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

TITLE: Managed Long-Term Services & Supports & Duals Integration Workgroup

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SPEAKERS

Hilary Haycock
Anastasia Dodson
Kerry Branick
Marla Rothouse
Pat Curran
Jack Dailey
Tiffany Huyenh-Cho
Cassidy Acosta

Hilary Haycock:

Welcome and good morning to everyone. We're going to go ahead and get started with some meeting management while folks are still joining. We are excited about this morning's Managed Long-Term Services and Supports and Duals Integration CalAIM Workgroup. We have some wonderful presenters with us today, including Anastasia Dodson, Deputy Director of the Office of Medicare Innovation and Integration at DHCS. Kerry Branick and Marla Rothouse have joined us from the CMS Medicare Medicaid Coordination Office, and we're going to have some wonderful presentations from Pat Curran the CEO of Health plan of San Mateo, Jack Dailey the Cal MediConnect Ombudsman with the Health Consumer Alliance and Legal Aid of San Diego, and Tiffany Huyenh-Cho the Senior Staff Attorney at Justice in Aging, as well as a presentation from Cassidy Acosta the Deputy Outreach Director at Aurrera Health Group, working on outreach for this transition. A few meeting management notes before we begin, all participants are on mute while we're doing presentations, but please feel free to use the chat feature.

Hilary Haycock:

We will be monitoring that throughout the morning and very helpful to get your comments and questions in real time. When we open up for discussion, if you would like to ask a question or provide a comment, please raise your hand and we'll be happy to call on you. The meeting materials, including the slides will be available on the CalAIM website after the meeting. We will post a link in the Zoom chat and hope to get those up soon. As always, we request that folks add your organization's name to your Zoom name, so it appears "Your name, comma or dash, organization." Just helps us when we're doing meeting notes to know who is talking, what perspective you're offering. So, click on the Participants icon at the bottom of the window, hover over your name, click More, and select Rename, and then you can update your name to include your organization. Next, we'll have the agenda for today. We've got a lot of topics to cover, so we'll be walking through this.

Hilary Haycock:

We're going to be talking through Medicare Advantage network requirements around the transition. We will be talking through proposed state-specific Medicare continuity of care requirements for all 2023 D-SNP plans, and this is where we're going to have some panel presentations looking at some Cal MediConnect continuity of care issues and considerations, some lessons learned that we can carry forward into the transition and have a discussion. We'll be providing an update on the Public Health Emergency unwinding, and we're going to be reviewing the 2023 Cal MediConnect to Exclusively Aligned Enrollment D-SNP transition, Aligned Enrollment policies, as well as the D-SNP look-alike transition enrollment policies. And then finally, we will wrap up with a review of the 2023 Cal MediConnect to EAE D-SNP outreach efforts. So, a lot of technical terms in there, but stick with us. We'll walk you through and explain it all and excited to hear from you all and have some great discussions today. With that, I will transition to Anastasia.

Anastasia Dodson:

Good morning, everyone and welcome. Thanks Hilary, and thanks for walking through the agenda. Just a reminder on this workgroup purpose and structure, so we began these meetings over a year ago to serve as a collaboration hub for the CalAIM efforts around managed long-term services and supports and integrated care for dually eligible beneficiaries. We want to have a balance here with these meetings to give you all the latest information from the department about CalAIM and Cal MediConnect transition and MLTSS, and also have opportunities for other presentations and stakeholder discussions so that there's a variety of voices that can contribute and make sure that we hear from everyone. We have a lot of materials that we've posted over the last year or so. Those are on our website. As Hilary said, some of the topics you're going to hear about today are maybe new things that we haven't presented on in the past and then we're also going to be doing some reminders and recapping of topics that we have discussed, because there are a lot of technical details and moving parts.

Anastasia Dodson:

We have our charter and again, we really appreciate our partnership with all of you, advocates, beneficiaries, providers, health plans, caregivers, and our CMS partners. You're all playing a really important role in the transitions that we're making in the upcoming year for 2023, and also even in the current year as some of the topics that we're going to dig into will demonstrate. We have a lot to work on together and we appreciate your partnership. I'll hand it back to Hilary. Thank you.

Hilary Haycock:

Thank you so much, Anastasia. We're going to hand it now over to our colleagues at the CMS Medicare Medicaid Coordination Office for presentation on Medicare Advantage Network Requirements and Transition.

Kerry Branick:

Thanks Hilary, thanks Anastasia. My name is Kerry Branick. I'm joined by Marla Rothouse. We work for the Centers for Medicare and Medicaid Services or CMS, and it's the federal agency that is responsible for Medicare and also Medicaid in coordination with state Medicaid agencies like the department. We both work in the CMS office that focuses on individuals who have both Medicare and Medicaid, the dually eligible individuals. The state asked us to start the meeting today by speaking to the federal requirements for Medicare Advantage health plans, provider networks, and the policies for when beneficiaries transition between health plans. States like California that contract with dual eligible special needs plans or D-SNPs, which is a type of Medicare Advantage plan, those states can add more requirements for the enrollees in those plans. And DHCS is going to, in a great panel, is going to follow our brief remarks to talk about the additional requirements that the state is interested in layering on top of these federal requirements that Marla and I will briefly walk through. I'll turn it over to you, Marla.

Marla Rothouse:

Thank you so much, Kerry. So, the Medicare Advantage network requirements are highlighted on the slide in front of you. CMS looks at a minimum number, a time, and a distance for 27 different provider-specialty and 13 facility-specialties to ensure that 90% of Medicare beneficiaries within the service area have access to our specified standards. Those standards are also posted on our CMS website. For Medicare Advantage, the networks are assessed every three years and whenever there is what we call a triggering event. Triggering events include submitting an initial application or a service area expansion application. Just to recognize and highlight, right now when you submit the application Triggering Event, there is in the proposed rule where the comment period recently closed, a proposal to move the network review back into part of the application, so this may change a little bit in the future. But for now, any entity that is applying for a service area expansion or applying for an initial Medicare Advantage Part D contract will have their Medicare networks checked later this year. I think it's typically in the June timeframe.

Marla Rothouse:

For those of you on the call that may not be familiar with this process, each year, CMS publishes on our website a randomized beneficiary sample file that represents but does not include real addresses for beneficiary locations that the Medicare Advantage organizations and CMS use to determine mapping between the provider and facility locations and those beneficiaries. MA organizations provide to CMS what we call health service delivery tables that identify the providers and facilities by location, national provider identifier, and several other fields we have in those health service delivery tables. We then take those uploads and, through software, map those tables against our standards to generate network reports that identify where the MA organizations are passing or failing our standards. For those health plans that have been participating in Cal MediConnect, the processes are slightly different, and I strongly encourage your organizations and all organizations on this call to review the guidance and take advantage of the ability to pre-check your networks prior to any official submissions.

Marla Rothouse:

All sponsors can use the plan-initiated network check through our health plan management system to check your network at any time. And just so you have a comfort level with that, CMS staff do not have access to see your results on what you submit through the plan-initiated upload. So, there's no chance of you wanting to check your network, seeing that there's an issue, and that we're going to see it as well. It is truly only for the plan's use. Again though, for the Cal MediConnect plans, I want you to really pay attention because in some instances, the standards that have been used through Cal MediConnect are different than the Medicare Advantage network standards overall, and the exception forms that you may have used to request an exception are different than what is used in Medicare Advantage overall. Just so while we are talking about networks as a whole, I don't want to forget about mentioning your Part D pharmacy networks. Those networks are checked during the time of the application and through timeframes that are set forth in other reporting.

Marla Rothouse:

And just for reference for everyone on the call so you understand it, the standards for pharmacy network access is at 42 C.F.R. 423.120. And what those standards are at a high level, for retail pharmacy, at least 90% of Medicare beneficiaries residing in an urban setting have to have access to a network pharmacy within two miles from their home. And at least 90% of beneficiaries residing in a suburban setting have to have access to a network pharmacy within five miles. And then percent of Medicare beneficiaries that reside in a rural setting have to have access to a network pharmacy within 15 miles. CMS also does a separate analysis for those health plans that utilize preferred cost sharing pharmacies to ensure that health plans are not misleading beneficiaries about access to pharmacies that have preferred cost sharing.

Marla Rothouse:

Without going in on further detail on the pharmacy side, I just wanted to note that CMS also looks at the home infusion networks, the ITU or Indian Tribal networks, your mail order networks, and long-term care pharmacy networks. That was a lot on the networks and I'm going to turn it back to Kerry to go through some of the transition requirements.

Kerry Branick:

Thanks, Marla. Next slide please. This slide highlights the regulatory provisions related to continuity of care for Medicare Advantage and Part D. Continuity of care is meant to ensure continued access to care when a beneficiary transitions to a new health plan. There is discretion in the Medicare Advantage continuity of care, but we encourage health plans to look at Chapter Four of the Medicare Managed Care Manual for guidance. Medicare Advantage plans are required to have policies and procedures in place to ensure continuity of care and these include how the plan ensures continuity in situations like when there's a new enrollment or when there's a significant change in a provider network. For durable medical equipment or DME covered by Medicare, health plans are responsible for maintaining continuity of care for enrollees by ensuring uninterrupted access to the medically necessary DME item. This includes when the item needs to be repaired or replaced, and if necessary, the plan must purchase or rent a replacement for the beneficiary to use.

Kerry Branick:

And then lastly for Part D transition, health plans are required to provide a onetime fill and if necessary, longer, depending on the time it takes to change the enrollee's medication to a product that's on formulary or until an exception request determination has been made. Every year in early June, plans submit transition attestations on the Part D side at the same time as the bid and CMS does monitor implementation of those transition policies through a random analysis of prescription drug event data. This has been a summary of the federal requirements of Medicare Advantage, but as I noted before, I think the bulk of today's meeting is to talk about California-specific requirements that have been proposed for 2023 and informed by feedback and experience and Cal MediConnect, so I will turn it over to Anastasia Dodson.

Anastasia Dodson:

Great. Thank you so much, Kerry and Marla. I think many of you may be quite sophisticated in your understanding of how the Medicare requirements are administered and how they relate to the state requirements. But for those who are not, I want to take a quick note to say that what Marla and Kerry went through is again, what the federal requirements are for D-SNPs and also related to what the federal requirements are related to Cal MediConnect plans. In California, in our upcoming D-SNP contracts, we are proposing some state specific requirements around Medicare continuity of care that are in addition to the federal Medicare requirements that Kerry and Marla have just talked about, so hope that's clear. Let's go to the next slide. Again, these are California state specific Medicare requirements that are on top of the federal CMS requirements, and these are also separate from Medi-Cal continuity of care policies. So, the Medi-Cal continuity of care policy that's in all plan letters, there's a webpage on the DHCS website that describes Medi-Cal continuity of care.

Anastasia Dodson:

What we are doing for the D-SNPs in 2023 is looking at the continuity of care requirements that we had in Cal MediConnect, which we worked on together with you stakeholders, health plans, with CMS partners. We came up with requirements around continuity of care in Cal MediConnect that we are going to, for the most part, just move into our D-SNP plan requirements. That is a big takeaway that I want to share with you all, is that the Cal MediConnect continuity of care requirements that we had for Cal MediConnect plans, we're going to apply those same rules to the D-SNPs in California in 2023, and this will be for both Exclusively Aligned Enrollment D-SNPs and the other D-SNPs that are not exclusively aligned. Some of those are affiliated with Medi-Cal plans, some are not. But anyway, that's the big message from this slide.

Anastasia Dodson:

The proposed policy around again, the state-specific Medicare continuity of care policy, and it's going to be in our policy guide, includes the following, and you can see on the slide that upon beneficiary request or other authorized person D-SNPs must offer continuity of care with out-of-network providers to all members if all of the followings circumstances exist and in accordance with, and then there's this Dual Plan Letter 16-002 that I think the Aurrera team can put into the chat. But the requirements relate to the beneficiary having an existing relationship with a primary specialty care provider, and explaining what does that existing relationship mean, that the beneficiary has seen an out-of-network primary care provider or specialty provider at least once or a specialty care provider at least twice during the 12 months prior to the date. Sorry, my little chat box is blocking some of the slide for me, and the provider is willing to accept a minimum payment from the D-SNP based on the current Medicare fee schedule as applicable, and the provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

Anastasia Dodson:

So, these again, are the Cal MediConnect existing requirements that we have in place right now, and we are proposing to carry those over. Next slide. The other piece of the proposed state specific Medicare continuity of care policy is related to members transitioning with existing durable medical equipment rentals to allow them to continue to keep those rentals, the existing rental equipment for the remainder of the rental period authorized by the previous plan or until the D-SNP is able to reassess the member and, if medically necessary, authorize a new rental and have an in-network provider deliver that rental. This is a new policy that we have developed with stakeholders, advocates in particular, who have identified this as a particular issue that needs to be addressed. Again, this is around Medicare covered DME and we have an existing Medi-Cal continuity care policy, but this is for the Medicare piece.

Anastasia Dodson:

In addition, members that are transitioning from Cal MediConnect or a look-alike that have an open authorization to receive Medicare covered medical supplies can continue to use their existing provider for three months, or again, until the D-SNP can reassess the member and, if necessary, authorize supplies and have an in-network provider deliver those supplies. We're really pleased to have developed those again, in partnership with stakeholders and the general provisions that we just talked about, state specific Medicare continuity care policies, those will be in the D-SNP SMAC contract. We've talked about that SMAC contract as between the state, DHCS, and the D-SNP. It will be at a high level in the SMAC contract and then we will have the details in the policy guide. And again, we have all of the details already published through that Duals Plan Letter, so it's only what's on this slide right now that is new policy, that previous slide existing policy, and we will carry it over. With that, let's see, I think we're transitioning to the next panel. I know we're going to have lots of questions, Q&A, and looking forward to that as well.

Hilary Haycock:

Yeah. I just want to say we are going to hold questions and discussion until the end. Now, I am excited to introduce our first panelist, Pat Curran the Chief Executive Officer at the Health Plan of San Mateo. Take it away, Pat.

Pat Curran:

Great. Thanks very much, Hilary and thank you for having me here today. Looking forward to this conversation. What I want to do in just the next few minutes is highlight a couple areas that you see on this slide regarding continuity of care, from a plan perspective. And admittedly, what I'm really doing is it's not a critique of the policy. We're adhering to the policy; we will continue to. We're advocates of continuity of care, but I want to highlight some of the challenges that we face and actually, also admittingly with perhaps a stunning lack of creativity, I don't have any elegant solutions for this. But would love your input on this and look forward to the questions and the dialogue as well. Just to frame this again, really quickly, which leads into the first item I have on my slide about the complexity very quickly, a little bit about Health Plan of San Mateo, I've been

here about six years. Health Plan of San Mateo is a county organized health system. We coordinate all the Medi-Cal services for members in San Mateo County. We've had a D-SNP since 2006, since the beginning of the program.

Pat Curran:

And we've been active also now, 16 years, and also participating in Cal MediConnect from the very beginning and we'll transition into a D-SNP. The other thing to note about our plan is we are perhaps the simplest form of a D-SNP in that again, we're a county organized health system. We take care of all 16,000 duals on the Medi-Cal side. 9,000 of those, about 60% are enrolled in our D-SNP as well, so pretty much, we have a single network. We do not have a lot of delegated relationships. In fact, the only one we have is with Kaiser, which adds an interesting wrinkle to these continuity of care discussions. But very simple. We don't have sub networks, so we try to keep things as simple as possible. We try to remove barriers for members. But leading into the slide, one of the challenges that we have in this continuity care, again, really supportive of the policy, is just the inherent complexity of the process. That it lends itself to, with our plan, about four departments being involved in every single continuity of care transaction.

Pat Curran:

Usually, a member service person is involved, a provider service person is involved, an IT or system person is involved, and a clinical person is involved. And all that is to say that because of that complexity, it's hard for us to standardize how we do that process, which would make things facilitated, which would make them less variable, etc. So, all that is to say is even in our situation, which I think is one of the simplest, there simply is inherent complexity. The second item that is on here is maybe stating the obvious in terms of the enrollment process but creates some of the challenges with continuity of care in that with Medi-Cal enrollment, for us, it's very standardized. We're the only health plan in the county. We receive data from the state. We have standardized enrollment packets. We send new information to members to onboard them, ID cards, everything standardized. For Medicare plans, as you know, it's individually marketed by the plans. So again, for us, we're probably the simplest example and we try to control that process.

Pat Curran:

We employ all of our sales associates, so we do not use brokers in the external community so we can control the messaging. But still even with that, we try to reduce the variability, but inherent in the process is a single conversation, usually between a potential enrollee and a salesperson, which in and of itself just inherently introduces variability in terms of, what is that person promising or what's happening in that conversation, and how is the member hearing that conversation about what their rights are with regard to continuity of care? So again, just the variability of the Medicare plan enrollment process introduces a complexity. The next area is the one that we find introduces problems and it's here in terms of primary care and documentation. Because totally supportive of the idea that's in the current policy and written into the policy to not have barriers for the members. They should be able to call and say, "I'm going to join

this plan. I'm seeing an existing provider. I have existing equipment. I want to continue with that." Totally understand.

Pat Curran:

We don't want to say, "You have to fill out a form. You have to talk to this. You have to get this approval." We don't want to introduce barriers. What usually happens though then is inevitably when we're following up to actually execute on it, the clinicians or others involved want more information and so they're going to say, "Well, what about the clinical documentation? What's the best service? What do we make sure that we incorporate?" So again, not to introduce barriers, but just to learn more to facilitate the process, and that usually doesn't come through. So almost inevitably, we have requests for follow up documentation, just to understand better the situation to try to involve the primary care physician or one of our medical directors, or ideally both, and I'll come back to that at the end. Ideally to involve them in the process as well. Sometimes the documentation ends up being a barrier. It's in the policy, this fourth item about Medicare payment rates. That's great that it's in the policy.

Pat Curran:

Just to let you know, that's one of the biggest challenges that we face is in continuity of care, where providers don't have or don't agree to Medicare payment rates, which sets up a difficult situation for us. Because if they don't have those rates or they don't respond, which I'll get to in the next bullet point, we have a difficult situation to decide what criteria do we use to approve the request, again, if they don't accept the payment rates. If they do, there's usually no problem. If they accept it, we put them in our system and even with the complexity I talked about earlier, it ends up not being a problem. We approve it for 12 months, no problem, and then hopefully there's communication. But if they don't, it presents some challenges, which leads to the last slide or last item on this, is how to standardize this process when it's time sensitive. For example, we have a member having a continuity of care request. Great. We put through and we try to contact the provider so we can get their tax ID information, put them in our system, make sure that everything's flowing correctly.

Pat Curran:

The provider doesn't respond to us. So not only do they not accept, but we don't hear anything from them. Then we hear from the member, saying, "Yeah, but I have an appointment scheduled for next week." We try to outreach to the provider to make sure that they're okay to see the member and they want to do that. They still don't respond to us. How we are within the timeframes, the 30 days and other timeframes, less important the 30-day timeframe that's in the policy is making sure that we meet the member's needs. How do we do that when the provider isn't responding to us and how do we then make that decision, which usually is time sensitive due to the member's needs? So, all that is to say, to wrap this up, it isn't meant to just be a laundry list of challenges, because again, very supportive of the process and look forward to questions and discussion about this. I think if I were to have one nugget that I don't know if you even include in a policy, but if there were one thing that is a common denominator that makes this process work is when there is clinician to clinician dialogue. When we have a

medical director talking to this provider, who's been seeing the member previously for continuity of care, or the primary care physician as well. When there are clinicians involved in that dialogue, there's usually never a problem. When there isn't any of that, that's when some of the variability. And so, again, I don't know how we put that in a policy. Maybe others have great ideas for that, but that's really the best recommendation I would have.

Pat Curran:

So, with that, I'll pass it on, although I did see one question in the chat about how many enrollees we have. So, Health Plan of San Mateo has 150,000 members. We have 16,000 of those who are dually eligible, and we serve all of them for Medi-Cal. Of those 16,000, we serve 9,000 for both Medicare and Medi-Cal services, so people who are dual eligible. I think that was the question in the chat. With that, I'll pass it back and again, look forward to the questions and the discussion.

Hilary Haycock:

Great. Thank you so much, Pat. Appreciate it. All right. I'm going to hand it over to Jack Dailey, from the Cal MediConnect Ombudsman. Jack, go ahead.

Jack Dailey:

Great, thanks so much. I'm happy to be here to talk about this important topic. And I think, I promise you that Pat and I did not get together and coordinate our comments, but I think what was really great about Pat's comments, and I think you'll see some themes overlapping here, is a level of detail he went into about these challenges. And I think on the consumer advocate side, and consumer's perspective, I think we saw that complexity translate itself into delay and frustration on the consumer's end. And so, I think, I really appreciated Pat's comments. I'm going to take you through a couple bullet points here, things that we've picked up over our eight years and then the roles that Cal MediConnect, Ombudsman, and starting there, I think a very basic and elemental item for discussion here is just consumer's awareness of continuity of care options.

Jack Dailey:

And I think this really does go beyond noticing, it really requires all stakeholders to be on the same page as to what continuity of care involves and what's available, and to help educate consumers about these options, especially when they're undergoing a transition of their plan. So, I think that's key. I think the most common barrier faced by consumers when seeking continuity of care, following a plan transition it is when plans and providers could not efficiently agree to an agreement, a single letter of agreement or a one-off contract in order to continue that care. And I think Pat really hit on some really interesting elements from a plan's perspective, why that could be difficult. From our perspective, we often found that providers were not willing to accept the offer, if you will, from the plan. Payment rate is obviously a point of contention. But often I think some of the concerns related to actual or perceived administrative burden that comes with adding on for this one or small group of patients, this additional set of processes that this provider now has to engage in, in order to make that care delivery to continue.

Jack Dailey:

So, I think there's some really key points here that I just wanted to add in terms of where we saw opportunities for success. I think, and Pat hit on this, the frontline member services staff need to be really well trained on not only being able to identify or anticipate continuity of care scenarios when communicating with consumers. Because it won't always bubble up in a conversation with a consumer to say, I would like to request effectuation of my continuity of care rights. It doesn't come out like that. So really training staff and being able to identify the scenarios in which continuity of care may be needed and helpful. And then as to what Pat was speaking about, have very clear processes internally about how that is initiated, and routed, and processed. And as Pat hit on, this hits multiple divisions. And so, I think that complexity on the plan side was really well laid out.

Jack Dailey:

I think where we've seen effective engagement is scenarios in which plans, provider relations, enrollment divisions, clinical staff, even I was really happy to hear Pat talk about the medical director getting involved. When those entities or individuals are involved and engaged proactively in that provider enrollment effort, persistence here wins the day. And low effort passive attempts, routinely fails. So, the idea that some provider enrollment department calls up and leaves a message about an individual's continuity of care request, and opportunity for a letter of agreement, just doesn't usually succeed. Providers are busy, their staff are busy, their plans that have this successfully work, were plans that were very proactively engaged.

Jack Dailey:

And aside from those payment rate negotiations, I mentioned that the either perceived or actual additional administrative burden that providers anticipate from having to engage in these one-off kind of contracting arrangements with plans force, they're not an already a network provider. So, to the extent possible, and I think this is as Pat noted something for continued discussion, continued thought by both all stakeholders, how can this process be more streamlined? What can be done to lower the burden on providers, lower the burden on plans in this process? And I think if we can think about this for the perhaps as other best practices or models that can be shared. And then I think finally, education to outreach providers proactively is really important prior to the engagement of these individual continuity of care and letter of authorization efforts. So, for example, just from the outset, DHCS plans, provider associations, make sure the word is out about these processes and the benefit to the consumer to be able to continue that care, and where there are opportunities to model best practices to reduce those barriers. I think that's really important.

Jack Dailey:

I love that we're talking about the expansion of continuity of care with regards to DME and medical supplies. I think that's fantastic. This is one of the anticipated improvements that we're happy to see in this process. And we're very happy to see the continuation of generous continuity of care term alliance that we enjoyed in the Cal

MediConnect's experience plan. In terms of the anticipated things that we want to look out for and opportunities to engage in the future, I kind of already hit on the idea that I think more thought needs to occur in and around how to make this more streamlined process. So, I think that's one. I think certainly, we largely expect CMC and D-SNP networks to be aligned and overlapping. However, we're really watching for those instances in which that's not the case. And I have a hunch that may happen most where plans relied on some level of delegation into various medical groups or IPAs. And so, we'll be watching those moments carefully for consumers that are having difficulty in that process.

Jack Dailey:

And I think as noted above, I think we really want plans and providers to be encouraged to actively work with patients that are scheduled to transition. So, to the extent that plans and providers know that a patient will be transitioning in the future, that those discussions start early and often to ensure that we are taking advantage of the time in advance of that transition to work out some of these wrinkles. And I think this is going to be in particular important for those that are currently in look-alike plans that are transitioning to D-SNPs, I think to the extent that those plans and those providers can begin speaking with consumers now, about any anticipated transition, and what that will mean for their continued access to care and engagement of this continuity of care process. I think that'll be really important. So, I'll stop there. Happy to be part of this discussion, and hand it back to Hilary.

Hilary Haycock:

Great. And I'm excited to hand things over to our next presenter, Tiffany Huyenh-Cho, from Justice in Aging.

Tiffany Huyenh-Cho:

All right. Thank you, Hilary. Good morning, everybody. Happy to be here. Going last means that my comments will mirror a lot of what Jack and Pat highlighted already in their presentations. I just wanted to highlight a bit, as a policy organization, we are happy to see the Cal MediConnect continuity of care provisions are going to be applied or mirrored in this upcoming D-SNP model under CalAIM. Even with notices, many enrollees are caught unaware when elements of their care delivery change. There are a lot of notices that at go out, continuity of care is not always the front-line paragraph that pops up. So having care continuity protections in place is essential because it allows members health to continue, and not be endangered during plan transitions. For example, allowing dual eligible beneficiaries to retain access to their providers, regardless of whether those providers have contracted with their new plan will mitigate any disruptions to care.

Tiffany Huyenh-Cho:

We're appreciative to hear that the plan networks between the Cal MediConnect and the D-SNP, are anticipated to be substantially similar. And overall, the hope is that the protections put into place will give the plan and the provider enough time to come to an

agreement. And the provider can come into that contract network. Like Jack mentioned, administrative barriers to coming to an agreement or submitting a continuity of care requests, still leaves a lot of improvement, and work that can be done in future iterations as well of these policies. I also wanted to highlight the DME protections for Medicare covered, durable medical equipment. These are really great to see. These protections are an improvement from Cal MediConnect because they did not extend in the same level in the Cal MediConnect plans. To illustrate this point, in the past, continuity of care extended to the durable medical equipment itself, such as medical supplies, but did not extend to the provider of the DME supplies itself.

Tiffany Huyenh-Cho:

And with that, it's critical to have these enhanced protections, because a new enrollee is unlikely to be aware they're established DME suppliers, not a network with their new plan. And they're likely not to learn this fact until they go to refill their DME prescription, or to schedule a repair, or what have you. So, these protections provide additional time to continue to receive the durable medical equipment and enrolling needs until the transition to a new supplier, new equipment can be authorized as needed. And then lastly, on my third bullet point, both what Jack and Pat highlighted continuity of care is a complex process. It's not automatic. It requires either the provider be aware of these protections to submit paperwork, and like Jack really highlighted, there's a lot of administrative burden that comes with that.

Tiffany Huyenh-Cho:

It also puts the burden on the consumer, or their relatives and caregivers, to raise their hand and ask for continuity of care. So, for protections to work, providers must be well educated on the mechanics of how they can participate in care continuity. And the protections must also be easy for both providers and enrollees to navigate, so that they can be taken advantage of. Plans can take a leadership role by elevating these protections through their plan representatives on the telephone, front lines really actively educating new enrollee on these protections. In an ideal world, the burden of seeking these protections would shift away from a consumer or the provider, and plans would have the capacity to identify those members whose providers will not be a network, and the enrollee you would not need to navigate this process. Like others, we really support a streamline process to reduce the burden on all parties. It benefits the consumer itself; it increases retention in the plan, it helps the provider reduce their administrative burden, it keeps established relationship with their parent, and it benefits the plan itself.

Tiffany Huyenh-Cho:

So now we're looking forward to continuing this work and working with DHCS and other advocates on this. And thank you so much for your time, and I'll transition back to Hilary.

Hilary Haycock:

Great. Thank you so much for your comments, Tiffany. Appreciate all of our panel being here today with us. We are going to open it up now for questions and discussions. So, if anyone has questions, they can either put them in the chat, or you can raise your hand,

and we'd be happy to unmute you. We did get one question, direct message to the team. And I thought maybe we would start with Anastasia. Just a request for a little bit more just to review the basics of continuity of care. How does a beneficiary request it? Is there a paper form? And how long does it last?

Anastasia Dodson:

Excellent questions. And I think actually, maybe some of the other presenters could speak to that. I don't know if anybody can walk through a quick example. Maybe Jack or…

Jack Dailey:

Yeah, I'm sorry. I was just adding a resource in the chat there. What was the question? I apologize.

Hilary Haycock:

How does the beneficiary request continuity of care and how long does it last?

Jack Dailey:

Yeah, so I think the idea here is there's no specific form, or requirement, or paper kind of requirement to initiate the process. Just by calling member services is generally the way to go about requesting continuity of care from your plan. Your provider, or your authorized representative, can also help engage that process for you as well. And under this model, it's if both a provider and the plan agreed to a continuity of care letter of authorization, it can last 12 months or longer, depending on the plan's policies. So, I hope that answers the question.

Hilary Haycock:

Perfect. Any other questions from folks? Rick.

Rick Hodgkins:

Yes. I asked this question last week, but it never got answered. I can't remember what we talked about last week. But you can reach out to patients all you want, but have you also reached out to all of the teaching hospitals? Because I get most of my care any way, except for Barton Health up in Lake Tahoe, I get all of my care now through all the teaching hospitals. Have they been educated? Not just on the issue of community care, but through all of the... Continuity of care, but all of everything that we talked about last week, whatever we talked about last week. And again, I asked this question last week, it was never answered even though I-

Hilary Haycock:

No, I think we did answer this in the chat, because I remember that question for sure. And I think this is leaning.

Rick Hodgkins:

Okay, I didn't hear it.

Hilary Haycock:

Oh yeah. I think we just answered it in the chat. We are going to be talking about our outreach work at the end of today's meeting, but absolutely providers and hospitals are the types of providers that we are going to be educating. Not just about continuity of care, but about the full transition. So, it's an excellent question and we, on the outreach side, agree that providers need to be well educated. But I'm not sure…

Rick Hodgkins:

Okay. Because while my computer does talk, it did not say in the chat last week that it was discussed.

Hilary Haycock:

Oh, sorry about that. Yes, apologies. I just didn't want you to think that we had ignored you. But yeah, for sure. Providers and teaching hospitals would absolutely be a part of that outreach effort. Anastasia, if you want to add anything.

Anastasia Dodson:

Yeah. I just want to make sure, because we're doing the agenda today a little bit different than in the past. But usually, we start out by saying that enrollment in Cal MediConnect now, and then the D-SNP in the future, is always voluntary. For Medicare beneficiaries, you can always remain in or transfer back to Original Medicare (fee-for-service Medicare.) There's no requirement for any dual to enroll in a Medicare Advantage plan, or to enroll in a D-SNP. We also want to make sure that you know that the Cal MediConnect of course is not in Sacramento County. It's only in seven counties, and the Exclusively Aligned Enrollment D-SNPs are going to be in those seven CCI counties, where Cal MediConnect has been. So, we are not making any changes, any requirements on the Medicare side, in the non-CCI counties, and in the CCI counties, the changes that we're making are the type of contract, the type of health plan, that Cal MediConnect is transitioning to a certain type of a D-SNP. But any dual can remain in Original Medicare. And this transition is only in the CCI counties.

Rick Hodgkins:

Oh, Okay. Then what changes are being made statewide, then?

Anastasia Dodson:

The changes that are happening statewide are on the Medi-Cal side. So, for dual eligible beneficiaries, the Medi-Cal piece is for long-term services and supports, but Medi-Cal does not impact your primary care providers or your specialty care providers. The Medi-Cal managed care plan right now is voluntary in Sacramento County. It will be mandatory for duals in 2023, but that Medi-Cal managed care plan just works on the long-term services and supports, and some other types of wraparound, or additional benefits that are not your primary Medicare physicians or specialty providers.

Rick Hodgkins:

Okay. Like what kind of services would the managed care cover? That's what I would like to know. I guess, because I hope that I can continue to see my specialists at like let's say UCSF, or Stanford, or Barton Healthcare, for example. What long term service, because the long-term services and supports that I receive right now as we speak, are through the Regional Center, as well as In-Home Supportive Services.

Anastasia Dodson:

Right. So, if you don't mind, maybe we're going to tackle that question a little bit later in the presentation, because we do have some time carved out to talk about the Medi-Cal and Medicare enrollment pieces. And I think Rick, if you don't mind, we're going to focus on continuity of care. But again, for Sacramento County duals, and really statewide, there's no requirement to enroll in a Medicare Advantage plan. You can keep your Original Medicare, your Fee-for-Service Medicare, there's no mandate there.

Rick Hodgkins:

OK, good.

Hilary Haycock:

There's a question from Stephanie Fajuri, at Center for Health Care Rights, about whether beneficiaries will be notified if their PCP is not in the new D-SNP plan network. So, I wasn't sure if Kerry just wanted to speak to the notices that are going to go out, and what information will be provided to beneficiaries.

Kerry Branick:

Sure. So, we are doing some beneficiary testing on those notices now, to get feedback. And we'll be sharing with making them public later this spring. And have gotten a lot of feedback on draft notices earlier this year. The notices themselves will not indicate beneficiary level information on whether your specific provider is in network or not in network. So, instead there is language encouraging beneficiaries to reach out to their plans when they receive the notices to talk with them, if there are any concerns about providers being in network or out of network. There are requirements that by the fall that the plans have provider directories posted and available for beneficiaries. So, that's another way that someone can check to see whether providers are in network in the receiving D-SNPs as well.

Hilary Haycock:

Thanks, Kerry. Appreciate that. There is a question from a plan. We'll take it, but I will just remind folks that we have multiple plan calls every month. And so, we try to reserve plan questions for those meetings. We have a little bit more time on this though. So, the question is, are the continuity of care provisions being discussed, being implemented statewide for all D-SNPs or just exclusively aligned D-SNPs?

Anastasia Dodson:

Yeah. We're proposing that this be for all D-SNPs, because well, first of all, they're important beneficiary protections. And with the transitions, again we're going to talk about later in the presentation D-SNPs look-alikes, and other movement going on for 2023 especially, we think it's important to provide those protections. And frankly, it's a good policy that we could have previously applied to D-SNPs. Again, thinking about the D-SNPs that are not connected with the Medi-Cal plan, what is the role of DHCS on D-SNPs that's been changing and expanding over the last year. So, we think it's a particularly good time for 2023 to implement this policy for all D-SNPs.

Hilary Haycock:

Right. Well, I think that wraps up the questions we've received in the chat, and otherwise on this topic. So, I just want to thank again all of our panelists for participating today, and offering their perspectives, and we will transition to our next topic. The Public Health Emergency Unwinding. So, I'll pass it to you, Anastasia.

Anastasia Dodson:

Thank you, Hilary. And I want to echo what you said, Hilary, what an interesting discussion. I've learned so much and get so much more understanding from the discussions with our partners here. So, thank you all. So, this is a little bit of a different topic than we have previously talked about in this workgroup, but I want to just spend a couple of minutes talking about the unwinding of our public health emergency. As you're probably aware, it's possible that in the coming months we will have a change in the... So sorry, the back up with the federal assistance programs that have been provided under the COVID public health emergency. There has been a pause on Medi-Cal eligibility redeterminations. And that applies to Medi-Cal only folks as well as dually eligible folks. So, in the federal requirements for the public health emergency, when those expire, and we don't know the date for sure yet, but upon expiration, then there will be a resumption of medical eligibility redeterminations. So, this is to talk a little bit more about what the department's next steps are there. So go ahead to the next slide please.

Anastasia Dodson:

So, we're calling it the unwinding. That's the term of art that people have used for when the special provisions, particularly around Medi-Cal, will be transitioning away from the public health emergency scope back to regular Medi-Cal eligibility requirements. It can't all be done in a day. There's a lot of redeterminations that need to take place, going back to the usual process. So, we are concerned that a large number of Medi-Cal beneficiaries could lose their coverage because of the resumption of redeterminations in particular, because there's been a number of people who may have moved in the last couple of years. And because we have not been disenrolling people from Medi-Cal, due to the public health emergency, we are concerned that there may be people who will lose coverage once the redetermination starts. So, we want to minimize beneficiary burden, and promote continuity of coverage for beneficiaries. So, we are asking all of you and your colleagues, your colleague organizations, everyone to become a DHCS Coverage Ambassador.

Anastasia Dodson:

There is an outreach toolkit that is on the DHCS website, and there's a DHCS Coverage Ambassador webpage, and you can join the DHCS Coverage Ambassador mailing list, to receive updated toolkits as they become available. Go to the next slide, please. So, the first phase, so we have a DHCS communication strategy around the upcoming resumption of redeterminations. So, phase one, will be to encourage beneficiaries to update their contact information. That is launching immediately. We will have a multi-channel communication campaign to encourage beneficiaries to update contact information with county eligibility offices. As you all probably know, it's the county eligibility offices, county social service agencies that redetermine Medi-Cal eligibility and beneficiaries when they move, change their contact information. They should keep the county office informed. There are going to be flyers in provider and clinic offices, social media, call scripts and website banners available for all of you to see and use in your interactions with beneficiaries to encourage beneficiaries to update their contact information.

Anastasia Dodson:

The next phase will be for those renewal packets to start going out in the mail. Please remember to, again, remind folks to update contact information so that those renewal packets go to the correct address. The renewal packets are going to launch 60 days prior to the public health emergency termination so we're asking that you remind beneficiaries to watch for renewal packets in the mail and update contact information with the county office if they have not done so yet. But, again, right now we're in Phase One, trying to get the word out for beneficiaries to update their contact information with the counties, make sure that information is up to date.

Anastasia Dodson:

You'll see on the website other information around actually getting information from health plans being sent to counties as well. There's a lot of work being done with all of our partners. But, with that, we're going to keep moving and you'll hear this same update at every meeting because we really think it's important to make sure people keep their Medi-Cal eligibility.

Anastasia Dodson:

All right. The next part of the presentation is going to cover topics that we have previously covered in other webinars, but we have had questions coming in on those previous webinars. And so, we want to make sure that we're hitting all the key points again and answering all of the questions. All right. First, the transition from Cal MediConnect to D-SNP Exclusively Aligned Enrollment. A reminder that beneficiary enrollment in a D-SNP or other Medicare Advantage plan is voluntary. Medicare beneficiaries may remain in Medicare Fee-for-Service or Original Medicare, and they do not 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 Medicare D-SNP and the Medi-Cal plan that are affiliated with their Cal MediConnect plan. There's no action needed by the beneficiary. We have, of course, talked about this but, again, there will be notices to Cal MediConnect beneficiaries that will go out in the fall to make sure that... And we're working very hard to make sure that those notices are in plain language but, again, there's an automatic crosswalk process for Cal MediConnect beneficiaries to be automatically enrolled in the D-SNP and the Medi-Cal plan that are affiliated with their Cal MediConnect plan.

Anastasia Dodson:

Next slide. As you probably know, D-SNPs are a type of Medicare Advantage plan that provide specialized care for dual eligible beneficiaries. D-SNPs must have a state Medicaid agency contract or SMAC with the state Medicaid agency, DHCS, in California. DHCS can choose whether to contract with specific D-SNPs and there is state statute that gives us certain boundaries by which we can operate in as far as contracting with D-SNPs. A D-SNP is somewhat different than a Cal MediConnect plan. The Cal MediConnect plan is a single contract for both Medicare and Medi-Cal benefits and it's a three-way contract between federal government, the state, and the health plan.

Anastasia Dodson:

The D-SNP has a separate contract with CMS and a separate contract with DHCS. D-SNPs include Medicare benefits, and they coordinate the Medi-Cal benefits. Technically, that is the difference between a D-SNP and a Cal MediConnect plan. But, in practical terms, our expectations of the plans, and this is hand in hand with our CMS partners, is that the beneficiary experience beneficiaries transitioning and then newly joining our special type of D-SNPs will be very similar to Cal MediConnect plan experience.

Anastasia Dodson:

Next slide. This special type of D-SNP you've heard me say is Exclusively Aligned Enrollment and that is a state policy that limits a D-SNP's membership to only individuals with aligned enrollment. What that means in practical terms is that this particular type of D-SNP only has members that are also in their matching Medi-Cal plan. Again, Exclusively Aligned Enrollment D-SNP is like Cal MediConnect, there's one entity that's responsible for both Medicare and Medi-Cal benefits that simplifies care coordination and allows the plan to better integrate benefits, communications and member materials.

Anastasia Dodson:

Next slide. A quick visual, aligned enrollment is when the beneficiary has the same organization for their Medicare and their Medi-Cal benefits, the same plan. If a beneficiary chooses to receive Medicare benefits through a D-SNP Medicare Advantage plan, they have to receive their Medi-Cal benefits from an aligned Medi-Cal plan. This aligned enrollment is only operable in certain counties, but it does provide a much better

level of care coordination and benefit integration. We think this is an excellent model. CMS has also been working on proposed role around this type of model, and it's the type of approach that can serve dual eligible beneficiaries very well.

Anastasia Dodson:

Next slide. For Exclusively Aligned Enrollment D-SNPs in 2023, in the CCI counties Medi-Cal plans are going to be required to establish these EAE D-SNPs and dual eligible beneficiaries can choose to enroll in those plans among other options. Cal MediConnect beneficiaries will automatically transition to these EAE D-SNPs and the matching Medi-Cal managed care plans January 1st, 2023. This is only in the seven CCI counties. The Cal MediConnect demonstration authority will end December 31st, 2022. You've heard me say we're putting our heart and soul into a smooth transition for Cal MediConnect beneficiaries so that there's no technical glitches, enrollment materials are clear, plans, advocates, beneficiaries, everybody is on the same page and that those D-SNPs will continue to provide the same level of integration in 2023.

Anastasia Dodson:

In non-CCI counties, our plan is for these types of D-SNPs, these EAE D-SNPs, to be launched no later than 2026. We're not going to get into too much detail on the call today. We are working with CMS and having conversations with health plans to begin that planning process for 2026 in the non-CCI counties. But, again, any type of Medicare Advantage D-SNP is voluntary enrollment.

Anastasia Dodson:

Next slide. For the 2023 transition, again, CCI and Cal MediConnect, they will continue until December 31st. And then, on January 1st, beneficiaries and Cal MediConnect plans are automatically transitioned. There will be no gap in coverage and the provider networks should be substantially similar. As we talked about earlier, there's continuity of care protections. Beneficiaries will begin receiving notices from their Cal MediConnect plans starting in October 2022.

Anastasia Dodson:

Next slide. The benefits and opportunities in this approach we've been talking about. Similar to Cal MediConnect, there's one entity that's financially responsible for both Medicare and Medi-Cal benefits. This actually provides greater incentives for health plans to provide community supports for duals because they are able to manage the full suite of benefits and providing those community supports can be more cost effective if they're also responsible for Medicare expenditures. Integrated member materials are permitted by CMS, and we are working on those.

Anastasia Dodson:

Benefit coordination across Medicare and Medi-Cal is permitted by CMS. We are working on those. Unified plan benefit package, coordinated at administration, DME unified process and integrated appeals. We may not have 100% of those benefit coordination components in 2023, but we will continue working on them and get them

into the D-SNP model as soon as possible. Integrated beneficiary and provider communications are permitted. Of course, there's simplified care coordination so that a single care coordinator can look across both sets of benefits, identify the needs and match up to services to those needs.

Anastasia Dodson:

Next slide. For integrated care coordination and materials, again, enrollment in the Medi-Cal plan and the Medicare plan that are owned by the same parent organization allows similar integration as in Cal MediConnect. The integrated materials are a benefit of these Exclusively Aligned Enrollment D-SNPs. Having one health plan card, one number to call for both Medicare and Medi-Cal benefits. The other D-SNPs, again sorry for all the acronyms, the non-EAE D-SNPs, those that are not paired up hand in hand with a Medi-Cal plan, they do not have the sort of one card, one number integrated materials. Even though we have care coordination requirements in regular D-SNPs, it's those Exclusively Aligned D-SNPs that really have the much higher level of care coordination and integration.

Anastasia Dodson:

Next slide. Again, the benefits of this transition, matching Medicare and Medi-Cal plans will help beneficiaries with all of their needs coordinate benefits. With this transition, beneficiaries will continue to have access to a provider network that will include similar providers, the same or similar providers. The matching plans will be responsible for helping beneficiaries find a new doctor if they transition and somehow their provider does not. But I also want to flag that, again, back to continuity of care. There are continuity of care provisions and providers enter and leave networks on the Medicare and the Medi-Cal side at different points throughout the year anyway. And so, continuity of care is an important protection for that. Beneficiaries will not pay a plan premium or deductible when they get services from a provider in their health plans network. If the provider's not in the network, again, there's continuity of care.

Anastasia Dodson:

Next slide. That, again, is a recap of what we have been talking about with exclusively aligned enrollment. Going to touch on the Medicare aligned enrollment in the non-CCI counties. These are slides that we have talked about before, but just to recap again. The matching plan policy or aligned enrollment, the concept is Medicare is the lead plan. Duals who are enrolled in a Medicare product must be enrolled in a matching Medi-Cal managed care plan if one is available. That is the overarching structure of aligned enrollment or matching plan policy.

Anastasia Dodson:

Next slide. Right now, in 2022 and ongoing, there are 12 matching plan counties or aligned enrollment counties where the Medicare plan choice determines the Medi-Cal plan, and that's at the Medi-Cal prime level. We'll get to the prime delegate in just a sec. In the counties that you see up there on the slide, Alameda, Contra Costa, Fresno, et cetera, in all of those counties, if a beneficiary chooses to enroll in a Medicare

Advantage plan, including a D-SNP, that plan choice, then our computer systems will look to see does that Medicare plan have an affiliated Medi-Cal plan? If so, then the Medi-Cal plan choice will be determined by the Medicare plan choice.

Anastasia Dodson:

This is currently at the prime level, which means in two plan counties, there's a local initiative and a commercial plan. That's where the Medi-Cal plan aligns to. And then, there are processes by Medi-Cal plans where they can continue to the delegate level and delegate the Medi-Cal enrollment at the delegate level that currently does not necessarily match the Medicare plan. But in 2023 in the CCI counties, it will. That's what that next bullet is saying so that, again, in Los Angeles, some of the other large counties in CCI counties, when there are Medi-Cal delegate plans, then that Medicare choice will then drive the Medi-Cal choice at the delegate level for full risk medical plans.

Anastasia Dodson:

And then, in 2023, the policy will remain the same in the non-CCI counties where aligned enrollment continues at the Medi-Cal prime level. We have gotten a number of requests for the notice and for a more detailed description and county by county kind of layout of how this works. We are busily working on the full description county by county and to have the notices posted all in one place on the DHCS website. We hear you wanting to get more details, and have it fully mapped out so we will do that. Thanks for your patience on that. All right, next slide.

Anastasia Dodson:

The D-SNP look-alike plan transition, that's a piece that, again, is very pertinent, timely, with this year. It just happens that we have a lot of transitions going on in anticipation for 2023.

Anastasia Dodson:

Next slide. We have talked about what D-SNP look-alike plan is. These are Medicare Advantage plans that are not actually D-SNPs. They are marketed to dually eligible beneficiaries, but these Medicare Advantage plans do not have any kind of a contract with DHCS. We do not have any care coordination requirements for Medi-Cal benefits, integrated care or joint enrollment with these particular Medicare Advantage plans called D-SNP look-alikes. The federal government, CMS, has described look-alike plans as being Medicare Advantage plans that have 80% or more of their members eligible for Medi-Cal. They mostly serve dual eligible beneficiaries, and that's how they have been identified by CMS. However, again, they do not meet our D-SNP integration requirements. There's no care coordination requirement, no information sharing requirement, et cetera.

Anastasia Dodson:

What we have seen, particularly in California, is that enrollment in these look-alike plans has increased significantly in CCI counties because of the marketing efforts and the limit on D-SNP enrollment in those counties. When Cal MediConnect was established, there

was the awareness that Medicare Advantage is a competitive market, particularly in some of the larger counties and that we wanted to limit the sort of D-SNP opportunities because Cal MediConnect, our demonstration would provide the most integrated type of care. Exclusively aligned enrollment D-SNPs were not on anybody's mind back in 2014. With that thinking in 2014, we limited new D-SNPs in the CCI counties and, again, it's a market conscious type of industry. Medicare Advantage, there's been a lot of marketing to duals for these D-SNP look-alike plans and that led to significant growth in the D-SNP look-alikes in CCI counties.

Anastasia Dodson:

To address that, CMS... I think let's go to the next slide. CMS issued regulations that limit enrollment into Medicare Advantage plans that are D-SNP look-alikes. Starting in 2022, that's this year, CMS has not entered into contracts with new Medicare Advantage plans that project 80% of their enrollment will be entitled to Medicaid. Basically, no new D-SNP look-alike plans in the current year. And then, for 2023, CMS will not renew contracts with Medicare plans that have enrollment of 80% or more dual eligibles.

Anastasia Dodson:

There are certain exceptions for relatively new Medicare Advantage plans with small enrollment but, in general, there are a number of Medicare Advantage plans in California that have contracts right now and have membership that will need to be transitioned. They are D-SNP look-alikes. They have a large majority of their members are dual eligibles, but they do not have SMAC contracts with DHCS. They do not have any type of care coordination requirements with Medi-Cal and many of them are not managed by parent organizations that also have a Medi-Cal plan. They have no formal arrangement with Medi-Cal, Medi-Cal managed care, and they are not providing the care coordination that the D-SNPs and, particularly, our Cal MediConnect plans do with regard to Medi-Cal benefits. This has been an important consideration for how we're planning for the upcoming years. Last year's trailer bill language addressed the transition issues here.

Anastasia Dodson:

Next slide. With regard to transition, the federal government will permit a Medicare Advantage organization to transition its D-SNP look-alike membership into another Medicare Advantage plan or plans, including a D-SNP that's offered by the same Medicare Advantage organization or another Medicare Advantage organization that shares the same parent organization. Essentially, there is a crosswalk process. There is a transition process that CMS has developed and will be working on with each D-SNP look-alike plan. Everybody here shares the same interest across the state, the federal government, Medicare Advantage plans, which is to have a smooth transition for beneficiaries in these look-alike plans.

Anastasia Dodson:

The Medicare calendar for this process is, frankly, heavily underway. There's a process by which Medicare Advantage plans indicate interest for the upcoming contract year. And then, at a certain point in the calendar, they indicate what their benefits would be, how their Medicare Advantage plans will be structured for the upcoming year. Right now, D-SNP look-alike plans and, frankly, all D-SNP Medicare Advantage plans are in the process of developing what they will be submitting to CMS and CMS will then review those and our understanding, I don't want to speak for CMS, but our understanding is that CMS will be having conversations with D-SNP look-alike plans in order to, again, facilitate a smooth transition.

Anastasia Dodson:

We all want continuity of care and cost sharing protections for dual eligible beneficiaries and better options for people that are enrolled in look-alike plans. Again, CMS will work with the D-SNP look-alike plan to facilitate a crosswalk enrollment of their members to D-SNPs or other MA plans. We don't have kind of the agenda scoped out to have a real detailed breakout as to how plan benefit packages compare with each other, D-SNP look-alikes and MA plans. But, just for your awareness, we want you to know that CMS and, to a certain extent the state, are engaged in looking at that.

Anastasia Dodson:

Again, we all share the same interest of making sure that there's a smooth transition and that there's little to no disruption and that, again, part of why we have the continuity of care provisions that we are proposing to apply both to exclusively aligned and, frankly, all D-SNPs is in recognition of this population so that these transitions can go smoothly. There are requirements on D-SNPs to have continuity of care for their new members who are coming over from Medicare Advantage D-SNP look-alike plans.

Anastasia Dodson:

With that, I know there's a lot of terminology. I'm not sure, Hilary, if there are any questions, this is material that we have gone over in the past, but we're trying to do it a little more slowly here just to make sure we're being clear.

Hilary Haycock:

Yeah. I think we were going to have Cassidy do their presentation on the outreach around the transition. And then, after they are done, we will open it up because we do have some questions in the chat. Hang with us for just a little longer, folks, and then we will open it up. Thanks so much. Cassidy.

Cassidy Acosta:

Thank so much, Hilary. As Anastasia mentioned earlier, the next handful of slides may be familiar to folks, specifically to those who joined this workgroup in November. We've received a lot of questions about outreach, and we wanted to make sure that we can bring this information back to this group and, hopefully, answer some of those questions.

Cassidy Acosta:

With that, we can go ahead and move to the next slide, please. Great. Thank you so much. Before we jump into our plan provider and partner outreach for the 2023 Cal MediConnect transition and D-SNP enrollment, I want to briefly recap some of our Cal MediConnect outreach in the prior years.

Cassidy Acosta:

Overall, we targeted three audiences, beneficiaries, advocates, and professionals and providers and, generally, our outreach included educational presentations and webinars, hosting and staffing health and resource fairs and creating tailored messaging and materials for these audiences. We took multiple approaches to reach these target populations, and a few examples include offering provider webinars for physicians and their staff who might be unable to join in person, facilitating county-based communications workgroups to connect with local stakeholders, as well as joining local collaboratives to make sure that we reach advocates and other professions. Next slide, please.

Cassidy Acosta:

Now, considering our previous Cal MediConnect outreach, we are able to identify successful strategies for future outreach and engagement activities. Some of these successful strategies include building and strengthening relationships with community stakeholders, such as through the county-based communications workgroups and other local collaboratives creating accessible outreach materials to ensure beneficiaries can easily access information about the health care options and informing community based organizations and social service providers about the Coordinated Care Initiative and the Cal MediConnect program so that they have the knowledge necessary to accurately educate the dual eligible beneficiaries they serve.

Cassidy Acosta:

We also conducted outreach to providers, and this specifically included tailoring messaging and materials for that audience, and then partnering with health plans to deliver that messaging, encouraging stakeholder feedback and participation when developing these materials and, of course, using both in person and virtual approaches to reach a variety of audiences. Next slide, please.

Cassidy Acosta:

Now, with these promising practices in mind, we developed three strategic outreach goals for the 2023 Cal MediConnect transition and new D-SNP enrollment. The first is that we will educate providers and community-based organizations about Exclusively Aligned Enrollment D-SNPs or EAE D-SNPs. We're targeting these audiences specifically as they are typically viewed as advisors to beneficiaries on a variety of topics including their healthcare. Our goal is to equip providers and community partners with the information and tools they need to help beneficiaries they serve, both through the transition and with new D-SNP enrollment.

Cassidy Acosta:

Additionally, we will continue to build and strengthen our relationships with key community stakeholders, and that includes HICAP, the Ombudsman, health plans, long-term services and supports providers, county agencies and, of course, other community-based groups. Lastly, we hope to increase understanding and participation in integrated care, and we hope to establish stakeholder buy-in for the initiative.

Cassidy Acosta:

Next slide please. Great. The plan, provider, and partner outreach strategy includes three main components. First, we'll take a look at the audiences of focus, which includes provider and community-based organizations. Then, we'll explore planned outreach activities which will be used to reach these audiences. This includes things like presentations, communication workgroups, collaborative meetings and, of course, other outreach events like town halls and health fairs. And then, we'll wrap up our discussion on the outreach strategy by discussing outreach materials like FAQs, slide decks, toolkits, fact sheets, and contact sheets. Over the course of the next few slides, we'll talk about these in a little bit more detail. With that we can go to the next slide please. Again, we have two primary audiences of focus. Providers and community-based organizations. However, each of these broad categories includes different populations.

Cassidy Acosta:

For example, on the provider side, we will not only target physicians and their office staff, but also LTSS providers, medical social workers, community health workers. We also plan to target those hospitals and clinics and other populations as we identify them.

Cassidy Acosta:

Then on the right side of our screen, we have our community-based organizations. Primarily this outreach will be to reach agencies that support or provide services to seniors and adults with disabilities who are dually eligible for both Medicare and Medi-Cal. This can include area agencies on aging, HICAP, independent living centers, senior centers, disability programs, a variety of social service agencies, and of course the county departments on aging.

Cassidy Acosta:

Next slide please. Great. Now this slide breaks down the planned outreach activities that I mentioned earlier, which will be used to reach providers and community partners and inform them about the Cal MediConnect transition and new D-SNP enrollment.

Cassidy Acosta:

First, we have educational presentations. These are going to be offered as a way to reach small, targeted audiences such as individual physicians’ offices and staff from community organizations. We're also interested in hosting regional town halls and partnering with key community stakeholders such as the health plans, HICAP, ombudsman, et cetera, in order to share this information about the transition and new D-SNP enrollment.

Cassidy Acosta:

In addition, we will continue to facilitate county-based communications workgroups to hear stakeholder feedback. We want to encourage participation in material developments and conduct other outreach activities with these groups as needed. We also hope that this will help strengthen local partnerships and support collaboration with community agencies.

Cassidy Acosta:

Then similar to our communications workgroups, we also want to participate in local collaboratives and stakeholder meeting to strengthen relationships with stakeholders. These meetings are hosted by other entities so our participation can include things like delivering outreach reports or sharing educational information and materials about the transition, as well as the new D-SNP enrollment.

Cassidy Acosta:

We're also planning to participate in outreach events and that includes things like health fairs and conferences that are aimed at reaching providers and community partners. This can include attending healthcare related conferences or staffing outreach tables at these events.

Cassidy Acosta:

Then lastly, I'd like to briefly highlight the beneficiary outreach, which is the final point on this slide. This is generally a separate effort. It's led by the health plans in partnership with providers and community-based organizations. But DHCS and CMS will provide overall support as needed.

Cassidy Acosta:

We want to acknowledge that beneficiaries need accurate information about their health care options and our goal is to reach the people they trust so that they can provide guidance on a beneficiary's health care. Next slide please.

Cassidy Acosta:

Thanks. Lastly, we have our planned provider and partner outreach materials. We've heard a lot of questions about outreach materials, so I'm hoping that by providing this overview again, we can help answer some of those questions.

Cassidy Acosta:

To start, we have our slide decks. Slide decks will provide a brief overview of CalAIM and then we'll include details about the new D-SNP enrollment and Cal MediConnect transition. They'll be used to provide presentations to educate providers and community organizations.

Cassidy Acosta:

We are currently working on our first outreach slide deck, and we hope to begin providing presentations to providers and community partners really soon. We are also in the process of developing a provider and community partner FAQ. This is being developed in partnership with the local communications workgroups. The FAQ is specifically tailored to medical providers, social workers, service providers, and community-based orgs to help answer their common questions relating to the D-SNP expansion and Cal MediConnect transition.

Cassidy Acosta:

The FAQs will also help us develop toolkits for these audiences. Toolkits will provide detailed information about new D-SNP enrollment and the Cal MediConnect transition. Our goal is to create a document that can be easily separated into specific inserts so our target audiences can use them as needed. We also plan to include some talking points and materials in the toolkits for providers and CBOs to share with the beneficiaries that they serve.

Cassidy Acosta:

Of course, we also have fact sheets. Another great tool for summarizing information to share with specific audiences. In this case, they'll be tailored to specific stakeholders including HICAP counselors, physicians, caregivers, beneficiaries, and others. And they will provide details about the benefits of exclusively aligned D-SNPs and MCPs in a concise and accessible format. We know folks have been really interested in fact sheets, so we appreciate your patience while we work on them.

Cassidy Acosta:

Then contact sheets might also be created. However, these are mostly helpful for our communications workgroups as they help identify key players in a county like the health plans, ombudsman, and HICAP.

Cassidy Acosta:

Now, we know folks are really excited about outreach materials. We are too. But we need to wait until policy is finalized before releasing any of the materials to the community. It's really important to us that we don't confuse providers and community partners and so we want all information to be accurate and up to date as possible before sharing it in these formats.

Cassidy Acosta:

Next slide please. That wraps up the overview of our plan provider and community partner outreach strategy. Before we conclude this section and move into Q & A, we just wanted to provide and share some contact information so if you or a beneficiary you serve has any questions about the current healthcare options available.

Cassidy Acosta:

Of course, you can contact HICAP, the Health Insurance Counseling and Advocacy Program to access free counseling on healthcare coverage. Someone can also contact

the Health Care Options if they'd like to join our change plans. If a beneficiary is in Orange or San Mateo, they should contact the Medi-Cal Managed Care plan directly.

Cassidy Acosta:

Then lastly, if a beneficiary has any issues resolving problems with their provider or their health plan, they can always reach out to the Cal MediConnect or Medi-Cal Managed Care Ombudsman. With that, I will turn it back over to Hilary. Thanks so much.

Hilary Haycock:

Thanks so much, Cassidy. All right. We are going to open things up for discussion and comment. I see we've already got one person raising their hand. I think we're going to go to a couple questions in the chat.

Hilary Haycock:

First, I'm just going in rough order. We have a question from Karen Widerynski with the California Association of Health Facilities, CAHF. Can we review how plans will need to proceed with contract amendments for providers? Will plans need new contracts for their providers?

Anastasia Dodson:

On the Medicare side, that is I would say the purview of the medic... You're talking about for D-SNPs. There's a whole set of requirements and processes on the Medicare side.

Anastasia Dodson:

I'm not sure if Kerry or others want to weigh in, but we also have a plan workgroup. But if there's a particular piece on the Medicare provider contracts that you're curious about, we'd be happy to help.

Anastasia Dodson:

On the Medi-Cal side, part of what's transitioning here for the Cal MediConnect plans splitting back to a Medi-Cal contract with DHCS and a Medicare contract with CMS for Medi-Cal providers like nursing homes and other types of Medi-Cal providers, the same existing Medi-Cal contract process provider contracting process, those rules would then apply.

Hilary Haycock:

Great. Thank you. The question from Janelle Sharp on whether the state will be providing a sample ID card for the new EAE plans and when will that be available? That's ID card is part of our integrated materials requirements.

Anastasia Dodson:

Yeah. Just back on the provider contracting piece. The Cal MediConnect plans are already Medi-Cal plans. I would assume that the providers that Cal MediConnect plan is

contracting with, that same health plan on the Medi-Cal side already has contracts with those very same providers because they serve dual eligibles within Cal MediConnect and then just as regular Medi-Cal beneficiaries. I hope that gives a further point on that.

Hilary Haycock:

Great. On the integrated materials, just to put... See if Stephanie Conde is available. We'll put her on the spot on a rough timeline on when we're thinking those might be available.

Stephanie Conde:

Yeah. We are working through the draft materials right now, and so I would say early summer, late summer, they might be out for folks to catch a glimpse of what the integrated materials will look like.

Hilary Haycock:

Thanks so much. A question from Yin Lai. Will those turning 65 after 2023 be required to enroll in Medicare managed care, or can they still choose to be in Fee-for-Service for their Medicare benefits?

Anastasia Dodson:

That's a great question. Early on we had talked about the... It's not passive enrollment and I just well put that out there right away. Passive enrollment is a special process that the federal government only has the authority to use for demonstrations like Cal MediConnect. And for D-SNPs, there's no federal authority for passive enrollment and the state doesn't have that authority either.

Anastasia Dodson:

However, there is a federal option for D-SNPs Exclusively Aligned Enrollment that if the Medicare plan, if the D-SNP meets certain requirements, that the state can ask CMS for approval for an automatic enrollment when a Medi-Cal only beneficiary turns 65. We have essentially tabled that issue for now. We want to make sure that we are a 100% focused on the technical issues with the transition from Cal MediConnect to D-SNP, as well as the policy issues like continuity of care policies, et cetera.

Anastasia Dodson:

One of the pieces that we've had looking at is with the health plans is what percent of overlap is there in their Medicare network and their Medi-Cal network. So that if somebody is in a plan's Medi-Cal network and they transition to the Medicare network with that same plan, are the same providers going to be available? We're still exploring that.

Anastasia Dodson:

And so, I don't want to derail the conversation right now to go any further on that, but we will have full stakeholder discussion about that. We will make sure that we have

answered every question and explored every thought there. Even then proceed. If we do proceed, it will be very cautiously and collaboratively with all of you. For now, we'll just say no at the moment and let's get through this transition and then perhaps we will look again in future years.

Hilary Haycock:

Great. Susan LaPadula, you have your hand up.

Susan LaPadula:

Hello, Hilary. Hello, Anastasia. To all of the presenters today, they did a wonderful job. Excellent presentations. I have a question on the PHE unwinding.

Susan LaPadula:

It's my understanding that President Biden's administration promised the Americans to give us 60 days advanced notice before the public health emergency would end. With that in mind, currently mid-April is the end date potentially, but we were not given the 60-day notice. I've been reading that nationally it may be an assumption that the public health emergency would be extended in April. Does anyone have any dialogue on that?

Anastasia Dodson:

Thanks for asking about that. That's a very good question. I don't have any further updates. The team that I work on is not working on the back and forth with CMS about what's the latest on the expiration of the public health emergency, but we will certainly keep everybody aware.

Anastasia Dodson:

That's the point of having that ambassador and signing up on that email list so when new information is available, we can push it out to everybody who's interested. Again, we're all on the same page of wanting to know as soon as possible and get factual information out ready for everyone.

Susan LaPadula:

Thank you so much.

Anastasia Dodson:

Thanks.

Hilary Haycock:

I think we dropped the link to that in the chat. So, for folks that want to sign up, you can find the link in the chat. Great. There's a question about how to keep on up to date on the long-term care carve-in updates. We are-

Anastasia Dodson:

Yeah. We're going to use this group to keep updates coming out and there is a separate group that's meeting working on technical documents and Hilary can provide more about that. But basically, we'll be sure to bring updates to this group.

Hilary Haycock:

Yeah. Yeah. There's a closed workgroup working on a number of the issues that has a broad representation for providers, plans, advocates, associations. We will keep bringing materials as developed to this group for broader stakeholder input. Rick, you have your hand up again.

Rick Hodgkins:

It's all fine and dandy that I can voluntarily enroll. I can voluntarily enroll into a Medicare Advantage Plan or a D-SNP. I know that Medi-Cal enrollment into a managed care plan is mandatory.

Rick Hodgkins:

What long-term services and supports will be paid for by that managed care plan? Because right now that the long-term services and supports I get are with in-home supportive services and with the Regional Center. Because if I continue seeing my primary care and specialists, even though that's covered by my Medicare, they may look and find that they're... My primary care is... Hopefully UC Davis will eventually choose a managed care plan to be contracted with.

Rick Hodgkins:

That though as for are any of my specialists in the Bay Area and whatnot, they may say, "You're in Sacramento County which has geographic Medi-Cal managed care. Go back there. We no longer want to see you."

Rick Hodgkins:

Luckily, that which you're saying is that the Medi-Cal managed care plan is only for long-term services and supports in my particular case. It is not for healthcare. But then what services will the Medi-Cal managed care cover in the case of dual eligibles. Thank you.

Anastasia Dodson:

Thank you so much, Rick. That is an excellent question. I'm so glad to have you on the call for this. The Medi-Cal managed care plans, they are in the CCI counties, and then soon in Sacramento and the no- CCI counties. They will be responsible for skilled nursing facility care.

Anastasia Dodson:

They're already responsible for CBAS. The Medi-Cal managed care plans are not responsible for IHSS. Those are the county social service agencies. They determine

eligibility for IHSS. And the Regional Centers they determine eligibility and approvals for Regional Center services.

Anastasia Dodson:

Neither IHSS nor Regional Center services are determined by Medi-Cal managed care plans. However, of course we want the Medi-Cal plans to coordinate with counties and with Regional Centers. We have a lot of expectations on Medi-Cal plans that they will coordinate with all of your care partners to make sure that everybody is aware of the types of benefits that you need that you're assessed for and to make sure that those benefits are being organized.

Anastasia Dodson:

But there is, the Medi-Cal managed care plans do not have any authority to determine or change IHSS hours. And the Medi-Cal managed care plans do not have any authority to determine or change Regional Center benefits.

Anastasia Dodson:

On the one hand, okay. That is less change for you and for beneficiaries like yourself who use these services. On the other hand, still we want to have all of the partners on your care team working together. Our expectation is that for services that are carved out like IHSS and Regional Center services, that the Medi-Cal plans and then the D-SNPs, if you're choosing to go that route, that they would share information, coordinate with care managers so that there's one care plan across all benefits.

Anastasia Dodson:

That's the goal and we have to have one organization be the lead and that it's not going to all happen overnight for especially individuals like yourself who access services from many different delivery systems. But at the very least though, we want better coordination across those delivery systems. How does that sound and what do you think about that?

Rick Hodgkins:

Hang on. Hang on.

Rick Hodgkins:

That all makes sense. What I was just wondering is what services will the managed care plans pay for? I'm obviously not going to go into a nursing home. In my case, then what services will the Medi-Cal managed care plans pay for? Because I'm in my own place. My meals are provided by me, but I also have help preparing meals if I need it.

Anastasia Dodson:

Yeah. There are some new benefits and services that Medi-Cal plans are taking up. And in the process of implementing enhanced care management and community supports, they are targeted to certain populations. Certain beneficiaries.

Anastasia Dodson:

We have the initial rollout has already begun. Then we're going to be continuing to roll those out with Medi-Cal managed care plans this year and next year. Just looking at the clock, we don't have the time or the slides to run through what those new benefits and services are that's part of the CalAIM initiative.

Anastasia Dodson:

But again, our expectation is that the Medi-Cal plans, we are raising the bar for them to assess individuals through our population health management strategy and think about what services are already being received. Then are there additional services that can be provided through Medi-Cal that can help people live independently, achieve their care goals.

Anastasia Dodson:

In addition to Community Supports and Enhanced Care Management, there are existing benefits on the Medi-Cal side for duals like additional transportation benefits, medical and non-medical transportation or non-emergency and emergency... Sorry.

Anastasia Dodson:

Anyway, different types of transportation benefits through Medi-Cal as well as again, CBAS 1915(c) waiver programs. It sounds you already have a good array of services, but those are the types of Medi-Cal benefits that are through a Medi-Cal managed care plan.

Rick Hodgkins:

Okay. Because I hope that if I continue to go where I'm going out of the county for specialty care, that won't be a question. I hope that they'll be able to utilize cross claiming that. Which is perhaps why the reason why I'm asking, have teaching hospitals including Stanford, including UCSF, have been done outreach.

Rick Hodgkins:

Because you can do patient outreach until you're blue in the face and until the cows come home, but that the people that really need to be educated and outreached, done outreach with are the providers. And not just community providers, it's the teaching hospitals.

Rick Hodgkins:

And speaking of the Regional Centers, they also need to be educated. And the Department of Developmental Services. I served on their client advisory committee for a number of years before I served on the client advisory committee for the Department of Developmental Services. And I served on that for six years.

Anastasia Dodson:

That's great. Yeah. Frankly we want all the partners we can get to make sure that information is clear and getting to the people that it needs to get to. Then if we need to improve programs or improve coordination, that we're talking to the right folks.

Anastasia Dodson:

There are a lot of things happening at the same time in different parts of the state. That can be also a little bit complex. But in Sacramento County at least, the big changes are on the Medi-Cal side primarily for duals to be enrolled in a Medi-Cal managed care plan.

Anastasia Dodson:

And the outreach to providers like you're saying, at this point I would suspect that there's not as much outreach on the Medicare side for providers in Sacramento because the focus of the Medi-Cal plans is frankly building up their Medi-Cal long-term service and supports Medi-Cal provider networks so that community supports different community-based organizations who provide all of those different services to help people stay independent living at home or in the community. That's where the focus of the Medi-Cal plans is now. But –

Rick Hodgkins:

I just hope it's not up to me as a patient to educate providers.

Anastasia Dodson:

I agree. Yeah. If you have a set of providers that is working for you, particularly on the Medicare side, we want you to be able to keep those providers. And on the Medi-Cal side as well. But the focus on the D-SNPs is around the Medicare network. Then the focus on the Medi-Cal side with CalAIM is on the Medi-Cal network. Multiple things happening in the state at the same time.

Rick Hodgkins:

I know. It's huge. It's huge.

Anastasia Dodson:

Yeah. Thank you for hanging in there with us, Rick.

Hilary Haycock:

All right. Well, we don't have any other questions in the chat or other hands raised. I think we can move to wrapping up. These are just some future topics that we might be coming back to. Integrated member material came up. Quality reporting, information sharing, updates to the State Medicaid Agency Contracts and continued information about Cal MediConnect transition process and status and crossover claims and balanced billing.

Hilary Haycock:

Next slide. Great. All right. Our next weekly meeting will be Thursday, April 21st at 10:00 AM. Thank you everyone for a robust conversation. We will be posting the slides and recording on the CalAIM website soon. Thank you everyone and have a wonderful rest of your day.