps them in their home, since the individual, the Medi‑Cal beneficiary, is the one who hires and fires, helps to train and supervises the provider who comes to their home. As Amber said, many, many of these individuals, providers are friends or family members who are being paid to assist the persons with disabilities.

The multiservice seniors program is one directed towards seniors and provides them with a variety of services, including home supports, Meals on Wheels, some healthcare that can come to the home. Again, it's designed to help individuals remain in their home, to age in place or to live in the community while receiving services in the community.

Finally, the nursing facility is that component in which individuals do go to an institution or remain, stay in a home, etc., that is not in the community, it is where they will live and reside and is a matter of that now managed care organizations will make contracts with nursing facilities and nursing facilities will be paid through managed care organizations for their Medi‑Cal individuals who live in their home.

Moving on now from straight Medi‑Cal on to Cal MediConnect benefits. There are required benefits under Cal MediConnect, so these are benefits only available to those duly eligible for Medicare and Medi‑Cal, and who have elected to join the Cal MediConnect plans. Of course, Medicare A, B and D. That includes your offices to a provider, therapy and hospitals and pharmacy services.

The Medi‑Cal services include what I spoke about on the last slide, all the in‑home supportive services, community‑based adult services, nursing facilities, and the multiservice seniors program. It also includes a vision benefit, a fairly basic benefit. You get one routine eye exam annually and $100 toward eye glasses or contacts every two years.

There's also a transportation benefit. It is medical in that it's transportation to your medical services, an appointment, therapy, etc. These are 30 one‑way trips per year. It's not medical in that it's not an ambulance. These are just essentially taxi rides or other ways of getting towards your transportation, and you have 30 of them for one year, which is sufficient for some people and not sufficient for others who have many visits to go and many providers. That's something to work out with your plan and to be aware of as well.

Then there is a care coordination benefit, which is a very large component of Cal MediConnect. Looking at it more closely, the care coordination can be very, very valuable to many individuals in the community dealing with multiple providers, multiple conditions, other issues happening in their lives, lots of scheduling. The care coordination benefit is offered by the plan, and there's really a number of things to note about it. It is supposed to be person‑centered, so you, the beneficiary, the Medi‑Cal beneficiary is very much supposed to be at the center of the care coordination. It's up to the beneficiary whether they want care coordination and how much of it they want, how much assistance they may want. It is supposed to focus on the needs of the individual and their goals, and also focus on the least restrictive setting for that individual.

If someone is a senior living in their home, they break a hip, they have other conditions that are happening, the care coordination team and service should be one that speaks with you and with your family or with your advocates to work towards a care setting for you, temporary and long‑term, that is focused more on the community, as much as possible, and there should not be any jump towards, Well, I guess now it's time for a nursing home. That's an important thing to think about. There's a health risk assessment that is supposed to happen for all new members coming into a managed care plan. That will look at the overall needs, and again, the overall needs and goals of the person entering the plan, including any need for long‑term services and supports in the community, as well as medical needs.

There is supposed to be an individualized care plan for those who enter and who indicate that they would like one and who need one. So it is, again, supposed to be focused on the needs and the goals and desires of the individual. Interdisciplinary care team, which will involve not only your medical doctors and medical providers, but also any social workers, any mental health providers, any ‑‑ and your in‑home supportive, your IHSS worker, if that is your desire, your family members if that is your desire.

Again, it's supposed to be focused on the needs and the desires of the dual beneficiary him or herself.

There is also additional information in the actual policy letter. You can see at the bottom of the slide the address where the Department of Health Care Services put up their policy letter about care coordination. That's a good document to go through if you're an advocate.

Finally, there are some Cal MediConnect benefits that are optional. These are not required from the plan, but the plan can choose to give them in cases where they're needed. They're home and community‑based like supports and services. If you need extra hours to stay safely in your home or if you ‑‑ or just to make it better for you to stay in your home, they are discretionary. They are also ‑‑ note they are in addition to, not as a trade for other required benefits. So for instance, if you're someone who doesn't use CBAS or you want to ‑‑ you're thinking maybe I'll use less CBAS and get more in‑home supported services hours. It can't be a trade. If you need more CBAS, you get that. If you need more IHSS‑like services, you can ask for those.

The need for these is supposed to be assessed during the health risk assessment. When you enter as a new member into the health plan.

If you receive some of these services or if you request them and they're denied, you can appeal that decision. It goes ‑‑ it's an appeal through the plan. The plan complaint and grievance process. Not to the state, because these are not required services, they're optional services. Again, there's additional information on that at the dual demo advocacy website that Justice in Aging runs. Also there's a policy letter from the Department of Health Care Services on this.

I think we are now back to Amber. Or the rest of the ‑‑ for some more thoughts.

>> Amber Cutler: I'm here. I don't think there are any questions here, so we're going to go ahead and move forward. One of the major problems we've seen so far with the rollout of the Coordinated Care Initiative is there's been a high percentage of opt‑outs, meaning people, dual‑eligibles who do not want to participate in Cal MediConnect. That means their Medicare is in fee for service and hasn't changed, but their Medi‑Cal is now in a health plan. That's caused a lot of confusion for both the duals who are impacted and for their providers.

So I just wanted to include a slide that shows what happens when a dual‑eligible opts out of Cal MediConnect and what Medi‑Cal is responsible for. So in that instance, the Medi‑Cal plan is going to be responsible for benefits that Medicare does not pay for. Most notably, that's the long‑term services and supports, Medi‑Cal is the primary funder of those, so the Medi‑Cal plan is responsible for coordinating the in‑home supported services, MSSP, CBAS and ultimately long‑term nursing facility care, since Medicare only pays for a small portion of any nursing facility stay.

The Medi‑Cal plan is also responsible for Medi‑Cal transportation services. For example, if you are someone who needs to go to Medi‑Cal appointments by a litter van, the Medi‑Cal plan is going to be responsible for paying for that vendor, that transportation service. We've seen as the rollout of the CCI has happened that the plans aren't necessarily contracted with the same transportation vendors that the dual was using previously. While there might be a change in the vendor of the transportation service, in theory there should be no disruption in the provision of that transportation benefit. That's not always been the case. We've seen major transportation issues, for example, going to dialysis centers where transportation has been disrupted, and I highly recommend calling the CCI ombudsman because they can quickly work with the health plans to get that transportation benefit set back up so that the member is not experiencing or the beneficiary is not experiencing any disruption in their care, because their transportation vendor has changed. Not that they're losing that benefit, but that the vendor of that service has changed.

The same goes with certain prescription drugs. Medi‑Cal covers supplies, so incontinence supplies, diabetic supplies are covered by Medi‑Cal, not Medicare. Again, the vendor may change, but there should be no ‑‑ in theory, no disruption in the provision of those supplies or that transportation benefit. Again, if there is a disruption, you should work with the CCI ombudsman to get that back in place, because they've been really good at working with the health plans to make sure that disruption is minimized if there is any.

Finally, this is probably the most confusing aspect, is that the Medi‑Cal plan is responsible for paying the cost sharing, the 20%. In theory, if you go to a Medicare doctor, the Medicare doctor gets paid 80% from Medicare, then that Medicare doctor can bill for the ‑‑ bill Medi‑Cal for the 20%. Most times that 20% isn't payable, because it's only payable up to the Medi‑Cal rate, and that is so much lower than the Medicare rate that most providers who serve dual‑eligibles never see that 20%.

In any case, if the Medicare provider wanted to bill the 20% before the CCI or before the dual had to join the Medi‑Cal plan, they would bill the state, and the state would pay the 20% if it was payable. Now, the difference under the CCI is that instead of billing the state, the provider bills the Medi‑Cal plan. Nothing else changes, just the payer changes, and the Medicare provider does not need to be contracted with the Medi‑Cal plan to bill the Medi‑Cal plan for the 20% cost sharing.

That's caused a lot of confusion, so we hear a lot of times someone will see their Medicare doctor, their Medicare doctor will say, Sorry, I can't see you anymore because I don't work with your Medi‑Cal plan. That is an education issue. It's not really a problem. They can bill the Medi‑Cal plan.

They don't have to be contracted with the Medi‑Cal plan, in order for them to get paid if they're actually going to get paid.

Or sometimes we hear where the Medicare doctor will say, Well, now you're responsible for the 20%. That's illegal. That's called balanced billing and duals aren't allowed to be balance billed, generally speaking. That should not happen, but it's a huge area of confusion. There are a number of fact sheets that are available in the provider toolkit on the Cal duals website that I recommend using if your a having a provider that is saying that they're not contracted with Medi‑Cal plan, can't see you anymore, in order to educate that provider.

On the state and we and other organizations are trying to do a massive education and outreach campaign to try to nip this in the bud, but it is a pretty big issue causing disruption where there doesn't need to be disruption.

All right, now on to some consumer protections. The big one being continuity of care. So that continuity of care means that an individual who enrolls in a health plan has the right to continue to see a provider that is outside of the health plan's network for certain period of time as long as several criteria are met. So for Medicare under Cal MediConnect it's six months. Medicare is 12 months. That's the baseline. The health plans can go above and beyond this. This is the required baseline that health plans have to provide in terms of continuity of care protection.

The first criteria is that there must be a pre‑existing relationship with the provider. It can't be someone you've never seen before that is out of network. You need to have a relationship. That's at least seeing your primary care physician at least once in the previous 12 months, if it's a specialist twice within the previous 12 months preceding enrollment.

The plan is supposed to use utilization data to see if there's that pre‑existing relationship. It's not the member of the health plan that has to prove that existing relationship at the outset. The plan is supposed to look at utilization data to see if they've seen that provider within the last 12 months. Then if the plan doesn't fit in the utilization data, the member can provide proof of that relationship.

The provider also must agree to accept payment from the health plan. That usually means a one‑page agreement with the health plan that says I'm going to accept payment for this specific member. Keep in mind that the health plan has to pay the provider the same rates that they got under fee for service. So if it's a Medicare provider who is seeing someone under continuity of care, they're going to get the same rate, Medicare rate, they would have received if they were just seeing the person through fee for service.

Then finally, the provider can't have any documented quality‑of‑care concerns, and in the plan's contracts there are certain things set out that say the provider is providing really terrible care, that the health plan doesn't have to work with them. They can't have any documented quality‑of‑care concerns.

There are some exceptions to the continuity of care policies. Generally it's a six‑month, 12 months, and it's for seeing all of your doctors and providers. But there are exceptions. Nursing facility is a big exception. If you are residing in a nursing facility and you're enrolled into a health plan, you have the right to continue to reside in that facility for the length of the demonstration. So that means just because you're in an out‑of‑network nursing facility, you don't have to move just because it's out of network. You have the right to continue residing in that facility.

That's a pretty good consumer protection for residents so they don't have to leave their home just because they're in a facility that is not in their health plan's network.

Now, if they're not in a facility and they're going into one, they're going to have to choose a facility that is within their health plan's network.

Another major exception is durable medical equipment, but this kind of goes in the opposite way. It's more narrow in that continuity of care does not cover durable medical equipment providers. So it covers the service, so you can continue to get your durable medical equipment, but it's not going to allow, the continuity of care protection is not extended to the provider of that service. You might have to switch providers of the DME.

Same with ancillary services. Maybe you're using a specific lab. You can continue getting lab services, but you might have to use a different lab.

Then of course, carved‑out services, behavioral health, provided by the county, dental provided by Denti‑Cal. The health plans have no responsibility to provide continuity of care there.

IHSS, continuity of care doesn't apply here, because under IHSS moving into managed care you always have the right as a consumer to hire, fire and supervise your IHSS provider.

Then when it comes to continuity of care with prescription drugs, it looks a little different. You have the Part D rules apply. You're going to get one‑time refill of a 30‑day supply, unless there's a lesser amount prescribed. Maybe you were only prescribed a 15‑day amount. That's what you get continuity of care for.

It's of any ongoing medication within the first 90 days you're in the plan. So there should be no reason when you join a Cal MediConnect plan that you should be told by your pharmacy that they won't give you your prescription drug, because even if it's not on the formulary continuity of care should cover it.

The problem, though, is that the pharmacies don't always know this. So there's been some outreach to the pharmacies to let them know that continuity of care is in place, and that even if you're in a new health plan that health plan is going to have to cover that refill at least for 30‑day refill.

There are additional protections when it comes to prescription drugs if you're in a nursing facility or institution. Just to know that these transition rules apply to both drugs covered only by Medi‑Cal and the drugs covered by Medicare. So pretty ‑‑ it's a pretty good continuity‑of‑care protection. Not always playing out so expansively in practice, but we're hoping that will continue to get better as pharmacies learn more and more about that protection.

Then there are other general protections that are available if you're getting an acute or serious chronic, pregnancy or terminal illness, any of those services, continuity of care must be provided pursuant to the California health and safety code.

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There were updates made to the continuity of care policy. Providers can request continuity of care. It's not just the member of the health plan that can request it, but actually providers can request continuity of care. Requests must be processed within three days if there is a risk of harm to the beneficiary.

Retroactive contestant is permitted, meaning that let's say you didn't know that you were enrolled in Cal MediConnect. You go to the provider, your provider doesn't know you are enrolled in Cal MediConnect and rendered services, then later go to bill and they find out you're in a Cal MediConnect plan, but they're not in network. That provider can bill the Cal MediConnect plan retroactively within the 30 days in order to get payment and reimbursement for the services rendered, even though they didn't know you were in a Cal MediConnect plan and you didn't initially request continuity of care. As long as the criteria is met.

Finally, I guess the ultimate continuity of care protection and this is under Cal MediConnect is the ability to disenroll from Cal MediConnect, because then you go back to either Medicare fee for service or some other Medicare plan you might choose, but then you can gain access to the Medicare providers you might not have had access to under the Cal MediConnect plan. You can disenroll at any time for any reason, but disenrollment becomes effective the first day of the following month. Keep in mind even though you're disenrolling from Cal MediConnect, you are still enrolled in a Medi‑Cal plan for your Medi‑Cal benefit. Only the Medicare side is voluntary.

Just a quick review of what continuity of care looks like if you're just on the Medi‑Cal side. Maybe you only have Medi‑Cal, you're going to be able to ‑‑ the contestant on the Medi‑Cal side is for 12 months. You have to have the existing relationship. It's the exact same kind of qualifications. Then even if you opt out of Cal MediConnect, so you're only in a Medi‑Cal plan for your ‑‑ basically in the Medi‑Cal plan for your long‑term services and supports, you're in a facility out of network, you're going to be able to continue residing in that facility. So same continuity of care protection on that side as well.

The final thing I will say about the Medi‑Cal managed care continuity of care is that individuals who only have Medi‑Cal, so they don't have Medicare, still have the availability of the medical exemption request or the MER. Available in the two‑plan counties, or the geographic managed care counties of San Diego. It allows you to stay out of managed care entirely, but only available to people with complex medical conditions. Again, the MER is not available to dual‑eligibles. Only to individuals who have Medi‑Cal only. The reason is that your Medicare providers are paid for by Medicare. So if you're not in a Medicare plan, only in the Medi‑Cal plan, a MER does not apply.

I'm going to switch back over to Silvia now. I don't see any questions.

>> Silvia Yee: It doesn't seem like it. I think we've been so crystal clear that no one can think of anything.   
[Laughter]  
Really, we're happy to have any questions come.

We're going to cover ‑‑ I'm going to cover a few more of the final consumer protections, which are pretty critical. One, do you have a right to receive materials and services in your language in a different language and in alternative formats. This will apply even if you are someone who does have someone ‑‑ if you are a Medi‑Cal or Medicare beneficiary, who has someone to assist you, it's still important to be able to read and understand what's happening to you, especially around passive enrollment, especially when you're entering a new plan, maybe making decisions about providers. So it is possible, you can request a language that's better for you, written language better for you or alternative formats such as Braille or CD.

There are a number of accessibility rights. There are federal and state disability rights laws that apply. You can get reasonable modifications so that you can gainful and equal access to services. Alternative formats is part of that. Also physical accessibility when you visit your providers, especially if you're entering a plan and you do have to see some new providers, and you go to a provider's office, you find they're inaccessible to you, the exam tables don't lower, you can't get ‑‑ there is no elevator, not enough room for you in an exam room. That is a reason to say that you need physical accessibility. You can bring that up with the plan. You can bring it up with your provider.

Also, the plans are required and have received training on disabilities discrimination and cultural competency. So that's something they have an awareness of. When you speak to your plan representative, they should understand what you're talking about, if you say that you have a complaint about inaccessibility or anything related to accessibility.

Going on to the next, finally, there are key organizations, California organizations that can help when encountering a problem, when faced with choices as you join a plan. The HICAP is California nonprofit organization that helps, it has especially expertise in Medicare. For those thinking about joining a dual‑eligible plan, they can provide you with some independent advice and information, or if you're encountering problems as a dual‑eligible they are a good place to go.

Also the CCI has an ombudsman set up, particularly for those facing healthcare changes and issues as they go through the process of being enrolled in a plan. Their number is on the screen as well. They're a great resource. They are all over the state. A number of legal service organizations. They can often help you resolve issues that come up. Let's say the plan is confused, for example, about you're trying to get DME under Medi‑Cal, for some reason the plan wants to apply Medicare rules, which include the fact that your DME equipment has to be used in‑house, for example, you have to use your wheelchair inside the house, and that's just not the case.

Well, that's a confusion. The Medicare rules shouldn't be applied to that. Talking to the ombudsman and getting an advocate or attorney to help you with that can help resolve it at the plan level without having to push it further. So that's information for you. We also have our information up there right now, Justice in Aging's website. They have a great, lots of resources on the duals demo advocacy website. Our information is up there as well. Also the Department of Health Care Services has a site. The Cal duals website, which is a lot of information.

I realize there is a question that has come up that ‑‑ I'm going to actually bring it up to everyone, because I think it's a good one for everyone to think about. A question here about confusion about do doctors often ‑‑ did we say doctors often don't bother to bill for the additional 20% because the Medi‑Cal rate is so low?

No, I don't believe we did say that. It's that doctors, providers have been confused about the fact that they can get reimbursed for their 20% through a plan. Amber, do you want to speak to that more?

>> Amber Cutler: Yeah. I do think that historically we have seen a great number of Medicare providers who served duals who don't even bother billing Medi‑Cal, because they know they're not going to receive any higher of a rate than they're going to get from Medicare, and they know that administratively it costs them money to bill, why even do it? There is an automatic crossover process, where if they bill Medicare Medi‑Cal is already billed when it was in the state. Now they have to bill the health plans. But generally speaking, yeah, the rate is so low that they're not probably going to see any change. A lot of providers know that. But there are other providers, and there are some instances, where you are going to see that 20% and where the confusion comes in is that instead of billing the HPS now, you're billing the plans. So providers think they need to be contracted with the plans as a network provider in order to bill them. That's simply not the case. They just have to ‑‑ there's like a very short form that says we're going to bill you and that's how it works.

Then on the provider toolkit, online, there is a spreadsheet that shows how you bill each plan, how a provider would go about billing each plan. It has the way to submit plans to each of the Medi‑Cal plans as a Medicare provider.

Again, I highly recommend using the provider toolkit in other words to help educate Medicare providers on that process.

Silvia, I saw one other question. It says why do some clients on dialysis still enroll in the CCI? The question kind of has a lot of subquestions in there, so some patients on dialysis have to, no matter what, have to enroll in a Medi‑Cal plan, if they're a dual‑eligible, they have to enroll in a Medi‑Cal plan. It's individuals who have an end stage renal disease diagnosis that are excluded from Cal MediConnect. So they shouldn't be getting Cal MediConnect notices. There are two exceptions to that. One exception is if you are already enrolled in a line of business that's operated by the Cal MediConnect plan, you'll get Cal MediConnect notices, to give an example, because that's just confusing.

Let's say you're in Health Net for your Medi‑Cal and getting dialysis. Then you would get Cal MediConnect notices from ‑‑ and with your default plan being Health Net, because you're already enrolled in a Health Net business product. So you're enrolled in a plan operated by Health Net, so you're going to get notices. That is one exception to the end stage renal diagnosis, disease diagnosis for enrollment.

The other is if you reside in either San Mateo or Orange County. You also are going to get Cal MediConnect notices if you live in one of those two counties.

I think the reason that the ‑‑ the behind‑the‑scenes rationale is that that health plan is already involved in your care somehow, so it's not as disruptive to the entire case management. Because individuals who are on dialysis have a lot of care coordination going on, a lot of times with their regional centers, and that the point of excluding them was because they didn't want to mess with that already, that coordination that's already in place. But if you're already enrolled in one of the health plan's product lines, which you are in Orange and San Mateo county or in any of the other counties, that you're going to get notices about Cal MediConnect.

If you want to follow up with me offline on that too, you can. Just send me an e‑mail.

>> Silvia Yee: There are three additional questions in the Q&A. I will go ahead and take a couple of those and give the third to you, Amber. One, does a CMC opt‑out dual who picks a Medi‑Cal plan have continuity of care for DME providers? That was asked earlier. I think Amber answered it later. But no, you do not have continuity of care for DME providers, even though DME is ‑‑ especially when it comes to wheelchairs and seating is a pretty individualized, some would say an art, but I'm afraid that the continuity of care both for checked and for Medi‑Cal, just straight Medi‑Cal plans, continuity of care does not include DME providers. That's been something we've fought, but that does seem to be the bottom line at this point.

Someone asked a question, what exactly allows someone to be passively enrolled? If you fit in the categories, if a beneficiary fits in those categories, you're dual‑eligible, you don't have the share of costs, you don't have ‑‑ you know, you're not in one of the special other categories, you're a native Indian or you're in the HIV waivers, etc., in general if you're a dual‑eligible you can be enrolled by doing nothing. That's what passive enrollment means. You get the notice. It tells you to pick a plan. If you do nothing and don't pick a plan and don't send anything back, you will be passively enrolled in a plan, according to an assignment algorithm that the state is using. Then you will have to actively do something to get out of the plan, the Cal MediConnect plan, then you will still be in a Medi‑Cal plan, because that's the only way you can receive Medi‑Cal services now.

Amber, anything to add to those? Then there was a third question. Do you want me to ask it ‑‑

>> Amber Cutler: No, nothing to add to that.

>> Silvia Yee: The third question, can you speak a little about the problems caused by the passive enrollment on Medicare? Returning Medicare was, and possibly best practices in resolving.

I'm working that out, best practices in resolving problems when passively enrolled in Medicare. I think that's what it may be getting at.

>> Amber Cutler: I guess the major issue that happens when someone is passively enrolled into a plan, there can be no disruption. That's possible. But most likely what happens if you're enrolled into a plan is that one of your providers is not going to be part of the health plan's network. The whole point of the continuity of care protection is that even though maybe your providers aren't in network, you will continue to see them at least for six months in order to make sure that your transition into the health plan, your healthcare, your access to services isn't disrupted.

So the continuity of care protections are in place because there's a recognition that you are not going to have all of your providers went a single health plan. And you may decide ‑‑ there are options then once enrolled. You're passively enrolled, and you continue to see your providers with continuity of care, and things go pretty swimmingly, you're pretty happy, our getting care coordination, you're happy with your health plan; you can stay enrolled. You may eventually change providers to in network providers only, but that would be over a six‑month period, possibly.

So that's kind of one option. There's also a scenario where you join the Cal MediConnect plan and continuity of care doesn't work exactly as it should. You experience disruptions. Some people may decide to stay in, but other people might disenroll. Just so that they can keep access to their out‑of‑network Medicare providers.

So we've seen not only a high percentage of opt‑outs, that means people choosing no the to participate in Cal MediConnect prior to their effective coverage date in the program, so they're getting out of it beforehand, but we're also seeing a pretty large percentage of people who, once they're enrolled, decide they're going to disenroll and put their Medicare back in fee for service.

With that, Cal MediConnect is a combined program. So your Medicare and Medi‑Cal benefits are being held by both, by one health plan. When you opt out, no matter what you're going to be in a Medi‑Cal plan. So like we discussed throughout the webinar there are some kinds with that. There certainly is no coordination. So your Medicare providers aren't going to be talking to your Medi‑Cal plans, and your Medi‑Cal plans probably not going to be talking to your Medicare providers. So that coordination, that Cal MediConnect is supposed to cover, is something that people who opt out don't get. But that may be the best option for someone, because they want to make sure they maintain access to their Medicare providers who aren't in, in any of the Cal MediConnect plans.

So there's a lot of different scenarios and a lot of different ways to help resolve disruptions, whether it's better education about the continuity of care policy, a more expansive continuity of care policy, one that is more broad, that offers more protections. There's also issues when people opt out in maintaining access to their Medicare providers and their Medi‑Cal only covers services. So there's a bunch of stuff that goes along with that. I hope I covered some of it.

>> Silvia Yee: Yes. I think so. They have a little ‑‑ the person has a little expansion there. I also want to cover, we're past time, but there's one last question that rolled in. I thought I would take that up. Can you discuss emergency disenrollment? A client kept her dual mom from having to pick a Medi‑Cal plan. She argued that the transportation authorization requirements of the plans were mother burdensome than in fee for service Medi‑Cal.

>> Amber Cutler: Did she win that argument?

>> Silvia Yee: I'm sort of astonished that it worked actually.   
[Laughter]  
Maybe we should talk more about that. It seems amazing someone would win that argument. It can definitely be valid, that the individual could have had more burdensome authorization requirements with the plans. What's surprising to me is that the plans allowed it.

So the person wrote, yes, the plans required her to call more regularly.

>> Amber Cutler: Yeah, I agree that there could be some additional requirements on the Medi‑Cal side that weren't there before, but I don't think that rises to the level of being able to obtain a medical exemption request.

>> Silvia Yee: Which is really the only way to stay out of the Medi‑Cal plan.

>> Amber Cutler: Right.

>> Silvia Yee: It's possible that it happened. I think it's pretty unusual.

>> Amber Cutler: Yeah.

>> Silvia Yee: It would be a hard argument to make. I think that ‑‑ well ‑‑ so since it's getting more individualized maybe we can do that on e‑mail.

There's another one, do you believe Cal Medi‑Cal plan is more dynamic than straight Medicare as far as a level of coverage and providers? We've had this in other presentations as well. It is a personal decision whether the plan is going to offer you benefits that make it worthwhile for you to join it or not. It's hard to tell without actually being in a plan for a while, seeing if care coordination is helpful.

With just a straight Medi‑Cal plan, the care coordination element is less of a defined thing, but with a dual plan it's clear, I think, that there is care coordination and what it's supposed to be. So joining a Cal MediConnect plan does have some benefits and can be very useful to someone. As far as a level of coverage and providers, well, I don't think a plan ‑‑ in general, I don't think a plan will offer you a greater depth or more access to providers than fee for service Medicare, but by its nature you will be restricted in general to the plan's network. If that's your greatest concern to have the widest possible choice of providers, then a plan may not be for you, but then on the other hand a plan, Cal MediConnect plan, will offer you care coordination and other benefits that you don't get from fee for service. It's not a straight comparison of levels of coverage and providers. It's a little more complicated, and that's why it's important in a complicated situation, a beneficiary's complex situation to really talk through all their options and their own needs.

>> Amber Cutler: I agree. There's also just wide variation among the health plans.

>> Silvia Yee: Yes, absolutely true as well.

>> Amber Cutler: That makes it very ‑‑ not only is it beneficiary specific, but what health plan you want to choose is a big consideration.

>> Silvia Yee: I think for any individuals who still have particular questions they want to follow, please feel free to e‑mail us. Thank you for your questions. It always ‑‑ it all enlivens the presentation to have real questions and real situations. I think we're done for this ‑‑ for today.

>> Amber Cutler: Sounds good. Thank you, Silvia. Thank you, everyone, for your participation.

>> Silvia Yee: Thank you, Amber. Bye‑bye!

[Webinar concluded at 11:08 a.m. PT, 2:08 p.m. ET]