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MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Department of Health Care Services
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SPEAKERS

Hilary Haycock
Anastasia Dodson
Tiffany Huyenh-Cho
Alexandra Kruse
Stephanie Conde

Hilary Haycock:
Good morning, everybody. We are going to get started here in just a minute.

Rick:
Hello, can you hear me?

Hilary Haycock:
We can. We can hear you.

Rick:
Excellent. I wonder what's on today's agenda?

Hilary Haycock:
We'll get to it in just a minute.

Rick:
Okay.

Hilary Haycock:
We're going to go ahead and-

Rick:
I just have one question. I wonder if at a future meeting if we're ever going to have a meeting with the medical providers, like UC Davis, if they're ever going to be notified of changes?

Hilary Haycock:
So I know you're very concerned about the expansion of Medi-Cal managed care, and we can certainly think about that for a future agenda, but I know there's a number of providers that are on our list, but I don't think we're going to be using this workgroup to do direct outreach to providers, but I'm happy to take that back. Thank you.

Rick:
Because I know you had a meeting with the health plans last week or the week prior.

Hilary Haycock:
Yes. The state has contracts directly with the plans and thus the state works with most of them, directly. But yeah, network issues are definitely going to be on the agenda so please stay tuned for that.

Hilary Haycock:
With that, why don't we go ahead and get started? We're a couple minutes after the hour and I think folks joining has slowed down a little bit. So welcome everybody. Thank you for joining us for October's Managed Long-Term Services and Supports and Duals Integration Workgroup. We are excited to have you.

Hilary Haycock:

We have some great presenters with us today. As always, we're joined by Anastasia Dodson, the deputy director of the Office of Medicare Innovation and Integration, Tiffany Huyenh-Cho, the senior staff attorney of Justice in Aging, Alex Kruse, associate director of integrated care, state programs at the Center for Health Care Strategies, Stephanie Conde, the branch chief of the Managed Care Operations Division at DHCS.

Hilary Haycock:

So a few meeting management items to note before we began. All participants will be on mute during the presentations. Please feel free to submit any questions you have for speakers using the chat. During the discussion, if you'd like to ask a question or provide comments and feedback, please use the raise hand function and we will unmute you during discussion. All slides and meeting materials are available on the CalAIM website and you can find a link to those materials in the Zoom chat as always.

Hilary Haycock:

So our next slide, we are asking folks to add your organization to your Zoom names so the folks that are offering comments, we know where you're coming from just for our note taking and other purposes. So go ahead and find that participants icon at the bottom of the window, find your name, hover over that, when it pops up on the right side of the Zoom window, click more and rename from the dropdown menu, and then make sure that your name and organization appears as you would like it to.

Hilary Haycock:

All right, so with that, I'm going to hand it off to Anastasia to kick us off this morning.

Anastasia Dodson:

Thank you so much, Hilary. Great to be here with all of you today. I know that there's a lot going on. We're talking about Cal-AIM here today. In particular, this workgroup is around managed long-term services and supports and integrated care for dual eligible beneficiaries, which includes the transition of Coordinated Care Initiative and Cal MediConnect. The purpose here is, as we've had these meetings every month, providing an opportunity for stakeholders to give feedback and share information from the department, as well as sometimes CMS and other folks, about policy operations and strategy for upcoming changes for Medicare and Medi-Cal in California.

Anastasia Dodson:

Of course, this meeting is open to the public. We have, as Hilary said, materials posted on the DHCS website.

Anastasia Dodson:

The last point again is really emphasizing how much we value our partnership with all of you. Sometimes we want to think about a strategy that we might pursue, but we share it with all of you in advance in the spirit of collaboration. So we appreciate your willingness to go along with this process as we maybe we don't have the final policy to give you, but we have a draft or giving you the conceptual outline and getting your feedback. So there will be some of that here today.

Anastasia Dodson:

Next slide.

Anastasia Dodson:

All right. So the agenda today, we're going to have takeaways from the last meeting in September. That's, again, really helpful to ground us on what we did at the past meeting and how do we connect that in with today's agenda to keep some continuity of the conversation. We're going to be talking a little bit more about the care coordination guidance for exclusively aligned enrollment. That's the type of D-SNP that we're moving towards. Then we will also at the end talk about our noticing structure.

Anastasia Dodson:

Next slide.

Anastasia Dodson:

All right. So I'm going to hand it over to Tiffany from Justice in Aging. I will note that we will have written materials and a summary of the last meeting posted on our website in the next day or so.

Tiffany Huyenh-Cho:

Thank you, Anastasia. Hello, everyone, and good morning, I'm going to share a brief summary of the last workgroup meeting in September.

Tiffany Huyenh-Cho:

In September's meeting, DHCS provided an update on the D-SNIP exclusively aligned enrollment policy and reviewed examples on how this policy will work in different beneficiary choice scenarios. DHCS also presented an overview of Medi-Cal covered services and carved out benefits for dual eligibles, including Medi-Cal Behavioral Health Services and Long-Term Services and Supports.

Tiffany Huyenh-Cho:

There was also a panel of presenters from Community Health Group, Health Net, and Riverside County. They shared best practices for coordinating with carved out benefits in Cal MediConnect plans.

Tiffany Huyenh-Cho:

Stakeholders then participated in breakout discussions on promising practices for coordinating carved out benefits.

Tiffany Huyenh-Cho:

Slide, please.

Tiffany Huyenh-Cho:

This slide lists some of the thought’s stakeholders shared during the breakout room discussions on promising practices that were shared. These include ensuring resources, structure, and requirements for coordination are the same for both plans. The providers of carved out services breakout room discussions also highlighted the importance of providing necessary information, including contact info and resources, to agencies that provide consumer information, and as well to beneficiaries.

Tiffany Huyenh-Cho:

For example, a behavioral health contact sheet for beneficiaries to use and refer to was highlighted.

Tiffany Huyenh-Cho:

Full behavioral health assessments and early dementia detection also help identify needs and ensure beneficiaries receive appropriate care. It's important to follow through with referrals to carved out benefits and forming acute hospital partnerships.

Tiffany Huyenh-Cho:

Providing education and training to plan staff, providers, and other service providers on LTSS and behavioral health benefits available to members in their community was also shared.

Tiffany Huyenh-Cho:

Slide.

Tiffany Huyenh-Cho:

Stakeholders also shared their thoughts on opportunities for coordinating with carved out benefits. These include in counties with multiple plans standardizing approaches to ensure beneficiaries receive same benefits regardless of the plan they are enrolled in. There is also opportunity to create more streamlined communication and coordination between plans, networks, and counties. There was also to train case managers to help beneficiaries navigate the system and focus interdisciplinary care team meetings and clinical discussions on beneficiary needs.

Tiffany Huyenh-Cho:

Also, an opportunity to improve collaboration of resources statewide, removing barriers in counties with fewer resources to improve coordination between health plans, and remove barriers to sharing health information in order to make collaboration between the health plans and counties easier.

Tiffany Huyenh-Cho:

That's all the takeaways from September. I'll pass it back to Hilary.

Hilary Haycock:

Great. Thank you so much, Tiffany. Really appreciate you walking us through.

Hilary Haycock:

So for now, we're going to switch to our main topic for today and we're going to be discussing the D-SNP model of care requirements as part of an overall discussion as we're talking about how we're going to be thinking about care coordination guidance for exclusively aligned D-SNPS moving forward.

Hilary Haycock:

So with that, I would like to hand it over to Alex Kruse from the Center for health Care Strategies.

Alexandra Kruse:

Great. Just turning on the camera and getting situated. So good to be connecting with everybody. I think a great place to start would be to shift to the agenda slide in what I'll – today. Sounds good? Thanks.

Alexandra Kruse:

So again, thank you for the introduction. I'm Alexandra Kruse. I'm associate director of integrated care at CHCS. I'll present some overview of the D-SNP model of care, as well as some background on how

states nationally are influencing it as they develop more integrated systems of care for their dually eligible populations.

Alexandra Kruse:

A few things to note digging into the content here is that the findings and just the state approaches are drawn from CHCS' familiarity with the existing D-SNP and MLTSS care management models. – contract provisions that are built into those models around the country to support, again, a more integrated arrangement of care delivery for dually eligible individuals.

Alexandra Kruse:

What's presented here is meant to be illustrative of the kinds of things that can be done often over time to influence the D-SNP model of care, and of course, it's very state what this ends up looking like state to state to really align with the Medicaid managed care goals and particular objectives.

Alexandra Kruse:

So go ahead and shift perhaps to the next slide.

Alexandra Kruse:

Great. So this is a snapshot that gives you a sense of what the D-SNP model of care looks like and what all is included in that. The D-SNP model of care is often referred to as the MOC or abbreviated as such. It provides the basic framework under which the D-SNP and other special needs plans under the Medicare Advantage Program demonstrate how it will meet the needs of each of its enrollees or its target population. In this case, D-SNPs are required to target their model of care and only enroll individuals that are dually eligible so they build a model that supports the care needs of that population.

Alexandra Kruse:

So while these model of care requirements and elements are comprehensive, including requiring that D-SNPs do things that you might expect, like assess members' needs, develop interdisciplinary care plans, use interdisciplinary care teams as part of their care management or care planning strategy, considering the federal requirements alone for D-SNPs, they really have significant flexibility to build a model of care and determine how they'll structure that care management model.

Alexandra Kruse:

They have flexibility to determine how and when care plans are developed and updated, how they are shared, and what frequency and method ICT meetings might look like in terms of the interdisciplinary care team.

Alexandra Kruse:

So you can see the specific requirements on the screen here. A lot of what is included in the MOC is what I just reviewed. There are standard MOC elements that you can also see here on the right side that D-SNPs are asked to address in developing and submitting a model of care to CMS for review and approval for the D-SNP that they operate.

Alexandra Kruse:

There are some requirements here that I kind of think about as other model of care requirements and standard elements that D-SNPs have to address, including the plan's approach to quality measurement,

performance improvement, and monitoring health and beneficiary outcomes. So while the CMS model of care elements are really comprehensive, they are not prescriptive.

Alexandra Kruse:

We can shift to the next slide.

Alexandra Kruse:

So this gives you a little bit of a sense of some of the high-level takeaways from looking at how states approach developing what are often referred as aligned D-SNP MLTSS care management models, or an integrated care management model.

Alexandra Kruse:

So a couple things to share here. One is without states providing specific guidance, the model of care tends to vary by plan, and it might be higher level in terms of coordination of Medicaid benefits and how a D-SNP takes that into account. Ultimately, D-SNP requirements for care coordination reflect both the Centers for Medicare and Medicaid Services' requirements, the plans' particular approach to care management for this vulnerable population, and then any state specific Medicaid agency requirements that are layered on.

Alexandra Kruse:

States can influence the D-SNP model of care or advanced specific care coordination standards in a couple of ways. One is using the state Medicaid agency contract, which is referred to as an SMAC, but using that state Medicaid agency contract with the D-SNP to further the Medicaid program goal by specifying specific care coordination requirements, which you'll probably hear about today in this meeting in the context of California-specific objectives. Then they also can specify requirements for D-SNPs to actually build into or address and put into their model of care submissions to CMS.

Alexandra Kruse:

One of the things that I find interesting is that a number of states, the state specific requirements are really developed incrementally over time or with some level of refinement, right? That there's a starting point and then an opportunity to build on requirements with D-SNPs to improve what that care management model looks like.

Alexandra Kruse:

State staff in Minnesota have a takeaway here that I think is helpful just for framing this a little bit, which is there's a relationship between the state's contract with the D-SNPs and the D-SNP's model of care, and in some respects they think about that as the contract being what the state uses to describe what the plans have to do and the model of care being the more granular tool that can describe how they'll actually do it.

Alexandra Kruse:

So we can go ahead to the next slide.

Alexandra Kruse:

But this is just a little bit of a picture of some of the kinds of things that states typically develop requirements around for particular care coordination elements that D-SNPs would want to address in coordinating care for dually eligible populations. This often includes things like managing care

transitions, requiring some type of reporting and data exchange the D-SNPs to support care coordination, health risk assessment integration comes up in a lot of states in terms of things they work to influence, and then family and other caregiver involvement and assessment is really an example of something where I think there's a growing focus on, in general, in both MLTSS and integrated models of supporting caregivers. So that can be another area that a state may tend to specify some requirements around.

Alexandra Kruse:

There's also opportunities for states to really step back and look at their Medicaid managed care program goals and align D-SNP care coordination requirements with that to look at certain things that may matter in terms of whole person care or person-centered care planning from the state Medicaid agency's perspective that they want D-SNPs to address, particularly if there are long-term services and supports benefits. Whether those be institutional long-term care benefits or community-based LTSS, there can be expectations around person centered care planning that map back to those benefits being included in something that the D-SNPs are responsible for coordinating.

Alexandra Kruse:

Then there's also often requirements for states require D-SNPs to integrate care planning processes when D-SNPs and Medicaid plans are aligned. As in the approach that California is working on implementing of having exclusively aligned D-SNPs and MCPs, there's opportunities there for sure. We see that around the country that states really work to align and integrate processes at the health plan level where it's possible.

Alexandra Kruse:

So we can go ahead and shift to the next slide, which I think will be the last. There it goes.

Alexandra Kruse:

So the last thing to cover here is just a little bit more information around some of the findings around that last point, care planning and interdisciplinary care teams. There's a lot of similarity across states in what's expected at the plan and delivery system level to improve care planning and coordination through the use of ICTs.

Alexandra Kruse:

When someone is in an aligned D-SNP plan, there is particularly an opportunity to develop an integrated care management model. It's naturally more complex to operationalize that when benefits are delivered outside of the integrated health plan, but this picture here gives you just a sense of the kinds of things that states have done looking at requiring comprehensive care plans that include Medicare and Medicaid service planning information, looking at specifying where care plans should be, which can be state specific.

Alexandra Kruse:

When benefit carve-outs exist, certain states, and Oregon is an example of this, require sharing with relevant Medicaid providers that are outside of that health plan system of care, and that happens in Oregon where there's some fee for service LTSS carve-outs.

Alexandra Kruse:

There's also often requirements for an interdisciplinary care team composition and participation. The most obvious one there is something that maps back to CMS requirements, which is to consider what the beneficiary's preferences are in who is included in that ICT, but also looking across Medicare and Medicaid and what are the most important participants to support that individual's needs.

Alexandra Kruse:

Then looking at state specific elements in care plans, again, including what I was referring to I think on the last slide a bit, which is thinking about building in specific requirements around person centered care planning.

Alexandra Kruse:

I think that is the last of the slides here that just give a little bit of a national lens on the D-SNP model of care and the kinds of things that states have done to influence that.

Hilary Haycock:

Great. Thanks so much, Alex. Now we'll turn back to Anastasia.

Anastasia Dodson:

Right. Yeah. Alex, thank you very much, and thank you, Hilary. This is a topic that has been new to us here at the state. Because we had our Cal MediConnect model that we had a three-way contract, we had a MOU between the state and federal government, and we have been operating with those documents for a few years now, and so this transition to this D-SNP exclusively aligned enrollment approach, it's underway and been used successfully in other states, but it is new to California.

Anastasia Dodson:

So I appreciate all of your patience as we go through and think about, okay, what does this framework mean? I know we have talked about this at previous meetings, I think, in May earlier this year, but we're revisiting. We're so glad to have Alex here again today. Then as we think about in California for our care coordination requirements, how do we carry forward what we had in Cal MediConnect and then put it into this new framework so that we don't lose anything of the good language and requirements that we built into Cal MediConnect and then shifted into this new structure, as Alex has said about the SMAC, the S-M-A-C, the state Medicaid contract? Then we're even thinking about how do we use our dual plan letters or all plan letters to be very clear and have everything posted on our website so everyone can see what the requirements are?

Anastasia Dodson:

So let's go to the next slide.

Anastasia Dodson:

So as we think about the care coordination requirements and what will be required for 2023 for people who are dually eligible and enrolled in exclusively aligned enrollment, which again is current Cal MediConnect beneficiaries will be automatically transitioned to these new contract structures, but they will be under the same plan. So if you're a Cal MediConnect beneficiary and you're in plan such and such right now, the same organization will have a D-SNP plan and the network and the services should all be, the services should be the same and the network should be pretty much the same.

Anastasia Dodson:

So again, we're looking at what do we have as far as requirements in Cal MediConnect, and then what do we have in the federal Medicare requirements for Medicare plans that are D-SNP, what are those requirements, and then we also think about what do we already have in our 2022 SMAC, which is the one that's coming up very soon, and we're all done with the language there, as well as what do other states require of their D-SNP?

Anastasia Dodson:

Then what are the Medi-Cal requirements for care coordination? Because we have a whole other effort with existing care coordination requirements in Medi-Cal and then CalAIM, we're looking at adding enhanced care management, supplemental benefits, and also other types of population health management strategies that are related to care coordination. So all those are in Medi-Cal, and so we're trying to say, all right, how should we?

Anastasia Dodson:

Then you can see at the bottom of this slide, for these particular items, the HRA, the health risk assessment, and risk stratification care plans, care teams, transition, discharge planning, training, high need populations, how can we weave all of those pieces from the sections above there, Cal MediConnect, the Medicare requirements that we're building on top of the Medi-Cal requirements, to address these particular issues?

Anastasia Dodson:

I know that some of this is pretty technical, but we do want to just be as transparent as we can and also make sure if we're missing something, if there's something that we're heading in a certain direction on and folks have a different idea or a different approach, we really want to hear about it.

Anastasia Dodson:

Next slide.

Anastasia Dodson:

So what we're planning to do is release high-level guidance this year around care coordination and also around provider network guidance, and then we will have the actual SMAC, the contract between the state and the D-SNPs, in the next calendar year, so early 2022. But what we're doing right now is preparing language that, again, takes the language that we have in Cal MediConnect already and then we're looking at are their technical edits that are needed, are there substantial policy edits that are needed? So we're going to walk through that particular language in these areas.

Anastasia Dodson:

I just want to flag for network guidance, those are requirements that the legislature and the administration worked out in our budget trailer bill. That language is really high level right now, but we are working on that language, and we hope to have a high level approach to share at a future meeting hopefully in November, but maybe December or January. Again, that language, there are provisions already in Medicare and Medi-Cal. So we're not starting with a blank slate, we are looking at what's already required and how can we merge them and make them sync up together between Medicare and Medi-Cal.

Anastasia Dodson:

All right, next slide.

Anastasia Dodson:

All right, so for the health risk assessment and risk stratification, and again, as Alex has said, this is kind of a standard topic that states include when there are requirements for managed care plans that have a combined Medicare Medi-Cal benefit package. So the risk assessment and the risk stratification must account for both Medicare and Medi-Cal needs and benefits, including data from the Medi-Cal managed care plan. Technically, these are requirements on the Medicare plan, but since they will be also responsible for the Medi-Cal benefits, we want that risk assessment and risk stratification to address both sets of benefits.

Anastasia Dodson:

In case you're not familiar, we can talk a little bit more and we ask Alex to talk about what is the risk assessment, risk stratification. But in general, those are ways for managed care plans to identify upfront when someone is newly enrolled what types of chronic conditions or other services they may need right away to make sure that their condition is stable or if they are undergoing some kind of transition into a facility, out of a facility, that that is prioritized for the plan and they can make sure to assign a care manager to address issues that may be coming up.

Anastasia Dodson:

Also, in the risk assessment and risk stratification, we're requiring that those include long-term services and support needs, including IHSS. As we talked about at the last meeting, this is where we need to have the health plans and county IHSS coordinating, communicating, so that if someone already has IHSS, the plan is aware of that. Then if there is an increased need that someone has for whether it's additional hours or something else besides IHSS that both parties are aware of that and they can make sure that the right services and the right amount of services are available for the beneficiary.

Anastasia Dodson:

The risk assessment and the risk stratification, also, this goes back to what we have already in Cal MediConnect, it must address specific populations of focus that may need additional screening or services such as those with Alzheimer's disease and related dementia.

Anastasia Dodson:

So as we have those populations of focus already in Cal MediConnect, we are also with our CalAIM population health management efforts looking into those additional populations of focus. We've gotten feedback from all of you on additional populations, potentially people who are experiencing homelessness or at risk of homelessness, palliative care, other areas. So we want to make sure that as we finish our edits in this area and provide the requirements that we're properly identifying these populations of focus and what the requirements are around those populations.

Anastasia Dodson:

Next slide.

Anastasia Dodson:

For individualized care plans, those are intended to identify, so as an individual dual eligible in, now, Cal MediConnect, and soon to be aligned D-SNP, they have a requirement for an individualized care plan that has to identify as a needed Medicare and Medi-Cal benefit. So a care plan, that's kind of a standard

practice for managed care plans but having that care plan identify both Medicare and Medi-Cal benefits that are needed, that's really important here so that we're not in silos, it's one care plan.

Anastasia Dodson:

The care plan has to identify member needs that are covered by the Medi-Cal plan and those that are carved out. Again, long-term services and supports, county specialty mental health, substance abuse disorders, and other types of Medi-Cal providers. Then the care plan also needs to include how the D-SNP will facilitate access and document referrals to needed medical benefits.

Anastasia Dodson:

I know some of this is very technical, but going back to what Alex said, there's requirements already for individual care plans in the Medicare requirements in the model of care that D-SNPs must already submit and develop for the federal government, and we are looking at requirements that are in addition to the federal requirements. So that I'm clear, these are California specific requirements, and again, they relate back to what do we already have, what do we already have in Cal MediConnect?

Anastasia Dodson:

Next slide.

Anastasia Dodson:

So interdisciplinary care teams, again, there are federal requirements already on the Medicare side, but we are just making sure that in addition to those federal requirements, we're saying to our D-SNP plans that your interdisciplinary care teams should also include any other relevant providers for primary care, but long-term services and supports, behavioral health and others. This language is already in Cal MediConnect and we will use the same language.

Anastasia Dodson:

Again, the populations of focus that we talked about in the last slide, that should directly inform the composition of the ICT. So that's where we think about a member's caregiver, other types, if there's a dementia care specialist for someone with dementia, and any other relevant folks that are necessary for meeting the member’s needs. It could be county behavioral health. Again, it just depends on the specific needs of the beneficiary.

Anastasia Dodson:

Next slide.

Anastasia Dodson:

Care transitions. Again, we're building on top of the federal requirements in the Medicare side. So we're saying from the state side that the care managers must be trained to identify and understand the full spectrum of long-term services and supports, including home and community based services and long-term institutional care, and those care managers must participate in the care teams and serve as liaison for LTSS providers.

Anastasia Dodson:

Very similar to what we have in Cal MediConnect and we're carrying that forward into our D-SNP model because, again, as we talked about at the last meeting, and Tiffany was reminding us, that with IHSS,

and soon MSSP, programs being carved out of Medi-Cal managed care, those are still benefits that some beneficiaries are receiving and so those need to be taken into account in care transitions.

Anastasia Dodson:

So if someone is moving out of the hospital or out of a skilled nursing facility into a skilled nursing facility, moving home, moving to an assisted living facility, making sure that all the right folks are being consulted and the right services are being put in place to meet the care needs and wishes of beneficiaries for care transitions.

Anastasia Dodson:

Next slide.

Anastasia Dodson:

Okay, so that's it in a nutshell. But I know that all of you are very detail-oriented and astute on the things so we will have specific language for you to look at in the coming weeks around these issues. So we're just giving sort of a high-level overview to make sure we're all on the same page and headed in the right direction, but I'm happy to answer questions now and then just know that there'll be more specifics coming soon.

Hilary Haycock:

Great. Thanks so much Anastasia. So we have Susan LaPadula has raised her hand, so we're going to go ahead and start the discussion with Susan.

Susan LaPadula:

Good morning, Hilary and Anastasia. Thank you for this opportunity. I have a question for Anastasia. Would the state consider adding an edit in the SMAC contract that would require the plans to automate the crossover payments for the Medicare and Medi-Cal recipients?

Anastasia Dodson:

That is a really good point. Thank you. We will look at that. I know that that has been a topic of discussion in Cal MediConnect and we're happy to make it work well in all directions.

Susan LaPadula:

Thank you so much. Last but not least, what about our veterans affairs? How will the veterans benefits be discussed in the SMAC contract or just in general for the SNPs?

Anastasia Dodson:

Great question. I will ask, Hilary, do you happen to know, or anyone else from the DHCS team, does Cal MediConnect already addressed veteran's benefits coordination?

Hilary Haycock:

They are not included is my understanding in being eligible for Cal MediConnect. I think we would need to look at ... I think we're going to need to circle with CMS about that for the transition, but because veteran's coverage is primary, but we're happy to look into it.

Anastasia Dodson:

Great.

Susan LaPadula:

Thank you so much. Thank you.

Anastasia Dodson:

Before you go, is there a specific county? Because I know that what we have also found in the past is that individuals who are residents of state veterans facilities, they already get a complete range of care coordination through that service so Cal MediConnect is sort of redundant and they're not enrolled. But you're talking about folks who are not in a facility but who living in the community and who are veterans?

Susan LaPadula:

Actually, both. We're finding statewide in long-term care we're receiving more veterans as inpatients. To expand on your point, Anastasia, for example, Napa County, we have a beautiful VA facility and all of those services are very specific in Napa County, but really my question would be statewide.

Anastasia Dodson:

Mm-hmm (affirmative). Yeah, I'm thinking of San Bernardino. I think they have a veterans' home there and this issue has come up. Okay, great. Well, we've got that down and we'll take a look.

Susan LaPadula:

Thank you so much. Thank you both for all that you do for us.

Anastasia Dodson:

Thank you.

Hilary Haycock:

Great. Did just hear from a friend of ours at MCOD, veterans are carved out of managed care in CCI counties. So, part of it.

Hilary Haycock:

A comment from Barbra McLendon at Alzheimer's LA. "Glad to see the inclusion of trained dementia care specialists as a requirement in the ICT." So thank you, Barbara, for your activism on this.

Hilary Haycock:

Great. Rick, want to go ahead and –

Rick:

Can you hear me?

Hilary Haycock:

Yep.

Rick:

Okay. One thing that I tried to raise, one comment that I had last meeting that I wanted to talk about this meeting, it was mentioned last meeting as well as this meeting that specialty mental health would be carved out. I tried several times to get mental health services through Sacramento County, particularly individual counseling, and it is not available through any of the Sacramento County mental health clinics, and even if it is, it's done on a limited basis.

Rick:

I finally found Advanced Psychiatry Associates, which by the way does accept Medi-Cal managed care plans, just not straight Medi-Cal, and they also accept Medicare and Medi-Medi, by the way. So I'll still be able to continue to use them even if I enroll into a managed care plan.

Rick:

My only other comment, and I put it in the chat, was in case nobody saw it is it's time for all current providers, all medical providers, to jump on the bandwagon if we're going to move forward with this. Because the state can't bully and accept patients to enroll into a managed care plan without having accepted medical providers to jump on the bandwagon. So, thanks. I would expect the state, us, to have a meeting with medical providers up and down the state to jump on the bandwagon.

Anastasia Dodson:

Got it. Thank you very much.

Hilary Haycock:

Thank you. I am not seeing any other raised hands or comments in the chat.

Anastasia Dodson:

Okay, good. Well, like I said, more to come with specific language about each of the items that we've outlined at a high level here. Again, thank you, Alex, for giving us the federal context here and we're learning about this new structure and adapting to it and appreciate all of your partnerships.

Hilary Haycock:

Great. All right. Well then we will transition to our next topic, which is the Cal MediConnect transition noticing structure. So welcome, Stephanie, and take it away.

Stephanie Conde:

Hi. Good morning, folks, or good afternoon to some folks as well, from CMS on the East Coast. Stephanie Conde, branch chief with Managed Care Operations Division. I've talked to you guys before. Thanks for having me. So a quick I believe it's an update, but if not, just about our Cal MediConnect transition noticing structure. Thank you.

Stephanie Conde:

So the plan is for beneficiary noticing for our Cal MediConnect members to get noticing and letting them know about the transition to align D-SNP Medi-Cal managed care plans effective 1/1/2023. Just as a reminder, this is a lift and shift for these beneficiaries from a Cal MediConnect plan to an aligned managed care plan which is operated by the same organization as their Cal MediConnect product.

Stephanie Conde:

We have discussed and CMS presented on the CMS-led transition for these folks, which means that really there's nothing for them to do. It's a lift and shift from one plan to another. So just wanted to remind folks of that. There is nothing for these beneficiaries to do. We will be transitioning them on the backend with CMS and they will be in their aligned product. So no action from the beneficiary is needed.

Stephanie Conde:

Next slide please.

Stephanie Conde:

So the noticing plan to let them know about this lift and shift and let them know about this movement from one plan to another. In October, the Cal MediConnect plans will send what we're calling the tailored non-renewal 90-day notice with a notice of additional information, which is just like an FAQ. Then after that notice is in hand by the beneficiaries, our Cal MediConnect plans will make outbound calls. This will all occur in October, the notice in early to mid, and then the call campaign. Oh, excuse me, the notice early to mid-October and then followed by the call campaign right after.

Stephanie Conde:

Then in November, the plans will then send an integrated 45-day notice along with the FAQ or what we call the notice of additional information, and then in December, either in December of 2022 or early January 2023, the receiving D-SNPs and medical managed care plans will send integrated welcome materials to our beneficiaries.

Stephanie Conde:

Just an example of what can be included or may be included in that welcome packet is the pharmacy directory, provider directory, a summary of benefits, the evidence of coverage, member IDs, and then information on how to choose a primary care provider. So just your normal welcome packet, but as an integrated product so they're just receiving one. Then just a final reminder that no choice packets will be sent to these beneficiaries.

Stephanie Conde:

Actually, I think that's my last slide on this. So a very quick presentation on our proposed noticing plan and happy to take questions.

Hilary Haycock:

Thanks so much, Stephanie. Are there any questions? All right. Carly?

Carly:

Hi, there. Thanks so much. Can you expand a little bit on the notices, how they're not going to be receiving options? So does that mean that they won't receive information about other plans they could potentially transition into like PACE or SCAN or another kind of managed care plan option?

Stephanie Conde:

No. Very good question, thank you. In the non-renewal and the 45-day notice, there will be information about the other choices, but it's just we won't be sending the choice packet. But definitely information and in the outbound calls about the other options out there, it's just there won't be the active choice and that's why the choice packet won't be mailed. But if they would like to make a plan change on the Medi-

Cal managed care plan side that is done monthly. So we'll have health care options, phone numbers, and information on there for them to call and make that change if they would like to.

Stephanie Conde:

Then just a little bit more information on that. Right now we're working with CMS to review the 90-day notice and draft the 45-day notice, but our stakeholders, we'll be sending it out to our stakeholders for input. So really looking forward to your feedback on these notices just to make sure we're capturing everything that will be helpful from a language and transition standpoint. Then as noted before, these will also be sent out to beneficiaries for testing.

Stephanie Conde:

So just trying to make sure these notices are the best they can be. We want everyone to provide that input and then also test it with our beneficiaries to make sure it's clear on the changing their plan,

Hilary Haycock:

A follow-up question from Carly. "Does this mean that beneficiaries will need to request an enrollment packet or reach out to HCO if they want to make a switch?"

Stephanie Conde:

They need to reach out to HCO to make a switch, correct.

Hilary Haycock:

Because the assumption here is that folks have chosen their Cal MediConnect plans so we're just keeping them with their existing plans in the new structure.

Hilary Haycock:

From David Kane. "How will the mailings be easily identifiable as official and trustworthy for beneficiaries who get a lot of health-related mail?"

Stephanie Conde:

I mean, it's a good question. The reason why we're having the plans mail the notices is because they usually get information from their plans already and that's a trustworthy source. So instead of coming from other areas, we did take that feedback from stakeholders and plans and so our Cal MediConnect plans will be sending those notices. So beneficiaries should know anything coming from there, the plan that they were in already, should be something they should open up and acknowledge.

Hilary Haycock:

Great. We have a raised hand from Jan Spencley.

Jan Spencley:

Actually, I went ahead and put it in chat, but I just wanted to be really clear, these letters and these rules are only going from CMC to CMC beneficiaries, right? This is not everybody, this is just them?

Stephanie Conde:

Yeah, correct. This is just our members in a current Cal MediConnect plan, so it will only go to them, those beneficiaries.

Jan Spencley:

Perfect. Thank you.

Hilary Haycock:

A question from Susan. "Will there be a radio and/or TV ads for beneficiaries?"

Stephanie Conde:

So, Susan, good question. Right now, the department is working with CMS on marketing overall on messaging overall, and so that information will be forthcoming, and we'll use one of these meetings in the next few months to kind of walk through that. But it's a good question and one that we've been considering, and more information is forthcoming.

Hilary Haycock:

From Tiffany, Justice in Aging, "For the October noticing will plans make multiple outbound calls if they do not reach the enrollee on the first try?"

Stephanie Conde:

Yeah. Yes, they will. We'll release the requirements around that. It's just our normal, and it's escaping me right now, but I think we say up to three based on not being able to reach the beneficiary. But yes, they will make multiple attempts.

Hilary Haycock:

All right. From Desirae Ortiz, "Will the members be placed in the same IPA or group with the health plan transition?"

Stephanie Conde:

I may need to reach out for an additional smear on this. I'm not too familiar with the network side. Hilary or Anastasia?

Anastasia Dodson:

Yeah. Just to say that so this is about Medicare in general. We would assume that. If this is about Medicare, then the Medicare rules would apply. We can ask CMS about that, but I know they have very structured and firm requirements around Medicare networks. So if anybody from CMS is on, that'd be great.

Anastasia Dodson:

Maybe, Nick? Great question. I see a note from Janine. So sounds like a good topic for an upcoming meeting to talk about networks.

Hilary Haycock:

Yep, absolutely. Another question from Susan LaPadula. "Will open enrollment timeframes remain in place?"

Stephanie Conde:

From the Medicare side, yes, that's the assumption. But then just as a reminder, on the Medi-Cal side you can change plans monthly.

Hilary Haycock:

Right. From the Medicare side, duals have quarterly enrollment opportunities and not just annual the way that Medicare only beneficiaries do.

Hilary Haycock:

All right. So CMS has chatted that working with DHCS on sort of continuity of care requirements is part of the transition. So to Anastasia's point, there will be more coming. This is definitely not just moving people with their plans, but with our providers is certainly an important goal of the transition.

Hilary Haycock:

All right. I am not seeing any additional chats or hands raised, so thank you again, Stephanie. Again, folks, we will have more to come as we develop those notices. Always fun.

Hilary Haycock:

All right. So I think that we are ahead of schedule here, but appreciate. Here's one more comment. If I understand correctly, assisted living providers will need to contract with the managed care plans to continue to participate in the 1915(c) waiver program, which will be new for the plans. Will network adequacy be assessed, and if so, when will that begin?

Anastasia Dodson:

This is Anastasia. The 1915(c) waivers, they have a separate authority so the assisted living waiver, they have their own sort of rules and structure based on that particular waiver. So our policy now is for Cal MediConnect plans and then the D-SNPs and Medi-Cal plans to coordinate with waiver providers if there are individuals who are enrolled in both. But for Cal MediConnect, our policy has been that, and Hilary correct me if I'm wrong, but I believe those folks who are enrolled in an Assisted Living Waiver were not enrolled in Cal MediConnect, but they are enrolled in Medi-Cal managed care in many counties.

Anastasia Dodson:

So we will provide further clarification on that, but it's really more of a Medi-Cal plan issue, and the expectation is that there will be coordination between the Medi-Cal plan and the waiver providers. As far as I am aware, there's not a requirement right now for assisted living waiver providers to be contracted with Medi-Cal plans. However, in our work on enhanced care management and community supports, we're encouraging those relationships because we know that assisted living waiver providers are a wonderful resource in California for home and community based services and we do want to encourage those relationships.

Hilary Haycock:

Great. Thank you, Anastasia.

Hilary Haycock:

A question about whether managed care and D-SNP plans will assist providers not currently contracted on becoming contracted with them if they are just Medi-Cal providers and are interested in becoming Medicare providers. Anastasia, can you outline how that works?

Anastasia Dodson:

Yeah. We want to have robust networks on the Medicare side and the Medi-Cal side for dual eligibles. I mean, I don't know what type of provider you might be thinking of, whether it's more of like a home and community-based service provider or a primary care or acute care provider. In general, the Medicare providers for primary acute specialty care, at this point, DHCS, we don't want to weigh in too deeply there because it's already where CMS Medicare, they have requirements, and we don't want to muddy the water too much with adding requirements on top of that for Medicare. But if it's about a Medi-Cal provider or some type of sort of overlapping areas, we'd be interested in talking further about that.

Hilary Haycock:

So there's a comment from Jan Spencley, any aids for healthcare coverage, about how last meeting we talked about exclusively aligned plans versus aligned plans. So she doesn't see that on the topics but would like a layout of the differences. So I wonder if maybe there's some confusion about the role that aligned plans will play, and I'm not sure if you want to speak to that at all, Anastasia?

Anastasia Dodson:

Sure, sure. I know that all this terminology is getting to be quite complex, but our vision here is that in the seven CCI counties, Los Angeles, Orange, San Diego, San Bernardino, Riverside, San Mateo, Santa Clara, the Medi-Cal plans in those counties will be required to stand up D-SNPs. Those D-SNPs are going to be managed by organizations that also have Medi-Cal plans, and therefore those D-SNPs are going to be exclusively aligned enrollment. That means the same organization manages both Medicare and Medi-Cal for duals that sign up for that, and we don't want to contract with any other D-SNP chips in those counties that are not affiliated with the Medi-Cal plan.

Anastasia Dodson:

There's a separate conversation, or it's a separate topic outside of those seven counties, but within those seven counties, which includes San Diego, our goal is to only contract with D-SNPs that have a relationship with a Medi-Cal plan. They might be the prime Medi-Cal plan, they might be the delegate Medi-Cal plan, but we want to have one organization that can coordinate both Medicare and Medi-Cal.

Anastasia Dodson:

However, there are some D-SNPs that had contracts with the state and federal government prior to these policy changes even prior to 2014, and those legacy D-SNPs, we are not saying that we would terminate those contracts, we're allowing those contracts to continue for now. But we don't want new enrollment in those D-SNPs because if they're not affiliated with a Medi-Cal plan, then they don't provide the full type of care coordination across both sets of benefits. So our vision with exclusively aligned enrollment is to have one organization that administers both benefits and can coordinate across both sets of benefits.

Anastasia Dodson:

I hope that helps. I know the terminology can be complex. I see your point about the seven plans and that's the intent here. I was not able to see the full question. Hilary, was there more to it?

Hilary Haycock:

No, I think that's right. I think we talked about those aligned plans. There's exclusively aligned plans, and our goal is to have exclusively aligned plans, right? So understanding the distinction isn't maybe super

important moving forward, just knowing that it's exclusively aligned is where we're going. So it's not like there's going to be one set of policies for aligned and another set of policies for exclusively aligned, right?

Anastasia Dodson:

Correct. Correct. Yeah. Then outside those seven counties then we don't have the same requirements right now, but we want to build those requirements then in future years.

Hilary Haycock:

Great. Okay. Hope that helps, Jan.

Hilary Haycock:

All right, Rick, you've got your hand raised again, so we'll go ahead and unmute you.

Rick:

Can you hear me?

Hilary Haycock:

Yes.

Rick:

Okay. You touched on something that, you touched on a robust network. You brought up one example of robust network. It turns out that where I get my primary care right now, UC Davis Medical Center, I just found out that while they accept Medi-Cal and Medicare, that they currently don't accept any Medi-Cal managed care plans. How can we get them to accept a Medi-Cal managed care plan? Because I don't want them to lose me as a patient.

Anastasia Dodson:

Right. Since it sounds like you, and again, I don't want to speak to you individually because there may be certain particular there, but just in general we know that there are some providers who might be Medicare providers but then they don't contract with Medi-Cal. But for people who are dually eligible, usually they get many of their services through Medicare. So if the provider, if the hospital, the health system has contracted with Medicare, that is where dual eligibles get most of their services.

Anastasia Dodson:

I think there's a more complicated issue we can save for maybe the next meeting or the following around people who start out as Medi-Cal beneficiaries only and then they become dually eligible and how do we make sure the networks-

Rick:

Yes.

Anastasia Dodson:

Yeah. But it sounds like the example that you're raising is for someone who is already using a provider that's covered under Medicare, and so the Medicare networks are not impacted by any of the state requirements here.

Rick:

Yeah. I started out as a Medi-Cal recipient at age 16 because I got SSI. Then how I became a Medicare patient is my father signed up for Medi-Cal, and because of issues he was having, he or his younger brother dropped the ball and forgot to tell Social Security that I qualify as well because I was born disabled. I had to go to Social Security about six years ago back in 2015 and fight and about a year later in 2016 in March 1st of that year is when I got onto Medicare.

Anastasia Dodson:

Right. Well, I'm glad that the eligibility stuff got worked out. So I see what you're saying is for folks who don't have dual eligibility, just Medi-Cal only, we do at DHCS, we want to make sure that we have good networks of providers on the Medi-Cal side and we are holding our Medi-Cal plans accountable to make sure that the network of providers that they have on the Medi-Cal side meets all of the federal and state requirements. So there may be specific providers that are not in certain networks for certain plans, but again, we make sure that the plans meet federal requirements and state requirements as far as who and how they're contracting with.

Rick:

I'm afraid that I don't know why UC Davis, I'm afraid I'll lose them and I'm just not ready to part ways with any provider.

Anastasia Dodson:

Yeah, I understand. I think your Medicare, usually that determination does not change if you're eligible for Medicare. So, I mean, there could be specific situations, but usually once you've established Medicare eligibility, that doesn't change.

Rick:

Okay. I'm just afraid I'll be balance billed on the Medicare side if I choose not to change. On the Medi-Cal side, if I choose not to change.

Anastasia Dodson:

Mm-hmm (affirmative). We want to make sure that that does not happen, and part of having one plan for both Medicare and Medi-Cal benefits would be hopefully to avoid. But you should not be balance billed regardless, but one plan can make it simpler on the backend.

Rick:

A D-SNP. Like a D-SNP.

Anastasia Dodson:

Yes.

Rick:

Okay.

Anastasia Dodson:

Exactly.

Rick:
Alright.

Hilary Haycock:
Thanks so much, Rick.

Rick:
Alright.

Hilary Haycock:
Alright. We have a raised hand from Robin Price with Anthem.

Robin Price:
Yes. Good afternoon. Can you all hear me?

Hilary Haycock:
Yes.

Robin Price:
Yes. So I did send the question in the chat, but probably to the wrong person. This is probably more for just upcoming conversations to discuss as the state works to add in language into our D-SNP SMACs, particularly the existing D-SNPs that will be transitioning to an exclusively aligned plans. I'm sure the state is aware many of us may have different populations in our existing D-SNP plans that will be transitioning to aligned, so just making sure that there's an opportunity to talk through those nuances. Because some of us may have partial duals that don't have or receive their Medicaid services fee per service and they're not of the same benefit design as the CMC members.

Robin Price:
So just wanted to put that call out for future discussions on our existing D-SNP members that are in these D-SNP plans that are transitioning along with the state's initiative to align exclusively.

Anastasia Dodson:
Great point, and we can add that to our discussion on the plan calls.

Hilary Haycock:
Susan LaPadula raised her hand again. Susan?

Susan LaPadula:
Thank you, Hilary. Just to add a point to Rick's question about balance billing for the beneficiaries, we can alleviate that if we have automation of the crossover. That does reduce those inappropriate balance bills from providers.

Anastasia Dodson:
Great point. Thank you.

Susan LaPadula:

You're welcome.

Hilary Haycock:

All right. Then we just have one comment in the chat from Debra Cherry at Alzheimer's LA just saying that a session on quality reporting and how it can lead to improved care processes and outcomes would be great. So I think we agree.

Hilary Haycock:

All right. Wonderful. Well, so here's the list of topics we're considering for upcoming meetings and so looking forward to connecting again with folks. But with that, I think we have come to the end of our meeting topics for today.

Hilary Haycock:

Our next meeting will be Thursday, November 18th at 10:00 AM. So we really hope to see you all there. Just as a reminder, we're continuing our CCI stakeholder webinars and so the next one on that will be on December 9th at 11:00 AM.

Hilary Haycock:

So thank you everyone for a wonderful discussion today and great questions and comments. We'll definitely take those back and make sure that we are tracking. So thank you again and have a wonderful afternoon.