Department of Health Care Services
California Advancing and Innovating Medi-Cal (CalAIM)

TITLE: Managed Long-Term Services & Supports & Duals Integration Workgroup

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SPEAKERS

Hilary Haycock
Anastasia Dodson
Kerry Branick

Hilary Haycock:

Looks like our attendees are still trickling in, but it's slowed a little. So just want to welcome everybody to our very first Managed Long-Term Services and Supports (MLTSS) and Duals Integration Workgroup. We are so excited to have you all with us today.

Hilary Haycock:

A few meeting management items to note before we begin. All participants will be on mute during the presentation. So, please feel free to submit any questions you have using the chat function or, I guess, the Q&A function on Zoom. We will have discussion periods towards the end of our time together today. And so at that point, if you would like to ask a question or make your comment or provide feedback, please raise your hand and we'll be unmuting folks as we go through that discussion time. All of the PowerPoint slides and all the meeting materials will be available on the county website. And you can find a link to where that will be in the chat function. So check out the chat. We'll be periodically posting links there as they come up. So, before we go into today's agenda, I would like to invite the folks who will be speaking with us today to introduce themselves. And we'll start with DHCS and Anastasia Dodson.

Anastasia Dodson:

Hi. Good morning, everyone. This is Anastasia Dodson, DHCS, in the director's office here, and very pleased to be here.

Hilary Haycock:

Great. Thank you. We are also joined by one of our colleagues and partners from CMS. So I don't know, Kerry, if you want to just say a quick hello.

Kerry Branick:

Hi, everyone. My name's Kerry Branick. I'm the deputy in the Models, Demonstrations and Analysis Group, and CMS's Medicare-Medicaid Coordination office. And familiar with many of you from working on Cal MediConnect and other duals issues. So, very happy to be included here in supporting DHCS.

Hilary Haycock:

Fantastic. Great. So then we'll go to today's agenda. We're going to be reviewing... So we can go the next slide. We'll be reviewing the charter for our work group and sort of our goals and scope. We'll be reviewing our updated policy brief, the Expanding Access to Integrated Care for Dual Eligible Californians. We'll be having a discussion about the MLTSS and D-SNP Policy. And then we're going to open it up to a discussion about future work group topics and other public comments before we close out today. And so with that, I am thrilled to hand things back over to Anastasia to walk us through today's presentation.

Anastasia Dodson:

Great. Okay. For this first section, we're going to talk a little bit about what is the scope and purpose of this work group and the charter document. We have a webpage on the DHCS website and I see that there's some chat about the links, so we'll make sure we'll put the link in there, but if you go to the DHCS CalAIM website and scroll down about two-thirds of the way, you can see the link to the MLTSS workgroup page, and all the materials are on that page. And thanks for your patience in the chat. We just got the materials posted today. So we'll make sure in the chat box to put all that information about the links, but... So we'll go to the next slide.

Anastasia Dodson:

So the purpose of this work group is really... Just as we say in the slide there, a stakeholder collaboration hub. Within CalAIM, there's several pieces that relate to dual eligible individuals. We have, of course, this transition of the Coordinated Care initiative within the CalAIM initiative, but there's also changes for dual eligibles and Medi-Cal managed care. And we also know that there's a lot of interest in topics related to the Master Plan for Aging that will also relate to CalAIM. So we're very excited then to bring this group together to be able to talk about these topics in a dedicated forum. We have initially thought that the meetings would be monthly. They could be less frequent or more frequent.

Anastasia Dodson:

The structure of the meetings we have right now, as we don't have a crew of individuals who are designated as work group members. We have used that approach in some of our other DHCS work groups. For this group, we thought we would try to have a less formal structure, but really I want to emphasize that we need to have a dialogue with all of you and amongst all of you. We have partners from CMS as we've introduced, DHCS, the Aurrera team, but also health plans, beneficiaries, providers, advocates, all of you. We want this to be a good forum for sharing ideas, asking questions and even sharing experiences that will help us make good policy in these areas.

Anastasia Dodson:

So, please take a look at the charter and we would very much welcome your feedback either in the chat and maybe take a question or two now if we want to. But the main thing also I want to emphasize is that if this structure does not work where we're not necessarily naming individuals as a set workgroup team, then we can go that path. We can have an application process where we would identify individuals to be workgroup members. And if we need to pivot and transition to that structure, we're happy to do so, but we're going to try this for now.

Anastasia Dodson:

And then in future meetings, what we are also really wanting to do is have stakeholders, plans, advocates, providers, et cetera, be presenting. This webinar, we don't want to be necessarily the standard for webinars going forward. Unfortunately, today is a lot of me talking, just presenting materials, but it's much more beneficial if we're having a dialogue or hearing presentations from folks outside of the department as well. So I

want to emphasize that and to say that we're very open to the format here. Today, we're going to try this, but we can pivot if needed. Again, the charter is posted on the website and Hilary and team, is there anything that is particular coming in the chat? Is there anyone who wants to make a comment over the phone on the structure and purpose of the work group?

Hilary Haycock:

There's a question about whether we'll be inviting social security participation, and that's probably a question around helping promote enrollment and supporting some cleaner enrollment.

Anastasia Dodson:

That's a great suggestion. Yeah. Thank you. Wonderful.

Hilary Haycock:

There is one person with their hand up. Pearl Santos. We can unmute. There we go. Pearl, you're unmuted. All right. Okay. Maybe we will move on to Tatiana, who also asked the social security question. You are unmuted on our end, but might be muted on yours. There we go.

Tatiana Fassieux:

Yeah. I just did unmute. Okay. Thank you. Yeah, I think the open structure is a good idea, but we want to make sure that if... I just thought about social security because being on the California Health Advocates and the HICAP side, they are an integral part of this effort here. But I think that as we come across more people or organizations, I think that that would be valuable. And again, I don't know how widespread your invitation is for the stakeholder group. If I think about somebody, I will definitely pass it on to them to participate.

Hilary Haycock:

Great. We welcome that.

Anastasia Dodson:

Wonderful.

Hilary Haycock:

All right.

Anastasia Dodson:

Great. Yeah, let's keep going on the slides. And then, again, people feel free to chime in, raise your hand or chat in the box in the Q&A. So, the next slide. Just some very basic table setting; dual eligible beneficiaries, individuals eligible for both Medicare and Medicaid. There are 1.4 million dual eligible beneficiaries in California, and it includes both people, 65 and older and folks eligible due to disability. And again, we're doing

some table setting at this meeting. All of you may know this, but we just want to make sure we are covering all the bases for all levels of knowledge. Next slide.

Anastasia Dodson:

Okay. So for most dual eligible beneficiaries, Medi-Cal and Medicare, they operate separately with different funding streams. Again, I think you're all very familiar. This is a fragmented system that doesn't really have enough incentives to provide these individuals with person-centered services. Many times dual eligibles report... They have poor health status with many more than other Medicare beneficiaries and many dual eligible individuals are more likely to be from systematically and historically disadvantaged populations. So, many years, this has been a high priority population at both the state and federal level to provide improved care. And these dual eligibles have high rates of chronic conditions and functional impairments, and so access to long-term services and supports and streamlined and person-centered ways is very important. So CalAIM does include several policy changes to increase the number of dual eligibles in coordinated care. Let's go to the next slide.

Anastasia Dodson:

We also need to really make sure that we are grounding ourselves in what has happened over the last year and what has been happening over many years. So recently with COVID and many years around health disparities. Sadly, tragically, COVID has had a disproportionate impact on older Californians and people of color. As a department and administration, we're certainly committed to addressing disparities in health care, and we want to continue to align ourselves with the health equity efforts at the federal level. CalAIM has several proposals that recognize the opportunities to target social determinants of health. We're very excited about that. And this work group is going to... We're going to make sure that we're grounded in the impact of COVID, lessons learned and strategies moving forward to address COVID and health disparities. Next slide.

Anastasia Dodson:

So, just to be clear, and because there's many, many issues we could be talking about here. We're focused initially on the CalAIM transition of Cal MediConnect and the Coordinated Care initiative to a statewide Managed Long-Term Services and Supports D-SNP structure. This is an important effort that will help us meet the goals, both for CalAIM and the Master Plan for Aging. We have a policy memo that we released in February of 2020, and we are in the process of updating that memo. Not huge changes, but as you all know, we released a CalAIM updated proposal, January 8th, and there are a few tweaks in relation to updated federal requirements on D-SNP lookalikes and other pieces that we're making a few tweaks on. And so we'll be posting that updated memo on our DHCS website in the next week or so. Next slide.

Anastasia Dodson:

And then this kind of gets to the initial topics and scope for this work group that we're proposing. But again, lots of feedback is welcome on this. So, we're thinking that it's

really important to make sure that we are correctly transitioning folks from Cal MediConnect to a D-SNP aligned enrollment structure. Thinking about how do we move that statewide. As you probably know, we're looking at 2023 for the Cal MediConnect transition in certain counties, but then 2025, statewide. So, there are a whole host of issues on statewide MLTSS and a D-SNP structure, model of care contract requirements, leveraging lessons learned, looking at different requirements to address dementia specialists and care coordination. How carved out LTSS benefits like IHSS can be effectively coordinated with? So, there's a whole host of issues here, but we're going to talk at the end about other topics that we could also include either weaving those in as we go along, or maybe once we make some further headway on these initial issues, then go into other topics. Next slide, please.

Anastasia Dodson:

And this is our initial meeting schedule and we are still working out topics for each of the next few meetings. Again, we can have more meetings, less – fewer meetings, structure them differently. So please keep your comments coming through on the chat and we will read them. And even if we can't respond to all of them real time, we'll go back after this meeting and huddle if there's any changes we need to make. All right, so…. Next slide, Hilary, or is there anything else you think we need to touch on before we go to the next section?

Hilary Haycock:

No, we're getting some policy questions. So I think probably we should get into some of the policy.

Anastasia Dodson:

Okay. Super.

Hilary Haycock:

Let’s see if we can answer some of that.

Anastasia Dodson:

Okay. So first we're going to go through the CalAIM Master Plan for Aging briefly. All of the details on this are on the DHCS website. And we really... Considering it's a two hour block on our initial meeting, we're not going to go through every detail, but certainly many of you may have heard the CalAIM webinar last week, and that provides more information. And there's been a lot of discussions about the Master Plan for Aging and the effort led by California Department of Aging. Next slide.

Anastasia Dodson:

So here are the key CalAIM goals throughout all of the CalAIM efforts. Next slide, please. This is an overview of the key components of CalAIM, which really are addressing a broader delivery system program and payment reform. And I want to highlight the Enhanced Care Management and In Lieu of Services efforts. We're going

to talk a little bit more about that and the intersection with this work group and the dual eligibles. There's changes in behavioral health, which of course also impacts dual eligibles and anyone over 65 and people with disabilities. That's an important area. Of course, dual eligible beneficiaries and MLTSS which is the scope of this group. There's changes in dental and other county programs. All right. Next slide.

Anastasia Dodson:

So for Enhanced Care Management and In Lieu of Services, DHCS will be releasing several draft documents around Medi-Cal managed care plan responsibilities for those benefits. And they'll be released as drafts for public comment, and then as finals later this spring. So, again, we really recognize that there's interest and overlap in these In Lieu of Services and ECM with dual eligibles. And I'll just say, dual eligibles are not precluded from those benefits, but there is some complexity around what's already included in Cal MediConnect and also the D-SNP model of care. So, we are working internally and then as part of the materials that get shared, we'll be clarifying how the different enrollment options for duals intersect with Medi-Cal managed care, ECM and In Lieu of Services, but just want to make sure everybody knows duals are not necessarily excluded, but there are some caveats there for Cal MediConnect enrollment and D-SNP enrollment that we'll be glad to talk about in future meetings in detail. Next slide, please.

Anastasia Dodson:

So, these are the CalAIM goals for Long-Term Services and Supports and Improved Care Integration is something that... Of course, this has really been a longstanding goal of the department. Again, with those bifurcated systems, Medicare and Medi-Cal, sometimes different providers. Certainly different benefits and different payment structures. So, we know that these are very vulnerable individuals, dual eligibles with significant needs and that integrating care does lead to better choices, better outcomes, but we need to find ways to align the incentives. And that's where I'm looking at leveraging this wonderful array of Home and Community-Based Services that we have in California. That is a key strategy building on the success of Cal MediConnect and CCI. Taking advantage and leveraging the expertise and input from the Master Plan for Aging. There was very good discussion there and then having a roadmap, a multi-year roadmap so that everyone knows sort of, what is the plan? How do all the pieces fit together? All right. Next slide, please.

Anastasia Dodson:

So just highlighting some key pieces in CalAIM. In 2022, there is a change around share of cost beneficiaries. They'll be shifted over to Medi-Cal fee-for-service, excluding long-term care share of cost. And 2022, there's also a plan to carve out MSSP and CCI counties. And again, I know we're going quickly through these. There's a lot of materials on our website and we want to get to some additional material later in this webinar, but sorry to be going so quickly through all of these. 2023 is when we're proposing mandatory statewide long-term care benefit carve-in, which includes the long-term care

share of class populations and mandatory statewide Medi-Cal managed care enrollment for all dual eligible beneficiaries, except those with share of cost or restricted scope.

Anastasia Dodson:

So these two bullets at the end here in 2023, those are major changes to help integrate care because right now, in many counties, dual eligibles are not enrolled in managed care for their Medi-Cal benefit and long-term care is carved out. So that has an effect of making the incentives not align and having kind of more diversity of providers, which can be a good thing, but there's no hub coordinator in many cases. So that having a managed care plan and their care coordination team and their partners can help better coordinate care and can help organize care for individuals getting better referrals than sort of the fee-for-service structure that many duals are enrolled in. Next slide.

Anastasia Dodson:

Okay. So this just gives a little more detail on the changes in 2022. Again, you can see in 2022, we also have the voluntary In Lieu of Services or Medi-Cal managed care plans and changes in 2022, we're going to talk about a little bit later around look-alike Medicare Advantage plans. And then the end of 2022 is when the Cal MediConnect demonstration will end. And then in 2023, we'll be transitioning to an aligned enrollment structure. In 2023, again, is carving of long-term care and carving of dual eligibles into Medi-Cal managed care. All right. And then in 2025, that's where there's aligned enrollment with D-SNPs in non-CCI counties.

Anastasia Dodson:

Let's keep going. Okay. The Master Plan for Aging. I think you're all familiar with is a major effort led by the California Department of Aging to bring together stakeholders, experts and develop a 10-year plan that includes a list of 130 initiatives under five bold goals. That is for both at the state level, the national issues and local issues with best practices for local communities. It was a significant effort, and in some ways, of course, COVID made things difficult for us all to communicate and stay connected, but the work on the Master Plan continued throughout the year, last year. And so we really have this wonderful blueprint now that we're going to be discussing a little bit more, but that informs the work that we're doing here today. Next slide.

Anastasia Dodson:

Okay. These are the five bold goals for the Master Plan for Aging. And I really want to recognize that topics that we're going to talk about in this work group cut across all of these areas. And as it should be because we're talking about the whole of a person and the whole of their care. And so housing, health, inclusion, avoiding isolation, caregivers, caregiving, and affording aging, all of those themes cut across the work that we will do here. And so we'll very much rely on the work of stakeholders and experts in the Master Plan for Aging. Next slide.

Anastasia Dodson:

Specific to health, these are the strategy areas in the Master Plan for Aging. And so again, all of these areas cut across the work that we will do here. Bridging health care with home, health care as we age, lifelong healthy aging, geriatrics, dementia, and nursing home innovation. All of those are themes that we will be mindful of and then draw from the recommendations from the Master Plan for Aging as we develop the policies here. Next slide.

Anastasia Dodson:

These next two slides... I'm not going to read each one, but these are the key components of the Master Plan for Aging that are related to DHCS or Medi-Cal programs. And so, again, it's very comprehensive and consistent with where we're going in CalAIM and the Master Plan for Aging. Again, ECM and In Lieu of Services, those will be foundational pieces for meeting the needs of people and having flexibility in those services and benefits. Having a coordinated approach to address Alzheimer's and related dementias. Highlighting the value of palliative care. Exploring different methodology changes for skilled nursing facilities. Let's go to the next slide.

Anastasia Dodson:

Housing for health, integrating older adult behavioral health needs in the Behavioral Health Task Force, modernizing the Medicare Savings Program. And then we're also... In the Master Plan for Aging, one of the components for DHCS is to establish a new Office of Medicare Innovation and Integration, and look at innovative models, not just for dual eligibles, but for individuals receiving Medicare only. That is a significant new effort that we'll be undertaking and we'll be presenting and discussing more throughout the spring on the rollout of that effort. And then, again, many of you as part of the Master Plan for Aging, participated in discussion around looking at a universal LTSS benefit and opportunities for federal and state partnership there. So we're going to keep that on our radar in these meetings as well. Next slide.

Anastasia Dodson:

This is an issue that was mentioned in some of the previous slides. DHCS is developing a grant proposal through the Money Follows the Person to accelerate LTSS system transformation and expand Home and Community-Based Service capacity. So there'll be a webinar on February 17th, but we're very excited about this effort as well because this will help us have a more definitive roadmap, gap analysis and a way to teach many of these components together. Next slide.

Anastasia Dodson:

So now we're going to the real crux of the technical transition issues from Cal MediConnect on a D-SNP aligned enrollment policy. Before we dive into this next section, Hilary, was there anything from the chat or anything that we should clarify?

Hilary Haycock:

So I think most of the questions in the chat are mostly about the Expanding Access to Integrated Care for Dual Eligible Californians policy.

Anastasia Dodson:

Great.

Hilary Haycock:

So, I think let's go ahead and walk through that and anything that we don't answer in the presentation, I am flagging for us to get after.

Anastasia Dodson:

Great. Okay. All right. Next slide. So we're going to start with some definitions and then go into further technical information, but before we start... Again, I want to flag that this policy is very, very similar to what was released in February of 2020. And we had a great in-person discussion right before the pandemic really got much bigger. So, we don't want to necessarily kind of recover all of the detail, detail, detail, but if we find that we need to at a future meeting, we can certainly do that, but there are not major changes in this current iteration with CalAIM. Some of the dates have changed as far as the carve-in of long-term care and dual eligibles, but the fundamental piece about aligned enrollment state is the same.

Anastasia Dodson:

Okay. So, Dual Eligible Special Needs Plans, those are Medicare Advantage plans, but they provide specialized care for dual eligibles. A new word that we're going to... The acronym we're going to start throwing around here is SMAC, the State Medicaid Agency Contract and a D-SNP-

Anastasia Dodson:

Track and D-SNPs must have a SMAC, special contract with the state Medicaid agency, which in our case is DHCS. D-SNPs also has a contract with the federal government for Medicare benefits. But the important thing for this workgroup that we really want to focus on is the SMAC, the contract requirements that the state has for a D-SNP, and also note that DHCS can choose whether to contract with specific D-SNPs. Next slide. Oh, and one more thing as we talk about SMACs is that we have posted the current SMAC contract for calendar year 2021 on the DHCS website on the MLTSS workgroup webpage. And we are in the process of building out a webpage with more information about D-SNPs, but we do have that contract language there.

Anastasia Dodson:

So a D-SNPs definition is, different then Cal MediConnect. Again, we had a lot of acronyms here, but we didn't want to take up too much space here. So CMC stands for Cal MediConnect. Cal MediConnect plans, they coordinate dual eligible member Medicare and Medi-Cal benefits under a single health plan and single contract. D-SNPs, they include Medicare benefits and coordinate with Medi-Cal benefits, but the D-SNP itself does not have the Medi-Cal benefits as to the contract. The Medi-Cal benefits are provided through the Medi-Cal managed care plan, but the D-SNP is expected to coordinate on Medi-Cal Medicaid benefits. And currently, dual-eligible beneficiaries can

enroll in D-SNPs without enrolling in the corresponding Medicare managed care plan. Next slide.

Anastasia Dodson:

So, the vision was aligned enrollment, and this is really important. And trying to learn from other States and our colleagues from CMS are helping with this, that dual-eligible beneficiaries will receive integrated and coordinated care through aligned D-SNPs and Medi-Cal managed care plans. And that the same health plan organization would have those both a D-SNP and a Medi-Cal managed care contract. So that same organization, that same plan provides both the Medicare and the Medi-Cal benefits. And that aligns program in fiscal incentives allows for better care coordination. And again, similar to Cal MediConnect with the same health plan, but just two separate contracts. But again, aligned incentives, if the same health plan covers care for both Medicare and Medi-Cal.

Anastasia Dodson:

We're going to talk more in the additional next slides about what aligned enrollment means, and how the individuals coming out of Cal MediConnect and moving into it, will work but effective in 2023 in the seven CCI counties. That's where we will start with aligned enrollment, having the same health plan for both Medi-Cal and Medicare benefits. And then in 2025, no later than 2025, it could happen sooner. We will have aligned enrollment in the remaining counties outside of CCI. Next slide.

Anastasia Dodson:

Okay. So more specifically in 2023, Cal MediConnect members will transition to aligned Medi-Cal and D-SNP plans that are operated by the same parent organization, as their plan beneficiaries that are already in non-aligned D-SNPs. When aligned enrollment is effective can stay in their current D-SNP, new enrollment into non-aligned D-SNPs will not be permitted after the aligned enrollment is effective. A lot of words, kind of complicated, but we have this again, this is no different than what we proposed last year. And if you need further details, I invite you to look at the aligned enrollment document that we have posted.

Anastasia Dodson:

In 2025, then all Medicare health plans in the remaining non-CCI counties will be required to operate D-SNPs in all service areas that they operate as a Medi-Cal managed care plan. Next slide. So just basic information, I'm sure you're all aware, but Medicare managed care enrollment is not mandatory. Again, this is on the Medicare side. Medicare managed care enrollment is not mandatory, but so, and individuals in Medicare fee-for-service will not be passively enrolled into Medicare managed care under aligned enrollment. Individuals that are already enrolled in a Medicare plan will remain enrolled in that Medicare advantage or D-SNP plan, except for individuals and look-alike plans. And we're going to get to that in just a sec. Next slide.

Hilary Haycock:

I think we have pitched to Kerry at some point in here, right?

Anastasia Dodson:
Oh, sorry. Yes.

Kerry Branick:
Thanks. Can you hear me?

Hilary Haycock:
Yes. Thank you.

Anastasia Dodson:
Okay.

Kerry Branick:
Thanks again for including CMS on the call today. And my colleague Gretchen Nye and Anna Williams are also listening very closely and we're really looking forward to a lot of feedback. As Anastasia mentioned earlier, we have been working closely with DHCS to plan for the transition to D-SNPs and the expansion of integrated care options for dually eligible beneficiaries in California, across the state. DHCS were highly interested in trying to carry forward aspects of Cal MediConnect that worked well for beneficiaries providers and plans and implement these as part of this aligned enrollment between the D-SNPs and a Medicaid managed care plan that are operated by the same organization.

Kerry Branick:
We have been, as part of this, also includes transitioning Cal MediConnect into this broader structure, and we've been working closely with the Cal MediConnect demonstration plans to plan for that transition. And the transition of the demonstration, particularly around the technical process for transitioning members that have enrolled in Cal MediConnect. We have done this before and moving beneficiaries from demonstration plans to D-SNPs aligned with Medicaid managed care plate, and Virginia, and the past, and so we have experience and lessons learned from those States that will be drawing on for this transition in California. CMA, really Medicare Advantage more broadly has at least two established processes for transitioning beneficiaries when there are changes in their Medicare health plans. For example, when this happens, sometimes a health plan may non-renew a product at the end of the calendar year.

Kerry Branick:
And so the Medicare enrollees in that product will move to other Medicare options offered by that organization. And so we'll be leveraging one or both of these processes that we have at CMS in close coordination with the plans and with the state. We want minimal disruption for beneficiaries that have chosen integrated care, and that have chosen these organizations for their Medicare and their Medicaid. The plans have been

working with us to provide feedback about these transition options and given us a lot of technical assistance on some of the technical aspects of it. We're working through some California and Cal MediConnect specific enrollment and eligibility nuances to help ensure that we have a smooth transition for as many beneficiaries as possible.

Kerry Branick:

We're very much looking forward to working with stakeholders through this group as well on and sharing more details about what the transition process will look like and including beneficiary communications for that transition and during this year as well. And I think I can pass it back to you Anastasia. Hopefully, you got to get a drink of water.

Anastasia Dodson:

Great. Thank you very much. Yeah, Kerry, we're very pleased and I'll say proud of the partnership that we have with you on this effort. And we really want to recognize that, what an important role Medicare plays in the lives of so many people in California and this effort really needs to be a close partnership. So then appreciate your help. So we can go to the next slide, I think. Okay. So this is a little more technical again, but very important. The crosswalk enrollment is where we will, again, in close partnership with CMS and the Cal MediConnect plans, there will be a process to transition dual eligibles from their Cal MediConnect plan into the aligned D-SNP and Medi-Cal plan that are going to be operated by the same parent company.

Anastasia Dodson:

This transition is called a crosswalk enrollment, and it's an automated process that we are going to be talking about further in the future meetings of this group and sharing with you all the technical, and processes that we'll be using, and how to communicate to beneficiaries providers, et cetera about this. If there is a D-SNP that is no longer available, the process we'll transition to all of those into a comparable D-SNP. For example, if the Medi-Cal re-procurement changes which D-SNPs provide aligned enrollment. Existing, recent health risk assessments and care plans are going to transition with those members being crosswalked. Again, we're going to work very closely with CMS and health plans on a technical process, and very closely with all of you on explaining it and thinking about how this process should be explained and noticed to beneficiaries, their families, providers, et cetera.

Anastasia Dodson:

The other piece I want to flag that we don't have time to kind of tackle today, but we're going to talk about at a future meeting is about individuals who are becoming newly eligible for Medicare, and they're already enrolled in Medi-Cal. So we're looking at allowing D-SNPs to get approval from CMS and DHCS, to enroll their existing Medi-Cal members into the aligned D-SNP when those members become newly eligible for Medicare because of age or disability unless the member chooses otherwise. So that's an important topic, we will certainly have that in detail and discussion presentation at each group. Next slide. I want to also emphasize that for these technical changes, these

crosswalk enrollments, et cetera, our DHCS teams that work on the enrollment processes will be working hand in hand with the CMS teams.

Anastasia Dodson:

And so it's not just a policy issue, but it is a technical issue that we're really committed to having it go smoothly. So we know there are some folks on the webinar here from our managed care operations division. Just want to give a shout-out to them for the work that they'll be doing on these technical transitions and Hillary, should I hand it over to the managed care team for a few minutes, or are we should we just keep going?

Hilary Haycock:

I think we should just keep going.

Anastasia Dodson:

Okay. So, look-alike plans are Medicare Advantage plans that are designed and marketed to dually eligible beneficiaries. But unlike actual D-SNPs, they do not have the same requirements, they don't have that SMAC contract to provide care coordination with Medicaid benefits. This is an issue that CMS has identified as a need for policy change, and so last year they finalized some regulations and they now will in the future restrict enrollment in these types of plans. And we did see that enrollment in look-alike plans increased in CCI counties because we limited D-SNP's enrollments in order to promote Cal MediConnect. So that these look-alike plans don't have the same limitation as D-SNP plans. So next slide. And this slide describes the new policy that CMS will implement, and they will not be entering into contracts with new Medicare Advantage plans, that project 80% more of the plans enrollment and titled to Medicaid, which is what a generally a look-alike is.

Anastasia Dodson:

So starting in 2022, that will be a change. And CMS will not renew contracts with Medicare Advantage plans, except for SNPs that have very high enrollment of dual eligibles. So, beginning in 2022, the state – DHCS - will allow an early crosswalk of some look-alike plan enrollees or health plans that have Medi-Cal managed care contracts. And that is a new policy that it's reflected in the CalAIM proposal. And it's also flagged in our budget trailer, the language that's also on our website. And we'll happy to talk further in future meetings about this issue, but we want to flag it here. Next slide. Okay. This is some more detail about the transition and enrollment policies, both for duals in non-aligned D-SNPs like they can stay in that D-SNP, but the D-SNP will not be allowed to enroll new members after aligned enrollment takes effect in the county.

Anastasia Dodson:

Delegated managed care plans. DHCS is going to work closely with CMS to make sure that we figure out a strategy to allow choice maintain aligned enrollment. So we will be working on that, that's a significant population and issue in some counties, and marketing and brokers will require D-SNPs to target their marketing, to manage care enrollees, and have enhanced training requirements on integrative care, health planets,

cultural responsiveness. Next slide. And again, all of this is detailed in our February 2020 paper, and we'll make some few minor updates, particularly around these look-like, when we update that paper in a week or two.

Anastasia Dodson:

For the integration requirements for 2023, again this is all detailed in our policy paper, integrated member materials, including dementia specialists for care coordination, coordination with carved-out LTSS benefits, such as IHSS, it's really essential, consumer involvement in existing D-SNP governance structure. Joint DHCS, and CMS contract management teams, and as much as possible, DHCS and CMS audit coordination. Next slide. So the last piece I want to mention is that beginning in 2021, the current year D-SNPs have new data-sharing requirements for hospital and skilled nursing facility admissions per federal requirements for at least one group of high-risk full benefit, dual eligibles.

Anastasia Dodson:

For 2021 DHCS our policy to implement this requirements has D-SNPs sharing hospital and nursing facility, admissions data with the state on a monthly basis. And we will be using that data and working with you all to develop an updated data sharing policy for 2023 in alignment with the other CalAIM integration policies. We think that data sharing is a really important way for integrated care to occur. But there's a lot of technical things that need to get worked out in order to make it work. So we'll be communicating with all of you and getting your feedback as to what we can put into the SMAC contract for 2023 to make this work well. Okay. So I'm going to the next one.

Hilary Haycock:

It's time for our discussion. So I know you all have been waiting patiently, and we have a lot of questions that are coming to the chat that we are organizing. And we'll ask our DHCS and CMS friends, at first, we've had some folks who have been patiently waiting with their hand raised, so we want to go to them first. So Jeff Thom, you are unmuted.

Regina Cabral-Jones:

Hello, this is Regina and I work closely with Jeff. Actually, I'm the president of the local chapter of the California Council of the Blind in Sacramento. And he asked me to attend on his behalf because he's meeting with the legislature at the moment. So I'm concerned in everything we've read and your presentation today, there is nothing about integrating audio or visual services into long-term care and older adults lose their sight at much higher rates. In fact, that's our highest growing blind population and it requires rehabilitation. And I'm imagining something similar for those that go deaf later on in life because it's not something you're used to, they live 60, 70 years without having that particular challenge. And it's not like me who has the challenge and is lived with it. It's a very daunting process, and I'm concerned that there's nothing in the long-term care that addresses that population, which is actually has a great number of people that are of color as well.

Anastasia Dodson:

Thank you very much. Yes. So we will, in development of the policies, absolutely. That is a very important requirement for health plans for the state for communication and in combination with the upcoming requests for topics. So let's, let's look at ways that we can incorporate that topic into our future discussions. Very important. Thank you.

Hilary Haycock:

Great. Thank you. We will now go to Peter Hansel.

Peter Hansel:

Hello. Can you hear me?

Anastasia Dodson:

Yes.

Peter Hansel:

Okay, thanks. Thank you, guys. Great overview. Few questions around the line, D-SNP policy, maybe for clarification. So I guess the point I want to make... I'm with CalPACE. We're representing the PACE plans. So PACE is also out there doing integrated care, fully integrated. And I guess the question is under the mechanisms that you're contemplating for coordinating or aligning coverage, do people have access to PACE in that process? So things that do concern us a little bit are unmet across blocks, things that may be diminished choice in the process, we would be very concerned if anything impacted the special election periods for PACE. I think continue to get us to the Medicare level. So, any further clarification, we did submit pretty extensive comments on this, on the initial policy draft and look forward to seeing the revised version as well. Thank you.

Anastasia Dodson:

Thank you. And we do absolutely recognize PACE as an important program array of services providers for integrated care for dual-eligible. It's a really showcase program in many ways, but we also want to make sure that statewide, we have access for dual-eligible. So we have both, we'll have PACE, we will have aligned care through Medi-Cal managed care plans and D-SNPs, and then we will have choice on the Medicare side in particular for other Medicare advantage. So all of those choices will remain and I'm happy to work with you on how that's communicated.

Peter Hansel:

Great. Thank you.

Hilary Haycock:

All right. I'm going to pull out a question from the chat before we go to our next participant who's raised their hand. There's a couple of questions about how the Office

of Medicare Integration and Innovation is going to interface with these efforts. So, I don't know if you have another couple of words to say about that, Anastasia.

Anastasia Dodson:

Sure. Well, we have a vision that we try to articulate in a brief description in our budget documents that this new office will be tackling issues such as integrated care for duals, as well as benefits and opportunities for Medicare only individuals. By having basically both of the aligned enrollment and the Medicare office at DHCS, we will be internally coordinated, we will have sort of coordinated conversations with the federal government because of course, CMS is a huge partner in this. And we want to look at ways that we can partner even more with the federal government on these innovative efforts. And frankly with the Medicare Advantage plans because the same plans that have D-SNPs also have often Medicare Advantage products.

Anastasia Dodson:

So it's a conversation with all the same partners, but just for an additional population. And again, looking at benefits that can be added to Medicare Advantage, looking for ways to better communicate about utilization of those benefits, and thinking of ways that we can better partner with the federal government. So all of those things are we have in mind and we'll be working on a more detailed proposal in the spring as part of the process to line up the resources there. And we can add those topics to this workgroup as appropriate, but again, we want to make sure first and foremost, we're working on the technical changes that we need for 2023.

Hilary Haycock:

Great. Debra Cherry. We're going to, we have un-muted your line.

Debra Cherry:

Thank you. And thank you for allowing all of us to have input in this very, very important discussion. I wanted to just say that as an advocate for people living with dementia, I really want to applaud you all for keeping the dementia care specialists in the new CalAIM contracts. And I also applaud keeping health risk assessments with the person as they transfer over, especially since we struggled so hard to have cognitive screening put into those health risk assessments. But there seems to me that there were other lessons learned during our five years, six years of doing Cal MediConnect for people with dementia. And so I would like to just urge you to consider not just having dementia care specialists exists, but having some sort of suggestion of when high-risk members with dementia should be cared for by them because our dementia care specialists actually did not have many caseloads of people with dementia in Cal MediConnect.

Debra Cherry:

I also want to encourage you to have the plan do more or continue to do screening of high-risk people for cognitive impairment. These could be people who are high utilizers or people with multiple chronic conditions, and cognitive impairment, who then would be identified and get assigned to the dementia care specialists and get specialized

supports. And then finally, a lesson learned in Cal MediConnect for people with dementia was that it was really helpful to have them look plans, identify, assess, and support family caregivers. And in fact, if that didn't happen very little happened for a lot of Cal MediConnect and reliefs with dementia. So I believe these things can be done, they aren't that complicated and they can lead to improved care. And I hope you'll consider it if you want me to write it up, I'm happy to write it up. Thank you all.

Anastasia Dodson:

Thank you very much. Is there, because I know there was a team that worked in Cal MediConnect around dementia issues, and I believe there were even recognized with some awards. So of course we want to keep all those policies and we want to make sure that they're properly lined out in decent contracts, et cetera. But yeah, if Hilary, do we already have sort of a connection there, or do we need to build that out?

Hilary Haycock:

I mean, I think this is definitely one of the topics that we want to be working on with stakeholders. We've clearly committed to carrying, not just the dementia specialists, but best practices into the aligned D-SNP and MLTSS framework. And so I think as we move forward with and our various workgroups with developing sort of what does that model of care look like? I think that is definitely going to be an area where we are going to tap your expertise, Debra, as well as your colleagues and other Alzheimer's associations, to make sure that we've got really, all of the lessons learned, fully loaded into the new framework moving forward. Because there's been so much great work done and we really want to be carrying that forward. You guys have done really amazing work with the plans to make strides and say we're definitely committed to helping keep moving them.

Debra Cherry:

Thank you.

Hilary Haycock:

Don't worry Debra, we're going to wrangle you into these work groups. Great. And there's been a few questions in the chat about how are we going to be supporting coordination across the Medicare and Medi-Cal benefits, everything from prescription drugs to various LTSS services. And so, I don't know, Anastasia, if you want to talk a little more, but I think that's part of the conversations we want to be having about working with stakeholders, and how are we better developing robust care coordination requirements for D-SNPs and Medi-Cal plans and serving this population. That's part of the goal of this conversation.

Anastasia Dodson:

Absolutely. And we will need to take a look. And that's why we're starting this work group now, frankly, is to prepare for 2023 so that if there's a language that needs to be included in the D-SNPs SMAC contract, we have the right language there. If there's language that needs to be included in the Medi-Cal managed care contract, whether it's

ECM and In Lieu of Services or other requirements that that language is there. And making sure that all of the important partners, whether it's CBAS, skilled nursing facilities, CCT, California Community Transitions, all of the MSSP, all of the partners, IHSS, other area agencies on aging, all of the partners, as well as providers, primary care physicians and hospital discharge planners. All folks are part of the conversation so that we're taking what's already working and adding to it in a way that makes things better. And again, data sharing as well, tackling that. So, that's why we need this work group, honestly though, there is more work to be done and we need your input both on the documents and then the communication.

Hilary Haycock:

Great. All right. We will go to... well let's see if I can say this correctly – Regin Mathew, you're unmuted. Regin Mathew? All right, we'll come back to you if you put your hand back up, we promise. Janine Angel?

Janine Angel:

Good morning or afternoon, depending upon where you are. Everyone, thanks for having this today and allowing this forum for us to ask questions. So I have a lot of questions because I'm responsible for a lot of making sure that a lot of this fall for us. So when we are thinking about the integration of members who are in our D-SNP and in our Medi-Cal plan, the biggest thing for us is trying to make sure that they have that single set of materials, the single set of their provider network of all these other things. And so for us to do that, and I think in a very seamless way, is to almost treat the member like they are in committee connect in a single plan in our systems.

Janine Angel:

So it makes it difficult for us, especially since we have multiple systems, depending upon which plan the members are on today. To do that, I wanted to understand number one, if there were any requirements that the member be... I'll call it their membership records physically be into two separate plans or is it up to the health plan to determine how they're going to systematically hold the membership record so that we can process the TOR, that we can process all the files from the state? Is there any requirements or restrictions for the health plans on how we do this in order to make this the most easily administrated, aligned enrollment situation that we can? That's my first question.

Anastasia Dodson:

Thank you. That's a great question. And I think our CMS colleagues and perhaps our managed care team, they may have thoughts particularly around the enrollment process to make sure, because we recognize that can be an area of risk if that's not shared correctly. But then I think maybe there's a second layer to that question, which is the encounters, the services that are being utilized and service providers and how those are being shared across Medicare and Medi-Cal, and what electronic medical record system is being used. So perhaps we'll start with CMS. Do you have any thoughts on that? And then we can also check with our managed care team.

Kerry Branick:

I think we would largely defer to the state or the health plans on how they can innovate to try to integrate their systems as much as possible internally. The plans offering, D-SNPs will be required to be compliant with all... And Medicare Advantage and D-SNP requirements. It's not necessarily to the extent we've perhaps waived the requirement in Cal MediConnect, that waiver wouldn't be in place anymore. But I would think that there would be certainly opportunities for you to integrate internally in your systems or at least improve the coordination and communication across both.

Janine Angel:

Got it. Thank you. I have another question with regards to... And I don't know if it's going to come out in any formal policies this year, is what are you guys anticipated or are anticipating specific reporting requirements when it comes to members in an aligned enrollment? So things with regards to the care coordination or with provider networks, or with appeals and grievances or contexts, and outside of the current existing part C and part D reporting that we have for CMS on the D-SNP or outside of what is currently required for our Medi-Cal MCP. So just trying to make sure that when we are looking to build these plans out, that we make sure that we are capturing data elements that would be needed to support any of the reporting for these members who are in an aligned enrollment scenario.

Anastasia Dodson:

Thank you again, I'll turn back to Kerry in just a moment, but I appreciate that comment because it's reminding me to mention that we do have a dashboard for Cal MediConnect that highlights not just in enrollment, but also things like appeals and grievances and other measures to show what's happening in Cal MediConnect, and then we'll look forward with aligned enrollment thinking about how should we modify that dashboard, and how can we modify it even now to reflect any other priorities that folks have.

Anastasia Dodson:

And so, yes, we will continue to have requirements that encounter reporting as well as appeals and grievances so that we're able to monitor and appropriately ensure that our managed care plans are following the requirements, monitor quality, but also in thinking about data sharing and back to the federal requirements around sharing hospital, skilled nursing facility, admissions and discharges, to the extent that we need to modify those requirements and we'll continue to develop them so that whether it's primary care providers, discharge planners, home- and community-based service providers as appropriate, get that information so that there is a coordinated and integrated system that will be something we'll be looking at. But Kerry is there more, would you like to add?

Kerry Branick:

Just to confirm, Janine, where you started that all the existing part C and part D reporting would continue to be a requirement, and then if the state wanted to require

additional reporting around aligned enrollment towards some of the other examples that have been discussed, we would defer to the state for that.

Janine Angel:

Okay.

Kerry Branick:

I don't recall actually, sorry if this was on one of the slides earlier, but one of the things we have discussed in the past is trying to, as another example of a promising practice from Cal MediConnect connect has been the contract management team, the joint CMS and state partnership to work, to join together and hold calls with the plan. We don't have a three-way contract in the same way with D-SNP and Medicaid managed care plans, but we do look forward to opportunities to continue to work with the state and the health plans in a collaborative way and something like that. And so, I could imagine that joint group might continue to ask plans occasionally for feedback and information about how aspects of integration are going through that vehicle as well.

Hilary Haycock:

Great.

Kerry Branick:

Thank you.

Hilary Haycock:

And Janine, I encourage you to take a look at the policy paper. We have a whole section where we talk about the department's proposed approach to thinking through reporting requirements.

Janine Angel:

Thank you.

Hilary Haycock:

So that language back to you. So thanks, Janine. Great. We have a question or comment from Cynthia Jackson.

Cynthia Jackson:

Sorry. It took me a second to unmute. I have a question about how behavioral health or mental health fits into this whole picture and the carve out and how that... I know how it worked. I pretty much know how it worked under the Coordinated Care Initiative, but I'm interested in how it's going to work with this for the dual eligible population. And I'll tell you, one of my very specific interests is the full service partnership program. When I look at the people with whom we work that have long-term severe persistent mental illness are homeless and have lots and lots of other stuff going on, they may very well be dually eligible, but in terms of behavioral health, it truly has needed to be carved out

and be within the county contract system. So what is that going to look like? That's one population. There are others, of course, but what is that going to look like? Because behavioral health has been such an underserved area for older adults and the dually eligible population in general.

Anastasia Dodson:

Thank you. I'm so glad that you chimed in and we really need your expertise and leadership on this. So, this is an area that as you know, with Cal MediConnect for specialty mental health and IHSS, both of those programs they're carved out of our Medi-Cal managed care and Cal MediConnect, but there is an expectation for coordination with the county on both of those programs. And we really need to keep that in a very strong way with the aligned enrollment. And so we want to make sure, because there is some language right now in the decent SMAC around that, but we're very happy to strengthen that and look for ways beyond just the language. But if there's technical assistance, if there's convenings, those programs are so essential or dual eligible.

Anastasia Dodson:

And also, I'm really appreciating that you are flagging that for us, those are not a homogenous group, that there are folks that variety of concerns and needs and goals. And we do want to hold the managed care plans accountable to meeting the diverse needs of those populations even back to ECM and In Lieu of Services, addressing social determinants of health and giving the managed care plans lots of tools and lots of requirements for how we have expectations for them to meet the individual needs of beneficiaries. So thank you. And yes, we're going to make that an important topic to proceed with this call.

Cynthia Jackson:

Thank you so much. I'm really glad to hear that.

Hilary Haycock:

Lots of questions about very similar to that, about behavioral health in the chat. So thank you Cindy, for asking that question on behalf of a number of people, and definitely sounds like a topic we should dig into in the work group. Jane Ogle, you're unmuted.

Jane Ogle:

Thank you very much. I was so excited. My hand was shaking to hit the unmute here. First of all, congratulations. I'm really delighted to see this forward. And I think you guys are doing a wonderful job. I wanted to just put on the radar 2024, or ‘25 and expanding into the rural counties. One of the issues with going statewide, which I applaud absolutely is just the difficulty in having the network and having providers and everything to comply with CMS requirements. I'm wondering if you have considered other financial models that CMS is offering or just, is this going to be an agenda item going forward, but basically congratulations guys.

Anastasia Dodson:

Thank you, Jane. And excellent point. I'm glad you raised it, and I thought I saw something in the chat about this, that we do also want to recognize both for duals and for Medicare only beneficiaries that CMS has been developing new models. And we have had some initial discussions with CMS and want to keep that dialogue going about geo models or other areas where dual eligibles and Medicare-only would be impacted. And we're pleased that there is not necessarily going to be any impedance of our aligned enrollment policy that either all positive, additive options, especially for individuals who do not select either decent or Medicare Advantage. So, fee-for-service on the Medicare side, duals keeping options and innovation there. But back to your other point, though, about the network for rural areas on the Medicare side, that is something that's on our radar.

Anastasia Dodson:

And we are glad to have further dialogue about that. I'll turn it over to Kerry from CMS, if she has any further thoughts on this.

Kerry Branick:

No, I don't think so. I think you raised good points then. Well, try to work with plans on the state, if we do face those barriers.

Anastasia Dodson:

But I do want to say that is still our policy. We're still committed to that in the 2025. No later than 2025. So we want to find solutions that meet the requirements, reflect the particular nature of different rural communities. But we do want to keep that as a goal and as our policy.

Hilary Haycock:

Great. Thanks, Jane. Always lovely to hear from you. Elizabeth Zirker? You have unmuted your line.

Elizabeth Zirker:

Hi, can you hear me?

Hilary Haycock:

Yes.

Elizabeth Zirker:

Hi. I'm Elizabeth Zirker, I'm from Disability Rights California. Thank you for the presentation today. I have a couple of questions or points. One of them is really around access to care at tertiary hospitals and specialists for dual eligibles and issues that we see at DRC with someone who might be in original Medicare, but in a managed care Medi-Cal plan, who is not able to go to see a Medicare provider because of the connection to the Medi-Cal managed care plan, including people who really need to

stay in original Medicare and fee for service, based on who will treat them for their complex medical condition.

Elizabeth Zirker:

And that may be an issue around providers and their choices. But I think it's a really important thing to keep in mind for people with complex medical issues, because it comes up for us where people cannot get care because of the configuration of their Medi-Cal and Medicare, and also for hospitals that don't want to take people in a Medicare plan and want to deal only with original Medicare.

Elizabeth Zirker:

So that's something that's, I think that is a huge issue for some of the people that we serve. And I guess the other thing that I would like to see talked about or explored is access to DME. This is another area where it is incredibly complicated for people who have both Medi-Cal and Medicare. And if depending on the configuration to get DME authorized, to get what they need. And so I think an integration could be really excellent, but I also think, as we're looking at this, that's a huge area where we have people waiting for over a year, year and a half to get their new power chair due to issues around being insured by both Medi-Cal and Medicare. So those are just two points I wanted to make.

Anastasia Dodson:

Thank you. Really great point. Thank you very much.

Elizabeth Zirker:

Sure.

Hilary Haycock:

Great. All right. And we will now turn to Denny Chan.

Amber Christ:

Actually, it's Amber Christ, with Justice in Aging, it's so great to see you all, and I will do my best to channel Denny. So, I wanted to raise baking in and at a higher level, the need to address the inequities and disparities we see in the duals populations, speaking about how they're not a homogenous group and thinking about that all the way up to that side about the CalAIM goals and making sure that we're being very explicit there, that we want to be addressing these disparities, as well as through every single policy we're thinking through, from outreach to provide –

Hilary Haycock:

We might have lost you, Amber. We will go back to her if we can, but certainly a really important topic that she raised regarding disparities and inequities, which we know are a huge issue for this population and is definitely on our radar.

Amber Christ:
Can you all hear me? I can't hear you now.

Hilary Haycock:
All right. It looks like we're having technical issues. Zoom, just a minute to sort itself out. It looks like folks are mostly... Looks like audio is mostly back.

Amber Christ:
I'm speaking.

Hilary Haycock:
Great.

Amber Christ:
I'm speaking, can you hear me?

Hilary Haycock:
Yes, we can hear you now. All right. Fun with technology.

Amber Christ:
Can you hear me?

Hilary Haycock:
Yep, we can hear you, Amber.

Amber Christ:
Could you hear me before?

Hilary Haycock:
We heard the top, but then we lost you. So I think you were asking a question about inequities and disparities in the duals population.

Amber Christ:
Yeah. So I was just saying that, could we be more explicit throughout from the beginning with the CalAIM goals and then just throughout each of the policies that we're thinking for from provider outreach and beneficiary outreach to the data that needs to be collected to make sure that we're tracking disparities throughout from the contract language and the SMACs and the decent contracts, and just making sure that we're centering that as a policy priority and every single area throughout the transition and the change in all of the different policy and contracts that we're developing here.

Hilary Haycock:

Great. Thank you.

Anastasia Dodson:
Thank you. And this is Anastasia. Can you hear me?

Amber Christ:
Yeah.

Anastasia Dodson:
Great. So, I want to also recognize that the work that the California Department of Aging has been doing on equity webinar, and that there's been a lot of good information there as well, that we do want to of course keep that issue and the connection to so many other issues in front and center, and that it does cross over into issues about provider network, language translation, all the different communication processes, as well as data reporting. So even back to the Cal MediConnect dashboard invite all of you, if you get a chance, to look at it consider how that dashboard might be able to incorporate equity measures and things that we can do now versus of course long-term as well. Thank you.

Hilary Haycock:
Great. All right. I think we have time for one more question before we move on to our next topic, but do want to let folks know that we are capturing all the questions in the chat, and we'll be thinking about how we can be answering those in FAQ's or other documents moving forward. So if you don't get your question answered, please know that we received it, and I'm working on how to get information out to folks. So our last question will come from Albert Lowey-Ball . Your line has been opened.

Albert Lowey-Ball:
Yes. Good morning. Thank you very much, Anastasia and Hilary for your great presentation on this. I just have a short but intensely pragmatic question. Can a Medicare Advantage plan with a D-SNP and a Medi-Cal managed care plan also with a D-SNP within a specific county after 2025, both get SMACs?

Anastasia Dodson:
If I heard it correctly, the SMAC is the contract between the organization with the D-SNP and the state.

Hilary Haycock:
Yeah, you cannot be a D-SNP without a SMAC, but Medicare advantage plans do not have SMACs because they are not intended to serve individuals who also have Medi-Cal or Medicaid.

Albert Lowey-Ball:

Okay. I was just wondering, because Medicare advantage plans, as I understand it can get separately, decent agreements with CMS.

Anastasia Dodson:

Yes. The same organization can... Yes, a particular health plan can have multiple contracts with CMS to serve Medicare beneficiaries, duals and non-duals. And they may have different product lines in different counties, both Medicare advantage, non-D-SNP, and D-SNP.

Albert Lowey-Ball:

Okay. Okay, thank you very much. That's an interesting though, somewhat confusing response, but I support it. Whatever. Thank you.

Anastasia Dodson:

Thank you.

Hilary Haycock:

We know this is incredibly technical and deeply wonky, weeds-y policy stuff. So we appreciate everybody hanging through with us and always happy to answer the technical questions because it's rough stuff. All right, so let's move on to our next slide. And I will hand it back to Anastasia.

Anastasia Dodson:

Great. So this discussion has been very helpful for us to hear about issues that are important and need to be prioritized. So flows right into the next section where we want to talk about what should we be focusing on in future meetings? So you can go to the next slide.

Anastasia Dodson:

So these are some of the proposed topics that we had thought of for the next few months, but in the meantime with the discussion we just had, behavioral health, networks, provider networks, DME, health disparities, social determinants of health, family caregivers, integrated materials, many other topics that have emerged and things that we knew, but we weren't sure where they should be in the priority list, inviting the Social Security Administration, care for people with dementia and Alzheimer's and thinking about how do we communicate PACE as far as one of the options we've already doing that, but continue to do that around the choices and then reflecting the needs of beneficiaries with hearing impairment or visual impairment.

Anastasia Dodson:

And how do those materials get shared in a way that they're readable or they can be heard by individuals with hearing impairment. So, we do – we know that this list on the slide right now is not a complete list. It's just a starting point. And so we'd really welcome your feedback on how we ought to prioritize the next few meetings. I'll say

there is one other issue. This lead plan policy that we have in mind to discuss in April and at the risk of getting too technical, I'll just try to stay... the Medicare and the Medi-Cal plans aligned enrollment means that same health plan is covering both the Medicare and the Medi-Cal benefits. But there is issue around the choice of the beneficiary and how that's effectuated. So if they choose such and such plan for Medicare, does that automatically enroll them on the Medi-Cal side with that same plan? Or is it if they choose a particular Medi-Cal managed care plan, does that automatically enroll them on the Medicare side? And what are the options there? How do we implement that? How do we communicate that? We'll just call that the lead plan policy for now because we do want to make it as least complex as possible and transparent as to how those choices get effectuated in working with high care programs, working with plans.

Anastasia Dodson:

So we're going to talk about that policy. We're planning to have that in April, and happily you won't hear my voice so much we're going to have presentations from experts and thought leaders on this and talking about the technical issues there. So that's what we have queued up as an example. Hopefully for April we also don't want to queue up an issue too soon. If there's still some background or technical things that we need to have ready because we want to make it a productive use of people's time. So that's one example.

Anastasia Dodson:

The SMAC contract provisions 2022. I want to let you know that for contract year 2022, for the SMAC contracts for D-SNPs, we have actually a very short runway to make additional changes in the SMAC contracts for 2022, just maybe six weeks or so, because of the timeline for those D-SNP plans to send their signed contracts and have those worked through with the State and with the Federal Government by mid-year 2021 in anticipation of the 2022 contract year.

Anastasia Dodson:

Bottom line, we don't think there'll be huge changes that we can make in the SMAC contracts for 2022, but we did receive some feedback already on some changes. So we'll look at those. And then for 2023, that's where there's a greater opportunity and a greater need to make changes in the SMAC contract. The Model of Care policies, which we'll talk about at a future meeting and how those intersect with Enhanced Care Management and In Lieu of Services, that's going to be an important topic. Communication and member materials and community engagement, beneficiary engagement, those are just essential topics that we want to reserve plenty of time at these meetings to discuss. And then the Long-Term Care carve-in, we may or may not need to necessarily dedicate a full meeting to that, but we can, and we do want to make sure that lessons learned from CCI are incorporated.

Anastasia Dodson:

Glad to hand it back to Hilary to solicit comments from all of you.

Hilary Haycock:

Great, thank you so much Anastasia.

Hilary Haycock:

And to just follow up on that lead plan policy, if folks got lost in that explanation, which was very clear, but again, we're doing real wonky stuff here. We will be developing sort of explainers and examples and doing a lot of pre-work for that meeting to make sure that we've got folks understanding what the policy is and lined up to talk it through perspective. So anyone super interested in that topic is more than welcome to contact us and let us know. And we will be working with a bunch of stakeholders say to put a productive meeting together on that.

Hilary Haycock:

We want to open it up for questions and comments. I'm going to ask folks to please limit your questions and comments to upcoming agenda topics and not to policy clarification questions because we want to make sure that we're getting really good feedback and developing a strong program for the work group going forward. And that we're really diving in on the topics that folks want to work through. And so we will go ahead and go to the folks who've raised their hands. Sarah Steenhausen, we will be opening your line.

Sarah Steenhausen:

Great. Can you hear me?

Hilary Haycock:

Yap.

Sarah Steenhausen:

Okay, perfect. Thank you so much for this really helpful discussion. I wanted to just build off your last suggestion on agenda items, Anastasia, which is in regard to lessons learned from the Coordinated Care Initiative. It would be great to have kind of a deep dive to refresh memories of what the lessons were from the evaluation of the Cal MediConnect program and how to apply that, but also to look at some of if possible data on MLTSS. I think there's a lot of questions. Something we haven't talked about for example, is the one other MLTSS program, which is a really critical program, the Community-Based Adult Services. There's a lot, that's unknown about how MLTSS worked for beneficiaries that were not part of Cal MediConnect and everywhere from care coordination, to referrals, to the Community-Based Adult Services program and nursing home use, et cetera. I know that there's not a lot of resources available for data collection and analysis, but anything that can be reported on and used as a topic for discussion, I think would be really helpful to inform the future direction of the MLTSS rollout statewide.

Anastasia Dodson:

Thank you. Great point.

Hilary Haycock:

Thank you, Sarah. All right. Susan LaPadula your line is open.

Susan LaPadula:

Hello, Hilary and Anastasia.

Anastasia Dodson:

Hi.

Susan LaPadula:

I would like to speak on behalf of the LTC carve-in. In reference to the skilled nursing facilities, majority of our residents are dual eligibles and currently with regular Medicare, we have a coordination of benefit trading partner agreement for those co-pays to automatically crossover to Medi-Cal. I'm hoping with the CalAIM program that we can address this in the future, not only for the CalAIM and the new alignment of benefits, but also for the geo plans. Is that something that's on your agenda?

Anastasia Dodson:

Great, it is now. Yeah. Thank you.

Susan LaPadula:

I've worked a little bit with Kerry. So perhaps if you need my assistance down the road, I've been in the business many, many years. I would love to help you with this because I did sit on the committee to make it happen for fee-for-service Medicare. But this really would be beneficial for state savings and also for your health plans communicating with each other on that automatic crossover of those insurances.

Hilary Haycock:

Great. We definitely got some comments in from other folks around the need to take a look at crossover payments. So it's definitely...

Susan LaPadula:

…and we learned that from the CCI rollout, it's been a tremendous difficulty for the skilled nursing facilities in the CCI counties. There is no coordination, it's just straight disconnect.

Hilary Haycock:

Great.

Susan LaPadula:

Anything I can do to help, please reach out and thank you all. Fabulous presentation. And it's an honor to hear all your voices, even Amber’s voice from the past when Cal MediConnect was being implemented. So thank you for all your hard work.

Anastasia Dodson:
Thank you.

Susan LaPadula:
You're welcome.

Hilary Haycock:
Amber is definitely CCI OG, always lovely. Thank you so much, Susan. That's very helpful. And we will put you on our long-term care list of folks to make sure we are pulling in.

Susan LaPadula:
Thank you.

Hilary Haycock:
Great. Janine Angel. We will open your line.

Janine Angel:
Hi everyone. Just a quick ask and what we want to look at in the next five months, I think for the health plans who are looking to implement what is shaping up to be pretty complex program, any heads up on things? For instance, like I said before, the reporting, but any specific expectations around integrated materials, integrated appeals and grievances, which I know exist on like the HIDE and FIDE SNPs side, but not quite sure how that's going to work here in California since we don't have HIDE and FIDE, anything regarding the State or CMS is expectations on addressing member call centers? If there's anything around eligibility notices and things like that.

Janine Angel:
Right now, when we have a D-SNP member and they move, we're able to take that updated address, our updated phone numbers and everything from the member directly. Whereas on the Medi-Cal side, we're more kind of, I'll call it limited to the files that we get from the State. And those members are needing to do a second step to go and notify HCO or their social worker, whoever they need to update for that demographic and stuff.

Janine Angel:
I just want to see if we can maybe have some early expectations provided to us in the next few months. Because, those are going to help us shape how we operationalize this for the most effective way to not only meet the expectations of the State and CMS, but also make sure that we design a plan and a process that is as smooth for our members and providers who this is going to be kind of new for all of them and the communications that need to go out. So the sooner we can understand those things,

that's my request. So thank you in advance for all of that. And again, just like the last person I'm happy to participate in any detailed discussions on health plan impacts or some of these things that we've already uncovered that are looking like they're going to be a little bit of – to jump over with this program, so thank you.

Hilary Haycock:

Great, thanks.

Hilary Haycock:

All right. I'm trying to focus on other folks in the chat who haven't spoken yet. Regin Mathew? We're going to try to this again. I'm going to apologize again. Your line is open. I hope I pronounced that correctly.

Regin Mathew:

Yeah. Hi. Can you guys hear me?

Hilary Haycock:

Yeah.

Regin Mathew:

Awesome. Sorry about that. I had some technical issues last time. Yeah, it's Regin. No worries. People get that wrong all the time, but this was great. I just wanted to say first off I think it's great that we're pushing toward aligned enrollment for D-SNP, and I think it's a great policy. One question that I had, and maybe this is a future topic, but are we going to kind of discuss the impacts of what happens to D-SNPs in counties where they don't offer a Medi-Cal plan? And they're just contract alone, if they're not involved in Medi-Cal in that county, what will happen to the enrollment for those plans? And is that kind of a future agenda item that we'll touch on?

Anastasia Dodson:

All right. We do have a description of the policy in our policy document. And we recognize there will be some individuals who will be in D-SNPs that had started even prior to Cal MediConnect, but prior to this aligned enrollment policy that we'll have in, some counties in 2023 and others in 2025. But we want to promote aligned enrollment. And so to the extent that, and there's not perhaps a one size fits all solution, but our expectation first off is for D-SNPs to be engaged in coordinating Medi-Cal benefits. That's part of the D-SNP contract requirements. And then, if there are partnerships that D-SNP that's not a Medi-Cal plan wants to look at with a Medi-Cal plan, perhaps that is something to consider, but sure. And we're glad to have that as a future discussion topic as well.

Hilary Haycock:

Great. Just another pitch for folks, there's a lot of detail in that policy document and definitely recommend taking a look and emailing us if you have any follow up questions

at the county inbox, and we'll have that email address on the screens shortly. Next, we'll go to Pat Blaisdell.

Pat Blaisdell:

Good afternoon. Thank you for this great presentation and for the opportunity to weigh in. In terms of future agenda items, I would like to suggest that we do some deep discussion on the appeal process. I think that, that's been an area of great concern in managed care in general, but in particular, when we have both managed Medicare and managed Medi-Cal. The managed care appeal process doesn't really allow for a real-time appeal. That is something that can help make a determination in a timely manner to allow for access if, for example, somebody is being asked to leave the hospital and go to another level of care.

Pat Blaisdell:

I think the appeal process can be quite confusing and doesn't really allow for individual beneficiaries to talk to someone and get an objective review in the Managed Care setting as it does in the traditional fee-for-service setting. So again, I'm starting to go down that wonky road that Hilary's been referencing, but I think a clear discussion on appeals and how we might be able to support a real-time beneficiary appeal process to promote appropriate access to care, especially when they're changing levels of care or moving among in between Medicare and Medi-Cal benefits.

Anastasia Dodson:

Great. Thank you so much. That's such an important issue. You're right. Thank you.

Hilary Haycock:

All right, we'll go to Lisa Hayes. Your line is being opened. Just one minute. Go, Lisa.

Lisa Hayes:

All right. Great to see you guys. Hi, Hilary.

Hilary Haycock:

Hi!

Lisa Hayes:

I am here representing the California Foundation for Independent Living Centers. We represent 20 plus independent living centers throughout the State of California, and a couple of my questions or hopes that we're going to be talking about or looking at. I'd like to see how the health plans used care plan options to improve... to keep people out of nursing facilities and how they enhanced independent living options for the consumers that we represent. I'd also like to see in this new CalAIM how we're going to ensure that there's some accountability for the health plans to avoid nursing facility admissions and how we're working with home and community-based services to avoid that. And how can we leverage? I know that there was some discussion about money

follows the person and how we can leverage the Aging and Disability Resource Connections, the ADRCs to end the CILs, the independent living centers to use that money follows the person to keep people, either transitioning out of nursing facilities and to keep them independent in their own homes. So those are the kinds of things I'm hoping we can address as we move forward. Thanks for your time.

Anastasia Dodson:

Thank you so much, great issues. And it reminds me of conversations we had over the summer with health plans and their partners in the Central Valley counties, and making sure that all of the partners, whether it's hospital discharge planners, planned other providers are aware of each other and particularly for money follows the person and the HCBA waiver program, the assisted living waiver program pays all of the array of services that are available. And so thank you so much independent living centers are extremely valuable partners.

Lisa Hayes:

Thanks Anastasia, appreciate it.

Hilary Haycock:

Great. And that definitely echo some of the comments we've gotten in the box. So very helpful. That's great. All right. We're going to go to Regina. Again, your line is opened here in just a minute. There we go. Regina, your line is open. (silence)

Hilary Haycock:

All right, maybe we've lost Regina.

Jeff Thom:

Okay. There I am. This time, it is Jeff Thom, and I'm with the California Council of the Blind. Thank you. And I'll be brief. I don't want to reiterate the prior comment of my colleague, but I did want to clarify that with respect to a discussion of concerns for people with vision and hearing loss, the communication of information is an important piece, but the larger piece and the one that has not yet been discussed is the inclusion of services for our populations within the endless service mix. And that's the discussion that really needs to be had, because you can't find those services in either Medicare or Medi-Cal. Thank you.

Anastasia Dodson:

Thank you very much for clarifying. Yes. We will add this to the list.

Hilary Haycock:

All right. Lydia Missaelides. And this might be our last question. We'll see. Lydia, your line is unmuted.

Lydia Missaelides:

Hi, Anastasia. Hi Kerry. I just have a quick question about rural counties who are not in Cal MediConnect CCI, and I just have to admit I'm not familiar with the landscape right now of D-SNPs in the rural counties. And will there be a requirement to start those up? And is that part of the 2024, '25 timeline? Could you just briefly address that for me?

Anastasia Dodson:

Yes. That is part of the 2025 timeline, the requirement for-

Lydia Missaelides:

Okay.

Anastasia Dodson:

All Medi-Cal managed care plans to have a D-SNP in place. And so one thing I think that we should look at doing perhaps posting information on our website about where D-SNPs are and how many that I think that would be good background information for everyone. And then I'll say that we recognize that the rural areas may not have as many D-SNPs or D-SNPs at all, but that we've got commitment from CMS to work together with us on that. And so we're going to keep proceeding and figure out what needs to happen to get that structure set up.

Lydia Missaelides:

I appreciate that, Anastasia. Thank you.

Anastasia Dodson:

Thank you.

Hilary Haycock:

Okay, great. So I think we have time for our last hand raised. Tatiana, your line is open.

Tatiana Fassieux:

Thank you. Thank you. And again, I am with California Health Advocates representing the HICAPs. This is a monumental project, and I remember when CCI came around, there was additional funding for those impacted counties. The pressure on the State... There are 26 HICAPs in California, and they're all going to be impacted by this transition.

Tatiana Fassieux:

So from a policy perspective, I would really like to have the workgroup consider additional funding for the HICAPs, but a technical part also, you've been speaking about

D-SNPs. There are D-SNPs PPOs, and there are D-SNPs HMOs, and some of them may not coordinate. So, is there a policy established as to what type of D-SNPs PPOs are going to coordinate with the Medi-Cal managed care plans?

Anastasia Dodson:

There are certain areas I'm certainly limited in expertise. I'm not familiar with D-SNPs PPO. All the D-SNPs that I'm familiar with are Medicare Advantage managed care, but Kerry, is there some clarification you can provide there?

Kerry Branick:

(silence)

Tatiana Fassieux:

You're welcome. And I just want to make sure that everything has been extremely well thought out, but June and July is quickly approaching for the managed care plans to finalize their contracts with CMS. So there is a sense of urgency there.

Anastasia Dodson:

Got it. Thank you.

Hilary Haycock:

Thank you. Great. Okay. Our last comment today, it will be from Eileen Harper. Your line is open. I think you might be muted on your end.

Eileen Harper:

Can you hear me?

Hilary Haycock:

Yes.

Eileen Harper:

Okay. Thank you. Sorry about that. I think several people have already mentioned about focusing on the lessons learned from the CCI, CMC rollout. But I want to really emphasize the whole issue of beneficiary outreach and the really critical importance of DHCS, look at ways that were not attempted with Cal MediConnect in terms of more widespread use of things like social media, ways to connect with beneficiaries that are not just notices or on-the-ground education efforts. I know that those types of efforts cost money, but I do think that to be successful in this effort, you really need to look at ways to reach beneficiaries on a wider scale. Thank you.

Anastasia Dodson:

Thank you. We absolutely agree. And going back to health equity and addressing the needs and the communication strategies for various populations, we want everyone's

feedback on that to think about probably not, it isn't just one venue, it's multiple, and it may vary by region or by population. So we really welcome that conversation.

Hilary Haycock:

Great. Well, we are just at time and I am sure Anastasia and Kerry will join me and just saying thank you to everyone for all the amazing input we got today, phenomenally helpful. We will be putting together an agenda for March based on this conversation, and definitely thinking ahead to our April conversation around lead plan for aligned enrollment, but our next meeting will be Thursday, March 4th. So please join us then. We've put in the chat again, a link to where all the materials from today's meeting where all that will be posted, as well as the inbox for any additional questions or comments or things that you didn't want a direct answer on, or we did not get you today. That's CalAIM@dhcs.ca.gov. So thank you again, everyone for your time. And we look forward to reconvening next month.

Anastasia Dodson:

Great. Thank you again.