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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FILE DURATION: 1 hour 59 minutes

SPEAKERS

Hilary Haycock
Anastasia Dodson
Susan Philip
Dr. Karen Mark

Hilary Haycock:

All right, we're going to go ahead and get started. Good morning. Welcome to today's Managed Long-Term Services and Supports and Duals Integration CalAIM Workgroup. We are so delighted to have so many folks with us today, and we've got some great presentations from a number of DHCS presenters, including Anastasia Dodson, Deputy Director of the Office of Medicare Innovation and Integration, Susan Philip, the Deputy Director of Health Care Delivery Systems. And, Dr. Karen Mark, Medical Director for DHCS, a few meeting management items to note before we begin. All participants will be on mute during the presentation. Please feel free to submit any questions you might have for the speakers during the chat, using the chat function while we're making presentations. And we'll be monitoring that as we go. During the discussion, if you would like to make a comment or ask a question, please use the raise hand function, and we will call on you and unmute you at that time.

Hilary Haycock:

The PowerPoint slides and all meeting materials will be available on the CalAIM website after the meeting, and you can find a link to where those materials are posted in the zoom chat. We'll be posting that periodically during the morning. As always, we would ask that you just take a minute to add your organization name to your Zoom name. Directions on the screen. Just find the participants icon at the bottom. Click that, find your name, hover, select rename. It's just helpful for us to know what organization you're representing as you're submitting questions and comments in the chat during discussion. Here is our agenda for today. We've got very robust agenda. We are going to begin with an update on the Long-Term Care Carve-In Benefit Workgroup, and a summary of Stakeholder Engagement Efforts to date on that. Then Dr. Mark will provide an update on Senate Bill 48 in the Dementia Aware Initiative.

Hilary Haycock:

And then we'll hear from Anastasia on some Alzheimer's and Related Dementias Prevalence Data followed by a brief discussion. Then we'll shift gears, and we'll go into reviewing the 2023 Cal MediConnect to Exclusively Aligned Enrollment, D-SNP Transition, Medicare Aligned Enrollment, D-SNP Look-alike Transition and CalAIM Mandatory Medi-Cal Managed Care for Dual Eligibles Policies, quite a mouthful, a lot of different CalAIM policies that we will review and have a brief Q&A, and then we'll go on, on an update for our 2023 D-SNP State Medicaid Agency Contract and Policy Guide. And we'll close out with a presentation on the Public Health Emergency Unwinding. So, with that, let us kick off our morning and I will transition to Anastasia. Thanks so much.

Anastasia Dodson:

Thank you, Hilary, and welcome everyone. We're again, very pleased to welcome you all to the Stakeholder Meetings we've had over the last year or so very good

discussions about a lot of different topics that impact dual eligibles and Managed Long-Term Services and Supports. So again, we're very pleased to have this array of topics and this workgroup today, we don't have breakout groups, but we're planning future topics that will, and hopefully we're getting the right mix here of breakout groups, updates, et cetera.

Anastasia Dodson:

So, we want to make sure that this workgroup is serving as a useful collaboration hub for stakeholders and providing an opportunity for everyone to give feedback and share information about what's working, new policies, updates on strategies, and we have a workgroup charter, things have evolved in the last year or so. We'll continue to think about how to make this meeting helpful. But again, we very much value the partnership we have with beneficiaries, providers, plans, advocates, and CMS on this work. And we look forward to future meetings with all of you. Next slide. Okay. So, I'll hand it off to Susan. Thank you again.

Susan Philip:

Great. Thanks Anastasia. Good morning, everyone. It's really a pleasure to join you all today. So as Hilary had said, I will be providing an update on the Long- Term Care Carve-In Workgroup effort. First, I'll begin by providing some background on what the Long-Term Care Carve-In Policy is under CalAIM, and then speak a little bit about the Stakeholder Engagement effort, including the guiding principles for our workgroup. And then really just wanted to give you a summary of the last two workgroup meetings, where we've had some very meaty substantive discussions first related to Managed Care Plan and Facility Communication Education Needs as well as discussion about Managed Care Plan oversight of Long-Term Care facilities. And then we'll also talk about the March 4, workgroup meeting, which focused on member communications. So, with that, we'll go to the next slide.

Susan Philip:

Okay. We can go to the next slide. Great. So just as a reminder, currently Long-Term Care facility benefits are carved-in, into Managed Care in County Organized Health Systems (COHS) and CCI plans. So, and then in the non-COHS, non-CCI counties it's carved out. So, the goal of this of the carve-in effort is really to make coverage of institutional long-term care consistent across all counties and ready for all Medi-Cal members.

Susan Philip:

As you all know, one of the guiding principles under CalAIM is really to streamline Medi-Cal benefits and experience for Medi-Cal members, really, regardless of which county they happen to reside in. So, in non-COHS counties right now, if a Medi-Cal Managed Care member ends up needing long-term care facility services, they would have to

disenroll from their Managed Care Plan and then be enrolled in the fee-for-service delivery system. So, it is a disenrollment process that would occur and the long-term care services again, are covered under the fee-for-service delivery system. So, then under the current timeline, Managed Care Plans will be required to cover Long-Term Care facility services, again, effective January 1, 2023. And then as of January 1, 2023, long-term care beneficiaries who are in fee-for-service in those counties where it is currently carved out will be required to transition into mandatory Managed Care.

Susan Philip:

So, in terms of facility types, I think it's important just to clarify, so Long-Term Care benefits really covers three buckets of facility types. We have the Skilled Nursing Facilities, and then we have Intermediate Care Facilities, which are for individuals who develop with developmental disabilities and then Subacute Care Facilities. So, three different facility types, and we have additional information in the appendix for this, but we want to clarify that Long-Term Care facility bucket really includes these three very different facility types, including in terms of population served and the facilities itself.

Susan Philip:

So, switching to engagement efforts to date next slide. So, the Long-Term Care Carve-In Workgroup has met since December 2021, we've met four times. And then throughout those times we've also had additional meetings really to engage, Managed Care Plans, facilities and the homes, and advocates to really inform the development of this policy and how we operationalize it. So, some of that includes looking at what promising practices can we glean from those counties where Long-Term Care is currently carved in. What are kind of the promising practices, or really must haves in terms of say contract Managed Care Plans and providers. What kind of guidance would be helpful and then discussions related to continuity of care, especially during the transition? So, we've been having a series of workgroup meetings, but then also including meetings as needed to really engage with our stakeholders. And then in addition to the Long-Term Care workgroup as a whole, we also have a subgroup specifically for ICF/DD facilities. So, we've been meeting regularly with that group as well.

Susan Philip:

Okay. Moving to the next slide. So, I thought it would be helpful just to review what we're calling the guiding principles for the workgroup, which we really established with the stakeholders. First, we will be striving to make the Long-Term Care Carve-In transition as seamless for members as possible, which means no disruption in access to care, that we want to ensure that Managed Care Plans are really conducting timely reviews and authorization of services, obviously continuity of care for existing authorized services. And of course, we're looking into ensuring that data that would enable that continuity of care, both for plans and for facilities are provided. So, we're working to ensure that we can get that data to plans in a timely manner. We're also

looking to identify education and outreach efforts, both for facilities as to really help ensure that the transition can really support members during this process.

Susan Philip:

Okay. We can go to the next slide. So, in terms of Managed Care Plan and facility education, there was some really great suggestions from our workgroup members. First, as I mentioned before, there really are lessons that we can draw from the CCI counties and plans. And so, we're really working to ensure that we are distilling that and having those conversations to understand those lessons learned. And then the workgroup has suggested, and that we as a department really do need to develop clear policy guidelines and as rules of the road, if you will, that will really serve as a basis for Managed Care Plan facility education. And that education and training really does need to include, not just focus on Managed Care Plans, but also providers and really looking really to providers at different levels, right. So, the different facility types, as well as looking from different perspectives of the provider, including care managers, excuse me.

Susan Philip:

So, we are also working to convening Managed Care Plans to really share effective approaches and really creating that two-way communication between Managed Care Plans and facilities. That's a theme we've heard from plans and where Long-Term Care is currently carved in, that where it's successful it, that there is really that seamless communication between the Managed Care Plans and the facilities, and they have that established relationship. So, for example, a Managed Care Plan might have a designated individual in their provider relations department that is just focused on working with Long-Term Care facilities. So, these are some of the lessons that we're learning here. And one thing we've also heard, as I mentioned that there are different facility types and there really was a strong recommendation to kind of separate out the policy development for SNF, ICF/DD, and Subacute Care Facilities. Again, since there is different considerations for them given the population serve and the facility types.

Susan Philip:

Okay, we can go to the next slide. So, in terms of communication, educational needs, again, already touched on that. There really is that needed close collaboration between the Managed Care Plans, facilities, as well as community stakeholders. So that was a lesson learned from the carve-in in the CCI counties. And we are working to develop guidance for Managed Care Plans in terms of thinking about how to really engage with facilities in their service areas, as well as ensuring that any delegated entities that manage Long-Term Care risk are included in those discussions and the guidance that we provide. So, in this year, we are planning to develop a number of provider education and Managed Care Plan education opportunities through policy guidance, which we're developing. So of course, first step is developing a policy guidance with our

stakeholders and then working to ensure that we have a cadence in terms of how we are sharing the policy guidance.

Susan Philip:

So, developing the policy guidance, ensuring that it's posted, that there's opportunity for review and stakeholder input. We also have regular touch base calls with Managed Care Plans. We are looking to also schedule webinars that will really provide an opportunity for planners and providers to be on the call, ask questions related to the operationalizing of this policy. As we develop it, of course, we'll be working with associations and looking for opportunities to provide communication out through various associations. And then of course through our regular materials, obviously through our website, but we're thinking about fact sheets, FAQs, and that would be helpful for quick high-level communication. But then as folks have more detailed questions, that we gather those questions and then really keep our FAQs updated as those questions come in.

Susan Philip:

Okay. We can go to the next slide. So, we heard from the workgroup members, they provided some great feedback in terms of topics that would be appropriate for webinars and education series. So, one with Managed Care Plans, being primary audience, just even a Long-Term Care 101, really there's certainly plans that have experience in terms of Long-Term Care Carve-In, but there are plans that don't have as much experience, especially in the carved-out counties. So really focusing on those facility types that might be new to certain Managed Care Plans in terms of contracting and developing networks, including ICF/DD facilities, which are really small group homes and thinking about how to work with these different types of facilities, right. So really thinking about how to work with these homes and then pediatrics of acute care facilities as well, where plans might not have that much experience in working with those facility types.

Susan Philip:

So, we're thinking about how to provide that kind of overview in education. And then in terms of outreach to providers and facilities, on the flip side, there are facilities that haven't contracted with Managed Care Plans. And so, understanding what does that take, what kind of infrastructure is needed, everything from potential, how do you build, how does invoicing work and kind of working with the facilities to really provide that education. So, we're thinking through how to provide that outreach and education to providers and facilities.

Susan Philip:

Stakeholders also recommended really including details on the authorization procedures too. So, we're thinking about that as well, and including that in the webinar and educational series. And then one thing that we've heard is that it would be helpful to

have guidance guardrails related to what ought to be considered to be included in the contract with Managed Care Plans and facilities. So, and then of course clarifying where we can in terms of standardizing billing practices and codes, and to provide that guidance as well. So, to the extent that we can help to streamline these processes the better.

Susan Philip:

Okay. We can move to the next slide then. Okay. So, we did hear from the workgroup that there has been really a number of different systems that are used for credentialing that can create kind of layers of challenges to facilities and we know that standardizing credentialing processes is a challenge. It's an ongoing issue in the industry. I think we had some really good conversations about it, but as a workgroup, we agree that it's currently outside scope for our efforts here in terms of Long-Term Care Carve-In, but certainly something to consider as a larger discussion industry wide for future years. And again, as I mentioned, there are aspects of plan contracting that the workgroup has suggested would be good for DHCS to really weigh in on and provide some guardrails in terms of standardizing and streamlining. So MCPs, Managed Care Plans have clear guidance, and their providers understand kind of what to expect. So that's something that we've heard and are taking into consideration.

Susan Philip:

Okay. We can move to the next slide. Okay, great. So then moving just to the March meeting, we had quite a good, robust discussion related to member communication. Again, this is a pretty substantial transition in terms of moving folks into Managed Care Plans and again, doing it in a way that is seamless and minimally disruptive, if at all. Again, we're really trying to ensure that members understand that they need to select a Managed Care Plan and understand the process and what that means for them. So, some feedback that we've gotten from the workgroup is of course the Managed Care Plans need data and information as soon as possible to understand who are these members who will be transitioning and how to ensure that there's clear communication outreach. So, that can be done as early as possible.

Susan Philip:

We are right now, developing our data feeds to ensure that we can provide Managed Care Plans that aggregate information that's needed to identify the potential population that will be carved in. And then later this year we'll be providing specifics in terms of individual members. So, that's something that of course is needed and that we've heard loud and clear. And of course, the other key piece is coordination between Managed Care Plans and the facilities to really ensure continuity of care for members. Again, that is to ensure that the Managed Care Plans are all reaching out to the facilities to let them know which manage care members will be part of their plan and ensure that members really have that information. And that there's a clear understanding of not just the Long-

Term Care facility services, but any other services that residents have and ensure the continuity of those services as well.

Susan Philip:

Okay. We can move to the next slide. So, in terms of the member communication plan, so one, again we've heard that from the workgroup members, of course, that we need to provide information to members directly, and to ensure that there is a clear understanding of what's happening on January 1, 2023. So, our plan is to send target notices to beneficiaries, to explain both the transition into Managed Care Plans, what options they do have, and then ensure that there's clear communication of continuity of care.

Susan Philip:

In terms of Health Care Options and our enrollment broker, we are working to ensure that there is training specifically on the Long-Term Care transition, that there are specialists on hand to answer questions that beneficiaries may have, beneficiaries or their caregivers and ensure that, that is addressed. So, we really are working to ensure that folks are trained and understand how to answer these questions. We are also ensuring that we're going to be launching Outbound Call Campaign directly to all beneficiaries that will be impacted directly by the transition. So, after the notices are received, we intend to call all the beneficiaries that will be transitioning. So, it's a big undertaking, but really important to ensure everyone understands what the transition is and how they're affected.

Susan Philip:

So, we will also be providing education. As I mentioned to providers, MCPs, our Ombudsman as well, to ensure that folks have a general understanding and that we provide them the toolkits and the educational materials that they need as well to then in turn, communicate consistently and answer questions for beneficiaries. And again, ultimately this is to ensure that our members and our providers are really supported through the transition.

Susan Philip:

Okay. We can move to next slide. So just in terms of other work effort and feedback that we've gotten from the workgroup, that we have a process to ensure that Managed Care Plans networks are ready. And so, some feedback that we've heard from the workgroup is of course, network adequacy is more complicated than just counting beds, right. We are currently in the process, addressing and understanding what the actual capacity is on a county-by-county basis, on a regional basis with the different facility types, there is different availability of beds and of facilities in a specific county or region. So of course, we're taking that into consideration when thinking through our network adequacy guidance, and we are also working to, again, ensure that network adequacy and in

guidance that we provide in terms of continuity of care really is grounded in that principle of minimizing any disruption to members during this transition.

Susan Philip:

Okay. We can move the next slide. Okay. So, I thought it would be helpful to just share also the current oversight of facilities that currently are in place, and that we're thinking through, in terms of ensuring that, that is outlined clearly in any of our guidelines as well. So, as many of you know, that providers are licensed by CDPH to ensure that they meet all state regulatory requirements and then certified by CMS to ensure that, meet all federal regulatory requirements as well, to be a Medi-Cal provider to a Medi-Cal enrolled provider must be enrolled through the provider application validation of enrollment system. And then Managed Care Plans could also provide direct enrollment as well. Providers are also then credentialed by the Managed Care Plans to ensure that they are demonstrating compliance with our credentialing requirements, including screening and enrollment of providers.

Susan Philip:

So, these are a number of steps that are in place to ensure that there is oversight of facilities. We are thinking over the longer term in terms of our overall quality at standards, how to ensure that as part of our overall efforts, to ensure that there's quality reporting how we're going to fold that into our standards, as well as our strategy. So that's something we're thinking about over the long term, not immediate guidance, but that's also something to look forward to, and we'll be engaging stakeholders in the future.

Susan Philip:

So, there's a number of contracting considerations, as I mentioned. And we're really working to ensure that the feedback that we're getting in terms of the various steps that need to be taken both on the part of the Managed Care Plans and the facilities to really make sure this transition happens as smoothly as possible, really taking that feedback into consideration. We are aiming to release an All Plan Letter to the plans in June and rates later in July, currently on track for that timeline. And I'll just say, I'm very grateful to all the stakeholders who have provided us input along the way. We need to hear from you all and really appreciate the time and commitment and energy. So, with that, I will transition back to Hilary or Dr. Mark.

Hilary Haycock:

Great. Thanks. I don't think Susan has time to stay with us for questions this morning, although correct me if I'm wrong. I think you've... But we are happy to take questions back, I know there were some in the chat and we can take those at info@calduals.org and circle back with folks. Okay. Wonderful, thank you so much, Susan. That was a

great presentation and lots of work happening. Now, we will transition to Dr. Mark to give an update on Dementia Aware and Senate Bill 48.

Dr. Karen Mark:

Good morning, everyone. Thank you so much, Hilary, if I can take the next slide. So, I wanted to provide an update for everyone on where we are with implementing Dementia Aware and SB 48. I know Dr. Sohrab Sidhu from my team provided an update to you all, I think a couple of months ago. So, Dementia Aware is our home and community-based services waiver and is our HCBS spending plan funded effort to provide provider training and culturally competent dementia care to develop referral protocols for folks and for providers to follow around cognitive health screening and dementia, and then to make continuing education available for providers in dementia care. And specifically, this aligns well with SB 48, which was written into law last year, which establishes an annual cognitive health assessment as a Medi-Cal benefit for beneficiaries 65 plus who are not otherwise eligible for a similar benefit under Medicare. And SB 48 requires that in order to receive payment, Medi-Cal providers must complete a DHCS required training and then use one of the validated tools recommended by DHCS to do this cognitive health assessment. And so, this is where these two are complimentary efforts because the DHCS required training is the training that we're developing as part of Dementia Aware. And then we're also utilizing the Dementia Aware effort to come up with a validated tools that we would recommend for this cognitive health assessment. We have identified 1494F, which is a category II CPT code as the code that we would use for the new benefit. Next slide.

Dr. Karen Mark:

So, we are happy to let folks know that we have contracted with UCSF to do the Dementia Aware initiative. And we were really looking for a contractor that would have both expertise in dementia itself as well as expertise in screening implementation primary care practices. And we really feel like we got that in this effort with UCSF. USCF is subcontracting with several other UCs throughout the state, as well as with other organizations to really have a broad footprint throughout the state to support this work. And the goal is to have the training available for Medi-Cal health providers by this July, which is the goal date for implementing the cognitive health assessment under SB48.

Dr. Karen Mark:

Next slide. We're looking at our Dementia Aware effort in two phases. The first phase from now through August 31st is focusing on developing the screening tools and then developing the training and making sure that the training is CME accredited and that physicians can get MOC credit for doing the training. Phase two, which will start at the conclusion of phase one is focused on practice level implementation support for the screening. As well as a full training outreach and engagement strategy to really make sure we reach as many primary care providers as possible throughout the state. And

then also evaluating the training, which will be a web-based training and updating the training as needed.

Dr. Karen Mark:

Next slide. We are working with UCSF to create a clinical advisory board for Dementia Aware. The first sessions have just gotten started. This is the clinical group that is providing expertise on the cognitive health assessment toolkit, the screening tools, and the development of the training. It's comprised of key stakeholders, including folks from primary care, community-based organizations and dementia experts. So wanted to just put a shout out to this group, if there's anyone who would like to participate, if you want to go ahead and send me an email. We'll be happy to connect you in and I can drop my email in the chat. And I think that's it. I'll turn it back over to Hilary. Thank you all so much.

Hilary Haycock:

Great. Thank you so much, Dr. Mark. We'll now transition to Anastasia Dodson to provide a presentation on Alzheimer's and related dementia's prevalence data.

Anastasia Dodson:

Great. Thank you here, Hilary and Dr. Mark, and looking forward to the questions after on both of these topics. So next slide. So, as you may know, DHCS has data, of course, Medi-Cal utilization data and diagnosis data. And then we also have Medicare Fee-for-Service beneficiary data for those who are dually eligible for Medicare and Medi-Cal. So, we pulled... We took a look at some data around Alzheimer's and related dementias diagnosis codes, and this was inspired by CMS. They have a Medicare chronic conditions data book website, and we thought, "Well, let's look at a little more recent data in California and among dual eligibles in California." And again, this is just for folks who are in original Medicare, Fee-for-Service Medicare, who are dually eligible in California. And what we found, which is similar but not exactly the same as the CMS data, is that for duals who are age 65 and older in Medicare Fee-for-Service in California, the statewide prevalence of Alzheimer's disease and related dementias was 18.1% in March of 2021.

Anastasia Dodson:

So, some of you may be very well familiar with this order of magnitude on the statistic, but for some it may be kind of like, "Wow, we didn't..." It may be that not everyone realizes what a significant portion of the dually eligible beneficiaries in California have Alzheimer's or related dementias. And so, tying back to the presentation we just had from Dr. Mark it's so important to consider what's the knowledge level among physicians and other practitioners? How can we improve that? What are diagnosis strategies and what are any other sort of care management issues related to this population? This is significant impact.

Anastasia Dodson:

The prevalence among the Medi-Cal only folks, and that's a very small population right now, but it will get bigger, was quite a bit lower. 6.8% compared to duals. But again, there may be some data issues there based on the particular situations for that population. There are a variety of situations could be going on, they may just be rarely in the Medi-Cal only category as they're gaining their Medicare eligibility, et cetera. But we will be of course, with our expansion of Medi-Cal for everyone age 50 and above, that may change in the coming years.

Anastasia Dodson:

Anyway, and then for dual eligible folks, there was wide variation in prevalence by county with the lowest prevalence in the Northern rural counties between around 6 or 7%, very much different from Los Angeles and Orange counties where the prevalence is around 20%. So interesting when we think about what are the strategies, and then where should the state, health plans, providers focus those strategies, and where might we consider... Are there other issues besides dementia and Alzheimer's for some populations and looking at the Los Angeles, Orange, large Southern California counties, where there may be more work and organizations that we can work with on some of those strategies there.

Anastasia Dodson:

Next slide. Again, in Medi-Cal populations for duals, for race and ethnicity, our data showed that the prevalence was highest among white beneficiaries and the data show that it's lower among black beneficiaries, but we think that figure is likely understated. There's a body of research that is substantiated, that there are differences in diagnosis, there's differences in acceptance or basically patients, individuals wanting to be screened. And I don't want to sort of make too broad of generalizations, but there's something there that even on a national level, there's been further discussion about as far as are some beneficiaries being diagnosed later in the progression of the disease? A lot of... A complex area that is very important for the discussion. So, I'll leave it at that, but hopefully in the coming months, whether it's this group or other groups at DHCS, we can continue to look at this perhaps in Dr. Mark's clinical group. Prevalence of Alzheimer's and dementia among in-home supportive services recipients who are above age 65 was 28%, perhaps not surprising given that IHSS is the program designed to provide long term services and supports at home or in the community.

Anastasia Dodson:

So, the prevalence among California duals was twice as high as Medicare only beneficiaries in California. And I think that is also especially important so that when we think about Medicare as a whole, including duals, but also all the other non-duals, the prevalence of Alzheimer's and related dementia diagnosis is twice as high in the duals population. So having the Dementia Aware, having all the efforts that Dr. Mark is

leading, is very important. This is the population to really focus on. Of course, there are folks with Alzheimer's and dementia among the non-duals, and they can benefit from Dementia Aware, but as far as the focus on duals, it again, much higher prevalence of the duals population.

Anastasia Dodson:

However, the prevalence among Medicare beneficiaries overall in California was lower than the prevalence among Medicare beneficiaries nationally. So, there's implications there for broader conversations, but the gist of it is that we have this prevalence data. We're going to be it on our website on DHCS. And we can further examine the data, either with this data set or in the future. But we'd like to just present this to you and make sure that you're aware, as we think about Dementia Aware et cetera, what is the prevalence? All right.

Anastasia Dodson:

Great.

Hilary Haycock:

Great. Thank you so much for that very informative presentation. We will go into questions now. So again, folks are welcome to input questions are comments into the chat, or you can use the raise your hand function, and we can unmute you. Question from Kristine Marck at CMA. I think this came in during the dementia discussion. She was wondering if there was an APL that has already been sent to the Managed Care Plans on the new dementia policy.

Dr. Karen Mark:

So, we have not issued an APL to Managed Care Plans, but we have been communicating regularly with them during our regularly scheduled meetings with them.

Hilary Haycock:

Great. A comment from Donna Poole on the data. "I think if we look at more recent data over the last two years, the prevalence is going to be much higher." So...

Anastasia Dodson:

I think that we will keep looking. The data from CMS showed a different prevalence overall and by race and ethnicity, by a few percentage points than what our data showed for 2021. Those were three years apart. Hard to know.... We'd have to do a more careful analysis to see if that was a true difference or if there's some methodology difference, but we could also look back and see if DHCS pulls the data from 2018. Does it show a difference? I don't know. Dr. Mark, do you have any thoughts on that?

Dr. Karen Mark:

Yeah, no, I mean, I agree with certainly continuing to look over time. I think we agree that certainly there may be under diagnosis in some groups. And so, we're not necessarily capturing all diagnoses and the data that we have.

Hilary Haycock:

Great. Those are the only questions I've seen come in. And so, unless there's anything else from our audience, we will thank Dr. Mark so much for her wonderful presentation and your time with us this morning. We appreciate it. It's an exciting, exciting initiative. Looking forward to continuing to hear more as it rolls out. So, thank you so much.

Dr. Karen Mark:

Thanks everyone.

Hilary Haycock:

All right. And Anastasia, we will transition back to you to move on to our Cal MediConnect transition to Exclusively Aligned Enrollment D-SNP update.

Anastasia Dodson:

OK. So, spoiler alert, there's nothing that's big brand new in these next slides. Most of it is a review, but I think we want to make sure that everybody hears the same thing and we're all on the same page because there's some complex transitions that will occur for 2023. So, we'll just go ahead and run through these slides and then definitely questions, et cetera. All right, next slide.

Anastasia Dodson:

Okay. Beneficiary enrollment in D-SNP or any other Medicare Advantage Plan is purely voluntary for duals and Medicare only folks. Medicare beneficiaries can stay in Original Medicare. Don't need to take any action to remain in Medicare Fee-for-Service. For 2023 beneficiaries already enrolled in Cal MediConnect, they will automatically be enrolled in the Medicare D-SNP and Medi-Cal plan that's affiliated with their Cal MediConnect plan. No action is needed. And again, we have very smart teams at CMS and DHCS and the health plans all in sync to make sure that transition occurs automatically, seamlessly for current Cal MediConnect beneficiaries. And again, enrollment is open in Cal MediConnect duals in the seven CCI counties all the way through essentially the end of this year. So, they can enroll anytime and then they'll be automatically transitioned into the Medicare plan and the Medi-Cal plan that match up with their Cal MediConnect plan. Next slide.

Anastasia Dodson:

Okay. A D-SNP is a type of Medicare Advantage plan that provides specialized care for dually eligible beneficiaries. D-SNPs, they have to have a contract with the state Medicaid agency, DHCS and DHCS can choose whether to contract with specific D-SNPs. D-SNP is slightly different than Cal MediConnect in just that the Cal MediConnect plans. They coordinate Medicare and Medi-Cal benefits under a single health plan, single contract, and D-SNPs they have a separate contract with CMS, for Medicare, and then a separate contract with DHSC or Medi-Cal, but it's the same organization that essentially holds both contracts. The goal that we've talked about, over the last year and a half, again, is the same level of care coordination and collaboration of all the aligned processes that we have in Cal Medi-Connect, moving those over to the D-SNP model.

Anastasia Dodson:

All right, next slide. So Exclusively Aligned Enrollment. We talked about this several times. This is a policy that limits a particular D-SNP membership to only the individuals that have aligned enrollment, where the beneficiaries enrolled with the same organization for Medicare on the D-SNP and Medi-Cal for the Medi-Cal side. D-SNPs are only going to be allowed to enroll new members who are in their aligned Medi-Cal plan under Exclusively Aligned Enrollment. Again, it's very similar to the Cal MediConnect approach, integrated benefits, align integrated communication and member materials.

Anastasia Dodson:

Next slide. Aligned enrollment. This is just a quick visual. If the same organization, company A in this example, is providing the Medicare D-SNP and that same company is providing the Medi-Cal plan, as you see on the left, then that is aligned enrollment. On the right you'll see company B providing the Medicare D-SNP and company A on the Medi-Cal plan that is not aligned. And that's what we are trying to avoid, because we think that example on the left gives much better integrated care, data sharing, care coordination, member materials, et cetera. Next slide.

Anastasia Dodson:

So, in 2023 Medi-Cal plans in CCI counties are going to be required to establish these Exclusively Aligned D-SNPs and duals can choose to enroll in these plans among other options. Cal MediConnect beneficiaries will automatically transition to these EAE D-SNPs in their matching Medi-Cal plans on January 1st, 2023. Non-CCI counties, the rest of the state, the Medi-Cal plans are required to stand up D-SNPs in those counties no later than 2026, and possibly sooner if they are ready, but that is the statewide approach that we have as part of CalAIM to these Exclusively Aligned Enrollment D-SNPs. Next slide.

Anastasia Dodson:

Again, the transition will be seamless. Cal MediConnect will continue all the way until the end of this year, and there'll be automatic transitions. There'll be no gap in coverage and the provider networks should be substantially similar. Notices will be going out, out to beneficiaries who are in Cal MediConnect. They'll get those notices in October of 2022. And we certainly recognize there'll be a lot of notices going out to various folks in the fall of 2022. Not every notice is going to every beneficiary in the sense that folks who are not in Cal MediConnect of course, will not get Cal MediConnect transition notices. You know, we're going to talk later on about some other D-SNP transitions. So, Medicare beneficiaries, dually eligible folks, they will get notices from their health plans about 2023 transitions on the Medicare side. And those notices will be from the health plan, so that it's not necessarily a mass mailing from DHCS, but more targeted mailings from each of the plans to their members about the transitions.

Anastasia Dodson:

Next slide. Again, opportunities and benefits for Exclusively Aligned Enrollment is similar to Cal MediConnect. One entity is financially responsible for both benefits. So, they have an incentive to work across both sets of benefits. For example, providing community supports, because that can reduce the sort of hospitalization inpatient care if the community support can meet that person's need and allow them to stay at home and reside in the community. Of course, benefit coordination, simplified care coordination, et cetera.

Anastasia Dodson:

Next slide. Integrated care coordination, and materials. That is something that we are working on. And so, in the upcoming meetings of this group, we will be sharing walkthrough the integrated materials. And we know that is such an important communication tool for beneficiaries, for members. So, we have been working closely with advocates, consumer advocates, and CMS health plans to try to get this language right and looking forward to sharing it with all of you.

Anastasia Dodson:

Next slide. I think we've mostly covered this. All right. Next slide. Okay. Hilary, should we pause for questions or just keep going through the matching plan policy?

Hilary Haycock:

I think we were going to pause for questions at the end.

Anastasia Dodson:

Okay. All right. And these sections are all tied in together, but we're definitely glad to answer in any and all questions on these transitions. That's exactly what this meeting is intended for. So, the Medicare Advantage plan matching policy. So, the Cal

MediConnect that we were just talking about and Exclusively Aligned D-SNPs for 2023, that's just in the seven CCI counties. These next slides on the Medicare Advantage matching plan policy that is broader. That is not just the seven CCI counties, but it is some additional counties that they don't have Cal MediConnect. They don't have the Exclusively Aligned D-SNPs. However, there are Medicare Advantage plans, let's say in Alameda, Contra Costa, you can see at the bottom of this slide those non-CCI counties, there are Medicare Advantage plans, and D-SNPs already in those counties that dually eligible beneficiaries can enroll in. According to the CMS timelines for when those enrollments can be made.

Anastasia Dodson:

So, the policy is that when a beneficiary chooses a Medicare Advantage or a D-SNP plan in either the CCI or the non-CCI counties that are listed at the bottom of the slide, then their Medi-Cal plan will automatically be aligned to match their Medicare choice. And again, this is policy that has been in place for quite some time back to even prior to 2014, but it's not been something that we have had stakeholder meetings on or provided a lot of discussion on until now until the last nine months or so. So, we've been wanting to make sure that people are aware of this policy and documenting it, et cetera. So that's what these slides are. And again, these are the same slides that we have talked about in previous meetings, this matching plan approach. So that again, if a beneficiary chooses to enroll in a Medicare Advantage D-SNP plan in any of these 12 counties, then their Medi-Cal plan choice will automatically be aligned to their Medicare plan choice if there are affiliations between plans.

Anastasia Dodson:

There are more details in the next slide, but just that slide did have a... And good. And this slide again, has the counties that are both CCI and non-CCI, where this matching plan policy applies. So again, all these 12 counties, the Medicare plan choice determines the Medi-Cal plan at the prime level. And we're not going to get too far in the weeds on prime versus delegate plans on the Medi-Cal side. But the idea is that in Los Angeles counties and some other large counties where there are subcontracted plans again, large enrollment in these delegate plans when a beneficiary chooses a Medicare Advantage or D-SNP, that has an affiliated Medi-Cal plan, whether it's prime or delegate then in 2023, that matching policy is going to apply at the prime and the delegate level in those CCI counties.

Anastasia Dodson:

And in the remaining counties, aligned enrollment stays at the prime level, same policy we've had for many, many years, which is, and again, these are not quite as large as Los Angeles or San Diego or San Bernardino, Orange County in these other, such as Fresno, Kern, Contra Costa, Alameda, the choice of the Medicare plan will trigger an alignment on the Medi-Cal plan side. And this is of course, very important for making sure that when one organization is able to provide both sets of services, then that's

where you can have a much better opportunity to have combined care coordination across both sets of benefits. Providers, when they're billing, they have just one organization that they bill with. There may be two sides within that organization, but there can be much better coordination for providers and a variety of member services. When again, it's the same plan for both Medicare and Medi-Cal.

Anastasia Dodson:

So, we will go to the next slide, that's it on the matching plan policy, I think, and going to the next slide. This is about D-SNP look-alike plans. So, for those who are not familiar, a D-SNP look-alike is a Medicare Advantage plan that's marketed to dually eligible beneficiaries, but that plan is not required to provide the same level of care coordination with Medi-Cal benefits or integrated care or joint enrollment. So, look-alike plans, this again, was defined by CMS, the Federal Centers for Medicare and Medicaid Services. Those plans are defined by CMS as having 80% or more of their members eligible for Medicaid or Medi-Cal in California, meaning that they mostly serve dual eligible beneficiaries. However, these D-SNP look-alike plans, they do not meet the D-SNP integrated care requirements.

Anastasia Dodson:

So DHCS, as the state we have a contract with D-SNPs where we can set integrated requirement, integrated care requirements for Medicare and Medi-Cal and how that integration and coordination should occur. For D-SNP look-alike plans DHCS does not have any kind of a contractual relationship with those Medicare plans, so we are not able to set any criteria or do any monitoring or what have you on the coordination across Medicare and Medi-Cal benefits for those dually eligible beneficiaries. In recent years, enrollment in these look-alike plans increased in the CCI counties. That is related to marketing efforts, and we had limits on true D-SNP enrollment in those counties. That is a part of the landscape, especially in large counties in Southern California, where there tends to be higher Medicare Advantage enrollment. These D-SNP look-alike products gained enrollment.

Anastasia Dodson:

And so, as you're going to see on the next slide, there's a transition process that CMS established in regulations that's coming up soon. Next slide. So, CMS per their regulations is limiting enrollment into Medicare Advantage plans that are, or D-SNP look-alikes. So, starting this year, CMS did not enter into contracts with new Medicare Advantage plans that project 80% or more of the plan’s enrollment would be entitled to Medicaid. So essentially no new D-SNP look-alike contracts in 2022. And then in 2023, which is coming up in seven or eight months, CMS will not be renewing contracts with Medicare Advantage plans, except for D-SNPs that have enrollment of 80% or more dual eligibles. There are certain exceptions for new plans or those with small enrollment, but essentially D-SNP look-alike contracts will no longer be renewed by CMS. So, we know that there is a process underway that, and this is really a CMS

federal government, they contract with these plans, and they have made the regulation to discontinue these types of contracts. So, CMS is working with each plan individually to provide technical assistance, and to figure out a transition strategy for the beneficiaries that are enrolled in those plans. In many cases, there are either true D-SNP or a regular Medicare Advantage plan that essentially give the same provider network, the same sets of benefits. And it's a matter of cross walking those beneficiaries, similar to how we do for Cal MediConnect, where we're going to have an automatic crosswalk of Cal MediConnect members to the D-SMP that matches that Cal MediConnect plan.

Anastasia Dodson:

CMS is working on ways to use that crosswalk authority to do a very seamless transition for beneficiaries in these D-SNP look-alike plans, so that they would automatically go to a regular D-SNP or a Medicare Advantage plan that would essentially provide the same, or very similar network providers and benefits, and same plan, because we know that disrupting beneficiaries network can be quite difficult. And so, CMS has been working very hard and they've issued guidance to D-SNP look-alike plans, et cetera. And so, in the coming months, they'll be working out the fine details on how those transitions will go. Next slide.

Anastasia Dodson:

Right so, CMS will permit another Medicare Advantage organization to transition its look-alike membership into another MA plan, including a D-SNP offered by the same organization, or another MA that has the same parent organization. Focus on continuity of care, cost-sharing protections for duals, and better options for people currently enrolled in a look-alike plan. We talked about the crosswalk. Okay, next slide.

Anastasia Dodson:

I think that's it for D-SNP look-alikes. Again, Hilary said that we're going to take questions on all these related topics at the end, so we have plenty of time for questions on all of these.

Anastasia Dodson:

Next topic is around statewide and, again, all of these things will result in notices to beneficiaries that will occur in the fall and again, on the Medicare side, the notices will be targeted by plan. So, Cal MediConnect beneficiaries are not going to get D-SNP look-alike notices and vice versa. Beneficiaries will get targeted notices based on their Medicare enrollment plan.

Anastasia Dodson:

So, switching years here to the Medi-Cal side for dual eligible beneficiaries. And go ahead to the next slide. So, right now in California about half of the counties, but more than half of the population for dual eligible beneficiaries, they are mandatory enrolled in Medi-Cal Managed Care. Again, there's no mandate for managed care on the Medicare side, but on the Medi-Cal side for a majority of dual eligibles in California, they are mandatorily enrolled in a Medi-Cal Managed Care plan. In some counties there's just one Medi-Cal plan. And some counties there's multiple Medi-Cal plans that they can choose from. But, again, the delivery system model that we have in California is dominantly through Medi-Cal Managed Care plans for Medi-Cal.

Anastasia Dodson:

So, with this policy change that will be coming up in 2023 in the remaining counties where dual eligible beneficiaries on the Medi-Cal side are not required to be in Medi-Cal Managed Care, starting in January they will be. So that, again, all dual eligible beneficiaries, there's a few exceptions, but almost all dual eligible beneficiaries on the Medi-Cal side will be required to enroll in a Medi-Cal Managed Care plan that's statewide. And it, again, it's no mandate on the Medicare side, but on the Medi-Cal side, there will be mandatory Medi-Cal Managed Care enrollment for dual eligible beneficiaries in 2023. So, for more than half the state, there's no impact because they're already mandatory enrolled on the Medi-Cal side in Managed Care. But for some remaining counties in certain areas of the state that will be the change. And there will be transition notices that go to beneficiaries to let them know, okay, coming up, January 1st, you'll be required to enroll in a Medi-Cal plan and there will be a choice packet that's sent, materials, et cetera. So, let's go to the next slide.

Anastasia Dodson:

So, you can see phase I was other populations, not duals for the most part that already occurred in January of 2022. And then, we're calling this phase two for January of '23. Those are all duals, except for share of cost who are not in a long-term care facility. Those will be mandatory. And we talked in the beginning, Susan talked about long-term care. Again, it's those same counties... Some in many counties, long-term care is already a Medi-Cal Managed Care benefit. But in those same certain counties, the long-term care is not part of Medi-Cal Managed Care. And dual eligibles are not mandatory enrolled in Medi-Cal Managed Care. And so, those changes are coming up January of 2023. Next slide.

Anastasia Dodson:

Okay so, here we are with questions on several different topics. So, happy to take those questions. And we'll ask you, Hilary, for help facilitating.

Hilary Haycock:

Absolutely. So, we've already got some questions in the chat, so we'll start there. And then we'll go to the hands that have been raised. First question is, "How will you tackle multiple PACE programs in a county? If someone is selecting a PACE program, how will you know which program to refer to?"

Anastasia Dodson:

Well, that's a good question. I wonder if somebody from our Managed Care Operations Division might know that, and maybe we could go to the next question while they're getting on perhaps, or maybe they can...

Hilary Haycock:

Yeah. I'm pretty sure the choice forms allow you to select which PACE program much in the same way you would select a health plan. So, I think that tends to be how it works.

Hilary Haycock:

There is a concern that the notices are going out at the same time as the annual enrollment period. So, acknowledging we know there's a lot of communication

Anastasia Dodson:

For sure. And we have... Well, we acknowledge that. And also, as we think about, for example, our Health Care Options, which is the program at DHCS that helps people choose Medi-Cal plans and gives information about that. We can think about making sure that they've got their messaging and then our HICAP partners we, of course, want to engage and make sure they're aware so that if people see open enrollment on the Medicare side, and then choosing a Medi-Cal plan, those HICAP folks can help the beneficiaries understand the difference there as well.

Hilary Haycock:

Great. I see Michelle Retke from MCOD popped on, so hi, Michelle, you want to weigh in?

Michelle Retke:

Yeah, no problem. You had me locked out, I couldn't unmute myself at first.

Michelle Retke:

I just wanted to add just a little bit of clarity for PACE. So right now, as most of you probably know, in CCI counties, PACE is on the choice form in CCI counties only. And the way that process works is the member can choose a PACE plan as an option, but they also choose a backup Medi-Cal Managed Care plan, for example. And that PACE

enrollment is sent to PACE, and they determine the eligibility for PACE. And then, we enroll into that.

Michelle Retke:

So, with 2023, there will be PACE added to Choice forms outside of those CCI counties. And so, I just didn't want folks to walk away thinking that was already happening now statewide. Right now, PACE is just on the choice forms in CCI counties, and all other counties have a PACE, what we would call, insert that explains what PACE is, and what options are available in their county. So, a little bit more clarity to that answer. Thanks Hilary.

Hilary Haycock:

Thanks for correcting. That's perfect.

Michelle Retke:

Yeah, no problem.

Hilary Haycock:

Appreciate it. Great.

Hilary Haycock:

All right so we have a comment from Tatiana about CMS crosswalk procedures not always including all information, including beneficiaries' medications, so an offer that's something that HICAP can help with.

Anastasia Dodson:

Yeah. And I see Tatiana has her hand raised, so maybe could you expand on that a little? And I'm pretty sure our CMS colleagues are on. They may be listening. So, anything else you want to share in that vein?

Tatiana Fassieux:

Yes. Thank you, Anastasia and Hilary in the past, when there have been cross walked plans for certain beneficiaries that crosswalk was not intelligent. In other words, it did not ensure that the risk receiving company would cover all of that beneficiary's prescriptions. That's why HICAP's have been involved a lot during that crosswalk... Or for crosswalk beneficiaries, because they may have to change that plan. So, we would there be any type of additional data that would be considered, such as the medications, so that the receiving company has all of that beneficiary's medications on the formulary?

Anastasia Dodson:

Yeah, I don't know if CMS folks are on, and are able to weigh in. However, I would assume that, for example, with the crosswalk of Cal MediConnect folks, that's something that the plan's NCMS should have well at hand.

Tatiana Fassieux:

Hopefully.

Anastasia Dodson:

Yeah. I think maybe for the D-SNP look-alikes, but that is again why the plans and CMS will be meeting in the coming weeks to make sure that the crosswalk information, and the plans that they're planning to crosswalk those populations to will be at the good fit. But I think for the D-SNP look-alikes, maybe that's probably a more important flag there.

Tatiana Fassieux:

Okay. And then, as sort of an adjunct concern is that can we, or the stakeholders receive a preview of all of the notifications so that we can be educated on what the beneficiaries are receiving, or at least provide comments? Thank you.

Anastasia Dodson:

Sure. And so, we've had actually beneficiary testing on the Cal MediConnect transition notices. On the D-SNP look-alikes, I think there's like a standard template that CMS uses there. I don't know if there's like a special form they'll be using for that.

Tatiana Fassieux:

Yes, CMS does have a standard letter when anything changes to the beneficiary's either Part D plan that is being cross walked or, what they call, a deemed change, the beneficiary does get a notification. Those are standard. But when it comes to specific with this project that may be a little more complicated.

Anastasia Dodson:

Yeah. Again, the Cal MediConnect, those are going through beneficiary testing, those transition notices. But, again, we'll pass that along to our CMS colleagues. Thank you.

Tatiana Fassieux:

Thank you.

Hilary Haycock:

A related notices question about whether DHCS, or the Medi-Cal plans will be doing outreach to inform duals not enrolled in an aligned D-SNP of the opportunity to do so. And if that might include information about other Medicare options, including PACE?

Anastasia Dodson:

Good question, and good point. We have been focused, as you know, on these transition populations. But getting maybe... Again, very glad you're raising this topic, Medi-Cal plans who have a Medicare D-SNP such as the plans in CCI counties, they can provide information to... Especially for the folks who are approaching Medicare age, as they're becoming dually eligible, or folks who are already dually eligible. I'm not aware of any sort of marketing restrictions even for the current duals. So, I assume that the Medi-Cal plans have been doing that to give information there. Also, our health care options information right now, there's information about Cal MediConnect plans, but then eventually our choice packets with this transition, eventually, we will have that information. So, there's a variety of different communication channels. And you're right, and even on our Health Care Options website, we're working on changes so that folks can see those options, those integrated care options.

Hilary Haycock:

Great.

Hilary Haycock:

There are a couple questions, a little bit more related to the long-term care carve-ins. So, I don't know if Michelle might be able to help with these. One, there's a question about facilities that want to make sure that they're working with the managed care plans in the months leading up to enrollment to make sure they're getting prior authorization for things like transportation, or other stuff that they might need. So, I guess the question to you, Michelle, is sort of, maybe you can talk a little bit about the data that's going to go to the plans to help facilitate cognitive care.

Michelle Retke:

Yeah, definitely. And I think maybe Susan talked a little bit in the beginning that there are various stakeholder groups, small and large, that we're working through for all of these transitions, including the long-term care transition. And part of that is hearing from folks how important data is to Hilary's point. And so, we kind of have a phased approach of sharing data with plans. For example, some transition planning data. So, they're understanding kind of the types of services and types of utilization that's happening with members.

Michelle Retke:

And then, as we get closer to the transition, there will actually be beneficiary level specific data that will be shared with the plans. Right now, we are working internally within the department to share that data around 60 days prior to the member transitioning to the plan. And also, that will allow plans to know what members they will be receiving. Of course, members always have the choice to change plans up until close to that January 1 date, there's always a cutoff time period. But our plan is to share that data at least 60 days prior, so that plans can do the necessary planning, and care coordination, and all of those things to prepare for January 1. So, hopefully, that helps answer your question.

Hilary Haycock:

Yeah, that's great. Thank you.

Hilary Haycock:

The second question was around share of cost beneficiaries. And so, if a beneficiary with share of cost would be now in fee-for-service moves into a long-term care facility, would they then be enrolled into a Medi-Cal Managed Care plan?

Michelle Retke:

Gosh, you're testing me on all the back and forth with the share of cost movement with CalAIM, to be completely honest.

Hilary Haycock:

We can, we can get back to you.

Michelle Retke:

No, well actually my friend Steph on the line, she will... I just don't want to mess it up. And I feel like I'm thinking opposite.

Hilary Haycock:

Phone another friend, Steph Conde.

Michelle Retke:

Steph, do you want to jump in on the share of cost one?

Stephanie Conde:

Yeah, share of cost. And I don't see the exact question but share of cost beneficiaries in long-term care aid codes will be a part of Managed Care.

Hilary Haycock:

So, if a –

Michelle Retke:

…for 2022, just like with any other long-term care. Go ahead, Hilary.

Hilary Haycock:

So, a member with share of cost, who's living in a community so maybe in fee-for-service at that point, if they move into a long-term care facility, and move into a long-term care aid code, they would become mandatory?

Michelle Retke:

Yes ma'am.

Hilary Haycock:

Beautiful. Thank you so much, ladies. I appreciate it.

Hilary Haycock:

All right, why don't we go to some of our hands raised. Rick? Go ahead and unmute yourself.

Rick Hodgkins:

Thanks. I have up to four questions because I raised my hand before, and somehow it got lowered, and I kept on raising it, and raising it, and raising it, and raising it.

Rick Hodgkins:

Okay, four questions. First, one of you, I don't know if the first presenter is still around, but she mentioned ICF/DDs. And I want to note and report for the record that I am two things. One, I am a stakeholder in this working group. And the other thing is that the ICF/DDs that were state run, that the vast majority of them are closed. We have one community facility; it's known as Canyon Springs that is in Cathedral City. That is a state-run community facility. It's known as a step-down facility for people coming out of Porterville, Developmental Center.

Rick Hodgkins:

And Porterville Developmental Center, their general treatment area closed in 2021 or was it 2020? But one way or the other though, the ICF/DDs run by the state are mostly

closed. We only have the secure treatment area at Porterville for people that have been in trouble with the law that is open. And then, a step-down facility for people coming back into the community at Canyon Springs, those are the only two places run by the state. Other than that, if you're talking about ICF/DD the intermediate care facilities for the developmentally disabled, you must be talking about privately run because the state no longer is going to run ICF/DDs.

Rick Hodgkins:

My second question is for... My second, third and fourth questions go to Anastasia. When she was talking about data with regards to... My second, third and fourth questions, go to Anastasia with regards to data with regards to Medi-Cal. When we're looking at the ethnic populations of people in Medi-Cal, has there been any data with regards to people with disabilities in Medi-Cal because you mentioned Brown, African American, white, Latino, and whatnot, if I heard you correctly.

Rick Hodgkins:

My third question is with regards to dual eligibles being enrolled mandatorily in Medi-Cal Managed Care plans, what are the are the few exceptions? Because I didn't think there were any exceptions for duals. I know that there is continuity of care, but I didn't... I mean, we all know that duals will have to mandatorily enroll into a Medi-Cal Managed Care but what are the exceptions, if any, because you said that there were a few exceptions that, which I was not aware of before.

Rick Hodgkins:

And I'm trying to remember what was my fourth question? My fourth question was around... Oh, my fourth question was around... Oh, when you were talking about... I guess maybe it was around D-SNPs where providers would only have to bill. In what cases between Medi-Cal and Medicare, where medical providers would only bill one plan where would that apply to me? Because, again, I see providers out of Sacramento County, like in the Bay Area. So, I guess, you might say that's my fourth question.

Rick Hodgkins:

So, if all those questions could be answered. Again, the first question was the first presenter talking about ICF/DDs run by the state. Because, again, the only two state run facilities for the DD is a community facility known as Canyon Springs in Cathedral City. And then, the secure treatment facility at Porterville Developmental Center, because the general treatment area has been closed, and has been revamped as the cure treatment program for the forensic population that's developmentally disabled. And if we do have any ICF/DD intermediate care facilities left in the state, they're privately run because the state's not going to pay for anymore.

Rick Hodgkins:

And then, the third is around one of the exceptions for duals not to enroll in the Medi-Cal Managed Care. And the fourth is if I just need one Medi-Cal Medicare plan to for all my medical providers to bill, whether it's at UC Davis, UCSF and Stanford or Barton Healthcare, how would that apply? So, thank you.

Anastasia Dodson:

Thank you so much, Rick. Great questions as usual. So, glad to have you on this call.

Anastasia Dodson:

And so, your first question around the ICF/DD facilities you're right. And I probably don't need to revisit all the slides on the ICF/DD issue, but just to say that there are facilities that are predominantly, the patients that they serve are to Medi-Cal beneficiaries. And this is where, you're right, I don't know if they're nonprofits or for-profit, what have you, but they're not state facilities, but they do have large majority, if not entirely Medi-Cal beneficiaries.

Rick:

They're private, then?

Anastasia Dodson:

Yeah, right.

Rick:

Okay. Just want to make that clear for the record that other than the two facilities I mentioned that the state is not going to fund... Because they cannot receive Medicaid funding.

Anastasia Dodson:

I think that's different than what I'm saying, but I don't want to get too far afield on this. It's not my sort of primary area, but there's Medicaid/Medi-Cal funding for these facilities. And that's part of the issue that we need to work through with the stakeholder group for ICF/DD and long-term care carve-in. So maybe we'll just...

Rick:

I guess I need to be part of that one as well. When do they meet next?

Anastasia Dodson:

Yeah. I'm going to keep moving to the other stuff, and then maybe Hilary or others can respond to you in the chat more on the ICF/DD stuff.

Rick:

I won't be able to read the chat, but if someone can send me an email because my email should be available to everyone, I'll type it in the chat, and someone send me an email.

Anastasia Dodson:

OK.

Anastasia Dodson:

So, your other questions, the second one was about data on race and ethnicity for Medi-Cal.

Rick:

Disability.

Anastasia Dodson:

Disability, okay. So, we have information on race and ethnicity that we publish on Medi-Cal and then recently on Medicare. As far as disability, the parameters, the way that we would look at the data for that is more complex. There's some survey data that has been done. We don't routinely report disability. We may report diagnosis codes. But that's something we'll look at and take back.

Anastasia Dodson:

On the Medi-Cal Managed Care, mandatory for duals and the exceptions. So, share of cost is probably the main one, so if individuals who are dually eligible, they have Medi-Cal, but they have a share of cost those folks, if they are not in a long-term care facility, then they are not mandatorily enrolled in Medi-Cal Managed Care. But, again, if they have a share of cost and they're residing in the community, or at home, they meet their share of cost then they can get full scope Medi-Cal. Share of cost, again, is another topic we're not going to get into full detail right this second.

Rick:

Because I reside at home, so I don't know.

Anastasia Dodson:

Right, yeah. And Rick, we're not going to do like individual beneficiary determinations on this workgroup. You can certainly talk to there's community groups, your county eligibility office, et cetera. But just broad policy for Medi-Cal Managed Care for duals the exceptions primarily for that mandatory Medi-Cal are related to share of cost.

Anastasia Dodson:

And then, the last question you had about D-SNP, and having providers have kind of one place for billing. So, Medicare providers who are serving dually eligible folks, Medicare is a primary payer, and Medi-Cal is a secondary pair of last resort. So, when a beneficiary is in two separate Managed Care plans, one for Medicare and one for Medi-Cal, then the provider first bills the Medicare plan, and then any sort of residual that Medi-Cal may cover, and Medi-Cal may or may not cover the cost sharing because of our lesser of policy. I know we're getting very technical here, but anyway, there's a secondary billing process that the provider would do to the Medi-Cal plan for any remainder that's not paid by Medicare.

Anastasia Dodson:

And if there's two separate plans, that's two separate operations. But if there's one organization that is covering both the Medicare and the Medi-Cal, then the provider can bill that same organization. And sometimes the claims process has to run through a few different wheels, but it's all within the same organization for both the Medicare and the Medi-Cal billing. So that is the advantage for providers of having beneficiary in one organization for both Medicare and Medi-Cal.

Hilary Haycock:

Great. Thanks so much Anastasia.

Hilary Haycock:

We're going to get back to the chat for a couple questions. Lots of stuff popping up. So, the presentation on matching plans called out sort of the policy for 12 counties. So, there's a question about what happens in other non-CCI and COHS counties.

Anastasia Dodson:

Yeah. So, again, there's lots of several things happening all at the same time. We're trying not to mix apples and steak and... I don't know. Lettuce, all in the same thing. We're all in the same populations for some of these things so we can certainly understand why it's complicated. The Matching Plan Policy is related to the Medi-Cal plan matching the Medicare choice, and that's for 12 counties. In the other non-CCI... Anywhere else, except for those 12 counties, the Medi-Cal plan decision is based on whether or not it's a COHS county or another county where there are multiple Medi-Cal plans to choose from. I know there's like different scenarios in different counties. If this

is a non-CCI, non-COHS county, that is not one of the Matching Plan counties, then and a good example of that, I think... Well, of course, I don't have an example on the tip of my tongue, but anyway, there are choices there on the Medi-Cal side for Medi-Cal plans, if it's not a COHS county. Again, Medicare choice drives the Medi-Cal plan choice, but there's still multiple plans in those counties.

Anastasia Dodson:

It's just you're a dual and you choose a Medicare plan and you're in one of those 12 counties, then your Medi-Cal plan will follow. For duals that transition to mandatory managed care, their options are layered underneath whatever they choose. If they choose to enroll in a Medicare plan and they're in one of those 12 counties, then that determines what their Medi-Cal plan choices are. Not sure if that was helpful or not, but we'll keep kind of chipping away at this and trying to... We're going to have some improved graphics and information setting up the different buckets, different types of counties. Hopefully, that will help.

Hilary Haycock:

Great. Thanks. We're going to go to Susan LaPadula.

Susan LaPadula:

Hi. Good morning, Hilary. Good morning, Anastasia. How are you?

Anastasia Dodson:

Good morning. Thank you.

Susan LaPadula:

Wonderful presentations all day. Thank you so much. It's been a tremendous amount of information. Got a couple of questions and a suggestion, please. My first question is, recently, we've had a pretty large health plan have their network compromised where their computer systems and network were down for several weeks. What are we doing to plan for this not to be an issue in the future? That's question number one. My second question is, when will we chat about crossover claims and balance billing? My third question is, have you considered reaching out to CMS regarding some of the implementation strategy they used when CMS changed every Medicare beneficiary's number in the nation?

Susan LaPadula:

One suggestion, may I share with you, that they used that was very effective for providers, for members, for everyone in health care, is they decided to designate one point person to be what they called their ombudsman and they designated one email

address so that anyone can send questions and the team would respond to us before the implementation during the transition and after. Perhaps, you would consider that for our seven CCI counties and the Cal MediConnect program sunsetting in December, because we have a tremendous amount of providers, beneficiaries, that will be affected. That was one of my suggestions.

Anastasia Dodson:

Thanks, Susan.

Susan LaPadula:

You're welcome.

Anastasia Dodson:

Let’s tackle the first two and then I do want to come back to your third suggestion. As far as data systems, there's certain security protocols that DHCS requires for are all contractors, Medi-Cal plans, et cetera. I'm not a technical expert on that, but just to say, we're... All health plans, all contractors, have certain response requirements in their contracts. We hold plans accountable for that. As far as the crossover claims and billing issues, so we've been taking some steps on that. We've been working to better understand what's working well in Cal MediConnect counties' plans, as far as the crossover claims and avoiding balance billing. We've also been talking with some technical experts about sort of next steps in that area.

Anastasia Dodson:

We will have a dedicated time in upcoming stakeholder meetings of this group to talk about that. It's been interesting to better understand how plan systems may work now and then what changes they need to make for Cal MediConnect. Looking forward to that discussion in the future, but thank you for raising it again, because it's a very important issue and we want to keep our eye on that as well. Back to the third point though, could you repeat that again? Because we have a Cal MediConnect Ombudsman already in the CCI counties. Can you say more about your suggestion around that?

Susan LaPadula:

Certainly. The suggestion would be someone specific for this transition that we're going to take place for the D-SNPs in the seven counties, whereby there would be an individual with a specific email address that could be utilized with questions and answers. This has been very helpful with CMS as well to build their FAQs as the transition is happening during and after the transition as well. It's an individual that is just responsible for using the team in the back scene to get the answers to the questions and perhaps elevate questions that may never get to them otherwise regarding the transition.

Anastasia Dodson:

Yeah. Why don't we... Good topic for a future meeting. Let's have Jack Dailey from the Cal MediConnect Ombudsman and maybe some plans talk further about that. I can't hear you. Sorry.

Susan LaPadula:

I'm sorry. I got muted by the staff, but I think I'm back. Perhaps, digital electronic notices on the plans' websites. In addition to the paper, I really believe that the fall of 2022, the paper notices are going to get lost, and the people are not going to be able to handle the volume. Perhaps, we can do a blast on their websites because there are tremendous amount of beneficiaries that are self-service. They will go out to the website. They will read what you have for them. They would prefer that over the paper.

Anastasia Dodson:

Yeah. Sounds good. It sounds like this is a good... I know we have more questions also in the chat and then we have a few more slides to get through, but basically, this topic we'll just keep revisiting every month because... We'll iterate. All the plans, CMS, DHCS, we all want to do a good job in this area in the fall. Point well taken. Thank you, Susan.

Susan LaPadula:

Thank you so much. Have a great afternoon.

Anastasia Dodson:

You too.

Hilary Haycock:

All right. I think we did get through pretty much all the questions in the chat on this topic. We do need to move to our next topics to make sure that we can cover everything. There were some questions in the chat about the public health unwinding, so we will get to those when we get to that topic.

Anastasia Dodson:

Great.

Hilary Haycock:

Great. Thanks, Anastasia.

Anastasia Dodson:

Yeah. The next topic is something we've talked about in the past but is an update. You recall we have this State Medicaid Agency Contract with all of the D-SNPs. We have drafts of those SMACs. There's one for those Exclusively Aligned Enrollment D-SNPs that have the higher integration standards, and then we have the non-EAE SMAC templates. Those are for D-SNPs that may not have the beneficiary enrolled in the same organization for the Medi-Cal side, but still, we have Care Coordination and other standards for those D-SNPs. Both of those contract templates were shared out with various plans, advocates, stakeholders, for written feedback in March. We're compiling all those comments and we're revising and editing those templates based on that input. We have the current 2022 SMAC contracts on the DHCS website. There's a link from the MLTSS page to that page that has the templates. Again, we're going to align those 2023 templates with the CalAIM integration goals. I'm sure there's things that we will continue to improve on in the future years, but we will try to get as much of it into the 2023 SMAC as we can. Next slide.

Anastasia Dodson:

In that vein, we have a policy guide that goes hand in hand with the SMAC contract because there are some areas that are so detailed, we don't need to put it in the contract. The policy guide is on our webpage. We published the first chapter around Care Coordination in December, and then we're working on the details around Provider Network Alignment, Continuity of Care, maybe in April, more likely May, to have those chapters published in the policy guide. That way, you can look at the SMAC contract and then the policy guide, and particularly the policy guide, will really give the complete picture of what are the requirements that we're holding the D-SNPs to. We can amend those policy guides periodically. We're not bound to the once per year timeline for the SMAC contracts. Again, the D-SNPs are held to those requirements. Next slide.

Anastasia Dodson:

The policy guide chapters for those who have not taken a look. Care Coordination, we talked about those actually last year and we published some. The Quality Reporting Requirements, we discussed earlier this year. We are thinking about how those would work, particularly in light of what we may or may not get for Medicare encounter data and how those two issues relate together. Provider Network Alignment between the Medi-Cal and the Medicare provider networks. We talked about those in March and as well as Continuity of Care. We are considering revisions and how those guidance chapters should be finalized. Information sharing, that's another important area for beneficiaries who are being admitted, transferred, discharged. For hospital or nursing home, there's federal requirements there. This is another complex area.

Anastasia Dodson:

There's really great benefit in improving those business processes and the information sharing between plans, providers, hospitals, physicians, nursing homes. But that is really a long-term effort that we are going to undertake enrollment and disenrollment processes and integrated materials. Those are especially coming up very soon in this stakeholder meeting we will have further discussions about. Yes, posting information on our website, for sure, as notices and other information is finalized, we will have those on our website. Next slide. Okay. Any questions on the SMAC or the D-SNP policy guide?

Hilary Haycock:

Great. There's one question in the chat about when the list of 2023 D-SNPs will be released. I think CMS is going to be releasing that information in the chat in the early fall. I don't see any other questions on this specific topic.

Anastasia Dodson:

Well, I'm really pleased with the work that we've done collaboratively on that SMAC contract and there's still much more to do, but that's really the heart of the policies that we're implementing here with the collaboration of all of you. Thank you.

Hilary Haycock:

All right. Well, if folks have additional questions, feel free to put them in the chat. We will probably have a little bit of time, but we can otherwise move to the next topic because I know there are some questions that folks have about the public health unwinding, so we'll move on to that next, Anastasia.

Anastasia Dodson:

Yeah. These are the same slides that we presented last time and the same slides you will find in other DHCS stakeholder meetings. Next slide. We don't know exactly the... We don't have an exact date for the end of the COVID Public Health Emergency, but when there is a date that is set, then we are wanting to alert all of you that there's a sort of unwinding process that all state Medicaid agencies have to undertake to transition away from the rules that we temporarily had during the Public Health Emergency. The biggest one for Medi-Cal eligibility is around... There was a, it's kind of a suspension, in redeterminations on the Medi-Cal side during the Public Health Emergency. We want to make sure there is a risk of people losing their Medi-Cal coverage, Duals, Non-Duals, anyone who has Medi-Cal, and if their redetermination is not done after the end of the public health emergency and if it's not responded to, there's certain things that could happen when packets are mailed out, that if people don't respond to the packets, et cetera, then people could lose their Medi-Cal.

Anastasia Dodson:

We want to make sure that all the information that we have, that counties have, is up to date. Eventually, we don't have a date, but eventually, when the redetermination packets are sent out, that they're sent to the correct addresses and that people receive those packets and are able to respond back as needed to ensure that they maintain their Medi-Cal coverage. We have a DHCS Coverage Ambassador program. There's an Outreach Toolkit and a webpage that are linked here. You can also join the DHCS Coverage Ambassador mailing list to get updated toolkits as they're available. I think there's one more slide.

Anastasia Dodson:

The first phase in the communication strategy, again, we don't have a date yet for the end of the public health emergency, but phase one is to encourage beneficiaries to update their contact information, and that can be done anytime. We really, really encourage beneficiaries to keep their contact information up to date. This is something we've been talking about for the last couple of months. Still, we want to maintain that information to flow to people to update your contact information with your county eligibility office. We've got various channels campaign to encourage beneficiaries to update their contact information and encourage all of you to help us with that with that messaging.

Anastasia Dodson:

Renewal packets will start to be sent 60 days prior to the termination of the public health emergency. Again, we don't have a date certain, but to remind folks that they should watch for the renewal packets in the mail, and again, update contact information with the county office if they haven't done so yet. Also, just on the structure of how those packets will go out, there is a regular annual redetermination date that every Medi-Cal beneficiary has, and the packets will go out in accordance with that regular annual month of eligibility redetermination. The beneficiaries will not be batched based on any particular aid codes. It'll just be staggered across the 12 months after the public health emergency is terminated. I think that is the last slide. Okay.

Hilary Haycock:

All right. Great. I think you answered one of the questions in the chat, which was sort of when the Medi-Cal redeterminations will happen. We don't know. The other question was if outreach materials, on any of the other transitions, would include any information about the public health unwinding and redeterminations.

Anastasia Dodson:

That's an interesting question. I think because we don't know the date of the public health unwinding and also because of the different sort of timeframe for preparing some of those information materials for beneficiaries on the Medicare side, I don't know that we'd be able to insert specific information. But I wonder if we... I see there's another

comment in the chat. Yeah. We are basically having plans and counties build bridges to each other, to get that updated information from the plans to the counties if that is more up to date. I think we can look at... I mean, I don't know for sure if we'd be able to include information about unwinding public health emergency and the Medicare information, but we can think about ways that...

Anastasia Dodson:

I mean, maybe some of the health plans may have some comments on their call centers and what they're doing in relation to communicating information about Medi-Cal to Dual Eligible beneficiaries. This is where, at future meetings, we could have discussions with health plans, et cetera, and share information about what plans are already doing. I'm not the person that will know everything on this area. Glad to have others chime in.

Hilary Haycock:

Great. Thanks so much. I think those are all the... Comment from Tatiana that when a person moves, they should be contacting both Social Security and their county Medi-Cal office. That is definitely the case for Duals.

Anastasia Dodson:

Great point.

Hilary Haycock:

Yeah. Great. All right. Well, I think those are all the comments and questions that have come in so we can move on to meeting topics.

Anastasia Dodson:

Great. Well, we're, again, really appreciative of all of you engaging with us on these meetings. This is just short list of topics. You see crossover claims, balance billing. Every month, of course, we'll have an update on the Cal MediConnect transition process. Information sharing, as I said, is a big topic. Quality reporting. And then the beneficiary communications integrated member materials, we have that more information coming in future meetings on that. Again, I'm just looking at my notes. Just a lot of topics that we could talk about further. Of course, the long-term care carve-in, we can have further reports on how that's going as well. Hilary, I see a question from Rick. We just have a couple more minutes, but…

Hilary Haycock:

Yeah.

Rick Hodgkins:

Not really a question, but I'm glad, Anastasia, that you brought up that there are exceptions. The reason why I asked if any of those exceptions apply to me, I live in my home and I hope I meet my share of cost because I don't pay anything into Medi-Cal. I asked those questions because I'm scared because there was a time when I did have mandatory Medi-Cal Managed Care when I was not a Dual. For a while it did work, then it did not, and scared. That's all. That's actually one of the reasons why I'm part of the stakeholder working group, because I'm afraid it won't go as I want to go because I have rights.

Rick Hodgkins:

I just feel that my rights won't be protected or recognized on the Medi-Cal side like they are on the Medicare side. I'm just afraid that I will have to make a huge transition. I will have to switch doctors and everything all because of things on the medic... I mean, I know doctors and everything will stay the same on the Medicare side, but all because of changes on the Medi-Cal side, I may have to switch everything just because on the Medi-Cal side.

Anastasia Dodson:

Thank you, Rick. We absolutely understand that. I mean, particularly people with disabilities, people who are Dual Eligibles, who have worked very hard to find just the right array of specialists, primary care providers, a care system that works for them, we absolutely understand and want to be very careful not to disrupt that system of care and providers that in you and others have assembled for yourselves because it really is life and death. We totally understand that. Just as you said, on the Medicare side, we don't want any disruption unless you yourself or others... If a Medicare beneficiary chooses, maybe there's good reasons to choose to go to a different Medicare plan or a new Medicare plan. That's great. That needs to be a choice. We absolutely want to... We understand that and we want to make sure that the information that we communicate and part of having other folks from... Shout out to all the HICAP folks here on the call. Tatiana, I see your hand is also up making sure that all of our community partners are looped in and can help explain what's happening.

Anastasia Dodson:

The Medi-Cal piece, it really it should be better, although... It should not cause disruptions on the Medicare side. But I can totally understand and respect what you're saying that change and the health care is a complex area and there could be unintended consequences here. But we are not aware of any though and that other counties have had mandatory Medi-Cal Managed Care for Dual Eligibles and has not caused any disruption on the Medicare side. This is not sort of a something brand new that's never been tried. We have this already in most parts of the state, but we-

Rick Hodgkins:

It's not in Alameda County. It's not in Contra Costa County. I mean, I don't know if it's in Contra Costa or San Francisco County. I know that there's Health Plan of San Mateo. It's in Contra Costa County. It's not in San Francisco where UCSF is. It's not in Contra Costa County where the UC Berkeley School of Optometry is because they take both Medi-Cal... They take Medi-Cal in their eye clinics.

Anastasia Dodson:

Mm-hmm (affirmative) Yes. No, you're right. There are some counties that have Medi-Cal fee for service, or optional managed care on the Medi-Cal side for Duals. There are hundreds of thousands of Dual Eligibles in other parts of the state that are mandatory enrolled in Medi-Cal Managed Care, and it does not interfere in their Medicare benefits. But very happy to have your feedback. But again, there's no requirement for any changes on the Medicare side. People are voluntarily enrolling in Medicare, Medicare Advantage plans, and that will not change with the Medi-Cal changes.

Rick Hodgkins:

I just hope that my county, Sacramento County eligibility office, is already aware of these changes.

Anastasia Dodson:

Yes. We certainly have very frequent conversations with county eligibility offices. We know that, again, it's a very important issue for people with disabilities, people who are dually eligible because of the array of service providers that they need to keep intact.

Rick Hodgkins:

All right.

Anastasia Dodson:

Thank you.

Rick Hodgkins:

Yeah. I'm just-

Anastasia Dodson:

Yeah. Thank you, Rick. I know we just have one minute left. I don't know if, Tatiana, you just have a 30-second comment you want to share.

Tatiana Fassieux:

Yes. The fear is very valid. I want to make sure that beneficiaries know that HICAP can help with any share of cost issues because that really will impact their access to know, to their costs. The HICAP can help them figure out how to eliminate that share of cost together with a local county. It doesn't have to be that a person has to be in a Medicare Managed Care plan. Sometimes, fee for service will work best. But definitely, we help duals with their share of cost issues.

Anastasia Dodson:

Thank you, Tatiana. Just a reminder for folks, for Rick or others, if you don't already have a share of cost, then it's not something that you need to worry about or focus on. It's just people who have incomes above the regular Medi-Cal income limit. There is a process that if they have higher Medi-Cal expenses, then they can be eligible for full scope Medi-Cal if they meet their share of cost. But again, if you're already eligible for full scope Medi-Cal and you don't have this share of cost, don't worry about it. It does not affect you. It's really only for people who have incomes above the regular Medi-Cal income limit. If no one has mentioned share of cost to you as a beneficiary, then it's not an issue.

Hilary Haycock:

All right. Well, that was a very robust conversation this morning. Huge thanks to Anastasia for answering such a wide range of questions and to everyone for participating. Your feedback is so valuable. We are looking forward to seeing you on May 19th at 10:00 AM. Thank you everyone.