State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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

TITLE: MLTSS and Duals Integration Workgroup

DATE: Wednesday, July 20, 2022, 10:00 AM to 11:30 AM

NUMBER OF SPEAKERS: 4

FILE DURATION: 1 hour 20 minutes

SPEAKERS

Mary Russell
Anastasia Dodson
Barbra McLendon
Jennifer Schlesinger

Mary Russell:

Good morning, everyone, and welcome to today's CalAIM Managed Long Term Services and Supports MLTSS and Duals Integration Workgroup. We're looking forward to today's conversation. We have some great presenters with us, including Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS. We will also hear a presentation from Barbra McLendon, the Director of Public Policy and Advocacy, and Jennifer Schlesinger, the Vice President of Healthcare Services and Professional Training at Alzheimer's Los Angeles. 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 have for the speakers via the chat, and during the discussion, if you would like to ask a question or provide comments and feedback, please use the raise hand function, and we will unmute you.

Mary Russell:

A quick flag that the PowerPoint slides and meeting materials will be available on the CalAIM website in the next few days. We'll provide a link to those materials in the Zoom chat. Before we jump in, let's take a moment, and we'd just like to ask you to add your organization's name to your Zoom name, so that it appears as your name dash organization. To do this, please click on the participants icon at the bottom of the window, hover over your name in the participants list on the right side of the Zoom window, click more, and select rename from the drop down menu, enter your name, and add your organization as you would like it to appear. Appreciate your help with that.

Mary Russell:

Taking a quick look at our agenda for today. We're going to begin with an update on the Medicare Medi-Cal plans, formally known as Exclusively Aligned Enrollment D-SNPs. After that, we'll walk through the summary of the January 2023 enrollment changes and Q and A. Following this, Anastasia will provide an update on the release of the 2023 State Medicaid Agency Contract and the CalAIM D-SNP policy guide. Then we'll hear about the D-SNP care coordination policy guide chapter in practice and a have a stakeholder discussion. And finally, we will hear about the public health emergency unwinding updates, and we'll close out the meeting by discussing upcoming meeting topics and next steps.

Mary Russell:

A quick reminder, if you are attending on behalf of a health plan, we're requesting that you hold some questions for the meetings that DHCS has regularly with plans, so that we can ensure that other stakeholders have the opportunity to be part of this discussion today. Thank you, and we appreciate that. With that, I will hand it over to Anastasia Dodson with DHCS. Thank you.

Anastasia Dodson:

Wonderful. Thanks so much, Mary. And I'm really excited for this meeting today, especially the discussion and the second part around Alzheimer's and dementia care, and such an important topic and population to consider, and learning from all the experts that we have here, so very good. As you all know, this work group purpose is to serve as a collaboration hub for the CalAIM components around managed long-term services and supports and integrated care for dual eligible beneficiaries. We really appreciate the feedback that we get from all of you, and some of these are challenging topics to work through, and that's why we're having work groups.

Anastasia Dodson:

So we really appreciate the candid feedback that we get, and then we try to incorporate that feedback, and learn, and keep improving our policies here, but we know it's many of these things, it's really a journey as we go through and think about how do we do outreach? How do we improve policies? How do we consider the voices of everyone in these discussions? So thanks for your patience and chiming in in all these meetings, and we'll just keep moving forward together on these issues. Next slide.

Anastasia Dodson:

So you have hopefully seen the announcement that went out via email, but we have a program name for our EAE D-SNPs that we've been talking about. Next slide. So we're calling them Medicare Medi-Cal plans, nothing too fancy or spicy here, just trying to be clear for beneficiaries, and caregivers, and providers on the type of plans these are. In the past, we with Cal MediConnect, we required each health plan to include Cal MediConnect in the name of their demonstration plan, and we don't have the same policy here. We're just using this broad term Medicare Medi-Cal plan to describe the type of plan just with then using EAE D-SNPs, and this is a more beneficiary-friendly name we think, than EAE D-SNPs.

Anastasia Dodson:

But as you know from our other discussions, there are other types of D-SNPs. There are regular Medicare Advantage plans, there's PACE, and, of course, Medi-Cal Managed Care plan. So how we will be using this name is in, for example, our healthcare options website, and materials that go out on a sort of generally describing these types of D-SNPs, these successor plans to the Cal MediConnect plans, but we know from information that we've got from plans and from beneficiaries, that it's in many cases, it's clearer to beneficiaries when they hear from the plans to use the plan-specific name. So we have no sort of restrictions on the use of those plan-specific names, because again, eligible beneficiaries have other types of Medicare choices such as Medicare Advantage and other D-SNPs.

Anastasia Dodson:

So at any rate, again, these Medicare Medi-Cal plans or MMPs, as we've said before, very similar to the Cal MediConnect approach, where one entity is responsible for both Medicare and Medi-Cal benefits. There's simplified care coordination, and then we have working with CMS authority to have the plans, integrate benefits, integrate the communications to members and providers, and then have integrated member materials. So all of those things are on track, and this is just, again, a general program name. Thank you. Next slide.

Anastasia Dodson:

All right. So now these are, again, no new policy here in these next few slides, just a reminder. And we've kind of cut down on the number of slides, because I think many of you are familiar with these policy changes, but let's go through them, just make sure, remind ourselves where things are at. All right. So the first is the transition of Cal MediConnect to MMPs, Medicare Medi-Cal plans. Next slide. So reminder that as always, beneficiary enrollment in a D-SNP or any type of Medicare Advantage plan is voluntary. Medicare beneficiaries can remain in Medicare Fee-for-Service, original Medicare, and don't need to take any action to remain in Medicare Fee-for-Service.

Anastasia Dodson:

For 2023, beneficiaries that are already enrolled in Cal MediConnect will automatically be enrolled in the MMP, the Medicare EAE D-SNPs, as we've been calling them before, and the corresponding Medi-Cal Managed Care plan, and that automatic enrollment will be with the plans that are already affiliated with their Cal MediConnect plan. So, if health plan X has Cal MediConnect, then health plan X is also going to have MMP, and they also have a Medi-Cal Managed Care plan. So those enrollment transactions that will occur around January 1st are automatic, and there's no action needed by the beneficiaries.

Anastasia Dodson:

So again, we've been talking about what to say to beneficiaries or providers, and it's really that if someone is already enrolled in Cal MediConnect, no action is needed. They can just stay enrolled in that particular health plan organization, and there'll be seamless transition, and then they will still with health plan X, if they like health plan X, they can still be in a plan for Medicare with health plan X. The MMPs, Medicare Medi-Cal plan, that's just the California specific program name for, and you can see it spelled out at the bottom, Exclusively Aligned Enrollment Dual Eligible Special Needs Plans. All right. Next slide.

Anastasia Dodson:

Again, January 1st, beneficiaries in Cal MediConnect plans will be automatically transitioned into the plans that are under the same parent company, and there'll be no gap in coverage. Provider networks should be substantially similar, if not exactly the same, and there are continuity of care provisions. We've talked about those in previous meetings, but there is definitely a Medicare continuity of care provision, if

there are providers that a beneficiary is already working with, and those are important, and we know that network issues and continuity care are important. Health plans have, in some cases, started to communicate about these upcoming changes with beneficiaries once they get approval from DHCS and CMS about their materials, and so you may start hearing about some of these communications, and we do have information on the DHCS website about the future of Cal MediConnect, and we've been putting summary information there.

Anastasia Dodson:

Beneficiaries will begin to receive formal notices from their Cal MediConnect plans, soon to be in January their MMP, about this transition starting in October 2022, and that's the traditional time period for Medicare plans to notify beneficiaries. Next slide. And again, the same information that we have presented in the past. MMPs, there are, again, very similar to Cal MediConnect approach. There are integrated member materials that we have worked with CMS on. There's benefit coordination, so a unified plan benefit package, and covering both Medicare and Medi-Cal benefits. There's coordinated benefits administration. There's a unified process and policy for Durable Medical Equipment. That, again, crosses over into both Medicare and Medi-Cal benefits, and we also have plan-level integrated appeal that we have worked out with CMS.

Anastasia Dodson:

Integrated beneficiary and provider communications, very important and helpful, and then simplified care coordination. That is one of the important key elements here to have a care coordination team or a care coordinator individual, who can look across those sets of benefits, help with referrals to services, providers, making sure that there's no hiccups in beneficiaries getting access to the types of providers, where they need them, when they need them across both sets of benefits. So that care coordination is really essential. All right. Next slide.

Anastasia Dodson:

Okay. And so, Mary, I do see questions in the chat, but I guess we'll keep going through these, all this section, and then we'll go to the questions. Is that right?

Mary Russell:

Yeah, that sounds great.

Anastasia Dodson:

Okay. All right. So, D-SNP look-alike plan transition. Again, nothing new policy here, all the same policies we've been talking about, but just a reminder that D-SNP look-alike plans, those are Medicare Advantage plans that in the past have been marketed to dually eligible beneficiaries, but they do not have the care coordination requirements with Medi-Cal, integrated care, or joint enrollment process. The federal

government CMS is making some changes in their rules around these types of plans. So, they've made a definition that look-alike plans are defined as Medicare Advantage plans with 80% or more of members eligible for Medi-Cal, so that they mostly serve to eligible beneficiaries. But again, these look-alike plans don't meet our D-SNP integration requirements, and we have current in 2022, and then much more robust in 2023 integration requirements for D-SNPs.

Anastasia Dodson:

Enrollment in look-alike plans has increased in the seven CCI counties in recent years due to plan marketing efforts and then limit on D-SNP enrollment. So the action that CMS took in regulation is in response to the significant growth in those plans. Next slide. So, CMS has limited enrollment into MA plans that are D-SNP look-alike plans. So already in 2022, CMS is not entering into new MA plan contracts that expect to be 80% or more in Medi-Cal, and then starting in 2023, D-SNP look-alike contracts are not going to be renewed by CMS. So there has been a lot of work that our colleagues at CMS have done to make sure that there will be a smooth transition for beneficiaries who are already enrolled in MA plans that are D-SNP look-alike. So let's go to the next slide.

Anastasia Dodson:

So, CMS is allowing a Medicare Advantage organization to transition it's D-SNP look-alike membership into another Medicare Advantage plan or plans offered by that same Medicare Advantage organization or another MA organization that shares the same parent organization as the MA plan. So in other words, different health plans, health plan Y, they may have a Medicare Advantage, a regular Medicare Advantage plan. They may have a regular D-SNP, and then they may have a D-SNP look-alike, and some combination of those in certain counties. And so, CMS allows that health plan to crosswalk transition the beneficiaries that are in the look-alike plan into the regular MA or the true D-SNP, but that contract that is the D-SNP look-alike contract must be sunset at the end of this year.

Anastasia Dodson:

So, this transition is absolutely designed to ensure continuity of care and cost-sharing protections for dual eligible beneficiaries, and better options for people who are currently enrolled in a look-alike plan. So, the health plans, of course, are very interested in maintaining their members, and so they have been working with CMS to have a crosswalk enrollment. And again, these are the types of notices that beneficiaries will be seeing in the fall, and they will just say, "You are in such and such name for health plan Y, and you will be transitioned. If you take no action, you'll be automatically transitioned to a different type of plan all within health plan Y," and that will happen, again, through crosswalk process, that CMS will work with the D-SNP look-alike plans.

Anastasia Dodson:

So, I think that's the last slide on the look-alike transition. All right. And then statewide Medi-Cal Managed Care with... Again, this is no new policy, but we do have some new data here that might help put things in context. So, as you all know, Medi-Cal provides benefits through both fee-for-service and managed care delivery systems. Over the last 15 years or so, there's been a shift moving toward Medi-Cal Managed Care for various populations and geographic areas, because the Medi-Cal fee-for-service delivery system does make it hard for the beneficiary to get care coordination, and to have sort of a risk-based type of services, because the fee-for-service system is really up to only providers, and there's no coordinating entity.

Anastasia Dodson:

So in line with the transition that we have undertaken over the, again, past 15 years or so, under CalAIM in January 2022, there were some transitions, and there'll be some additional transitions in January 2023 to transition certain populations into Medi-Cal Managed Care, and then a few groups go to fee-for-service, but any changes around Medi-Cal Managed Care do not affect a beneficiary's Medicare plan or their choice of a Medicare plan. So, if someone is in original fee-for-service Medicare, and they enroll in a Medi-Cal plan, that does not change their Medicare. Medicare choices are made entirely differently than Medi-Cal plans, and in fact, when it comes to even for Cal MediConnect, and then for MMPs, generally the transaction is initiated on the Medicare side, because Medicare goes first, because Medicare is the primary payer and is the lead choice for beneficiaries, who are dually eligible.

Anastasia Dodson:

So, this transition that we're talking about for Medi-Cal Managed Care in certain counties, that does not have any impact on an individual's choice of whether to be in original Medicare or a Medicare Advantage plan. So we'll talk about that in the next couple slides. Next slide. Okay. So over 70%, maybe closer to 75% of dual eligible beneficiaries in California are already enrolled in a Medi-Cal Managed Care plan, and that has been the case since 2014, 2015, with various transitions over the years. So in January 2023, and again, that 70%, 75% is over 1.1 million, close to even 1.2 million. So, in January 2023, about 22%, or about 325,000 dual eligible beneficiaries are going to be newly enrolled in a Medi-Cal Managed Care plan.

Anastasia Dodson:

This transition will be a little bit different depending on if someone is enrolled already in a Medicare Advantage plan. So, folks who are already enrolled in a Medicare Advantage plan, they're going to be enrolled in their matching Medi-Cal plan. So back to our examples, if health plan W has a Medicare Advantage plan, and they also have... And that could be D-SNP, any kind of Medicare Advantage plan. So, if they are already enrolled in Medicare Advantage plan W, and they're not enrolled in a Medi-Cal plan right now, then they will automatically be enrolled into the Medi-Cal plan W, and then they will have the same organization that is managing both their Medicare and their Medi-Cal. It may not be technically an MMP, depending on the

county, but there will still be the same organization for their Medicare and their Medi-Cal, and that's our Medi-Cal matching plan policy that we had talked about with this group earlier.

Anastasia Dodson:

So, this will mean that, again, of those 325,000 or so individuals, those who are already enrolled in a Medicare Advantage plan, if that plan also has a Medi-Cal plan, then that will be the Medi-Cal plan that they're enrolled in in January, in the matching plan count. Those who are not in a Medicare Advantage plan, or if they're in a Medicare Advantage plan that doesn't have a corresponding Medi-Cal plan, then they can choose their Medi-Cal plan based on materials that they will get in the fall of 2022. So, in a few months, the folks who are in original fee-for-service Medicare, they will choose which Medi-Cal plan they want to enroll in, or if they are in a Medicare Advantage plan that doesn't have a corresponding Medi-Cal plan, either one of those scenarios, they will get to choose which Medi-Cal plan they want to enroll in. And so, again, the materials choice packets that get sent out in the fall. Next slide.

Anastasia Dodson:

Okay. And I do want to just spend a brief moment, and then we'll get to the questions around what do the Medi-Cal Managed Care plans provide to dual eligibles? Because again, dual eligible beneficiaries, they get most of their healthcare services through Medicare, but one core piece is that Medi-Cal plans, they are responsible for coordinating across long-term services and support. So certainly, nursing home care and CBAS, but also referrals to IHSS, and then CalAIM Community Supports. In some cases, those also are long-term services and supports.

Anastasia Dodson:

So that is a really important responsibility and benefit that Medi-Cal Managed Care plans can provide to dual eligible beneficiaries. There are other Medi-Cal benefits that are not usually provided through Medicare, such as transportation to medical appointments. So Medi-Cal Managed Care plans also are required to provide that, but as you can see Enhanced Care Management, another important part of CalAIM, that is provided through Medi-Cal Managed Care plans, and especially for someone who is not enrolled in a Medicare Advantage plan, and they have a high utilization, high need for a lot of help to coordinate their care, then the CalAIM Enhanced Care Management can really be very helpful for them. All right. Next slide. Okay. So we have the number of different topics that we covered, and sounds like it'd be a good time to go through questions.

Mary Russell:

Great. Yes, thank you, everyone. If you have a question, feel free to drop it in the chat or raise your hand, and we can call on you and take you off mute. So a couple from the chat so far, Anastasia. The first is from Marni Soltan, "What if a beneficiary's current doctor does not accept the new plan? Are you letting them know, or are they

auto assigned to another doctor?"

Anastasia Dodson:

So again, there's a difference between Medicare and Medi-Cal as far as networks and providers. So, if a dual eligible beneficiary is already working with a particular Medicare doctor, specialist, or primary care, going into a Medi-Cal Managed Care plan does not change anything about the relationship with that doctor, because again, these are people already have Medi-Cal. So the physician's office should already be familiar with any co-insurance that they're billing to Medi-Cal. The transition is just they will do that co-insurance billing over to the Medi-Cal plan instead of Department of Health Care Services. And there should be no difference in the payment rate that of their co-insurance. So I assume that's what that question is about, is for dual eligible Medicare physicians, Medicare providers, and how does the Medi-Cal plan impact that.

Anastasia Dodson:

Maybe the question is about Cal MediConnect? I don't know. So if that's about Cal MediConnect physicians, the networks that the Cal MediConnect plans will have as MMPs should really be substantially similar. That's not any sort of large scale provider network transitions that we're aware of, and there are additional continuity of care requirements. So again, a transition in a Medicare Advantage plan, that can be a change for beneficiaries, but this type of transition is within the same plan parent organization, and so there should be no network changes, but if there are, then we want to make sure we work with the beneficiary and with CMS to make sure that those disruptions are minimized.

Mary Russell:

Thanks, Anastasia. The next question from Robert Erio, "How will fully integrated dual eligible SNPs be impacted by this transition? Will the new EAE D-SNPs have any of the same benefits as FIDEs?"

Anastasia Dodson:

So we just have one, we call it a FIDE SNP. In California, that's SCAN, and so there's no change. SCAN is still an enrollment option on the Medicare, and Medicare and Medi-Cal side for beneficiaries in the counties in which SCAN has a contract. So FIDE SNP in California is similar to the EAE D-SNPs or MMP model. There are some differences in terms of how personal care services are coordinated and delivered, but by far they're really very, very similar. And I think for beneficiaries working with HICAP or working with other partner organizations to look at the benefits, there's a lot of choices in Medicare and Medicare Advantage, and so we won't say which exact health plan has which benefits on this call, but people can compare.

Mary Russell:

Thanks, Anastasia. Next question is from Anthony Barbosa with PharMerica, "For MMPs, will pharmacies need to bill to a new BIN/PCN, or will prescription drug coverage still be done through Medi-Cal Rx?"

Anastasia Dodson:

So for the most part, dual eligible beneficiaries get their prescription drug benefits through Medicare, Medicare Part B, and so pharmacies that already have contracts with Cal MediConnect plans, presumably, the same pharmacies would contract with MMPs, and the plans will, again, work on, make sure their networks are adequate. So the vast majority of pharmacy benefits for dual eligibles are not through Medi-Cal Rx. The vast majority of pharmacy benefits for duals eligibles are through Part B, which is included as part of the package of benefits through D-SNPs and MMPs. Med-Cal Rx covers very, very few benefits, because most pharmacy benefits for those are already covered through Part B, but for Medi-Cal only beneficiaries, then, yes, Medi-Cal Rx is the way that pharmacy benefits are delivered, but again, that's for the 13, 12 and a half million Medi-Cal only beneficiaries.

Mary Russell:

Thank you. Next from Tatiana, "Just wanting to confirm fee-for-service Medicare beneficiaries with Medi-Cal share of cost enrollees will not be enrolled in a Medi-Cal managed care plan?"

Anastasia Dodson:

So, right. And it's really all Medicare beneficiaries with a Medi-Cal share of cost, except for those in long-term care. So irrespective of the delivery system on the Medicare side, if a Medi-Cal dual eligible or otherwise beneficiary has a share of cost, they are not enrolled in Medi-Cal managed care, except if they have a share of cost, and they are in a long-term care facility. In that case, those individuals are in Medi-Cal managed care, and that is one of the other transitions. I didn't list it on the slide, but in 2023, folks who are in long-term care facilities, skilled nursing facilities in January, and then other facilities in July, but skilled nursing facilities' residents will transition to Medi-Cal managed care January 2023.

Mary Russell:

Great. So a couple more in the chat, and then we'll get to the raised hands. So, Marcelo with an interesting question, "How or what would ECM entail for a dual with original Medicare, or how would it differ from what is offered by MSSP?"

Anastasia Dodson:

That is a great question, and it's excellent. Thank you for bringing that up. And I probably won't give the most complete answer, but we have materials on our website about essentially two populations of focus in enhanced care management that most likely would impact dual eligible beneficiaries, that relate to long-term services and

supports. So people who are at risk of going into an institutional setting, or who are already in a skilled nursing facility, and through a combination of enhanced care management, community supports, et cetera, can be safely transferred to home or community based settings. Those are the populations of focus that we think are most likely to impact dual eligibles, and great example, a dual in original Medicare does not necessarily have those types of intensive care management resources that they can access to find a path to transition to the community or to avoid that institutional stay.

Anastasia Dodson:

MSSP does offer kind of a similar suite of services, and so I don't have a line by line on MSSP versus ECM, but similar target populations, and we do have materials on our website around ECM for those populations, and so that ECM, those populations of focus go live January 1, 2023 as well, so more great resources available for dual eligible beneficiaries and Medi-Cal only, who are at risk of institutional care, but refer to our website, and then we can at a future meeting talk more about that.

Mary Russell:

Great. Next, let's go to Karen Hess with your hand raised. Karen, you should be able to come off mute now. Want to try one more time, Karen? Oh.

Karen Hess:

Okay. Can you hear me now?

Mary Russell:

Yep. There you go.

Karen Hess:

Okay, great. So I work for a care coordinating agency for the Assisted Living Waiver program, and so I was wondering about the eligibility for Assisted Living Waiver and MSSP with these new plans?

Anastasia Dodson:

Great point. So, the Assisted Living Waiver and the HCBA waiver, they have separate eligibility criteria, and so people are not simultaneously enrolled in both an MMP and Assisted Living Waiver or HCBA waiver, however, in the... I mean, that's a great topic that we should think about more as far as, for example, and I know we've provided some clarification, but we'll refresh that on if someone is in the Assisted Living Waiver, and then they may already be enrolled in a Medi-Cal plan, but the Medi-Cal plan would not be providing enhanced care management to Assisted Living Waiver beneficiaries, because they're already getting the equivalent there through their Assisted Living Waiver care management.

Anastasia Dodson:

So we do want to avoid duplication. We don't need to have 25 care coordinators for the same individual, but there can be referrals. That's I guess the other point we might want to think about too at a future meeting. How do referrals work back and forth between agencies and partners for enrollment in the Assisted Living Waiver? Anyway, it's a great topic. Yeah.

Karen Hess:

Right. In other words, it'll stay the way it is now, that you can't enroll in ALW or HCBA waiver if you're part of the MMP program?

Anastasia Dodson:

Right, right. Yeah. But again, referrals, and I mean, we really want to encourage communication across programs for referrals.

Karen Hess:

Yeah, I understand. Thank you.

Anastasia Dodson:

Thank you.

Mary Russell:

Great. At this time, I don't see any other hands raised. Any other questions in the chat on this section, or I think, Anastasia, we could transition to the next element of the presentation on the release of the 2023 State Medicaid Agency Contract and D-SNP policy guide.

Anastasia Dodson:

Sounds good. And maybe I'll just sneak one more response in. I saw the question about Medicare supplemental plan and retiree plan. Again, a Medi-Cal Managed Care enrollment is independent from a Medicare plan, because I know that there are retirees who have kind of a different type of Medicare Advantage plan that's related to their former employer or retirement program, but again, the Medi-Cal Managed Care plan, we would want to coordinate with that Medicare plan. We want the two plans to coordinate together, but that there's no sort of exemption or restriction on the Medi-Cal plan based on the Medicare plan in that case. And supplemental plan again, Medigap, those policies are not appropriate for dual eligible beneficiaries, because they need to pay for those, and there's no need, because the cost sharing for Medicare is covered by Medi-Cal, but retiree plans, yes. I can see the connection there. Sorry, Mary, to sidetrack a little bit.

Mary Russell:

No, that's great.

Anastasia Dodson:

So, on the State Medicaid Agency Contract for 2023, next slide, we have executed and finalized those contracts. And again, these are the integration requirements CMS sets a standard for, and then we can make additional integration requirements for D-SNPs. And this is both for the EAE D-SNPs now known as Medicare Medi-Cal plans, and also the non-EAE, which is many existing D-SNPs that do not have an affiliation with a Medi-Cal plan, or they may have an affiliation with a Medi-Cal plan, but not in one of the seven coordinated care initiative counties.

Anastasia Dodson:

So at any rate, there are two different SMACs based on whether MMP or not. They've been finalized, and the boilerplates are in the process of being posted on the DHCS website. I believe one of them is there, and the other will be posted in the next couple of days. So you're welcome to look at them, and then, of course, we will want to think about what we can do in 2024 for those SMACs, and also thinking about how the policy guide, and I think it's on probably the next slide, how that interacts with the contract language, so next slide.

Anastasia Dodson:

Yes, so the policy guide provides more detailed information and requirements for the health plans, and we have the policy guide also published that there are parts of it that still being worked on, and having a dialogue with stakeholders, and plans, and thinking about exactly how to cross all the Ts and dot all the Is on those policies. The SMAC gives us the overall framework, and then the policy guide fills in the details, and again, there's some provisions that apply to all D-SNPs, and some just through the MMPs. So we try to clarify in the documents which sections apply to which people or which contract. Alright. And the policy guide is published on a DHCS website. Next slide. Okay. So, anything else, Mary, any other questions or anything before we hand off to Barbra and Jennifer, our wonderful presenters from Alzheimer's LA?

Mary Russell:

Yeah. It looks like Tatiana did chime in with a clarification on, "Medicare beneficiaries with Medi-Cal share of costs have an opportunity to purchase a guarantee issue Medigap in order to reduce their accountable income, unless the Medi-Cal eligibility criteria has changed." Anything to add on that?

Anastasia Dodson:

Right. Yeah. Great point, Tatiana. Right. Right. So, folks with a share of cost, that is a strategy in order to get sort of full, without share of cost, Medi-Cal, and so great point,

and, yes, we will not go further down that road, but both points are true. We don't want to encourage dual eligibles necessarily to feel like they need to buy a Medigap policy in order to cover their basic expenses, but if they have a share of cost, that can be a strategy to help them buy down their share of cost, so to speak. Thank you.

Mary Russell:

Great. Thank you for that dialogue. Well, we're very excited to have some special guest speakers today, so I am going to pass it over to Barbra with Alzheimer's Los Angeles to kick us off. Thank you, Barbra.

Barbra McLendon:

Great. Thank you so much. Anastasia and Mary. So we're going to transition now. We've been talking about all these technical aspects, and all these different kinds of plans, but ultimately, what does this all mean? This ultimately means what kind of care are people getting out there in the real world. So I hope that the information that I share and my colleague, Jennifer Schlesinger, shares helps to begin bringing to life some of what's in the D-SNPs care coordination policy guide, as it relates to people living with Alzheimer's or another form of dementia or their caregivers.

Barbra McLendon:

So first, let me just introduce myself. I am Barbra McLendon with Alzheimer's Los Angeles. I am our public policy director, and we really thank you so much for this opportunity to present today on best practices for dementia care in the CalAIM program. So my organization, Alzheimer's LA, we are an independent community based organization, and we do focus on the services that we provide families here in Los Angeles, and we also are really strong advocates on policies that have statewide and even sometimes national impact. We appreciate the commitment that the state and our health plan colleagues have shared with us in ensuring that CalAIM meets the needs of families that are affected by dementia. So today, we're going to focus on the best practices for dementia care in CalAIM that are based on those requirements in that policy guide.

Barbra McLendon:

However, I really do need to say that quality dementia care and best practices for dementia care are not limited to just what's in the CalAIM D-SNP policy guide. California is making great strides in improving dementia care, but the healthcare landscape is dynamic, and there are always room for improvement and innovation. So we hope that we can continue collaborating with those of you on the call today, and encourage you to reach out to us to continue the conversation. Next slide, please. We always appreciate our funders, and this presentation in particular is supported in part by the Hearst Foundation and the Rosalinde and Arthur Gilbert Foundation. Next slide, please.

Barbra McLendon:

So why do we care so much about what's in the CalAIM program as it relates to people with Alzheimer's and dementia? Next slide, please. Overall, just the broad population, this goes nationwide too. We're focusing specifically on California here, but the number of people who are going to be living with Alzheimer's or another form of dementia is increasing fairly rapidly. So it's estimated that right now, there are 660,000 Californians living with Alzheimer's over the age of 65. By 2025, anticipated that's going to increase to 866,000, and by 2040, that number is going to be almost 2 million. So what does that translate to when we're talking about the dual eligible population? Next slide, please.

Barbra McLendon:

Prevalence rates among the dually eligible are even higher than they are for the general population. So I would say to you that it's a conservative estimate, and I'll talk on the next slide about why I think it's a conservative estimate to say that 20% of those among the dually eligible population 65 and over are living with some form of cognitive impairment. That compares to just over 10%, almost 11% within the general population over 65. So those of you who are part of a health plan here on this call today, and you you're serving dual eligibles, it is highly, highly likely that you are going to be serving people who have some form of a cognitive impairment. Next slide, please.

Barbra McLendon:

So why do I say, "I think that percentage of 20% is probably conservative,"? Well, as much as we know that people over 65, who are on Medicare, are supposed to be getting annual screenings, that are supposed to include a memory screening, it very often doesn't happen. Recent data has shown us that only one in seven older adults receive those regular cognitive assessments. So if they are not getting those annual memory screenings, how many diagnoses of Alzheimer's or dementia are being missed? Even for those who are being screened, we know that there are issues around diagnoses actually being documented in the medical records, and even if people being told that they have a dementia diagnosis, or their caregivers being told. So again, we have statistics showing us that only 45% of people who are living with a dementia that has been diagnosed are told about that diagnosis. So all of this complicates care for these individuals. Next slide, please.

Barbra McLendon:

So why are those rates of cognitive impairment higher among the dually eligible population? Well, it's because this population is coming to us with a lot of other chronic health conditions. You can see these numbers here, 60% with hypertension, 26% with coronary heart disease, 25% with stroke, 23% with diabetes. All of these chronic health conditions increase the likelihood that individual is also going to have some form of cognitive impairment. Next slide, please. And the next thing we just have to talk about, while we are really focused on quality of care, and frankly, quality of life for people who are living with Alzheimer's or another form of dementia, we also

really we need to be upfront about the fact that cost is a driver of care, especially in this country. So it's important to note that people who are coming with some form of cognitive impairment are also some of the most expensive patients to care for.

Barbra McLendon:

You can see here, the Medicare numbers of people living with a cognitive impairment are three times as expensive as those who do not have some sort of cognitive impairment. That's largely driven by hospitalization costs. And then when we look at Medicaid, that increases to 23 times as expensive, largely driven by costs for care provided in nursing facilities. Slide, please. And we cannot talk about people who are living with a cognitive impairment without talking about their caregivers. It's important to note that if you are caring for someone with Alzheimer's or another form of cognitive impairment, that you are also going to have a caregiver and maybe multiple caregivers that are part of that ecosystem. Caregivers really are the backbone of our long-term services and support system. If they all disappeared tomorrow, we could not meet the needs of these individuals through what is institutionally available.

Barbra McLendon:

Caregivers enable members with dementia to stay at home. I think a lot of people think once you've got a cognitive impairment, you're moving straight into a nursing facility. Nothing could be further from the truth. The vast majority of people with a cognitive impairment are still living in their communities, and that is where they want to remain. We also have some recent data. This is kind of interesting, that 25% of those caregivers are also members of the same health plan. So in the next slide, I'm going to talk a little bit more about the health implications for our caregivers, and so those are also going to need to be addressed, because they may well be a beneficiary of that same plan. So the impacts of caregiving on caregivers really can't be overstated. A lot of them report... Actually, can we go to the next slide, please?

Barbra McLendon:

Oh, I'm sorry, back a slide. I thought we had another. We'll just stick there. Great, thank you. So it is estimated that there are 1.1 million Californians, who are providing over 18 billion in unpaid care to people living with Alzheimer's or another form of dementia. As I said, most live at home, relying on this network of family/friend caregivers, and most of these caregivers don't have formal training. So their loved one gets that diagnosis of dementia, and all of a sudden they're expected to help with activities of daily living like bathing, cooking meals, providing transportation, managing their loved one's healthcare, administering medications, providing emotional support, and managing challenges, such as aggressive behavior and wandering. These caregivers also provide care for more hours each month than those caring for someone who doesn't have a dementia, and they report almost twice the level of impacts on their own emotional and physical health and on their financial health.

Barbra McLendon:

So again, a lot of these impacts really can then impact the physical health of these caregivers, and those also need to be addressed. Okay. So next slide. We have, as you can see, many motivations for being deeply involved in what this CalAIM program ends up looking like. We really see a lot of potential benefit to our families, if the CalAIM program embeds within it many of the best practices that we have learned over the years working with programs such as Cal MediConnect. We had a dementia Cal MediConnect project that provided a lot of the best practices that my colleague, Jennifer Schlesinger, is going to be talking about in a moment. So we have basically missed no opportunity to be a part of the CalAIM stakeholder process. That has involved almost every public comment opportunity that we're given, so that we can carry forward, raise up those best practices, and ensure that they are embedded in all of these different technical documents that Anastasia was walking us through before we started our presentation here, and participating in stakeholder groups just like this one.

Barbra McLendon:

And then finally, ongoing technical assistance. So I know my colleague, Jennifer, is going to say this. I'm going to say it here as well, is that we are absolutely available to provide information, answer questions, and technical assistance, so that as this program rolls out, it's done in a way that really does best meet the needs of people living with Alzheimer's or another form of dementia, and those family caregivers. With that, I'm going to hand over to my colleague, Jennifer Schlesinger.

Jennifer Schlesinger:

Hi, everyone, and thank you, Barbra, so much for kicking off this presentation and giving me the opportunity to talk specifically about some of the dementia requirements in the CalAIM policy guide. So we really want to make sure that we are providing all stakeholders with support and technical assistance, as Barbra said. And one of the best ways to do that is to dig into the policy guide, and look at where there are references to dementia and caregivers. And we really want to make sure that we're looking at all the different elements that are in that guide, so we referenced for you the page numbers and some of the major elements in the guide.

Jennifer Schlesinger:

So the first one is about the HRA, identifies populations that may need additional screening or services, including people living with Alzheimer's disease or related dementia. There's reference in the guide that the ICP makes referrals to CBOs, serving members with Alzheimer's disease and related dementias when there are documented dementia care needs, irrespective of a diagnosis, and that's really important, because as Barbra spoke about, many people with Alzheimer's disease, and related dementias, and cognitive impairments never get a dementia diagnosis, but if they do have documented dementia care needs, such as wandering, safety concerns, poor self-care, behavioral issues, poor management of medications or medication adherence, poor management of coexisting conditions, or issues related

to management of ADLs and IADLs, then the ICT must include a caregiver and a trained dementia care specialist, and, of course, that dementia care specialists receive training.

Jennifer Schlesinger:

So while this slide is an overview, so you can easily reference the requirements, what I'd like to do is dive into each of these individual requirements. Next slide. And talk about how we operationalize them through best practices, tools, and resources. And as I'm speaking about these, what I encourage everyone to think about is your own system of care, and how you may be able to develop processes and workflows to utilize the tools in a systematic way that works for your members and their caregivers. I'm going to be referencing various tools and resources. They are available on the Alzheimer's Los Angeles website, and there's a slide at the end of the presentation that has that website for you. Next slide.

Jennifer Schlesinger:

So the Health Risk Assessment identifies populations needing additional screening or services, and this includes people with Alzheimer's disease and related dementias. The HRA has a cognitive impairment trigger question. So in the LTSS HRA from Cal MediConnect, we have a question, "Have you had any changes in thinking, remembering, or making decisions," and it's a simple, yes/no question. It's not the end all be all, and we know that there are limitations in asking such a broad question like that, but that's exactly why it's a trigger question. It triggers something else. So if someone says, "Yes," then there needs to be a validated screen that is in place, and that is administered.

Jennifer Schlesinger:

We have been teaching the AD8, because it is validated and it can be used telephonically, and we know that a lot of care management happens telephonically, but there are other validated cognitive screens as well, the MoCA, the Mini-Cog. So from that trigger question in the HRA, my first question for everyone to think about is whether or not you have a validated cognitive screening tool that is used. And after that validated screen is used, what is the process in place for a full diagnostic workup, if in fact the validated screen merits a full diagnostic workup? To do this effectively, there needs to be workflows and processes in place.

Jennifer Schlesinger:

It's not enough just to have identified the tools and to train care managers on the use of those tools. There needs to be processes in place and pathways to communicate the results of the screen, to communicate with the providers, so that a full diagnostic workup can happen as well. And there's going to be a lot of training and clinical support happening. We're very excited through the state's initiative with Dementia Care Aware to do more training and clinical support for providers on how to effectively assess for cognition. So more to come on that, but really need to start thinking about

what the processes and workflows are for not just this trigger question to happen, but for potentially a full diagnostic workup to happen, if it's merited. Next slide.

Jennifer Schlesinger:

The Interdisciplinary Care Plan needs to be making referrals to community based organizations serving members with Alzheimer's disease and related dementias. It's very important to identify your local Alzheimer's organization and other local resources within your community that can be serving people who have cognitive impairment, things such as disease education. Most people when they're dealing with cognitive impairments have not received a lot of education about what is dementia, what is Alzheimer's, what's the trajectory, what are some of the things that they need to be thinking about as the disease progresses? We know that caregivers are asked to do an awful lot, but are often not provided with training or support in how to do that. So they're at home dealing with behavioral symptoms of the disease, like wandering, or sundowning, or hallucinations, but our caregivers probably have not gone to nursing school.

Jennifer Schlesinger:

They're not social workers. They're lay people that provide a lot of support and keep people in their homes, and we need to make sure that they are provided with the training and the support so they can do so as effectively as possible. We need to consider resources for people who wander, because wandering is a very significant safety concern when someone has cognitive decline and cognitive impairment, and psychosocial support, especially for the caregiver or the care partner, to make sure that they have what they need in place to be able to navigate caregiving as effectively as possible. Alzheimer's organizations have different pathways for referrals to happen.

Jennifer Schlesinger:

At our organization, Alzheimer's Los Angeles, we have a helpline that families can call. We also have a direct warm handoff referral program called ALZ Direct Connect, where a provider or a healthcare professional can make a referral to us on behalf of usually it's the caregiver, and then one of our social workers will reach out to the caregiver, and establish what their needs are, and provide them with that support. In making referrals, not all organizations are the same and have the same resources, have the same staffing, very important to identify what's available in various geographies, what is available in various languages, the cultural competence of an organization, and whether it is really meeting the needs of your members and caregivers. Next slide.

Jennifer Schlesinger:

So as I mentioned, when there are documented dementia care needs, irrespective of a diagnosis, the interdisciplinary care team must include a caregiver and a trained dementia care specialist. So we'll take a moment to look at the caregiver side of this,

and then we'll talk about the dementia care specialist. We all know that it is challenging to engage caregivers, but I want us to take a step back from even talking about including the caregiver on the ICT, because we can't include people that we have not identified. And so even though our healthcare system generally is the care manager is working with the member, or the provider is working with the member, when it comes to dementia and Alzheimer's care, that caregiver is central to that care team as well. And so we need to be identifying who the family or perhaps friend caregiver is.

Jennifer Schlesinger:

We have a tool that we used in the dementia Cal MediConnect project for helping to identify an informal or a family caregiver that looks beyond just who the authorized representative may be. Does the person live with the individual with dementia? What kind of care are they providing when it comes to ADLs and IADLs? Who's providing that hands-on care that is helping keep that member at home? And once we've identified who the family or friend caregiver is, it's incredibly important that that information is documented as well. Next slide.

Jennifer Schlesinger:

So a best practice, caregivers with unmet needs and with high levels of stress may be unable to contribute to the ICT. Most caregivers have some high level of stress, especially when they're caring for someone with Alzheimer's disease or dementia, and so it's not uncommon that there may be unmet needs. There may be barriers in that person's ability to provide care, and they may be experiencing stress, and fatigue, and burnout as well. So in addition to identifying who the caregiver is and documenting who the caregiver is, it's also important that we are assessing that caregiver for their own needs as well. And as Barbra said, if that person is a member of your plan as well, and about 25% of caregivers are also your plan members, there's a dual benefit in assessing them for their own needs.

Jennifer Schlesinger:

And then, of course, providing them with the support they need, whether that's disease education, caregiver training, support from a social worker, brainstorming how to deal with challenging behaviors, attending support groups. There's a lot of resources available, especially now that many resources are available via Zoom and via telephone as well. So some of the geographic barriers that we've had in the past, hopefully, for some communities have been minimized, though we know that not everyone has equal access to technology, and what opportunities that may afford, but it is important to think about not only identifying the caregivers, but also assessing them and supporting them. Next slide.

Jennifer Schlesinger:

If you can go back one? Thank you. So in addition to having the caregiver on the ICT, there's also a requirement to have a trained dementia care specialist, and I'll say that

dementia care specialist plays a really important role in supporting the caregiver as well. So considerations need to be made for who is a dementia care specialist? Alzheimer's LA has a dementia care specialist position description. I'm happy to share it with anyone, and it outlines the education for a dementia care specialist, roles, and responsibilities, and recommended training, and this may help serve as somewhat of a guide for health plans when they're considering staffing and the qualifications for a dementia care specialist. We also need to ensure that there are enough dementia care specialists on staff to serve your members with cognitive impairment. And as Barbra said, that one in five of your members likely has cognitive impairment.

Jennifer Schlesinger:

About six, seven years ago, there was a lot of initiative in the state to train dementia care specialists, but we know that a lot of the folks that were trained as dementia care specialists in the Cal MediConnect health plans are no longer at the health plans, or perhaps they're serving different roles now. So really give some consideration to who are your dementia care specialists? Do you have enough of them on staff to be supporting the ICTs, and your members, and the caregivers? And what tools are your dementia care specialists using? Are they using best practice care plans, for example, and I put on the slide a screenshot of a best practice care plan that we have available on our website. There's 23 of them, and when we assess for unmet needs and caregiver stress and strain, we're able to identify certain best practice care plans that can be used for dementia care management.

Jennifer Schlesinger:

Next slide. And then, of course, dementia care specialist training. The policy guide does not stipulate frequency of training. However, we all know that anyone new to a position requires training, and that all professionals need refreshers. Hopefully, we are all lifelong learners, and we make sure that our dementia care specialists continue to receive education and support in their roles. So do give considerations to frequency of training of dementia care specialists.

Jennifer Schlesinger:

Alzheimer's Los Angeles will be offering dementia care specialist training in the fall. It'll be offered live on Zoom, so it will be virtual, and it will be open to all health plans in the state who are interested in training dementia care specialists, subject to our capacity to continue offering that, but again, if anyone is interested in dementia care specialist training in the fall, you are more than welcome to reach out to us. I will put my email. It's on the slide deck, but I'll type it into the chat as soon as the presentation part is over as well. Next slide.

Jennifer Schlesinger:

So I've mentioned several tools today. I've shown a few screenshots of some tools as well. You are more than welcome, and I encourage you to spend some time looking at the tools available on our website. There are other tools as well that exist, that are

very high quality. So what is on the Alzheimer's LA website is not all inclusive of all tools, but the ones that I've referenced today, you can find there, and you can download them for free, and hopefully be able to put them to use. So next slide. With that, Barbra and I will open up to questions that you may have.

Mary Russell:

Thank you so much, Jennifer and Barbra. I was keeping an eye on the chat, and I saw some great dialogue and some sharing of links and resources, but, yes, if there are additional questions, to drop them in the chat or raise a hand, and we can take people off of mute at this time.

Anastasia Dodson:

Mary, can I take a point of privilege here? Just first of all, to recognize Jennifer and Barbra for their excellent work, and what a tremendous resource they are for the whole state, and if you all have any thoughts on particular resources for physicians as well. I know we've talked about Dementia Care Aware, but we have health plans, caregivers, and how about physicians? How do they fit into all of this?

Jennifer Schlesinger:

Well, physicians absolutely are a critical component to this. And through Dementia Care Aware we're going to be seeing a lot of initiatives throughout the state to increase provider training around how to do a cognitive assessment and some functional assessments as well, as well as recognizing the needs for caregivers. Dementia Care Aware is launching in the next couple months, where there will be on demand CME available to providers, so that they can learn how to do a full diagnostic workup, but in addition to that program, there's also going to be complimentary education for providers around doing dementia screens and diagnostic workups, as well as clinical support. So it's really exciting what our providers are going to be having access to. Some of the best and the brightest in the state are going to be available to provide that training, and also that clinical support.

Jennifer Schlesinger:

Our organization in spring of 2023, we're going to be providing some CME around specifically for providers, but it'll be available to all healthcare professionals, where we're going to be looking at health equity, and what providers can be doing to push forward more equitable care, and dialogue around brain health, as well as the diagnostic process, and care, and support. So there are a lot of opportunities for providers to be more engaged, but I can't stress enough providers need support, but we need to integrate that into the process with how we work with our health plans. Right? And vice versa, we can be training dementia care specialists, but we also need to make sure that there's processes in place to communicate with our providers when they're doing a validated screen, or they're identifying unmet needs as well.

Anastasia Dodson:

Thank you.

Mary Russell:

Great. Thank you, Jennifer. I'm seeing a question here from Kathryn Stambaugh, "Can you restate the trigger question you recommended for HRAs? I think it was one on one of your previous slides, any changes in thinking or remembering. What is the full text of this question, and what is the source, or is it validated?" Can you comment on that?

Jennifer Schlesinger:

So the trigger question that was used by the state, and it comes from the BRFSS from the CDC. It's a variation of it, but it's based in there is, "Have you had any changes in thinking, remembering, or making decisions?"

Mary Russell:

Thank you. And, yes, thank you, Tatiana, for that call out, that local HICAPs are available to support, so thank you for dropping in that contact information. Any other questions, or notes, or thoughts at this time? Okay. Thank you again. Thank you so much, Jennifer and Barbra. And with that, I think we will shift gears. I'll pass it back to you, Anastasia, to cover the public health emergency unwinding updates.

Anastasia Dodson:

Thank you, Mary. And thank you again to Jennifer and Barbra. That was a really wonderful, excellent, thorough presentation, and I still have many other questions and thoughts percolating, and many of you may as well. So look forward to continuing to discuss, and when we have the launch of Dementia Care Aware, I think it's going to be in the next few weeks, we can come back at future meetings, and talk more about that, because, again, the high prevalence and also high impact on caregivers. And we see many opportunities, and even beyond our work in the MMPs and Cal MediConnect, other ways through CalAIM, as was pointed out, to support people with cognitive impairment and Alzheimer's.

Anastasia Dodson:

So the next few comments are the same that we have heard discussed in previous meetings around the public health emergency unwinding. Nothing new here, just that we don't know yet the date of when the COVID Public Health Emergency will end. So it's been recently extended. When it does end, then there will be a requirement to redetermine eligibility on the Medi-Cal side. So we want to minimize the burden, and folks are welcome to become coverage ambassadors. You can sign up for that list and help improve continuity of care for beneficiaries on the Medi-Cal side. Next slide.

Anastasia Dodson:

And you've seen this before, the call out is to encourage beneficiaries to update their contact information. That's, again, launching immediately. We want people to make sure they have their correct address and contact information listed at the county eligibility office, also through their health plans, and there's communication between the counties and health plans to make sure that the Medi-Cal information is up to date, so that eventually when the public health emergency does end, and there are Medi-Cal eligibility renewal packets sent out to beneficiaries, that people respond timely, and so that they're able to maintain their Medi-Cal coverage. Okay, next slide. And then upcoming meeting topics. Next slide.

Anastasia Dodson:

This I think is kind of the same that we had in previous meetings, and you can see, we've been talking about some of these examples, and we can talk about more soon. Flagging on community supports for seniors and persons with disabilities, our CCI webinar coming up, I believe, next week is going to go into that topic. Crossover claims and balanced billing, we know that's been a hot topic here, and we're working on some internal information materials, so then we can go and discuss with all of you, and make sure we're getting that right and improved as much as we can over the coming months, but really going to be an ongoing topic to improve their beneficiary communications and integrated member materials. We can talk about what we've got so far, and in future meetings, give you some screenshots of what things look like.

Anastasia Dodson:

We've been covering the Cal MediConnect transition, quality measures, and reporting for dual eligible individuals. So even just tying back to the Alzheimer's and dementia care, we have quality measures for the MMPs that are for the most part, we're continuing some of the same measures that we had for Cal MediConnect, but also looking at ways that we can combine in with the work on Dementia Care Aware, and look at ways to measure that assessment and screening compliance, and then also thinking about other chronic conditions and different ways that we need to talk about the eligibility and enrollment process, but we're also really eager to get all of that sort of tied up, and then really talk about chronic conditions and strategies that health plans and all of the partners here, we can all work on together.

Anastasia Dodson:

Kidney disease, ESRDs, another interesting topic, heart disease. Thinking about ways that all of us together can work on strategies to improve care, and improve quality of life, and making sure that folks have access to the kinds of services they need to, especially long-term services and supports as well. Updates to the SMAC contract, Medicare Advantage benefits, supplemental benefits. We have some research that is going on right now around those, categorizing and listing the benefits, both supplemental benefits and the SSBCI, that we can at some point present on and have researchers present on. Care management for Alzheimer's and related dementias, and then, of course, strategies to improve health equity.

Anastasia Dodson:

So we have a lot to do on all of these topics. We do need to make sure we get the eligibility transitions done correctly, but really eager to be talking with all of you on these other topics, such as Alzheimer's and related dementia care, because that doesn't go away, still going on, regardless of all these different eligibility and enrollment transitions. So any other topics or questions in the chat, Mary, that we need to close out before we sign off?

Mary Russell:

Yes, I was just going to flag. So I wanted to acknowledge Rick Hodgekin's questions about the housing component of CalAIM. And I think, Rick, there is a CalAIM inbox to direct some of those more specific questions, and we're happy to message you with that information, if that would be helpful. And then a question from Tatiana. Oh, did you want to add to that?

Anastasia Dodson:

Oh, just that there are a lot of housing related benefits and coordination in CalAIM, so great question, Rick, and there's a lot there, so probably we don't have a ten second response, but great question.

Mary Russell:

And then a question from Tatiana about, "Will the DHCS beneficiary notification letters be posted on the CalAIM website, so partners can be informed?"

Anastasia Dodson:

Yeah, we can look at that. I think we have to, again, get some kind of generic version, but I think that should be fine. And if not, then we can email them out to anybody who's interested. I know there's a variety of materials, but we will do our best to either post them or just email them out.

Mary Russell:

Great. Okay. Well, with that, thank you all so much for participating today. Thank you to our speakers for the wonderful presentations. Wanted to note that the date for the next MLTSS and Duals Workgroup meeting is Thursday, August 18th at 10:00 AM, but before that, we'll have our next CCI stakeholder webinar on Wednesday, July 27th at noon. So thank you all so much for joining us today. The slide deck and meeting materials will be available on the DHCS MLTSS and Duals Stakeholder Workgroup website in the next few days, and, of course, feel free to reach out to the info@Calduals inbox with any questions in the meantime. Thanks, everyone.