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

Mary Russell
Anastasia Dodson
Jack Dailey
Julianne Holloway
Karl Calhoun
Caroline Chung
Alison Klurfeld

Mary Russell:

Hello. Welcome, everyone. We will give others one more minute to join before kicking off today's meeting. All right, good morning. Welcome everyone. This is today's CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup. I'm Mary Russell with Aurrera Health supporting the Department with today's meeting. We have some great presenters with us today. We have Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS, as well as Jacqulene Lang, a Policy Manager with OMII, Jack Dailey, Health Consumer Alliance Coordinator with the Legal Aid Society of San Diego, Julianne Holloway, Director of Medicare Dual Eligibles with Blue Shield of California Health Plan, Karl Calhoun, the Director of Community Health, Caroline Chung, the Manager of Community Health, and Alison Klurfeld from L.A. Care Health Plan, and we're very excited for today's agenda. A few quick meeting management items to note before we begin. All participants will be on mute during the presentation.

Mary Russell:

As a reminder, the monthly MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions. We ask that plans that join these calls, hold their questions for their multiple other workgroup venues they have with the Department throughout the month. Please feel free, though, to submit any questions you have for the speakers via the chat, and during the discussion. If you would like to ask a question, and, or provide comments, and feedback, please use the raise hand function, and we will unmute you. A quick note that slides, and meeting materials will be available on the CalAIM website in the next few days, and we'll provide a link to that location in the Zoom chat. Before we get started, please take a minute to add your organization name to Zoom. You can do that by clicking on the participant's icon at the bottom of the window.

Mary Russell:

Hover over your name in the participant's list on the right side. Click more, and select rename from the dropdown menu, and enter your name, and your organization as you would like it to appear. A quick preview of today's agenda will begin with an update on the Continuous Coverage Unwinding with some time for Q&A. After that, we'll hear an update on the January and February 2023 transitions impacting dual eligible beneficiaries from DHCS. Then we'll hear presentations from Jack Dailey, and Julianne Holloway on the Cal MediConnect transition. Finally, we'll hear a presentation from L.A. Care on their Community Supports housing services with some time for stakeholder questions. And we'll end the call with some information on upcoming meetings, and next steps. So, with that, I will transition to Anastasia.

Anastasia Dodson:

Good morning. Thank you so much, Mary. As you can tell, I'm sort of losing my voice, so if anything gives out, then I have Jacqulene here to continue the presentation. But the purpose of the workgroup, as you all know, is to serve as a stakeholder

collaboration hub for CalAIM MLTSS for all members as well as integrated care for dual eligible beneficiaries. This is a public meeting, and we really value the partnership and the collaboration that so many of you bring to this meeting series. It's been a great opportunity to have a variety of voices, and today's meeting is great example. We're going to have not just DHCS, but many other presenters, and local examples to discuss, and look at. Next slide.

Anastasia Dodson:

So, focus on 2023. Now that we have succeeded in those transitions, we've been working with you all for the past over a year. We're talking about implementation, and data, and results, and plus opportunities, and challenges on the CalAIM initiatives. And we want to flag any related efforts for Medi-Cal members who are older adults, or people with disabilities, which is still a very broad range of topics, but again, less focused now on the technical operational piece, and more on the implementation, and the ways that we can keep improving. Next slide. Okay, so you all are probably aware, next slide, due to the change in the Public Health Unwinding, Medi-Cal redeterminations are going to begin on April 1st for the June 2023 renewal month. We at DHCS, along with our county eligibility partners, we want to minimize beneficiary burden, and promote continuity of care for members. You're probably well aware there's a coverage ambassador webpage, and mailing list.

Anastasia Dodson:

Next slide. We've been urging folks to, and you all have been partnering with us to urge folks to update their contact information. We have many different channels, communication strategies to encourage folks to update their contact information. And then the renewal packets will start going out for, again, April 1st for June, and then monthly thereafter. So, we want to remind folks to look for those renewal packets in the mail. Next slide. Okay, so any questions about this?

Mary Russell:

Not seeing any questions in the chat, or hands raised at this time.

Anastasia Dodson:

Okay. And there are definitely other forums at DHCS where this is discussed in more detail. So, just a reminder for all of you. All right, next slide. And which beneficiaries will receive a renewal package? So, it's based on their month of renewal. So, every beneficiary has a renewal month, and so it goes out on that schedule. So, folks, the renewal packets will be spread among 12 months. So, the next section is again an update on the January and February transitions. There's only really a brief amount of new information here. All of this is the same policy we have discussed in previous meetings. Next slide. So, again, the folks who were in Cal MediConnect plans were automatically transitioned into the Medi-Medi Plans, over 112,000 folks, and there's no gaps in coverage. Next slide. There's the numbers again, over 112,000. The vast majority. There was a few folks who could not be shifted. Sometimes there were discrepancies in addresses between the Medicare, and the Medi-Cal system, or other

reasons that the automatic process couldn't work.

Anastasia Dodson:

And we review all of the individual cases, and any other transition issues there, you all have been very wonderful, and gracious about sending us emails to flag if there's certain things happening to certain beneficiaries, or certain providers and we are researching those providing information as needed. Next slide. We did have transition monitoring, so we've been keeping track of any issues that have come up. Anything that's plan specific, then we work with that plan, and we haven't had any sort of widespread issues, but we are keeping an eye out and requiring the plans to routinely send reports to us. Next slide. And again, here's a technical issue, some files, and then a few complaints, and grievances, but nothing significantly widespread that we want to flag for you all. Next slide. This is the new information that we have not shared before, so the highlight is that we now have, well, previously Cal MediConnect had about 113,000 members, and now in Medi-Medi Plans that are the successors to Cal MediConnect, we have 218,000.

Anastasia Dodson:

And so many of the Cal MediConnect members are included there as well as some people who are in D-SNP look-alike plans that transition to the Medi-Medi Plans as well as regular D-SNP members that transition to Medi-Medi D-SNPs. So, this gives you a flavor. We have about of dual eligible members in California, there are about 727,000 total that are in some type of Medicare Advantage plan, and that includes PACE, the SCAN FIDE-SNP, as well as other SCAN products. Other SNPs, which does include chronic C-SNPs, and I-SNPs. So, overall, you can see the numbers there as far as the distribution of that 727,000. And so, we're pleased that many of those members are in integrated plans like the Medi-Medi Plans, SCAN FIDE-SNP, and PACE, and also worth noting there are 287,000 duals who are in regular MA plans that do not have an integrated approach. But some of those folks may also be in the matching Medi-Cal plan, which does help. So, again, this is new data. Next slide.

Anastasia Dodson:

And then these next few slides are about the transition in the non-CCI counties about Medi-Cal managed care for duals. So, you're familiar with this map. The counties in blue had skilled nursing facility, and skilled nursing facilities were previously carved out of Medi-Cal managed care, and dual eligible members were optional to enroll in Medi-Cal managed care previously in those counties. As of January 1st, then all duals are enrolled, well, technically February 1st for some of those folks who did not make a selection in late December. But basically, in the blue counties now all duals are enrolled in Medi-Cal managed care, and long-term care, skilled nursing facility care is part of Medi-Cal managed care. Next slide.

Anastasia Dodson:

Again, these are the same slides you've all have seen before we had the transition. Most of the 325,000 duals newly enrolled in Medi-Cal managed care are in counties

where it was optional before, but still previously over 1 million folks were already enrolled in Medi-Cal managed care for duals. Next slide. Really important reminder. Medicare providers that are serving dual eligible patients do not need to be enrolled in the Medi-Cal plan to continue receiving their Medicare reimbursement as usual. So, we know this has been an important communication element. Medi-Cal Managed Care Plan enrollment does not impact Medicare provider access or choice of original Medicare, or Medicare Advantage. Next slide. So, most folks, of those 325,000, most of them did not make a choice at the end of December. And so, they were default enrolled February 1st into the Medi-Cal plan that was on their notice. Next slide. And this is just a reminder on the crossover billing process for Medicare providers.

Anastasia Dodson:

Medicare providers, normally in original fee-for-service Medicare, they bill a Medicare administrative contractor known as Noridian. Noridian processes that primary claim, and then forwards the claim as needed to the Medi-Cal plan, or DHCS. We send information to the CMS system that connects in with Noridian so they will know which Medi-Cal plan to send the secondary to. So, Medicare providers, again, can submit their claims to Noridian as usual, and Noridian will continue to process even when a beneficiary is enrolled in a Medi-Cal Managed Care Plan. For Medicare Advantage, the same process as before, the provider bills the MA plan, and then if it's the same plan as Medi-Cal, then they'll process the secondary. Next slide. And another reminder balance billing is actually prohibited in federal, and state law. So, dual eligible beneficiaries should never receive a bill for their Medicare services. Next slide. Okay, so we went quickly through those slides because we have wonderful presenters here that we want to hear from but sounds like we should....Mary look at any questions?

Mary Russell:

Yeah, there are a couple questions in the chat I wanted to highlight. There's a question from Diane Sargent about look-alikes and understanding the current restrictions around offering D-SNP look-alikes and understanding the 287,000 enrolled in regular MA.

Anastasia Dodson:

Yes, those are not necessarily look-alike plans, but regular MA plans that are not marketed to duals because yes, CMS did restrict the D-SNP look-alikes. So, yeah, it's interesting to know that's a number that, that is large. And again, a lot of the opportunities, and marketing that the Medicare plans do is also seen by dual eligibles, and so they may select a non D-SNP MA plan.

Mary Russell:

Thanks, Anastasia. Another question of what happens if a beneficiaries already enrolled in an advantage plan, not through Medi-Cal, this is from Debra. I'm not sure if I'm missing a detail there, Debra, if you want to raise your hand and come off mute.

Anastasia Dodson:

Yeah, but there's no... There's flexibility, and many options for dual eligibles to choose

their Medicare plans. And so, there's no restriction on them having to choose a D-SNP. They can choose a regular MA plan.

Mary Russell:

Great. And a question from Bertha, and I see Janine has responded, but the question is in the MA scenario, we do not bill the IPA, but rather the MA plan, I believe Bertha's with a clinic.

Anastasia Dodson:

Right. It really depends, as Janine is saying, it depends on what the payment arrangements are. So, if normally you send, I mean, again, this is just a regular billing process for Medicare. It's nothing different with folks enrolled in Medi-Cal plans. It's just on the Medicare side, whatever you would normally do, if you would normally send the bill to the MA plan, continue sending it to the MA plan. If you would normally send it to the IPA, then send it to the IPA.

Mary Russell:

Great. And question from Kristen in the chat. Can you explain how enrollment in the SCAN FIDE impacts eligibility for MSSP, and IHSS?

Anastasia Dodson:

There are federal regulations around how, and it's probably a bigger question than we have time to answer today, but essentially the federal requirements for a FIDE-SNP require that Long-Term Services and Supports be carved-in. So, that's why IHSS is not permitted outside of the... So personal care services are included in SCAN’s FIDE-SNP, and so they get personal care services through the health plan rather than IHSS. And that's, again, a federal requirement for the FIDE-SNP. And it's kind of similar to PACE, as well, where personal care services are covered through PACE rather than IHSS.

Mary Russell:

And I know we are eager to get to our next section, so we'll take Rick's question. Rick, if you'd like to come off mute, and then we'll transition at that point. Go ahead, Rick.

Rick Hodgkins:

First off, I would like to say that my change in managed care plan on the Medi-Cal side has gone great. It's a lot better than I expected. This whole thing about Medicare benefits, having to coincide with Medicare, I'm glad we were able to debunk that myth. But my question is what has to be done by March 31st, or April 31st, the continuation of the Medi-Cal, or discontinuation of the Medi-Cal for people previously enrolled because of COVID? I missed that part. I was late.

Anastasia Dodson:

Right. So, the Medi-Cal... The renewals that have been suspended, so normally there's a schedule, every Medi-Cal beneficiary has a certain month where their Medi-Cal is

renewed, paperwork is sent by the counties. And so, as you know, like you said, it's been suspended for a while, that is going to start again. So, the first packets are going to be sent out by county eligibility offices April 1st. And those are for people that have a renewal month of June. And then every month after that, whenever your renewal month is, that's when you would receive a packet from the County, and they will include the information that they already have, and then any beneficiary that gets that packet would correct that information if it needs to be corrected, and return it back to the county.

Rick Hodgkins:

So, they'll go out April 1st?

Anastasia Dodson:

For only the people that have... They will start going out April 1st, but there's going to be a monthly phase in, so depending on your month of renewal, that will determine when you get the renewal packet. So, sometime in the next 14 months, or so you'll get a packet.

Rick Hodgkins:

Okay, because I'm trying to report back to my People First chapter, as I report back to them. So, starting April 1st packets will start come... Because I know a lot of people, more people were on Medi-Cal during COVID-19, whereas prior to that it was not as many people.

Anastasia Dodson:

You're right, yes. And so, this is a big change, and we have our eligibility team, and our communications team working hard on this, and anybody that would like to have a presentation, or get involved in that communication, feel free to join that ambassador's list. And I believe there's an email where you can request presentations, too.

Rick Hodgkins:

Okay, great. Thank you.

Anastasia Dodson:

Thank you.

Mary Russell:

Thanks so much Rick. And in case you missed this at the beginning, too, we will be posting these slides that have more of that information, so we can make sure that you get those if that's helpful.

Rick Hodgkins:

Okay, great.

Mary Russell:

Thank you. Alright, so let's transition at this point, we are going to transition over to our presentation on how the CMC transition is actually going on the ground. And first we'll hear from Jack Dailey, Health Consumer Alliance Coordinator and with the Legal Aid Society of San Diego. And Jack, we're ready for you to take it away.

Jack Dailey:

Great. Yeah, thank you very much. As Mary noted, I'm Jack Dailey with Legal Aid Society of San Diego, but we partner with the state to provide, well, we provided CMC Ombudsman services in the seven demonstration counties since 2014 and have recently transitioned into a Medicare Medi-Cal Ombudsman program for all 58 counties serving duals very broadly, but focusing on MMP members, members in Medicare Advantage plans, and also those in PACE. And so happy to be here. Thanks to the state for the invitation to chat about the CMC to MMP transition. Next slide. So, wanted to share kind of perspectives of not only our office but in San Diego, but throughout the demonstration pilot counties, just what we learned through the process and now that we're into it over a month, and a half, kind of how it's going from our perspective. And thought I'd start with just giving kudos where kudos are due.

Jack Dailey:

I think the state probably over a year, and a half ago, probably a little bit longer, started this very active engagement process, in terms of its efforts to communicate to stakeholders about these transitions, and also learn from stakeholders. And I think this meeting in and of itself has been a major vehicle for that, bringing together a broad array of stakeholders learning perspectives. But behind this meeting are dozens of, if not more meetings every month, that I think DHCS has engaged with stakeholders from particular perspectives to learn more about how this transition will impact the particular sectors, and consumers, and to develop effective policies. And so, I think want to start there, and give credit for a really engaged stakeholder process. And similarly, the outreach, and education about this transition has been, I think, a success. And that this is not just DHCS's effort, of course they were very active going out there talking about the transition, meeting in specific counties where this transition was going to occur.

Jack Dailey:

But all stakeholders in our area, plans have been a big part of that education, communicating with their members, their CMC members about the transition, and what that will look like for them and what their options are. And as well as advocates, county staff, provider staff, I think everyone has really done a great job of communicating about the transition. What it will look like trying to assure folks that there should not be access to care barriers, but if there are, there's resources to support them. And I think that's been largely played out to be a success. And Anastasia just highlighted very quickly some of the specific data regarding the transition, and where they had very high rates of connection of CMC members to the MMP plan. There was a very low rate of transition errors, and I think that's, again, a reflection of all the planning, and efforts have gone into it by all stakeholders, but by DHCS of course. And so, that's been largely a

success. Of course, for those individuals that were those few hundred folks that were part of a disconnect there, that was very confusing.

Jack Dailey:

And we did get some of those calls, and we worked with DHCS, and plans. I know plans were very active working with those folks that did not connect in the MMP plans, and they were making outbound calls. And so, I think that's, I don't want to downplay the impact of those Individuals of course, but I think from a system perspective has been something that all stakeholders can be really proud of, in terms of how this process played out. And that played out, in terms of our call volume that related specifically to the transition. We honestly did not get tons of calls throughout our demonstration sites about this particular transition CMC to MMP transition. I think that there were a number of calls about details of the transition, how it impacts individual folks, where we were offering education to consumers in advance, but by and large, there were not a significant number of complaints, or grievances that we were helping to facilitate relating to the transition. So, that's relatively sunny.

Jack Dailey:

Now, there were some challenges, and I think one of the challenges came with some of the communications, actually the notice approach seemed to be rolling out very smoothly where we're sending out the 90 day notice, and the follow up 45 day notice. But at the end of November, there was an erroneous notice sent out from DHCS. And this had been discussed previously as to why that occurred, but that impacted, or was received by 87,000 CMC members. And it effectively notified them that they were being dis-enrolled from CMC. And that, I think, did cause a significant spike in call volume, and communication from consumers, raising concerns, fear of how that will impact their ability to access their providers. And what this means with regards to the transition. I know our offices received those calls. I know our partner HICAP offices received those calls. I know that Medicare, I'm sorry, Medi-Cal, and CMC Member Services received those calls. And as well, the state did.

Jack Dailey:

What was helpful was that there was really clear communication about what happened, why it happened, and that there were in fact not going to be any disenrollments. And the messaging was consistent amongst all of our partners that I just mentioned, that the HICAPs, our offices, the plans, and the MMCD Ombudsman at DHCS, we're all singing the same song about what this actually meant, that it was an error, that it will not be any implications for folks. So, that was a brief challenge in early December. We navigated that. I think everyone communicated well, and hopefully allayed any concerns about impacts to folks. Slightly outside of the specific MMP transition, I think the most recent challenges that the Ombudsman offices have been navigating are concerns about mandatory Medi-Cal MCP enrollment in those 31 counties.

Jack Dailey:

That's driven a lot of volume to folks leading up to the new year, and subsequently has

continued to drive calls, and concerns about the mandatory Medi-Cal enrollment, and concerns about folks whether they can continue to see their Medicare provider, provider education getting on the phone with provider offices talking about, I think, what Anastasia just highlighted in terms of how providers should be billing, and not submitting claims for services when someone's enrolled in Medi-Cal Managed Care Plan, and not billing consumers. So, I think there that did drive activity in our offices as well. As did the understanding of the matching plan policy. I think that that continued to drive some consumer calls, and concerns, confusion about what their options were, why their plan selections were not being honored if they were in that Medicare Advantage plan that had a matching Medi-Cal plan, and thus they were being enrolled in that Medi-Cal Managed Care Plan. So, that, I think, is what our offices have been seeing from a very high level of late, we continue to watch for emerging trends, and issues of course, and collaborate with partners at the state as those come up. Next slide.

Jack Dailey:

Oh, one more. There you go. So, just wanted to highlight some of the things that I think, specifically, within the MMP that we're watching for, and is of course importance to us. And these are constant themes throughout even the CMC demonstration but are things that we are particularly interested in as MMP members experience their new plans, and access care. So, one of the things that care coordination is such an important feature of these integrated care plans, and in the Cal MediConnect demonstration, I think we found some inconsistency with the care coordination, and how frequent, and regular the communication was, and the identification of who a member's care coordinator was, became fuzzy for folks after time. And so, we really want to... From our perspective, we're watching how MMP plans implement their care coordination services, how those care coordinators are engaging consumers. There should be a fair amount of consistency over from those plans that have been doing this as Cal MediConnect plans of course, but again, these were concerns we had previously.

Jack Dailey:

And so, I think this continues to be a challenge for consumers. And so, we'll be watching how this changes under the guise of the new MMP plans. Benefits coordination is another issue that I think is something that's important, and does have a consumer impact when a plan is... When these MMP plans are delivering care to consumers. And so, this has two levels. One is claims coordination, and just ensuring that both benefits are being considered when services are being requested, when pre-authorization is sought for a particular service, ensuring that both the Medicare standards, and the Medi-Cal standards are being considered. But it's also about communication with the consumer, and the member, that when the member is communicating with the plan, that the plan is really presenting a unified front about what that MMP plan consists of, and how it's going to interact, and serve their needs. And so, we've already actually seen some slight wrinkles there. We've had some members communicating with their MMP member services and being told that they need to talk to the Medi-Cal plan, and that created some immediate confusion, because that is their Medi-Cal plan.

Jack Dailey:

And so that set up a communication with a Medi-Cal Managed Care Plan member services pointing back at the D-SNP, or MMP side. And so, we want to make sure that those messaging, and communication channels are really aligned, and so that consumers understand that this is one integrated plan that's serving them and meeting their needs. Provider education is always an ongoing process, right? Provider networks change over time. And so, even if there's been tons of efforts by plans, and by state, and other entities to educate providers about how these plans operate, I think that just needs to be an ongoing basis because there is often turnover in networks, and new providers join. And so, when they join, it's really important that they understand how MMPs operate, how they're different from a standard MA plan, or a standard Medi-Cal Managed Care Plan, what that pre-authorization, and claiming process looks like. And of course, really importantly, what the billing protections are for both MMP, and dual members.

Jack Dailey:

So, that's something that we'll look to plans, we'll look to the state, and our other stakeholders to ensure that we're messaging consistently for providers, and that there's toolkits, and information available to providers on a regular basis should there be any challenges. And then again, want to give some credit to the state here for producing some really helpful toolkits that we as advocates can use, and send out to providers when we're having those interactions, and when there may be some disconnect about what their responsibilities are. And then lastly here, I think if anyone's heard me chat about this, it's something, a song I'm always singing about CalAIM, ECM, and more importantly for the MMP members, Community Supports are such an important benefit that have been implemented in this state. And we want to ensure that MMP members, and all duals are taking advantage, and gaining the benefit of these services.

Jack Dailey:

So, we're keenly interested in ensuring that these are being implemented, and referrals are being made for MMP members to Community Supports, and that those Community Supports are being utilized. That MMP members are not having difficulty accessing those services, or through the course of the delivery of that particular service, there's no challenges. So, I think we'll be, from an advocate perspective, I think we're interested in working with the plan, and this, and state partners to continue to learn about how this is going, whether there needs to be iterative improvements, changes in how this has rolled out. This has to be informed by data, data being reported by the plans about utilization by duals, and by MMP members.

Jack Dailey:

And we have to know more specifically about what individuals experiences are. So, really, interested in understanding how noticing is occurring for Community Supports, and how Community Supports vendors are communicating about these benefits with consumers as well. So, that's something that we are very interested in monitoring as this continues to roll out, and we'll be in continued communications with DHCS, and our partners about. So, that's it for me. I think I can hand it back to Mary unless there's questions I can speak to.

Mary Russell:

Jack, thank you so much. That was excellent, and really great to hear that perspective, so thank you. We'll shift gears now and here a little bit from the health plan perspective, and then I think we'll have time for questions for both of you after Julianne's presentation. So, Julianne Holloway with Blue Shield of California.

Julianne Holloway:

Thanks, Mary. Good afternoon, everyone. Julianne Holloway, Director of Medicare Dual Eligibles at Blue Shield of California here to present on Blue Shield's perspective of how our Cal MediConnect to D-SNP transition went. On the first slide, I'm going to present a little bit on our transition results. So, we had a 94% retention rate for about 5,600 members across our two Cal MediConnect counties of Los Angeles, and San Diego. And we retained all but one group of providers across Cal MediConnect, and our D-SNP provider networks. So, we had a really high provider network retention rate as well, which was really key, and all but 46 of our Cal MediConnect members were also able to retain their primary care provider, which we also know is key to retaining the level of care that our members keep. And those relationships are super important to our members as well. So, that was a high priority for us to ensure that we map not only the primary care provider but also the specialty care providers.

Julianne Holloway:

And we also wanted to ensure that we kept our benefit parity for our benefit packages across the Cal MediConnect, and D-SNP plans. So, we not only kept the benefits, not the medical supplemental benefits, but also, or not just the medical benefits, but the supplemental benefits across the Cal MediConnect, and D-SNP plans, but we improved them. So, members got a better benefit experience when they moved into that D-SNP plan. And then we also hired nearly 80 additional care managers, RNs, and social service staff. And this was not only to continue supporting the Cal MediConnect members, but also, we were transitioning our SNP look-alike membership at the same time. So, we had to hire some additional staff to support that additional volume and we wanted to ensure that with Community Supports and some of the other social service work that needed to continue with CalAIM, that we had enough staff to support those activities, and those outcomes for this population.

Julianne Holloway:

And as Jack mentioned, there's also not all sunny outcomes with the transition. We have had about 50 complaints since January 1st, mostly related to plan change questions, plan change issues. There was some confusion around subscriber ID changes, not really understanding why things were changing. Also, around benefit coverage changes, and confusion, not understanding what is Medicare versus Medi-Cal. Some of these are typical questions that come up year-to-year, year-over-year, but these were all around our Cal MediConnect to D-SNP transitioning members and have all come in since January 1st. But these are our outcomes so far for our transitioning population. And then if we transition to the next slide, I'll go over some of the highlights,

and challenges. And it may look like Jack, and I copy pasted our slides, but we didn't, I'm glad to know that our perceptions of the transition align so well. Highlights first, we did have a really robust communication plan.

Julianne Holloway:

So, from the health plan perspective for providers, for brokers, for members, for our community stakeholders, even for internal staff. We were doing webinars, we were doing print campaigns, we did telephonic campaigns where we were doing outbound calls, digital, and member portal banners, and campaigns. We had FAQs going around internally, and externally that were written just to make sure we were touching all of our external points. And again, made sure that our brokers, our providers, our members were all being touched to ensure that they understood what was happening, and when, and even though we were focusing on our Cal MediConnect transition, we also had other transitions ongoing. So, we wanted to make sure that there wasn't confusion, and that everyone understood who was moving, where they were moving ,and when they were moving. There was also some really close collaboration happening between the Cal MediConnect plans, the D-SNP plans, the Medicare plans, DHCS, and CMS.

Julianne Holloway:

And it was ongoing for quite a while. And this led to some really good identification of gaps for improvement. And one of the things that I think really stands out for me, and hopefully for some of the other health plans is we got really into the weeds around how eligibility is exchanged. And we were able to improve how 834 and HCO files are exchanged for Cal MediConnect members, and for Medi-Cal members, and actually able to improve how the eligibility is transferred for Medi-Cal members so that we have Medicare, and D-SNP indicators on those files. So, that may not sound like a lot to the members, and to the stakeholders on this call, but for the health plans it's huge. And I think getting into the weeds on how those files are exchanged, and understanding what indicators are there, and improving that is huge for the health plans. And I think just having that collaboration between the health plans really improved those files, and hopefully we can continue to build on how files, and information are exchanged.

Julianne Holloway:

And that's just one of many of the examples that came out of many of those meetings that Jack mentioned behind the scenes. We met for hours on end, so I think that collaboration across the plans, and our regulators really helped to ensure that we were thinking through end to end how this transition was going to go. And then another highlight is larger provider network offerings. For whatever reason, providers are more supportive of D-SNPs, they've been more open to working with D-SNPs. And so, we've seen that they've been more willing to be in the D-SNP network. So, we have a much larger provider network offering in our D-SNP. And we actually had an existing D-SNP plan that we left open for years on end, even though it wasn't active.

Julianne Holloway:

And so, we had a larger network existing that we could transition our Cal MediConnect members to, so they were ready and willing to go. And so, we've had a larger network offering for our members, and we're seeing the members really take advantage of that, and really enjoy that. So, that's been a highlight for us as well. And something that we hope as more members come into our D-SNP, they take advantage of as well. For the challenges, this isn't anything new for our dual eligibles, our hard, or unable to reach members, were still unaware of the transition. And some of them did call in after. Some of them came up in those 50 complaints I mentioned on the previous slide and were unaware that the transition was happening. So, they would call in, and they wanted to know why their coverage changed, why they got new materials, what happened.

Julianne Holloway:

So, they were still unaware that the transition was happening. And that's just one of those inevitabilities where we did everything we could to try, and reach them, and we just still couldn't connect with them. So, we're still going to have to get creative in the future with how we connect with those members even though we do everything we can. So, that's one of those challenges that we'll still have to continue to work through and get creative with in the future. We were still missing our Ombudsman, and some key stakeholders in the community in some of our other policy discussions. While we did get their feedback on some of our communication development, and notice development, I think we could have had them at the table a little bit more for some of our other policy development conversations. It might have helped kind of round out the conversation, especially our ombudsman. I think, Jack, you probably hear from all health plan views, and can have a more rounded view of what our members go through and can provide some good input.

Julianne Holloway:

So, I think, in the future it would be helpful to have you in some of those conversations for some of our other policy development conversations. Also, multiple transitions were ongoing at the same time, and overlapping, and some of them touched the same population. So, it was a little confusing for our membership. We had the Medi-Cal transition going on where the mandatory Medi-Cal transition where members were being moved into a Medi-Cal plan. We had Cal MediConnect to D-SNP, we had the members moving from a SNP look-alike into another plan. We had the matching Medi-Cal plan alignment going on, and there were just so many notices and then you've got AEP marketing. And so there was so much going on at this time. I really felt for the membership, I really felt for the providers out there, everyone who was in the community trying to figure out what was going on at this time.

Julianne Holloway:

It was a lot of confusion. And so, we were doing our best to be clear with our members, with our providers about what was happening. And so there was still some confusion, and we were trying to do our best to be clear with our members, and not inundate them

too much, but that was still a challenge that we did have to work through. And then resolving the few Medicare, and Medi-Cal alignment issues that did pop up, we're still working through a few right now, especially in Los Angeles County. It's a complicated county, especially if you're a health plan that works there in a prime, and delegated model, you know what I'm talking about. So, we're still working through some of those issues, and we hope that we can figure out a process to escalate those prime, and delegated issues a little bit better.

Julianne Holloway:

So, those are challenges that we'll smooth out in the next couple months. I forget that it's only February, so we're only on month two of this new model that we're in. And then transitioning into a less integrated model, it was hard to explain to some of our staunch Cal MediConnect supporters, either providers or members, why they couldn't stay with Cal MediConnect, and why they had to transition into something that was not Cal MediConnect. So, that was also a challenge that we had to overcome. They wanted to stick with one plan, they wanted to stay with Cal MediConnect, and it was hard to explain to them the bigger picture, and why that couldn't happen, and why eventually that this would scale up into something that would feel like Cal MediConnect and look like Cal MediConnect. So, that was a challenge too, to say hopefully in the end it'll feel and look like Cal MediConnect, and we'll get there, and the member experience should hopefully reflect that same member experience that you're getting today. So, Mary, back to you.

Mary Russell:

Thanks so much, Julianne. That's so helpful, and interesting. So, thank you for sharing that with all of us. I think we have some time for questions, and answers with Jack, and Julianne. And I know there have been some conversations going on in the chat and our team has been providing some additional links, and context there. So, I see a raised hand from Rick, and I'll ask you to unmute Rick, and jump in with your question.

Rick Hodgkins:

Okay. So, you're just basically giving an update on what's been working, and what has not been working. And also, when you mean moving from an integrated model to a non-integrated model, what you mean is non-community based, correct? Because when we mean integrated from a disability perspective... We mean when we mean integrated from a disability perspective, we mean community based, so I'm confused when you use the word integrated to non-integrated. Thank you.

Julianne Holloway:

Mary, I can go ahead, and take that one, because I think that was directed to me. Rick, I’m sorry, that was my fault. When I meant integrated, I was speaking about Cal MediConnect. I wasn’t necessarily speaking about the disability perspective. Cal MediConnect was one health plan that had everything in it. It was Medicare, Medi-Cal, everything. And so, I was speaking from the perspective of it was integrated all into one single health plan. And these new Medi-Medi Plans, the Medicare Medi-Cal plans are

kind of two plans that feel like one plan where it's the D-SNP, and the Medi-Cal. And so that's what I meant by a little less integrated. It feels like Cal MediConnect, but it's still kind of two separate plans. So, that's what I meant by less integrated.

Mary Russell:

Thanks, Julianne. Any other questions for Jack, or Julianne, and their experiences in the transition, or comments to share? Okay. Well, thank you both so much. We really appreciate it and I know you'll be sticking around. So, of course if other questions come in, we may ask you to jump back in. So, at this point we will transition to the L.A. Care team who will be sharing a bit about housing related CalAIM services, and we'll be hearing from Karl Calhoun, Caroline Chung, and Alison Klurfeld. So, go ahead team. Thanks for joining today.

Karl Calhoun:

Thank you. Thank you very much, Mary. Good morning, everybody. Karl Calhoun here. I'm the Director of Safety Net Programs and Partnerships at L.A. Care, and I oversee the housing suite of services under CalAIM. We'll be talking basically in three phases about our services related to housing at L.A. Care. I'm going to start off with some broad kind of strategic description of our approach to CalAIM, and our approach to people experiencing homelessness at L.A. Care. And then my colleagues, Caroline Chung will talk a little bit more detail about our provider network with housing, and our housing programs. And then my other colleague, Alison Klurfeld, will talk a little bit about D-SNP, and dual eligibles. And we'll make some connections and answer any questions you may have about how housing, and the dual eligibles are connected at L.A. Care. So, next slide.

Karl Calhoun:

So, by way of review, I'm sure many of you are quite familiar with this. The Community Supports are services provided by the MCPs to… They're designed to be cost effective alternatives to traditional services. And in this instance, cost effective often reflects metrics that are designed to show improved health metrics, usually associated with cost effectiveness, and lower utilization at hospitals, especially fewer emergency room visits, and fewer admits to the hospital. Next slide. So, our approach to people experiencing homelessness is a three-pronged approach. We focus on clinical needs, supportive services, and a subgroup of those supportive services being housing. Clinically, we're looking at all areas of members'' clinical needs, their physical health, social needs, especially related to substance abuse, and their behavioral health needs, mental health as well. We also combined that focus with looking at their supportive services, case management, care management specifically with respect to CalAIM , we're looking at Enhanced Care Management, and helping address all social needs, and associated wraparound services.

Karl Calhoun:

And third, one of those key wraparound services is related to housing. We're looking at all aspects of housing, financial resources, looking at ideal ways to get people placed

into housing. I think Julianne mentioned that L.A. is a unique territory, and that's absolutely true, especially related to housing, considering the barriers around limited housing stock, and the price of housing, the traditional barriers associated with our region. And then we also focus, though, on when we are able to secure housing, we focus on aspects of successfully, maintaining housing on a long-term basis, and combining all of those three that represents our comprehensive strategic approach to people experiencing homelessness. And next slide. So, regarding our housing related suite of services under CalAIM, we like to think of our housing services, in terms of a continuum, a logical continuum for an individual who is unhoused either unsheltered, or sheltered, we think first of three programs, Housing Navigation, Housing Deposits, and Tenancy Sustaining Services.

Karl Calhoun:

The first program, Housing Navigation is the first step in that continuum. This is the program that helps us identify needs, and to address, and identify barriers associated with obtaining housing. Individuals are screened for their needs, and for any barriers that are preventing them from pursuing housing. We also use Housing Navigation to identify units, and to also identify any subsidies that can support the long-term sustenance in a new unit. And then the legwork begins obviously with Housing Navigation. The hardest part of Housing Navigation I think is the actual legwork of taking a member physically, assisting them in the journey to find units, checking out housing opportunities. When they do find a unit that works, the housing navigators will help them complete applications for both housing subsidies, EHV vouchers or Section 8 vouchers, but they'll also help them complete the actual application for tenancy in those units. When that process is complete, we move on to the second phase of the housing continuum, and that's the Housing Deposits program.

Karl Calhoun:

And quite frankly, that is simply to help cover the costs of moving into a unit. Many of our members struggle significantly with this phase of the process, but the Housing Deposits program identifies a series of, excuse me, a series of services that are approved by the MCPs. And those services help individuals cover the costs of move in. They include things like first, and last month rent, obviously Housing Deposits, but a series of other move-in necessities appliances, and so forth that will help them stabilize as they begin their tenure in the new unit. And after Housing Deposits, after they've moved in, and secured the unit, the third phase of the continuum begins, and that's Tenancy Sustaining Services. And this program is just as it's described, the purpose is to provide education, and support so that our members maintain their housing on a long-term basis. Some of those services include education around their responsibilities to regarding the lease, education around their financial obligation.

They still do have obligations related to their portion of the rent that the subsidies do not cover, so we educate them in about financial literacy. Also, one of the more subtle pieces of Tenancy Sustaining Services is to support them, and advocate for them, and educate them as needed around their key relationships in tenancy meaning their relationships, and responsibilities to their neighbors, to their unit, and to the landlord. Next slide. So, these are the 14 Community Supports that are offered. We at L.A. Care

are providing all of the services that are bolded. And the first three there are the traditional housing suite of services that I just discussed. Next slide. So, I will go ahead, and hand it over to Caroline now to talk a little bit more in detail about our housing services, and the layout of our structure here.

Mary Russell:

Caroline, are you able to come off mute? Great, there you are.

Caroline Chung:

Sorry. Thank you, Karl. So, I'm going to go into a little bit more detail about our three housing programs. So, our Housing Navigation and Tenancy Services, we together can call them HHSS, those programs were launched January 1st last year. Currently, we have about 11,000 members enrolled, and have a provider contracted provider network of about 22. About 58,000 of our current enrolled members were grandfathered in from the Whole Person Care & Health Homes programs. Our Housing Deposits launched a little bit later. They launched last year in July. We have it integrated, as Karl mentioned, with our HHSS programs. Currently, Housing Deposits are offered to our members who are sort of at the tail end of their Housing Navigation services. So, in other words, they've identified housing, and are preparing to move in. Currently, 13 of our providers are providing HD as well. It's a separate contracted service. We also have about eight new providers who are currently loading to go live with our HHSS services. And about half of those are also contracting to be HD providers. Next slide.

Caroline Chung:

So, this is our referral pathway for our HHSS, so Housing Navigation and Tenancy. Once a potentially eligible member is identified, they are referred into our team for review. Once reviewed for eligibility appropriateness, they get matched to one of our contracted providers. And then our providers will do the outreach within five days, and get the member enrolled. The initial authorizations for HHSS, so both Housing Navigation, and Tenancy Services is 12 months with an additional possibility for six month extension depending on need for continued services. Next slide. So, for Housing Navigation and Tenancy Services, sort of the eligibility criteria, we're looking at the member meeting, the HUD definition of homelessness as well as meeting high utilizer, high acuity criteria. Or this portion in red, or orange rather, is really mainly pertaining to our DHS referrals. So, sometimes we get referrals and from DHS through their ICMS, or PSH programs. And because they do an assessment for high acuity, and homelessness through those programs, we don't do a second assessment for that criteria.

Caroline Chung:

Next slide. So, this is our HD referral pathway. It's a little bit different. So, again, these members will already be enrolled in Housing Navigation with us. Once they're preparing to move in, a separate request will come into them where the provider will do an assessment of sort of move in needs, like Karl mentioned, that includes Housing Deposits, basic household items as related to kitchen, bedroom, bathroom, living room, et cetera. And they'll submit a request for funds, request for a total assessed amount.

Once that gets reviewed by our team, and we'll go ahead, and approve that total anticipated amount. And then once the provider works to expend, and purchase all the needed items, a claim gets sent back to us, and they are paid via reimbursement.

Caroline Chung:

Next slide. And eligibility, again, this could be similar to our HHSS because the member should already be in our HHSS program. So, there'll be a member enrolled in Housing Navigation, and with one of our contracted providers. And this is just a quick sort of overview of how our CS kind of overlaps with a couple of our other Safety Net programs. It's obviously not all inclusive, but these are a couple of key programs that we also work with at L.A. Care. And with that, I will pass it on to our colleague, Alison.

Alison Klurfeld:

Great. So, I want to share a little bit about how L.A. Care thinks about housing support services for people who are dually eligible. So, out of our current population of members enrolled in these Housing Navigation Tenancy Services suite, about 10,000, or almost 11,000 people, duals are about 14%. And so, I think this is important to know, people don't always think of older adults, people with disabilities when they think about people experiencing homelessness, but actually this is a really growing group, the fastest rising group of people experiencing homelessness in California is seniors. So, definitely we see housing, and the kind of transition from homelessness into housing, and maintaining that housing as part of our overall dual eligible strategy. One of the things that we did in designing the program was to include dual eligibles, and kind of the unified housing strategy. Rather than doing a separate dual strategy, we really wanted them to get the full benefits, the same kind of access to programs that other people experiencing homelessness get.

Alison Klurfeld:

And we actually have a slightly higher enrollment than expected in our programs, which is great because duals represent about 10% of our homeless population. It really varies county to county. Another decision we made was to kind of create a unified program, in terms of payment for dual eligibles. So, for capitation, we pay out for Housing Navigation and tenancy services, a monthly rate. And what we looked at was, is there any kind of Medicare equivalent service outside of Medi-Cal? And really there's not, I mean there's not housing services of this kind of same type. So, we decided the population is pretty small, we really want to focus on... The work for the providers to do Housing Navigation, or Tenancy Services is the same, no matter if that person is a dual or not. So, we wanted to get them the same payment, and really just focus on getting people into previously Cal MediConnect, and now D-SNP to get those integrated benefits.

Alison Klurfeld:

So, it's available to all duals. And as mentioned, we really want to focus on helping people with the transition. I think another thing that's important to note is that with our

Community Supports programs, Housing Navigation, Tenancy Services, Housing Deposits, these are really important, but they're not the only thing people experiencing homelessness need. So, as part of another DHCS program called HHIP, the Housing and Homelessness Incentive Program, we actually have a priority initiative where we're partnering really closely with the other managed care plan in L.A. Blue Shield, you heard from Julianne on the line is one of the other planned partners in L.A. we're also partnering with all our planned partners, and with the county on an ADL expansion strategy. So that's basically saying, "Hey, for people experiencing homelessness who need help with their activities of daily living, what can we do over, and above these community support services with these HHIP dollars to expand services?"

Alison Klurfeld:

So, we're going to be creating an assessment team that can go out, and figure out, "Hey, what does this person experiencing homelessness really need to thrive?" Do they need some personal care services like IHSS, or the Community Supports? Do they need actually a nursing level of care? What does this person need? So, an assessment team can go out and see them. They can also start personal care services right away in interim housing, even before IHSS, or plan Community Supports can start, and then help to transition that person into Community Supports with a plan as well as Housing Navigation, or other Community Supports with the plan. And then we're also doing an enriched residential care program for people who actually need more help than you can get in independent housing, but don't need a nursing level of care.

Alison Klurfeld:

So, we'll be working with adult residential facilities, and residential care facilities for the elderly on a model that's pretty similar to the assisted living waiver, where it's basically providing help for folks to live in a less restrictive setting than a nursing home, but still get care, and supervision to assist with their activities of daily living. So, we just mentioned this because we really see kind of the strategy, all things have to go together. It's not just the services we offer, but also how can we work with the county? How can we work other plans? How can we work with provider partners to bring everything together, so that people experiencing homelessness who are older adults, or have disabilities can get connected to all the services, and programs that they need. So, I'll go to the next slide, which I think is just our contact info. If you have any questions. Oh, sorry, I think I'm going back to Karl for this one. Let me let you go to that one.

Karl Calhoun:

Oh, yeah, well, you said it. If there's any questions, be happy to address them, or field any questions you all have?

Alison Klurfeld:

Oh, sorry, Karl, do you want to do the success, sorry. Do you want to do successes, and challenges, or was that me? I'm sorry.

Karl Calhoun:

Oh, oh, you can go ahead with that, Alison. Sorry.

Alison Klurfeld:

Sure, no problem. So, just wanted to share again, some high-level kind of sense of where we are, what's gone great, what's a little harder. So, I think some of the success is we have really great provider partners. Caroline mentioned the partnership we have with L.A. County who's been just a real partner in this space in creating programs, and also bringing in other resources outside of the plan. But we have great engagement also from some non-traditional kind of housing supports providers like community clinics who are able to integrate housing navigators into other care management programs they're providing in clinical care. So, we've been able to expand the provider network somewhat beyond some of the traditional healthcare partners, and beyond some of the traditional housing partners. And as mentioned, there's also other initiatives that the state has offered that we can combine to get a whole picture for our providers.

Alison Klurfeld:

So, I mentioned the Housing and Homelessness Incentive Program, but we also have the Incentive Payment Program, which lets us provide upfront startup funding to help providers build up their infrastructure because for example, a lot of housing providers, healthcare billing is totally new to them. Getting organized with this crazy world of managed care, this program lets us give them some money to get started. Some of the challenges, not surprising in California, that the providers are identifying housing placement as a really big challenge. So, we're really excited at the plan level to be able to provide support with services.

Alison Klurfeld:

So, a housing navigator, the one-time payments for housing deposits, tenancy services for ongoing support from a housing focused case manager. But the housing itself, we can't pay for rent as the health plan. So, that's a real barrier, and we're having to work a lot with other partners to find housing placements. Another challenge, though, you might not think about is hiring though, just because it's really challenging right now to find folks. This is a demanding career, and there's a lot of burnout. And then the last thing I'll just say is billing, and claims, and sorry, let me go back to Karl.

Karl Calhoun:

Yeah, I'm so sorry Alison. I was just going to add regarding the challenges around housing placement, many of our non-county providers, we have a very large portion of our services provided by the county of Los Angeles, but the CBO provider network, they struggle mightily to identify housing subsidies, and we do work with them as best we can to support them in that, but that is a significant part of the challenge associated with housing placements. I just wanted to add that. And the billing, and claim is more of an internal challenge that we are facing with many of our providers. They also are struggling to develop infrastructure to support billing in the MCP environment.

Karl Calhoun:

Many of them, it's their first engagement, and in this degree of a partnership with managed care plans. And so, there's a lot of technical hurdle to overcome regarding billing, and data communication, and data sharing. That's the only other piece I would add to that. And so yeah, with that I think that does bring us to the end. This is our information; contact information and we would be happy to address any questions anyone has. I see a couple of hands raised there.

Mary Russell:

Thank you so much Karl, and Caroline, and Alison, this is so interesting and helpful. Yes, and I think there were a couple questions in the chat that Alison was able to get to so far, but I will first call on Brianna, and I saw you had a question in the chat as well, so if you'd like to come off mute and ask your question, go ahead.

Brianna Moncada:

Sure. Hi, thank you so much for all the information. And my question is the same one that was in the chat, I wasn't sure if it got answered, because I've been in and out from some Wi-Fi issues, but just, and I'm sorry if I'm late to the game, but are all MLTSS and duals eligible for Community Supports at this time, or does that vary from plan to plan?

Karl Calhoun:

Well, yes. I mean, for us, I can't speak for the other plans, but they are all eligible for us. Yes.

Brianna Moncada:

Okay. For any of the... Oh, go ahead.

Alison Klurfeld:

And this is Alison, just to add a little nuance, one of the things Karl mentioned, the very first slide was that plans are responsible for Community Supports for ensuring cost effectiveness. So, it's a little different, it's not quite like a benefit, but that means that some plans worked with DHCS to set their cost effectiveness criteria. They may have limited certain Community Supports for duals. So, for L.A. Care, it's kind of everybody, but for other plans it sometimes can vary. And the reason why is actually it's a federal requirement around cost effectiveness, and just because that duals work is a little bit, the dollars work a little bit differently, but generally for most of them, people will probably all be eligible, but you do need to check with that specific plan.

Brianna Moncada:

Gotcha. Okay. Thank you so much. Yeah, we're a medically tailored meal provider for community support, so that's why I just wanted to make sure if they're eligible that we knew that. So, thank you. I really appreciate it.

Mary Russell:

Thank you. And I see a raised hand from Marjorie Swartz. Marjorie, would you like to jump in?

Marjorie Swartz:

Hi, yes, I have a question related to the way L.A. Care is handling. I think you mean when you say plan partners, you mean the plan, a separate Knox-Keene plan, that's one of your partners. They're the ones responsible for all the services. But my question relates to the enrollees you have who are delegated into a medical group. In that case, is L.A. Care providing the Community Supports, or have you delegated that to the medical group? And the reason I'm asking is because I was trying to assist a homeless person who was in a medical group, and the person did not realize they were in L.A. Care. They kept telling me their plan was the medical group. And so, I'm not sure how people like that are supposed to know that L.A. Care is responsible for their Community Supports unless you're telling me the delegated medical group is, and if they are, how are you monitoring whether they're meeting the same standards you are, for your non-delegated enrollees?

Alison Klurfeld:

Yeah, I can take that one, Karl. We haven't delegated it to any groups. All the Community Supports are managed by L.A. Care directly. There's some information on our website about that if people have questions, but I know it can be confusing. We've also provided education to all of our medical groups about how to refer to Community Supports, because even though L.A. Care is covering them, we want them all to know. So, hopefully, I mean think and if you have this specific case, maybe it's also good to follow up with the team after, because we can just double check for this person. But the medical group should be able to refer, it's a forum, and the referral form is also on our website. Anyone can refer, you could help the person refer, the person could self-refer by calling up as well. So, the idea is not just for us but for all plans, you have to kind of have a no wrong door approach. It doesn't matter who makes the call. It's our responsibility to get the person to the right program.

Marjorie Swartz:

Thank you. But the person can't self-refer if they don't realize they're in L.A. Care.

Alison Klurfeld:

Yep, that's definitely a challenge. So, that's why we do the medical group education, and maybe we could follow up after. I think would be good too.

Marjorie Swartz:

Thank you.

Mary Russell:

Thanks for that question. Thanks, Alison. Rick, would you like to come off mute, and ask a question?

Rick Hodgkins:

Yes. I was trying to take notes on my iPhone, and only put in the talking points, but what specific services are... Is it the same services that are covered for people with disabilities for everyone, or are there additional services? Not only do I report to my people first chapter, but I also sit on the Lanterman Housing Alliance that we are a housing alliance that advocates for the housing needs statewide for the I/DD community as I receive services. And also, what about for people that are not homeless, or in a homeless shelter, but also for people that just want to move from one apartment to another. I see that the only one time expense here is a housing deposit, and also first, and last month's rent. Thank you.

Karl Calhoun:

Sure. So, I'll try to address those questions. Regarding special services for the disabled, the suite of services is the same for everyone regarding housing services. Housing Navigation, Housing deposits, and Tenancy Sustaining Services are all geared toward identifying, supporting, move-in and then supporting sustained residents in a unit. And those services are applicable to everyone. Regarding the question about whether someone's in a shelter, or unsheltered if you are homeless, and sheltered, it does still qualify you for the services. Many of our members in our provider network are CBOs that run interim housing, or transitional housing programs. And so those members absolutely qualify for all three of the housing services. And I forgot, I'm sorry. I'm so sorry. I forgot the last question that you asked there. Can you tell me again what the third question was, Rick? I'm sorry about that answer. I know you had another question there, but I can't recall exactly what the third question.

Mary Russell:

Yeah, Rick, you should be able to come off mute. I think it was about someone who was interested in moving between housing.

Karl Calhoun:

Oh, that's right. Yes, yes. Somebody who is currently housed. And so if someone is housed, they would not qualify for Housing deposits, because Housing deposits are for people who are coming from an unhoused status, and moving into housing for the first time as a result of navigation services.

Rick Hodgkins:

That's one thing I just wanted to make, because I need to report back to... I'm not a member of Brilliant Corners, but we have two or three people that sit on the Lanterman Housing Alliance that are with Brilliant Corners, and that might be one of their concerns with the Housing Navigation Services. Not everyone in our community can afford housing deposits. So, I wanted to make sure that... And also, one of your... I bring up people with disabilities because one of your colleagues, when she mentioned people with disabilities, she talked about people coming out of hospitalizations, and that type of thing. So, I wanted to clarify that. Thank you.

Mary Russell:

Thank you, Rick. Thank you. It looks like we have a couple more questions in the chat, and a few minutes to go. So I wanted to highlight a question from Eileen. Is the health plan, or provider assessing members who are at nursing level of care, and referring folks who qualify to the existing waiver programs? I'm not sure L.A. Care team if you saw that question in the chat.

Alison Klurfeld:

Yeah, I think the answer is yes, it's kind of happening both places, but I think that right now, in terms of folks being assessed for Housing Navigation or Tenancy Services, one of the key kind of criteria to look at is that the provider's looking at is can this person really live independently? And are they going to be able to be successful in that environment, or do they need a higher level of care? We see this a lot also with people coming out of recuperative care for example, after a hospital setting. The program I mentioned that's new is one thing we're finding is there's a need in our region for assessment that's also field-based specifically for interim housing. So, that's where we're going to be working with L.A. County to set up the enhanced care assessment teams to be able to go out teams of... We're still figuring out the composition, whether it's nurses, occupational therapists, different types of professionals who can actually go out to different types of shelters, and interim, and transitional housing to assess what folks need, and get them connected to services right away, including Community Supports.

Mary Russell:

Great. Thanks, Alison. And a last question here from Kristen. Have you used the Community Supports for personal assistance for people in shelters, for example, during the time between IHSS authorization, and initiation of service?

Alison Klurfeld:

So just a quick comment to that is sort of, yes, but we're just getting started. So, L.A. County has a program that focuses on that specifically. They work, and they became a personal care assistance contractor just a couple months ago. So, they're just starting out. But we think that this will be really important in terms of how to get people connected because we can get started often faster than IHSS, and that gets somebody what they need right away can help them to stay in interim housing rather than going back to the hospital, or a higher level of care.

Mary Russell:

Great. Thank you so much. This has been so helpful, and thank you everyone for your questions, and comments in the chat. So, at this point we just wanted to remind everyone of the next MLTSS, and Duals Integration Stakeholder Workgroup, which will be Wednesday, April 19th at 10:30 AM, and we will be sharing a registration link for that meeting, shortly. I do see one raised hand from Susan. Susan, would you like to jump in for our last question of the meeting?

Susan LaPadula:

Thank you, Mary, and thank you to all our presenters today. Wonderful information. My question is for the Department, and all the plans, skilled nursing facilities, and long-term care are in need of a 2023 billing policy update to manuals. We're finding that we have 2022, but not the new information available at the plans' websites. Can you help us with that?

Mary Russell:

Thank you, Susan. I'm not sure we have the right people from the Department. I know our team shared the link to the LTC call tomorrow, I believe. And so, I think that then you might be able to get more support there, and we're also happy to take this back and help you with follow up.

Susan LaPadula:

Wonderful. Thank you so much, Mary. And once again, thank you everyone.

Mary Russell:

Great. Thanks so much everyone. We appreciate your participation today and look forward to seeing you at the next meeting in April. Take care.