Consumer Advisory Board
Meeting Minutes
11.30.16

1. **Welcome:** Consumer Advisory Board (CAB) members were welcomed to the November Consumer Advisory Board meeting. Members were reminded about the confidentiality agreement and to not share personal health information in the open group forum and any individual health concerns can be addressed privately with health plan representatives after the meeting. Meeting minutes from the last Consumer Advisory Board meeting were distributed for review, along with a required non-Discrimination Provision handout.

2. **Presentation –Model of Care. Lori Andersen, Santa Clara Family Health Plan, and Raquel Tablang, Anthem Blue Cross,** provided a presentation regarding their respective Models of Care. The Model of Care (MOC) is a guide for both health plans to determine clinical operation in order to meet the health and social support needs of the members. This is a requirement from Center of Medicare/Medicaid Services (CMS) and annual submission of the MOC is required.

What are the elements of the MOC

- Targeting to identify vulnerable members through gathering information on diagnosis, conditions, and risks
- Conducting the Annual Health Risk Assessments and Reassessments
- Establishing an Individual Care Plan that is person-centered.
- Establish an Interdisciplinary Care Team, as needed to support care plan implementation. M (members can elect who they want to be involved i.e. Family Physicians, IHSS Provider, Social Workers, etc.
- Care Coordination
- Training on Model of Care: All health plan staff, Providers
- Other areas including quality improvement and care transitions

Example of how MOC works

- Member is in the hospital and needs to be discharged home. Case coordinator can work with Hospital discharge planners to provide services to help members transition to home like: setting up Durable Medical Equipment, arrange transportation for follow-up post-hospital doctor visit, and check on Medications.

Question and Answer

Q1: How to question and/or change the discharge date when in the hospital?

A1: Members/Families can speak with both the hospital Case Managers and the Health plan's Care coordinator. All cases are reviewed for medical necessity for extension of care or discharge by the health plan. If you feel the decision is not correct, you can file an appeal.

Q2: How to know if an authorization has expired or denied?
A2: Typically, it is the provider who requests the authorization from the health plan for benefits or services needed and you, as the member will be asked to follow up with your physician if needed. The provider or the health plan will notify you if there is a problem with an authorization and something is needed. You can also call you Case Manager to ask about a benefit or authorization.

Q3: What's the difference between the two plans' benefits in Cal MediConnect?
Q4: The Cal MediConnect plan requirements and benefits are essentially the same. There are only minor differences.

Member Stories/Feedback:
1. Future meeting topics suggestion:

- Preventive Services
- Caregiver training and support
- Consumer Rights
- Grievances and Appeals
- Member Surveys
- HRA - Assessments

Next meeting: December 28, 2016 @ 11 a.m.