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**“COORDINATED CARE INITIATIVE BASICS:  
PREPARING FOR CHANGES”**

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>>Anna Rich: Hi, my name is Anna Rich, senior staff attorney at the National Senior Citizens Law Center. I'm delighted to have you all here today, and also delighted to introduce our two speakers for today. The first will be Amber Cutler, a staff attorney at the National Senior Citizens Law Center, Los Angeles office. We'll also have Silvia Yee, from the Disability Rights Education and Defense Fund. Welcome, and thank you, Amber and Silvia, for coming to share your expertise today.

>> Amber Cutler: Thank you, Anna. This is Amber, from the National Senior Citizens Law Center. Today we're going to present the Coordinated Care Initiative Basics training. If you guys have any questions that you want to post during the webinar, please type your questions into the chat box, and we will try to answer your questions during the webinar presentation. If we are unable to get to your question during the presentation, we will do so after the presentation, to the best of our ability. Everyone will be on mute during the presentation. The only way to ask questions is through that chat function.

We're going to get started. There's a cue for slides, a brief explanation of the National Senior Citizens Law Center and of DREDF. I'm not going to spend any time on those. We're going to dive right into the Coordinated Care Initiative and what it is.

This presentation is going to focus on the what, who, where, when and why of the Coordinated Care Initiative. In a nutshell, the Coordinated Care Initiative is a new state program that changes the delivery of Medi-Cal, long-term service and supports and Medicare to dual-eligibles and seniors and persons with disabilities living in eight

California counties, set to begin no sooner than April 1, 2014. It is aimed at coordinating care and reducing healthcare spending.

I want to point out that the April 1 date is a new date. That just changed last week. It was initially the start date was October 1 of 2013, and then that was postponed to January 1, now most recently changed to no sooner than April 1 of 2014.

So what is the -- before I start, I forgot the glossary. So you guys are all on the same page about what all these terms are I'm going to throw out during the presentation, I'm going to go through some of the definitions that I'll be using throughout the presentation. The first is, obviously, the Coordinated Care Initiative, or CCI, which also includes Cal MediConnect. Dual-eligibles are on there, individuals eligible for Medi-Cal and Medicare, also known as Medi-Medis. The major ones are long-term support and service, LTSS, an umbrella term under the Coordinated Care Initiative with a very specific meaning. It refers to four specific programs provided through Medi-Cal.

First is in-home supportive services, IHSS. That is the program that is paid for through Medi-Cal, where it allows beneficiary to remain safely in the home rather than a nursing facility or other institution. It includes services like housecleaning, shopping, meal preparation, laundry, personal care services, and it's county administered, and individuals are assessed by the county and the individual IH assessed consumer has the right to hire, fire and supervise their IHSS provider.

The second program is the community-based adult services, formerly known as adult day healthcare. Those are licensed programs that provide services to older

persons, with either chronic medical, cognitive or mental conditions or disabilities, that are at risk for institutional care. There are certain eligibility requirements people have to meet to receive the services.

The other is the Multipurpose Senior Services Program, MSSP. That is a site-provided service, social and healthcare management, aimed at the frail or elderly clients who are certifiable for nursing home placements, but can still live safely at home in the community. They must meet certain eligibility requirements to be a part of that program.

The final Medi-Cal benefit that falls under that LPSS is nursing facility care.

The final definition I'm going to point out here are seniors and persons with disabilities, or SPDs. That has a very specific meaning under the Coordinated Care Initiative. I'm referring to individuals with Medi-Cal only. Not dual-eligibles, not individuals with Medicare, but individuals who only have Medi-Cal and have received that benefit or are eligible for that Medi-Cal benefit based on their age or because they have a disability.

So there's a glossary of terms that you can refer back to throughout the presentation, if you need to.

What is the Coordinated Care Initiative? If there is one slide I want you to pay attention to, it is this one. The Coordinated Care Initiative encompasses three major changes, the first change is mandatory enrollment into Medi-Cal Managed Care. Back in 2011, California started moving seniors and persons with disabilities, or those SPDs,

into managed care for their Medi-Cal benefit. However, there were certain populations and services carved out of managed care. For example, individuals with share of cost were excluded from enrollment. Also individuals living in a nursing facility were excluded. Most notably, dual-eligible beneficiaries, those with both Medicare and Medi-Cal were excluded from mandatory enrollment into mandatory managed care. Not under the CIC. Now all of those populations have to sign up for managed care for their Medi-Cal benefit. To receive the Medi-Cal benefit, they're going to be in a managed care plan and receiving their benefit through a managed care plan. That's change number one.

Change number two is integration of LTSS into the managed care benefit package. In 2011, when SPDs were mandatorily enrolled, there were certain services carved out of the package, those included the LTSS, IHSS, nursing facility care, CBAS. CBAS went in last year, but the other three are also integrated into managed care.

For example, if an individual right now living in the community, an SBD, medical only, they're probably in managed care for their Medi-Cal benefit. Let's say they go into a hospital, then into a nursing facility. Today, if they went into that nursing facility, the nursing facility, they would be disenrolled from managed care after about a month. Then their nursing facility care is paid by Medi-Cal through fee for service. Under the CCI that will not be the case. They stay in managed care and their managed care plan is responsible for paying nursing facility care. That's change number two, integration of the long-term services and supports into managed care.

The third change is the change that most people are talking about, and you probably have heard the most about, that is the integration of Medicare and Medi-Cal into one managed care plan. That program is called Cal MediConnect. We're taking the benefits, placing both into a managed care plan so they're receiving their benefits, both sets of benefits, through the managed care plan. So far, Cal MediConnect received federal approval through a memorandum of understanding that the state of California entered into with the Center for Medicare and Medicaid Services in March of 2013.

The other two changes, the state of California has submitted approval for those changes to the federal government and is awaiting approval of those changes. There's no reason to believe those won't be approved. They just haven't happened yet.

A major change that happened in May was all three of these changes, when the law was first enacted to get this program off the ground, all three of them were going to move forward together, and if they couldn't move forward together they wouldn't move forward at all.

Under the budget bill that was passed in May, that changed. All three of these components can now move together, or move separately from each other, or be the link. So that means that Cal MediConnect for example can move forward, where the other two changes do not. Or the other two changes can move forward, and Cal MediConnect cannot. That is something that can happen, but right now all three changes are set to happen together and set to begin no sooner than April 1, 2014.

Just to give you guys an overview of what the current system looks like and what we're moving into, so right now individuals are receiving their Medi-Cal service, most individuals are receiving benefits through managed care, but there's still a large chunk of individuals who get Medi-Cal through fee for service. All dual-eligibles get their services through fee for service. All of the long-term supports are paid through the fee for service, except for CBAS. That is your IHSS, nursing facility care, all paid that fee for service. The Medicare benefits, most people get Medicare paid through fee for service, but some people, some individuals with Medicare are getting their benefits through managed care. That would be a Medicare Advantage plan or dual special need plan, which is a special Medicare Advantage plan aimed at duals. But they're getting their benefits through managed care for Medicare. There are fewer of those. The default is fee for service.

The Coordinated Care Initiative is moving everything into managed care. So you're going to see the Medi-Cal benefits delivered through managed care, LTSS, and Medicare through managed care. Now, behavioral health has an asterisk, because it is -- there are specialty mental health benefits paid for by the county and administered through the county. That will continue to be the case. That's the case now, and that will continue to be the case under the Coordinated Care Initiative.

So that's what we're moving towards. To give you an overview, so fee for service, this is what it looked like. We saw a senior or person with disability going to see their different providers. As long as that provider accepted their Medicare or

Medi-Cal card, they could see that provider. That provider provided service, for example, an exam or an x-ray or evaluation, then that provider for that service would bill the Department of Health Care Services or Medicare for that particular service. Medicare and DHS would pay for the service. That's the fee-for-service model.

Under managed care, we have the senior or person with disability who, instead of seeing their provider directly, they're in agreement with the health plan and the health plan is receiving a lump sum of money from DHCS or Medicare or both to provide services to that senior other people with disabilities, then the health plan contracts with the different providers to provide those services to the senior or people with disabilities.

Those providers are within the health plan's network. As we all know, there are certain providers not within the health plan's network, and those providers the senior or person with disability can no longer see because they're outside of the plan's network. That's managed care in a brief summary to give you guys an idea what we're moving into.

Just to review who is impacted by the Coordinated Care Initiative, it's going to be individuals who are eligible for both Medicare and Medi-Cal, dual-eligibles, and those individuals who have Medi-Cal only, or SPDs. Individuals who only have Medicare are not going to be impacted by the Coordinated Care Initiative.

Different groups of duals and seniors and persons with disabilities are going to be affected differently by the Coordinated Care Initiative. This is what makes the Coordinated Care Initiative incredibly complex. I'm not going to go into all of these

different exceptions and exclusions in detail, because that's beyond the scope of this basics presentation, but I'm going to give you guys a sense of how different populations are treated differently under the Coordinated Care Initiative.

For example, SPDs, those individuals with Medi-Cal only, that are already in Medi-Cal Managed Care, they're not going to see a huge change. They're going to get a notice that their long-term services and supports are now going to be integrated into their managed care plan. They're not going to have to do anything. They're just going to be told that, where before they would have gotten those service through fee for service, now their managed care plan will provide those services. That's one population affected.

There are those SPDs that will remain exempt from mandatory enrollment in managed care. Those are individuals who live in a veterans' home and individuals who successfully obtain a medical exemption request, because they have a chronic condition and need to continue to see their providers outside of managed care. There are very few of those individuals, but they will be impacted by the CCI, they will get notices, but may remain exempt from enrollment in Medi-Cal Managed Care.

Then we have dual-eligibles that will be passively enrolled into Cal MediConnect. That's most dual-eligibles. Most will be passively enrolled into Cal Medi-Cal. I will go into passive enrollment in a second.

Then we have dual-eligibles that can enroll in Cal MediConnect, but will not be subject to passive enrollment. Who are those individuals? Individuals who are enrolled

in Kaiser currently, they're individuals who live in certain zip codes in San Bernardino or individuals currently in a home and community-based service waiver. They can disenroll from that waiver and enroll in Cal MediConnect, but they're not going to receive notices about Cal MediConnect.

Finally, there are dual eligibilities that cannot participate in Cal MediConnect. Those are individuals with renal disease, except for certain individuals in Orange County or San Mateo County, certain individuals in San Bernardino and Riverside. There are a lot of exemptions, exclusions, exceptions to the exceptions. We're not going to go through all of those. There are many different populations, and many of those will be treated differently under the Coordinated Care Initiative.

The total impact of the Coordinated Care Initiative. The total impact is about a million people. We have 418,000 dual-eligible beneficiaries that will receive notices about enrollment into Cal MediConnect. Only about 395,000 can be enrolled into Cal MediConnect. That is because Los Angeles County will have a cap on enrollment, of 200,000.

Then there's about 592,000 additional individuals who either are not eligible for Cal MediConnect or not subject for passive enrollment into Cal MediConnect or have Medicare only, aren't in managed care, who will now go into managed care for their Medicare benefit. We have about a million individuals impacted by the Coordinated Care Initiative.

I'm going to stop there for questions.

>> Anna Rich: Thanks, Amber. We don't currently have any questions about the -- I would encourage, if you have comments or questions, submit those using the chat function. There's a tab that says Room, and you just type in your chat, your question or comment through the chat function, then the next time we take a break for questions, I'll share those with Amber or Silvia.

>> Amber Cutler: Great. Thanks, Anna.

Back to Cal MediConnect. It only affects dual beneficiaries. Duals will be subject to passive enrollment into Cal MediConnect. What does passive enrollment mean? Passive, an individual, a dual-eligible, who will be subject to passive enrollment, will receive a notice, receive notices about enrollment into Cal MediConnect. When they get those, there will be three options. The beneficiary has the option of opting in to Cal MediConnect. Then they will be given the choice of what plan under the Cal MediConnect program they can choose. When they opt in, they'll choose their plan, it will be a Cal MediConnect plan that will integrate both their Medicare and Medi-Cal benefit. That's option number one, when they receive those notices.

Option number 2 is that they can decide they don't want to take part in Cal MediConnect. They can opt out of Cal MediConnect or keep their Medicare the same. That means they can stay in fee for service Medicare if that's where they are, or decide that they want to join a Medicare Advantage plan or that they want to enroll in PACE, for example. No matter what, they get to make a choice about their Medicare.

However, even if they decide they don't want to participate in Cal MediConnect

and they want to keep Medicare the way it is, or do something different with their Medicare benefit, they still have to choose a Medi-Cal plan for their Medi-Cal benefit. No matter what, a dual-eligible is going to have to select a managed care plan for their Medi-Cal benefit, with very few exceptions. That's important to remember. Even if an individual decides they don't want to participate in Cal MediConnect, the Coordinated Care Initiative still impacts them, because they still have to choose a managed care plan for their Medi-Cal benefit.

Finally, if they get that notice and do nothing, this is where passive enrollment comes in. If they do nothing, an individual will be automatically enrolled into a Cal MediConnect plan. The state will choose that plan for them. So that's where passive enrollment comes in. If an individual does nothing they're going to be automatically enrolled into a Cal MediConnect plan that will integrate both their Medicare and Medi-Cal benefit into one managed care plan.

Now, it's important to remember that even if someone gets passively enrolled into Cal MediConnect and they decide they don't want to be there, that they can always disenroll on the Medicare side. They can do that at any point on the Medicare side; it's optional. They're still going to have to be in a managed care plan for their Medi-Cal benefit.

So just to reiterate, even if a dual-eligible opts out of Cal MediConnect they still are going to have to enroll in a Medi-Cal Managed Care plan. Individuals who have Medi-Cal plan, or SPDs and dual-eligibles who either aren't eligible for Cal

MediConnect, who decide not to participate in Cal MediConnect, all of them are still going to have to choose a Medi-Cal Managed Care plan. This included individuals who are on Medicare Advantage plans.

Medicare Advantage for the year of 2014 they will not be -- individuals enrolled in a Medicare Advantage plan will not be subject to passive enrollment in Cal MediConnect. They're not going to receive notices about Cal MediConnect. They're still going to receive notices though telling them they have to pick a plan for the Medi-Cal benefit. They're still going to have to choose a managed care plan for their Medi-Cal benefit. They're just not going to receive notices about Cal MediConnect.

For definition purposes, the D-SNP is Dual Special Needs Plan, a special type of Medicare Advantage plan for individuals who are dual-eligible. It's a Medicare Advantage plan. Those individuals aren't going to receive notices about Cal MediConnect but still have to choose a Medi-Cal plan for their Medi-Cal benefit in 2014.

I'm going to stop there again for questions.

>> Anna Rich: We still don't have any questions that are substantive submitted to the chat function, so again, either that means everything is clear and no one has any questions, or it means you folks are shy about using the chat function. So I really encourage people to submit questions. Amber, anything else you want to add before we turn it over to Silvia?

>> Amber Cutler: No, I don't think so. Go ahead, Silvia.

>> Sylvia Yee: Thanks, Amber. You have been remarkably clear. I'm not surprised there are no questions. I expect more after my section.

I'm going to start by looking more specifically into what the Cal MediConnect benefits will be. These are the benefits that are supposed to be available to duals if they join the Cal MediConnect. First of all, let's look at what the plans have to provide, are required to provide. They have to provide Medicare service A, which is basically inpatient, hospital care; Medicare service Part B, everything from providers and outpatient hospital care; and Part D, which includes prescription drug coverage. Plans are also required to provide Medi-Cal services, which include all of the long-term supports and services. These are the ones that Amber talked about earlier, IHSS, CBAS, nursing facility services, and MSSP waiver services.

The additional thing that is supposed to be provided under the waiver, and just to the Cal MediConnect individuals are visions, that's preventive, restorative and emergency vision services, and nonemergency transportation. The nonemergency transportation is actually capped. We're not sure yet what that cap is and how it will work, but plans apparently are able to cap it. We don't know what happens once that cap is reached.

Another thing to note is that Medi-Cal services are going to include dental as of May 2014, and that's for all Medi-Cal beneficiaries, not just for the Cal MediConnect folks.

The other thing to note is that the big benefit really that Cal MediConnect is

supposed to provide is care coordination. That's having all of your services available under one umbrella. Under the umbrella of the plan, all your benefits are supposed to be paid for that way, and your plan is supposed to help you coordinate those services. So that's one of the primary benefits. You will not have to be dealing with two systems. You should be dealing with Medi-Cal and Medicare under that one umbrella, with one card.

Now, Cal MediConnect also involves some optional services, and these are services that are at the discretion of the plan. These include waiver-like service that were available, home and community-based service waivers. Well, the waivers are still around, but if you are receiving home and community-based services waiver now, these benefits are not discretionary. These same types of benefits under Cal MediConnect will be discretionary, and these are the kinds of services like home and facility respite, community transition services to help you adapt back to the community after extended stay in the nursing home, for example; home accessibility adaptations, if your mobility is affected and you need modifications to your home, to move around in that home in the community; private duty nursing. These are all of the kinds of additional services that a plan may well want to provide to you because it will help you as a member to stay out of a hospital and remain in the community, but a plan is not, at this point, required to provide them to you.

So another optional service that a plan can offer is additional IHSS-like services, services involving hours and other kinds of assistance you may need to stay in your

home safely.

There are also some services that will be provided and will remain outside of the plans, and these two, the two main categories of these would be specialty mental health service and behavioral health drug Medi-Cal benefits. So these have been carved out of the demonstration. They have traditionally been paid for by the county and provided by the county, and that's going to continue.

I'm going to stop there for a second to see if there are additional questions about Cal MediConnect benefits.

>> Anna Rich: I don't see any questions currently submitted, but I want to be -- I would be curious, Silvia, at what point we're going to know more details about exactly what's in the vision benefit, exactly what a particular plan is going to do to provide care coordination.

>> Sylvia Yee: Those additional details, is there a timeline on that, Amber, as to exactly when additional details have to be provided?

>> Amber Cutler: I think that the plans are still trying to figure out what these different benefits will look like. They're working those details out in their three-way contracts, which hopefully will be completed by September. That's when it is supposed to happen. With the delay until April 1, I imagine we might not get details about the extent of these benefits until further down the road.

>> Sylvia Yee: I think it will be -- the critical point is that people will really need to know these details, of course, is that when they're having to choose between plans. That's

when it's really going to be -- the rubber hits the road. You need to know, What am I going to be getting? But I don't know about a set date right now that this information is supposed to be clarified or made public, widely public.

>> Anna Rich: A couple other questions that just came in. First, for people who are in Medi-Cal funded nursing home and are getting Medi-Cal long-term care, will the financial eligibility criteria change at all for people who are in the Cal MediConnect or managed care plan?

>> Sylvia Yee: I don't believe it is supposed to change. Do you have additional information on that, Amber?

>> Amber Cutler: No. Everything should remain the same. The point of these transitions is not to make a beneficiary any more responsible financially for any of the benefits they're currently receiving, or take away any of the benefits they're currently receiving. It's just a change in how the services are being delivered, and it's supposed to better coordinate those services so that costs are reduced that way, but not through making the beneficiary any more responsible financially or at the cost of losing any benefits.

>> One more question, then we'll go back to the presentation. Elisa wants to know if you can talk more about care coordination provided by the health plan and how that compares to the kind of care coordination or case management that someone would get from an MSSP program or CBAS program. Also, can you get both the care

coordination from a plan and also be enrolled in MSSP and CBAS, or could the plans contract with the MSSP or CBAS providers to fulfill that care coordination function?

>> Sylvia Yee: Some of these details are going to be worked out. I think, though, that absolutely it is possible for plans to contract with the CBAS, existing providers. They have to contract with MSSP providers. I think the goal, the ideal is that for individuals who are being served by care coordination now, that there will be as little disruption as possible, just as Amber indicated. So that if you, as an individual, are receiving care coordination and you like it, you should not have to give that up.

Now, in practice, how that will work, that a plan will actually be able to go out and make all of the contractual arrangements they need to and should, that's not a done deal yet. Just to put it bluntly. I think some of the plans are working really hard on that, and working really hard on a long-term services and supports network that will include experienced care coordinators and experienced LTSS providers. The jury is out. I don't know. I don't think that we can say yet how successful that will be.

Amber, any other thoughts on that?

>> Amber Cutler: No, I think you covered it well, Silvia.

>> Anna Rich: We have a few more questions, and please keep sending them in. We'll take other breaks later in the presentation. Also, if Amber and Silvia can't get to all of the questions, they'll follow up with you later. Why don't we turn it back over to you, Silvia, to keep going with the slides.

>> Sylvia Yee: Sure. We'll be looking a little bit more closely here now at the kinds of plans that will be available in the counties. Reviewing again, the CCI will be implemented in eight of California's counties, these are basically the largest and most populous counties. As of right now, the intention is that all three aspects of the CCI will take place in April 2014.

Going on to the next slide, the different Cal MediConnect plans that are available in each county, in general you can see from the slide that there are two counties in which you will not have a choice of plans. In Orange County and San Mateo County there is just one county-organized health system. So one plan, one option. As a dual-eligible, you can join that plan, or you can just opt out of Cal MediConnect entirely.

In five other counties, Alameda, Riverside, San Bernardino, Santa Clara and LA, there are essentially two choices of plan. You can choose from those two plans. They should be providing you with information as to what each will offer.

There's a further wrinkle with LA, which I will cover in a second. San Diego is actually a little different in that they have four health plans there. So you have even more choice there about which one you could choose to be your Cal MediConnect plan.

The wrinkle in Los Angeles is that, yes, there are two main plans, but LA Care is further subcontracting with additional plans. So you have some more choices there. And yes, one more complication in LA, the most populous county, under the memorandum of understanding that was signed between the state and the federal government, duals who are already Kaiser members will not be subject to the passive

enrollment.

If you or your client, you are a dual-eligible, you are already a member of Kaiser as a dual-eligible, if you do nothing when you get these, your Cal MediConnect notices, you presumably will just get to stay a dual who is a Kaiser member.

If you are a dual and you are not a member of managed care, but when you get your Cal MediConnect notices you want to become a member of Kaiser, I'm not absolutely certain about this, I think that you should be able to do that, but there is maybe some legislation that could affect that. So that is something that you need to specifically check.

So if you are in LA, you are a dual, you are thinking of joining Cal MediConnect and you want to choose Kaiser, that's a specific question to check with LA Care. I just wanted to make that available.

Going on to the next slide, and there will be opportunity for questions too. So as we've said, April 1. It's a slightly unfortunate date, perhaps, April Fool's Day, the day that information -- implementation of the CCI is supposed to start. Everyone is supposed to get 90 days -- a 90-day notice. Your notice about all of these changes, the first time it's supposed to come to you is January 1, or perhaps January 2 given that January 1 is a postal holiday.

Here is enrollment timing and process, which again, like much of what we've talked about, is somewhat complicated.

There are three, essentially three processes, and timelines. The simplest one, I'll

say, would be in San Mateo, which is a county-organized health system. So there's one plan. There is no voluntary enrollment period; That is, no initial period during which you as a dual could voluntarily decide on your own to enter the plan immediately.

Passive enrollment begins April 1, 2014, like the other eight counties, but it is phased in over one month. Essentially, everyone is going to be enrolled all at once. Where San Mateo is, its state of readiness and size is what helped, I think, to determine that. So San Mateo is unique in that.

The other, there are six other counties, Alameda, Santa Clara, Orange, Riverside, San Mateo, San Bernardino, their timeline is a little different. They have no voluntary only enrollment period. The same start date, April 1. Passive enrollment is supposed to be phased in over a one-year period, over 12 months, and the phasing method is by the first day of your birth month. So that's if your birthday is in -- August 1, August 6, August 8, by August 1 you're supposed to be enrolled.

Los Angeles as the largest county has some more safeguards and more complications. There is an initial three-month voluntary only enrollment period that begins April 1. So passive enrollment doesn't actually begin until July 1, 2014. The rest of it, how the passive enrollment works, how long the period over which passive enrollment will happen is not decided yet. I think Los Angeles is in a stakeholder period still where they're discussing these things.

So I'll just leave that. There are exceptions. Having gone through that rather complex enrollment timeline, there are some exceptions to the general enrollment

strategies, and some of them are listed here. Probably the most major exception is that dual-eligibles who are already enrolled in MSSP, it may be that they will all go into managed care all at once, but I don't think that's completely decided yet. Whether that date will vary between the counties is also unclear.

Some other exceptions are dual-eligibles who are already enrolled in Medi-Cal Managed Care Alameda and Santa Clara, dual-eligibles enrolled in Part D as of January 1, 2013, and those subject to Part D reassignment, January 1, 2014. So you can see that there are some exceptions. It's good to keep them in mind, but for the vast majority of people April 1 is the date to really watch out for, and you will be getting your notices prior to that date.

so I'm going to stop here again to see if there are additional questions.

>> Anna Rich: Yes. We have several. One, I think, might reflect some misunderstanding, and may be an opportunity to review some of the concepts here. Someone wanted to know if a dual-eligible opts out of a plan, does that mean that they don't have dual Medi-Cal/Medicare coverage anymore?

>> Sylvia Yee: Oh, OK. No, your status as a dual-eligible, someone who received Medicare and Medi-Cal services is not changed, is not changed by the Coordinated Care Initiative.

The Coordinated Care Initiative changes how you receive those services, but not your eligibility for them. So if you opt out that means that -- by opting out, I assume you must be in fee for service right now, that you will keep getting your Medicare services

the way you're getting them now through fee for services, but your Medi-Cal services, your long-term services and supports, you will have to join a managed care plan to get those. So distinguishing between your Medi-Cal and your Medicare services.

>> Anna Rich: Right. Someone who is a dual will stay a dual, as long as they remain eligible?

>> Sylvia Yee: Yes.

>> Anna Rich: Makes sense. OK. One other question, a couple questions actually relating to rates. Do you know when the providers are going to get rates for participation in the Cal MediConnect?

>> Sylvia Yee: We continue to hear that they are working on that, and actually I believe they are. They're working quite hard on this. I have no prediction as to the date that that will be made clear.

>> Anna Rich: Do either of you -- are either of you willing to hazard a prediction whether those rates will be high enough to insure a sufficient number of providers?

>> Amber Cutler: Well, I think there needs to be a distinction made. So plans are going to receive -- to simplify things a little, they're going to receive a lump sum for each beneficiary, or rate from both CMS and DHCS to provide Medi-Cal and Medicare services, so a sort of lump sum payment to the plans. The point of Cal MediConnect is not to, in fact -- the point is not to reduce payment to the providers. Rather, it's to reduce utilization or change utilization. So providers are supposed to -- and it's guaranteed by the law that they'll receive the same rates that they're currently getting

under the Medi-Cal rates, and the hope is that they would still get the same rate for Medicare. However, the Medicare law has some flexibility in that.

The hope is that the providers will continue to receive the same rates that they currently receive under Medicare and Medi-Cal, and it will just be shifts in utilization that reduce spending and results in savings. That's how the kind of rate process works.

What's being negotiated right now are the rates that the plans are actually going to receive from the government, both the state and federal government. So they're trying to negotiate those rates now so that the plans can sufficiently contract and provide the services that they are required to provide underneath the program. Does that help, Anna?

>> Anna Rich: That's very helpful. One specific, one Alameda County specific question is whether the Kaiser Senior Advantage Special Needs Plan is still going to be available in Alameda County. As far as you guys know?

>> Amber Cutler: Yes, as far as we know, the Kaiser has no intention of taking away its special needs plan. Like I said earlier, individuals in a Medicare Advantage plan, including those dual special needs plans, they are not subject to passive enrollment in Cal MediConnect. Those individuals aren't even going to receive notices about Cal MediConnect. The only thing they'll receive notices about is joining a Medi-Cal plan. I think Kaiser's Senior Advantage Special Needs Plan is actually a truly integrated plan, where their Medi-Cal benefit is already being integrated into their Medicare benefit, if I

remember correctly. So that means that they're probably going to be able to stay in Kaiser for both Medi-Cal and Medicare benefit.

>> Sylvia Yee: If I could add one thought to the person asking about the rates.

Obviously, rates are a key component of a provider's decision whether to join a plan or not, but there are a lot of other factors. For a lot of providers I think a whole administrative -- what is perceived as administrative burden if you join a plan is a big issue. So that's something that, for you, for you all as advocates and as patients, can actually talk to your providers about, in terms of helping to try to persuade an important provider to join a plan. I just wanted to make that point.

>> Anna Rich: Great. Thanks to you both. That's it for questions for right now. I will turn it back over to Amber to go on with the slides. If anyone has further questions, please feel free to submit those using the chat function.

>> Amber Cutler: Thanks, Anna. Individuals who are going to be subject to Cal MediConnect, passive enrollment, and also individuals who have to choose a plan for their Medi-Cal benefit are going to receive three notices. Those are going to come out at 90 days, 60 days and 30 days prior to enrollment.

Let's say you're someone who has a birthday on April 8, for example; you're enrollment, your passive enrollment date is April 1, 2014. Like I said before, an individual has three options when they get that notice, if it's for Cal MediConnect. They can opt in right away; they can opt out, at which point they'll still have to choose a Medi-Cal Managed Care plan; or do nothing. If they do nothing, they'll be automatically

enrolled on April 1.

They'll get their first notice in January, their second notice in February, their third notice in March , with enrollment on April 1. I just give the example also August date of birth they'll receive a notice in May, June, July with enrollment on August 1, 2014.

That's the same for someone who has just -- is going to have to choose a Medi-Cal Managed Care plan as well. They're going to receive those three notices telling them they need to choose a plan, then if they don't choose a plan one will be selected for them, and they will be enrolled into that managed care plan. That's how the notices will work.

Those notices will contain the 90-days notice letting them know the change is occurring, a general description of what the change will be. The 60-day notice is really the meat of the information that a beneficiary is going to receive. They're going to receive a notice and it's already going to have a plan on there. It's going to have a default plan listed. The way that the state does that, they are going to collect data, if it's for Cal MediConnect, from both Medicare utilization data and from Medi-Cal. If it's just Medi-Cal, they look at the Medi-Cal utilization data. The primary factor is who the primary care physician is or who the person is that that beneficiary is seeing the most. They're going to choose the plan where that provider is within the plan's network.

It's this algorithm. It's pretty complex. They choose a plan; based on that utilization data it's going to have that default plan on the notice. Then there's a choice packet, and that is going to explain how the beneficiary can make a choice about which

plan to choose. It includes what factors a beneficiary should consider in making that choice. For example, is your specialist in the network? Is your primary provider in the network? Is your therapist, is your pharmacy? It will include information on how to select a plan.

There will be a health plan guide that will describe the different health plans available in that person's county. That will include what benefits that health plan is providing, because the goal, what Silvia explained, the Cal MediConnect plan can differentiate themselves. There are certain required benefits they have to provide, but other benefits they can provide above and beyond those required benefits, those care plan option services. They can be providing a whole bunch of those benefits depending on the plan. So the health plan guide is going to help a beneficiary compare those plans to see what services each offers.

Finally, there's a provider directory, which shows which providers are in which networks. The 60-day packet has a lot of information in this. Then finally, they're going to receive a 30-day notice, a reminder notice, that will have that default plan on it, if they haven't chosen a plan. If they've affirmatively chosen a plan there's that affirmative choice listed on that reminder notice.

That's the notices. Description of them, what beneficiaries can anticipate in terms of notices.

So if you look at the reasons behind why the Coordinated Care Initiative is occurring, the state, the Department of Health Care Services and Centers For Medicare

Medicaid Services are looking to improve access to care and promote person-centered planning. They're also trying this new model to keep people in the community longer. Placing people in nursing facilities and hospitals readmissions or unnecessary hospital readmissions are very costly, and dual-eligibles more than any other population are the highest-costing population. They have chronic conditions and are medically frail. The idea is to try to coordinate those benefits in a better way to improve the care and to keep them in the community and provide the right type of care, which will ultimately lead to more cost savings for the state and federal government.

So those are the reasons that the state has provided for providing -- or changing the way that we're delivering healthcare here in California.

So we're sort of a long way through the process. As you know, it's been moved back again to April 1. A lot of that is, I think, the state's recognition that there is a lot of moving parts with regard to the Coordinated Care Initiative. The three major changes are complex. There's a lot that's the fundamental change in the way healthcare is being delivered to individuals. So there's a lot of readiness that has to happen.

The MOU was signed in March 2013, but the LA enrollment process needs to be finalized. The plans have been undergoing readiness reviews, which means there have been desktop reviews, meaning paperwork reviews, but there have also been onsite visits from a third party contractor looking at the planned systems in place, policies in place, to make sure the plans are ready to provide services. For a lot of the plans this is the first time that they're going to be responsible for long-term services and supports,

and bringing Medicare and Medi-Cal into one care coordination. They want to make sure the plans are ready.

The plans are still contracting, are still contracting with CMS and with the Department of Health Care Services and trying to develop their rates and make sure those are all together and there's three-way contracts that have to be developed, where really the meat and details are supposed to be of what the plans will be responsible for.

The plans are also still contracting with all of the different providers that they're trying to build up their network. They're having to contract with all of those Medicare providers, with all of the LTSS providers and make contracts with the counties, they have to get contracts with the IHSS, public authorities, and the behavioral health counties, and just to make sure that they have all of their network in place in order to have adequate network to support the new population coming into managed care.

They're developing notices that will have to go out to beneficiaries. All of that has to happen before people are actually subject to enrollment. There's just a lot that has to be done before that April 1 date. You can imagine that was a lot to get done before that January 1 date and why it was necessary to move that until April 1.

I'm going to stop there, Anna. I'm going to let Silvia finish up before we take any questions.

>> Anna Rich: We'll have Silvia finish out, and we'll save the questions to the very end.

>> Sylvia Yee: OK. Thank you, Amber, Anna. Here we are, the meat of the choice. Should your client enroll in Cal MediConnect? The slide tells you whether to enroll in

Cal MediConnect is an individual choice, and it's absolutely correct. But I really want to emphasize here it's only a choice if you know you have a choice and you actually make one. Because of passive enrollment and how it works, if you do nothing you will be placed in a plan, and then it's not your choice.

As a dual-eligible, if you don't want to be in Cal MediConnect you have to actively opt out of it. On the Medi-Cal side there really is only a choice of which plan. That's only true for those in certain counties.

If you want or need or rely on Medi-Cal long-term supports and services or on home and community-based services like IHSS or CBAS, you must join a managed care plan to keep getting or start getting those services. So that's an important thing to really remember.

Going back to the choice, however, it's not a simple choice. It involves a lot of factors. So some of those factors include do the plans, does the particular plan you're looking at have the kind of provider networks that include your current medical providers in it, your current doctors, current specialists? Or if they only have some of them, then you have to start thinking, Well, who do I really need? Who is critical to me?

You have to think about if your current provider isn't there, does the plan contract with or have relationships with specialists and other providers that are equally good, that you would consider going to, or treatment centers that will know what they're doing with regard to your specific conditions and disabilities?

Does the plan you're thinking about have strong relationships with the kinds of

social service providers and long-term supports and services providers that are important to you?

Does the client have a course of treatment, you, do you or your client have a course of treatment that should not be interrupted?

How important are the additional benefits that are supposed to be available under Cal MediConnect? How important are those to you, vision and transportation? They can be very important to many individuals.

Just a note that because adult dental is now going to be restored for all-Medi-Cal enrollees as of May 2014, that in itself, the dental, is not necessarily a strong incentive to enroll in Cal MediConnect, since it will be available to all Medi-Cal beneficiaries.

Another factor, this is a critical one, will the plan improve you or your client's care coordination? I know many individuals with disabilities who do manage all of their services, all of their care. That can be a very heavy burden. There are a number of individuals with disabilities who also would really appreciate some assistance, some informed, good, effective assistance in managing the different kinds of care and services that are in their life. Is that something that is important to you? Is that assistance needed?

So these are all factors to really think about as you move forward.

What to watch out for: There are some benefits that should be coming out of here, and they are very good benefits. Care coordination is one of them. There's a

simple fact that you don't have to carry around two cards or be worried about two systems.

There are supposed to be additional required benefits, as we've discussed the vision, transportation, the dental. Also, some discretionary additional home and community-based service benefits.

There are also assessments and care plans that can be very helpful to an individual who is faced with many different treatments, many different needs, many different services.

So these are things that you or your client should expect, with an integrated plan, a managed care plan that handles everything, if everything goes smoothly. And that is a -- these are important benefits, and it's also a rather big "if." There are things to watch out for that are bad.

Some of this concerns the timing, the fact of confusion and mistakes, especially for those individuals who will be going through transitions.

The categories we have are not watertight. Someone who is Medi-Cal only can turn 65, become eligible for Medicare and become a dual. There are lots of transitions that happen to individuals, as their conditions change, as their health changes.

How a health plan and how the state handles these transitions in your lives is going to be an issue, as the whole overall large transition of the Coordinated Care Initiative is going on.

Access to providers and disruption of care is, of course, a critical issue for many

individuals with disabilities. You have established relationships with providers for many years, even for decades. The fact that you may not be able to access that provider because he or she is not in a health plan network is a very, very big concern. There are some protections, consumer protections that are intended to preserve that relationship for up to one year. But they don't extend at this point beyond one year. So that's important to remember.

And there are other issues as well. One of the reasons that the department has given for delaying the implementation date until April is the fact that there is a lot going on right now in healthcare. The state's exchange covering California starts in the fall, in October. There is rural expansion, expansion of Medi-Cal to low-income childless adults, healthy families transition. There is a lot going on, and the CCI added another very significant change.

The additional three months should help and provide an opportunity for plans and advocates and the department to try to bridge some of these cracks that individuals can otherwise fall through. But three months is not necessarily going to fix everything. Regardless, a change puts a burden on the people who are undergoing the change.

You have to find out about the plans. You have to find out what they offer. You have to find out where your providers are going, whether your providers are affiliated with and whether they are with a plan or whether they may become part of a plan.

Going on to the next -- I wanted to add just one moment of a sense of scale to

this. Amber had gone through how many, there are 400,000 duals and essentially over 1 million individuals who may be affected by the Coordinated Care Initiative. To give you a sense of scale, when seniors and people with disabilities are transitioned to managed care, that involved about 240,000 seniors and people with disabilities. This is bigger.

While the department hopefully has learned from some of the mistakes that happened to them, we're also talking about a bigger transition and more things going on right now.

So what can you do? The department is holding quarterly stakeholder meetings. The first one is actually happening next week in Sacramento, August 27, 1:00-4:30. You can try as an advocate, as an individual, as a beneficiary, to influence how these programs develop. There are stakeholder meetings. You can talk to your plans. You can get involved in legislative advocacy.

You can prepare to provide, as an advocate, as a consumer organization, you can prepare yourselves to provide good counsel and good referrals to the individuals that are going to be coming to you and needing some answers.

Also critical, report problems to advocates and consumer organizations. That's just important to know what is happening to individuals and to see if there is a systemic problem going on, because those are the ones that we might be able to fix.

So one last summary, what is Coordinated Care Initiative? I'll begin this in a slightly different way. Almost everyone who is eligible for or receives Medi-Cal service

in one of the eight-counties affected by the CCI is going to have to get those Medi-Cal services through managed care, after April 1, 2014.

So this is going to apply to medical services, such as primary or specialty care and prescription drugs, and to long-term supports and services, such as IHCC, CBAS or MSSP.

This change is going to apply whether you are only eligible for Medi-Cal or whether you are duly eligible for both Medi-Cal and Medicare. But if you are duly eligible for both Medi-Cal and Medicare you can choose to keep getting your Medicare services outside of a managed care plan. But everyone who wants or needs Medi-Cal services will have to choose a managed care plan for those services.

I think that will be it. I know we're running out of time. Additional questions? Are there additional questions we can address in a few minutes?

>> Anna Rich: There were a couple of questions about switching plans and the timing for switching plans. For instance, if someone is moving from one county to another or if someone enrolls in one plan but decides it isn't working out for them, what's the timeline for when they're allowed to switch plans?

>> Amber Cutler: Individuals who are -- this is true for individuals who have Medi-Cal only or individuals in Cal MediConnect plan, they are able to switch plans at any time, and disenrollment and re-enrollment happens the next month. If you disenroll in one month, the enrollment begins the next month.

So individuals are able to move from plan to plan. I don't really recommend

doing that. I think that any transition, whether it's just from one plan to another, can cause pretty significant disruptions. But it may be necessary in certain circumstances, particularly if a certain provider is in one plan's network, not another, or there are certain services one plan is offering that another plan is not. I can see where that could occur. That's why people are being given the choice to do that. But people should be cautious in doing so, since it could lead to disruptions and ability to access their providers.

In terms of moving from county to county -- sorry, Silvia.

>> Sylvia Yee: I wanted to add to the caution, there is the continuity of care, the protection, the consumer protection, so if you're moving from fee for service, you join a plan, there are one, two really important providers, they're not part of the plan but you want to keep relationships with them, that protection is supposed to help you be able to keep going to those providers for a year.

When you switch from plan to plan, that may have an impact on your continuity of care, on how well you can keep up relationships with providers. Maybe not with a fee for service provider you had before, you should be able to keep those, but potentially if you're with a plan, you find a doctor, "Hey, I kind of like this doctor. Can I keep them if I go to another plan?" That answer is really up in the air. Maybe the answer is no.

So that is an additional caution to add to the switching from plan to plan route.

>> Anna Rich: Great. Well, thank you so much, Amber, Silvia. I know we've used a little more of your time than we planned, but I also know that you guys are happy to

respond to follow-up questions by e-mail. Is there a final slide that has your contact information on it? Thank you.

We'll leave that up for a few minutes. We also shared with everyone the link to the transcript and the audio recording and the slide presentation. So please feel free to contact either Amber or Silvia or myself if you have any follow-up questions, also to get more information. Elisa points out that anyone can also call Disability Rights California, their phone number is 1-800-776-5746, in order to be connected to regional office closest to where they're calling from. Disability Rights California is able to provide individualized assistance for people with disabilities. And NSCLC and DREDF, speaking for NSCLC, we provide technical assistance to advocates, rather than individuals and to consumers.

Anything else either of you want to add before we sign off, Amber, Silvia?

>> Amber Cutler: No, that's it. Thank you, everyone, for participating. Silvia?

>> Sylvia Yee: Let me turn myself back on. Yes. Thank you for participating.

>> Anna Rich: Great. Thanks to everyone. Bye.

[Webinar ended at 12:07 p.m. PT, 3:07 p.m. ET]