Coordinated Care Initiative
Santa Clara County Stakeholder Advisory Committee
Meeting minutes for **November 18, 2015**

12:15 pm – 2:00 pm

1. ***Welcome & Introductions***
2. ***Health Plans Update and CCI Program Implementation Issues:***

Anthem Blue Cross (Anthem): Tammie Pitkin shared the following:

- Enrollment: 3384 active.
- HRAs: 383 completed. 41% with 32% unable to contact
- LTSS: NF (custodial only) – 78, IHSS – 1388,
    - CBAS -18, MSSP -- 10
- Behavioral Health members: 208 open BH cases with 160 of these BH-prime. 50% of these members receive specialty mental health services.

Santa Clara Family Health Plan (SCFHP): Lori Andersen shared plan activity for SCFHP:

- CMC Enrollment – 8906; *Opt*-out were around 36-40%.
    - MLTSS Enrollment
    - MSSP: 246 members with 39 in CMC and 207 Medi-Cal
      CBAS – 546 members with 95 in CMC and 451 Medi-Cal
      IHSS – Total of 9965 – unable to break out by program at this time
      LTC – 1,348 members in LTC with 285 in CMC and 158 Medi-Cal. Another 905 are members who are Duals but not enrolled in CMC.

PACE - OnLok Lifeways: Katherine Kelly reported that there are updated numbers for PACE on the CMC Dashboard. They are unable to contact 20% of members and have encountered a difficult issue where beneficiaries get "stuck" in PACE even when they have not enrolled yet. This occurs when a member selects PACE as an option under CCI, but if they do NOT move forward with enrollment, they are not released and are told they have to disenroll even though they have not enrolled. The state is working on this issue. It is not an issue caused by or controlled by the health plans or PACE.

3. ***Issues from Last Meeting***

- Care Coordination Summary – SCFHP Presentation – Katrina Leestma, Manager, Medical Management.
  Ms. Leestma described the SCFHP Care Coordination or case management program that is offered to all members with specific requirements for high risk members including Cal MediConnect members. Case managers learn about and assess their member's health care needs and social factors that influence their ability to care for themselves. They help members navigate the health care system and get access to social support resources that impact their health.
  Each CCI health plan has an approved Model of Care that lays out how care coordination will be provided. Care must be coordinated across a continuum of service providers including medical, Behavioral health and LTSS. It must also reflect a person-centered approach and follow the member's direction about involvement of caregivers and medical providers. Key components of care coordination include:
  1. RISK STRATIFICATION that identifies high and lower risk members based on their health care use and demographics,

2. ASSESSMENT with a review of clinical information, Health Risk Assessment (HRA), and LTSS assessment review for members who participate in LTSS programs such as IHSS, MSSP, CBAS and long term care in a nursing facility.
3. CARE PLANNING - engage member in creating a care plan that has actionable and achievable goals.
4. CARE TEAM – offered to members; helps develop and implement the care plan.

In response to a question about care coordination being focused on care transitions, Ms. Leestma explained that this is a subset of care coordination.

Below is the definition of a Care Coordinator from the 3-way contract that the CCI health plans have with the CA Dept. of Health Care Services and Medicare.

> ***"Care Coordinator*** *— A clinician or other trained individual employed or contracted by the PCP or the Contractor (health plan) who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves."*

- Copies of a SCFHP publication entitled "Member Perspectives" were shared with the group. This was produced to help SCFHP partners (not members) learn about the impact and benefits of Cal MediConnect, particularly care coordination. Organizations needing additional copies should request them from SCFHP.
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- Work Group Report on Strategies for Hard to Reach**:**
  Time did not permit a report out on this item. Lori shared that a small group had met and would share their discussion and suggested strategies at the next meeting.

- Deeming: SCFHP began Medi-Cal deeming process November 1, 2015. Laura reported that letters were mailed to 78 members who might be deemed but that SCFHP does not have 'real' data yet on outcomes. Tammie shared that an average of 30-40 members come into Anthem monthly but the majority turn out to be ineligible either because they are deceased, have moved out of area, or for other reasons. The deeming will be for one month.

- SCC CCI Dashboard & Discussion on Committee Role and Meeting Structure
  Lori distributed a revised draft summary of the Committee role and commitment that she prepared with input from member John Arnold and from Tammie Pitkin. John asked if the Committee members would revisit their purpose and goals and discuss the commitment made by committee members to not just share information and hear from the health plans, but to engage in problem-solving around key issues. While the health plans are required to have such a committee and must meet a set of requirements, John and others expressed that committee members can also provide support on issue resolution and be helpful to the plans. Tammie referred to an example where the health plans sought a list of low income, senior or family housing sites in the county and asked members to help. Steve Church felt it was important for the members to bring updates from their respective networks to the larger group.

  After reviewing the Dashboard provided by Sonali, as a tool for sharing updates, the group decided to pilot a new method through March of 2016 and then review how it has worked.

For future meetings, updates will be submitted in advance of the meeting through the use of the SCC CCI Dashboard. Members will be sent a link to the Google-doc prior to the meetings with a request to insert their respective updates. The Dashboard will then be sent out in advance of the meeting for all to review, saving meeting agenda time for presenting this information. Any/all questions should then be brought to the meeting.

4. ***Regulatory Review:***
   Lori Andersen shared the following:
   - HCBS High and Institutional Indicator Files – error report – correcting indicators so plans can identify these members
   - Out of Area Guidance & Disenrollment Request Form – processing timeframe for HCO 3-5 business days; boxes to check re. when members refuse to provide move date or new address
   - CCI/CMC Satisfaction Survey Data – SCAN Foundation released evaluation data from "Rapid Cycle Polling Project"
   - 3 Way Contract Amendment – been in discussion for over year
   - APLs/DPLs under Review on:
     - Rate Recasting
     - CMC Deemed Continued Eligibility Requirements
     - Care Coordination

5. ***CMC Ombudsman –*** Tiffany Huyenh-Cho was not present at this meeting.

LTSS and Behavioral Health Updates

The following reports were given by designated representatives. As described above, the group agreed that for future meetings, these updates would be replaced by written updates submitted in advance of the meeting through the use of the SCC CCI Dashboard. Members will be sent a link to the Google-doc prior to the meetings with a request to insert their respective updates.

Behavioral Health – Laura Luna was welcomed back and reported on an amendment to the MOU with plans that would streamline the business association agreement for sharing the eligibility file. This would allow for matching members with the services being provided and for streamlined coordination and data sharing.

In-Home Supportive Services Update – Kingston Lum reported that the CCI unit now receives about 100 calls per month, including 25 expedited referrals from health plans. They have reduced the timeframe for expedited referrals to 30 days with an 8 day initial response time.

MSSP – Elisa Alarcon reported that MSSP is now at 99% capacity with approximately 30% of their members with Anthem and the remaining with SCFHP. A small percentage of MSSP beneficiaries are still enrolled in fee-for-service Medi-Cal. MSSP staffing is now at 7.5 case managers and 2 full time RNs. They have enrolled 83 since January and lost 69. Roughly 8 new members enroll monthly. Issues they see include referrals for non-emergency medical transportation and the timing for wheelchair accessible transport. They have also seen issues with members going to medical appointments with specialists and being told that they (provider) are not in the Cal MediConnect network. Representatives from the health plans suggested that MSSP case managers refer clients to the phone number on their membership card that members can use if encountering an issue with a provider saying they are not in the network. MSSP is also seeing continuity of care issues related to PCPs and care managers when members switch from plan to plan and require different vendors.

CBAS – John Sink shared a flyer that was developed by SCFHP in partnership with its CBAS providers. It was produced to educate providers (not members) about the impact and value of

CBAS, as part of a larger outreach strategy to increase enrollment in CBAS. John asked about sharing of member data on high risk members with CBOs and other partners so that CBAS sites could reach out to them about CBAS.

LTC – Steve Church raised the issue of skilled nursing facilities (SNFs) being able to make decisions on behalf of patients and that if they were no longer able to do this, the SNFs would no longer be able to take patients that did not have a POLST (Physician's Order for Life Sustaining Treatment) and were unable to decide about a hospice referral.

Meeting Adjourned

Summary Notes prepared by Lori Andersen & Tammie Pitkin