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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FILE DURATION: 1 hour 27 minutes

SPEAKERS

Mary Russell
Anastasia Dodson
Stacy Nguyen
Stephanie Conde
Dr. Shaw Natsui
Tracy Meeker

Mary Russell:

Good morning everyone, and welcome. We will give it another minute or two before we officially kick off today's meeting. All right. Good morning. Hello. Welcome to today's CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup. We have some great presenters with us today. We'll be hearing from Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS; Stacy Nguyen, the Branch Chief with the Managed Care and Quality Monitoring Division at DHCS; Stephanie Conde, Branch Chief with the Managed Care Operations Division at DHCS; Dr. Shaw Natsui, a Medical Director with the Quality and Population Health Management Team at DHCS; and Tracy Meeker with Managed Care and Quality Monitoring Division at DHCS.

Mary Russell:

A few quick meeting management items before we begin. All participants will be on mute during the presentation. As a reminder, the monthly MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions. We'd like to ask the plans that join these calls to hold their questions for the other venues that they have with DHCS throughout the month. Please feel free to submit any questions for the speakers via 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. Also, a reminder that the PowerPoint slides and all meeting materials will be available on the CalAIM website in the next few days. We'll provide a link to those materials in the Zoom chat.

Mary Russell:

Before we officially kick off, we'd like to ask that you take a minute to add your organization's name to your Zoom name so that it appears your name, dash, organization. To do that, click on the participants icon on the bottom of the window, hover over your name in the participants list on the right side of the Zoom window, click more, select rename from the drop down, and enter your name and organization as you would like it to appear.

Mary Russell:

We'll take a look at today's agenda. We'll start with an update on the Skilled Nursing Facility Long-Term Care Carve-In transition with some time for Q&A. Next, we'll hear updates on the January 2023 transitions and the DHCS monitoring with some time for Q&A as well. After that, we'll hear an update on the launch of the Enhanced Care Management, or ECM, 2023 Populations of Focus. Then we'll do a quick overview of the recently released 2023 CalAIM D-SNP Policy Guide chapters. And finally, we'll hear an update on the 2024 D-SNP Care Coordination Guidance. We'll end the call with some information on upcoming meetings and next steps. As a reminder, there are additional background slides on the Public Health Emergency Unwinding, which are available in the appendix. With that, I'll hand it over to Anastasia Dodson.

Anastasia Dodson:

Thank you so much, Mary. Pleased to be with all of you today. Just a reminder of the purpose of this meeting and also talk a little bit more about the agenda. This workgroup purpose is a collaboration hub for both CalAIM Managed Long-Term Services and Supports, that's for all Medi-Cal beneficiaries who need long-term services and supports, and integrated care for dual eligible beneficiaries. We, in the past, have been focusing a lot on D-SNP topics, the transition of Cal MediConnect to Medi-Medi Plans, and also talking about enrollment of duals into Medi-Cal managed care. But we do also want to flag that we intend to have this venue for the Managed Long-Term Services and Supports such as Enhanced Care Management and Community Supports for people who are using long-term services and supports. To that end, as you saw on the agenda today, we're going to get an update on Enhanced Care Management for the new populations of focus that include LTSS.

Anastasia Dodson:

And in future meetings for this group, we do want to make sure we're addressing a variety of topics, not limited to D-SNPs. That said, we do have a lot of updates to flag for you all about the D-SNP care coordination requirements and other components of D-SNPs. But we're happy to think about for future meetings, what's the right balance? How much on D-SNPs? How much on other topics related to dual eligibles that are not in D-SNPs, and Managed Long-Term Services and Supports that are beyond just dual eligibles? Because there are Medi-Cal only folks that are using those services and enrolled in those programs.

Anastasia Dodson:

With that said, we will go forward. We've got a very packed agenda. We can talk about what particular topics we might want to focus on for the next meeting in February. But again, for this meeting, we're just going to put the most relevant critical issues up top. We're going to talk about the long-term care carve-in updates, et cetera. You'll see as we get toward the end of the agenda, we're going to zoom through a lot of slides. We won't really have time for as much discussion as we'd like to, but we want to get the materials in front of you, and then future meetings, we can have more detailed discussions on those topics.

Anastasia Dodson:

Next slide, I think. This is the general perspective on these meetings. There's a lot here and there's a lot to discuss. Next slide. Good. So, with that, I'm going to hand it over to Stacy. Thank you.

Mary Russell:

Great. Thanks, Stacy, for being with us today. And feel free to go ahead.

Stacy Nguyen:

Great. Thank you, Anastasia and Mary. Thanks for having me today. Good morning, everyone. Today I will be providing a brief overview of our Long-Term Care Skilled Nursing Facility Carve-in policy, as well as an overview of some practices and resources for managed care plans related to the carve-in. Long-term care services are included under the umbrella of MLTSS or Managed Long-Term Services and Supports. CalAIM's goal is to make coverage of institutional long-term care consistent across all counties and all Medi-Cal members. These changes are implemented in phases based on the long-term care facility or provider type. On January 1st, 2023, Medi-Cal managed care plans in all counties began to cover the long-term care benefit for SNFs. This includes a distinct SNF or a unit within a hospital. All Medi-Cal beneficiaries residing in a long-term care facility are mandatory to enroll in a managed care plan for their Medi-Cal coverage services.

Stacy Nguyen:

The SNF carve-in is intended to standardize benefits and coverage for SNF services under managed care across the state. This transition of SNF services to managed care helps members maintain their Medi-Cal managed care enrollment and eligibility for extended SNF stays and helps avoid disenrollment from managed care to fee-for-service. Under managed care, members also obtain access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal beneficiaries in skilled nursing facilities.

Stacy Nguyen:

The department has made some revisions to the APL 22-018, which is SNF long-term care benefit standardization and transition of members to managed care. We included a section on PASRR to prevent inappropriate nursing facility admission and retention of individuals in accordance with federal law. These requirements are applicable for Medicaid certified nursing facilities and for all admissions. Managed care plans are required to work with Department of Health Care Services and network providers, including discharging facilities or admitting nursing facilities, to obtain documentation validating this process completion.

Stacy Nguyen:

The Population Health Management Requirement section was also edited to add transitional care services, which managed care plans must provide in a phased approach. By January 1st, 2023, the plans must implement timely prior authorizations for all members and know when all members are admitted, discharged, or transferred from facilities, including SNFs. Managed care plans must also ensure that all transitional care services are completed for high-risk members, including assigning a single point of contact, referred to as a care manager, and to assist members throughout their transition and ensure that all required services are complete. By January 1st, 2024, managed care plans must ensure that all transitional care services

are completed for all members.

Stacy Nguyen:

Other updates to our SNF APL include requirements that managed care plans must maintain a comprehensive quality assurance performance improvement program for long-term services provided. Managed care plans must also have a system in place to collect quality assurance and improvement findings from the Department of Public Health to include, but are not limited to, survey deficiency results, site visit findings, and complaint findings.

Stacy Nguyen:

Additionally, there was also clarification that managed care plans are reported to report on long-term care measures within the Managed Care Accountability Set of performance measures. Managed care plans are required to calculate the rates for each accountability set long-term care measure for each SNF within their network for each reporting unit. Managed care plans will be held to quality and enforcement standards in APL 19-017 and APL 22-015 respectively, or any superseding APLs. Managed care plans are also required to annually submit quality assurance performance improvement program reports with outcome and trending data, as specified by DHCS.

Stacy Nguyen:

During the first quarter of 2023, the Department will be monitoring plans for network adequacy, continuity of care, grievances and appeals, and assessment of treatment authorization requests or prior authorizations. Managed care plans are required to report to DHCS daily on continuity of care and grievances and appeals. The plans have provided daily post-transitional monitoring reports and there are no significant issues or concerns at this time. These post-transitional monitoring reports have included the number of continuity of care requests, for example, bed hold authorizations and statuses, and long-term care calls from providers. The Department continues to regularly monitor call center reports from our DHCS Medi-Cal Ombudsman and Health Care Options.

Stacy Nguyen:

As part of our plan readiness, the Department established network readiness requirements in APL 22-018. Specifically, that the plans must attempt to contract with all SNFs in the managed care plan service area and contract with a minimum of 60% of SNFs. As we are now post-transition, it is DHCS's intent that managed care plans transition from a minimum contracting requirement for network readiness to ongoing network capacity building to ensure that access to skilled nursing facilities are available for its members. DHCS encourages managed care plans to contract broadly with all CDPH, our Department of Public Health, enrolled and licensed skilled nursing facilities.

Stacy Nguyen:

The Department also sent guidance to managed care plans that reminds them that letters of intents do not count toward the contract requirement, as they're not intended to be used for long-term arrangements. Letters of agreements should only be used during the interim while contracts are in progress. If any managed care plans were using letters of agreements to meet readiness requirements, our guidance specified that managed care plan should seek to replace the letters of agreements with network provider agreements for readiness requirements.

Stacy Nguyen:

For longer term monitoring, which will start in mid-2023, DHCS will be using a transitional monitoring template for ongoing monitoring, which examines access, quality, and encounter data quality, and other customary managed care plan compliance monitoring activities, such as grievances and appeals or continuity of care, as previously mentioned. Starting April 2023, which is 90 days after January 1, managed care plans must submit their completed transitional monitoring template on a quarterly basis, and we'll be in the midst of reassessing members. Providers will need to contact the managed care plan and their managed care plan LTSS liaisons or representative to escalate and resolve any issues with the managed care plan, including payment, billing, or claims issues. And if any SNF providers are having challenges with identifying or getting into direct contact with appropriate plan contacts regarding billing, DHCS will be happy to provide SNFs the appropriate contact or contact list in order to support.

Stacy Nguyen:

For more information about the long-term care transition and CalAIM, please visit our website linked on this slide. If you have any follow-up questions, feel free to also reach out to info@calduals.org. I know I think I saw a few questions pop up.

Mary Russell:

Thanks so much, Stacy. Sure. I'm taking a look at the chat. I know we've been able to post some additional resources in the chat. Scanning additional questions. Let's see. I know Beth Garver is asking, "Is the department collecting the number of patients and non-contracted SNFs from the plans?”

Stacy Nguyen:

That one, I will have to take back just to confirm. I know we're collecting a lot of information. I don't want to misspeak. We have our templates, and I can't recall right now off the top of my head if that's included.

Mary Russell:

We can track that one for follow-up. I see a hand raised from Susan LaPadula. Susan,

would you like to unmute?

Susan LaPadula:

Yes. Hi. Happy New Year, Mary. Hello, Stacy.

Stacy Nguyen:

Hi.

Susan LaPadula:

Hi. My question is regards to the LTSS managed care plan liaison. How soon will the department be publishing that list for us statewide?

Stacy Nguyen:

So, I actually don't think that's with my group. I don't have that right now. I'm not sure if there are any other department contacts that might have a timeline for that that can speak to that.

Mary Russell:

That's a good flag. That might be something... I'm not sure we have the right DHCS resource on. Anastasia, do you have a perspective on that?

Anastasia Dodson:

We're chatting behind the scenes. Any of these that we're able to, even in other sections of the presentation, if we're able to let you know. Otherwise, we'll definitely do more follow-up with you individually.

Susan LaPadula:

Thank you so much.

Stacy Nguyen:

Thanks for your question, Susan.

Susan LaPadula:

You're welcome.

Mary Russell:

Thanks. I see a hand raised from Beth Garver. Beth, would you like to unmute and ask your question?

Beth Garver:

The question that Susan just asked, we've asked that for several months. The point of contacts for each plan is critical. But my question is about the plans that weren't staffed appropriately to execute contracts in a timely manner. They're not willing to do retroactive effective dates. That's going to negatively impact SNFs, and it's almost like a financial punishment. Is the state aware of that? Is there any plan to address that? Because we're talking about thousands of days for providers that are out of network.

Anastasia Dodson:

We will flag that for the WQIP team. Thank you.

Stacy Nguyen:

The department did also, in its reminder to the plans about ongoing contracting efforts, did ask plans to backdate that contract ….

Beth Garver:

They're not willing. Not one plan is willing to do that.

Stacy Nguyen:

Like Anastasia mentioned, we'll take that back. But also, if you guys have specific plans that you're encountering those issues with, we can take those back in also.

Beth Garver:

Consider this almost every plan, because I've been waiting for over two years from some plans. But I don't think any plan was staffed up for this. We still, despite efforts of over a year preparing, I don't think any plan was staffed for this. So, you can consider almost every plan in that category. I think that's safe to say.

Stacy Nguyen:

Thank you, Beth. We'll let our WQIP team know about that as well.

Mary Russell:

Thank you. Susan, it looks like you have another question. Would you like to come off mute?

Susan LaPadula:

Yes, thank you. I would just like to lift up the fact that Kaiser is really difficult for the providers, especially in Sacramento County. We're unable to contract with Kaiser at all, even though we have Kaiser members in our buildings. We really could use the Department's help on the brand of Kaiser, specifically Northern California and

Southern, regarding contracting.

Stacy Nguyen:

Thank you, Susan. Yes, we will reach out to Kaiser as well. I know Kaiser and all the plans are part of our outreach efforts as well on these concerns.

Mary Russell:

Thanks, Susan. I want to acknowledge a note from Erin in the chat with additional detail that I think, Stacy and Anastasia could be brought back to the WQIP team. And a question from Maura Gibney. Many hospital discharge teams are telling people they can go to only one SNF because of their managed care plan. Is there a minimum amount of SNFs a plan should contract with? What is the solution to this?

Stacy Nguyen:

As part of our network readiness requirements, the number of SNFs available for plans or contract within each service area does differ. We required prior to January 1 a minimum of 60%, which plans met, but we understand that there is still an ongoing greater need. And so, that's something we're working with the plans on to encourage more contracting. That gets back to your note. We ideally would love for plans to contract with as many as licensed, but we understand that that's not always 100% possible. That is something that we are continuously working with plans to increase and improve.

Mary Russell:

Thank you, Stacy. Thanks, all, for these questions. Again, feel free to drop anything in the chat as the workgroup continues today. But appreciate you, Stacy. Thank you for joining today. I think we'll transition on to the next topic. At this time, we'll shift gears and discuss updates on the other 2023 transitions and DHCS monitoring. We'll start by hearing from Stephanie Conde, Branch Chief with the Managed Care Operations Division. Thanks, Stephanie, for joining today.

Stephanie Conde:

Hi. Good morning, everyone. Thanks, Mary. All right. I'm going to go through some of our Cal MediConnect to Medi-Medi Plan transition updates. I refer to the Medi-Medi Plans as the MMPs, just as a quick note.

Stephanie Conde:

So, overall, as folks are already tracking and know, on January 1st of this year, beneficiaries in our Cal MediConnect plans were automatically transitioned into the MMPs, the Medi-Medi Plans, operated by the same parent company as the Cal MediConnect plan. As a reminder, there was no gap in coverage. Provider networks should be substantially similar, and continuity of care provisions were put into place.

Our Medi-Medi Plans combine Medicare and Medi-Cal benefits into one plan. These are available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties, which is our former CCI Counties. Next slide, please.

Stephanie Conde:

So, just as a way of an update, very successful transition. We transition successfully 99.62% of our Cal MediConnect beneficiaries into an MMP, or the managed care plan aligned to their current Medicare Advantage plan. What that means is we have 12 counties that are considered in our Medi-Cal Matching Plan Policy that we've presented on before. So, our Cal MediConnect folks were either transitioned into the parent managed care plan or their matching MCP based on their Medicare enrollment. 429, so 0.38%, of CMC beneficiaries, were not shifted, but that was for valid plan exclusion reasons. So, there was a reason they did not transition, but it was a very small percentage. Next slide, please. Excuse me.

Stephanie Conde:

As a way of post-transitional monitoring, we call this PTM in the DHCS world. Plans were reporting daily for a period of time, then weekly, and then monthly. You can see below those frequency and the dates aligned with that. And what we were looking for in regard to the plans reporting, provider phone calls on access to care issues, technical issues, grievances and appeals. These are submitted via Survey Monkey. And again, the frequency of that reporting is below on this slide deck. Next slide, please.

Stephanie Conde:

At this time, no major access to care issues have been reported for our Cal MediConnect transition. Plans did flag some technical issues, which we had updated some of their technical resources to understand from a Medi-Cal perspective what plan that beneficiary is in from a Medicare enrollment. So, a few technical issues we're working through. Our technical file is called the 834. We are working through those. Again, those are not major issues, and of course, not access to care. I think that's my last slide. I will transition, for Mary, over to Anastasia to report out on the Medi-Cal Managed Care Enrollment for Dual Eligibles.

Anastasia Dodson:

Thanks so much, Stephanie. And just to clarify, I think at the end of this next section then, we're going to go to Q&A on these topics. All right. So, one of the other transitions we've been working on, you all have been working on, has been enrolling dual eligibles statewide into Medi-Cal managed care. Next slide.

Anastasia Dodson:

This is the map you're probably all familiar with. The counties in the purple, COHS

counties where skilled nursing facilities services and dual eligibles are already in Medi-Cal managed care. The pink are the counties where skilled nursing facility services and most dual eligible beneficiaries are already enrolled in Medi-Cal managed care. The bluish color for parts of the Central Valley, Bay Area, Imperial, those are where dual eligible beneficiaries have been optional for enrolling in a Medi-Cal managed care plan, and long-term care has not been carved into Medi-Cal managed care. That is the transition, both for long-term care and dual eligible beneficiaries, that was begun January 1st. I will just flag that... Well, you'll see on the next slide, some people did select a Medi-Cal managed care plan. So, that transition was effective for them January 1st. A majority of folks did not select a Medi-Cal managed care plan, so they will be default enrolled February 1st. Next slide.

Anastasia Dodson:

Prior to this, 70%, more than 1.1 million, dual eligibles were already enrolled in a Medi-Cal managed care plan. In January or February, there'll be a total of about 325,000 dual eligible beneficiaries that will be and have been newly enrolled into a Medi-Cal managed care plan. Let's see. The key impacted counties. You can see there; they align with the blue counties on that map. But again, there are some folks in the larger Southern California counties, the CCI counties, that also received notices and need to enroll in a Medi-Cal managed care plan. Materials were sent out in the fall to inform beneficiaries of this change. The Medi-Cal matching plan policy does apply, so folks who are already enrolled in a Medicare Advantage plan that has a corresponding Medi-Cal plan in certain counties, they then were automatically enrolled into the Medi-Cal plan that matches their Medicare plan. Next slide.

Anastasia Dodson:

This gives you some information about how many folks made a selection and how many folks were enrolled in a Medi-Cal plan as a result of the matching plan policy. About 25,000 beneficiaries enrolled by choice into a Medi-Cal managed care plan effective January 1st, and then 33,000 or so were enrolled into a Medi-Cal plan that matched their Medicare Advantage plan, also effective January 1st. Thinking about the number that we had on the prior slide of about 325,000, and then subtracting the two figures here, the 25,000 and the 33,000, then we end up with something like 260,000 dual eligible beneficiaries that will be automatically default enrolled into a plan effective February 1st, 2023.

Anastasia Dodson:

The takeaway that we have at DHCS from that is that we have been doing a lot of Medicare provider outreach on this topic and we will continue to do so. We're going to talk about some of the resources that we have to try to help Medicare providers better understand and their front offices. And of course, we've done a lot of outreach to Medi-Cal beneficiaries, to dual eligibles. But there's still quite a large number of people that have not yet enrolled in a Medi-Cal plan and will need to as far as dual eligibles So, just will continue all the communication on that. Next slide.

Anastasia Dodson:

This is just a reminder about the 31 counties. In bold here, this is what we're trying to send out to as many folks as we can. Medicare providers serving dual eligible patients do not need to enroll in Medi-Cal plans in order to continue to receive reimbursement as usual. We'll even go through more of the detail there. But that is the fundamental message that we're trying to get out in every way possible, that Medi-Cal managed care enrollment doesn't impact Medicare provider access or the choice of either original Medicare or Medicare Advantage. Again, Medicare providers, we'll go through the details. Their billing process can remain very similar with this transition. They do not need to be part of the Medi-Cal plan network for getting Medicare reimbursement or the secondary Medi-Cal. Again, we have fact sheets, notices, et cetera, in many languages. They're all posted on the DHCS website. Next slide.

Anastasia Dodson:

This is getting a little bit into the weeds, but in case you hear of something, and you can share this information, we would appreciate it. In original Fee-for-Service Medicare, providers bill what's called the Medicare Administrative Contractor, Noridian. And then, Noridian processes the primary claim for the Medicare payment, and then forwards the claim to the Medi-Cal plan or DHCS for the secondary Medi-Cal payment. Noridian gets Medi-Cal managed care enrollment information from what's called the Medicare Benefits Coordination Recovery Center plans. Medi-Cal plans and DHCS send information to the Medicare benefits center.

Anastasia Dodson:

That is the process that's been long-standing and that remains. Again, that's how it works in all the other counties and will work in these 31 counties. The original Fee-for-Service Medicare providers, they continue their billing process to Noridian as usual for Medicare Advantage. Again, close to half of dual beneficiaries are enrolled in some type of Medicare Advantage or D-SNP plan. The provider bills the MA plan or the D-SNP for the primary Medicare payment. And if the Medicare plan is also the same organization as the Medi-Cal plan, then they can do the secondary billing basically in-house. In some cases, the MA plan can send that secondary claim to the Medi-Cal plan, or the provider would need to bill the secondary to the Medi-Cal plan. Again, that was an existing process already, and the main point is that the Medicare provider sends their claim to the Medicare Advantage organization, which is the same as today. Next slide.

Anastasia Dodson:

There was an all plan letter that was posted a number of years ago. It still holds. We're doing a few updates, clarifications, reminders. We'll do a refresh of that APL, but the fundamental piece of crossover billing remains the same. We also have a new document, we're going to show you some slides, that has the actual crossover claim contact information for each of the Medi-Cal plans. We've been sharing that with

advocates. We have county specific versions of those that we're publishing as well. Let's go to the next slide.

Anastasia Dodson:

We're calling it the Crossover Billing Toolkit for Medicare Providers Serving Dual Eligibles. It's very similar to a toolkit we posted with the Coordinated Care Initiative. Next slide.

Anastasia Dodson:

This is, again, the language from the toolkit. Just like we talked about in the previous slide about patients in original Medicare versus patients in Medicare Advantage plan. The physician bills for Medicare services just the same way as they did in the past. Next slide.

Anastasia Dodson:

That toolkit also includes this chart, which we hope is helpful to providers, around which scenario someone may be in, whether they're an original Fee-for-Service Medicare or Medicare Advantage, and then Medi-Cal managed care plan or Fee-for-Service Medi-Cal. We are continuing to publish. Again, this is nothing new, but we're just trying to refresh and repost. Next slide.

Anastasia Dodson:

And then This gives an idea of how the particular crossover billing information for each plan is available on that document. Next slide.

Anastasia Dodson:

A reminder about balance billing. Dual eligibles should never receive a bill for their Medicare services. This is improper billing. It's illegal. So, for folks who are in a Medicare Advantage plan, it's their dual eligible. They don't pay for doctor visits or other medical care when they get services from a provider in their Medicare Advantage provider network. They may still have a small co-pay for prescription drugs. Next slide. Okay.

Mary Russell:

Thank you so much, Anastasia. At this time, we'll open up Q&A on the updates Anastasia shared as well as the updates Stephanie shared. I'm taking a quick look at the chat. I also see a hand raise from Rick Hodgkins. Rick, would you like to unmute and ask your question?

Rick Hodgkins:

Yes. I'm not on my computer today because I'm having trouble with my Zoom app, so

I could not introduce myself in the chat because it would take forever on my iPhone. So, I need to introduce myself. My name is Rick Hodgkins. I am with Capital People First. That's an organization that advocates for the I/DD community in the city and county of Sacramento. I'm also with the STEP Agency, Strategies to Empower People. We provide employment and vocational services; ILS, Independent Living Services; SLS, Supported Living Services; Mobile Crisis; Tailored Day Services, or TDS, which is a one-on-one service. I mentioned the mobile crisis services. I'm also with the Lanterman Housing Alliance. We advocate for the independent and housing needs of the I/DD community statewide.

Rick Hodgkins:

And my question or comment is, are there still talks with all the medical providers statewide, including Barton Health and UC Davis, UCSF, Stanford, and the like? Because I had to switch one of my appointments with UC Davis from next week to the following week. So, I just hope all the providers are updated and on board with the changes. As a side note, I have already picked my dental plan and health plan. My health plan will be Anthem Blue Cross and my dental plan will be Liberty Dental. Because Anthem Blue Cross does not have a dental plan, so I picked Liberty Dental, and I am all set. Both things will be launched for me February 1st, and so I am all set. I just hope that all the healthcare providers are on board and updated. So, that is my spiel. Thank you again, Anastasia.

Anastasia Dodson:

Thank you so much, Rick. Your feedback has been invaluable for us. I just can't say enough how much I appreciate you joining the calls and keeping us updated. I think we have your contact information, and you have ours, so if anything comes up outside of this meeting, please feel free to contact us and we will do our best. Yes, we have for sure UC Davis, we have outreached with and talked to several times. I have frankly lost track of the list of all the individual providers and health systems that we've spoken to, but I believe Barton Health is also on the list. But for anyone, please, you can email the info@calduals, you can email me. Many of you know my email.

Rick Hodgkins:

I don't know your personal email, though.

Anastasia Dodson:

Well, I'm sure the team can share that with you. But really, to everyone, though, it's very helpful for us to hear of specific providers, not a gotcha list, but just who else can we help educate. We also find that there is no master list of Medicare provider emails in California. We've talked with CMS about that. So, just getting the word out to all of you on this call and all of your networks, the materials that are available. We know that over time, we just need to just keep at it, sharing this with providers through every channel we can. We really appreciate everyone's help sharing this information.

Mary Russell:

Thanks so much, Rick. Thanks, Anastasia. I see a raised hand from Skyler. Skyler, would you like to come off mute and ask your question?

Skyler Rosellini:

Hi there. Thank you so much for all of this information. And I apologize if I missed this detail, but at the last CFSW meeting, you had reported out that all former CMC enrollees had been successfully shifted to their Medicare Medi-Cal plans except for just a small fraction. I think it was about 429 who weren't shifted for all sorts of reasons. And I was just wondering if there was an update on that fraction of folks. And again, apologies if I missed that update

Stephanie Conde:

Hi, Skyler. Stephanie Conde with Managed Care Operations. There's another question on this in the chat box as well, so happy you asked. Those 429 folks didn't transition for various reasons. They could have been now successfully in a managed care plan. But some of the reasons, and I'll just go through it, are death, that they would not then have transition. And that's, again, a valid reason. They moved out of state. They became ineligible, which is a very, very small group of those folks. But some of those, and I'm trying if I can remember my numbers. 90 didn't transition initially because of an address issue. We were able to follow up with that beneficiary and work with the managed care plans to get that information updated. That subset, the 90 or so, will be enrolled on a 2/1/2023. We have worked through the 429 that were able to be worked through, but then some are truly valid reasons that they did not shift over. Let me know if you have any follow-up.

Mary Russell:

Thank you, Stephanie. I think that captures a question from Jason in the chat as well. I'm just looking at the chat. There are some notes of appreciation for these additional billing resources. Stephanie, I think this is another question for you. Is there a deadline as to when dual eligible patients can enroll into MCP before they're auto enrolled?

Stephanie Conde:

Very good question. It's not a specific date, it's a date listed in the beneficiary's enrollment packet. There's a date given on the enrollment packet, but there's a cushion period because we allow for mailing days, so on and so forth, so it really truly is towards the end of the month before they are auto enrolled. We will start, based on that date in their enrollment packet, placing them into that plan and sending what we call a confirmation letter to that beneficiary. But at any time before that cutoff right at the end of the month, they can call into healthcare options and change, and/or ask questions about what their available plan options are.

Mary Russell:

Great, thank you. At this time, I'm not seeing any other questions in the chat, or any hands raised. Any other questions for this section? With that, thank you, Stephanie. Thank you, Anastasia. We will transition over to Dr. Shaw Natsui, Medical Director with QPHM. Thanks for joining today. Go ahead.

Dr. Shaw Natsui:

Great. Thank you, Mary. Hi, everybody. My name is Shaw Natsui. I'm a physician with DHCS's Quality and Population Health Management Team. I serve as a Medical Director for PHM. I'm here today, I normally would be joined by Dr. Laura Miller, to share with you also updates regarding Enhanced Care Management for 2023. So, if you can go to the next slide.

Dr. Shaw Natsui:

I just wanted to make sure we started at a very high level and make sure we're providing a shared understanding of what ECM is. As you all know, managed care plans are required to provide a broad range of programs and services to meet the needs of the members. The way we conceptualize this is that we have a tiered approach based on need and risk. As you see here on a very, again, conceptual level and basic level, we have a foundation around basic population health management. Again, these are an array of programs and services for all MCP members, regardless of risk and things like that. And so, it includes basic care coordination and wellness and prevention programs. Again, this is for all members. Overlying that are complex care management and ECM. Complex care management has been around for some time. It's targeting higher and medium rising risk members for more chronic care coordination, as well as temporary needs, and disease specific management interventions. ECM, as many of you know, is for our highest need members to provide more intensive coordination of care.

Dr. Shaw Natsui:

A big focus this year and moving forward now with PHM is transitional care services. In January of this year, transitional care services are now a requirement for plans to provide for their highest risk members. In the future, in 2024, will be applied to all members. I'm happy to answer more questions about that but focusing on ECM. Next slide, please.

Dr. Shaw Natsui:

Again, what is ECM? As I described, it's really the intensive coordination for both clinical and non-clinical needs of the highest need enrollees, spanning healthcare services as well as a lot of the health related social risks and needs. And really, to provide a single point of contact and support system that meets them where they are, whether that's at their home or on the street or in a shelter or in their doctor's office. And really trying to bridge the gaps that a lot of these members face in coordinating

their medical and non-medical needs.

Dr. Shaw Natsui:

There are ultimately seven core services, as you see here, ranging from essentially the continuum from outreach, identifying these members, engaging them into ECM, and explaining what ECM is and why they may benefit, and what it would do for them to support them. From that point, leading into developing a comprehensive assessment leading to a care management plan, coordinating the care, coordinating transitions, making sure family members and others are involved and supported as well. Next slide, please.

Dr. Shaw Natsui:

So, who is eligible for ECM and how does it work? As many of you have heard, there are different populations of focus that have gone live through the past year. Each population of focus has specific definitions attached to them as to eligibility criteria. These are all listed in our ECM policy guide, which is available on our DHCS website. Once a member meets the criteria and is eligible, they can be identified via self-referral, they can be identified by the plan themselves, as well as family members or community-based organizations. Ultimately, then, this leads to an assessment, and then a referral or assignment to an ECM provider, which can be an FQHC, it could be a community-based organization, and so on. Ultimately, a lead care manager is assigned to coordinate the care for that member. Next slide, please.

Dr. Shaw Natsui:

Now turning specifically to this conversation here today and talking about dual eligible beneficiaries. As we all know, dual eligible beneficiaries have high cost health care and long-term services and supports needs from their chronic conditions, and benefit from care management across Medicare and Medi-Cal benefits. A high proportion, over 75% of IHSS recipients and 80% of long-term SNF residents, are dually eligible. Again, with regard to the makeup or distribution of a lot of these members, more than half are in original Medicare Fee-for-Service while others are, of course, in a Medicare Advantage plan of some type. Next slide, please.

Dr. Shaw Natsui:

As I mentioned, the populations of focus for ECM have gone live since January of 2022, starting in our counties that had participated in Whole-person Care or Health Home pilots. Through the course of 2022, you can see that the populations as listed have primarily focused on homelessness, avoidable hospital and ED utilization, and so on and so forth. In the middle of the slide, noting that January 2023 was the exciting go-live for our long-term care related populations of focus. First, our adults living in a community at risk for LTC institutionalization, and then second, adults who are currently nursing facility residents who would be transitioning to the community. You'll see that we have a few more populations of focus that are slated to go live later this year and next year, including the children and youth populations, birth equity, and

those involved with transitioning from incarceration. Next slide, please.

Dr. Shaw Natsui:

As I mentioned, the LTC populations just went live. Many of the dual eligible beneficiaries are highly represented in both of these populations of focus. Core care coordination across the plans and providers becomes both critical and a big challenge. We want to make sure that we're supporting these ECM providers in serving these populations. And also, we didn't talk about Community Supports here today, but as you know, this is not a benefit, but an optional additional program or support that plans can provide. A lot of this does support the same population of at-risk members in making sure that we can provide things that enable them to stay in the community if that's their wish. Next slide, please.

Dr. Shaw Natsui:

This is just a quick preview, again, of the other population of focus that will go live later this year and in 2024. The boldface populations, we would expect to have dual eligible members as well. Next slide, please.

Dr. Shaw Natsui:

I wanted to briefly mention KPIs and how we look at quality for ECM. This is going to be an even greater focus for us over the coming few months, and then beyond through the rest of the time for ECM. Right now, we receive several indicators from the plans in terms of performance and quality, but it's mostly focused around understanding the enrollment patterns, the members served, the types of services that are involved, and better understanding at this early stage the challenges around outreach and enrollment. For example, understanding the penetration of being able to get members actually enrolled in TCM who are eligible, because we know that's been a challenge. We have quarterly implementation data that we receive from the plans. Over this coming year, we'll be further developing additional KPIs for the plans to provide us. We really welcome this group's feedback and other ideas around important things that we should be monitoring from an ECM standpoint as the LTC populations continue to go live and expand. Next slide, please.

Dr. Shaw Natsui:

I will take a pause here. Happy to take any questions around these populations of focus or ECM in general. Otherwise, thank you for your time.

Mary Russell:

Thank you so much. We really appreciate your participation today. I am taking a look at the chat. I just wanted to flag that we did drop in the link to the ECM policy guide and additional ECM information. If people are looking for additional resources, hopefully that can help. And I see a raised hand from Jennifer Schlesinger. Jennifer, would you like to come off mute and ask your question?

Jennifer Schlesinger:

Thank you so much for this information and presentation. Really helpful information. I'm Jennifer Schlesinger with Alzheimer's Los Angeles. My question, and forgive me if this has been answered in previous webinars, but how is it that we are determining risk for long-term care? And I wonder if a dementia or Alzheimer's diagnosis is sufficient for risk eligibility, given that half of people residing in long-term care institutions have Alzheimer's or related dementia.

Dr. Shaw Natsui:

So, that's a great question. Just to make sure I'm following our own details too. If you have a chance to go into the ECM link that that was posted for the policy guide, the population of focus for LTC starts, I think... I'm actually trying to pull it up now. It's around page 30 or so. We do try to spell out how we're defining risk. It's essentially those who are meeting SNF level of care criteria, and so require requisite types of levels of care. There isn't a disease specific or condition specific definition for the LTC ones. We do incorporate other aspects of risk, including social and environmental factors. I'm not sure if I'm directly answering your question. I'm not sure if this is helpful, but is it essentially, how do we define risk if Alzheimer's or dementia is such a widely prevalent condition?

Jennifer Schlesinger:

Yeah, just given that we know that people who are in nursing homes and institutions often have Alzheimer's or related dementia. So, whether that would be sufficient criteria for saying that someone is at risk for institutionalization, given the prevalence of cognitive impairment of nursing home residents.

Mary Russell:

I think that's a great flag, Jennifer. Thank you. I think Dr. Natsui, thank you for pointing to where in the policy guide that information lives. We can definitely take that back too if there are additional details to share after. I see a raised hand from Andy Perry. Andy, would you like to come off mute and ask your question?

Andy Perry:

Sure. Hi. So, you published a really useful infographic summarizing ECM programs so far. I was struck in that by the reduction in caseload from folks who had gone on automatically from Whole Person Care or Health Homes after the initial... I don't remember if it was half a year or a quarter. Anyway, what it made me realize is... I'm not sure. So, my question is, for people who are experiencing homelessness, what does a transition off of ECM look like? How is it monitored? Are they being transitioned off because they're no longer homeless, or is it just because they're still homeless, but their health has stabilized so they're not high cost enough anymore? Are supports that they're connected with when they're on ECM maintained and are they monitored? I think you get the kinds of questions I'm asking.

Dr. Shaw Natsui:

No, definitely makes sense. Thank you for your question. Yes, what you're referring to, I think, is the fact sheet for ECM Community Supports that reviewed the early data, I suppose, for the first two quarters or first half of the year of 2022. We haven't published. We're still looking through the data for quarter three. This is expected. We saw increased enrollment from for newly eligible members, and then we saw the initial grandfathering in of the Whole Person Care and Health Homes members with a decline over time, which was expected. Part of that decline comes from folks, as you referred to, graduating out of ECM because, let's say, they no longer need those services. There are others who are disenrolled from ECM as part of a process that the plans have of reassessing the members based on the ECM criteria. Depending on the population of focus, there are some differences for sure. That can change whether a member remains eligible based on how the plan is assessing them.

Dr. Shaw Natsui:

With regard to homelessness, I think part of the question may be getting at, are members graduating when they are now housed? Or is it just they're still unhoused, but they're more clinically stable? And so, that's a great question. I don't have a breakdown. I think it's a mix of both. But I think if you're trying to understand the decline over the year of the number of enrollees in there, I think a lot of it is actually driven by the reassessment process, and not necessarily a majority from graduation for either reason, from being housed or from a clinical stabilization standpoint. Hopefully that helps.

Mary Russell:

I think that's great. Thank you. Feel free, Andy, if there are additional questions to drop that in the chat. There is a question in the chat from Diane, “How do these three layers of managed care case management interact with the case management services provided through the regional center system for individuals with IDD?” I'm not sure, Dr. Natsui, if you are the contact for that or if there's someone else you want to call on?

Dr. Shaw Natsui:

I don't know if there's anyone else on the webinar today who wants to jump into this one. It's a fantastic question. Something that's been high on our radar. It's actually an active area of discussion. We plan to have... We, as in folks from both the ECM team and the Community Supports team. I believe we are trying to organize a formal conversation with the Regional Centers Collective or the interest group to discuss how these services overlap, how do we not duplicate, and how does care coordination specifically work in that scenario. It's a complex area. I don't have a quick answer to that, other than we know this is a challenge, but also hopefully an opportunity to make sure that the services for I/DD populations are well taken care of.

Mary Russell:

Great. It sounds like more to come on that. Thank you for that question.

Dr. Shaw Natsui:

I also would mention that the members who are currently being served by regional centers with I/DD are eligible for ECM based on qualifications for other populations of focus, just to be clear.

Mary Russell:

Great. Thank you. Any other questions on these ECM updates? Thank you so much, Dr. Natsui, for joining today. We appreciate your time. At this time, I'm going to transition back to Anastasia Dodson to take us through the 2023 CalAIM D-SNP policy guide and some updates on the recently released chapters. Anastasia, go ahead.

Anastasia Dodson:

Thank you, Mary. Thank you again, Dr. Natsui. Again, it is a very interesting topic. This will certainly not be the last time we discuss it in this workgroup. Is the February meeting appropriate or March to come back and have a deeper dive? Especially as we get maybe more feedback from plans and from local CBOs that are working with patients on these new populations of focus for ECM. Again, we'd like to have dialogue on this where we have examples, promising practices, et cetera, to share on this as well.

Anastasia Dodson:

Now we will talk a little bit about D-SNPs. We have the 2023 requirements, which frankly, just in all transparency, it's been quite a lift for the department and for the plans and for all of you to absorb the transition of what was in the Cal MediConnect contract, the three-way contract, and then moving those provisions to this D-SNP model where we have the existing Medicare infrastructure for a D-SNP that is irrespective of California or any other state. It's a federal model for a type of Medicare Advantage plan that serves dual eligibles, and then the SMAC, the State Medicaid Agency Contract, which is the state's additional provisions for D-SNPs in California.

Anastasia Dodson:

So, we have worked a lot with all of you on the provisions for 2023, and now we are already starting for 2024, but we still have some updates we needed to make for 2023, so we're going to talk about those first, and then we will transition to the care coordination of other provisions. That's the first piece of what we're building for 2024. So, that's the roadmap or scorecard for these remaining issues. Next slide.

Anastasia Dodson:

For 2023, again, we have the 2023 State Medicaid Agency Contract that is posted on

our website. And then we have a policy guide that is a companion to... Called the SMAC, is what the contract is called. That policy guide, we have a couple of updated chapters. One is the revised Integrated Appeals and Grievances. One of the key points for Medi-Medi Plans, EAE D-SNPs, is that we need to have an integrated appeals and grievance process. We did that for Cal MediConnect, and we had needed to build that out for EAE D-SNPs. We also have revised the quality metrics and reporting requirements. Again, we had an extensive set of quality and reporting requirements for Cal MediConnect. Many of them, we carried over into 2023 for D-SNPs and for EAE D-SNPs. Just a heads up, we are thinking about what to do for 2024. But for 2023, we got some technical corrections. Next slide.

Anastasia Dodson:

With that, I'll hand it off to Samantha, I think, is going to talk about integrated appeals and grievances. Let's see. Mary, did I miss-

Mary Russell:

I'm not sure we have Samantha for this portion. I think if you're clear to go ahead, that would be great.

Anastasia Dodson:

Sure. Next slide. There is a federal requirement for applicable integrated plans, which our EAE D-SNPs fit that criteria. Again, according to federal regulations and our overall intent to have a comparable program to Cal MediConnect, we need to provide state specific guidance for…appeals and grievances at the plan level, how to have an integrated approach across Medicare and Medi-Cal. And particularly for benefits where there's some overlap between Medicare and Medi-Cal, because it can be confusing for beneficiaries to figure out which appeals and grievance process applies. We have been working very closely with Department of Managed Health Care as well. We have posted that revision and shared that with key advocates, so hopefully we have got all of our pieces clearly indicated and guidance out.

Anastasia Dodson:

If there's any further clarification needed, we will update the policy guide. But wanted to flag that for all of you. For those of you advocates who work with members on appeals and grievances, our latest and greatest version for 2023 is posted. We also have additional supplemental documents posted on that same webpage where we have the policy guide. Next slide. Quality metrics and reporting. Is that me as well?

Mary Russell:

We do have Tracy on the line to jump in on this. Tracy, thank you for taking us through this.

Tracy Meeker:

Sure. We'll just talk about, as Anastasia alluded to, there are a few just technical updates, not major updates, but we'll go through those in the next couple slides. Next slide.

Tracy Meeker:

For the policy guide, we did release the policy guide chapter for reporting requirements later in 2022. We did make some changes that went into effect January 1, 2023. And I'll talk about those on the next slide. Just as a reminder, the state specific reporting requirements are part of the larger quality strategy with DHCS, including the Comprehensive Quality Strategy, the LTSS dashboard, and the Master Plan for Aging. The measures that are included in this policy chapter have been reviewed in many meetings that probably many or all of you have been attending. They've been vetted and are very similar to the Cal MediConnect reporting requirements. That was just a little way of background. Next slide.

Tracy Meeker:

A couple of the updates. We added back in core measure 2.1, as it was named in Cal MediConnect. That measure is about members with an assessment completed within 90 days of enrollment. And then core measure 2.3, which is members with an annual reassessment. We had inadvertently left those off when we released the reporting requirements chapter in December. As that was brought to our attention, we added that back in. So not new, it's just they were omitted previously. The measures are the same as they were in Cal MediConnect.

Tracy Meeker:

And then the second bullet here is about HEDIS measures. We added the requirement that the plans are to report their HEDIS measures to DHCS stratified by race and ethnicity according to the Office of Management and Budget standard definitions. Which may be a little bit different than the definitions, I guess, by DHCS. But we're keeping those standards so we can compare apples to apples as far as these stratifications. Finally, we clarified language regarding state specific data for the LTSS measures and about which plans, whether they're an EAE or non-EAE and which measures you do have to report on or you don't have to report on depending on what plan type you are. So just made some clarification updates there. Next slide.

Tracy Meeker:

Similar to many of the other topics today, there is a webpage, and we have all of these reporting requirements and key resources posted. The link is there for you to access. DHCS created what we're calling the technical specifications document. It's very similar to the Cal MediConnect reporting requirements document that we had from the beginning of the demonstration on, so it should look very similar. Obviously, some changes were made as appropriate to reflect D-SNP rather than the Cal MediConnect, but that document is very similar to what the plans have been able to reference and use throughout the demonstration, and now going into the D-SNP

reporting. Next slide. I'm not sure if this was the last one. Sorry, this is the last one.

Tracy Meeker:

What we also have released are three reporting requirements templates so that the plans have the same template to report their data on. There's an annual measures reporting template for measures that are just reported annually. Similarly, there's a quarterly reporting template, and then finally, there's the mild cognitive impairment annual reporting template. So, three different templates that the plans will submit to DHCS via SFTP, secure file transfer protocol. Some of the measures, I'm not sure all, will then be reported out publicly after we've had time to analyze them and all of that. So, taking all of the data from those templates and sharing with you all as we get there and have time to analyze the data. I believe that is the last slide for me. Is that right, Mary?

Mary Russell:

Yep, that's right. We'll take a break here for some questions and answers on any of the 2023 policy guide updates related to grievances and appeals or the reporting requirements. Feel free to raise a hand or drop a question into the chat. If there are no questions at this time, we'll continue with the 2024 care coordination updates from Anastasia. But of course, if there are questions as we continue, feel free to drop it in the chat and we'll keep an eye out.

Anastasia Dodson:

Thank you, Mary. I, again, want to acknowledge we're cramming a lot into this meeting. Again, we can revisit these things in more detail at future meetings if you like. Now we're moving on to 2024. What we talked about earlier was for 2023 requirements. For 2024, next slide.

Anastasia Dodson:

For each contract year, according to the CMS Medicare schedule for D-SNPs, the first piece that needs to be developed by states if we want to have state-specific requirements is around care coordination. We have California's 2024 state-specific care coordination requirements for all types of D-SNPs published on the DHCS website. Our approach here was to take what we had in 2023, which included many components of Cal MediConnect which were successful, well vetted. We started with that as our base. We added in a few things in 2023, but then in 2024, we have more substantial changes. Those substantial changes are around palliative care, D-SNPs, Enhanced Care Management, and dementia care. I'll just flag that in the Cal MediConnect contract, there were already dementia care pieces, and 2023 also had dementia care pieces. But the more substantial changes are around palliative care, and then for some types of D-SNPs, ECM. Next slide. Let's go to the next slide.

Anastasia Dodson:

This is about palliative care. Many of you know what palliative care is. It is an overarching approach to medical care for people with serious illness. It is not the same as hospice. It is a specially trained team of doctors, nurses, and other specialists who work together with a patient's other doctors. It's appropriate for any age, any stage in a serious illness. And it's provided along with curative treatment. Again, it's not the same as hospice. It's provided along with curative treatment. And there's, of course, many studies demonstrating the value to patients of palliative care. Next slide.

Anastasia Dodson:

In Medi-Cal, we have had, for several years, a Medi-Cal palliative care policy thanks to the support of the legislature, many experts that contributed to the policy and our health plans. This gives a little brief overview in someone's life course. If they develop a serious illness, then prior to hospice, what you see in yellow is palliative care. It can actually be at the same time as when someone may be eligible for hospice. But the intent is earlier in the disease progression, to have a team based approach and to have the right team of folks able to treat serious illness. Again, it's not excluding curative care. That is one of the significant differences between palliative care and hospice. But it is with discussion with the patient and their family and having a care plan. Many of the pieces of palliative care around an interdisciplinary care team and a care plan, they have in common with the D-SNP model of care. Next slide.

Anastasia Dodson:

Medi-Cal palliative care. I won't go into too much of the details here. It's published on our website. Next slide. The eligible conditions under SB 1004. There are disease specific criteria and there are also general criteria. And Medi-Cal plans can authorize palliative care for patients with other conditions as well. Next slide. This gives the general eligibility criteria. Next slide. Let's back up one slide.

Anastasia Dodson:

This same criteria is copied into our D-SNP care coordination guidance. What we have done for D-SNPs for palliative care is, in order to better coordinate and minimize confusion for people who are dually eligible across Medicare and Medi-Cal, we have the Medi-Cal equivalent. The same requirements that you see here on the screen around general eligibility criteria. There are also disease specific criteria. We have put those into the requirements for D-SNP Medicare plans, and those requirements are part of their model of care. The model of care is something that D-SNPs must develop. It's beyond the regular Medicare Advantage requirements, D-SNP model of care. Anyway, an important policy change in California for D-SNPs is to include palliative care in their model of care. I won't belabor it too much, but I'll just flag this as a significant milestone for the department. We're really pleased to have this and I'm happy to talk about it more in a future meeting. Next slide. Mary, I think this is me as well.

Mary Russell:

Correct. Yes.

Anastasia Dodson:

Again, still on the 2024 care coordination requirements for D-SNPs. And again, I want to flag that because of the transition of Cal MediConnect, there are many more people now in exclusively aligned enrollment D-SNPs and other D-SNPs compared to 2022. We are still looking and waiting for the final figures, but because of the transition of D-SNP look-alike members and the open enrollment period, we expect the numbers will be quite a bit higher as far as enrollment in D-SNPs for 2023. We'll publish that data soon as we get it. Back to ECM. Next slide.

Anastasia Dodson:

As you heard, we have these new populations of focus in 2023. And our policy has been for 2023 that for the EAE D-SNPs, the Medi-Medi plans, that they are responsible for providing ECM-like services for 2023 because there is so much overlap between ECM and that model of care for D-SNPs. Many of the same Medicare requirements for D-SNPs in their model of care duplicate what is in ECM state requirements. So again, similar to palliative care, we're trying to have more of a combined approach so that there's fewer differences between Medicare and Medi-Cal care models in California. The ECM-like services is a requirement for the EAE D-SNPs in 2023, and then it will be a requirement for all D-SNPs in 2024. So, the D-SNPs that do not have an aligned Medi-Cal plan, the new requirements for 2024 then apply particularly to those plans. There are D-SNPs throughout the state that don't have an affiliation with a Medi-Cal plan. They will need to provide the equivalent of ECM services for their members in 2024, and the Medi-Cal plans will not be required to offer ECM for the members that are in a D-SNP.

Anastasia Dodson:

Again, to avoid confusion, because the federal requirements for D-SNPs are that they have the responsibility to provide care coordination across all Medicare and Medi-Cal benefits. That's a federal requirement. So again, to align with the federal requirement and to reduce complexity across Medicare versus Medi-Cal for dual eligibles, we are putting this requirement, a few more pieces of detail to match up the ECM type services for the D-SNPs. Next slide. I think there's a little more on this. Yes. Again, this duplicates some of the previous slides, but those two populations of focus, January '23. Next slide. Right here. 2023, certain D-SNPs were required to provide the equivalent of ECM, and then 2024, the requirement goes to all D-SNPs. Next slide.

Anastasia Dodson:

This sums up the policy. I don't know if this is helpful, but trying to see where do duals who are in either a D-SNP or PACE or the SCAN FIDE-SNP, where do they get

Enhanced Care Management if they qualify for it? For Medi-Cal members in Medicare Fee-for-Service, so not in any type of Medicare Advantage. And those who are in a Medicare Advantage but not a D-SNP, the Medi-Cal plan is still providing the ECM if the member meets the population of focus. But then for non-EAE D-SNPs in 2023, the Medi-Cal plan has the responsibility, and then in 2024, the D-SNP has that responsibility. And then for EAE D-SNP members, the requirement is for 2023 that ECM is provided. PACE and SCAN is already part of the model of care. Next slide. This gives a timeline of the points we just went over. Next slide.

Mary Russell:

Great. Thank you, Anastasia. I appreciate you doing that. I know that was a speed run and there's been a lot packed into this meeting. We have about five minutes left, so I wanted to open it up for questions on the 2024 care coordination guidance or other topics that were discussed. I know our team has been working to address some direct messages that have come in and some other questions through the chat. But please feel free to raise a hand or drop a question into the chat and we can help get to that. And of course, questions can always be submitted through the info@calduals.org inbox. I know our team has noted a few follow-up questions that the department will be coming back on, so we'll continue to track those. Not seeing any questions at this time. Anastasia, do you want to take us through the next MLTSS and Duals Integration Stakeholder Workgroup and schedule in January?

Anastasia Dodson:

Yes. We have the next meeting coming up in February. You can see, we have plenty of topics to talk about. As we get through the January 1st transitions, there's still many pieces ongoing for us to work through together.

Anastasia Dodson:

I do also want to flag, let's go to the next slide around Public Health Emergency Unwinding. These are the slides that we have been showing for some time, next slide, about public health emergency, et cetera. But then, as you all know, we released, and CMS through the omnibus bill released, additional guidance that redeterminations will resume in April. So, there's updated messaging. The same people should keep their contact information updated with the counties. There are other stakeholder workgroups that will talk more about the specifics on the redeterminations. Just want to keep all of you aware that we do have a start date for redeterminations, and we hope that you all will be the wonderful partners that you have been for helping people keep their coverage, be able to understand and navigate what to fill out for their redeterminations. There's been changes in asset limits and there's been some other eligibility changes in the meantime, so some new things to look out for.

Anastasia Dodson:

I see the question in the chat about workgroups and webinars. I know the Consumer Focused Stakeholder Workgroup, they often talk about that topic. Anything related to

older adults, people with disabilities, dual eligibles specific, we can see if we can put it in this group. But I definitely recommend the Consumer Focused Stakeholder group. I think that's it, Mary.

Mary Russell:

Great. Well, thank you all for your participation today. We did drop a link into the chat for registration for the February MLTSS and Dual Stakeholder Workgroup. We look forward to seeing you all there. Thank you, everyone. Take care.