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: 4

FILE DURATION: 1 hour 48 minutes

SPEAKERS

Mary Russell
Anastasia Dodson
Dr. Karen Mark
Bambi Cisneros

Mary Russell:

All right, well, good morning. Welcome everyone to today's CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup. This is Mary Russell with Aurrera Health Group. We have some great presenters with us today. Anastasia Dodson, the Deputy Director for the Office of Medicare Innovation and Integration at DHCS, Dr. Karen Mark, the Medical Director at DHCS, and Bambi Cisneros, Assistant Deputy Director with the Health Care Delivery Systems branch at DHCS.

Mary Russell:

Let's walk through a few meeting management items before we begin. All participants will be on mute during the presentation. As a reminder, the monthly MLTSS and Duals Integration workgroups are designed to provide stakeholders with the opportunity to ask questions. With that, we'd ask that plans that join these calls, hold their questions for the other workgroup venues they have with the Department throughout the month. Please feel free to submit any questions you have for the speakers via chat.

Mary Russell:

During the discussion, if you'd like to ask a question or provide comments and feedback, please use the raise hand function and we will come around and unmute you. As a reminder, the PowerPoint slides and meeting materials will be available on the CalAIM website in the next couple of days. We'll provide a link to those materials in the Zoom chat.

Mary Russell:

We'd like to ask you now to take a moment to add your organization's name to your Zoom name so that it appears as your name dash organization. Click on the participant's icon at the bottom of the window. Hover over your name in the participant's list on the right side of the Zoom window. Click more and select rename from the dropdown menu. Enter your name and add your organization as you would like it to appear.

Mary Russell:

Taking a look at our agenda for today's meeting, we're going to start with an update from DHCS on the erroneous dis-enrollment letter that was sent out last week and a reminder of the transition noticing timeline. Next, we'll hear an update from Dr. Mark on the Long-Term Services and Supports Dashboard. After that we'll walk through a summary of the January 2023 enrollment changes and share some updates on the 2023 D-SNP policy guide, followed by time for Q&A.

Mary Russell:

Finally, we'll hear a brief update on the Skilled Nursing Facility, Long-Term Care Carve-In from Bambi. We'll end the call with some information on upcoming meetings and next steps. As a reminder, additional background slides on the Public Health Emergency Unwinding are available in the appendix. And with that, I'll hand it over to Anastasia Dodson.

Anastasia Dodson:

Good morning, Mary. Thank you. Thank you everyone for joining. We're very glad to be here with you all again doing these regular meetings in the lead up to the January transitions. And then afterwards, we'll still have lots to talk about with this group. Where our intent is for this stakeholder meeting series to be a collaboration hub for all kinds of stakeholders, beneficiaries, health plans, community partners, providers, all kinds of advocates. Everyone is welcome here.

Anastasia Dodson:

We do have a broad scope for this group, but then we try to have particular items on our agenda that we've included in sort of advance, so people will know what topics, and we can have the presenters on. I'll just flag that we know there is a lot going on in this space around the transition for Cal MediConnect, the enrollment of dual eligibles and others into Medi-Cal managed care in January, as well as the Long-Term Care Carve-In and other topics related to long-term care.

Anastasia Dodson:

We will need to be cognizant here of we have certain presenters, certain speakers able to answer questions, but there may be topics that we don't have the exact experts on. There are other meetings, other stakeholder meetings, for example, about the WQIP and the Long-Term Care Carve-In that, if we either run out of time or we don't have the right expert on this particular meeting, there are other meetings and other email inboxes that we can use for those questions. I want to manage expectations of what can we get through and as thoroughly as people might like. We're trying to again, have agenda items. We'll do our best on those and other questions may need to be deferred. All right, next slide.

Anastasia Dodson:

Again, these are some of the key topics, but as we move into January, we're talking with folks about how to evolve this meeting series, and again, how this meeting fits in with other meetings. But there's plenty and lots of really good things to talk about here. Next slide.

Anastasia Dodson:

All right, so let's start with some updates, and there's no new policy on the January 2023 transitions. This is just updates about different pieces that are moving. But again, no policy changes as far as the January 2023 transitions.

Anastasia Dodson:

In addition to the notices that the health plans for Cal MediConnect sent out around the transition, there was a 90-day and a 45-day notice. We at DHCS sent a notice that was triggered by certain transactions and that notice should not have been sent. It was an erroneous dis-enrollment letter that was sent in error, but there was no actual dis-enrollment at all from Cal MediConnect related to this notice.

Anastasia Dodson:

The letter was sent to Cal MediConnect members in Los Angeles, Riverside, San Bernardino, San Diego, Santa Clara counties. It was sent on or around November 30th, and again, was sent in error, not part of the outreach plan. Cal MediConnect members were not disenrolled early at all from their Cal MediConnect plans. Part of the reason that notice was triggered was because of transactions that we are doing with CMS in order to effectuate the transition to the EAE D-SNPs, January 1st.

Anastasia Dodson:

Anyway, we, DHCS, then last week conducted an outbound call campaign to everyone who was sent that erroneous notice. We have tried to use every platform and forum and method we can to let all of you know, basically, members can disregard that notice. There's no action is needed. It's just a simple error.

Anastasia Dodson:

Health plans have also been reaching out to members and we appreciate all the work that you all have done in reaching out to members. It appears we did have some increase in call volume as a result of the notice, but our call volume has now gone down substantially. It's back on a sort of even level. We think that it appears that members know now to disregard that letter. Continue as before, the transition will occur January 1st.

Anastasia Dodson:

Again, in the meantime now our technical teams are working very hard and have been working for many months to make sure that those enrollment transactions, along with the CMS teams, the health plan teams, the DHCS teams all working together to make sure that the January 1st transition, everything is executed as it should. We will keep you posted on that. We expect there may be certain scenarios for small numbers of people, whether it's issues with maybe an address or if there was some other transition issue for small numbers of individuals based on sort of narrow circumstances.

Anastasia Dodson:

You know, as those questions come in either from plans or from CMS or from the DHCS side, we're examining those and resolving them as quickly as we can, but we don't expect any sort of large-scale issues. But again, the teams are working very hard, and should there be anything that actually is not going according to plan as far as enrollment, we will let everybody know and act accordingly to notify people. But at the moment, everything seems like the systems are talking correctly to each other and the transition should go smoothly. Okay, next slide.

Anastasia Dodson:

This is the noticing timeline that we have showed in the last six months or so. The notices in September, October, November, December, those have all been sent, and this is beyond the Cal MediConnect transition. This also includes the enrollment of dually eligible individuals into Medi-Cal managed care plans as well as the Long-Term Care Carve-In to Medi-Cal managed care for skilled nursing facilities. Those notices for all three of those transitions plus the D-SNP lookalike have gone out, and again, all of the health plans, call centers, et cetera, at DHCS, CMS, health plans, people are being given information about that.

Anastasia Dodson:

I'll say I haven't been looking at the chat, but I think I may have seen something from Rick. We are continuing our work at DHCS to outreach to providers, to Medicare providers. We are still hearing some numbers of people. There is some confusion either somewhere along the line related to providers who are Medicare providers and there's t a misunderstanding at times that Medicare providers need to be enrolled into the Medi-Cal plan network and that is not true. Medicare providers do not need to be enrolled in the Medi-Cal network in order to continue seeing their patients.

Anastasia Dodson:

Just yesterday, we had a call with group of hospitals. Later today, and then tomorrow, we're doing more outreach. We're continuing to outreach. We're partnering with CMS to outreach to all Medicare providers, particularly in the Bay Area and Central Valley counties, because we know that's where this transition is sort of a bigger difference than the current enrollment patterns.

Anastasia Dodson:

We know, in Southern California, this enrollment transition for dual eligibles occurred a number of years ago, so providers, members, everyone, they're used to it as well as in coastal areas and the far north. But it's in some Bay Area counties and the Central Valley where we're still hearing some questions and concerns. We are talking to providers as much as possible and we have beneficiary fact sheets on our website in

many languages. We also have videos in three languages and our Health Care Options team. Many other community groups have been appraised of this and trying to reinforce the message that enrollment in a Medi-Cal plan does not interfere with your Medicare provider access. You can continue seeing your Medicare providers even as you are enrolling in a Medi-Cal managed care plan. Next slide.

Anastasia Dodson:

So, we also have the outbound calls that have been made and are ongoing, particularly right now in December for managed care enrollment in into Medi-Cal for dual eligibles and others. There are some other Medi-Cal only folks transitioning to Medi-Cal managed care as well as the Long-Term Care Skilled Nursing Facility Carve-in. Those are ongoing calls that DHCS is making. Next slide.

Anastasia Dodson:

Again, we have a lot of materials online. We have both for the Cal MediConnect transition and for the transition of dual eligibles in into Medi-Cal managed care. Again, this outlines some of the communication efforts that we have going, and we're happy to do more, and happy to continue those communications in January as well. If any provider group, any community group wants to meet and talk about any of this with a smaller group, Q&A, we're happy to do that. Next slide.

Anastasia Dodson:

The other thing I want to flag, and I believe we've talked about this in prior meetings, so that we have currently a Cal MediConnect Ombudsman program. That Ombudsman program was previously part of a federal grant with the Cal MediConnect program. So now, because of the CalAIM 2021 trailer bill that authorized a continuation and an expansion of the Ombudsman , and that this Ombudsman program for dual eligibles is provided by a network of organizations, the Health Consumer Alliance that has expertise in enrollment and also access to care and benefits issues. So, anyone who is dually eligible in any county in California and has particularly questions about a Medicare Advantage plan, a Medi-Medi Plan, our EAE D-SNPs, or either an enrollment question or a question about if they’re believed that there’s a benefit or a procedure they would like to access and they’re having an issue with their Medicare plan or their Medi-Medi Plan, they can use this number as a resource. There will be one-on-one help. Very similar, same as what is already provided through the Cal MediConnect Ombudsman.

Anastasia Dodson:

This, again, applies to all type of Medicare Advantage plans, including PACE, including our SCAN FIDE SNPs, and of course the EAE D-SNPs, and any other regular D-SNP and any other MA plan. We know that people who are dually eligible, they have two sets of benefits, and oftentimes, they could be through different plans, or even if it's the same plan, maybe there's a concern that they have and the Ombudsman can help with that.

Anyway, that phone number is still the same and the great team at Health Consumer Alliance and Jack Dailey, his group, are well positioned to serve all of us in this role. Next slide. Okay. Let's go to questions.

Mary Russell:

Great. I'll flag a few questions in the chat, but again, please feel free to raise a hand or drop a question in the chat related to noticing outreach or other resources at this point. Anastasia, I'll start with Rick Hodgkins' question in the chat. I think it was to your point about DHCS's outreach with some of the UC Medical centers, "Has there been any contact with Barton Health in South Lake Tahoe on the California side?"

Anastasia Dodson:

I don't think we have specifically reached out to Barton, but we'll absolutely put that on our list. Yeah, thank you.

Mary Russell:

Thank you, Rick. There were also a few questions, I think to your earlier point. There are several other venues for other questions. Beth Garver is asking about the WQIP. I believe there's other venues for that element, correct?

Anastasia Dodson:

Yeah, I think so. And I'm hoping someone else from DHCS who's maybe got the date for the WQIP meeting, because I believe that's next week. I'm not sure what day, but there is a stakeholder meeting on that.

Mary Russell:

Sure. Great. We'll try to get that info and drop it in the chat, Beth. Also, a question from Mariam with the Congregate Living Health Facilities and their connection to the MLTSS transition.

Anastasia Dodson:

Yeah, so when Bambi Cisneros is on later, she may have an update on that. But for right now, our main focus is making sure that the enrollment transactions and the other sort of affiliated work that we need to do for the skilled nursing facility transition to Medi-Cal managed care and those 31 counties, as well as Medi-Cal managed care enrollment for dual eligibles and the Cal MediConnect transition. Those are our very, very top priorities right now.

Anastasia Dodson:

If there are unresolved issues with CLHFs we may not necessarily be able to resolve those by January 1st, but we recognize that an important part of the continuum of care in long-term services and supports. But again, we really need to make sure that everything goes as it should or as best it as can for our enrollment issues for January 1st. So, if any new policy issues we may not be able to resolve in the next few weeks, but certainly, we can continue meeting and if we don't have the right people on the call for that topic, we can have them on a future call.

Mary Russell:

Great. And then Mariam, to answer your follow-up question, yes, Bambi will be presenting later in the meeting on the Long-Term Care Carve-In transition. Other questions related to noticing or outreach? At this point, I don't see other hands raised or questions in the chat.

Anastasia Dodson:

Mary, we could, perhaps, I know this might be a little funny, but skipping forward, because if we're at the dashboard, I don't know if Karen Mark is on yet, but we could skip ahead for a few minutes.

Mary Russell:

Yup. I think that works. Let's jump to the 2023 transition slides. And Anastasia if you want to kick those off.

Anastasia Dodson:

Sure. Again, these are the same slides that we have been showing in the previous meetings, but there may be some of you that have not been there or you want to just a refresher. So, here is the refresher. Same policy, but you know, many moving pieces. Let's go to the next slide.

Anastasia Dodson:

For Cal MediConnect, that's a demonstration that's currently, for the next couple of weeks, still in California. That demonstration is transitioning, it is Cal MediConnect right now. It's transitioning to what we're calling Medi-Medi Plans in the seven counties where we had the Cal MediConnect. Medicare Medi-Cal plans, or Medi-Medi Plans, those combine Medicare and Medi-Cal into one plan. They are replacing the Cal MediConnect plans and they're available in seven counties. You can see that third bullet. Los Angeles, Orange Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties.

Anastasia Dodson:

Enrollment in a Medi-Medi Plan or any type of Medicare Advantage plan is voluntary. We are definitely hearing some confusion from people about the Medi-Cal managed care enrollment versus the Medicare enrollment. Medicare Advantage and Medicare managed care is always voluntary. Medi-Cal managed care, that is a requirement that, starting in January, essentially all dual eligibles in California must enroll in a Medi-Cal managed care plan, but enrollment in a Medicare plan is voluntary.

Anastasia Dodson:

So, we appreciate all of you in community groups, HICAP organizations, stakeholders, health plans, that are helping to reinforce this message clarifying that enrollment in a Medicare plan is voluntary. Enrollment in a Medi-Cal plan is required, but enrollment in a Medi-Cal plan doesn't impinge in any way on Medicare provider access.

Anastasia Dodson:

With the Cal MediConnect transition, it will be automatic. No action is needed by the member to transition to a Medi-Medi Plan. And it's the same parent organization that the health plans that have Cal MediConnect plans have the Medi-Medi Plans in those seven counties. Next slide.

Anastasia Dodson:

Again, the Medi-Medi Plans are a similar approach to Cal MediConnect and those, the Cal MediConnect plans had high consumer satisfaction. There's simplified care coordination, one care coordinator, or a care team, across both sets of benefits, Medicare, and Medi-Cal. There's combined integrated beneficiary and provider communications across both sets of benefits, so unified process for durable medical equipment. And then, plan level appeals and grievances are integrated. Next slide.

Anastasia Dodson:

So, again, January 1st, Cal MediConnect beneficiaries will be transitioned and there should be no gap in coverage. The provider networks should be substantially similar. There’s also continuity of care provisions for any providers that are not in the new plan network, but the network should be very substantially similar. Next slide.

Anastasia Dodson:

For integrated materials, the Medi-Medi Plans, they have integrated member handbooks and Annual Notice of Change, member ID card, summary of benefits, and provider and pharmacy directory. Again, just like the Cal MediConnect model combined across both sets of benefits. Next slide.

Anastasia Dodson:

So, these next few slides are the same as what was presented last month about the Medi-Cal Rx, and the gist of it is that, in Cal MediConnect, the Medi-Cal pharmacy benefit was included in that contract. But with the transition to the Medi-Medi Plans, the pharmacy, the Medi-Cal pharmacy benefit, goes back to Medi-Cal Rx. The Part D Medicare pharmacy benefit stays with the Medi-Medi Plan and that is the vast majority of pharmacy benefits that people use when they're dually eligible. So, I believe we may have someone from our pharmacy team if anybody has any questions about this. Next slide.

Anastasia Dodson:

Right. There's this more information about outreach. Next slide. Again, here's additional information about providers with this transition. Again, it should be very ... a relatively small transition. It's important, but again, the vast majority of pharmacy benefits that dual-eligible members access are through Part D, and then some through Part B Medicare. Again, our Medi-Cal Rx webpage and team is handling outreach to pharmacies and providers on this. Next slide.

Anastasia Dodson:

Here's some other technical information. Again, the slides will be available and posted. If there's questions on the pharmacy transition, we're happy to have the team members speak up on that. Next slide. Okay, let's keep going.

Mary Russell:

I wonder, Anastasia, do you want to pause here? We do have Paul from PBD on.

Anastasia Dodson:

Sure.

Mary Russell:

If Paul wants to, if you want to jump in with anything, Paul, or if there are questions for that team?

Paul Nguyen:

Thanks, Mary.

Mary Russell:

Yeah, go ahead.

Paul Nguyen:

Yeah, hi. I am Paul Nguyen. I'm with the pharmacy benefits division within DHCS. So, the pharmacy transition for Medi-Cal Rx, that is happening on January 1st. This slide here just goes over some billing information for Part B co-insurance billing claims. That link there will take you to the payer specification sheet, which may have some additional information to kind of help you process claims, especially if it says something new for you. Next slide, please.

Paul Nguyen:

Yeah, and I think that was the last slide. Just so everyone is aware, the notification from Medi-Cal Rx, the 30-day notification, was already sent out on December 2nd. And so that's already been kind of sent out to the plan, and obviously, the 45-day went out before that. But I think this is the end of the slide presentation as it pertains to Medi-Cal Rx, so I'm happy to try to answer any questions, and if not, we can definitely kick it back and take a look at it.

Mary Russell:

Thank you, Paul. There is one question in the chat that others may be having as well, but Rick is asking, "Whatever pharmacy I have, will I be able to stay with them if they are a Medicare provider?"

Paul Nguyen:

Yes. What's happening is the drugs that are covered by Medicare Part D, that will continue to stay with the managed care plan. Medi-Cal Rx is going to pick up all Medicare Part D excluded drugs, and so those are typically going to be drugs such as over-the-counter drugs that are covered by Medi-Cal Rx.

Paul Nguyen:

There may be some diabetic supplies and whatnot. Those are going to be the more common drugs that you see. As far as the Part D drugs, which are going to be prescription drugs, those will be covered by the plan and whatever the specific plan's pharmacy network is, they're the ones that'll kind of see which pharmacies are there.

Paul Nguyen:

For Medi-Cal Rx, the pharmacy does have to be a Medi-Cal enrolled pharmacy provider. I think we've got 94% of the pharmacies and pharmacies can always enroll and kind of start that process. Rick, I hope that answers your question.

Mary Russell:

Thanks, Paul. A question from Leah about how pharmacies have been informed or educated about these changes.

Paul Nguyen:

Yes. Medi-Cal Rx actually went live last January and now the Rx portion for Cal MediConnect is going live this January.

Paul Nguyen:

So, pharmacies have been processing claims for dual eligible beneficiaries for this past year. But yes, pharmacies are aware. Like I said, the notices, the 30-day, 45-day notice have gone out. We've had numerous meetings with various pharmacy organizations, all the major chains and some of the, I think, organizations that represent independent pharmacies. And so most pharmacies, I would suspect, if not all pharmacies, that are enrolled with Medi-Cal, at least have some experience with Medi-Cal Rx.

Paul Nguyen:

And we've also been working with the managed care plans, and they also help us with provider outreach, both in terms of, say, physician provider outreach as well as pharmacy provider outreach as well.

Paul Nguyen:

And we do have a website, I can share the link that talked about the CMC transition, and it's linked to the Medi-Cal Rx homepage. I'll do that at the end of this.

Paul Nguyen:

As far as the counter, as far as the pharmacy staff, that's really going to be up to the individual chains. I cannot speak for the chains, but I suspect that this information should be filtered down since they are the ones that typically are processing these claims.

Mary Russell:

And of course, Paul, I know Anastasia just presented on Ombuds' contact information and other ways to get help, but any other notes for people that might be experiencing challenges at the pharmacy?

Paul Nguyen:

Yes, and also thank you, Alisa. The Medi-Cal Rx, that's Medi-Cal Rx webpage, the customer service center is also listed there, and the Medi-Cal Rx customer service center is open every day, all day, including holidays and whatnot. So, if there is a question, a beneficiary or pharmacy, they can always call them to try to get help processing a claim, and there should always be someone to pick up the phone.

Mary Russell:

Great. Thank you so much, Paul. Appreciate the time and thanks for the questions in the chat on this. Rick, I see your hand. Actually, at this point we're going to transition to an update from Dr. Karen Mark on the LTSS dashboard, but we will have time for additional questions later in the presentation. So, we will just shift gears really quickly. Thanks, everyone. And then, Dr. Mark, you should be able to come off mute.

Dr. Karen Mark:

Great, thank you so much. I wanted to just give a brief update on Long-Term Services and Supports Dashboard. If you can go to the next slide. Just by way of background, of course, we're all aware of the growing need for long-term services and supports to support our older adults and people with disabilities. There is, fortunately, within California a wide array of LTSS Home and Community-Based Services available. But there is, unfortunately, a lack of universal national and state quality standards for HCBS. Although there is progress being made in this area at the national level. We've really recognized a need for more publicly reported data on the provision of LTSS in California to really track and understand our progress around these programs. Next slide.

Dr. Karen Mark:

The LTSS dashboard initiative goals are to publish utilization cost and quality data on Medi-Cal LTSS, including both long-term care and HCBS data. We will really want to increase the accessibility of accurate, timely, and meaningful data. And we want this data to be used to inform regulators, policymakers, advocates in the public on efforts to expand, enhance, and improve the quality of LTSS in all of our home, community, and congregate settings. Next slide.

Dr. Karen Mark:

This shows our timeline for the overall initiative. In this month, we have just published an initial version of the LTSS dashboard. Over the next year and a half, we'll be building and expanding on that initial version. So, we are working on gap analysis, an HCBS gap analysis, we'll be adding and refining measures related to that gap analysis, and then we'll be publishing newer versions of the dashboard over time, including expanding or improving the way that the data is displayed. And then in March of 2024, this is when the HCBS spending plan funds expire, for this initiative. But we do after that date expect to continue to update the dashboard. We won't be building new metrics, per se, after that date, but we'll be updating it with new data and obviously use the data to perform our program development. Next slide.

Dr. Karen Mark:

And if you can go on. So, as I mentioned, we just released the initial version of LTSS dashboard this last Monday. And if you haven't seen it, it is on our website. So, if you

just google “DHCS LTSS dashboard”, you'll get to our LTSS dashboard landing page. And from there, there is a link to the Cal HHS Open Data Portal, which is where the data actually sits. We also have a link to measure specifications that really define more exactly what these measures are. We have a user guide that walks you through how to use the data in the open data portal. And we've also included a link to a fact sheet.

Dr. Karen Mark:

For those of you who's ever used the open data portal, it's really a way to download and look at very detailed data. But for people who aren't super data savvy, it can be a little bit tricky. And the fact sheet really just outlines some of the major findings and some basic information for those of you who may want to just get an overview. This initial dashboard has data from 2017 through 2021 and it includes 40 measures related to enrollment and utilization. As I mentioned, we will be adding additional measures on a flow basis. And this data, the data are stratified by sex, race/ethnicity, primary language, county of residence, and Medi-Cal managed care plan, as well as dual status. Next slide.

Dr. Karen Mark:

So future dashboard releases, as I mentioned, first of all, we will be enhancing the data visualization and the user interface. The open data portal is not super user friendly, but we have plans to have a separate data visualization and user interface that will make it easier for people who want to just take a quick look at the data. We also will be adding metrics related to quality and cost. And as I mentioned, as part of the Money Follows the Person HCBS gap analysis, we've contracted with Mathematica who will be looking at a number of different quality and cost metrics we could potentially add.

Dr. Karen Mark:

We'll be continuing our stakeholder feedback and engagement as we develop new metrics to add and really want to outline or emphasize, we have this email, the ltssdashboard@dhcs.ca.gov. So if you have any feedback, if you look at the dashboard and there's things that you'd like to see that you don't see yet, if you have suggestions for us or if you have any questions as you're looking at the dashboard, please send us an email because we will be making additions to the dashboard and want to make sure that it's basically most useful to all of you. Next slide.

Dr. Karen Mark:

This just shows the programs that are included in the initial release of the dashboard include the AIDS Medi-Cal waiver program, the Assisted Living Waiver, Multipurpose Senior Services Program, the Community-based Adult Services, Home and Community-based Alternatives Waiver, In-home Supportive Services, Program for All-inclusive Care for the Elderly, and Long-Term Care, which includes skilled nursing facility, subacute facility, intermediate care facility, and/or custodial care facility. We do have some

measures in development, as I've mentioned. This includes a measure related to California community transitions, home health, self-determination program, and home and community-based services for the developmentally disabled. Next slide.

Dr. Karen Mark:

We did want to highlight for all of you that there are differences in the way LTSS data are presented by department. So, most DHCS LTSS dashboard measures report the annual number of certified eligible Medi-Cal beneficiaries who used LTSS services within a year. However, the Department of Social Services reports monthly counts of IHSS recipients. And similarly, the California Department of Aging reports monthly CBAS Medi-Cal participants. And so, our annual utilization enrollment counts for both IHSS and CBAS are larger than the CDSS and CDA's monthly counts because of data source differences and also because of new enrollment and program attrition over time. So, we just want to make sure everyone using dashboard is aware of that, so they're not confused when they see that the numbers do not exactly match what other departments are presenting. Next slide.

Dr. Karen Mark:

Next, I wanted to just share some of the key findings and the data that we're releasing. The dashboard shows that California continues to have a strong rate of LTSS rebalancing, otherwise known as HCBS utilization compared to overall LTSS use. So, in 2021, 85% of Medi-Cal beneficiaries that used LTSS services used HCBS, and only approximately 15% of LTSS beneficiaries stayed in a long-term care facility but did not use LTSS. The dashboard shows an increase in HCBS utilization each year, as well as a decline in average monthly census and overall use of long-term care facilities in 2020 and 2021. And this, of course, has been seen nationwide, and is likely due to the impact of COVID-19. The population utilizing HCBS is more likely to be people of color and those whose primary language is not English compared to the population utilizing long-term care.

Dr. Karen Mark:

If you go to the next slide, we just show some of these data that I've just summarized. So, this looks at the percent of LTSS beneficiaries who used the select HCBS services that I've mentioned over time and how it's increasing to almost 86% in 2021. Next slide.

Dr. Karen Mark:

And this shows it in the top number, the count of people using select HCBS services and show that it's increasing over time. And then in blue, we see the long-term care beneficiaries, and you see it's relatively stable, but it decreases slightly in 2020 and 2021. And then you see sort of a similar trend in the monthly average count of long-term care beneficiaries. Next slide.

Dr. Karen Mark:

And this shows the percent of select HCBS beneficiaries of various race/ethnicities. And then, similarly, in the next column, the percent of long-term care beneficiaries of select race/ethnicities. And what you see is the percent of select HCBS beneficiaries who are people of color is somewhat higher than the percent of long-term care beneficiaries. And sort of similarly, the percent of long-term care beneficiaries who are white is somewhat higher than the percent of select HCBS beneficiaries who are white. Next slide.

Dr. Karen Mark:

And this shows the primary spoken language of select HCBS beneficiaries and the primary spoken language of long-term care beneficiaries. And, similarly, you see that the percent of select HCBS beneficiaries who speak really just a wide variety of languages and really just shows the percentage of those who speak a language within the spoken language category is slightly higher among the HCBS beneficiaries. And then if you looked in the percent of long-term care beneficiaries that speak English, that's slightly higher than the percent of HCBS beneficiaries who speak English as a primary language. Next slide.

Dr. Karen Mark:

And this just shows a few other demographics of both the select HCBS beneficiaries and the long-term care beneficiaries. So, the long-term care beneficiaries are slightly more likely to be older and more likely to be dually eligible for Medicare. Next slide.

Dr. Karen Mark:

So, with that, I really want to just open it up for questions or comments that people may have on this initial release and really looking forward to any suggestions that people have as well as for things they might want to see in the future.

Mary Russell:

Thank you so much Dr. Mark. Flagging a few things in the chat. Slightly different, but Barbara McLendon is asking if there will be a dashboard that tracks community supports. Understanding the level of uptake on those supports would help identify areas that need training or technical support or consumer engagement. Any thoughts on that?

Dr. Karen Mark:

Great question. So, I believe that is also in development. It won’t be part of the LTSS dashboard, but there’s a separate dashboard that I believe is in development to track community supports.

Mary Russell:

Great. And there's been a bit of chat about if the data and the LTSS dashboard is available at the county level.

Dr. Karen Mark:

Yes, it is stratified by county of residents of the Medi-Cal beneficiary, so you can stratify that way.

Mary Russell:

Got it. A question from Meredith at LeadingAge California, "Will the gap analysis include non-Medi-Cal funded HCBS?"

Dr. Karen Mark:

The current data that we have include just the select HCBS services that I outlined.

Mary Russell:

Okay. Got it.

Dr. Karen Mark:

And I'll just go back to the question also around the county. I'm not sure if this is quite what that person was asking, but, unfortunately, in this first version of the dashboard, you can only stratify by one of the stratifications that I mentioned. So, for example, you can look at services by county, but you can't further stratify like, let's say, services by county and then look by race/ethnicity or then look by language. So that is something that I know would be helpful and we're looking at potentially as something to do in the future.

Mary Russell:

Got it. Can you speak to how the LTSS dashboard aligns with the Master Plan for Aging Dashboard?

Dr. Karen Mark:

Yeah, great question. So, we have been working and in discussions with the folks working on that as well to make sure that the two are complementary and certainly not duplicative. So, I think that dashboard is a little bit more sort of consumer focused, and this dashboard is, as I mentioned, looking at the utilization of our services, but we're definitely wanting to sort of cross link between the two and make sure, again, that the efforts are additive and not duplicative.

Mary Russell:

Great, thank you. A couple other questions that have come in. So, I know you touched on how stakeholders can provide feedback on the dashboard, and if there are suggestions for additional measures, the best way to get those to the Department and then maybe how often the dashboard will be updated.

Dr. Karen Mark:

Great. Yeah, so definitely send any suggestions that you have to that email that I shared. And, also, if you're interested in being involved in future stakeholder efforts, definitely let us know through the email. So, as we build the dashboard, we will be reaching out to groups of folks as well. So just to let us know if you're interested in being involved in that process.

Dr. Karen Mark:

In terms of, I think, what was the second question? Around how frequently the dashboard will be updated?

Mary Russell:

Right.

Dr. Karen Mark:

We don't have an exact planned frequency, if you will, but what we are doing is sort of on an ongoing basis there are a number of other measures that were not included in this initial dashboard release. So, like I mentioned, the developmental disabilities waiver, et cetera, that we're working with other departments and working on the specifics to get some of those measures ready. We'll be releasing additional measures as soon as they're ready on sort of an ongoing flow basis. We do expect after we have the recommendations from our contractor, Mathematica, around the gap analysis, sort of another major dashboard release that will include more inequality and cost metrics. That will be several months away from now, sort of into late next year, I think. But we'll be making a smaller update before then.

Mary Russell:

Great, thank you so much. One other question that we saw. Can you speak to any plans for future data visualizations or other details that would be included in future iterations of the dashboard?

Dr. Karen Mark:

Yes. So, certainly we're working with our data colleagues and with a data visualization contractor to build basically another site that would enable much, much easier visualization of the data, and we do expect to launch that in the next several months, and we'll certainly update this group when we're ready to do that.

Mary Russell:

Great. Thank you so much, Dr. Mark. Any other questions on the LTSS dashboard? Okay, hearing none at this point, thank you. We appreciate you hopping on for today's presentation.

Dr. Karen Mark:

Thank you, everyone.

Mary Russell:

So, I think at this point, looking at our agenda, and I appreciate everyone's patience as we sort of jump around a bit managing some different scheduling needs. Why don't we jump to a quick update on the policy guide, the D-SNP policy guide chapters. Great. So, I am happy to provide a quick update on this, and, Jacqulene, please feel free to chime in here, but as has been discussed in previous meetings, the 2023 CalAIM D-SNP policy guide is in development and is working towards finalization. The current version that was updated last week is live on the CalAIM website, and the policy guide provisions that apply to all D-SNPs and those that apply only to MMPs are flagged within each chapter. So, the hope is that that is very clear which guidance is relevant for which plans. And a note that the provisions of the policy guide are part of the DHCS SMAC requirements for 2023. So that's the State Medicaid Agency Contract that D-SNPs have with DHCS. Next slide, please.

Mary Russell:

So, as I mentioned, there was an update to the 2023 policy guide, and that was posted on the website last week. And you can follow this link to find the latest version. The most recently released chapters relate to network guidance for MMPs, so non-EAE D-SNPs, and then integrated appeals and grievances for MMPs as well. And so, you will find those updated chapters in the link on the DHCS site, and there's also some supplemental materials that accompany each of those chapters, and those are also posted on the site. A quick visual here just to show you where these materials live on the CalAIM site. The 2023 policy guide is right there under that purple header for the contract year 2023 D-SNP policy guide. We're adding a link to the chat right now to hopefully make that easy to reference.

Mary Russell:

And then as I mentioned, the supplemental materials are linked under that sub-bullet. You can see that two of them relate to the network guidance chapter, and one is related to the integrated appeals and grievances. And that is a requirements comparison table that was provided by CMS that DHCS has collaborated on as well. Next slide.

Mary Russell:

So, I'll share a few highlights of the 2023 network guidance from MMPs. As a reminder, so this is effective January 1st, 2023, and the requirements have been developed per federal and state provider network requirements. DHCS has developed these requirements in consultation with stakeholders and health plans. We appreciate those stakeholders that were part of those conversations going back for quite a few months now. And the goal of the aligned networks is to ensure continuity of access to providers across Medi-Cal and Medicare. For contract year 2023 DHCS intends to solicit information from EAE D-SNPs about the extent to which their networks are aligned and will be providing subsequent guidance on aligned network requirements for 2024. So, as has been discussed in other conversations, the goal of the data that DHCS is requiring in 2023 is to inform the guidance and requirements for contract year 2024. So, I know the Department is really interested in what the numbers show and what that means for beneficiaries and how that will inform future requirements. Next slide.

Mary Russell:

So, a few highlights from the Integrated appeals and grievances chapter that was just updated and released. The intent of this state-specific guidance is to ensure integrated processes for grievances, organizational determinations, and reconsiderations for enrollees in MMPs starting in 2023. So super important elements for the beneficiary experience. And this process is detailed within the policy guide chapter as well as that comparison table that I mentioned that is linked on the website. And there has also been a very robust conversation with the multiple stakeholders that were part of this development as well as CMS, and DHCS, and DMHC. So, on the website you'll find the revised chapter and the requirements comparison table. And I know there have been some ongoing conversations with plans to just really clarify the implementation of these requirements, and the Department is happy to continue that conversation as well. Next slide.

Mary Russell:

Great. I know we just wanted to provide a few highlights. Jacqulene, I'm not sure if you have anything to add there, but a few highlights on the current version of the policy guide and let's jump back into the 2023 updates, and I know Anastasia will be ready to pop back in just a few moments.

Jacqulene Lang:

Thank you, Mary for that update. Appreciate it.

Mary Russell:

Sure. Jacqulene, do you want to share anything on these slides on the look-alike plan transition?

Jacqulene Lang:

Sure, we can go through these slides.

Mary Russell:

Great.

Jacqulene Lang:

Good morning, everyone. I'm Jacqulene Lang over at the Office of Medicare Innovation and Integration. And so just an overview of the D-SNP look-alike plans. There are Medicare Advantage plans that are marketed to dually eligible beneficiaries, but they're not required to provide care coordination with Medi-Cal benefits, integrated care, or joint enrollment. Additionally, look-alike plans, they have 80% or more members who are eligible for Medi-Cal, meaning that they mostly serve duals. Again, they do not meet D-SNP integration requirements, and enrollment in these look-alike plans has increased in the CCI counties in recent years due to heavy marketing efforts and limits on D-SNP enrollment in those counties.

Jacqulene Lang:

Thank you for that. Now, Mary, I can take the next slide. So as a result, CMS is limiting enrollment into MA plans that are D-SNP look-alike plans. So, this year CMS did not enter into contracts with new MA plans that projected 80% or more of the plan's enrollment members that would be entitled to Medicaid. And starting next year, in 2023, CMS will continue not to renew contracts with MA plans that have that 80% or more of duals unless the MA plan has been active for less than one year and has limited enrollment of 200 or less individuals. And we can go ahead and transition to Anastasia if she's on. If not, I could take the next slide.

Anastasia Dodson:

Thanks so much, Jacqulene. And as we have discussed in past meetings, again, this is no different than the existing policy we've been talking about. For 2023, Medicare Advantage organizations are going to transition their D-SNP look-alike members into another MA plan, which could be a true D-SNP or a regular MA plan. In working with CMS, they are designing this transition to ensure continuity of care and cost sharing protections for duals. And there's a crosswalk of the different plans that's been posted on the DHCS website to show the different plans and which one connects to which other plan. Next slide.

Anastasia Dodson:

Okay, and the next topic, again, no policy change, but just a reminder of what's happening and what we're planning for January 1st. The purple counties along the top and along the coast of California, those are the counties where dual eligible beneficiaries are already enrolled in Medi-Cal managed care.

Anastasia Dodson:

The pink counties in Southern California and the parts of the Bay Area are where dual eligible beneficiaries, almost all of them, are already enrolled in a Medi-Cal managed care plan. The blue color, those counties in Central Valley, California, as well as parts of the Bay Area, that's where we have a policy change that we've been talking about in this group for some time where dual eligible beneficiaries are in. Some of them, it's their option to enroll in a Medi-Cal plan right now and they will be required to enroll in a Medi-Cal managed care plan effective January 1st. Again, it's those 31 counties that are marked in blue on this map where the policy change of required enrollment in a Medi-Cal managed care plan is going to be effective January 1st. Next slide.

Anastasia Dodson:

A reminder, over 70%, more than 1.1 million dual eligible beneficiaries, are already enrolled in a Medi-Cal managed care plan. The transition for January 2023 affects about 325,000 dual eligible beneficiaries and they will be newly enrolled in a Medi-Cal managed care plan starting in 2023. The counties that are impacted are listed here. Just a final note that beneficiaries can choose their Medi-Cal plan. There's at least two plans in all of those counties, Medi-Cal plans for people to choose from. But again, their Medicare providers do not need to be in the Medi-Cal plan network in order to continue seeing those Medicare providers, and they can choose any Medi-Cal plan, and they don't need to confirm that their Medicare providers are in the Medi-Cal plan. Next slide.

Anastasia Dodson:

Why are we doing this? We have additional requirements for Medi-Cal managed care plans throughout the state to provide coordination for long-term services and supports and those Medi-Cal managed care plan benefits that can be helpful for dual eligibles, particularly include CBAS, adult day healthcare, transportation to medical appointments, community supports under CalAIM, which are only available through Medi-Cal managed care, CalAIM Enhanced Care Management, again, only available through Medi-Cal managed care, and long-term care skilled nursing facility care, which is going to be a Medi-Cal managed care benefit starting in 2023. Next slide.

Anastasia Dodson:

So, we do have outreach materials especially for providers or members. Anybody who would benefit from materials, we have those on our webpage. We have videos, fact

sheets in multiple languages. And of course, our Health Care Options team at DHCS is happy to answer any questions. Next slide. Okay. And just a flag, I know we're going to go to questions in just a second, but just flagging other Medi-Cal changes, no new policies here, just a reminder. Next slide. We have the Older Adult Expansion effective May 2022. Full scope Medi-Cal is available for individuals aged 50 and older, regardless of immigration status. Of course, Medi-Cal income limits still apply.

Anastasia Dodson:

For the asset limit increase, that was effective July of 2022, the Medi-Cal asset limit increased up to 130,000 for one person. It was previously around $2,000. That is also a big change that can help a lot of people, either people who are already enrolled in Medi-Cal and then they know they do not have to keep their checking and savings account balances below $2,000, but also people who may have some savings but low income because the income limits still apply. So, people who have low incomes but have some savings or other type of account that they would otherwise need to spend down, they no longer need to do that to qualify for Medi-Cal. Next slide. Okay, so let's go to, Mary, I think we'll go with questions now.

Mary Russell:

Great. Let's do it. Why don't we go to slide 53 and then we can just hold there for Q&A. I want to acknowledge, Rick, I know you've had your hand up for a bit and a few questions in the chat. Do you want to come off mute and ask your questions?

Rick Hodgkins:

Well, I did have a question for Dr. Mark earlier, but I was rushed. My question involved, since Regional Center clients like myself are forced to utilize generic resources first when it comes to the I/DD population, which I'm a part of, when it comes to, for example, housing supports, shouldn't managed care plans when it comes to I/DD population, be required to provide housing supports? My question only applies to the I/DD population, not to other populations. As you are aware, as we all are aware, clients like myself in the I/DD population have to utilize generic resources first before asking the Regional Center to pay for anything. Therefore , the managed care plans have to step up to the plate and pay for certain things like housing supports before we could ask, because even though the agency I...

Rick Hodgkins:

Because I can't. I, of course, can't pay for the first and last month's rent and things like that. It's a good thing that we have these supports, because my point is, is that if I ever need to move, I will count on my managed care plan for things, because the housing. My point is, when it comes to the I/DD population, shouldn't we require managed care plans and Medi-Cal to step up to the plate since clients like myself have to utilize generic resources first? Thank you.

Anastasia Dodson:

Thank you so much, Rick. Great question, great point. I'm definitely not the best person to address the question. However, I will say that just, generally, because of federal law, Medi-Cal is the payer of last resort. That is a constraint that we have to work with in various ways. It may be that the impact part of the policy that you're talking about is from a federal law impact. That's, again, it's true in all states where Medicaid is a payer of last resort. But you're raising a really good point about housing, and I know that's a concern for many people across the state. A good question also about the connection and interplay between regional center services, which many of them are Medicaid-funded and then Medi-Cal managed care services.

Anastasia Dodson:

I hope that we, at a future meeting, I don't know if it would be with this group or another group, but really good point to explore in future meetings and to map out. And again , I'm not the best person. There's probably others who know if there's been some mapping already done and consideration of opportunities in ways that we can have better partnerships between Medi-Cal plans and regional centers. Thank you. Very great point.

Mary Russell:

Thank you so much, Rick. Thanks, Anastasia. I wanted to acknowledge Tatiana's comment in the chat, and it sounded like you had an additional question as well. Tatiana, if you'd like to come off mute or raise your hand and I can unmute you and share some feedback.

Anastasia Dodson:

I do see Tatiana's comments in the chat. We are frankly also concerned at some of the marketing and confusion that has happened related to Medicare Advantage plans and open enrollment advertising confusing people with the Medi-Cal managed care transition.

Tatiana Fassieux:

Yes.

Anastasia Dodson:

Oh, Tatiana, are you there now?

Tatiana Fassieux:

Oh, yeah. I managed to unmute myself. Thank you, Anastasia. Yes. Just today, an egregious third-party marketing of a Medicare Advantage plan, it happened to be an Anthem PPO. Consistently, they are targeting duals and they don't have in the specific counties, they don't have a D-SNP. In this case, was Colusa County. That is a problem that I am very concerned about, the confusion that our beneficiaries are experiencing and the continual advertising that goes on year-round targeting duals. And I just don't know what can be done if a dashboard is impacted. If you want to get those statistics, we will be more than happy to gather them. We just need to make sure that beneficiaries are clear in what their options are. Yes. And the other one that is coming through is that you've got some major providers that are just totally resisting seeing Medicare duals with a Medi-Cal managed care plan. When in the Sacramento HICAP, you've got Sutter and you've got UC Davis, just blatantly saying, "We will not accept beneficiaries in a Medi-Cal managed care plan." Anastasia, what should we do?

Anastasia Dodson:

Right. Thank you so much, Tatiana. Yeah. Just back to the first part about the marketing, I noticed that, yesterday, CMS put out some proposed regulations, tightening even further.

Tatiana Fassieux:

Yes.

Anastasia Dodson:

There are some restrictions on third-party marketing and holding plans accountable. Hopefully, that will help, but definitely an issue of concern and national issue, frankly, that people are watching. As far as the providers in the Sacramento area, and at times in the Bay Area, so we are actively speaking to, and yesterday, this morning, have been emailing, pushing out information to those large health systems. As soon as we get off this call, we'll keep emailing folks asking to meet with them. I don't want to overpromise that everything is going to be smoothed out by January 1st, but we are really actively meeting with people, pounding on emails to make sure the message gets across. I'll just be honest, hopefully by February everything is resolved, but I do expect the next few weeks, we'll just continue to keep pushing out information about that and appreciate all of the support that all of you are also providing in reinforcing that message. We will get there, but I think it's going to be a few more weeks.

Tatiana Fassieux:

Thank you.

Anastasia Dodson:

Thank you.

Mary Russell:

Thanks, Tatiana, for that question. I believe we have Stephanie Conde on, and I think this would be a question for her, a question from Beth Garver wanting to clarify the cutoff day for each month for patients changing plans for the change to be effective the following month.

Stephanie Conde:

Hi. Good morning, Mary. Can you hear me?

Mary Russell:

Yep. You sound great.

Stephanie Conde:

Okay. Hi, good morning. Good question, thank you. The date that the beneficiary has to choose a plan is listed in their My Medi-Cal Choice packet. The beneficiary should have gotten that if they're not part of the Medi-Cal matching plan policy and they should use that date to know when they need to make that active choice. If they don't choose by that date, then they'll be defaulted based on the plan listed, again, in their My Medi-Cal Choice packet.

Mary Russell:

Thank you. A question from Lynette, "Will all dual eligibles receive these materials and Medi-Cal choice forms in the mail?"

Anastasia Dodson:

Mostly yes. There is this Medi-Cal matching plan policy that we talked about earlier this year and have reminded folks but may not be fresh in everyone's mind. In some counties, if someone chooses voluntarily to enroll in a Medicare Advantage plan and that Medicare Advantage plan, it could be D-SNP, has also a Medi-Cal line of business in that county, then we will automatically enroll the person in the Medi-Cal plan that matches their Medicare plan. We are not interfering with Medicare choice in any way. It's just to avoid people being in a different plan for Medicare versus Medi-Cal, we're aligning their Medi-Cal plan with their Medicare choice. In that case, those individuals who are already enrolled in a Medicare Advantage plan, they won't receive a choice packet. Because that would be confusing if we give them a choice packet, but then say, "Actually, we're just going to enroll you in such and such plan."

Anastasia Dodson:

We have a separate that particular scenario, that goes out to people in that situation. Again, this is the Medi-Cal notice for matching plan policy that's in 12 counties. You all may remember we talked about it over the summer and the fall, and happy to talk about it more here if people have questions. But everybody else who's not in a Medicare Advantage plan that has a matching Medi-Cal plan, all of those other people who are dually eligible, the folks who are in original Medicare, Fee-For-Service Medicare, they all got choice packets by December 1st if they were in those 31 counties or other counties and not already enrolled in a Medi-Cal managed care plan.

Mary Russell:

Great. Thank you, Anastasia. Another question from the chat from Anthony, "Is there a projection date for when Health Care Options will update the webpage and will the MMPs be listed for the beneficiaries to make a choice from?"

Stephanie Conde:

Hi. Again, this is Stephanie Conde. The matching list, we call the Medi-Medi list, is posted on the homepage of the Health Care Options website now. Some of those other updates are being made as we go throughout this month just based on timing, but that Medi-Medi list, the matching list is posted already.

Mary Russell:

Thank you, Steph. Sorry, to clarify on Beth Garver's previous question, it was not for initial enrollment, but going forward when a patient wants to make a change.

Anastasia Dodson:

Just to restate, and I think this might be a question for Stephanie, but I want to state it to make sure I'm understanding it correctly. When someone who has Medi-Cal, whether they're dual eligible or Medi-Cal only, if they want to change their Medi-Cal plan, then they can call Health Care Options. They can go online with Health Care Options to change their Medi-Cal plan. They can change their Medi-Cal plan actually every month, although we certainly don't encourage that because that cause more confusion. But again, just to flag that Medi-Cal matching plan policy, we don't allow people to change their Medi-Cal plans if they're enrolled in that matching Medicare plan. If they want to do that, then we advise them to first change their Medicare plan, because Medicare is the way they get most of their benefits.

Anastasia Dodson:

We will, on the back end, align their Medi-Cal plan to match their Medicare plan. And again, that's really for people in the larger counties. Again, if there is a matching Medi-Cal plan for that particular Medicare plan. I truly wish that the names of these programs

sound a little bit different, because Medicare and Medi-Cal sounds so similar, but they are different programs as you all know well, but it's a confusing topic.

Mary Russell:

It is, yes. Anastasia, I'm not sure if you want to speak to Beth's note here in about the DHCS letter with the date of 12/23?

Anastasia Dodson:

Let me look for that in the chat. Let's see. It says, "A DHCS letter that was sent to a Medi-Cal beneficiary indicated the cutoff date for initial enrollment was December 23rd." Right. That is the cutoff date for beneficiaries to indicate which Medi-Cal plan they want to choose. Stephanie can correct me, but I believe if they do not indicate their Medi-Cal plan choice before that date, then there's a default plan that they will automatically be enrolled in. That default plan is listed on the beneficiary's letter. Go ahead, Stephanie.

Stephanie Conde:

Yep, you got it. That date is for the effective date of 01/01. But to Anastasia's point, if you do not choose a plan, and there's a little leeway in there, I just want to note that that date allows for the choice form to be mailed in. So, there's a little bit of a buffer period there and the beneficiary outreach campaign from Health Care Options will talk to that buffer date, but they have a little bit more. But that is the date that they should call in or send that choice form to get their plan choice.

Anastasia Dodson:

Anybody that doesn't indicate their choice, they will still have their Medicare and their Medi-Cal benefits. It's just that they will, again, go to the default Medi-Cal plan that's on the letter. As Stephanie said, there's also a little bit of cushion in that time there. But again, everybody keeps their Medicare and their Medi-Cal benefits. There's no impact to IHSS. There should not be an impact to Medicare providers, but that is the cutoff date that we're asking people to respond if they want to make a choice on which Medi-Cal plan to choose from.

Mary Russell:

Great. Thank you. Okay, I'm scanning the chat for additional questions, and I don't see any other hands raised at this time. I know we have Bambi on the line for our next presentation. Anastasia, any other notes on this section?

Anastasia Dodson:

I see this good point from Tatiana about Medicare has another enrollment period, January to March, Medicare Advantage open enrollment. Again, more choices for those

who are in a Medicare Advantage plan can make another Medicare plan choice. I don't want to get too much in the weeds on this other item, but there are some other changes that CMS has made around periods of time for people who are newly eligible for Medicare, for making choices. Many other policy changes on the Medicare space around enrollment in Medicare. Just to say your local HICAP group is a really great resource for people who have questions about Medicare Advantage plans, choosing a plan, whether to choose a plan or stay in original Medicare. I really encourage you all to contact your local HICAP.

Mary Russell:

Great flag. Rick, I see your hand raised. Would you like to chime in with a question?

Rick Hodgkins:

I don't really have a question, but I would like to follow up on something you said. The question I asked earlier was not for you Anastasia, but for Dr. Mark. But to follow up on that, what you said earlier on, here in California, Medicaid, or Medi-Cal as we call it, is not the payer of last resort. I was referring to the Regional Center. They are the payers of last resort. For example, if I want something that which Medi-Cal can't pay for, I have to go to the Regional Center. If I go to the Regional Center first, if I go to the Regional Center because Medi-Cal denies something, they say, "Well, you need a treatment authorization request letter from... You need to go back to Medi-Cal and get a TAR," that which stands for treatment authorization request.

Rick Hodgkins:

And if that TAR is denied, there's still no guarantee that Regional Center will pay for it. That's what I was referring to. Once again, my question was not for you, it was for Dr. Mark when she was on the line. But again, I was rushed, so thank you. Again, this is the only group I can join. I know there is a subgroup which deals solely with the I/DD, but I cannot join that group. Next time Dr. Mark is on a future call and I'm able to join that call, that would be my question for her because she deals with MLTSS. Thank you.

Anastasia Dodson:

Thanks, Rick. Yeah. We try to cover multiple areas. We'll take that down and then we'll see also if we can, in conversations with DDS and our other experts in-house, provide some more information on that.

Rick Hodgkins:

Yeah. I understand Jim Knight was on the call, and Jim Knight is the Deputy Director with DDS.

Anastasia Dodson:

Right. Yes. Our DDS colleagues are excellent experts in this area.

Rick Hodgkins:

Hey, thank you.

Mary Russell:

Thank you, Rick. Thanks, Anastasia. I think we are ready to transition to Bambi Cisneros to take us through the Long-Term Care Carve-In updates. Thank you, Bambi, for joining today.

Bambi Cisneros:

Sure. Thank you so much. Mary, can you hear me, okay?

Mary Russell:

Yep. Sounds great.

Bambi Cisneros:

Okay, great. Thank you. I think before I get started, Rick, I just wanted to acknowledge your question as well. If you do want to send that into the CalDuals email inbox, we'll make sure it gets addressed, because we are working on the ICF/DD carve-in with Department of Developmental Services. I just want to make sure we're acknowledging your question. Just wanted to flag that. Okay. Good morning, everyone. It's still morning. Thank you for your time today. I wanted to share some information about the Long-Term Care Skilled Nursing Facility Carve-In policy, and give an update on resources that were developed for managed care plans, and a skilled nursing facility provider specifically related to the carve-in. We can go on to the next slide. Thanks for dropping the email address in the chat box here. Thank you.

Bambi Cisneros:

Today, to start, I think I want to orient to CalAIM's goals for this Skilled Nursing Facility Carve-In. As you know, under CalAIM, there are various initiatives. Where this SNF, skilled nursing facility, carve-in falls under is benefit standardization. What this means is that we are really intending the coverage of institutional long-term care to be consistent across all counties in the state so that the member experience stays the same no matter where they live or where they move to. The carve-in changes that are being implemented are happening in phases based on long-term care facility or provider type. On January 1st, 2023, Medi-Cal managed care plans in all counties will cover the long-term care benefit for skilled nursing facilities, as well as all Medi-Cal beneficiaries residing in a long-term care facility will be required to be enrolled in a managed care plan for their Medi-Cal covered services.

Bambi Cisneros:

Just wanted to note that that phase in is that the SNF carve-in will occur January 1st. We are working separately on the intermediate care facility and subacute facility carve-in at a later time. The presentation today is really focused on skilled nursing facilities, so I just wanted to mention that as well. We can go on to the next slide, please. Today, long-term care skilled nursing facility services are covered by COHS model type plans and CCI counties. What that means is that for all other plan model types, the plan is responsible for the month of admission in the following month. What happens from that point is then they will need to disenroll that member to fee-for-service to continue to receive those services in the facility, which can be disruptive.

Bambi Cisneros:

When we say carve-in, what that really means is that after January 1, 2023, beneficiaries who go into a skilled nursing facility, that would have otherwise been disenrolled from the managed care plan because they're in those non-COHS, non-CCI counties, will stay in their managed care plan from that point ongoing, as well as beneficiaries that are staying in a skilled nursing facility will be enrolled in a managed care plan effective Jan 1, 2023. This includes most Medi-Cal beneficiaries, such as Medi-Cal only, dual eligible beneficiaries, so those eligible for Medicare and Medi-Cal beneficiaries with other health coverage including private coverage, as well as share of cost Medi-Cal beneficiaries in the long-term care aid codes.

Bambi Cisneros:

And so that is what is going to be transitioning on January 1st, which is just around the corner. And we can move on to the next slide, please. As we talked about in the previous slide, some plans do cover a long-term care skilled nursing facilities today. Those are reflected in the pink counties here on this map. And in the remaining counties, which there are 31 counties where it's carved-out today, are in blue here. And this is where the carve-in policy will be new to those counties. And we do estimate that about 28,000 individuals that are residing in skilled nursing facilities will be carved into Medi-Cal managed care with duals representing the majority of those individuals. So, this is just a good snapshot across the state on where it is carved-in today. And in order to make the benefits standardization to be happening statewide, the counties in blue.

Bambi Cisneros:

We'll see those changes starting Jan 1st, 2023. Because we are only two weeks away from the carve-in go live, I wanted to provide an update on some key milestones for the carve-in. So, we did convene a workgroup to talk specifically about the policy issues surrounding skilled nursing facilities, and we did meet seven times between December 2021 through September earlier this year. And so, the really good outcome or product from that workgroup is a skilled nursing facility carve-in APL, which is APL 22-018. And so that APL really is a culmination of all the work that the workgroup has done to really

inform those policies. One of the other things, as part of the key activities, is that the Department did share detailed member data with the managed care plans. And that happened in November. And so that information has information on members that will be affected by the carve-in.

Bambi Cisneros:

And so, this data included utilization data and history, which also includes the treatment authorization request information. And then, what we are having do is the managed care plans and the skilled nursing facilities are then required to coordinate with each other to share data in order to really facilitate the seamless transition for members, and help to ensure that we will have coverage, and there's no lapse in coverage or services. Another key activity that took place is that, and it sounds like we talked some about noticing earlier, is that members and their authorized representatives received the 60-day member notice, which is accompanied by what we're calling a Notice of Additional Information. It's an FAQ format. So, they received that in early November. And then the 30-day notices were in hand with members on December 1st. Member Choice Packets were also mailed at the end of November.

Bambi Cisneros:

And then just a note here, that choice packets were only mailed to members that were not part of the Medi-Cal matching plan policy, which I think you were all talking about earlier as well, what that kind of policy entails. And so, hand in hand with that, we do have Health Care Options, which is the Department's enrollment broker conducting an outbound call campaign that started this month in December. So, I just really wanted to make sure that members were really aware of this transition. So, they're getting the notices, the FAQ, as well as the call campaign. And then the managed care plans in the skilled nursing facilities continue their communications and outreach with each other and are aware that contract negotiations are ongoing. We did require plans to outreach to skilled nursing facilities in order to ensure contracts and agreements that should be in place.

Bambi Cisneros:

I think one point here that we would like to make is that if you are a provider and you have not heard from your health plan yet, the Department does encourage you to reach out to your managed care plan if you haven't already done so. I'm hoping that that communication has already taken place. And then also linked here on the slide is some FAQs that were developed. And also, from a culmination from the stakeholder workgroup and some kind of additional detail that we wanted to clarify from the APL was included in the FAQs. And this is ongoing work for the team as well. So, we have posted the first round of FAQs, and then as questions and clarification needs to occur, we are kind of working on additional iterations as well. And so, we just provided here as a link on this webpage where we will be posting those materials. And we can go to the next slide, please.

Bambi Cisneros:

As another material, in addition to the FAQ and the all-plan letter, we have also developed what we're calling a Resources document, which houses promising practices and a model sample language that plans and skilled nursing facilities can use in their plan to provide our contracts. And so, these really came from the discussions from the workgroup, and also shared by the managed care plans in the coast counties where the services are already carved-in today. So, just wanting to share that out broadly as the managed care plan. Then the skilled nursing facilities continue to work with each other on this carve-in. And so, this resources document is really intended to be a tool for the plans and the facilities to use during the transition, and so we do highlight certain themes or elements here.

Bambi Cisneros:

What's included in the promising practices are things surrounding care management, so some clarification and authorization processes between plan and provider, for example. Outreach and communication tips among skilled nursing facilities and the managed care plans. We have also highlighted the LTSS liaison, long-term services and supports liaison. And so, we described this as the single point of contact for facilities that would serve both as a provider liaison, as well as serving as a care coordination role for the member. And so, what we see this individual doing is really helping to address claims and payment issues and help with care transitions to best support the member's needs during this transition. And so that is a promising practices that we have listed in the document. We also addressed some leaves of absence and bed holds, which I think you are all aware is really established in regulations.

Bambi Cisneros:

Just pulling out that regulatory language and providing some sample contract language, that plans and facilities can use just to ensure that there's just clarity there in that policy. And then lastly, just addressing prompt claims and payments and clean claims. One of the things we heard from the workgroup is that when plans are able to offer shorter payment timeframes for clean claims, that of course helps support provider operations. But then again, from the plan's perspective, the claim does need to meet certain required elements in order to be paid appropriately. And so here we say that, when possible, a promising practice is to expedite payments to long-term care facilities, and we provided model contract language here that can be used in those contracts to make sure that there's common language and requirements between plans and facilities.

Bambi Cisneros:

And then the next slide just gives the webpage where we are providing all of these resources, including the all-plan letter. And so, as we continue to hear from stakeholders and provide additional clarity on policy, please be on the lookout on this webpage, which is where we will be posting the materials. I think that is what I wanted

to cover this morning. And so, Mary, I think maybe I'll turn it over to you and how you want to handle questions.

Mary Russell:

Great. Thanks so much, Bambi. Yeah, there are a few in the chat and, of course feel free to raise hands and we can unmute you if anyone has additional questions. Bambi, a question from Jackie in the chat, “Are plans required to pay for admin days if they cannot find SNF placement to discharge a patient from the hospital now that there is a statewide carve-in?”

Bambi Cisneros:

Sorry, these are in the chat you were saying, Mary?

Mary Russell:

Yes, in the chat. I know it's a little bit busy in there right now. But question from Jackie here.

Bambi Cisneros:

Yeah. Okay, yeah. I see it now. Okay, yeah. Thanks, Jackie. I think, and I don't know if our rates folks are on the line, I think there is some additional guidance coming out on this. Do acknowledge that sometimes there are a shortage of beds and an ability to find placement. And so, I think I'll hold off on this. I think we'd want to confer with our rates team on what kind of guidance is coming out on this piece, if that's okay with you?

Mary Russell:

And they're not on the line at this moment, so make sense to... We can help you take that back.

Bambi Cisneros:

Okay, thank you. Yeah, we'll respond to this one in writing, if that's okay.

Mary Russell:

Thanks, Jackie. Another question from Sarah, “Are there any scenarios where Medi-Cal SNF residents may stay in fee-for-service? And what choices are members given in the member choice packet? Is it just Medi-Cal managed care plans?”

Bambi Cisneros:

Yeah, so I think the transition is really by aid code and accommodation codes. And so, if a member falls in one of those, it is mandatory managed care enrollment. And so, again, part of CalAIM's benefit standardization and making sure that we have a standard benefit package across all of the plans, where we have oversight and the ability to make sure that the services are aligned across the state. So, there could always be scenarios where someone can stay in fee-for-service, but it's very rare and under certain scenarios. And so, I think that's what I would say. And then, what choices are members given? So, the member choice packets, we do try to honor an upfront provider linkage.

Bambi Cisneros:

We do try to assign a member to a health plan where they've had maybe a previous relationship with, or if there is a family linkage, for example. And so, we would offer that plan, and if it's available, and if the member chooses another plan, or doesn't make a choice, then they would go down that default enrollment. But I think what we would say is we would want to preserve that relationship if there is one that exists with a managed care plan.

Mary Russell:

Great. Thanks, Bambi. And a question from Tatiana, "Who will assist duals living in a SNF who have no one to help them with enrollment concerns, or who haven't reported a change of address with SSA or the county? Is the SNF responsible to help?"

Bambi Cisneros:

Oh. Yeah, hopefully. That's been having a lot of trainings and webinars, and just a lot of open forums to make sure that everyone is really aware of this carve-in that's happening. And the reason why we want to do that as well is just to really seek the help from all of our advocates and stakeholders so that they can help members be informed of this change as well. So of course, we would welcome the SNF to help with that. I know there's also a Long-Term Care Ombudsman that really works with members on these types of communications as well. And so maybe we will, maybe Aurrera can grab that information that we could share out with this group as well. We've spoken with them, we've presented at their arenas, and I know they are ready on standby and willing to help as well. So, we'll share out that information.

Mary Russell:

Great. Yeah, we will add something to the chat for people to reference.

Bambi Cisneros:

Yeah.

Mary Russell:

Thanks, Bambi. And question from Heather, “If a member is denied an exemption to stay in fee-for-service, can a member appeal?”

Bambi Cisneros:

Yeah, I think there's information in the notice about that medical exemption request process, and all of the various kind of appeal rights, process, and timeframes. The team is flagging that this information is actually contained in that Notice of Additional Information or the FAQ document. And I think Alisa shared that in the chat. Oh, and thank you for also dropping the Long-Term Care Ombudsman phone number in the chat as well.

Mary Russell:

Great. And yes, of course, feel free to share any other questions with the info@calduals.org inbox for the Department to process that way as well. Any additional questions on the Long-Term Care Carve-In? Okay, I'm just looking at this question that came in from Katy Weber, “With the change in CalAIM ECM populations of focus for CalAIM health plans to include nursing home residents who want to transition to the community, will individuals that have selected a yes on the Q-0500 on the MDs 3.0 be eligible for ECM starting in January 2023?” Bambi, is this something you can speak to?

Bambi Cisneros:

Yeah, I think we'll have to take this one back. I'll be the first to admit, I'm not familiar with that code. But I am aware of the population of focus that's going to be coming in through ECM. We'll have to check in with the quality and population health management team for a response on this one. If you can help me track, Mary.

Mary Russell:

Will do. Yep. Thanks, Katy. Okay, well thanks everyone. Thank you, Bambi. I really appreciate your sharing your time with us today. I think at this point we'll transition back to Anastasia if you want to walk through some of the upcoming MLTSS and Duals Workgroup meeting topics in the new year.

Anastasia Dodson:

Great, thanks, Mary. Yes, so just to lay out broadly what we're thinking for 2023, but then also again, reminder of the next few weeks, how we'll be communicating and keeping folks abreast of what's going on. So next slide. So, these are some of the topics we are looking at for 2023. We have meetings on the books for January and February of 2023. Our top priority is the status and monitoring of the January 2023 CalAIM transitions. We have also got some great suggestions and requests around local

examples, and discussions around, for example, enhanced care management community supports, and other ways of having a more comprehensive MLTSS approach for services. So, we want to have discussions about that. We're still thinking about what's the best way as far as breakout groups, how much should be covered in this meeting versus some other meetings. But for sure, we want to have that conversation with you all, and less of me talking and more of you all talking and sharing information.

Anastasia Dodson:

We do want to also keep on the radar that we're working on the 2024 SMAC, which is the D-SNP contract and the policy guide. So, we want to keep people updated. And then again, as we have specific topics for discussion, incorporate that into these meetings. We know that there are many delivery systems in some ways, especially across the Medicare space for people who are dually eligible. But we want to try to think of how, for example, the D-SNP contract is a really important lever for providing integrated care. And there's other models as well. So having those conversations. Crossover billing kind of goes a little bit with the CalAIM transitions. We've been doing a lot of work behind the scenes with specific provider groups, but we want to keep refreshing folks on that and make sure there's no technical questions or we get those resolved.

Anastasia Dodson:

And then different types of Medicare Advantage benefits and how the state can use its D-SNP contract and other levers to make those benefits available, and how they connect in with CalAIM Medi-Cal benefits. Health equity is an important topic throughout all of these efforts. And as you can see with the dashboard, we're trying to make that data more available so that we can have more informed discussions, and have data to understand where are the gaps, where are the opportunities there. Assisted living, assisted living for memory care and housing topics continually coming up, and housing support. So, there's many more topics, but these are the ones that have been rising more to the top the last few months. And so, I guess, next slide.

Anastasia Dodson:

This is the date for the January meeting. Between now and then we have a weekly DHCS email stakeholder blast that goes out on Fridays. You probably are all subscribed to that. We will keep folks updated if there's anything that goes differently than what we expect. Of course, then we will use all the different channels that we have to inform people about that. The other thing is, we expect to have data, and I don't know if it'll be the first week of January, the second week of January. But as soon as we have a snapshot of how many people successfully transitioned with the Cal MediConnect to MMPs, how many people are enrolled in a Medi-Cal managed care plan of those who got notices and getting those kinds of data. And we can post those. It may not be in a real fancy format.

Anastasia Dodson:

We might just a high-level fact sheet of where we are at so far with the transition as soon as that data is available in January. And certainly, duly noted about people wanting data about Enhanced Care Management and community supports for duals, and people with disabilities for Medi-Cal only. So, we will try to keep building that out into our dashboards and other dashboards. But just want to say that January 19th is not the next day that you'll hear from us. You will hear from us in your email inbox. And as needed, if we need to, we will reach out to particular groups if there's anything that is urgently needed to be discussed prior to January 19th. And again, there's other stakeholder workgroups on different topics that DHCS is hosting, but we do want to keep this group, especially for January to, we should have all of our data statuses updates available for that January 19th to report back to you all on what has happened. And then any cleanup issues we'll be able to go over at that meeting. But again, if there's something urgent, you'll hear from us from via email.

Mary Russell:

Great. Thank you so much, Anastasia. And I'm just looking at the chat to see if there's any final questions coming in. I see a note from Beth with a clarification on a APL 2115. Do you see that, Anastasia?

Anastasia Dodson:

Yeah, I see the question, and it seems to be a question about share of cost. And so just to clarify, so for dual eligible beneficiaries that are living in the community that are not in a skilled nursing facility, those folks are not enrolled into Medi-Cal managed care. That was a transition, actually, that occurred January 1st, 2022. So that, because the vast majority of people with a share of cost in the community do not meet their share of cost every month, we do not have them enrolled into a Medi-Cal managed care plan. In skilled nursing facilities, however, there's a significant population that do have a share of cost, and they are going to be enrolled into a Medi-Cal managed care plan if they're not already. We do recognize that as those folks, if they return to the community and they have a share of cost, they would be dis-enrolled from their Medi-Cal plan.

Anastasia Dodson:

However, based on, again, the experience that we see in the data from many years, oftentimes the people who, if they have a high share of cost in a skilled nursing facility and then they return to the community, they do not have medical expenditures living in the community that are high enough to meet that share of cost. So, they don't maintain their Medi-Cal eligibility. It's not appropriate to enroll them into a Medi-Cal managed care plan if they're no longer eligible for Medi-Cal benefits. So, I hope that helps, and happy to talk further. Okay, I see that now. Thanks.

Mary Russell:

Great. Thanks, Anastasia. And thanks Beth for that question.

Anastasia Dodson:

Yeah, and I'll take a prerogative here by saying in our LTSS dashboard, one other dreamy thing we think about, but it is complicated, is “can we include the number of people with a share of cost above a certain amount in skilled nursing facilities?” Because then we could get an estimate of what's the size of that subpopulation in skilled nursing facilities that would likely not be eligible for Medi-Cal if they were in the community. Not for any eligibility or treatment or care coordination purposes, but just to have some kind of order of magnitude of how big is that population.

Anastasia Dodson:

I see the other question of AB 1900 share of cost reform. We'll just see. I certainly can't commit for the Department or the Administration, but we know there's a lot of interest and a lot of changes both at the federal level and contemplated at the state level in the future around dual eligibles and older adults. And thank you, Tatiana. Good point about what the share of cost. Right, and I think that's why it's a tricky conversation because if someone has a share of cost of $300 or $500 a month, that's a really different situation than someone who has a share of cost of thousands of dollars, $3,000 or $4,000 a month. Which they could have in a skilled nursing facility, but unlikely to meet that share of cost if they're in the community. So, it's a complicated situation, but an important conversation.

Mary Russell:

Great. Well, with that, I'm not seeing any other questions or raised hands. I just want to thank all of our presenters for today, for joining our presentations today. And thank all of you for your participation, and hope everyone has a healthy and safe holiday season.