DISABILITY RIGHTS EDUCATION & DEFENSE FUND

WEBINAR: THE CALIFORNIA COORDINATED CARE INITIATIVE: CONSUMER PROTECTIONS AND BENEFIT PACKAGE SUMMARY – ADVANCED TRAINING

Tuesday, September 22, 2015

6:00 p.m. – 7:00 p.m.

Remote CART Captioning

*Communication Access Realtime Translation (CART) captioning is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.*

*This transcript is being provided in rough-draft format.*



www.hometeamcaptions.com

>> Sylvia Yee: Good afternoon, everyone. I just wanted to welcome you all to the "Coordinated Care Initiative (CCI) ADVANCED I" webinar. This is Justice in Aging and DREDF presenting the webinar. The webinar goes into a little more detail on the benefit package and consumer protections of the Coordinated Care Initiative.

 A little bit of housekeeping right at the very beginning. Just to let you all know how the closed caption works, to access the captioning, it depends whether you're a MAC user or a Windows user. MAC will click on a button called Media Viewer in the lower right‑hand corner of their screen. For Windows users, click on a Media Viewer button in the upper right‑hand corner. This will open up a window for you in the right‑hand side of your screen. There you will read a transcript of what is happening, what we are saying, done by our wonderful captioner, Christine. Also, you'll see ‑‑ I'm afraid it's in very, very tiny letters, the lower right‑hand corner of that caption screen says “show or hide header.” If you hit that, it will take away the little header on there with numbers, DREDF and the time. That opens up your closed caption window and gives you more room to see.

 During the presentation, if you're opening up some other window such as a chat window or looking at the participant window, then the Media Viewer may collapse. If that happens, all you need to do is, once again, press on the Media Viewer button to bring back the closed captions.

 I'm going to leap ahead a little bit. I'm Sylvia Yee, an attorney with Disability Rights Education and Defense Fund. We have been around for about 36 years now, founded by people with disabilities and parents of children with disabilities. We work on national law and policy issues and also in California, because we're based here and dedicated to protecting the civil and human rights of people with disabilities.

 Now I'm going to turn this over to my co‑presenter and colleague, Amber Cutler, who will introduce herself and go through the first few slides.

>> Amber Cutler: Thanks, Sylvia.

 As Sylvia just said, my name is Amber Cutler. I'm a staff attorney with Justice in Aging. We are a national nonprofit. We focus on advocacy on behalf of low‑income seniors particularly in the areas of Medicaid, here in California, Medi‑Cal and Medicare.

 With that, I'm going to jump right into our discussion for today. As Sylvia mentioned, this is a advanced presentation on the Coordinated Care Initiative. So we are going to do a quick review of the Coordinated Care Initiative, what it is, who it impacts. We're going to talk about what it looks like to integrate Long‑Term Services and Supports. We're going to look closely at what the benefit packages are under the Coordinated Care Initiative. And we're going to end the presentation with a summary of the consumer protection that people are offered under the Coordinated Care Initiative.

 I always like to start with a glossary. The Coordinated Care Initiative has a bunch of definitions and terms that may or may not be familiar you. The first being a dual eligible or a dual medi‑medi, they have both Medicare and Medi‑Cal health coverage. This is one of two populations impacted by the Coordinated Care Initiative. The second population impacted by the Coordinated Care Initiative is that very last term on the glossary page. That's Seniors and Persons with Disabilities, or SPDs. These are individuals who have Medi‑Cal coverage only. And the basis for that Medi‑Cal eligibility is either age or disability. So when we're talking about the Coordinated Care Initiative, we are talking about it impacting those dual eligibles and SPDs.

 Another important term under the Coordinated Care Initiative is Long‑Term Services and Supports or LTSS. The LTSS definition under the Coordinated Care Initiative is very specific. It refers to four Medi‑Cal, primarily Medi‑Cal‑funded programs. The In‑Home Supportive Services or IHSS, the Community Based Adult Services, formerly known as Adult Day Healthcare or CBAS, the Multipurpose Senior Services Porgram, MSSP, available to individuals 65 and over who need intense case management, and then finally, the Nursing Facility benefit. So when Sylvia and I are referring to LTSS, under the Coordinated Care Initiative we're specifically referring to those four Medi‑Cal‑funded programs.

 I'm not going to worry about that definition -- well, a Duals‑Special Needs Plan or D‑SNP gets thrown around a bit. That's a special care of Medicare Advantage plan. Medicare Advantage plans are those private HMO, PPO type plans that if you're a Medicare beneficiary, you can enroll in. A D‑SNP is a special type of advantaged care plan aimed specifically at duel eligibles. And the way if you're enrolled in a D‑SNP under the CCI, you're treated ‑‑ your enrollment is treated differently than if you were in some other enrollment category or health insurance coverage option. So you often hear under the CCI the word D‑SNP being thrown around. And that's because individuals enrolled in those D‑SNPs have a very different enrollment process than those who are not.

 The Coordinated Care Initiative, in some, it is three major changes. The first is that anyone who has Medi‑Cal and in the seven CCI counties has to be enrolled in some type of health plan for their Medi‑Cal benefits. This transition started in 2011. SPDs had to join a Medi‑Cal plan to continue receiving their Medi‑Cal benefits. That has expanded to now rural counties in California and individuals with CBAS had to join a plan in 2012. So this has been an ongoing transition happening in the state of California. And this change under the CCI is basically that anyone with Medi‑Cal really has to be in a Medi‑Cal plan or some other type of health plan that's covering their Medi‑Cal benefits. So where there were people who were carved out. So if you were in a Nursing Facility, for example, you didn't have to join a health plan. If you have shared costs, you didn't have to join a health plan. If you were dually eligible, you didn't have to join a health plan. Now you are going to have to join a health plan in order to continue to receive your Medi‑Cal benefit. Very few exceptions to that.

 The second major change under the CCI is the integration of Long‑Term Services and Supports. In other words, those health plans are now going to be responsible for Long Term Support and Services. Previously they were carved out. To give you a concrete example, I like to focus on the Nursing Facility benefit. So before if you had just Medi‑Cal coverage, you had to join a health plan, back in 2011. And let's say you needed to go to the hospital. So you go to the hospital and when you're being discharged from the hospital, you need to go to a Nursing Facility. Pre CCI, you could go to any Nursing Facility. And once you were admitted to the nursing facility, you were disenrolled from your health plan and put back in Fee‑for‑Service Medi‑Cal.

 That's no longer the case under the CCI. Now you're in a plan, you go to the hospital and you need to go to a nursing facility, you're going to need to choose a nursing facility that is in your health plan's network of providers. So that's a very significant change to the delivery of the Nursing Facility benefit. So that's the second major change under the Coordinated Care Initiative. Those Long Term Support and Services, IHSS, CBAS, are now the health plan's responsibility. So that's change number two.

 Change number three is the one we hear the most about. And that's the creation of this new type of health plan that combines someone's Medicare and Medi‑Cal benefits under one health plan. And these new health plans are called Cal MediConnect plans. This is a voluntary program, meaning that if you don't want to be in a Cal MediConnect plan, you do not have to be in a Cal MediConnect plan. You can do with what you want with your Medicare benefit. But under the CCI, you still have to be enrolled in a health plan for your Medi‑Cal benefit.

 The way that individuals are enrolled in Cal MediConnect, at least initially and still ongoing in Orange and Santa Clara Counties, is through a passive enrollment process. In other words, if you don't make an affirmative choice not to enroll in Cal MediConnect, you will automatically be enrolled into the program.

 So those are the three changes under the CCI. Again, to reiterate who is impacted, it's those individuals who have both Medi‑Cal and Medicare, or duals or medi‑medis and those with Medi‑Cal only, the SPDs. Individuals who only have Medicare coverage are not impacted by the Coordinated Care Initiative.

 And to give you a better sense of just how complex the CCI is in terms of who it impacts, it's kind of broken out how people are impacted. So there is a certain category of dual eligibles who are excluded from enrollment into Cal MediConnect. So if you have end stage renal disease, you cannot ‑‑ and you're not already enrolled in the program, you can't enroll in Cal MediConnect unless you live in either Orange or San Mateo County. Keep in mind there's always an exception to the rule. And under the CCI. And sometimes there's an exception to the exception. So end stage renal disease you're generally excluded from participation unless you reside in a close county or if you're already enrolled in the program. There are certain zip codes, if you live within those zip codes, you're excluded from Cal MediConnect enrollment.

 If you're a resident of a veterans home you're excluded not just from Cal MediConnect but you also do not have to join a Medi‑Cal plan. Earlier I said there are few exceptions to mandatory enrollment in a Medi‑Cal plan, and being a resident of a VA home is one of those exclusions. As is being a resident of an immediate care facility for the developmentally disabled and if you have other health insurance coverage. So if you have Medicare and Medi‑Cal and you also have say employer‑based coverage, you do not need to join a Medi‑Cal plan and you're not allowed to enroll in a Cal MediConnect plan.

 Then there are those individuals who are excluded from Cal MediConnect if they don't meet their share of costs regularly. And those who are in a DVS waiver or receiving services the a regional center or developmental center. Again, those individuals still have to choose a Medi‑Cal plan but they cannot enroll in the Cal MediConnect program.

 On the other side are duals who can participate in Cal MediConnect but who will still be subject ‑‑ who are not subject to passive enrollment. So these are individuals who are already enrolled in PACE which is a health plan much like Cal MediConnect except eligibility requirements. If you're enrolled in the [Indiscernible] Healthcare Foundation, if you live in certain zip codes if you're enrolled, say, for example, in Kaiser or you're in one of these D‑SNPs that's not operated by a Cal MediConnect plan, or if you're enrolled in a waiver, you shouldn't get notices about Cal MediConnect but all of those populations will still have to enroll in a Medi‑Cal plan. Again, very few exceptions to that Medi‑Cal plan enrollment.

 I went through that very quickly. I know that is an incredibly complicated set of exceptions and exclusions to enrollment. And for that reason and the Advocates Guide to the CCI and DREDF and Justice in Aging have published and also on the Cal dual's website there are population charts that explain who is subject to what type of enrollment or if they're excluded from participation in the program.

 In the event that you think that someone has received a notice in error, the state has put together an e‑mail address where you can submit those concerns. And how you do that is you use the e‑mail address to flag the issue without any client or patient identifying information. The state will then send you back a secure e‑mail to provide that confidential information or PIH and you send that back so you can get that enrollment issue fixed because a lot of individuals through this process. Because it is such a complicated enrollment process with a lot of different populations impacted in a lot of different ways, the state has put together this e‑mail address to allow people to submit those concerns to the state to help people get out of the enrollment process when they're not supposed to be in it at all. So there are instructions on the slide about how to do that and what that e‑mail address is.

 Again, just to emphasize who and how this program works, by and large everybody has to join at least a health plan for their Medi‑Cal benefits and Cal MediConnect is voluntary. So even if you decide you don't want to participate in Cal MediConnect or even if you're excluded from participation in Cal MediConnect, most likely you are still ‑‑ fall within one of those populations that have to be enrolled in a health plan for your Medi‑Cal benefit. That Medi‑Cal enrollment is now mandatory.

 To give a sense of ‑‑ I think I'm handing it over to Sylvia now. I apologize. I'm handing it over to you.

>> Sylvia Yee: Thank you, Amber.

>> Amber Cutler: I'm just going to keep on going.

>> Sylvia Yee: Let me just take back the little ‑‑ ok. I will fix that in a bit.

 The next few slides are looking specifically at the changes of CCI to Medi‑Cal Managed Care. The first thing we're looking at is ‑‑ Medi‑Cal Managed Care, Managed Care plans administering Medi‑Cal in the past, typically have taken over the medical portion of your care. You go to that Managed Care plan's doctors, their medical providers, their pharmacy, etc. The change that the CCI has brought is that in the seven CCI counties the Medi‑Cal plans are also taking over Long Term Services and Supports. And those are those supports that amber has mentioned, the MMSP ‑‑ I think the next slide will go into some additional detail about that. Oh, well. No. We'll go back to this. The four elements of Long Term Support and Services as well as nursing homes. So your Managed Care plan, your Medi‑Cal Managed Care plan is now administering the IHSS, MSSP, CBAS, and the nursing facilities.

 However, what that actually looks like is a little bit different. So, for example, the Managed Care actually has been administering CBAS since, as amber mentioned, 2012. So if you are a dual or a Medi‑Cal individual, Medi‑Cal beneficiary and you receive CBAS, you have been getting it through a Managed Care plan all of this time, since 2012. That's been the only way you can get it except potentially if you have like a medical exemption request. But that's a relatively rare thing now.

 CBAS has been put in. That means that the Managed Care plans are contracting with CBAS providers. Payment is not coming to those CBAS providers through the Department of Health Care Services now. It's coming through the healthcare plans. Ideally for the individual, they continue to go to the same CBAS provider and those services continue. Again, that was always the ideal.

 In terms of IHSS, it's what the Department of Health Care Services has termed a lift and shift. The intention was that the basic structure of In‑Home Supportive Services remains the same, at least for a certain period until I believe it's 2017 so that the county IHSS authority is still in place. For the individual beneficiary, you still have the right to hire, to train, to supervise, and fire your IHSS provider. It's just that the administration above the level of the IHSS county agency is now through the Managed Care plan. There's an additional intermediary there between the Department of Health Care Services and the IHSS public authority. So again, at the level of the beneficiary it shouldn't feel different.

 MSSP services was also a matter that the Managed Care plans ideally were contracting with your MSSP providers, Meals on Wheels, different kinds of case management and coordination and service providers. And the Managed Care plan through those contracts would be paying those providers and the community based providers would continue to provide services to the Medi‑Cal beneficiaries who used those services. That was the hope and the idea behind this transfer, that those Medi‑Cal services, those four key LTSS services, would remain.

 As Amber has said, the nursing facility one is the matter that each plan has to build its network to contract with individual nursing homes. So there was a beneficiary protection in place so that for a Medi‑Cal beneficiary who is already in a nursing home, they should not have to change their nursing home if they went into a Medi‑Cal Managed Care plan. For those new individuals who are entering nursing homes, new Medi‑Cal beneficiaries entering nursing homes, now they have to find a nursing home that contracts with their specific Managed Care plan.

 So looking at a couple of additional Medi‑Cal benefit changes, there is a new mental health benefit that came into place in January 2014. The new mental health benefit is available to all Medi‑Cal recipients; not necessarily ‑‑ yes, to all Medi‑Cal recipients. It is delivered through the Medicare plans. It's a mental health benefit that is meant to address not probably the most serious mental health conditions. It does address a variety of mental health benefits, though. Some group therapy, some initial diagnosis and other therapies and services. You can get those now through your Medi‑Cal plans.

 There's also a dental benefit that came into place at the beginning of May in 2014. The dental benefit restored to all Medi‑Cal recipients some basic preventive dental services. Those, however, are not delivered to the Medi‑Cal plan. They are delivered through Denti‑Cal. So while some plans have actually undertaken some degree of coordination with Denti‑Cal, especially in cases that may require that, it's not something that you get typically through your plan.

 And this is a slide I was looking for before which talks about the four components of LTSS that are going into Managed Care. I'm not going to repeat what I said but you see it again in the graphic where you have CBAS, IHSS, MSSP, and Nursing Facility going into Managed Care and how each of those can look a little different. The intention always was to try to preserve the experience of the Medi‑Cal beneficiary so that the providers you had, the services you had before you got Medi‑Cal through Managed Care will continue after.

 Now looking at the Medi‑Cal connect benefits, moving on to that, there are a number of benefits that Cal MediConnect plans offer. And what are those? Well, Medicare, of course, A, B, and D. Part A deals with hospital services. Part B deals with doctors, providers. And Part D deals with the drug benefit. So that's what you get from Medicare.

 Your Medi‑Cal services under Cal MediConnect include everything we have talked about before, all the LTSS services: IHSS, CBAS, the Nursing Facility and MSSP.

 There are some additional ones that are specific to Cal MediConnect. One of those is vision. One routine eye exam annually and $100 towards eyeglasses or contacts every two years. That's a specific new benefit that comes with Cal MediConnect, with joining a Cal MediConnect plan.

 There is also transportation to medical services, 30 one‑way trips per year. It's often by taxi or another service that will take you to your medical appointments and back home.

 And also, this additional benefit of care coordination. That's a pretty critical and interesting benefit to have. That is a benefit that is valued by a number of beneficiaries, especially those who have complex care needs and who have, in the past, had to coordinate that care themselves. It means that the plan should bear some responsibility for coordinating the different kinds of healthcare services and LTSS services that you need that they will facilitate communication among your different providers.

 Looking a little more closely at that Care Coordination benefit, the Cal MediConnect Care Coordination benefit is supposed to be person‑centered. It is really supposed to pay attention to the beneficiary and the needs of the beneficiary, social needs as well and not just medical needs. It is supposed to focus on the least restrictive setting for the beneficiary. So if that beneficiary desires to be in the community, that's something that the care coordinators in the plan really need to pay attention to, are required to.

 There is a health risk assessment component so that as a new member entering the Cal MediConnect plan, you are supposed to receive an overall assessment that, again, looks at your social goals, your own goals for your life or your client's goals for their life and not just their diagnosis or medical health needs.

 There's a requirement for an individualized care plan, especially for those individuals with complex care needs especially. And the plan provides an interdisciplinary care team if that is the desire of the beneficiary. And that can include your providers, yourself ‑‑ I mean, the individual with the disability, the beneficiary, as well as the individual ‑‑ let's say their family member, if they wish or their care providers, their IHSS care providers, or friends. It's meant to be the ICT, the Interdisciplinary Care Team, is meant to be a multidisciplinary approach to helping the individual stay healthy and functional and well in the fullest sense.

 The Cal MediConnect benefits also include Care Plan Option services. The CPO services are a new thing. They were meant to be home and community‑based like supports and services. They are discretionary. They are up to the plan whether they will provide them or not. They are not a requirement. They are not a Medicare requirement or Medi‑Cal requirement. And they can't be given in trade, as some kind of a trade, with other required benefits. They are supposed to be in addition.

 So when a new member enters the Cal MediConnect plan and undergoes a health risk assessment if it seems there are some unmet needs there, then the plan can decide to provide CPO services. And these could range ‑‑ be anything from someone who has a newly acquired mobility disability or a long‑term one, requires some home modifications, a ramp or some additions to their bathroom, to help them continue safely in their home. It could be something like an assistant who would help them read mail if they're blind or visually impaired since historically that hasn't been an IHSS service. So these are additional needs that are unearthed during the health risk assessment and that the plan can choose to meet to help individuals stay safely in the community.

 There are also some Cal MediConnect benefits that are carved out from the plan. These are primarily around specialty mental health benefits and some substance use benefits. They are benefits that accrue to Cal MediConnect members but they're not administered through the plan. They're administered through the counties because the counties had an existing network of providers and expertise. So examples include intensive day treatment or inpatient psychiatric services that are not covered by Medicare. These are Medi‑Cal health benefits, day rehabilitation, crisis intervention, adult residential treatment services, and particular things like methadone therapy for individuals who have used heroin in the past. All of these kinds of specialty mental health benefits that are carved out from the plan's administration and delivered through the county.

 I mentioned before also the dental benefit is also ‑‑ it's a carved out benefit that is not administered through the plans.

 So I think this now turns back to Amber. I'm just going to briefly ask if anyone has any questions and invite you to put any questions that you have, type them into the chat window and we will be happy to address them as we go along.

>> Amber Cutler: Any questions, Sylvia?

>> Sylvia Yee: There are no questions in the chat window. I will let you know if it comes up.

>> Amber Cutler: All right.

 We've added this slide to the Advanced presentation because one of the things that's happened with enrollment under the Coordinated Care Initiative is a large number of dual eligibles decided not to participate in Cal MediConnect. So they opted either to remain a Medicare Fee‑for‑Service or they remain enrolled in some other Medicare product and then they are enrolled in a Medi‑Cal Managed Care plan. So there's a very large number of dual eligibles who are either in Fee‑for‑Service Medicare or some other Medicare product and then they are enrolled in a Medi‑Cal plan on the Medi‑Cal side.

 So in that instance, what is the Medi‑Cal plan responsible for? As a dual eligible, someone who has just enrolled in a plan on the Medi‑Cal side, the Medi‑Cal plan is going to be responsible for benefits Medicare does not pay for. Most notably that's going to be those Long Term Support and Services. Those are Medi‑Cal, almost primarily funded Medi‑Cal benefits. So In‑Home Supportive Services is a Medi‑Cal benefit, MSSP is a Medi‑Cal benefit. Community Based Adult Services is Medi‑Cal. And adult ‑‑ Medicare pays for the first portion of a nursing facility admission and certain circumstances but only up to 100 days and only a certain percentage. Those Long Term Service and Supports is what the plan is responsible for. The plan is responsible for transportation benefits that Medicare doesn't pay for. That's going to be that non‑emergency medical transportation that people need who, for example, need to travel by van or a medical mode of transportation to get to their medical services. Medi‑Cal also pays for some durable medical equipment costs that Medicare doesn't pay for, some prescription drugs and some supplies; for example, incontinent supplies and things like that.

 So those are all things that the Medi‑Cal plan would be responsible for if you're a dual eligible. Generally speaking, Medicare is primary and then Medi‑Cal is secondary but there are some things that Medicare doesn't pay for that the Medi‑Cal plan would be responsible for. So it would be really important if you were using those services that you would have to use providers that are contracted with your Medi‑Cal plan.

 The other big thing that Medi‑Cal plan covers is the cost sharing. So generally speaking, Medicare pays 80% and then the Medi‑Cal plan would be responsible for the cost sharing, the 20%. If in fact, it was payable. So you go and see your primary care physician who is your Medicare provider. They're going to submit that claim to Medicare. Medicare will pay 80%. And then that claim would go to the Medi‑Cal plan to pay the 20%.

 In this instance the Medi‑Cal plan is just taking the place of the state for payment. A big problem with what's going on today is the Medicare providers will tell their patients that they will not see them because of the patient's enrollment in a Medi‑Cal plan, basically saying we're not contracted with that Medi‑Cal plan so we're not going see you or the other scenario is we're going to charge you for that 20%. Neither of those things should happen because the Medicare provider does not need to be contracted with the Medi‑Cal plan in order to build a Medi‑Cal plan for the cost sharing. Instead, the Medicare provider can submit that claim to the Medi‑Cal plan just like they would have submitted ‑‑ well, the process is different but just as they would have submitted it to the state for payment.

 Keep in mind that most of the time primary care physicians and specialists aren't going to see that 20%. And that's because the Medicare rate is so much higher than the Medi‑Cal rate. Medi‑Cal only has to pay up to the Medi‑Cal rate. So those providers don't actually get paid that 20% regardless of whether it was the state or the health plan paying. But a lot of times those providers still want that opportunity to bill. And so it's really important that people understand that they do not have to be contracted with the Medi‑Cal plan to submit the claim to the Medi‑Cal plan.

 Under no circumstance should they be billing the dual eligible for the cost sharing. Almost across the board balance billing is prohibited of dual eligible beneficiaries. There are both federal and state protections against balance billing of dual eligibles.

 So I just want to make that clear. That's become a very big issue under the CCI and generally under the state of California. But nationally it's magnified because of how many dual eligibles have now enrolled in Medi‑Cal plans and then are continuing to see their providers and Fee‑for‑Service in a Medicare Advantaged plan on the Medicare side.

 With that I'll move on to the next slide. It is talking about the consumer protections under the CCI. Specifically for Cal MediConnect, the continuity of care protections.

 So continuity of care is the ability for an enrollee to continue to see their out of network providers for a certain period of time. So they've joined a health plan and their providers are not contracted with that health plan. So continuity of care protections allow the member to continue to see those providers even though they're out of network, at least for a period of time. Keep in mind that these protections are the minimum protections. The health plans can provide expanded continuity of care protections if they so desire.

 So the continuity of care, if it's a Medicare provider, would be for six months. And by and large we're talking about Medicare providers but for whatever reason if it might be Medi‑Cal, it would be 12 months. There is a link there to the continuity of care dual plan letter.

 There is criteria, though, that you have to meet in order be afforded continuity of care protections. Most notably you have to have a preexisting relationship with that provider. And to demonstrate that preexisting relationship, if it's a primary care physician, you had to have seen that primary care physician at least once within the 12 months preceding enrollment into the plan for non‑emergency visit if it's a specialist, it's twice.

 The plan is supposed to use the utilization data that it gets from CMS and the state to kind of determine if that preexisting relationship exists. It's only if they can't establish that preexisting relationship to utilization data that that we would ask the member or provider to provide proof of that preexisting relationship.

 In addition to that preexisting relationship, the provider must agree to accept payment and enter into an agreement with the plan. The plans have to offer the same rates the provider would have received under Fee‑for‑Service rates. So payment is not usually the issue. And usually that's like a one‑page agreement that they enter into with the health plans. Although we do continue to see pushback. For whatever reason, the Fee‑for‑Service providers don't want to enter into even those single case agreements for continuity of care purposes.

 And then finally, the provider can't have any documented quality of care concerns that would have prevented the health plan from contracting with the contracted provider under their guidelines to begin with.

 Those are the three criteria to establish continuity of care. You have to have a preexisting relationship. The provider must agree to accept the payment. And the provider can't have any quality of care concerns. So if all three of those criteria are met, the plan will offer the member the ability to continue to see those out of network providers for at least up to six months. Again, with the ability to extend that if the health plan thinks that it basically doesn't want to disrupt that relationship yet.

 There are some exceptions to continuity of care, the big one being nursing facilities. If you are someone who is residing in a nursing facility and then enroll in a plan, so you've already been in the facility, you can continue to reside in that out‑of‑network facility indefinitely as long as you need nursing facility level of care. So it's sort of a carve‑out, recognizing that forcing people to move out of their out-of-network nursing facility after six months would be beyond disruptive since that's their home.

 Durable medical equipment providers on the other hand, and ancillary services, continuity of protections don't actually apply to those providers of those services. So if you were getting your wheelchair serviced at a certain provider and that provider is not contracted with your health plan, you're going to have to change that provider. And there's no six‑month continuity of care protection afforded. The regulation states or the rule states that continuity of care does not need to be afforded to those providers.

 Keep in mind, however, that the services are still ‑‑ have to be provided. So even though you can't go to see the same provider that was servicing your wheelchair, you would still have ‑‑ the health plan would have to supply an alternative provider to service the wheelchair. So it's continuity of care is provided with regard to services just not of to that particular provider. Same thing for ancillary services like pharmacy or labs. So the continuity of care protections don't apply there. They also don't apply to carved out services. That makes sense. Because the health plans have no control over the carved-out services. They can't guarantee continuation of services are a provider like with the county mental health or with a particular dentist or Denti-Cal. So those protections aren't afforded there.

 IHSS, continuity of care is not really required because under the IHSS program, a beneficiary remains in control of who they want to hire and fire or supervise as their IHSS provider. So that control is completely within the control of the actual member. So continuity of care is inapplicable, basically.

 Some additional things about continuity of care. Prescription drugs. Part D rules apply, which is really easy and consistent. So Part D rules allow someone one‑time refill up to a 30‑day supply; a lesser amount if a lesser amount was prescribed, of any ongoing medication within the first 90 days of plan enrollment.

 So in theory, this is a really great protection because in theory you go to the pharmacy and your drug's not on your new health plan's formulary, there's always going to be at least a one‑time refill. However, the problem in practice has been that pharmacies don't recognize ‑‑ don't understand that protection and so end up telling those individuals who ship at the pharmacy that their drug's not covered. It's usually a simple fix by calling up the health plan and the health plan gets it resolved. But it's unfortunately in practice a problem with pharmacies not having enough education on that issue to prevent the disruption.

 There are some additional protections for residents in nursing facilities. Under Cal MediConnect the Part D rules apply to both the Medicare covered drugs so what your Part D plan would have been responsible for, and also those Medi‑Cal covered drugs of which there are some of them that Medi‑Cal covers that Medicare doesn't cover. So pretty good protection there with some problems in practice.

 Some other protections under continuity of care. The plans have to complete services for acute, serious, chronic, pregnancy, terminal illnesses, and surgery that are scheduled. There were some updates to the continuity of care protections that made them better in practice. For example, not just the beneficiary can request continuity of care, so can their provider. There were some time limits shortened that health plans must grant those requests. So they have to be processed within three days if there's a risk of harm to the beneficiary. And a lot of health plans are processing those requests within 24 hours. So that's been really great.

 Another good protection is retroactive continuity of care. A lot of beneficiaries were passively enrolled into these health plans and didn't know they were passively enrolled, didn't know that their health coverage had changed and so then they go to their doctor and their doctor may or may not check eligibility at that time. Especially if it's a doctor that they've been going to for, you know, pretty consistent basis for a long time and pretty regularly. They might not check eligibility right away at every visit.

 So what this allows is that ‑‑ so you go to the doctor, they don't check eligibility or maybe the eligibility system is not up to date. You see that doctor and then the doctor then submits their claim either to Medicare or maybe to Cal MediConnect and it turns out that they're not a contracted provider. As long as they submitted that bill for payment within 30 days, the Cal MediConnect plan will pay retroactively so that individuals who are enrolled passively aren't stuck with a bill from their provider which they can't pay anyway because of passive enrollment. So that was a really great update to the continuity of care protections.

 And then finally, the ultimate I guess continuity of care protection for individuals on the Cal MediConnect program is always the ability to disenroll from the program. They disenroll and they can go back to Fee‑for‑Service Medicare or they can decide to enroll in some other Medicare product but they always have that option. They can do what they want to do with their Medicare benefit. They do have to remain enrolled on the Medi‑Cal side but on the Medicare side they can go back to Fee‑for‑Service Medicare or some other Medicare plan and then they just stay enrolled in the Medi‑Cal plan. And that disenrollment can happen at any time for any reason. There's no ‑‑ they don't have to have a reason to disenroll. And then it becomes effective the first day of the next month. So if they disenroll today, that disenrollment would become effective as of October 1.

 And then finally, on the Medi‑Cal side for continuity of care protections, it's pretty much the same as Cal MediConnect except if it's just a Medi‑Cal‑covered benefit or a Medi‑Cal beneficiary, you get 12 months. Again nursing facility residents can continue to reside in an out-of-network facility. If they weren't in that facility, they would have to choose an in-network provider nursing facility if they were enrolling.

 And then the medical exemption request is available to those individuals with Medi‑Cal only who are residing in the two‑plan counties, so like Los Angeles or the geographic Managed Care counties, so like San Diego, the medical exemption request is available. That's the ability to stay out of a Medi‑Cal Managed Care plan if you have some sort of complex medical condition and your providers are out of network. But keep in mind that the process is not available ‑‑ MER process is not available to duals. They can continue to see their Medicare providers. So the MER is pretty much available to the Medi‑Cal only beneficiaries.

 All right. I'm going stop there and hand it over to Sylvia to finish off the consumer protections.

>> Sylvia Yee: Yes. But I'm also going to give you a couple of questions I think. How's that?

>> Amber Cutler: Great.

>> Sylvia Yee: One of the earlier ones was ‑‑ let me just find that. There was a question about can you expand on IHSS and MSSP and the level of participation by the Managed Care plans. The IHSS and MSSP staff remain in place? Please explain what the Managed Care plans will be reviewing for and implementing with both programs.

 It is a great question.

>> Amber Cutler: It is a great question. I'll start with IHSS. So right now IHSS looks exactly the same to the beneficiary as it did prior to the CCI. The beneficiary retains the right to hire, fire, and supervise their IHSS provider. The county is still responsible for determining the level of need and hours. And the county social worker is the one who would participate on plan care meetings and such.

 Right now the health plans are sort of the fiscal intermediary is the best way to put it. That could change moving forward. And we don't know what that would look like yet. But right now that's the way it looks.

 The way that the health plans really play a role right now is actually, hopefully, increasing access to IHSS. So all the health plans have to do a health risk assessment. And the goal of that is to kind of see what needs individuals have. It could be IHSS and then referring them to the county for an IHSS assessment, hopefully helping with filling out the physician certification to get IHSS services. If it's a Cal MediConnect enrollee who is already on IHSS, it could be through the care planning process, seeing that maybe they need increased hours in trying to work with the county to get those increased hours. So hopefully what we'll see right now with IHSS is an increased referral to the program or advocacy with the program to get increased hours.

 MSSP is different. The Multipurpose Senior Services Program for right now the health plans have to contract with all of the MSSP sites. So right now they have to, yes, use the same MSSP staff that are currently in place and that people have access to. That is only up and through ‑‑ that just changed under the budget discussions. I think that MSSP was able to get it through the demonstration period so that the health plans have to contract through the entire ‑‑ I'm going to forget the exact ‑‑ I think there are two criteria, either a length of time or until the health plans can prove something has happened. But in any case, right now it does remain the same. They do have to contract with them.

 I think that there is discussion about taking MSSP quote/unquote in‑house. But I think by and large ‑‑ I would argue that as ‑‑ as an advocate, recognizing that quality of the services that MSSP sites provide, the extent of the intense case management that people receive that are enrolled in that program, that it's ideal to keep the MSSP sites that have been providing those services continue doing them. No matter what, the health plans have to continue to provide MSSP. It's just that after a certain period of time they no longer have to contract with the MSSP site. So I'm hoping that the health plans recognize that those local relationships and those individuals who have those community connections that are doing those services right now are best suited to continue to provide those services.

 I think we've seen even that happen with health risk assessments. Some of the health plans have contracted out with, you know, third party contractors where other health plans have contracted with sort of community‑based groups. I think we're seeing that those who have contracted ‑‑ that have the local connections and relationships with the beneficiaries are better able to complete those sort of health risk assessments. That sort of flows through to who is best suited to continue to provide the really intense case management, those who have been doing it for, you know, years and years and who have those community relationships seem to be the best suited. But, again, legislatively the MSSP program could change pretty significantly moving forward.

>> Sylvia Yee: Just adding one thought. It's hard for us to know exactly what plans are looking for and how they will assess the programs. I think one thing that is pretty important to plans is sort of seeing a value added. So to the degree that community‑based organizations really demonstrate their expertise and their value, they have those relationships, they know the resources that are in the community in‑depth, that they forge relationships with plans, with nurse case managers, etc. I think all of those things help the community‑based organizations to really demonstrate their value to plans. And as practical strategies, it's a good thing because I think ‑‑ I believe those community‑based providers are invaluable.

 There was one other sort of question -- I've answered a couple in the chat box but was wondering your viewpoint. I think on the CBAS issue someone was asking specifically about Alzheimer's day programs for low‑income elderly.

>> Amber Cutler: Say again?

>> Sylvia Yee: I think someone is asking specifically about what happens with Alzheimer's day programs for low‑income elderly.

>> Amber Cutler: So ‑‑ well, I guess it depends. I'm not exactly sure of the funding source for that.

>> Sylvia Yee: Right.

>> Amber Cutler: Yeah. If it's not a Medi‑Cal‑covered benefit or a Medicare‑covered benefit, then it's entirely outside of the CCI and will remain that way. If it's actually being covered by one of those two programs, then it would have ‑‑ if it's CBAS, the health plans have to contract with all the CBAS centers. So I'm not sure if this is an adult day healthcare center that's focusing on Alzheimer's and therefore is just a CBAS center. If so, then the health plans have to contract with them. That's a requirement. If it's outside of that, it would be ‑‑ but it's still covered by either Medicare or Medi‑Cal in some way, most likely Medicare.

 It kind of reminds me of a home health agency. So they would have to be a contracted provider. So let's say the member is enrolled in Cal MediConnect and they're going to this Alzheimer's day center and Medicare has been paying for it, if they're now enrolled in the plan, that center would have to be a contracted provider with the plan in order to continue that relationship or they could disenroll from the plan and continue to that relationship or you could reach out to the plan and say this should be one of your contracted providers.

 So there are a lot of different options. That was not the best answer. If you want to e‑mail me for a more coherent answer, definitely do that.

>> Sylvia Yee: The answer that I typed in the chat box pretty well assumed that the Alzheimer's elderly program you were talking about was a Medi‑Cal‑funded program. So if that isn't the case, yes, the lid sort of comes off on what happens.

>> Amber Cutler: Right.

>> Sylvia Yee: Ok. We're on to our pretty well our last couple of slides. Let's just finish up here.

 There are some other consumer protections that can be very important to different beneficiaries depending on their needs. One is the right to receive materials and services in their own language. And this includes alternative formats such as Braille or large‑print or electronic disk. The CCI communications are supposed to be accessible and available in all the threshold languages.

 As well, there are some key accessibility rights. There was recognition by plans in the department that this is a new population going into Medi‑Cal and going into Managed Care Medicare and that it's a population that many had complex conditions and various disabilities. So those individuals as individuals with disabilities have a right to reasonable modifications to gain full and equal access to healthcare services and to LTSS services. So there's a ‑‑ there needs to be physical accessibility. Even completely aside from the fact that there is public funding going to healthcare clinics and providers offices, those providers offices have an obligation to provide physical accessibility to a threshold of being readily achievable.

 With the fact of a federal funds and state funds being involved with Medicaid and Medicare dollars, there's even higher obligation to ‑‑ I would argue to be physically accessible. And that includes looking at height adjustable exam tables and other diagnostic and medical equipment needed by people with mobility and other disabilities.

 The plans have also been required to receive training and give employees training on disability discrimination and cultural competency. I've actually been involved in some of that in the past so I know what's going on.

 And here is our final slide indicating how local advocates can help. The HICAP is an invaluable source of information, with especially expertise around Medicare. The CCI Ombudsman is located. There is Ombudsman in all the affected seven counties. They are legal services organizations and they can provide information and advocacy and assistance on many levels. And if you're facing a grievance or a complaint or an issue that's arising for you, they are a great resource for that as well as just getting information.

 I think with that we are basically done with our presentation. If there are any more questions, you can type them in. Our e‑mails aren't on here.

>> Amber Cutler: The next slide.

>> Sylvia Yee: Oh. I forgot there was another one. My apologies. There. Additional resources, of course. Justice in Aging has been a fantastic resource on all aspects of the CCI. As Amber mentioned, the Advocates Guide is available on the website. On the website there are fact sheets. You can sign up for alerts. Amber's e‑mail is there. And her colleague Denny is also there. We also have some resources, the Advocates Guide as well is on our website. And my e‑mail is up there as well. And then the Cal Duals site is an excellent source of information about the CCI in general.

 The slide show will be available on your site, Amber, and the transcript as well?

>> Amber Cutler: I think you guys put it on your site as well.

>> Sylvia Yee: Right. Yes. Because it has the closed caption transcript. So it will be available ‑‑ don't look today. But look in the next few days. It should be up.

>> Amber Cutler: Yeah.

>> Sylvia Yee: Thank you, everyone, for your attention.

>> Amber Cutler: Yeah. Thank you, everyone. Do not hesitate to contact us with questions if you have them.

 Thanks, Sylvia.

>> Sylvia Yee: Thank you, Amber. Bye.

>> Amber Cutler: Bye‑bye.