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California Advancing and Innovating Medi-Cal (CalAIM)

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SPEAKERS

Mary Russell
Anastasia Dodson
Gretchen Nye
Kristine Loomis
Araceli Garcia
Amira Elbeshbeshy

Mary Russell:

Good morning and welcome to today's Managed Long Term Services and Supports and Duals Integration CalAIM Workgroup. I'm Mary Russell with Aurrera Health Group supporting DHCS on this effort. We're very excited to have some great presenters with us today, including Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS, Gretchen Nye with the Medicare & Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. We'll also hear from a great panel, which will include Kristine Loomis, an advocate and member of the Inland Empire CCI Stakeholder Advisory Committee, Araceli Garcia, the Senior Program Manager for Consumer and Stakeholder Engagement with Blue Shield Promise Health Plan, and Amira Elbeshbeshy, the Director of the Health Consumer Center, Legal Aid Society of San Mateo County. So, thank you all for being with us.

Mary Russell:

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. During the discussion, if you would like to ask a question and/or provide comments and feedback, please use the raise hand function and we will come around and unmute you. The PowerPoint slides and all meeting materials will be available on the CalAIM website in the next few days. We will drop a link to those materials in the Zoom chat. Really quickly, we would ask that you take a minute now to add your organization's name to your Zoom name, so that it appears as your name - organization. You can do this by clicking on the participant's icon at the bottom of the window. Hover over your name in the participant's list on the right side of your Zoom window. Click more. Select rename from the dropdown menu. Enter your name and add your organization as you would like it to appear.

Mary Russell:

That will help us as we are facilitating any questions and answers. And we'll take a look at the agenda. It is jam packed for today. So, we'll kick it off with an update on the CalAIM Enhanced Care Management and D-SNPs, followed by some questions and answers. After that, we'll hear from CMS MMCO on the CMS Final Rule regarding enrollee advisory committees, then from DHCS on the language around consumer governance boards in the 2023 D-SNP State Medicaid Agency Contract, or SMAC. Following this, the panelists will present on the consumer advisory boards and lessons learned from Cal MediConnect, followed by a breakout room discussion and report outs. So, I hope everyone will be able to stay on for that portion of the meeting. Following the report outs, Anastasia will present on the Public Health Emergency unwinding. Then we'll have a summary of the January 2023 enrollment changes. And finally, we'll close out the meeting by discussing upcoming meeting topics and next steps. With that, I will hand it to Anastasia.

Anastasia Dodson:

Thanks so much, Mary. Good morning, everyone. So glad that you're all joining us. Really, the strength of this meeting is having diversity and robust attendance here at these meetings, and wonderful conversations in the chat and from presenters and with all of you. So, thank you again for coming. So, this meeting is a stakeholder hub for collaboration on CalAIM MLTSS and integrated care for dual eligibles and populations beyond. We want to get your thoughts and strategies, comments, on all these topics. And we really value the partnership that we have with you. All right. Next slide.

Anastasia Dodson:

So, this topic, I'm going to go through it briefly and it's kind of technical, but we'll just stay at the high level. And then of course, if there's questions, folks can ask them. Next slide. So, Enhanced Care Management is a part of CalAIM. It's a program intended for folks who are most in need and at risk for emergency department visits, institutionalization in skilled nursing facilities, et cetera. And so, the Enhanced Care Management part of CalAIM has had its own stakeholder process and discussion, but there is overlap here with the topics that we've been talking about for dual eligibles, for D-SNPs, et cetera. So, the policy that we're going to be talking about is outlined in both the D-SNP Policy Guide and the ECM Policy Guide. So, these are documents that are comprehensive sets of policies, so that things are not piecemeal in various documents. It's all together in the D-SNP Policy Guide for D-SNP requirements and then all together in the ECM Policy Guide for Enhanced Care Management. And the links are there. Next slide.

Anastasia Dodson:

So, we know that dually eligible beneficiaries, they have generally high health care and Long-Term Services and Supports needs due to chronic conditions, and they certainly benefit from care management across Medicare and Medi-Cal. A large number of IHSS recipients and skilled nursing facility residents are dually eligible. So, as we think about the Enhanced Care Management effort that Medi-Cal plans, again, Enhanced Care Management is a Medi-Cal/CalAIM effort, then we want to think about the overlap for dual eligibles. Another piece of the puzzle is that more than half of dual eligible beneficiaries are in original Medicare. That's Fee-For-Service Medicare. And so again, how does that work with Medi-Cal Enhanced Care Management? And there's a table in a couple of slides that we will look at, and that lays that out. But just want to do a little table setting here as far as what Medicare delivery systems folks are in and flagging, again, that Enhanced Care Management is a Medi-Cal benefit.

Anastasia Dodson:

Also, Enhanced Care Management has some populations of focus that shapes different policy strategies around Enhanced Care Management. And so, number five and number six in the Enhanced Care Management structure are for those who are at risk and utilizing skilled nursing facility long term care. Many of those beneficiaries are in Medicare Fee-For-Service and the Medi-Cal Managed Care Plans would then coordinate as needed with the Medicare Fee-For-Service providers. And as needed, required, the Medi-Cal plans would implement Enhanced Care Management for those

individuals. So, there is a wrinkle here though for D-SNPs, which is the type of Medicare program and delivery system we've been talking about in these meetings. Next slide.

Anastasia Dodson:

So, in the D-SNP model of care, there is quite a bit of overlap in the requirements there compared to the Enhanced Care Management requirements, which in some ways is great because really it shows that we're aligned on the same page with Medicare about the types of strategies that could be most beneficial, and that we want our organized delivery systems, Medicare and Medi-Cal, to provide to individuals who need this type of care management. However, since they are somewhat duplicative across Medicare and Medi-Cal, then there's potential for confusion and duplication for members and for care teams, particularly those that have long-term services and support needs. So, we are basically, over the next year or two, going to be putting in more state-specific D-SNP model of care requirements to more closely align with the Enhanced Care Management requirements.

Anastasia Dodson:

And so for 2023, we have made updates to the D-SNP Policy Guide in the model of care requirement, basically saying the intent is for EAE D-SNPs, those are the ones that are transitioning from Cal MediConnect, for those types of Medicare plans that will have both Medicare and Medi-Cal in the same organization, we are saying that our expectation is for those plans to provide essentially the same type of care management so that folks who would otherwise qualify for Enhanced Care Management under Medi-Cal to get that same level of care, type of care management through Medicare through their EAE D-SNP. And we've talked with the health plans that will be those EAE D-SNPs, currently the Cal MediConnect plans. They agree. Everybody's on the same page, so that should be seamless. And it's a good policy, Enhanced Care Management on the Medi-Cal side.

Anastasia Dodson:

And then we'll make sure that those members get the same benefits on the Medicare side. For D-SNPs that are not exclusively aligned D-SNPs, which is still in many parts of the state, the timing will be that in 2024 we will add additional requirements to essentially make those D-SNPs responsible for the equivalent of Enhanced Care Management for those members. And this is not a small group, either. So, that's our phased approach. It'll be in 2023, EAE D-SNPs will have essentially the same requirements as Medi-Cal plans to provide that type of Enhanced Care Management. And then in 2024, that will apply to all the rest of the D-SNPs for all their membership throughout the state. Next slide.

Anastasia Dodson:

And this is, again, the same policy we've just been talking about in a little more detail. So, again, for MCP, those are Medi-Cal members that are in Medicare Fee-For-Service and regular Medicare Advantage, then the Medi-Cal plan, and this is MCP on the slide there, the Medi-Cal plan will provide Enhanced Care Management as needed. And

again, we can talk in future meetings about how we want to promote collaboration between Medi-Cal plans and Medicare plans and/or Medicare providers. But this is a large group, the dual eligible beneficiaries who are in Fee-For-Service on the Medicare side and regular Medicare Advantage plans. And again, the responsibility's on the Medi-Cal plan for Enhanced Care Management. Just as we talked about on the previous slide, in 2024 all the D-SNPs will have this requirement. And then in 2023, for the non-EAE D-SNPs, the Medi-Cal plan will still be responsible for Enhanced Care Management. For the EAE D-SNPs in 2023, they will be responsible for Enhanced Care Management. And then in PACE, again, similar to EAE D-SNP, there's already a care management, a similar requirement. Next slide.

Anastasia Dodson:

So, this just gives the same information in a table format with some numbers on the left-hand column. You can see there's about 1.2 million dual eligible beneficiaries. And these are very rough, rough numbers. And we don't know for sure what these enrollment numbers will look like in 2023. It's just some ballpark. So, a large majority of dual eligible beneficiaries are either in original Medicare or in a regular Medicare Advantage plan, and that's where the Medi-Cal plan is responsible for Enhanced Care Management. For the D-SNPs, you can see the non-EAE and the EAE are broken into two different rows, but by 2024 we'll have alignment where there's the same requirements for both types of D-SNPs to provide essentially the same as Medi-Cal Enhanced Care Management through the Medicare plan. Okay. Next slide. So, questions. And it looks like there were some in the chat.

Mary Russell:

Yeah. I think we have one from Jan Spencley asking about how Community Supports fit into this, or are they under the ECM umbrella?

Anastasia Dodson:

What a great question. Thank you. Yeah. So, Community Supports are separate from Enhanced Care Management, and they are part of the CalAIM program and they're already effective now. And all Medi-Cal plans and also Cal MediConnect plans are able to offer Community Supports. And we certainly encourage it. And there is a lot of benefit to looking at, of course, the whole person and seeing if they need Enhanced Care Management, might they also need community supports. Those two programs can go hand in hand, but also can be independent. So, currently Cal MediConnect plans, as I said, can offer Community Supports. Also, Medi-Cal plans can. And then in 2023, exclusively aligned D-SNPs and all other D-SNPs, that's the Medicare side of the house. On the Medi-Cal side, again, those Medi-Cal plans can offer Community Supports to their D-SNP members.

Anastasia Dodson:

There's no restriction, and we would certainly encourage it. And part of the interesting part about this, the EAE D-SNP structure, is that Medi-Cal is still a separate contract with DHCS and those plans separately report what they're doing on the Medi-Cal side.

So, we would expect them to report what they're doing on EAE D-SNPs, just as they're reporting in regular Medi-Cal for all their members. So, I hope that makes sense. But we can certainly provide any additional information in writing, but there's no restrictions.

Mary Russell:

Thanks, Anastasia. I don't see any other questions in the chat at this time or hands raised.

Anastasia Dodson:

Oh, it looks like Jan wants to chime in again.

Mary Russell:

Okay. Can we take Jan off mute?

Jan Spencely:

Hi. I'm sorry, Anastasia. I guess maybe I should ask this another way just to make sure. Whether you're EAE D-SNP or you're a MA in another Medi-Cal plan, no matter what that client would be eligible for ECM, if they meet criteria, ECM and Community Supports one way or the other, right?

Anastasia Dodson:

Yes. I mean, if they meet the population of focus, right? And all the relevant criteria that there is on the Medi-Cal side. But are you asking for the folks who are in the EAE D-SNP? Or which Medicare-

Jan Spencely:

The EAE, I think it's great. I wish everything had just gone on to one contract, but I know you can't do that. But I'm talking about the people that might stay Fee-For-Service Medicare, might stay MA Medicare because that's where their doctors are, right?

Anastasia Dodson:

Sure.

Jan Spencely:

But they might have some other needs. And I'm trying to figure out... I mean, I get questions about this all the time, and we help them. So, I want to make sure those people are still eligible for community supports, the Medi-Cal beneficiaries, regardless of how they get their Medicare covered.

Anastasia Dodson:

Right. Their source of Medicare or their Medicare delivery system for Community Supports does not impact the Medi-Cal framework for Community Supports. So, each plan determines which Community Supports to offer. And I think there's tables on our

website that show which plan is offering which of those Community Supports, but it is irrespective of someone's Medicare delivery system. Okay, great.

Mary Russell:

Thank you for that question, Jan. Oh, did you have more to add or are you okay? Okay. So, a question from Jason Bloome in the chat. Community supports can be offered by all Medi-Cal plans, not only MLTSS plans. And also asking for a link or a list of Medi-Cal plans in Los Angeles County.

Anastasia Dodson:

Oh, good. Mary, is your team-

Mary Russell:

We can drop that in the chat.

Anastasia Dodson:

Great. Okay.

Mary Russell:

We will grab that, Jason, and add it to the chat. Okay. Other questions on Enhanced Care Management and D-SNPs? Okay. Then I think we will transition and of course, feel free to... Oh, a question from Tatiana. How can one find out if a particular provider is in a Medi-Cal plan?

Anastasia Dodson:

Well, there's provider directories for Medi-Cal plans. Is that the question maybe? Or is it more related to Community Supports providers or ECM providers?

Mary Russell:

Tatiana, would you like to come off mute and add more to that?

Tatiana Fassieux:

Thank you. Yes. I'm encountering situations that a Medicare beneficiary will become eligible for Medi-Cal, and they want to make sure that whichever plan they are in or choose to be in as far as the Medi-Cal plan, that their providers will be in. So, bottom line here is that, before a person gets assigned to a Medi-Cal Managed Care Plan, is there an auto assignment process or can a Medicare beneficiary choose a Medi-Cal plan available in their region?

Anastasia Dodson:

Well, maybe there's two parts to that question. The first is, if they're already in Medicare and they have a set of Medicare providers that they're working with, the choice of the Medi-Cal plan does not impact their Medicare providers. So-

Tatiana Fassieux:

Well, yeah. That is the problem. Because we come across a lot of Medicare providers that say, “We are not contracting," or "We are not a Medi-Cal provider, period."

Anastasia Dodson:

Yeah. So, there may be some miscommunication. I'm not sure to the specifics of that situation. But maybe to the point that they are a Medicare provider, and if they are concerned about the patient's share of the billing, I mean, that's one issue. But to be clear that they're still getting their payment through Medicare, it's just the secondary payer is Medi-Cal, and there's-

Tatiana Fassieux:

Correct.

Anastasia Dodson:

Yeah. I know that we have some other stuff on the agenda to handle this morning, but if the overall concern is about Medicare providers who are concerned about that secondary payment getting up to 100% of the Medicare reimbursement, I think that's a bigger issue than we have on the agenda for today. But again, we just really want to emphasize that choosing a Medi-Cal plan does not impact which Medicare providers you can see. I mean, I understand your point about some Medicare providers being concerned about getting the 20% payment share. But I do think that's maybe a larger issue than what we have for the agenda today. Again-

Tatiana Fassieux:

That's fine. As long as you could table that question because this is very important to Medicare providers. I mean to Medicare beneficiaries.

Anastasia Dodson:

Yeah, I do. But Tatiana, I hope that you are also emphasizing to people though that, I mean, individual Medicare providers may make certain decisions, but which plan to choose on the Medi-Cal side does not limit whether a beneficiary can see a certain Medicare provider. It's not about which Medi-Cal plan. And there's a lot of financial benefits to beneficiaries of having those Part B premiums, and to the extent Medi-Cal covers. Certainly legally, providers are bound by the Medicare and Medicaid rules on that secondary payment. So, I just, again, I don't want to leave people with the impression that there's any kind of restriction on Medicare providers by choosing a particular Medi-Cal plan.

Mary Russell:

Thanks, Anastasia. And yeah, I'm so sorry. I do see a few more hands raised, and I know there will be some follow up questions, so we're happy to take additional questions in the chat and, of course, at the info@ email address, which our team has just dropped in the chat. But I think at this point-

Anastasia Dodson:
And-

Mary Russell:
Oh, Anastasia, do you have something to add?

Anastasia Dodson:
Yeah. So, Mary, if there's more questions, let's go to our key topic for the meeting, but then in the last section of this meeting, I know we have the usual slides about the transition for Medi-Cal Mandatory Managed Care, and we can revisit at the end of the meeting based on the amount of time we have left.

Mary Russell:
Great. That's a good idea. So, at this point I'm going to transition to Gretchen Nye with CMS to take us through the CMS Final Rule and the elements related to the enrollee advisory committees. So, Gretchen?

Gretchen Nye:
Good morning. Yes. I'm here to talk about the Final Rule. So, building on experience of Medicare Medicaid plans, like Cal MediConnect and PACE organizations, CMS proposed requiring that all Medicare Advantage organizations which offer a D-SNP to establish one or more enrollee advisory committee in each state to solicit direct input on enrollee experience. We received wide-scale support for this proposal, and it was finalized in April in the 2023 Medicare Advantage and Part D Final Rule and is effective for 2023, next year. Enrollee advisory committees are an important beneficiary protection to ensure member feedback is heard by Managed Care Plans and to help identify and address barriers to high quality coordinated care for dually eligible individuals. So, for 2023, all D-SNPs must stand up at least one enrollee advisory committee. D-SNP enrollee advisory committees have to be specific to a state, i.e., they cannot cross state lines even if a D-SNPs or the Medicare Advantage plan that houses that D-SNP crosses state lines.

Gretchen Nye:
CMS is requiring that a D-SNP enrollee advisory committee include a reasonably representative sample of enrollees in the D-SNP. We'd expect the D-SNP committee to reflect the diversity of the plan on factors like race, ethnicity, gender, disability, and other demographic indicators. CMS is requiring that, at a minimum, D-SNPs enrollee advisory committees solicit input on ways to improve access to covered services, coordination of services, and health equity for underserved enrollee populations. In parallel, there are existing requirements that Medicaid Managed Care Plans that cover certain LTSS services also convene an advisory committee.

Gretchen Nye:

CMS is allowing for one committee to meet both the Medicaid and Medicare requirements should a state's state Medicaid Agency Contract, or their SMAC, with the D-SNP allow for that arrangement. Finally, CMS established the D-SNP enrollee advisory committee requirement as a floor. States can require more prescriptive requirements for D-SNP enrollee advisory committees in their SMAC contracts. And I know Anastasia's going to talk a little bit about that later about the California-specific requirements for the EAE and non-EAE D-SNPs in California for 2023. Next slide.

Gretchen Nye:

The next two slides are just providing links to resources that are already available to plans on enrollee advisory committees through MMCO's contractor resources for integrated care. There's a variety of webinars, tip sheets, and videos available for plans and other interested parties. We're working to deploy additional TA later this summer on this topic too. So, feel free to take a look at all those links. And I think that is about it for me.

Mary Russell:

Thanks, Gretchen. So, now Anastasia is going to take us through some of the SMAC language on consumer participation in governance boards.

Anastasia Dodson:

Thanks so much. All right. Next slide. So, you will all recall, I think, that SMAC is the name of the contract between DHCS and the D-SNPs. And so, this is the additional state provisions that we have for D-SNPs in California. In the EAE D-SNPs, we have the language that you can see on the screen here about the D-SNP ensuring consumer participation in governance boards. And in fact, we had this language, very similar, in Cal MediConnect because in the development of that, we recognize the importance of consumer participation in governance boards. And as we are thinking ahead to the federal requirement, we know that this will fit nicely with that. I think that's basically the contact setting California, we have this language already, and we're appreciative for DHCS to have that. It looks like there's some stuff going on in the chat. Maybe, why don't we pause the chat for a few minutes, so if we can focus on the agenda topics for now. Maybe let's see if we can do that.

Mary Russell:

Yeah. We'll do that. And just a reminder to please keep the comments respectful, and thanks so much everyone. All right. Thank you, Anastasia, for this. At this point, we'd like to transition to our panelists before we head into our breakout room. So, during the panel presentation, we're going to hear from Kristine Loomis, an IHSS Consumer Advocate and member of the Inland Empire CCI Stakeholder Advisory Committee. Araceli Garcia, the Senior Program Manager for Consumer and Stakeholder Engagement with Blue Shield Promise Health Plan, and Amira Elbeshbeshy Director of the Health Consumer Center, Legal Aid Society of San Mateo County. Kristine's up first. I know Kristine, you are joining us by phone. So please go ahead and jump in. Thank you.

Kristine Loomis:

Thank you. Can everyone hear me?

Mary Russell:

We can. You sound great.

Kristine Loomis:

Okay. Great. Yes. Thank you. I am really honored to be here because I've been very involved since the beginning of CCI in Riverside and San Bernardino County. And I'm speaking of course, primarily from the consumer's point of view today. Although all of these things do relate to implementation and program policies within the integrated care management. And so, the first thing I wanted to do is just mention that I jumped on this committee originally because of two overarching concerns when I saw that this was coming in. And to name those, which I think are common to all consumers, basically we are concerned about losing access to particular doctors, which we have longstanding relationships with.

Kristine Loomis:

And especially if you are a person with multiple complexities, those relationships become absolutely crucial. Any of you who have developed regular relationships with doctors, well, try that exponentially by 10 times, if you have extreme conditions and you need to find someone that can relate to your condition, it becomes really important to keep those doctors. And so that was one of my concerns and other people's concerns going into coordinating care. And the other one is of course having to do with our home care, which is IHSS largely in California. And the advantage to us of having IHSS, which is huge is that we retain control over who's in our home. And that means that we can train, and we can choose, hire, and fire our providers.

Kristine Loomis:

And again, if you think about having someone stay in your home or someone visit your home every day four hours at a time, you'll understand that there's so many important issues. And so, the fear that in some way, a plan will take over and send us people of their choosing, on their schedule, turning our homes into institutions is a huge fear and that's always on the horizon. So, the doctors and the home care are the two main issues going into this. And there was a lot that I thought about in doing this presentation about what to consider as being the top issue. And one of the reasons that I put near the top, the issue of basically case management is because I don't hear that one being discussed a lot.

Kristine Loomis:

And again, each one of you, many of your professionals understand your own program well, and understand the complexities involved within that program. But from the point of view of a consumer or a person that is looking after a consumer, this would be a family member or a very good provider. Someone that's reaching out above and beyond to help with their case management is dealing with, well, just consider the amount of

technicality and work you put into doing your annual income tax, and then think about someone that is a senior with complex care, finding out about the different programs that they're eligible for and filling out the forms and doing the annuals and all the things that are involved in that.

Kristine Loomis:

I, in preparation for this look to see how many programs I had to do paperwork for so far this year that were directly related to medical care and my survival on those issues that are related to Coordinated Care Initiative, and there were 10. There were 10 different programs. And so, think of the amount of case management involved in that for someone. So, the reason that I'm bringing that up is because I'm suggesting that there be some sort of overarching funding, or resource provided to help people through this process. And I know there are things on the statewide level and even on the national level, are no wrong door approach. But we need people that, especially after COVID where a staff has been reduced and you've tried to call an office to resolve an issue, and there's no one there you can talk to and can't make an appointment.

Kristine Loomis:

You really need someone to talk to help you through this process of case management. It takes hours and hours and hours and hours. And for instance, very quickly with myself, I had to get durable medical equipment this year, a new wheelchair. And so far after four months of case management, that's involved four specific doctor visits, four home visits with people to my home and much paperwork. And we haven't even begun the process of advocating with Medicare Medi-Cal yet. This is just the beginning. So that's the kind of thing we're up against with case management. And we need help with that. And it was one of my biggest hopes and dreams and wishes that coordinated care would be able to help with this.

Kristine Loomis:

And unfortunately, in my case, it has not. It has made it even more complicated. And so hopefully that will get better as we progress. And so, I'm going to try and go more quickly through these other issues and make a couple suggestions also. The other issue that I've mentioned already is IHSS. I do consider that as being one of the primary fundamental tools for keeping seniors and persons with disability out of hospitals and in their own homes of course. So, our biggest fears as consumers are basically about abandonment, not having a care provider, and or our homes being taken over by managed care in a way that makes things very problematic for us.

Kristine Loomis:

And so, we have coordinated in Riverside County, the county that I live in, we have coordinated with our care plans and there has been some forward movement with their cooperation that's been very helpful. But the bottom line is that we're still, the biggest problem with IHSS and probably this is statewide as well is the lack of IHSS providers, and the complete inability to deal with emergency backup. We've had for several years emergency backup systems in Riverside, but it's not adequate going through public

authority and IP method. It just there's too much need. And so that's one we really need to work on.

Kristine Loomis:

My suggestion is to work on that through the IP system, support of the IP system, but also, if necessary, contract mode for emergency situations. And so, the final individual topic that I put on here was medical transportation, because I believe that again is an issue that directly relates to the bottom line of plans that look after people's health and their costs. And as a consumer myself, and also talking with many other consumers, one of the big problems that we run into is the five-day window of waiting in order to get medical transportation. And what that creates is a gap between there really is no urgent care transportation. There's only non-urgent care and emergency care. Okay. So, if you have, say you have an infection, you want to go to an urgent care clinic and you can't wait five days, then you end up going, you either call an ambulance and go into ER, which could be ridiculous, depending on the extent of the problem, or you let the problem go too long and then you become medically compromised.

Kristine Loomis:

And so, this five-day window is a real issue that needs to be addressed, perhaps having some sort of limited transportation gap there for special circumstances. And so, the other thing is scheduling with medical transportation, which there is an issue of oversight and there's also an issue of data gathering. I found out through talking at the committee when I reported problems, that were completely caused loss of doctor appointments. And as you know, sometimes if you lose an appointment, you can't get another one for three or four months, and this is a big issue. And everyone I talk to has the issue of transportation being late, or not showing up at the correct address and things like that. And when we ask of the committee, what happened, they say, oh, well, our records show that we have 95 or 97% scheduling efficiency. And so, when I ask the people I talk to, do you report your problems? All of them saying, no, they're so overwhelmed, they do not report.

Kristine Loomis:

And so, you need a different method of really finding out what's going on and oversight with the medical transportation. Because that is something that it's very expensive, I know at the end of providing it, but it's also very expensive if you don't have it. So finally, I'm going to loop back to one out of order because I skipped it and it's incredibly important. This was basically continuity of care. I mentioned how important it is for us to keep our doctors. And when I went on the committee, I really tried to push continuity of care for as long as possible, and the best I could get was one year. And for those of us that have specific doctors we must stay with, after that one-year period, what that caused for me personally, was that I could not take advantage of dual integration within my plan because this doctor did not belong to their plan.

Kristine Loomis:

And I did take it to hearing, I knew all about this, having helped make the policy for the hearing and was extremely surprised and dismayed to find out that this was in fact, the only hearing I've ever lost, that the plan was not at all receptive to special circumstances which had been written into the policy on this topic for when hearings are taken. And they just said no basically. And so, this again, I'm not sure how my time is running, but this also inter ties with the question that was brought up with the last speaker about billing, and the connection between Medi-Cal Medicare. And in fact, I have also run into that with this doctor that I wanted to keep, which is a Medicare doctor. And the Medi-Cal health plan that I have through CCI will not pay that 20% Medi-Cal copay. And that has been a real problem.

Kristine Loomis:

And it's also problem just understanding it. Again, this goes back to the case management and the help provided for people, trying to understand all the acronyms, all the obligations, all the opportunities, and all the things involved in making choices around these systems, and how they will impact individual clients. So, in closing, what I want to comment about are some of the things that really worked with the committee, because I think it's been actually one of the most valuable committees I've been on in terms of coordination with local organizations, with counties, with statewide people, all of them. There's been some really forward thinking and intelligent people coming to our coordinated care initiative meetings, and the impact of consumers given during those meetings has been listened to.

Kristine Loomis:

As I mentioned, there's still things that need to be worked on that have not been achieved, but they have been listened to on this committee in a way that a lot of times they're not. And heard the more, the different community-based organizations like the ombudsman and advocacy organizations that come to this committee and give information and interact with policymakers at both county and state levels that are in those meetings are really, really valuable. So, I want to underwrite the importance of having these committees and getting consumer feedback from the trenches as it were, so that can be integrated with people that are working on this at the policy level. And I do understand that you're trying to simplify a really complex issue, and particularly with people that have high need and are complex care management individuals.

Kristine Loomis:

And I myself, I'm really sorry that I could not be a dual within my plan and take advantage of some of the things that are provided, all because of this continuity of care issue and the inflexibility around special circumstances, because there's many doctors that do not want to become part of a big plan, where they're required to take multiple patients from that plan. But if the plans could provide special circumstance for, especially for complex care patients, it would give them more business. I would have been able to join their whole dual program and many other people that I talked to are in the same situation. How's my time?

Mary Russell:

Thank you so much Kristine, that was amazing. Thank you so much for sharing your perspective. I really appreciate it. And I think we're going to transition over to Araceli Garcia with Blue Shield Promise Health Plan. Araceli?

Araceli Garcia:

Good morning, everyone. Can you hear me?

Mary Russell:

Yep. We can. Thank you.

Araceli Garcia:

Great. Well, good morning once again. Thank you. It's a great pleasure to be here. I'm excited to share some of our best practices with Blue Shield Promise Health Plan. And actually, I joined managed care health plan during the inception of MLTSS. So just eight years ago. For Blue Shield Promise, our commitment to really create that safe and inclusive environment for our members is to focus on to be present, to get engaged and provide that feedback that really drives that change in how we deliver our care to them. Next slide, please. Our goal is to really create health care system that is worth our family and friends, and sustainably affordable for everyone. Prepping for our meetings for each meeting has been meaningful achievement for our members and meetings that has really created that human, that honest, and that courageous environment. And what do I mean by prepping?

Araceli Garcia:

So, we have prep meetings prior to every single meeting. We have quarterly meetings and during those meetings, our members have a copy in front of them with one slide only per page, one sided. Because we learned through our experience that we can have double sided PowerPoints, on one sided, big font for them to easy to read accessible for them to understand the information we're going to talk about the day of the meeting. And really understanding why is this meeting important for them, why are they part of this meeting, understanding that their voice is really important for us at the health plan. To know what is working, what is not working, where can we improve.

Araceli Garcia:

So, having this prep meeting, going through every single slide, really dissect that information that we're going to talk about for them to understand, does this make sense to you? The information that we're going to talk about the day of the meeting, does it resonate, do you have questions, and really creating that peer-to-peer interaction where the day of the meeting, it just really changes that environment that say that they are comfortable to answer questions. As I had some members shared that, with this prep meeting, they're comfortable to say, "Oh, I was afraid of asking this question because I thought it was going to be an appropriate question."

Araceli Garcia:

So not just within each other, you hear member A calling member C, "Hey, so what do you think about this question? This is the way I understood the question." So not just creating this more inclusive environment with they're comfortable within each other, understanding who is your audience. They see the agendas, and they see medical officer, the CEO so that's a little of intimidation because they're not used to be part of meetings with leaders like that and understand that we're all human. We really care to get your feedback. So, I think it's really going through the prep meetings, those details that we might not realize that they're important, but they're important for our members because this is a form that they're not used to participating.

Araceli Garcia:

And as they understand, this is a requirement, but it's more for us and a requirement because we need their feedback. So, we support each other with the questions. And then as through the pandemic, we have to move in our meetings, obviously virtually. That was a whole different journey going through the Zoom experience. At first, we were just, we learned that feature from Zoom, which is calling the members, all the members had to do was just answer the call. But we needed more than that to continue to create the momentum, that excitement of being virtual. So how are we going to have our members at least be on camera? So, it was great that we actually collaborated with our community-based organizations who are part of the committee, and they're the experts. We have CBOs for independent living centers to help us provide that Zoom training to our members of one on one and group training.

Araceli Garcia:

Because we know that every one of our members needs are different. So, we did multiple trainings. I can say I probably have a major on Zoom by now. But just really to see that empowerment for our members to be able to go and understand, first of all, because we got to take some steps back and understand that many of our members in the community don't even know what an application is, or a link. When I was telling members, "I sent you the link is click on it." Well, what is the link? So, wait a minute, I got to take a step back during prep meetings going over, here's the Zoom during our virtual, with our training, with the independent living center, understanding this is what an app looks like. This is what the link means, be able to understand what phone they have, because here they calling and asking me why my phone is asking me this, what do I press?

Araceli Garcia:

I don't know what phone you have. But I think it was such a critical aspect to collaborate with our CBOs, to help us with the Zoom training. In addition, we learned that many members didn't have a smartphone. Okay, what is our second option to overcome the barrier, is our CBOs had this lending program that we can borrow iPads or a laptop, depending on the member's need. In addition, that was one challenge barrier, and then the other one was having access to internet. So, then we partnered with other CBOs to help us provide the internet to our members. So, it's been a journey, and it really has changed the momentum of that empowerment for our members to feel that they belong

here, that they are safe, and that we're going to find other ways to continue this environment to be part of the advisory meeting.

Araceli Garcia:

So, we went through the Zoom training. It wasn't enough to just provide a Zoom, A through Z process. I know we had to go through 101 training, even through our prep meetings, we practice how to mute, unmute, how to be on camera. It happens through those who are used to being in meetings every day. But those prep meetings of understanding why is this important to you? Why is this important to us as a health plan? Why are we looking for your feedback? And understand the content that we have there, which has really kept most of our attendance rate at 95 and above of participation of members attending all our meetings. And creating that we get to hear from everyone. It's not just one member who I would say at first it was those more outspoken members. But now it's the balance of that outspoken to the quiet one, calling each other to feel that I belong here, I'm safe.

Araceli Garcia:

The CEOs on the meeting, the CMOs and meeting, but it's okay for me to express my thoughts. Because then they feel like if I ask those questions, my help here might be ended. And I'm like, no, this is a safe environment for you because we care to hear from you. Other best practices have been sharing our agenda dates in advance, which has been one of the reasons I feel like it has kept our attendance rate, because members know in advance, when are meeting, when are the prep meetings consistent on the time of the meeting. And of course, providing that hands-on support the day of the meeting. Knowing that you're not alone. Technology has its own mind, so things might happen the day of the meeting, but we're here. You call me, we log in before the meeting to know everything's running right. We always have a plan B option to know that you're still part of the meeting just because something happened, we'll figure it out.

Araceli Garcia:

So, creating a safe environment, that confidence within each other during those prep meetings has really changed that journey throughout meeting parts, indirectly with advisory meeting to now be really involved with this work, is that it's day and night. To really get to hear from every single committee member, and to see their confidence that they feel empowered. They feel human to say, I have a question and I'm going to ask, and I'm not afraid to ask the question. And then how do we get engaged? I think it also comes onto the internal team. It's not just about prepping our external committee members but prepping that internal team and understanding that the content has to be very simple extent and sixth grade language. As we were doing the slides, I would tell our presenters, I'm like, this is really complicated, we cannot use acronyms, our members do not understand acronyms.

Araceli Garcia:

So, we got to really take a step back, have visuals, minimum to two to three slides maximum to really keep our members focused and attentive to the data that we're talking about the topic. And we make sure that we are intentional of what the ask is. It's easy to just come and talk to them, but then we are going to lose the focus. So, part of the presentation, they have questions already included. So, both our internal members, our internal team understand why we're doing this for intentional, why the topic is essential to them and how is it going to impact to them? When we are clear on the ask, it just makes the presentation the day of the meeting flow easier.

Araceli Garcia:

Because members understanding, well, why is this important to me and having the questions. Otherwise, I think it becomes more of just a one-way dialogue and not a two way dialogue. One of the things that we have improved through our meetings is, it was one approach, even though we were asked questions, but no, not having our internal team, intentional, having those slides minimum, visuals, very little words, easy to understand, a one topic per meeting. We used to have couple topics, and we realized that we didn't have enough time for everyone's voice to be heard. Well, let's pause and let's change it to just one topic per meeting and we'll have enough time to hear from every single committee member. I would say that for both accounts that I oversee, we get to hear from everyone. And it's just nice sometimes when one member gets a call from another member, and the variety of our perspective of our membership that we have, that they feel comfortable to ask the question, they're not intimidated, if I'm comfortable to ask the question.

Araceli Garcia:

And of course, having the limit of internal guests. Because technology is technology, I think sometimes we forget to unmute or mute our lines, so I think just being limited to how many guests are invited to the meeting is important. It also avoids such as our members to see, "Whoa! There's so many on this list." So that becomes still a little intimidating. As much as we prep when we go over who's the audience on this meeting, it's just really limiting that, avoiding that background noise, making sure we're all on the same page, understanding and focused.

Araceli Garcia:

And of course, we provide interpretation services. Even through in-person and virtual now, we provide those services, which is another little barrier to add because there's a special way to select your language on Zoom, which is another lesson to teach our members. But I think it's great that they know everything's welcome. We find a way if they need their service, whether it's interpretation or other services, we have it. We're here because we are here for them. We need their feedback. Their voice is important. And how are we going to do that? Are we're going to find a solution to have them feel as inclusive as possible?

Araceli Garcia:

And I think other key aspect of this is getting the feedback from our community. Being intentional that our presenters are getting the feedback that we want, and that it's actionable. Because we can just ask questions, but if we're not tracking or being intentional of the feedback and keeping track of that, we might lose the little bit of that momentum. Which is why moving forward, all our presentations have a recap slide. To keep that presence from our members, is we have a slide, "This is what we talked about the previous quarter meeting. This is what we talked about. This is what we heard. This is what we're doing."

Araceli Garcia:

And yes, we might not have a solution to all of their feedback that they shared with us, but at least they know that "Yes, we are here to get your feedback. This is what we're doing. This might take longer than other items, but this is on the work, so this might not go through." And really an amazing, one of our examples that I can share, a recent actionable item that came out of our meeting was this informational sheet. Our committee members created this sheet, it went through different meetings to get their feedback, and it was great for them to also get a copy of this kind of cheat sheet where they said, "Those packages that we get from you are great. However, sometimes we misplace them, we use them for storage for other things. So, what is one thing that is easy and accessible for everyone?"

Araceli Garcia:

So, we create an informational sheet with key numbers that they feel are important for members, and a magnet that is easy to find, it doesn't get misplaced. It was a great success. It went through the whole process, got approved, and now our turn. Any new members have that. Thanks to their feedback. I think that even empowers them to say, "Wow, our helpline really cares for what we're saying." And really just also training data. One of our challenges is always definitely recruiting, but I feel like now with this whole prep meeting and creating that confidence within there, now they're spreading the word among their friends, and they're like, "Oh, I have a friend or a granddaughter who wants to join a meeting."

Araceli Garcia:

I say, “Great. Now you're making my work easier in recruiting.” And also knowing that, they said, "I have a disability and I didn't think I was capable of being part of a meeting like this. But now with all the support and all that guidance that you provide to us, I feel like I'm welcome here and that my voice matters to you." So, it's been great. I think today, what I see during the prep meetings, that they are facilitating the meeting. I'm like, "Great. Sure, you guys would just be meeting these meetings, and it's on. You guys won't need me." But I think just being intentional, continue to have those prep meetings and say, "Why is this important to you to ask?" Be clear.

Araceli Garcia:

I think we forget sometimes as we're just working within the company that we're going in a fast mode, but just pausing to say, "Make it as simple as possible for them." And I

think that's where we get the best feedback, the best interactions. So, everyone feels welcome.

Anastasia Dodson:

Sorry to interrupt. We have one more presenter before we go to the breakout group. So, we just want to keep going, but thank you so much.

Araceli Garcia:

Thank you.

Mary Russell:

Thank you. I really appreciate your perspective on this. Our next panelist is Amira Elbeshbeshy, the Director at the Health Consumer Center for Legal Aid Society of San Mateo County. Go ahead, Amira. Thank you.

Amira Elbeshbeshy:

Thank you. Hello. Good morning, everyone. Thank you for having me. Can we go to the next slide? Thank you. I'm going to do my best to be quick because they see that we are a little behind schedule, and I am very excited about the breakout rooms. So, I will go through this pretty quickly. I just wanted to touch upon a few things that I really think are beneficial that come out of the consumer advisory committee meetings.

Amira Elbeshbeshy:

First, the data review. I feel like a lot of us in this room are probably big data nerds, so we all love the data. A wide variety of data is shared at these meetings, from grievance trends, new language trends, timeliness of grievances and appeals, overturn response. And that's really helpful information for a number of reasons. We as attorney advocates, we use a lot of this information to guide our outreach when we see specific trends in types of grievances that are being filed.

Amira Elbeshbeshy:

I also think it provides an opportunity for us to try to gain a better understanding of the practices and procedures at the managed care plan. And to maybe question some of the practices. A lot of this will be explained with examples, so just bear with me. But here, for example, at one meeting, they had shared data about pharmacy grievances, and I think it was something like over 50% of the denials are overturned at the health plan level, which I found perplexing because it's the same folks that are initially denying are then overturning their own denials more than half the time.

Amira Elbeshbeshy:

And so, it was an opportunity for me to ask how that happens and to understand why that happens. And I was provided an explanation by the presenter. And while the explanation wasn't necessarily helpful, it provided insight into how they do things and it was helpful for my, my practice in offering direct service to clients and understanding

how they process their grievance and appeals. So really helpful. It's also an opportunity to learn about new program changes, how they are implementing, what they're doing towards implementation, any issues, and concerns with the changes.

Amira Elbeshbeshy:

For example, the pharmacy carve-out and the dental integration pilot program. I think the dental integration was just in our county, but that was a big one and a really helpful forum to learn about it. I was aware that historically, our county was severely lacking in Medi-Cal dental providers. And so, at the first meeting, after the integration launched in January, we learned that they had enrolled dozens and dozens and dozens of new dental providers. They had about 70 waiting to be onboarded. We were able to ask questions. We were able to ask what outreach would be helpful in making folks aware of these changes. Just great opportunity for learning and for collaboration.

Amira Elbeshbeshy:

Which leads to the next point. It presents an opportunity for broader discussion because of how many different agencies are represented in the room. We typically have like the Health Plan of San Mateo CEO and the grievance and appeals manager and the IHSS supervisor, the human services agency supervisor. My program meets with these agencies individually on a fairly regular basis, but we don't often meet with them together. And so, it, again, provides an opportunity for us to ask questions that might pertain to more than one agency.

Amira Elbeshbeshy:

Another example here. We had raised concerns with individual agencies about how spousal impoverishment screenings are supposed to happen, and it seems like there's some confusion on the procedure, but when we had met individually with each agency, that's the response we got, like, "No, that's not handled here." And so having everyone in a room created the opportunity for collaborative problem solving rather than just like passing the buck along. So really valuable. Lastly, a big thing I wanted to talk about was, it provides opportunities, not just at the quarterly meetings, but in between meetings.

Amira Elbeshbeshy:

We sometimes get emails where they email the whole group, and its so many different levels of stakeholders that participate in these meetings. So, it's a unique opportunity to solicit feedback from so many different levels on specific things. I think the last one we got was from the Health Plan of San Mateo asking about our input in response to a request from DHCS about phone calls actually for the CCI transition. And as an attorney advocate, I might have an opinion of what might work, but hearing from the consumers who are actually receiving the phone calls and receiving all this mail, it's really helpful to hear how they receive all this and if it's more overwhelming than helpful, and then how to address that.

Amira Elbeshbeshy:

Next slide please. What might help? I will address these individually, but just as a preface, the overall goal I had in mind in coming up with these suggestions was just how to ensure that everyone is participating meaningfully and that everyone who is present on these calls feels empowered to share concerns, suggestions, questions, any other feedback that they have. I just think the goal should be to create the time and the space for meaningful collaboration. These are just some ways I think this could be accomplished.

Amira Elbeshbeshy:

So clearer goals and a mission statement for the purpose of the advisory committee. That might be something that's already in existence, but I joined these committees maybe a year and a half ago as a new member, and none of this information was provided to me. So perhaps there could be some kind of like new member information packets, or even some kind of orientation where we provide examples of meaningful contribution and explain what the roles are so folks do feel empowered to share at these meetings.

Amira Elbeshbeshy:

I'm going to skip two for a second. Dedicated time on the agenda for member input, suggestions, and questions. That, again, goes towards the goal of if there's specific time allocated for member contribution rather than just... Like the agendas for most of the committee meetings I attend are all report outs from various agencies. And I know that's so valuable and there's so many people with so much information to share. I don't know if that's addressed by having more frequent meetings or longer meetings, but I think it would be really valuable to have dedicated time set aside and agenda to create that space for folks to contribute.

Amira Elbeshbeshy:

It's easier for some than others. I know the lawyers in the room know it doesn't take much prompting for us to talk, but not everyone has that empowerment. And so, I think that's really important to make sure we do everything we can. And then the number two, work groups and subcommittees. That's something I'm hoping to discuss in a breakout session. Again, along the same lines of like creating the space for folks to contribute. I think it's much more overwhelming for someone to raise their hand on a call with 50 or 100 people rather than in a breakout session or a smaller group.

Amira Elbeshbeshy:

So, I think that's something that's worth exploring, but I just, unfortunately don't have the huge suggestion there. But again, similar to the breakout rooms and what we will find beneficial from them, I just think it's a different forum. And I think multiple forums and multiple opportunities will ensure that we have the best contribution. So yeah, that's as much- I think I went quicker than I thought, because I was really trying to make up time.

Mary Russell:

Thank you so much, Amira. That was really great. I think it's great. So, we'll transition now to our breakout room discussions. We're going to cut them back just to 10 minutes instead of 15 today so we have time to regroup and report out. So, you will be automatically placed in a breakout room and each breakout room will be staffed with a note taker who will help to pose questions and take notes on the discussion.

Mary Russell:

We would ask that each breakout room choose a participant who will be in charge of reporting out to the larger group at the end of the breakout session. And we will have as many groups report out verbally as time allows. Of course, we can also take that through the chat when we reconvene. Before we head to the breakout rooms, the questions that we will be posing for all of you will be the following. What topics should D-SNP consumer advisory group discuss? What should or who should be included in the D-SNP consumer advisory groups? How can D-SNP consumer advisory groups empower beneficiaries? How can D-SNP consumer advisory groups address barriers to participation?

Mary Russell:

I think we just heard some great insight from our panelists on some of these areas and we look forward to additional discussion and feedback on these thoughts. All right. I think at this time everyone should be getting a popup about what room they will be moving to. And we will see you all back here, let's say 11:22. Thank you, everyone.

Looks like most of us have made it back to the main session. Hope everyone had a productive breakout and really looking forward to hearing people's thoughts about their discussion. All right. Let's think about, our chat has been reopened, let's think about any groups that are willing to go first, chime in first with any observations or some of their thoughts from their group. Jack Dailey, why don't we hear from you from group one?

Jack Dailey:

Hi. Thanks. Group one. Good discussion. I think everyone appreciated the presentations, kudos to the presenters, everyone did a great job. I think some of the things we talked about were setting the agenda and making sure that there's sufficient space in the consumer advisory group meetings for consumer feedback and into consumer engagement, limiting the amount of content presented by the plan and/or other stakeholders drawn into the group to present is really important. I think we also discussed the importance and difficulty getting representation from the broad range of planned members that tends to be, in my perspective, heavy involvement from older adult populations and populations with disabilities, but not as much with other distinct chronic disease groups and/or working adult and youth representation in these meetings.

Jack Dailey:

That is an ongoing, I think, task and challenge for the groups. And then also I think there was a discussion about in terms of the content, making sure that the presentations and

the information shared speaks to the broader array of social services and other impacts that members may be experiencing. So, making sure that you have ample information about food security and how to support and bringing in key stakeholders to present and share information and take feedback as well. So, I think that wraps it up unless anyone else from group one flags anything I miss.

Mary Russell:

That sounds great. Thank you so much, Jack. Next let's go to Leza Coleman. And Leza, if you want to share what group you were with, you should be able to unmute.

Leza Coleman:

Wonderful. I was in group five. As a new participant to this, we did talk about the need for an orientation perhaps prior to the meeting so that we could kind of get a table setting of what the expectations of this group are in terms of what topics should be covered. There was a little bit of conversation about health equity and the coordination of benefits, maybe modeling some of what's going on at the federal level with what is going on at the state level. Again, because I'm new, I'm just faking it. I'm going to call out that our group did not have a bunch of talkers, so we did not have a bunch of lawyers in our group or if we had lawyers, they were very quiet lawyers. So maybe next time, it'll be a more robust conversation.

Leza Coleman:

So, seeing as the new person and I dominated the call of, okay, well what's important to me when we were talking about the, I got to go back to the question, sorry, who should be included? We had a conversation about, should the members or the people that are coming, should they be reflective of the demographics of the consumer participants? And I thought, well, I don't know that we needed to have members who were of a certain age or of a certain gender, but we needed to make sure that we had entities that represented those. And so, in my former life, I was representing the Long-Term Care Ombudsman.

Leza Coleman:

And so, I was thinking in terms of having those advocates there, because they are working with residents that are in this program and it is helpful for them to know what these rules are. Then the third question of empowering the beneficiaries, I think that the suggestion was, when a person is a new enrollee, are they informed about this advisory as just something a person can learn about? But I think probably more important than when you first enroll, because when you first enroll, everybody's happy, it's when a person actually submits a grievance, that might be the best time for them to be informed about the existence of this advisory committee, because that's when they're probably more motivated to participate in something like that.

Mary Russell:

Great. Thank you so much for sharing that perspective. Thank you. Next, let's go to Jane Ogle and Patricio Camacho. I think were in the same group, should be able to unmute.

Patricio Camacho:

Yeah, we were in the same group. Go ahead Jane.

Jane Ogle:

Oh, I was going to say, you go ahead. So first we talked about the importance of having caregivers as well as the other groups that were described in the consumer advisory group. And we talked about really using the consumer advisory group as a vehicle to understand how to communicate benefits and programs more clearly so that people aren't continuing to be confused as they are about the intersection of Medicare and Medi-Cal. And then I'll let Patricio talk about the rest of it.

Patricio Camacho:

Yeah. We also talked about what topics should be included and we talked that it is very important and something that continues to create confusion and delay of services for the members is the coordination of benefits between Medi-Cal and Medicare. And perhaps the plans or specific departments in the plans, they know how that works, but being part of the plan and at the same time being part of going out to the community, they are either, I work for L.A. Care, and we hold the Medi-Cal part or we coordinate the Medi-Cal part for many dual beneficiaries, but many of our members have different Medicare plan.

Patricio Camacho:

Some of those Medicare plans have reached out to me stating, "Well, we don't know how to coordinate the benefits, the Medi-Cal benefits, how my client needs incontinent supply." So, we definitely need to address this issue that continue to repeating itself. We call it balance billing that delays the services for members that in this cases, incontinent supplies, but that might be a draining in financial resources for the family while the services cover coordinated between the two plans. What we talked also is about who should be part of this advisory group.

Patricio Camacho:

We talk about we want the members to be part of that, but a great part of the members, the dual members have a caregiver. So, the caregiver is very important as is the spokesperson and he speaks on behalf and has to learn to navigate this confusing system that a lot of us work in this Medi-Cal industry are still learning how to do that. And obviously, we discussed that, the PCP, so not only just the PCPs, there are staff, because they are the ones that have to coordinate the benefits. Obviously, the help plan representatives or the agents that go around the community, they need to be educated as they, a lot of the time speak on behalf of the members.

Patricio Camacho:

As far as the third point, I believe we didn't get a chance to discuss that because our group was very talkative, and we had a lot of participation.

Mary Russell:

Thank you so much. We really appreciate that. And we're going to shift to the next portion of our agenda, but again, thank you and appreciate everyone's engagement during these breakout sessions. I know it's always very valuable. If there were additional comments that were not able to be shared, feel free to submit them to the info@calduals inbox. And with that, I'll transition to Anastasia to touch base on the Public Health Emergency Unwinding Process. Anastasia.

Anastasia Dodson:

Thank you, Mary. And thank you to everyone for those great report outs. And I can see that there are themes running through. And one of those is that, although nominally the consumer advisory groups are about Cal MediConnect and then in the future about D-SNPs, these are issues that affect all dual eligibles to some degree in the sense of, as you say, clarifying, which benefits are Medicare, which ones are Medi-Cal, how do health plans work together, or if they're two different health plans, how do providers, consumers and health plans communicate with each other about policies?

Anastasia Dodson:

So, it gives us a lot to think about what can we do at the state? And then also what requirements do we have, should we have for health plans and how do we monitor and enforce those requirements? And again, very glad to have the Cal MediConnect Ombudsman here and many others from health plans and consumers and others with great knowledge about all of this, because it is a complex system. And even if we have the policies clarified, communicating those policies out really requires the whole community here. So, thank you. Onto the Public Health Emergency Unwinding, these are the same slides that we have presented in the past.

Anastasia Dodson:

Next slide. A reminder that the COVID Public Health Emergency will end soon. It has not ended yet, we don't have a date, but when it does, then there will need to be resumption of Medi-Cal eligibility redeterminations. And we certainly have a goal of minimizing beneficiary burdens and promoting continuity of coverage for Medi-Cal. There's a coverage ambassador program that you can sign up for. And we want to make sure... Go ahead to the next slide. Right now, the action that we're promoting is for beneficiaries to update their contact information so that when those enrollment renewal packets go out, they're sent to the correct address and then people can respond and make sure that they keep their Medi-Cal if they meet the income level.

Anastasia Dodson:

All right, next slide. These are also the same slides that we have reviewed in the past. I'll go through them quickly and looks like if there's still topics that we had in the beginning of the conversation, we can revisit those. And it sounds like in the future, we

may want to have a deeper dive on some of the Medi-Cal topics related to this so that everybody is... Certainly we want to promote information and we want to promote access for Medicare and Medi-Cal. So, the transition of Cal MediConnect to exclusively Aligned Enrollment D-SNP is coming up January 1st, 2023.

Anastasia Dodson:

Next slide. Key reminder. On the Medicare side, enrollment in a D-SNP or any other Medicare Advantage Plan is absolutely voluntary. All Medicare beneficiaries can choose whether to stay in original Medicare or to elect to enroll in a Medicare Advantage Plan. And there are many types of Medicare Advantage Plans. D-SNP is one type of Medicare Advantage Plan specifically for people who are dually eligible for Medicare and Medi-Cal. Medicare beneficiaries can remain in Medicare Fee-for-Service. They do not need to take any action to remain in Medicare Fee-for-Service or original Medicare. For 2023, beneficiaries who are already enrolled in Cal MediConnect. They will be automatically enrolled in the Medicare D-SNP and Medi-Cal plan. That's affiliated with their Cal MediConnect plan. No action is needed by the beneficiary.

Anastasia Dodson:

We know that in the fall, there are a lot of materials and advertisements that go out to Medicare beneficiaries, including dual eligibles, and there will be notices to Cal MediConnect beneficiaries about the transition, but there are again, no action needed by current Cal MediConnect beneficiaries in order to stay in the same Medicare plan and staying with the same Medi-Cal plan as they're currently in for Cal MediConnect. Next slide.

Anastasia Dodson:

As I said, D-SNP is a special type of Medicare Advantage plan that provides specialized care for dual eligible beneficiaries. There's a contract between state Department of Health Care Services and that Medicare plan that's called a SMAC. And we've been talking in the last six months or so about the state's provisions in that SMAC to have the same type of care coordination that was provided through Cal MediConnect in the D-SNPs.

Anastasia Dodson:

Some technical stuff here. Cal MediConnect plans they have a single contract. The D-SNP, they have separate contracts with Medicare and separate contract with Medi-Cal. But again, it's still the same type of care coordination and the same benefits. Next slide.

Anastasia Dodson:

Exclusively Aligned Enrollment. And I know this is very unwieldy acronym here, but there's some types of D-SNPs that will have only members who are also in that health plan's Medi-Cal plan. And that is very similar to Cal MediConnect. One entity is responsible for both Medicare and Medi-Cal benefits that simplifies care coordination, and it allows plans to better integrate benefits, communication to members, coordination with providers and member materials. Next slide.

Anastasia Dodson:

This is a visual of aligned enrollment on the left. The same organization provides the Medicare and the Medi-Cal benefits. Again, this is under Medicare Advantage D-SNP. On the right, this is example of non-aligned enrollment, which is the case for some folks who have their D-SNP, or it could even be any other type of Medicare Advantage with a particular organization. And then they have their Medi-Cal with a different organization. Just a visual of that. Those two different scenarios. Next slide.

Anastasia Dodson:

In 2023, the Medi-Cal plans in the seven CCI counties will be required to establish exclusively aligned D-SNPs, and dual eligibles can choose whether or not they want to enroll in those plans. If they do not want to enroll in an EAE D-SNP, they don't need to take any action. There's no automatic enrollment, except for Cal MediConnect beneficiaries. They will automatically transition to the EAE D-SNPs and matching Medi-Cal plans. So, they'll stay with essentially the same health plan. In the non-CCI counties, the state law calls for those plans to have this type of EAE D-SNP and matching Medi-Cal plans no later than 2026. Next slide.

Anastasia Dodson:

Again, this transition for Cal MediConnect will happen at the end of this year. December 31st, January 1st. That's when the transition will happen automatically for current Cal MediConnect members. There will be no gap in coverage, and the networks should be substantially similar. There will be notices from Cal MediConnect plans to beneficiaries starting in October 2022. Next slide.

Anastasia Dodson:

These are the opportunities and benefits of the EAE D-SNP. Very similar to the Cal MediConnect approach. Integrated member materials, benefit coordination, integrated provider communications, and simplified care coordination. Next slide.

Anastasia Dodson:

This is more about the integrated care coordination and materials that we've talked about in the past. Next slide.

Anastasia Dodson:

Again, these are some of the benefits of this transition. Next slide.

Anastasia Dodson:

Okay. And then briefly on the look-alike transition. Next slide.

Anastasia Dodson:

These are the same slides we've talked about in the past. Look-alike plans are Medicare Advantage plans that are marketed to dually eligible beneficiaries, but they don't have that same care coordination requirement with Medi-Cal. There's a federal

definition of look-alike plans. And enrollment in these types of Medicare Advantage plans has increased a lot in the CCI counties in recent years because of plan marketing efforts and limits on D-SNP enrollment. Next slide.

Anastasia Dodson:

So, CMS, the federal government is limiting enrollment into Medicare Advantage plans that are D-SNP look-alike plans. So, in the current year, CMS did not allow any new contracts with essentially these types of look-alike plans. And then in 2023, CMS will not renew those contracts. Next slide.

Anastasia Dodson:

So, there is a transition that the federal government is handling to allow a Medicare Advantage organization to transition the D-SNP look-alike members into another MA plan, including a D-SNP that's offered by that same organization or their sort of parent organization.

Anastasia Dodson:

The transition is designed to ensure continuity of care and the cost-sharing protections for dual eligible beneficiaries, and better options for better care coordination for people who are currently enrolled in look-alike plans. CMS, the federal government is working as we speak with D-SNP or Medicare Advantage plans related to these look-alike members to have a crosswalk enrollment. So that it's a seamless transition.

Anastasia Dodson:

Notices will be sent out in the fall. And then January 1st, 2023, that crosswalk will be implemented. And again, it's only for people who are currently enrolled in these types of Medicare Advantage plans. And for the most part, my understanding is that folks will transition to another type of plan, but the same parent organization, on January 1st, 2023. So those notices will go out to beneficiaries in the fall. Next slide.

Anastasia Dodson:

Okay. And next slide. So CalAIM has an initiative to require almost all Medi-Cal beneficiaries to enroll in a Medi-Cal managed care plan. This does not impact someone's Medicare providers or delivery system. If you are already in Medicare Fee-For-Service or original Medicare, choosing a Medi-Cal plan does not have any impact on your Medicare delivery system. If you are already in Medi-Cal and you're choosing a Medi-Cal health plan, that will not change your Medicare benefits for your Medicare providers. Next slide.

Anastasia Dodson:

So, phase one has already occurred. Certain populations have been transitioned from Medi-Cal Fee-For-Service to Medi-Cal managed care. Phase two, which is most dually eligible beneficiaries, will be required to choose a Medi-Cal managed care plan, and that will be effective January 1st, 2023. Again, choosing a Medi-Cal health plan does not change your Medicare. You can be in original Medicare, Fee-For-Service Medicare,

and whether you're in Medi-Cal Fee-For-Service or Medi-Cal managed care, that does not impact your delivery system on the Medicare side. Next slide.

Anastasia Dodson:

Okay. So, any questions? Again, this last topic probably relates to what folks were talking about in the beginning of the meeting, so…

Mary Russell:

Thanks, Anastasia. There are a couple things in the chat so far, and again, if others want to add their question to the chat or raise a hand, we can unmute you. Quickly from Janet. There was a question about the new end date of the public health emergency, which I don't think has been announced yet, correct?

Anastasia Dodson:

That's correct. Right. So just stay tuned. And then as soon as we hear from the federal government, then being on that ambassador's list, you will get the latest and greatest updates there.

Mary Russell:

Great. And then a question in the chat from Kathryn Hedges, she was informed by the county that she is not allowed to remain in her original Medicare and that she would be required to transfer to managed Medicare with the same plan as her managed Medi-Cal.

Anastasia Dodson:

Okay. Well, the information if that's what you were told, that's not correct. And if you have something in writing from the county, then we would like to see that. But it may be a situation of crossed wires or miscommunication because you're basically Medicare choice can be made however you like. Original Medicare, choosing a Medicare advantage plan, that is really at the discretion of beneficiary.

Anastasia Dodson:

If you are already enrolled in a Medicare Advantage plan or Cal MediConnect plan, you may be impacted. Certainly, if you're a Cal MediConnect plan, there will be an automatic transition, but the Medicare choice always comes first. And then the Medi-Cal plan that follows. So, if you have chosen a particular Medicare Advantage plan, then your Medi-Cal plan will automatically align in some counties. But again, your Medicare is a primary payer, primary source of coverage. And, per federal law, that choice is up to you. As to whether you're an original Medicare or a Medicare Advantage plan.

Mary Russell:

Thanks, Anastasia. And thank you for flagging that Kathryn and I was just going to encourage you. I know you've emailed with members of our team, but if you'd like to submit an email, we're happy to connect you with your local ombudsman if that would

help. A question from Kelsey, is the department working on helping to reduce confusion between EAE and non-EAE D-SNP?

Anastasia Dodson:

We are. And one of the things that we're thinking about is this sort of acronym situation EAE, non-EAE D-SNP. So, we're thinking about better ways to describe the difference, but we also know that the information coming from the Medicare plans will be exclusively aligned D-SNP we'll have different member materials to explain the coordination across both sets of benefits. And so that those materials from the health plans should also help to clarify.

Mary Russell:

Great. And I see a hand raise from Susan LaPadula. Susan, would you like to go next?

Susan LaPadula:

Thank.

Mary Russell:

Oh, I think you are back on mute, but you should be able to unmute.

Susan LaPadula:

Hello, Anastasia. How are you?

Anastasia Dodson:

Good. Thank you. How about you?

Susan LaPadula:

I'm well, thank you for asking. My question relates to the SMAC contract in the state provisions. What's the likelihood of eliminating balance billing and require the plans to automate the crossover claims? So, providers do not have to submit a second claim? And that would be specific to skilled nursing facilities, long-term care, and subacute care.

Anastasia Dodson:

Right. Well, that's an issue more broadly even than just EAE D-SNPs and D-SNPs. But we have been talking with health plans about ways to automate that crossover billing, and we know that that's important for skilled nursing facilities. We just wrapped up a different stakeholder meeting on the long-term care carve-in, and I'll find out if there was language and other stuff. All plan letter that's pending, et cetera. So, we'll find out the latest there and get back to you.

Susan LaPadula:

Wonderful. Thank you so much. May I ask another question while I'm here?

Anastasia Dodson:

Sure. Of course.

Susan LaPadula:

Oh, thank you so much. Considering that we have so many meetings, we have our CCI quarterly, our MLTSS and duals monthly. And then we did have the LTC carve-in. Would the department consider joining these meetings together in separating the silos? Because this is really a population that is our elderly. And if we connect the elderly population and the disabled, I think we're going to learn more together going forward in our remaining six months to build infrastructure and to build a two-way loop or a hub also perhaps for when we have to start triaging issues. As you know, fall and the holiday season is coming. And perhaps that's something the department would consider as we look to the last six months of this year and what we're expected to be ready for January 1st.

Anastasia Dodson:

Right. I'm a little hesitant to say combining the meetings, just because in each one, we get into such detail around specific topics that, for example, the long-term care carve-in, goes way deep on certain issues that folks who are more at the broad level around Medicare issues that I think that it would swamp the ability to focus on particular topics in each of the meetings, but we do, within DHCS and with the consultants that support us in these efforts absolutely have internal meetings. And so, on the long-term care, I'm sorry, I don't have it right at my fingertips. But we can certainly provide that information quickly. But rest assured, within DHCS, we're looking across all these areas. Thank you.

Susan LaPadula:

Wonderful. And perhaps we can take a nod from Ben of the behavioral health division, where they're producing weekly, Friday updates in email blast to all of us so that we can stay updated weekly. Perhaps you might consider that as we get closer?

Anastasia Dodson:

Sure. And DHCS even more broadly does have Friday updates. So, yeah. We'll make sure that we're queuing into those updates. Thank you.

Susan LaPadula:

Thank you. Have a wonderful day.

Anastasia Dodson:

You too. Thanks.

Mary Russell:

Thank you, Susan. Anastasia. There's a quick question from Rick Hodgkins in the chat asking if provider asks to bill Medi-Cal and you are in geographic managed care as a Medicare beneficiary?

Anastasia Dodson:

Medicare providers. I'm not totally sure I understand the question, but there are standard billing practices that physicians' offices use on the Medicare side. And they're very used to either submitting the co-insurance bill for folks who have Medi-Cal. They either submit it to DHCS, or they submit it to the Medi-Cal plan. And that's a process that in most counties, the transition has happened, and the providers know that secondary billing goes to the Medi-Cal plan when in the remaining counties for January 1st, that is a process that we are working on at DHCS to make sure that the Medi-Cal plans, and the Medicare providers know about and they're communicating with each other. So that's one of the things on our list in the next couple of months around educating providers. But that's a standard process in the rest of the counties.

Mary Russell:

Great. Thank you. And a question in the chat from Matthew Flake. Can Cal MediConnect member opt-out of enrollment into a Medicare advantage plan?

Anastasia Dodson:

Definitely. Yes. A Cal MediConnect member can choose if they want to stay in their existing Cal MediConnect plan and then automatically transition to the corresponding D-SNP, or they can quarterly dis-enroll from their Cal MediConnect plan, or they can in 2023, if they do remain in transition to an EAE D-SNP, then they can subsequently dis-enroll and go back to original Medicare. There's Medicare rules on when are the enrollment and dis-enrollment periods. And all of those same periods apply whether it's Cal MediConnect or any other type of Medicare advantage.

Mary Russell:

Great. And a question from Tatiana, when will the final list of Medi-Cal managed care plans be posted?

Anastasia Dodson:

Are you talking about for perhaps their re-procurement for 2024? Because 2023, there's no change in the Medi-Cal plans, the current plans, and the 2023 plans. So those Medi-Cal plans are set. 2024, procurement is still being reviewed, and later this year will be announced.

Mary Russell:

Great. Thank you. And I see, oh, Susan, a follow-up on the calendar of MLTSS and duals meetings for the remainder of 2023. And I know we are working to finalize some of those dates, so we can certainly share that as soon as that's confirmed.

Anastasia Dodson:

Susan, you read our minds. We were just talking yesterday and this morning. Okay, let's just post the rest of the meeting dates. So, we'll do that.

Mary Russell:

There you go. Susan, did you have something to chime in on about that?

Susan LaPadula:

Yes, I do. Perhaps I can share what CMS did. CMS recently published the 2023 dates for the public health emergency unwinding, and they provided us one step registration. We registered once, and it populated for all the dates for the rest of the year. Any chance you could look into that?

Anastasia Dodson:

I'll check with Mary about how the meeting registration works.

Mary Russell:

Yeah, we can-

Susan LaPadula:

‘Cause that was phenomenal. That was phenomenal. It was a one step process and our calendars populated for the whole year.

Mary Russell:

Yeah, that sounds very helpful. We can check with our team. I know something that we struggle with is just with DHCS calendars and having consistency with having things on same time, same date, same place, but that's a great flag, and we know it's really important to get these on people's calendars as early as possible. So, thank you for raising that.

Susan LaPadula:

Thank you. I appreciate it.

Anastasia Dodson:

Looks like there is one more question from Matthew Flake. Information sent out to Cal MediConnect members with instructions on how to opt-out of auto enrollment. So, and this is where I don't know if we have perhaps CMS so on, or anybody, Stephanie, but those notices will have information. So just maybe actually the last word if CMS is still on if they want to share anything about that.

Kerry Branick:

Hi, this is Kerry Branick from CMS. Can you hear me?

Anastasia Dodson:

Yes. Thank you.

Kerry Branick:

Oh, great. Apologies, my video is not working today. Cal MediConnect enrollees have the ability and right to choose any other Medicare Advantage plan, or Part D plan or original Medicare like they do today. And the notices for the transition from Cal MediConnect to the integrated D-SNPs in Medicare plans offered by the same organization as their Cal MediConnect plan. Those notices include information about how beneficiaries can choose other ways to receive their Medicare if they so wish.

Anastasia Dodson:

Great. Thank you, Kerry. Okay, Mary, I think that's it. I know we have just a few seconds left.

Mary Russell:

Yeah. Let's just transition to our final slide Anastasia. I wanted to give you a minute to just touch on upcoming meeting topics.

Anastasia Dodson:

Yeah, we will. So go ahead to the next slide. We've got this list, and we're going to try to fit in as many different pieces in the right timing as we can. There's so much that we could talk about and appreciate having breakout groups today because, in some ways, that's a good way to hit many of these topics because they're not in silos, as Susan said. They're all connected to each other. So, again through this meeting and maybe others, try to hit all these topics, and we'll keep putting the updates in the Friday DHCS updates. And thank you all very much for your participation today.

Mary Russell:

Yes. Thank you so much. Thanks to all of our great speakers. Just a quick reminder that the next MLTSS and Duals Workgroup is on Wednesday, July 20th at 10:00 AM. And the next CCI Stakeholder Webinar is Wednesday, July 27th at noon. Thank you all for joining. And we look forward to talking to you soon. Take care.