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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NUMBER OF SPEAKERS: 5

FILE DURATION: 1 hour 47 minutes

SPEAKERS

Mary Russell
Anastasia Dodson
Dr. Karen Mark
Stephanie Conde
Anna Williams

Mary Russell:

Good morning and welcome to today's CalAIM Managed Long Term Services and Supports and Duals Integration Workgroup. We have some great presenters with us today, including Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS; Dr. Karen Mark, Medical Director at DHCS; Stephanie Conde, Branch Chief in the Managed Care Operations Division at DHCS, and Anna Williams with the Centers for Medicare and Medicaid Services Medicare Medicaid Coordination Office.

Mary Russell:

A few quick meeting management items to note before we begin, all participants will be on mute during the presentation. Please feel free to submit any questions you have for the speakers via the chat. During the discussion. If you'd like to ask a question and/or provide comments and feedback, please use the raise hand function and we will unmute you. Quick note that the PowerPoint slides and meeting materials will be available on CalAIM website in the next few days, and we'll provide a link to materials in the Zoom chat. We'd like to take a minute to ask you to add your organization's name to your Zoom name so that it appears "Your Name - Organization."

Mary Russell:

To do this, please click on the participants icon at the bottom of the window, hover over your name in the participants list on the right side of the Zoom window, click more and select rename from the dropdown menu, enter your name and your organization as you would like it to appear. And that is just helpful for us, especially during Q and A facilitation. Let's take a quick look at the agenda for today. We're going to start today's meeting with the walkthrough of the summary of the January 23 enrollment changes followed by time for questions and answers. Next, Dr. Mark will share an update on the Dementia Care Aware initiative, and we'll have some time for additional questions and answers then.

Mary Russell:

Following that, DHCS and CMS will present on notices, monitoring, and timelines for the January 23 transition impacting dual eligible beneficiaries. And we'll close out the meeting by discussing upcoming meeting topics and next steps. A quick reminder, if you are joining us from a health plan today, we're requesting that you save questions for the specific meetings that DHCS has established regularly with plans, so we can prioritize other stakeholder questions and discussions for today's meeting. Thank you. With that, I'd like to transition to Anastasia Dodson. Thank you.

Anastasia Dodson:

Thanks so much, Mary, and really excited to be here today. I know I say that every time, but especially today, we've got updates for you on the notices. We've been talking about these transitions for well over a year now. And so, we have notices and then... That we don't have the notices themselves ready to post, but we have timelines and additional information that we think will really help as you all prepare.

Anastasia Dodson:

The other thing that we're going to be talking about as Mary said, is Dementia Care Aware, which is such a wonderful effort and opportunity to help so many individuals and families with dementia or cognitive impairment and providing more resources to physicians and information that can help families and individuals understand better what's going on and prepare. So, really great topics today. So, with that, the overview of this work group we've got... This is a collaboration hub for the CalAIM, MLTSS efforts and integrated care for dual eligible beneficiaries.

Anastasia Dodson:

We want to hear from everyone, some of you email us at the Cal Duals inbox, which is wonderful. We get emails through all kinds of other channels, which is great. We really value having your information and participation here. And I'll say we'll keep having these meetings monthly in this forum through the fall and winter, but then anybody who needs offline individual meetings or group meetings, we will try our best to accommodate that.

Anastasia Dodson:

We really want to make sure that everyone's hearing the same thing. And in addition to the enrollment notices and materials also about the policy changes that we have in CalAIM that can support individuals with disabilities, older adults, some for dual eligibles, but for Medi-Cal only as well. So, a lot of great things here. Okay, next slide.

Anastasia Dodson:

So, these next few slides, there's no new policy here. It's just a reminder of the information that we have shared over the last few months. And we are more than happy to answer any questions that folks have that, again, no new policy information, just a reminder of where we are and what's going to be happening over the next few months. And then after Dr. Mark's presentation on Dementia Care Aware, then we'll go back and have a more detailed chat about the timeline and what mailings will be sent to which beneficiaries in the coming months. Next slide.

Anastasia Dodson:

Okay. So, the first is reminders about the Cal MediConnect to Medicare Medi-Cal plans transition. Next slide. Always enrollment in a D-SNP or other Medicare Advantage plan is voluntary. There's no mandate there. Medicare beneficiaries can remain in Medicare

Fee-for-Service, also known as original Medicare, and they do not need to take any action to remain in Medicare Fee-for-Service original Medicare. That continues to be the case. Medicare Medi-Cal plans.

Anastasia Dodson:

Medi-Medi plans is the name that we're giving to health plans in California that coordinate Medicare and Medi-Cal benefits together for people who are dually eligible. We previously in meetings were calling these EAE D-SNPs. That's the technical name, but we're moving away from a lot of letters and to a more regular sounding name, Medi-Medi plans. Each health plan that is a Cal MediConnect plan and is transitioning to a Medi-Medi plan, they may use their own marketing name, but overall, they are called Medi-Medi plans in California.

Anastasia Dodson:

For 2023, individuals who are already enrolled in Cal MediConnect, they'll automatically be enrolled in the Medi-Medi plan that's affiliated with their Cal MediConnect plan. So, the same Medicare Advantage organization that's managing a particular Cal MediConnect plan will newly have a Medi-Medi plan. And those beneficiaries will just seamlessly go to that new plan name, but we'll have substantially the same network of providers and with continuity of care assurances and the same parent organization for their health plan. Next slide.

Anastasia Dodson:

So, January 1st, 2023, that's when this transaction will take place for the health plan and in the CMS systems and the DHCS systems. There should be no gap in coverage. The networks will be substantially similar. There's continuity of care provisions. Health plans are communicating with beneficiaries now about the upcoming changes and the notices will be going out October 1st. And again, we're going to talk about that timeline there, but we have talked about this, again, the same thing, information that we've shared at previous meetings, and we really want to hear from you, if there's any questions you have, thoughts, suggestions about how to communicate this. We're all ears and we will be posting soon, some fact sheets and materials, similar to what we did for Cal MediConnect, but updated with the new name and then lessons learned. Any other thinking that you all may have suggested over the years about how to improve outreach there. Next slide.

Anastasia Dodson:

So, the Medi-Medi plans are similar to Cal MediConnect. There are integrated member materials, there's benefit coordination across Medicare and Medi-Cal. There are care coordinators, very important. That makes sure that individuals who need additional help figuring out transitions, how to navigate across different sets of benefits, care coordinators are available and all the different levels of need that people have. And

again, this is all in the seven Coordinated Care Initiative counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and San Mateo.

Anastasia Dodson:

Cal MediConnect is available in those counties right now. And the Medi-Medi plans will be available in those counties in 2023. Again: Los Angeles, Orange, San Bernardino, Riverside, San Diego, Santa Clara, and San Mateo counties. And I should, before leaving this slide, I want to remind you all of also one of the benefits of having one plan organization administering both the Medicare and the Medi-Cal is that there is also simplified and integrated provider communications so that as far as primary and secondary billing coordination of benefits, one organization can work across both sets of benefits, and that's better for providers as well. Next slide.

Anastasia Dodson:

Again, we've talked about it before, but well, there's time for Q and A shortly about the Cal MediConnect transition. D-SNP look-alike plan transition, this is a type of Medicare Advantage plan. Next slide. So, D-SNP look-alike plans are actually Medicare Advantage plans, but they have been marketed to dually eligible beneficiaries in recent years, but they do not have the same care coordination requirements. So, CMS set a regulation to require the transition and the termination of these contracts because they are not providing the same level of care coordination beneficiaries as true D-SNPs. So, next slide.

Anastasia Dodson:

CMS is taking action to limit enrollment into these types of plans, and it will be effective for 2023. Next slide. So, what that means is the Medicare Advantage organization has chosen either their regular Medicare Advantage plan or a true D-SNP, and the beneficiaries that are in that D-SNP plan, that is a D-SNP look-alike, will be automatically transitioned within that same Medicare Advantage organization that oftentimes Medicare Advantage organizations, they have multiple plans.

Anastasia Dodson:

Many of, when you go to Medicare plan finder, the same health plan organizations may have multiple offerings in the same zip code, et cetera. Those are all managed by the same organization, and so, if a plan had a D-SNP look-alike, then they will have either a regular MA plan or a true D-SNP that their beneficiaries will be automatically transitioned to. And there will be notices that go out to those beneficiaries. That transition is called a crosswalk, and we will talk a little bit later about when the notices will go out, what notices they will get. Next slide.

Anastasia Dodson:

The last of the three policies, again, nothing new, things that we've been talking about for the last year or so is statewide Medi-Cal managed care enrollment for dual eligible beneficiaries. Next slide. So, in Medi-Cal we have both a fee-for-service and a managed care delivery system. 15 years ago, most Medi-Cal beneficiaries were in Medi-Cal fee-for-service, but over the years, we have moved to an organized delivery system for Medi-Cal, so that individuals have better care coordination, and we can monitor quality and improve access.

Anastasia Dodson:

In January 2022, we made some transitions. And then in January 2023, there will be transitions of dual eligible beneficiaries into Medi-Cal managed care. This change for dual eligibles will not impact beneficiaries Medicare choice. So, if someone is already in original Medicare, fee-for-service Medicare, if they are then newly enrolled into a Medi-Cal managed care plan, that will not impact their original Medicare. The existing providers that they're already working with do not have to be in the Medi-Cal network in order for them to continue to be seen by that provider. Next slide.

Anastasia Dodson:

So, right now, over 70% of dual eligible beneficiaries in the state are already enrolled in a Medi-Cal managed care plan. 1.1 million is 70%. So, there are a lot of people already in Medi-Cal managed care throughout the state. So, about 325,000 dual eligibles will be newly enrolled in a Medi-Cal managed care plan effective January 1st, 2023. And which plan they're enrolled in does depend on whether they're already enrolled in a Medicare Advantage plan, and that's that Medi-Cal matching plan policy that we've talked about. So, in those 12 counties, a beneficiary that's in a Medicare Advantage plan, if that plan has an affiliate Medi-Cal plan, then that's the plan that the beneficiary will be enrolled in. If they're in a Medicare Advantage plan, that doesn't have an affiliated Medi-Cal plan, or they're not in one of those 12 counties, then they can choose a plan using the materials that they will receive in the fall.

Anastasia Dodson:

Next slide. And certainly, we want to emphasize what does it mean to a dual eligible beneficiary to be enrolled in a Medi-Cal managed care plan? Medi-Cal plans for dual eligibles, one of their primary purposes is to provide coordination for long-term services and supports. So, that's CBAS, that's long-term care, skilled nursing facilities, as well as transportation to medical appointments, and then CalAIM Community Supports such as home modifications, medically tailored meals, et cetera. And that does vary by plan. There's also CalAIM Enhanced Care Management, and we've talked in previous meetings about what that means and what populations of focus or potentially would be for dual eligibles.

Anastasia Dodson:

And won't get into the detail here now, but again, looking at this list of benefits really highlights the value that Medi-Cal plans can bring to dual eligible beneficiaries. And of course, we really want to promote models that have the same organization, the same Medi-Cal plan and Medicare plan working together so that there is coordination across all sets of benefits, Medicare, and Medi-Cal. But, again, there's more than half of dual eligible beneficiaries in California are enrolled in original Medicare, fee-for-service Medicare, and so being enrolled in a Medi-Cal plan doesn't mean that you have to be enrolled in a Medicare plan. It's just that the Medi-Cal plan can help you with referrals and coordination, again, for transportation to medical appointments. Okay. Terrific. Next slide. Good. So, let's get to questions and then we're going to hear from Dr. Mark.

Mary Russell:

Great. So, I see a few questions in the chat so far. If there are other questions or comments, please add it to the chat or raise your hand and we will unmute you. Anastasia, I wanted to start with a question from Angelica Murch, "My understanding is that as of 2023 Medi-Medi plans in Orange County cannot enroll new members. Is that correct?"

Anastasia Dodson:

Mary, can you repeat the question? Say it more slowly?

Mary Russell:

Sure. And it might be helpful for Angelica to raise your hand so we can unmute just to make sure we're understanding the question, but clarifying, as of 2023 Medi-Medi plans in Orange County, are they unable to enroll new members?

Anastasia Dodson:

Good question, okay, there's only in Orange County, CalOptima is the county organized health system and will be the Medi-Medi plan transitioning from Cal MediConnect in Orange County. So, right now in Orange County, the CalOptima plan, and forgive me I don't remember the marketing name, but that same health plan will then be a Medi-Medi plan in Orange County. That does not mean that there aren't other Medicare Advantage or D-SNP plans in Orange County that can enroll dual eligibles on the Medicare side.

Anastasia Dodson:

But as far as coordination and integrated materials, et cetera, with our Medicare Medi-Cal plans, that will be CalOptima in Orange County. And right now, a dual eligible can enroll in a Cal MediConnect plan all the way up to the end of the year. So, again, that level of coordination is available to duals in the seven counties right now through Cal MediConnect. And then the end, there will be a seamless transition of the Cal

MediConnect members in Orange County and all of the CCI counties to the Medi-Medi plans, the Medicare Medi-Cal plans, in the seven CCI counties.

Mary Russell:

Thanks, Anastasia. Thanks for clarifying that. A question from Rick Hodgkins in the chat, and I want to make sure I get this right, but Rick is confirming if you are not in a long-term nursing facility or a skilled nursing facility and/or don't have a share of cost, you don't have to join a Medi-Cal managed care plan. Is that correct?

Anastasia Dodson:

Well, partly, individuals with a share of... And I should say no, that’s the opposite, actually. So, individuals who are not in a long-term care facility, it's the same policy either way. Whether you're in a skilled nursing facility or living in the community, or at home, it's the same policy where all duals without a share of cost will be enrolled in a Medi-Cal managed care plan. Dual eligible beneficiaries with a share of cost for living in the community, those are the individuals that will not be enrolled in Medi-Cal managed care.

Anastasia Dodson:

That's a fairly small number of individuals, because oftentimes people who have a share of cost, they may not meet it every month. So, for the vast majority of dual eligible beneficiaries, they do not have a share of cost, and they will be enrolled in a Medi-Cal managed care plan January 1st, 2023. Including those who are in a long-term care facility. And the folks who are in a skilled nursing facility and have a share of cost, those individuals will also be enrolled in a Medi-Cal managed care plan January 1st, 2023.

Mary Russell:

Thank you.

Anastasia Dodson:

Yeah. And again, there's a choice. I want to emphasize that as well. On our Health Care Options page, if any of you are curious to have a preview of what Medi-Cal plans are available county by county, Health Care Options page has information you can navigate to that particular page and then find a dropdown box where you can select the county. And then you can see which Medi-Cal plans are available by county. And there's information, I believe, also about quality scores and other information on that Health Care Options website.

Anastasia Dodson:

So, if you are someone in that roughly 325,000 person group, and you want to get a head start in looking at your Medi-Cal plan options, you can go to the Health Care Options page and check out your options. But again, that Medi-Cal plan choice does not impact anything about your access to your Medicare providers. Those Medicare providers, if they're already seeing you, they already have you in their system as being a dual eligible, there should be no impact to providers in this transition. The providers, the Medicare providers who are currently billing the state for the secondary coverage for Medi-Cal, they will simply bill the Medi-Cal plan and we will on the back end, make sure that is facilitated and make sure that information goes out, again, as that transition gets closer.

Mary Russell:

Great. Thank you. And I think we did just drop the HCO link in the chat if that's helpful for people. A question from Brenda White, "In the 12 matching counties for the subcontracted plans, will beneficiaries be transitioned to the Medi-Cal prime plan, and then the subcontracted plan must work with the prime plan to match the enrollment?" And I know we have Stephanie Conde on the line who might want to speak to this?

Anastasia Dodson:

Yeah. Great question. And Stephanie, if you want to answer it, that's fine. Or I can do my best.

Stephanie Conde:

Either way, but yes, the prime plan is responsible of getting the delegated entities beneficiary information over to them just as they are today.

Mary Russell:

Great.

Anastasia Dodson:

So, Steph, and actually maybe just to follow up on that. Stephanie, as far as... if a beneficiary is already in a Medicare plan in let's say in Los Angeles County, then... Well, Los Angeles is not a good example, because it's already a CCI county, but Alameda County, for example. Then it's not effective at the prime and delegate level for the matching plan policy, but it is effective at the prime level, right?

Stephanie Conde:

Yes. Sorry. Thank you. Good clarification.

Anastasia Dodson:

Yeah.

Mary Russell:

Great. I think we'll just take one more question here because I know we want to get to the next section and then we will have time for additional questions after some of the noticing discussions, but, Anastasia, a question from Jan Spencley, "Is there additional information on the latest regarding mandatory managed care in rural areas and rural counties?"

Anastasia Dodson:

Right. It's the same policy of statewide for Medi-Cal managed care. And so, in rural areas, there are choices of Medi-Cal plans. And back to that Health Care Options website, any rural county that you like, you can pull down and see. And some rural counties are covered by County Organized Health Systems where the beneficiaries are already enrolled in that Medi-Cal plan that is called a COHS. So, it's really just in the rural Eastern counties in California primarily where the beneficiaries may not already be enrolled in a Medi-Cal managed care plan.

Anastasia Dodson:

And so those choices are on Health Care Options, and they will get the same notices as everybody else. And we know that in those rural counties, there are many fewer beneficiaries enrolled in a Medicare plan. And those counties, the rural counties are not matching counties anyway. So, most everybody in rural counties, they can choose whichever Medi-Cal plan they want to enroll in among the Medi-Cal plans that are offered in their counties. And then we know, for example, transportation is an important benefit to dual eligible beneficiaries. So, another good reason for beneficiaries as they're enrolled in a Medi-Cal managed care plan that Medi-Cal plan can help them make arrangements for transportation to their medical appointments among other benefits of the Medi-Cal managed care plans.

Mary Russell:

Great. Thank you. Thank you all for these questions. We are saving some of these in the chat for the next Q and A moment, but at this time we’re going to transition to Dr. Karen Mark, Medical Director at DHCS, to share some updates on the Dementia Care Aware initiative. Thank you.

Dr. Karen Mark:

Thank you very much and good morning, everyone. So, the first update that I don't know if we've shared with this group is that we have changed the name of what we were calling Dementia Aware, to Dementia Care Aware. So, we're very excited about our new

name because we really feel like it puts the emphasis on care, which is really what it's all about. So next slide.

Dr. Karen Mark:

So, Dementia Care Aware, as we have explained before is very closely tied to the implementation of SB 48, which established an annual cognitive health assessment as a Medi-Cal benefit for beneficiaries who are 65 and older, if they're otherwise ineligible similar assessment as part of the Medicare Annual Wellness Visit. So, this benefit it's a small population of folks who are over 65, but are not on Medicare, but obviously very important. And I see a note that the sound is choppy, I'll move closer, hopefully that helps.

Mary Russell:

Yeah, you're sounding okay. To me. You're a little choppy in the beginning, but now I think it's smooth out a bit if you want to just say a bit closer to your microphone. Thank you.

Dr. Karen Mark:

Okay. Thank you. Let me know if there's more problems. So, the SB 48 Medi-Cal cognitive health assessment benefit did go live July 1st, and providers are eligible to receive this payment for Medi-Cal only beneficiaries. If they do two things: If they complete a cognitive health assessment training as approved by DHCS, and this is the Dementia Care Aware training that I will be talking about in a minute. And then also they need to use one of the validated tools recommended by DHCS. Next slide.

Dr. Karen Mark:

So, this shows the training that we also launched in July at dementiacareaware.org. So, you can all go to dementiacareaware.org and anyone who wants to can register for the training. There's a register button, and that takes you... Once it collects some information about you, it goes ahead and brings you to the training itself. Next slide.

Dr. Karen Mark:

And the training is outlined here. There's some brief introductory information. There's then an hour and a half training on dementia care. It really goes over why the brief cognitive health assessment is important. The three step process for administering the cognitive health assessment, and then options for next steps if the screen is positive. And then there's a course evaluation and that's required because the course does provide continuing medical education, as well as continuing education for other healthcare providers as well as the certification credit. So, it provides a lot of those credits that physicians and other healthcare providers need. And it's always great to get those free trainings. Next slide.

Dr. Karen Mark:

Oh, all right. Sorry, go ahead. Next slide. So, the Dementia Care Aware training is case based and it's interactive. It addresses key Medi-Cal populations. So, non-English speaking, co-morbid people, with co-morbid substance use disorder or serious mental illness, people with disabilities, and older adults experiencing homelessness. And it also addresses how to do the assessment over the phone or asynchronously or by other team members. So, we recognize the way medical care is provided has really changed since the pandemic, so it really tries to address all the issues around telehealth. Next slide.

Dr. Karen Mark:

The cognitive health assessment is also designed for primary care providers. So really the goal for training is to train internists, to train family practice docs, to train Pas and nurse practitioners who care for older adults. It’s not a specialist training. It includes assessments that are free to use, quick to administer, easy to score, validated in primary care and in multiple languages. And again, can be done by different members of the healthcare team. The assessments can also be done longitudinally over multiple visits because we recognize primary healthcare providers have very limited amount of time with patients, but it’s really designed to be a brief assessment that can be done during primary care visit. And then there’s follow up assessments that could be done during follow up visits if that's needed. Next slide.

Dr. Karen Mark:

So, I'm going to walk you through just a little bit of what the cognitive health assessment entails. It's a very brief overview of what's really the hour and a half training, but just to give you a flavor of what's involved. So, the cognitive health assessment is really designed for all patients 65 and older, without a dementia diagnosis. The same procedure can be done for patients younger than 65, who present with complaints around cognition. So that's important to recognize as well. There's really three steps that we talk about, is head to toe: the head being assessing cognition, the arms being assessing function, and then the legs being assessing a support system. Next slide.

Dr. Karen Mark:

In terms of starting with the head or with cognition, there’s really two steps. One is seeing if the patient has any complaints of cognitive issues. So, this can be just a simple question, “Do you or others think that you are having more trouble remembering things or any changes in your mental abilities?” If there’s any concern that’s expressed by the patient, we recommend going to an assessment tool that are explained in more detail in the training.

Dr. Karen Mark:

Then it’s also important to get information from a collateral source or a family member or someone else who may be coming to the visit with the patient, or who may be able to be contacted afterwards with patient’s permission. So, this can be… If an older adult comes to a visit perhaps with an adult child or another family member or a spouse, you can ask the informant if whether that person has noticed in the past few years that the patient has any more trouble with their cognition or their mental abilities. If there's any concern addressed by the informant, we also recommend going to the assessment tool. And also, if there’s no informant available, which often could be the case, then we would also recommend going to the assessment tool. Next slide.

Dr. Karen Mark:

So, then the next part of really assessing cognition and potential issues with dementia is to assess function. And this is also important to verify with both the patient and with an informant. So, it can be asking the patient, "Are you needing any more help with daily tasks, maybe having more difficulty paying your bills? Having any more difficulty with preparing meals, unexplained weight loss, poor hygiene?" And then also similarly talking to any family members or informants asking if the patient has needed more help doing some of these things over the last few years, and if so, who assists them? And then there are also assessment tools that can be used, and the training discusses around function. Next slide.

Dr. Karen Mark:

And then the last very important thing is asking about the support system. Asking if the patient has a support system and if they do, identifying that person's name and contact information. And if the person isn't at the visit asking if it's possible for the provider to contact that person to get some more information. Next slide.

Dr. Karen Mark:

So, this slide just emphasizes that this is sort of a brief screen. Again, primary care visits often have limited time, and this is the first step and then subsequent visits can be scheduled to focus on really doing a more in depth assessment. But some of the things we talk about in terms of next steps are Screening for mental health conditions or substance abuse if there's concerns around cognition, scheduling a more in depth assessment, ordering labs that are recommended, potentially head imaging, arranging for a referral, if it's needed. And then in terms of function, referring for caregiver support, if the person is needing additional support and in terms of the support system, documenting that caregiver or the partner's information and asking if the person has identified a surrogate decision maker, if they're at some point not able to make their own decisions. Documenting that in the chart if it's available, and then arranging for future visits, if needed, to assess the caregiver’s health and making referrals to caregiver resources. Next slide.

Dr. Karen Mark:

And this is really designed to talk about the fact that brain health is really whole person health. And this is again, we're talking about the primary care setting. Knowing if there's cognitive concerns in an older patient or in any patient really steers the care for all of their conditions. If someone's having trouble remembering things, they may be having trouble remembering to take their medication, for example, for other chronic conditions. And then also really illustrates how we can start brain health plan at the very earliest signs even before we've made, or we may not make a diagnosis of dementia in addition to treating any medical or other causes of symptoms. So, focusing on making sure that we've assessed the older patient's hearing and vision, reviewing their medications for anything that might be causing problems with cognition, and potentially could be removed, encouraging social and physical activity, which have been really... There's good evidence to show helps people maintain their brain health and then optimizing management of blood pressure and diabetes, which also optimizes brain health as well as physical health. Next slide.

Dr. Karen Mark:

So, this is just a quick example from the training. I mentioned that its case based and it just kind of steps us through how this would roll out in a primary care visit. So, Mrs. Perez is a 72 year old woman who comes to her appointment with her daughter that she lives with, Ana. You discuss the agenda for the appointment and ask if she's having any more trouble remembering things. She knows that she's forgotten to pick up her grandson more often as she often loses track of time. So that's a positive symptom, and then you would move on to a test of cognition and function. Next slide.

Dr. Karen Mark:

And the GP-COG test is one of the tests that's gone over in the training, and that's a positive screen for Mrs. Perez. And then you would go talk with the daughter and there's an informant interview score for that. That's gone over in the training as well. And Mrs. Perez' daughter, Ana, indicates that she doesn't see any problems with Mrs. Perez' function. Next slide.

Dr. Karen Mark:

You next could discuss the support that she has asking if there's ways that she needs... That she gets support from Ana in her day to day life. "We support each other. We go grocery shopping together." Ana helps her keep track of her bills and asks about coordination with medical care. Ana comes to appointments with Mrs. Perez, but Mrs. Perez really makes her own appointments and follows up on her own. So, she doesn't really need the help of Ana for these things. And then the provider asks if she has a healthcare agent, someone that can make healthcare decisions for her if she isn't able to herself, and Mrs. Perez says she hasn't set that up. And then the provider asks if she can document Ana's contact information in the chart, and she says, "Yes." So next slide.

Dr. Karen Mark:

So, the next step that's important and required for billing is discussing the results of the screen with the patient, and if present, the family member. So, thanking her for taking the time to review her brain health, mentioning that Mrs. Perez has forgotten to pick up her grandson more often, but when they did a brief test, she had a little difficulty, but Ana's report is indicating that she's really able to function very well on a day to day basis and that there's not a serious problem at this time. So, making a note of that, the provider will share some suggestions around supporting her brain health and making sure Ana's contact information is in the chart. And then following up on this every year or whenever there's any new symptoms. So really making sure that this is followed up in case there's any further cognitive problems in the future. Next slide. And actually, can you go one more? I think there were two slides that were...

Dr. Karen Mark:

Yeah, here we go. And then documenting in the chart, the history that Mrs. Perez's forgetting to pick up her grandson, the exam or assessments that were done, the GP-COG, the first one was positive and the next one was negative. The informant was her daughter, Ana, and the interpretation, which is that she has a negative screen for dementia at this time. And then a support system documenting Ana's contact information and that she doesn't have a healthcare agent designated because that's something that could be discussed at a further visit and is really important for all older adults. And then documenting that the result was disclosed to the patient and the plan for annual screening and the brain health plan. So, if you can just go back to one slide.

Dr. Karen Mark:

We've really, at this point finished what we had described as the first phase of Dementia Care Aware, which was getting this training up and running and available to everyone. But there's a whole set of additional activities in what we had called phase two of Dementia Care Aware that we're just beginning to launch, and we'll continue through March 2024. So, this training is just the very beginning. We will be working with our contractor at UCSF to develop additional trainings going into more depth on some of these issues. There will also be monthly webinars and additional modules for CME or Continuing Medical Education. There will also be outreach to providers in all 58 counties, both in person and virtual outreach media campaigns.

Dr. Karen Mark:

And then there's also a component of practice support starting in the fall and winter of 2022. So, a website with practice management resources, but also a warmline for clinicians who might be starting this and having questions. Virtual teaching conferences and also, hands-on coaching. And then there also will be a component of evaluation of the whole program. So, if you go forth two slides.

Dr. Karen Mark:

There we go. So, I wanted to just end with a huge thanks to Dr. Anna Chodos who's the Principal Investigator at UCSF, who's leading this effort and the entire UCSF team that we're working closely with. So, at this time let’s open it up to questions, I think there were a couple of questions I saw coming in the chat.

Mary Russell:

Yeah. Thank you so much, Dr. Mark. I'm happy to pull in some of the questions that we've received so far in the chat. And then if there are others from participants, feel free to raise your hand and we can unmute you or drop them in the chat. A first question from Tracie Lima, "Who is qualified to perform this screening?"

Dr. Karen Mark:

The screening is designed, as I said, for primary care providers. So that would be both physicians, nurse practitioners, physicians’ assistants, and done, as I said, as part of a healthcare team. So, the entire screening doesn't necessarily have to be performed by the clinical provider. It can be done in collaboration with a medical assistant, for example, doing some of the screen with the clinical provider and the billing provider, essentially assessing the results and discussing the results with the patient and the family.

Dr. Karen Mark:

And then I guess there's another question. "Can you provide some details of an assessment of the caregiver? Is there an assessment done of their needs?" I won't get into... This is sort of the first step, I guess, as this is a brief assessment of the patient initially. I think the question about assessing the needs of the caregivers is incredibly important, and that sort of comes in the subsequent steps. Because obviously many of the folks that are screened are not going to have dementia, but a small proportion will have dementia. And then there's whole steps there in terms of making sure that both the patient and the caregiver are supported. So maybe we can just put a tag on that for a subsequent meeting. We could have someone present on that.

Anastasia Dodson:

And Karen, I'm going to jump in here too, to say part of what we want... So exciting to have your presentation today and to think about then how does this roll into the model of care that D-SNPs and MMPs have, and frankly, all other Medicare Advantage plans. Are there protocols that our Medicare plans ought to be flagging for providers and their teams about referrals about next steps, even beyond the clinical assessment? And so really an area where we’re glad that we have many of our health plans on as well and provider groups. And so broader than even just Dementia Care Aware, what requirements and what strategies should we be promoting to plans and providers beyond this?

Dr. Karen Mark:

And I'll just note, there's a lot of discussion in the chat about the caregiver resource center, which is fabulous. And one of the efforts I mentioned in terms of next steps with this program is building out the website more. We've had discussions with CDPH as well, really making sure that we're linking to all of these other resources and making sure that providers and patients are aware of all these other resources. So, I'll definitely take all these in and make sure that we're doing that. And let's see here.

Mary Russell:

Yeah, Dr. Mark. I was just going to flag a question from Melissa Barrett about sort of the process and the billing for the assessments. “So, confirming the assessment is completed by a PCP or AMP at an office visit, provider bills for this assessment and plan then reports on the number of assessments completed for their members. Is that correct?”

Dr. Karen Mark:

So basically, the assessment can be billed by a billing provider. So, yeah PCP or a nurse practitioner, if they're a Medi-Cal billing provider and the... Oh, I see, and then the plan then reports on the number of assessments completed. So, actually if the provider's bill using this code, then we will be able to pull from our huge data warehouse how many assessments are completed by pulling how many of those codes are billed.

Dr. Karen Mark:

The one thing that I will really emphasize now though, is that process may underestimate the assessments that are done because as I mentioned, really the vast majority of people over 65 are on Medicare. So, the assessment will be done and billed to Medicare and the Dementia Care Aware program is really designed very broadly to provide education to providers to do this assessment on folks who are over 65, kind of, regardless of payer. Obviously, we focused on the Medi-Cal population for the purposes of making sure that we're not increasing disparities and that we're reaching some folks who need it most, but the goal is essentially to increase screening both that's paid for by Medicare and Medi-Cal, but all will really be able to pull in terms of seeing the screens done as those done in Medi-Cal.

Anastasia Dodson:

Yeah. So, one of the things... I know, Dr. Mark, we've got you on so early after the launch, we are still... I think one of the things that we might want to do is maybe some kind of a fact sheet on the Medicare side, because... And I'm not an expert on this, I believe that on the Medicare side is part of the Annual Wellness Visit.

Dr. Karen Mark:

Yes.

Anastasia Dodson:

And there's a certain... Yeah. So maybe again, for some of our next steps could be on FAQ for providers about that, because I don't think that it's a separate billing, but then I know that the Alzheimer's Association and folks have been pitching, is there a way to find out how many dementia screenings are done on Medicare side? And I don't know the latest on that, but just much, much more that we can all do and work together on.

Dr. Karen Mark:

Absolutely. And I see there's a question about who providers bill. So, this depends on if the patient's a fee-for-service or managed care. So, if the patient's a fee-for-service, they bill DHCS through the normal mechanism. If the patient is in managed care, they bill the plan through the normal mechanism.

Mary Russell:

Great. Thank you so much, Dr. Mark, at this time, I'm not seeing additional questions in the chat, or any hands raised and thank you Harinder, for adding that link to the chat. Any other questions for Dr. Mark on this presentation?

Mary Russell:

Okay. Thank you for being with us today, Dr. Mark. At this time, we will move into our next topic. Discussing the noticing, monitoring and timelines for the January 2023 transitions impacting dual eligible beneficiaries. Stephanie Conde, the Branch Chief of the Managed Care Operations Division at DHCS, and Anna Williams with CMS Medicare Medicaid Coordination Office will be presenting. So, Stephanie, go ahead.

Stephanie Conde:

Hi, good morning, everyone. Thanks, Mary. As Mary mentioned, I'm the Branch Chief in Managed Care Operations Division within DHCS. I'm going to be going over the outreach plan that will impact duals as we go through the next few months here. So next slide please.

Stephanie Conde:

So, for our 2023 transitions, there will be some noticing as folks know, and have had an opportunity to provide feedback on. But just to note, the notices that are going out to our members impacted by the transition. So, anyone impacted by the Cal MediConnect to the MMP transition, will receive a notice. And I'm going to go into the cadence of the notices in the next few slides. So, the beneficiaries who are impacted by that are in the seven CCI counties that Anastasia mentioned earlier. Also, Anastasia went over our D-

SNP look-alike transition. Those beneficiaries will also get noticing, and Anna will go over that in the next few slides as well.

Stephanie Conde:

And then our dual beneficiaries who are impacted by the Mandatory Managed Care transition, about 325,000 will also receive notices. And then lastly, beneficiaries impacted by the long-term care skilled nursing facility carve-in, will also receive notices. Next slide please.

Stephanie Conde

All right. So, the process for getting these notices ready, stakeholder feedback on the notices. As I mentioned earlier, we receive feedback from advocates, plans, stakeholder partners on the CMC notices, going from CMC to MMP. The LTC skilled nursing facility notices are CalAIM Mandatory Managed Care notices. The notices I just described in the earlier slide. We also sent the Cal MediConnect to MMP notices out for beneficiary testing.

Stephanie Conde:

And then we are just closing in on finalizing those notices and then getting them over to the right areas who will be mailing them. And I will definitely take some questions at the end. I see some hands being raised. Next slide please. Okay. So, the beneficiary feedback on the Cal MediConnect to MMP transition notices, the notices do contain the necessary information. Again, this is the feedback that we received from the beneficiaries. Responders understood that they could automatically enroll into the D-SNP without taking further action, noted that the prescription drug coverage was very important. There was jargon within the notices, while we were drafting them, that beneficiaries thought was not helpful or maybe confusing. And that's an example like using the word “network.” So, we had updated that. Many respondents noted that their care coordination as a resource they would reach out to for questions. That is included in the notices and the members noted that they were satisfied with their current plan, so also very good feedback from our beneficiary testing. Next slide please.

Stephanie Conde:

All right. So here is the timing of when our noticing will go out. So, in September D-SNP look-alike members will receive an annual notice of change, the ANOC, by September 30th, and then the CMC members will receive their ANOC by 9/30 as well. And then in October, the Cal MediConnect members transitioning to the MMPs will receive a 90 day notice. We also call that the non-renewal notice. In November, our long-term care and mandatory managed care transition impacted beneficiaries will receive what we call a 60 day notice, and then also in November, our Cal MediConnect to MMP beneficiaries will receive a 45 day notice. And then in December, long-term care and our mandatory managed care beneficiaries transitioning will receive choice packets, and there's a little

asterisk and note. Those choice packets will only go out to beneficiaries, not in a matching plan scenario or our MMPs. So just a little note that those beneficiaries will not receive the choice packets. Otherwise, they'll get what we call a confirmation letter. So that confirms what plan they are enrolled in based on the Medicare Advantage plan that they're already in. Next slide, please.

Stephanie Conde:

Following the notices, we will have outbound calls to our impacted beneficiaries. So, in October, our Cal MediConnect plans will be calling members impacted by the Cal MediConnect to MMP transition, and they will call those members after the 90 day notice. And then in December, our long-term care and mandatory managed care beneficiaries who are transitioning will get a call from the Department of Health Care Services to really go over the notices and then next steps and answer any questions. Next slide, please, which I will hand off to Anna.

Anna Williams:

Thanks, Stephanie. So as mentioned earlier by Anastasia, members will transition out of the D-SNP look-alike in January 2023. Each fall, all Medicare Advantage enrollees receive an annual notice of change, also called an ANOC, which describes the changes in coverage for the upcoming plan year. Beneficiaries that are enrolled in a health plan identified as a D-SNP look-alike will receive an ANOC with additional information about their transition from the D-SNP look-alike plan to another health plan offered by that same parent organization. And the plan the members transition into will have a combined Part C and Part D $0 premium for all eligible beneficiaries. As this transition happens, there are about 140,000 beneficiaries across the state that will move out of the D-SNP look-alike and receive that ANOC. Most of these beneficiaries are within those seven CCI counties that exist today. Next slide please. And I'm passing it back to Stephanie here.

Stephanie Conde:

Thank you, Anna. This is similar to the slides that I just went over. It's the timeline of all our noticing all just put together so you can see really the timing and impact to the transitions. So again, the Cal MediConnect to MMP transition will occur on January 1st, 2023. Our noticing plan is in September. The Cal MediConnect plans will send members an ANOC, which will be received by September 30th. In October, Cal MediConnect plans will send the 90 day notice, and two inserts. One is called the notice of additional information, which really is an FAQ, and we've gone through again using beneficiary testing and stakeholder input for what kind of questions the beneficiary may have. So, this FAQ is... We are hoping this will be helpful. And then also an insert that will list the other MMPs available in the county where they reside. So other options if they choose to make a choice to change. Let's see. And then as mentioned, plans will follow up with an outbound call. Oh, I'm sorry. There’s a question in the chat box here.

Stephanie Conde:

And then in November, the same beneficiaries will receive the 45 day notice along with the notice of additional information. Next slide please. So, our beneficiaries impacted by the mandatory managed care transition, that transition is implementing on January 1st, 2023. The noticing plan is as follows: In November, DHCS sends a 60 day notice with an insert. Again, this is the notice of additional information. It's just like an FAQ, hoping to answer any commonly asked questions. In late November 2022, choice packets will be mailed to beneficiaries that are not part of the Medi-Cal matching plan policy, as I noted earlier. And then just as a reminder, the Medi-Cal matching plan policy impacts 12 counties, and beneficiaries in the 12 counties who are already enrolled in any Medicare Advantage plan will be enrolled in the matching Medi-Cal plan under the same parent organization if there is a matching plan. And then in December, DHCS will send another notice. We call it the 30 day notice, again with the notice of additional information, and then we just gave a little bit of the statistics of the percent of folks who will be getting these notices. Next slide, please.

Stephanie Conde:

So, our long-term care skilled nursing facility carve-in impacted beneficiaries, or beneficiaries impacted by that transition, also occurs on January 1st, 2023. The noticing plan is as follows: In November, DHCS sends a 60 day notice and the notice of additional information. In late November, choice packets will mail to those beneficiaries, again to note that only goes to the beneficiaries that are not part of the Medi-Cal matching plan policy. And then in December, we mail the 30 day notice along with the notice of additional information. Next slide please. So, transitioning a little bit off our noticing and outreach plan, we go into the DHCS monitoring of transitions. So, we call this post transitional monitoring, and we are doing this for the transitions I've walked through already. So, for our long-term care skilled nursing facility carve-in, our Medi-Cal mandatory managed care enrollment transition, and our Cal MediConnect to MMP transition - DHCS will require daily check-in reporting with the managed care plans to monitor any access to care or technical issues.

Stephanie Conde:

DHCS will provide reporting dates and share the reporting template to managed care plans in quarter four, which will include the specific reporting requirements. Additional post transition monitoring will occur through the D-SNP SMAC, so our contract with our D-SNP MMPs, on reporting requirements, and this will be released soon. And then lastly, for the long-term care carve-in, DHCS will require managed care plans to report on a quarterly basis starting in 2023 through a secure file transfer protocol, so through a file upload in order to monitor any access to care or technical issues. This reporting will be done via an Excel template that plans will fill out and submit. And I think, Mary, that is it. So, any questions either on the noticing timelines or our monitoring presentation?

Mary Russell:

Thank you, Stephanie. Yes, so we do have a number of questions coming in from the chat. So, try to prioritize these for you. And again, we'll try to get to stakeholder questions, but also save some time for plan questions as we're able to.

Anastasia Dodson:

One thing, I'm going to jump in just a quick moment to say I see some questions in the chat. And we heard yesterday, we had a really good discussion with the HICAP organizations in CCI counties. And so as far as the list of plan names, because I think some of this is we all hear plan A, plan B, plan X, Y, Z. As soon as all of the formal marketing names and everything is updated in the CMS systems, we'll get a list of the exact plan names for the MMPs in the CCI counties. And then, we'll get lists, and I know people are in the chat about the D-SNP look-alikes and those transitions, so just so you'll know for sure we will get and compile that information, and have it posted on our website or links to the CMS website about all the specific plan names for all of these different Medicare plans that have various impacts in these transitions. So, sorry, Mary, go ahead.

Mary Russell:

Nope, that's a great flag. Thank you, Anastasia, Stephanie, and Anna, question from Jennifer Breen at CAHF, "Will noticing for the ICF/DD carve-in follow the same noticing timeline here?"

Stephanie Conde:

We're still drafting that, so more to come shortly, and we would be presenting to folks on that noticing outreach plan as well. So, just more to come.

Mary Russell:

Okay. And then the second part to that question is, "Will the subacute long-term care SNF residents be receiving the noticing during this fall, or delayed until 2023?"

Stephanie Conde:

Yeah, the same timeline for the ICF/DD is the subacute care facility, so changing 7/1 of 2023.

Mary Russell:

Great. Okay. A question from Jane Ogle, "Will SCAN Health Plan and PACE plan members be affected?"

Stephanie Conde:

They are not impacted by these notices. Nope.

Mary Russell:

Okay. And then a quick reminder for the requests for the slides. Yes, those will be posted online, and we will share that link. A question from Anna Lau, “Are there programs for assisted living besides the Assisted Living Waiver, which has a limited number of beds, especially in the San Francisco Bay area?” I’m not sure Stephanie, if you can speak to this Anastasia, you have additional insight.

Anastasia Dodson:

Yeah. That’s a great question. So as part of CalAIM, and I may not have the exact webpage or terminology handy, but there are structures within CalAIM programs to help with housing related types of services, including assisted living. So, the Medi-Cal managed care plans, that's part of what we're looking for them to do as far as partnering with local resources and organizations that can help with housing related issues, as well as even assisted living situations. We can put more information in the chat about that, a good topic I think for a future one of these sessions is to talk more about what kind of supports like that can Medi-Cal plans provide and then how does that work with Medicare as well?

Mary Russell:

Thank you. I wanted to ask for John Minot from Alameda to come off mute and ask your question. I know there's been some back and forth in the chat, but since it's a bit detailed, would you like to ask that question live?

John Minot:

Thank you. Yeah, so my question was, I wanted to fully understand the typical practical impact on a dual eligible, and I'm thinking of Alameda County, which I think is a non-CCI county. So, non-CCI counties, the effect of people who were not in a Medi-Cal managed care plan but are being auto enrolled on it January 2023 - if someone already in the past enrolled in a Medicare Advantage plan, and no aligned Medi-Cal plan existed. So, that's their starting situation before 2023. Then 2023, they get auto enrolled into a Medi-Cal managed care plan. What is the sum total of these policies impact on this person? What will be their new situation? Will they be in two non-aligned plans? Will they not be in one of them?

Stephanie Conde:

Alameda County is one of our counties in the 12 Matching County policy, so I'm going to state back the scenario just to make sure to make sure I understand. So, you have a member who is in Fee-for-Service today, and a Medicare Advantage plan that does not have a matching Medi-Cal plan. Based on our policy, this person would become

mandatory in 2023. If they stay in that existing Medicare plan that does not have a matching Medi-Cal plan, then they would get a choice packet. They would understand what plans are available in that county, and then make that choice to choose a plan.

Anastasia Dodson:

Yeah. And then Stephanie, at that point, which is already happening today in some counties, their Medicare plan will be different than their Medi-Cal plan and that can continue to happen ongoing, and it is happening for many beneficiaries throughout the state already. But one of the things that we would like to do is think about how we can improve care coordination, even for that scenario, thinking about what information can we share with the Medi-Cal plan so that they know which Medicare plan there are beneficiaries enrolled in and vice versa. Sometimes we may not have data feeds to all of the Medicare plans, especially if they're not D-SNPs, but we're thinking about ways that we can do that because it's important for crossover billing and other reasons for those two health plans to communicate with each other. So, thank you, John. That's a great question. A good scenario. It's not rare at all.

Mary Russell:

Thank you. Let's go to Rick Hodgkins who has had his hand up. Rick, would you like to come off mute? Let us know, Rick, if you're able to unmute.

Rick Hodgkins:

Anastasia, so again, real quickly, it looks like I would be going on to a Medi-Cal managed care plan after all. Could you clarify again... Sorry my computer was talking. Could you clarify again which people would not have to mandatorily go onto a Medi-Cal managed care plan? Because I was confused all this time. I live in Sacramento County, which is one of two different geographic managed care counties. And I have specialists at Stanford and at the University of California, San Francisco. And even though I have Medicare, which is my primary Medicare insurance, they may look at that and say, “Oh, you live in Sacramento County. That's geographic managed care. You need to go back there.”

Rick Hodgkins:

They may not realize that what the managed care plan pays for. They may balance bill me. They may not realize that's illegal. The other thing is about six years ago, when I had just Medicare and straight Medi-Cal, I had to get surgery down here locally, and I went up to my mom's house at South Lake Tahoe to recover. And we established care for me at Barton Health. What if I need to go up to my mom's house in South Lake Tahoe to recover again and Barton Health in South Lake Tahoe will say the same thing. "Oh, well, we can't serve him because he has geographic managed care. Make him recover at home in Sacramento County." And what if my mom wants to take care of me

at her house and have me get home health with Barton Health Care. You know what I'm getting at.

Anastasia Dodson:

Yeah. Great question, Rick. So right now, it sounds like the Medicare providers that you have are already working with you, so they know that you also have Medi-Cal. And I don't mean to be really just talking about you and your individual situation, because I'm trying not to do that on this call, but we're going to make you a hypothetical. And so, a hypothetical beneficiary like you, that has a set of Medicare providers through original Medicare that you're already working with and a hypothetical, then you have Medi-Cal already. Those providers already know that, and they are in their billing offices taking that into account. The change will be when you're in a Medi-Cal managed care plan that the providers for the secondary part of the billing, instead of... And sometimes providers, they don't even do the secondary part to Medi-Cal at all.

Anastasia Dodson:

Many providers do, but it just depends on the provider's office. But instead of going to the state Department of Health Care Services for the secondary, it goes to the Medi-Cal managed care plan. And the Medi-Cal managed care plan will need to provide a response on that claim. But again, that's already happening throughout the state for people who are enrolled in Medicare and they're in a Medi-Cal plan. The Medi-Cal plan, they have a process already developed and it's just the volume of these secondary claims that they'll need to process, but it's no change as far as the amount that your Medicare provider will receive by switching from cheaper service Medi-Cal to managed care Medi-Cal. So, we're not aware of any impact to dual eligible beneficiaries and Medicare provider access from this transition to Medi-Cal managed care. If there was a widespread provider impact, we would want to know about it and address it immediately, but if a dual eligible is already seeing their Medicare providers and those providers are already accepting them as dual eligible, it shouldn't make a difference and it should be better.

Rick Hodgkins:

So, if I need to go out of the county I can? If I need to go out of the county for-

Anastasia Dodson:

So, your other question is about what if you need to recover somewhere else. And Medicare is, especially if you're in original Medicare Fee-for-Service, your benefit doesn't change nationwide. And a lot of times, if you're recovering from a surgery and you have home health, that's actually a Medicare benefit. And again, it's irrespective of wherever you are in the country, but sometimes it can be challenging to make sure that your provider, your Medicare provider, is referring you to a home health agency that

provides coverage in the geographic region where you will be recovering. The final piece on that-

Rick Hodgkins:

And the other thing is if one of these days I get back into skiing in Lake Tahoe, I might want to see a sports medicine physician at Barton Health, and I hope that won't be a problem as well.

Anastasia Dodson:

So, if again, original Medicare, Fee-for-Service, those providers are all over the United States, but in some cases, some Medicare providers are hesitant or may not serve dual eligible beneficiaries because of, frankly, payment issues. And that's irrespective of the Medi-Cal changes. That's just a sort of effect throughout the United States. But if the-

Rick Hodgkins:

This would be an El Dorado County, not in...

Anastasia Dodson:

Yeah, no, I understand. It's just that some... And we probably don't need to get too far into the weeds here. And part of the reason that we encourage, but certainly do not mandate that dual eligibles consider a Medicare Medi-Cal plan or especially a Medicare plan that's affiliated with a Medi-Cal plan is because then the plan can work out those issues on the back end and any provider that's in the directory the beneficiary can see if they're seeing new patients and all of that crossover billing gets worked out in the background with the health plan and the provider and the beneficiary can just look in the directory and see any provider that's accepting new patients. But fully respect anyone who wants to remain in original Medicare, fee-for-service Medicare. And again, we will make sure that the Medi-Cal plans, they already coordinate on the secondary with providers, but we'll make sure that the Medi-Cal plans that are going to be getting a significant number of new dual eligibles are properly set up to communicate and coordinate with providers on that secondary billing.

Rick Hodgkins:

There're going to be plans that are both Medicare and Medi-Cal?

Anastasia Dodson:

Yes, and just in the seven CCI counties that they have an integration across both sets of benefits, but in some cases, in some counties you may have the same Medicare organization also is a Medi-Cal plan. And so, if you happen to be in a county that has that alignment, even if it's not an MMP, a Medi-Medi plan, those two plans, they're part

of the same organization. They can work together to coordinate on the back end all of the billing.

Rick Hodgkins:

Okay. Because I'll be at UC Davis and UC Davis has a plan as well that I'm going to check out.

Anastasia Dodson:

Great.

Mary Russell:

Thank you. It's so helpful to raise those scenarios. Thank you, Rick. I wanted to flag a question for you, Stephanie, from Rob in the chat. Do we know when examples of notification packets will be made available?

Stephanie Conde:

We are planning to post those September/October onto the DHCS website. I think that's the question when you can see these notices? Okay. Yes. We plan to post those on the DHCS website. We'll send out an email and let folks know that they are posted.

Mary Russell:

Great. And then Stephanie, I know there were some follow up questions about impacts to find D-SNP or PACE plans. Did you want to share a bit more detail on that?

Stephanie Conde:

Yeah. Sorry. I responded super quickly on those. So, in general, the notices that I covered for mandatory managed care, long-term care and Cal MediConnect to MMP, those notices don't impact SCAN or PACE members. I will pause though because I think maybe an impact to the look-alikes. Anna, I'm not sure if you know. Sorry to put you on the spot.

Anna Williams:

Yeah, so if there are members transitioning. There are members transitioning from SCAN D-SNP look-alike, they will receive the Annual Notice of Change, which will outline what will be different about their plan starting 2023.

Stephanie Conde:

Thank you.

Mary Russell:

Great. Thank you. There is a question in the chat from Sophie Exdell with the HICAP San Diego, and I will try to do this justice, but I know Sophie is asking about the language in the slide that's referring to the matching plan policy. So as of late November 2022, beneficiaries and 12 counties who are already enrolled in MA plan, will be enrolled in the matching Medi-Cal plan under the same parent organization, if there is a matching plan. And Sophie's question is if this is already happening in 2022, in any other counties, or if this will be happening for the first time in January 2023 in all counties? And Sophie, feel free to raise your hand if you'd like to add to that.

Stephanie Conde:

Sophie, I can initially answer, and then I can take a pause, but right now we don't do the enrollment following the Medicare plan. Even in our matching counties, we do deploy a choice packet for the beneficiary to choose. There is a matching policy, but we do provide the choice packet today. In 2023, in our matching counties, the change will be that they will receive a confirmation letter that explains that they're in the Medi-Cal plan based on their Medicare Advantage plan choice or selection.

Mary Russell:

Great. Thanks Stephanie. Is that clear? Anything to add there? Okay, great. I wanted to catch a question from Joe in the chat, “Will communications to beneficiaries be tested for linguistic comprehension and understanding? What measures are taken to make communication culturally sensitive?”

Stephanie Conde:

Great question, Joe. Thank you. We should have, oh, sorry Anastasia.

Mary Russell:

Oh, oh, I'm going to throw it.

Anastasia Dodson:

Anna, if you want to talk about the beneficiary testing and the work that you all do at CMS there.

Anna Williams:

Yeah, definitely. So, the notices that will be going out about the transition are based off of CMS models used across the country for Medicare transitions. We did solicit comments from advocates in California and got stakeholder feedback on the notices and incorporated that into what will become the final notices. We also, through

beneficiary testing, made sure we also tested the Spanish language version with Spanish speakers so that we could ensure that also makes sense to readers and is culturally competent. I think, I may misspeak, but DHCS also does a readability review too, to make sure that it's easily understood by recipients.

Stephanie Conde:

Yep. That's what I was just going to chime in on. For all the noticing that we went over, they also have undergone a readability review to make sure that they are at the reading level that they should be.

Anastasia Dodson:

Stephanie, can you say more about... I know we briefly touched on this in email this morning, so we will have notices in sort how many languages on the Medi-Cal side? And how do we trigger which language a notice is sent to a beneficiary in?

Stephanie Conde:

Good question. So, we will translate all the notices in threshold languages, and they will deploy based on their language that we currently have in our system, it's the MEDs system, and then what was the second question? The follow up?

Anastasia Dodson:

I think that's the gist of it is the notices themselves will be translated and then they will go to people… The specific language will be based on what we have in our system. So, if we have Vietnamese or any particular language that's in the threshold languages, a certain number of percent of beneficiaries speak those language and indicated their primary language, then we translate and we send them the notice in that language.

Stephanie Conde:

Yeah, you got it. And then we also have in our system recorded alternative format. And so, they will also be deployed in the alternative format that the beneficiary has selected in again, in our database, in our system.

Anastasia Dodson:

Great. And then if, let's just say, the system has a certain language, and they actually want a different language, then is there a kind of an insert that says if you need this in Russian, or something else, then who to contact?

Stephanie Conde:

Yep, you got it. There's a non-discrimination that insert with our taglines and the statement that you just made, if you want to get this in another language is translated in the threshold languages. And so, then they can contact Health Care Options. If the Department is mailing it, they contact Health Care Options to get that. If the plan is mailing it, they would contact their plan.

Anastasia Dodson:

Great. Thank you.

Mary Russell:

Great. Thank you so much. Any other questions, again, feel free to raise a hand and we can take you off mute. There's a question in the chat from Nancy Liu, the Area Director for Asian American. Sorry, the window just closed. But Nancy, this question's a little bit broad, but I want to make sure that we do it justice to clarify. And Nancy's question is about if it's mandatory for Medicare Medi-Cal recipients to switch to one of the insurance plans. And so, I know we're talking about a couple different scenarios, but Anastasia, perhaps you want to reemphasize the voluntary nature of many of the transitions.

Anastasia Dodson:

For Medicare, a beneficiary who is already in original fee-for-service Medicare, they are not required to join a Medicare plan or a Medi-Medi plan. And there's no process where if they don't take action, they will be enrolled in a Medicare plan. So, the folks who voluntarily choose to enroll in a Medicare plan in the seven CCI counties, they will have the option of a Medicare Medi-Cal plan. That's the successor to the Cal MediConnect plans. So, in those seven counties, mostly Southern California, plus Santa Clara and San Mateo, the Medi-Medi plans will be available, and they will have a combined benefit package across Medicare and Medi-Cal. But then there's also regular Medicare Advantage plans, also optional for Medicare beneficiaries to enroll in. But the only thing that is the sort of required transition will be for dual-eligibles in their Medi-Cal plan. And again, most beneficiaries, most dual-eligible beneficiaries in California are already enrolled in a Medi-Cal managed care plan.

Anastasia Dodson:

It's just most of the remaining dual eligible beneficiaries, they will get information about choosing a Medi-Cal plan, or if they're already enrolled in a Medicare plan that has an affiliated Medi-Cal plan, then they'll go to that Medi-Cal plan. But being enrolled in a Medi-Cal managed care plan does not change or restrict your Medicare provider options. If someone is dual eligible already working with Medicare providers, then it's just the sort of backend billing. The secondary goes to the Medi-Cal plan instead of the state. In fact, the Medi-Cal plan can help make arrangements for transportation to

medical appointments and other benefits referrals to IHSS, other resources for dual-eligible beneficiaries.

Mary Russell:

Thanks, Anastasia. Oh, let's see. There's a new question in the chat, “Can you confirm if CCI county plans need to develop a new MOU with managed care plans?” This is from LA county.

Anastasia Dodson:

Is that maybe related to specialty mental health? I wonder.

Mary Russell:

That is what I'm assuming.

Anastasia Dodson:

And I know that we have that question pending. We'll make sure to get that question answered, but I don't know off the top of my head, if a new MOU is required. And I think there was another question in the chat about skilled nursing facilities. If the Cal MediConnect plan already has contracts with such and such skilled nursing facilities because of their transition to a Medi-Medi plan, do they have to get those contracts re-signed? Oh, specialty SUD. Yeah. But for providers like nursing homes, I'm not sure if any of the plans that are on the call want to chime in about what they intend to do or need to do. And I don't know if you happen to know if this sort of transition in a type of plan from a Cal MediConnect plan to an EAE D-SNP, or Medi-Medi plan, do they need to get their provider contracts re-signed?

Mary Russell:

I think more to come on that, unless anyone from a plan wants to raise their hand and chime in.

Anastasia Dodson:

And then we'll follow up on the specialty SUD and specialty mental health around if a new MOU is required, I’ll find out.

Mary Russell:

Great. Well, thank you all so much for these questions. I think this is a really robust discussion. Anastasia, would you like to transition now to the discussion of future meeting topics?

Anastasia Dodson:

Sure, sure. I think we still have plenty of time on the call here. So, we'll talk about future meeting topics, but any other questions are very much welcome. And I noticed that even in the chat, I think there was a question about presentation for assisted living residents, and even perhaps an overall topic to consider there. That's a great question. We'll add it to the list. So next slide.

Anastasia Dodson:

So, this is the list that we kind of landed on a few months ago, looking ahead, and we have tackled some of these topics and some of them will just keep re-raising at every one of the next few meetings. Local examples and discussion of integrated care, we've had that as a topic in the past, and we'll look for ways to highlight that as well. We have so much detail on these enrollment topics that sometimes it’s also helpful to take a different perspective on how are patients impacted and what do these different models offer to members?

Anastasia Dodson:

And then, crossover claims and balance billing. We have been working with, internally and then assistance from experts in the field, about how to communicate this process. And so, we’re working on technical guidance and presentations likely for the September meeting on this topic. We know questions have come up and so we’re excited about having a dedicated discussion on that in the future. We know that at the same time, there’ll be many questions in the future, in the next few meetings about the transition notices. And we want to continue to put information out about what options people have, but crossover claims is very high on our list. Beneficiary communication, integrated member materials, we’ve tackled those, and we’ll continue the next few meetings on those. Same with the Cal MediConnect transition process. Quality measures and reporting, last spring, we talked about quality measures, and we do have the written specifications for the quality measures.

Anastasia Dodson:

Many are the same quality measures that we’re currently using for Cal MediConnect and are posted on our website. We’ll look at ways to post that in our D-SNP policy guide, that’s where we put a lot of those details. And then Provider-Plan information sharing for hospitals and skilled nursing facility admissions. There is a federal requirement about information sharing, and we included that in our D-SNP SMAC contract, which is also posted online and that is a very interesting and important topic. We may not get to that topic in detail for another few months, because probably there's a lot of appetite for talking about these upcoming transitions. But at a future meeting, we can certainly talk about what we expect the D-SNP to work out with their hospitals and nursing homes that they're contracted with. So, whether it's a beneficiary when they're

admitted to a hospital or a skilled nursing facility, how is that information shared back to the D-SNP and ultimately to the Medi-Cal plan?

Anastasia Dodson:

Because the Medi-Cal plan and the Medi-Cal benefits play an important role in getting the services and supports needed for individuals to have a successful transition back home, or to the community. And those Medi-Cal benefits are very important at that point. Medicare Advantage, special supplemental benefits for the chronically ill. There's actually another related topic here. Those particular benefits are kind of new and emerging benefits, and some of them are similar. They're offered by the Medicare plans, but they're similar to Medi-Cal benefits. Even on a broader scale, when we look at dental, hearing benefits, transportation, some of those benefits are offered by Medicare plans and through Medi-Cal. And so, where we're going to be working on technical guidance of how to sort out, of course, Medi-Cal is the payer of last resort, but how can beneficiaries really get the most out of these benefits and the coordination between their Medicare and their Medi-Cal plan?

Anastasia Dodson:

Those types of supplemental benefits are sometimes great interests to beneficiaries when they're choosing a Medicare plan. And so, we want to make sure that those beneficiaries also know what's already offered through Medi-Cal and think about how those two sets of benefits can be synced up. And again, if it's just one plan for Medicare and Medi-Cal than it is much easier for beneficiaries' providers, et cetera, to have a comprehensive benefit package. Updates on the State Medicaid Agency Contract, again, a lot of technical language, but the concepts, we really want feedback from all of you on what requirements we hold the D-SNPs to care management for Alzheimer's and related dementias, we had some of that today. Strategies to improve health equity, as we continue to refine and look at our data that we have within the department and then external researchers helping us, we want to share those results and think about what the implications are.

Anastasia Dodson:

Long-Term Services and Supports Dashboard update. Many of you may know we're working on a dashboard to provide information, that has not been regularly published in the past, about the number of residents in nursing homes across the state. And that information stratified by various demographics and by county and people using long-term services and support. IHSS data is already posted by the Department of Social Services, but then looking at the overlap between individuals that have IHSS and then may have a period of time in a skilled nursing facility or CBAS and IHSS. And what's the utilization of those long-term services and supports by people who are in health plans, Medicare plans, Medi-Cal plans, all of that is going to be in the dashboard. It's really exciting. And so that will be a topic that we'll be covering in the coming months. That's kind of a rundown of future topics. There's so many, so we will not stop these meetings

in January. They'll just continue to be ongoing, because there's so many important topics.

Mary Russell:

Great. Thank you so much Anastasia and yeah, some chiming in in the chat about additional topics as well, which is great. I do have a couple hands raised and since we have time, why don't we go to Jan Spencley, if you'd like to come off mute and ask your question.

Jan Spencley:

Hi, thank you. This has been a great meeting. One thing I thought I heard you say, Anastasia, was that in delegated counties, the CCI delegate counties, that the matching would take place at the PRIME level; and that may have given me some alarm. I'll be honest. So, I'm just checking.

Anastasia Dodson:

I probably misspoke there. Yeah, I misspoke.

Jan Spencley:

Okay.

Anastasia Dodson:

All these different categories and, it’s just complex.

Jan Spencley:

No, no, this has been rather confusing. I would also like to add to your list of potential meeting topics. The one about assisted living for memory care, it's a lot cheaper than putting them in a nursing home and two, um important because they're better actually, but the other is health plan marketing. And we've been living with health plan marketing under Cal MediConnect, which is I'm sorry, I'm just going to say it, sometimes called better harassment. So, I'd like to know if at some point, to just kind of say, let's get back to level setting, I'm hoping. To the marketing roles that were in place before. I'm hoping that's what we're doing.

Anastasia Dodson:

Sure. In fact, this question came up recently from the health plans and we sent a reminder in our state Medicaid agency contract and our SMAC and our policy guide. We do not have any additional state-specific requirements or restrictions on D-SNPs, which includes the MMPs, Medi-Medi plans as far as marketing, except for integrated

materials. So, in the Medicare realm, I believe that marketing and communications are combined together. And so, when it comes to the integrated materials that beneficiaries receive, that is a requirement. But aside from that, we do not have the same restrictions as we had in Cal MediConnect on marketing. And you said agents and brokers for the D-SNP?

Jan Spencley:

It actually helps. Sorry, go ahead.

Anastasia Dodson:

Oh, just one final piece though is because, on the Medi-Cal side we do have requirements for the plans and essentially, we have a file and use policy on the Medi-Cal side for joint Medicare Medi-Cal materials.

Jan Spencley:

And the real issue really is that they were allowed to do outbound calls to get members into Cal MediConnect and make a reasonable effort, and that reasonable effort people would call and say, “Please make it stop.” So, I’m saying normally Medicare does not allow you to make outbound calls to people unless they asked for those calls. Obviously during the transition, because they’re already with the plan, I get it. But after that I kind of have some issues with them getting lots and lots of calls that’s all, which is what has been happening.

Anastasia Dodson:

I see. Yeah. I mean, I’m certainly not an expert on the Medicare requirements there, but I don’t know if Anna has any thoughts, but essentially the Medi-Medi plans need to follow the same rules as regular MA plans and D-SNPs.

Jan Spencley:

Thank you very much.

Mary Russell:

Thank you, Jan. Rick, I see you have your hand raised. Would you like to come off mute?

Rick Hodgkins:

Yes. I have a question about housing, and I sent this question to CalAIM@dhcs.gov, have not yet heard back. I sent this about a month ago and again, have not heard back. I sit on, besides being a part of STEP and I mentioned that in the chat, as well as

Capitol People First, I also sit on the Lanterman Housing Alliance, and we advocate for the independent living and housing needs statewide of the IDD community. We have one member who's a part of Brilliant Corners and they work with one or two different health plans. I can't remember which one's offhand down in the Bay Area and another one, but they want to know, because they find that there are restrictions as to, they want to know what housing services will the Medi-Cal managed care plans under…

Rick Hodgkins:

They want to know what housing services, and I would like to know, so I could pass on to the person who I invited to today's meeting, what housing services will CalAIM, what the managed care plans under CalAIM will pay for? Maybe perhaps, first and last month's, moving expenses, or maybe the first month's rent or deposits. Again, I sent this off to CalAIM@dhcs.ca.gov. Haven't heard back, it's been over a month. Thank you.

Anastasia Dodson:

Thank you so much, Rick. Mary, is it possible for me to share my screen?

Mary Russell:

I believe so. Yes. Yeah.

Anastasia Dodson:

Yes. Let's go here. So, I'm going to share, this is a fact sheet that's on the DHCS webpage. It's about community supports and social drivers for health and Rick, we can email this link to you. On the second page, this includes the list of community support under CalAIM. It includes housing, transition, navigation service, housing deposits, tenancy, and sustaining services. Short-term, post-hospitalization housing; and then there are more materials on the DHCS website in the CalAIM page about definitions of those that are included. The other piece I'll just mention though, is that we're encouraging the Medi-Cal Medicare plans to offer these, as many as possible. But not every Medi-Cal plan offers each one of these, and there is a chart that we can send you, the link, that shows plan-by-plan, which of these are being offered. This information is available and sounds like we should consider having housing supports and related services through CalAIM as one of the topics in a future meeting, sounds like there's an interest in that. So, message received.

Mary Russell:

Thanks Anastasia, and we were able to drop that link in the chat to that fact sheet, so that's a great resource to flag. Thank you.

Mary Russell:

Other questions that we can address at this time? And as a reminder, any future questions, you're always welcome to send them to the info@CalDuals inbox for additional discussion or feel free to drop them and chat now or raise your hand.

Mary Russell:

All right, well thank you all so much and thank you to our speakers today for their presentation. The date of the next MLTSS and Duals Integration Workgroup meeting is Thursday, September 22nd at 10:00 a.m. As a reminder, the slide deck and the meeting materials will be available on the DHCS MLTSS and Duals Stakeholder Workgroup website in the next few days. We appreciate all of your participation. Thank you everyone.