CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup

DHCS

April 21, 2022

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- 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 and click “More.”
- Select “Rename” from the drop-down menu.
- Enter your name and add your organization as you would like it to appear.
  - For example: Hilary Haycock – Aurrera Health Group

Agenda

- Update: Long-Term Care (LTC) Carve-In Benefit Workgroup: Summary of Stakeholder Engagement Effort
- Update: Senate Bill 48 and Dementia Aware Initiative
- Alzheimer's and Related Dementias Prevalence Data
- Review of 2023 Cal MediConnect (CMC) to Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plan (D-SNP) Transition, Medicare Aligned Enrollment, D-SNP Look-alike Transition, CalAIM Mandatory Medi-Cal Managed Care for Dual Eligible Beneficiaries, and Discussion
- Update: 2023 EAE D-SNP and Non-EAE State Medicaid Agency Contract (SMAC) and D-SNP Policy Guide, and Discussion
- Public Health Emergency (PHE) Unwinding
- Next Steps and Upcoming Meeting Topics

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for CalAIM MLTSS and integrated care for dual eligible beneficiaries. Provide an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for upcoming changes for Medicare and Medi-Cal.
- The goal of the workgroup is to collaborate with stakeholders on statewide MLTSS and Exclusively Aligned Enrollment Dual Special Needs Plan (D-SNP) enrollment, including the transition of the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC), the D-SNP look-alike transition, and new enrollment in exclusively aligned enrollment D-SNPs.
- Open to the public. Charter posted on the Department of Health Care Services (DHCS) website.
- ***We value our partnership with plans, providers, advocates, beneficiaries, caregivers, and the Centers for Medicare & Medicaid Services (CMS) in developing and implementing this work.***

Update on Long-Term Care (LTC) Carve-In Benefit Workgroup

Summary of Stakeholder Engagement Effort

Outline

- LTC Carve-In Background and Stakeholder Engagement
  - Workgroup Guiding Principles
- February 15 LTC Workgroup Meeting
  - Managed Care Plan (MCP) and Facility Communications and Education Needs
  - MCP Oversight of LTC Facilities
- March 16 LTC Workgroup Meeting
  - Member Communications

Background on LTC Carve-In and LTC Carve-In Workgroup

Long-Term Care (LTC) Carve-In

Goal: Make coverage of institutional LTC consistent across all counties and members.

Starting on January 1, 2023:

- Medi-Cal managed care plans (MCPs) in **all** counties will cover LTC benefit for following facility types:
  - **Skilled Nursing Facility (SNF),** including a distinct part or unit of a hospital;
  - **Intermediate Care Facility (ICF);**
    - Intermediate Care Facility for Developmentally Disabled (ICF-DD);
    - ICF-DD/Habilitative;
    - ICF-DD/Nursing;
  - **Subacute**
    - Subacute Facility;
    - Pediatric Subacute Facility.
- All Medi-Cal beneficiaries residing in a LTC facility are mandatory to enroll in a MCP for their Medi-Cal covered services.
- Please see Appendix for additional information about the LTC Carve-In.

Engagement Efforts to Date

- The workgroup has met four times (monthly since December 2021).
- DHCS has held additional meetings with MCPs, facilities/homes, and advocates to inform policy development and content creation for workgroup and subgroup meetings, for example:
  - LTC Carve-In Promising Practices meetings with COHS Plans and with ICF/DD home
  - Discussion on Model Contract Language with subsection of workgroup
  - Follow-up on Continuity of Care with MCPs
- In addition to monthly LTC Carve-In Workgroups, DHCS has held monthly subgroup meetings since February 2022 with health plans, advocates, and facilities/homes focused on ICF/DDs.

February Meeting Summary

Guiding Principles for Workgroup

- **Transition should be seamless for members**
  - No disruption in access to care or services
  - MCPs conduct timely review and authorization of services
- **Ensuring Continuity of Care**
  - Provide timely data to plans to guide contracting and facility/member outreach
  - Require plans and facilities to coordinate through transition to support members

Workgroup Feedback: MCP and Facility Education

- Draw on lessons learned from CCI.
- DHCS should develop clear policy guidance and "rules of the road" as the basis for MCP and facility education.
- Education and training need to be broad and include key players, such as MCP provider call center staff and hospital case managers.
- Convening MCPs to share effective approaches and creating two-way communications flows between MCPs and facilities are best practices.
- Policies for LTC facilities will depend on facility types: recommend separating policy development for SNF (long term and short term); ICF/DD; and subacute.

MCP and Facility Communication and Education Needs

- Lessons learned from the Coordinated Care Initiative (CCI) include early planning and outreach efforts, as well as collaboration among Medi-Cal Managed Care Plans (MCPs), facilities, and community stakeholders.
- DHCS is considering developing requirements for MCPs to conduct outreach and engagement with facilities in their service areas, as well as with any delegated entities that will manage LTC risk.
- In 2022, DHCS is also planning MCP and provider education through:
  - MCP and Provider policy guidance
  - Regular MCP calls and email blasts
  - Webinars for MCPs and/or providers
  - Communication through associations
  - Other materials (fact sheets, websites)

MCP and Facility Communication and Education Proposed Topics

- MCP Topics
  - LTC 101: Facility/home types and services
  - Best practices on care transitions/intersection with Enhanced Care Management (ECM) populations of focus
  - Stakeholders recommended:
    - **Focus on LTC facilities that are new to all MCPs, including ICF/DD homes and pediatric subacute care facilities.**
    - **Include Community Supports and waiver programs available to support transitions.**
- Provider Topics
  - Managed Care 101: Understanding managed care and contracting, how to bill an MCP
  - Stakeholders recommended:
    - **Including authorization procedures.**
- Joint Topics
  - Model contract template/language
  - LTC billing/payment rules

Workgroup Feedback: MCP Oversight of Facilities

- MCPs and providers have very different systems they use for credentialing, which has created significant challenges to standardize credentialing processes during previous attempts. This might be a better goal for future years.
- There are many other aspects of plan contracting that DHCS may be able to help create standardization to reduce the burden on MCPs and providers, including developing model contract language and standardizing billing codes.

March Meeting Summary

Workgroup Feedback: Member Communications

- MCPs, facilities, and other trusted advisors (including hospital case managers) need data and information as soon as possible to be able to support members through transition.
  - DHCS should develop FAQs and other materials to support trusted advisors in working with beneficiaries during the transition.
- Coordination between the MCP and facility will be key to ensuring continuity of care for members.
  - MCPs need to reach out to facilities to let them know which residents will be MCP members and to ensure members continue to receive needed services.

DHCS Member Communications Plan

- Notices
  - Targeted notices to explain both the transition to MCPs, a beneficiary's options, and continuity of care for long-term care residents.
  - Feedback requested on whether DHCS should have 90-day notice in addition to 60-day, 30-day, and Notice of Additional Information.
- Health Care Options
  - Long-term care transition specialists will be trained specifically to answer questions beneficiaries may have about the transition.
  - Outbound Call Campaign to impacted beneficiaries after the notices are received
- Trusted Advisor Education
  - Provider and MCP education, Medi-Cal and LTC Ombudsman programs
  - General education materials
- Requirements for MCP Member Education
  - Ensure MCPs are supporting members and providers through the transition, potentially through outbound calls or other venues.

Workgroup Feedback: Network and Contract Development

- **Network Readiness**
  - Network adequacy is more complicated than counting beds, although there is often a shortage of beds.
  - If possible, network adequacy should also address the time it takes to transition members from the hospital into a facility/home. DHCS should consider availability of facilities by county and region.
  - Care coordination is very important during this process to ensure that where appropriate, members are being connected to Home and Community-Based Services (HCBS) and have care plans designed to help transition them home.
  - Network adequacy should ensure continuity of care and minimum disruption to members.

MCP Oversight of Facilities: Building A Network

- Current process for LTC facilities serving Medi-Cal beneficiaries:
  - **Providers are licensed by the California Department of Public Health (CDPH)** to ensure they meet all state regulatory requirements to provide safe and appropriate care to residents.
  - **Providers are certified by the Centers for Medicare and Medicaid Services (CMS)** to ensure they meet all federal regulatory requirements.
  - **Providers are enrolled to participate in the Medi-Cal Program** through the Provider Application Validation of Enrollment (PAVE) or the MCP directly by proving they are both licensed and certified and able to care for beneficiaries.
  - **Providers are credentialed with MCPs** by demonstrating compliance with all DHCS credentialing requirements specific to screening and enrollment of providers.
    - This process is specific to MCPs and provider types.
    - After providers are credentialed, they can contract with the MCP to become part of their network.

Update: Dementia Aware and Senate Bill (SB) 48

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Dementia Aware and SB 48

Dementia Aware:

- Provider training in culturally competent dementia care
- Referral protocol on cognitive health and dementia
- Make continuing education in geriatrics/dementia available to all licensed health/primary care providers
- Aligns with Senate Bill (SB) 48: Medi-Cal: Annual cognitive health assessment

SB 48:

- Establishes annual cognitive health assessment as a Medi-Cal benefit, for beneficiaries age 65+, if otherwise ineligible for Medicare Annual Wellness Visit
- To receive payment, Medi-Cal providers must:
  - Complete DHCS-required training
  - Use one of the validated tools recommended by DHCS
- 1494F (category II CPT code) identified as code new benefit

Dementia Aware

- DHCS is contracting with UCSF
  - UCSF subcontracting with several other UCs (UCI, UCD, Harbor UCLA, UCLA Division of Geriatrics, UCSD)
- Leverages necessary expertise in both dementia care and screening implementation in primary care practices
- Training available for Medi-Cal providers by July, 2022*

*Goal date for implementing cognitive health assessment Medi-Cal benefit in SB 48

Dementia Aware Phases

Phase 1 (Mar 1, 2022 – Aug 31, 2022)

(ongoing)

- **Screening Tool Development**
- **Training Development**
- **CME Accreditation**

Phase 2 (Sep 1, 2022 – Mar 31, 2024)

- Practice-level Implementation Support
- Training Outreach and Engagement Strategy
- Training Evaluation and Updating

Dementia Aware Clinical Advisory Board (CAB)

- Established the CAB to inform Dementia Aware activities (e.g., cognitive health assessment toolkit, screening tools)
- First sessions underway
- Comprised of key stakeholders including members from:
  - Primary care provider organizations
  - Community based organizations
  - Dementia experts from UC campuses, the ten California Alzheimer's Disease Centers, the CDPH Alzheimer's Disease Program, and the Alzheimer's Disease and Related Disorders Advisory Committee of California Health and Human Services (CalHHS)

Alzheimer's and Related Dementias Prevalence Data

Alzheimer's and Related Dementias Prevalence in Medi-Cal Populations

- DHCS compiled prevalence data for Medi-Cal beneficiaries as of March 2021. Information for dually eligible beneficiaries is only available for those in Original Medicare (Medicare Fee-for-Service (FFS)). DHCS will post detailed tables in the coming weeks.
- CMS has posted similar data for Medicare beneficiaries by state up to 2018 on its Chronic Conditions website: Chronic Conditions | CMS
- Overall prevalence:
  - **For duals age 65+ in Medicare FFS in California, statewide prevalence of Alzheimer's disease and related dementias was 18.1% in March 2021.**
  - Prevalence among Medi-Cal only age 65+ was strikingly lower (6.8%) compared to duals (18.1%), but that may change once the Medi-Cal expansion for age 50+ is implemented.
  - For duals, wide variation in prevalence by county, with lowest prevalence in northern rural counties (5.8 – 7.2%), and highest prevalence in Los Angeles (20%) and Orange (19.6%) counties.

Alzheimer's and Related Dementias Prevalence in Medi-Cal Populations

- For duals in Medicare FFS across all ages, statewide prevalence by race/ethnicity was highest among White beneficiaries (17.6%). Prevalence among Black beneficiaries was 12.5%, but that figure is likely understated, based on numerous research studies.
- Prevalence among In-Home Supportive Services (IHSS) recipients age 65+ was 28.2%, with wide variation by race/ethnicity, and by county.
- In 2018, prevalence among California duals was twice as high as prevalence among California Medicare-only beneficiaries.
- In 2018, prevalence among Medicare beneficiaries in California was lower than prevalence among Medicare beneficiaries nationally.

Questions

- Questions on Dementia Aware, or Alzheimer’s Disease Prevalence Data?

2023 Transition from Cal MediConnect (CMC) to Exclusively Aligned Enrollment (EAE) D-SNP

Key Policy Reminders

- Beneficiary enrollment in a D-SNP (or other Medicare Advantage plan) is voluntary.
- Medicare beneficiaries may remain in Medicare Fee-for-Service (Original Medicare) and do not need to take any action to remain in Medicare Fee-for-Service.
- For 2023, beneficiaries already enrolled in Cal MediConnect will automatically be enrolled in the Medicare D-SNP and Medi-Cal MCP affiliated with their Cal MediConnect plan – **no action needed by the beneficiary.**

D-SNP Definition

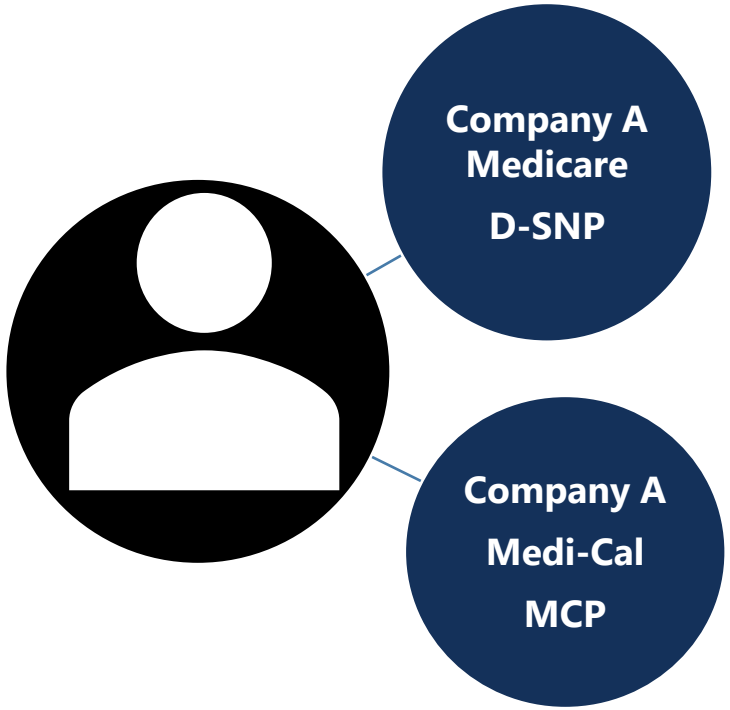
- D-SNPs are Medicare Advantage (MA) health plans that provide specialized care for dual eligible beneficiaries.
- D-SNPs must have a State Medicaid Agency Contract (SMAC) with the state Medicaid agency, DHCS, in California.
- DHCS can choose whether to contract with specific D-SNPs.
- How is a D-SNP different than a Cal MediConnect (CMC) plan?
  - CMC plans coordinate Medicare and Medi-Cal benefits under a single health plan and single contract.
  - D-SNPs include Medicare benefits and coordinate with Medi-Cal benefits. D-SNPs have separate contracts with CMS and DHCS.

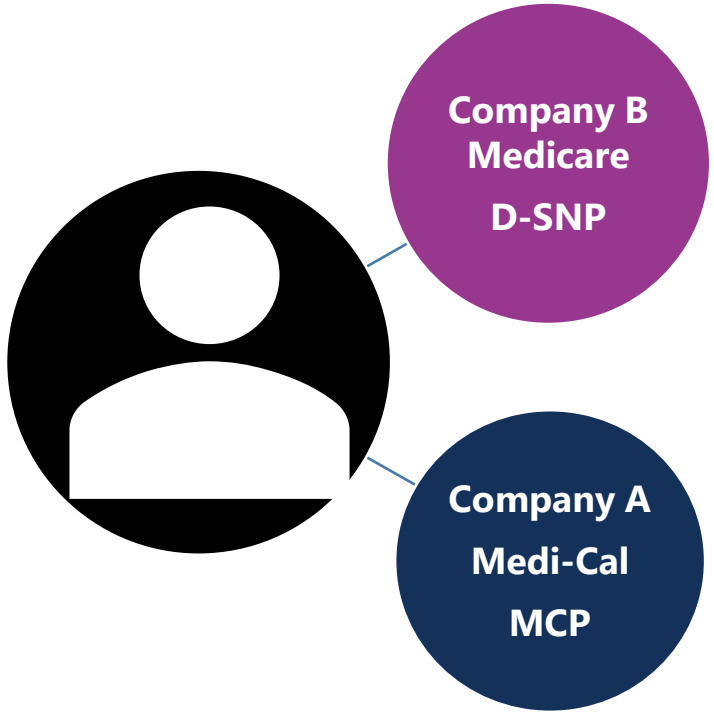
Exclusively Aligned Enrollment (EAE)

- EAE is a state policy that limits a D-SNP's membership to only individuals with aligned enrollment.
  - All beneficiaries enrolled in a D-SNP are also enrolled in a matching Medi-Cal plan.
  - D-SNPs will only be allowed to enroll new members who are in their aligned MCP.
  - Ensures beneficiaries receive more integrated and coordinated care.
- EAE is like the CMC approach:
  - One entity is responsible for both Medicare and Medi-Cal benefits.
  - Simplifies care coordination.
  - Allows plans to better integrate benefits, communication to members, and member materials.

Aligned Enrollment

- If a dual eligible beneficiary chooses to receive their Medicare benefits in a Dual Eligible Special Needs Plan (D-SNP), they must receive their Medi-Cal benefits from an aligned Medi-Cal managed care plan (MCP) operated by the same parent company.





EAE D-SNPs in 2023

- EAE D-SNP Policy in 2023:
  - In 2023, Medi-Cal plans in CCI counties will be required to establish EAE D-SNPs, and duals may choose to enroll in those plans, among other options.
  - Cal MediConnect beneficiaries will automatically transition to EAE D-SNPs and matching Medi-Cal MCPs on January 1, 2023. The Cal MediConnect demonstration will end on December 31, 2022.
  - Non-CCI counties will have EAE D-SNPs and matching Medi-Cal MCPs no later than 2026.

2023 CMC to EAE D-SNP Transition

- CCI and Cal MediConnect will continue until **December 31, 2022**.
- On **January 1, 2023,** beneficiaries in CMC plans will be **automatically** transitioned into exclusively aligned D-SNPs and MCPs operated by the same parent company as the CMC plan.
  - There will be **no gap in coverage**.
  - Provider networks should be **substantially similar.**
- Beneficiaries will begin to receive notices from their CMC plan about the transition **starting in October 2022.**

EAE Opportunities and Benefits

- Similar to Cal MediConnect (CMC) approach
- Financial Incentives
  - One entity financially responsible for both Medicare and Medi-Cal benefits
  - Incentivizes Community Supports for dually eligible beneficiaries
- Integrated Member Materials permitted by CMS
- Benefit Coordination permitted by CMS
  - Unified plan benefit package integrating covered Medi-Cal and Medicare benefits
  - Coordinated benefit administration
  - Unified process/policy for authorizing Durable Medical Equipment (DME)
  - Enable plan-level integrated appeals
- Integrated Beneficiary and Provider Communications permitted by CMS
- Simplified Care Coordination

Integrated Care Coordination & Materials

- Enrollment in the Medi-Cal MCP owned by the same parent organization will allow similar integration and care coordination as members in CCI counties saw in Cal MediConnect.
  - For example, integrated member materials and coordination across Medicare and Medi-Cal benefits and services.
- Integrated materials are a benefit of EAE D-SNPs, DHCS is working closely with CMS on their development. For example, members will have one health plan card and one number to call for both Medicare and Medi-Cal benefits.

Benefits of the Transition to EAE D-SNPs

- Matching Medicare and Medi-Cal plans will help beneficiaries with all their health care needs and will coordinate benefits and care, including medical and home and community-based services, DME, and prescriptions. This coordination will be similar to what is done in CMC.
- Beneficiaries will continue to have access to a provider network through their matching D-SNP and MCP, which will include similar providers they see today, or the matching plans will help them find a new doctor they like.
- Beneficiaries will not pay a plan premium or deductible when they receive services from a provider in their health plan's network.
- If a beneficiary's provider is not currently in the network, there will be a continuity of care period, where the beneficiary can continue to see their provider for up to 12 months (in most cases). The beneficiary must have a prior relationship with the provider, and the provider and health plan must agree to terms, including payment terms.

Medicare Advantage Plan Matching Policy

Medicare Advantage Matching Plan Policy Summary

- The current matching plan policy applies to dual eligible individuals who choose to enroll in a Medicare Advantage (MA) plan for their Medicare benefits.
  - Medicare Advantage products include regular MA plans and Dual-Eligible Special Needs Plans (D-SNPs).
  - Dual-eligible individuals are beneficiaries eligible for both Medi-Cal and Medicare. The current matching plan policy includes full and partial dual-eligible individuals.
- DHCS currently requires dual-eligible beneficiaries residing in 12 supported counties who are enrolled in a MA to be enrolled in matching Managed Care Plans (MCPs) if one is available and if they are mandatorily enrolled in Medi-Cal managed care. The matching counties are:
  - **Non-CCI: Alameda, Contra Costa, Fresno, Kern, Sacramento, San Francisco, and Stanislaus**
  - **CCI: Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara**

Matching Plan Policy

- In 2022 and ongoing, in the 12 "matching plan" counties, Medicare plan choice determines Medi-Cal plan at the Medi-Cal prime level.
  - Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus counties.
- In 2023, in CCI counties, Medi-Cal plan alignment with Medicare choice extends to Medi-Cal delegate plans with full-risk for all Medi-Cal managed care benefits.
- In 2023, in the remaining non-CCI counties (Alameda, Contra Costa, Fresno, Kern, Sacramento, San Francisco, and Stanislaus counties), aligned enrollment will continue at the Medi-Cal prime level.
- Beneficiaries choosing a MA plan will have automatic enrollment into the matching Medi-Cal plan.

D-SNP Look-Alike Plan Transition

Overview: D-SNP Look-Alike Plans

- D-SNP “look-alike” plans are MA plans marketed to dually eligible beneficiaries but not required to provide care coordination with Medi-Cal benefits, integrated care, or joint enrollment.
- Look-alike plans are MA plans with 80% or more of members eligible for Medi-Cal, meaning they mostly serve dual eligible beneficiaries.
- Look-alike plans do not meet D-SNP integration requirements.
- Enrollment in look-alike plans increased in CCI counties in recent years, due to plan marketing efforts and limits on D-SNP enrollment in those counties.

D-SNP Look-Alike Plan Non-Renewal

- CMS is limiting enrollment into MA plans that are D-SNP look-alike plans.
  - Starting in 2022, CMS will not enter into contracts with new MA plans that project 80% or more of the plan's enrollment will be entitled to Medicaid.
  - Starting in 2023, CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80% or more dual eligibles (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

D-SNP Look-Alike Transition

- CMS will permit an MA organization to transition its D-SNP look-alike membership into another MA plan or plans (including into a D-SNP) offered by the same MA organization, or another MA organization that shares the same parent organization as the MA organization.
- The look-alike transition is designed to ensure continuity of care and cost-sharing protections for dual eligible beneficiaries, as well as provide better options for people currently enrolled in a look-alike plan.
- CMS will work with D-SNP look-alike plans to facilitate the “crosswalk” enrollment of their members to D-SNPs or other MA plans.

CalAIM Mandatory Statewide Medi-Cal Managed Care for Dual Eligible Beneficiaries

CalAIM Mandatory Medi-Cal Managed Care

Background

The Medi-Cal program provides benefits through both a fee-for-service (FFS) and managed care delivery system. Enrollment into one of two systems is based upon specific geographic areas, the health plan model, and/or the aid code for which the beneficiary is determined to qualify.

Goals

January 2022/January 2023, select aid code groups and populations will transition into mandatory managed care enrollment or mandatory FFS enrollment.

Benefits

- Mandatory managed care enrollment will **standardize and reduce the complexity of the varying models of care delivery** in California.
- Medi-Cal MCPs can **provide more coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.**
- DHCS can move to a regional rate setting process to **reduce excessive administrative work.**

Timeline: Mandatory Medi-Cal Managed Care

Mandatory Managed Care Enrollment	Implementation
Phase I	January 2022
Phase II	January 2023

Phase I

- The populations/aid code groups transitioned to managed care are: Trafficking and Crime Victims Assistance Program (dual and non-dual), Breast and Cervical Cancer Treatment Program (non-dual), individuals granted accelerated enrollment, beneficiaries with other health care coverage* (non-dual), beneficiaries living in rural zip codes (non-dual).
- The populations/aid code groups transitioned to FFS are: those covered under the Omnibus Budget Reconciliation Act (OBRA) in Napa, Solano, and Yolo counties and share of cost (dual and non-dual) beneficiaries in county organized health systems and Coordinated Care Initiative counties.

Phase II

- All dual populations/aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care on 1/1/2023. Individuals in long term care (dual and non-dual) will also be mandatory in Medi-Cal managed care.

Questions

- Questions on 2023 CMC to EAE D-SNP transition, Medicare Advantage Plan Matching Policy, D-SNP look-alike transition, or mandatory statewide Medi-Cal managed care?

Update: 2023 EAE D-SNP and Non-EAE SMAC and D-SNP Policy Guide

2023 EAE and Non-EAE SMAC Templates

- D-SNPs must have a State Medicaid Agency Contract (SMAC) with DHCS, and the Department can choose whether to contract with D-SNPs.
- DHCS shared drafts of the 2023 EAE and Non-EAE SMAC templates with plans, advocates, and other stakeholders for written feedback in March. The Department is currently reviewing all comments and will revise and edit the templates based on this input.
- The 2023 draft SMAC templates reflect feedback from stakeholders and advocates on 2022 contracts and align with CalAIM integration goals for 2023.

2023 SMAC and D-SNP Policy Guide

- The 2023 EAE and Non-EAE SMACs will refer to the 2023 CalAIM D-SNP Policy Guide.
- The Policy Guide contains multiple chapters with detailed operational requirements and instructions for D-SNPs.
  - Chapter 1, Care Coordination, was released in December 2021
  - Chapters containing guidance around Provider Network Alignment and Continuity of Care are planned to be released by the end of April.
  - The Policy Guide is available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Documents/Duals/DHCS-CalAIM-D-SNP-Policy-Guide-Dec-2021.pdf
- D-SNPs will be held to the requirements referenced within the Policy Guide.

D-SNP Policy Guide Chapters: Stakeholder Discussions

- DHCS values stakeholder, advocate, and plan feedback on the D-SNP Policy Guide Chapters. The dates that DHCS discussed these chapters during MLTSS & Duals Stakeholder Workgroups (as well as upcoming discussions) are listed below:
  - Care Coordination - Discussed June 10 and July 15, 2021
  - Quality Reporting Requirements – Discussed February 24, 2022
  - Provider Network Alignment – Discussed March 24, 2022
  - Continuity of Care – Discussed March 24, 2022
- Discussions are forthcoming on:
  - Information Sharing
  - Enrollment/Disenrollment
  - Integrated Materials

Questions

- Questions on 2023 SMAC or D-SNP Policy Guide?

Public Health Emergency Unwinding

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a ***DHCS Coverage Ambassador!***
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

Upcoming Meeting Topics

Future topics may include, but not limited to:

- Beneficiary communications and integrated member materials
- Quality reporting
- Information sharing
- Cal MediConnect transition process and status
- Crossover claims and balanced billing

Closing

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, May 19th at 10 a.m.**

California Advancing and Innovating Medi-Cal (CalAIM) Background

CalAIM: Overview

- California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by DHCS to improve the quality of life and health outcomes by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

CalAIM: Goals for Managed Long-Term Services and Supports

- Improved Care Integration
- Person-Centered Care
- Leverage California's Robust Array of Home and Community-Based Services (HCBS)
- Build on Lessons and Success of Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI)
- Support Governor's Master Plan for Aging
- Build a Multi-Year Roadmap to integrate CalAIM Managed Long-Term Services and Supports (MLTSS), Dual Eligible Special Needs Plan (D-SNP), and Community Supports policy, the Master Plan for Aging, and all HCBS, to expand and link HCBS to Medi-Cal managed care and D-SNP plans

Current State of LTC Services Coverage for Beneficiaries

In COHS and CCI Counties

- MCPs are contractually responsible for all medically necessary LTC services (for most facilities) regardless of the length of stay in a facility.
- Medicare-Medicaid Plan (MMP) and MCP members requiring long-term stays at nursing facilities continue to stay enrolled in their Plan and do not transition to Fee-For-Service (FFS).
- MMPs, MCPs, LTC facilities, and other support services are required to coordinate care and transitions of care for beneficiaries.

MCP	Counties (* are CCI counties)
CalOptima	Orange*
CenCal Health	Santa Barbara, San Luis Obispo
Central California Alliance for Health	Santa Cruz, Monterey, Merced
Gold Coast Health Plan	Ventura
Health Plan of San Mateo	San Mateo*
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
LA Care Health Plan, Health Net	Los Angeles*
Inland Empire Health Plan, Molina Healthcare	Riverside*, San Bernardino*
Anthem Blue Cross Partnership Plan, Santa Clara Family Health Plan	Santa Clara*
Aetna Better Health, Blue Shield, Community Health Group Partnership Plan, Health Net, Kaiser Permanente, Molina Healthcare, United Healthcare	San Diego*

All Other Counties

- MCPs are contractually responsible for medically necessary LTC services provided from the time of admission into a LTC facility and up to one month after the month of admission for LTC.
- MCPs are required to submit a disenrollment request to DHCS for beneficiaries who require LTC in a facility for longer than the month of admission plus one month.
- Until the disenrollment is approved by DHCS, MCPs must provide all medically necessary covered services to the beneficiary.
- MCPs are also required to coordinate the beneficiary's transfer to the Medi-Cal FFS program upon the effective date of disenrollment.

MCP Contracting and Payment Requirements for SNFs Today

- MCPs are responsible for contracting with SNFs as licensed by the California Department of Public Health and other credentialing standards, as applicable.
- MCPs must pay SNFs rates that are not less than Medi-Cal FFS rates (Assembly Bill 133 – Chapter 143, Statutes of 2021).

LTC for Managed Care Members Today

- Medi-Cal Managed Care Plans (MCPs) in COHS and CCI counties cover LTC services for enrolled members (for most facilities.)
- MCPs in non-COHS and non-CCI counties cover LTC services for enrolled members for their month of admission and the following month.
  - Subsequently, the member is disenrolled from the MCP into the FFS delivery system and LTC services are covered under FFS.
- MCPs pay LTC providers according to the terms of their negotiated contracts.

LTC Services in FFS Today

- FFS LTC per diem rates are developed based on their respective facility specific methodology as outlined in the California State Plan.
- The Fiscal Intermediary (FI) processes FFS claims via a weekly check write process.
- FFS providers submit electronic or manual claims to the FI and providers are paid directly through a weekly check write process.
- Program provides the FI any rate changes, such as an annual rate update, so they can install the changes into the payment system.
  - Once updated rates are installed, the FI will pay FFS providers at the updated rates on a prospective basis. The process typically takes 60-90 days before provider's will see the updated rates in their weekly check write.
  - There is typically a lag between the beginning of the Rate Year and when the system is updated with the updated rates. During this time providers will continue to be paid at their prior rate.
  - Approximately 90-days following the prospective rate update, the FI retroactively reprocesses claims paid at the prior rate through an Erroneous Payment Correction process (EPC).
  - The EPC process retroactively adjusts payments so providers receive the difference up to the updated rate and will be included in their weekly check write.

Long-Term Care Carve-In

LTC Carve-In

- Effective January 1, 2023, MCPs will become responsible for the full LTC benefit in all California counties. Institutional LTC services will be carved into all plans, including those provided by ICF/DD homes.
- Some of the carved-in LTC services are currently within the scope of Medi-Cal managed care plans in COHS and CCI counties, but many services will be new to Medi-Cal managed care plans in other counties.

LTC Carve-In Requirements

- Beneficiaries who enter an LTC facility and would otherwise have been disenrolled from the MCP will remain enrolled in managed care ongoing.
- All Medi-Cal-only and dual eligible beneficiaries in Medi-Cal FFS residing in a LTC facility on January 1, 2023 will be enrolled in an MCP effective January 1, 2023. Beneficiaries will be defaulted into an MCP if they do not make an MCP choice.

LTC Carve-In Policy

- Welfare & Institutions Code, section 14182.201(b) states, in part:
  - "For contract periods from January 1, 2023, to December 31, 2025, inclusive, … each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services shall accept the payment amount the network provider of institutional long-term care services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102…"