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SPEAKERS

Mary Russell
Anastasia Dodson
Ken Pham
Shel Wong
Tracee Roque

Mary Russell:

Hello and welcome to the DHCS July Quarterly CCI Stakeholder Update Webinar. Today we will hear some great presentations from Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS; Ken Pham, a Research Data Analyst with the Data Reporting Unit at DHCS; Shel Wong with MCQMD at DHCS; and Tracee Roque, the Community Supports Manager at Inland Empire Health Plan. A few quick meeting management items before we begin. All participants will be on mute during the presentations. Please feel free to submit any questions via the chat feature on Zoom. During the Q&A portions of the webinar, if you would like to ask a question or provide comments and feedback, please use the raise hand function, and we will be sure to unmute you.

Mary Russell:

A quick look at the agenda for today. We'll start with an update on Medicare Medi-Cal Plans in California, and a summary of January 2023 enrollment changes. Next, we'll get an update on the June Cal MediConnect Dashboard. For the second half of our webinar, we'll have a brief overview of the CalAIM Community Supports program, and this will be followed by a presentation from Inland Empire Health Plan on their Community Supports. Finally, we'll close out the meeting with a brief update on the Public Health Emergency Unwinding and next steps. Thank you all for being here. And with that, I will hand it over to Anastasia Dodson.

Anastasia Dodson:

Thank you so much, Mary, and welcome everyone. Glad to be here with all of you today. We are going to talk about a few updates, but many of these are the same updates that we talked about in our MLTSS and duals stakeholder meeting last week. So, just want to start out by saying there's no new policy here, but important reminders and reiterating points in case folks were not able to make previous meetings. So, this brief section is about the name of, we used to call them Exclusively Aligned Enrollment D-SNPs or EAE D-SNPs, and these are the successor plans to the current Cal MediConnect plans. And so we have a new name, a simple name for these types of Medicare plans, we're going to be calling them Medicare Medi-Cal Plans. We tried to choose a name that would be self-evident, clear to beneficiaries as far as the type of plans these are.

Anastasia Dodson:

And specific health plans that offer these types of plans, they are able to make their own branding names. Many of them already have branding names that they use for other Medicare Advantage Plan offerings. But when we at DHCS are referring to these types of plans and stakeholders, you all are having discussions of, "Is it a regular Medicare Advantage Plan? Is it a D-SNP or is it an MMP?" we hope that this broad name is helpful. Our health care options website and materials will also use this Medicare Medi-Cal Plans or MMPs to describe these types of integrated plans. And again, we tried to make the name simple and straightforward. So, many great things about these types of

plans, Medicare Medi-Cal Plans. In California, these are integrated plans. One entity is responsible for both Medicare and Medi-Cal benefits. There's simplified care coordination. And this integrated approach allows plans to integrate benefits, communications, member materials, et cetera. So, again, Medicare Medi-Cal Plans, that's the name. And you have probably seen it before in other stakeholder venues by now because we announced the name a couple weeks ago. Next slide.

Anastasia Dodson:

So, again, these slides are just reminders. There's no new policy here, but a reminder about the transition that's coming up for Cal MediConnect members to MMPs, Medicare Medi-Cal Plans. First of all, of course, beneficiary enrollment in a D-SNP, Cal MediConnect, MMP, or any other type of Medicare Advantage Plan is voluntary. There's no requirement to enroll. Medicare beneficiaries can remain in Medicare Fee-For-Service, Original Medicare, and they don't have to take any action to remain in Medicare Fee-For-Service. For 2023, beneficiaries that are already enrolled in Cal MediConnect will automatically be enrolled in the MMP, Medicare Medi-Cal Plan, that is affiliated with or administered by their Cal MediConnect plan. So, health plans are, in many cases, organizations that serve multiple types of beneficiaries and offer multiple types of health plans. And so that same health plan that currently offers Cal MediConnect will then offer a Medicare Medi-Cal Plan.

Anastasia Dodson:

There's no action needed by the beneficiary in order to stay with the same health plan organization that they're in right now through Cal MediConnect. So, there will be materials, as we've spoken about before, that go out in the fall informing beneficiaries of this, that they'll be automatically enrolled into the same health plans. Medicare Medi-Cal Plan, it's the same type of plan, but again, there is a technical crosswalk process. So, those notification letters will go out. And when we have final versions of them, of course we'll share them and post them. Again, Medicare Medi-Cal Plans, that's the California-specific program name for what we have been calling EAE D-SNPs. Next slide.

Anastasia Dodson:

This transition on January 1st, 2023 will not result in any gap in coverage. The provider networks should be substantially similar and there are also Medicare continuity of care requirements that the state is requiring for the MMPs, the Medicare Plans, to implement. Health plans have already started to communicate about these upcoming changes with their members when they get approval on that from DHCS and CMS, and then beneficiaries will start to receive notices from their Cal MediConnect plans about the transition starting in October of 2022. Next slide.

Anastasia Dodson:

And again, a reminder that MMP, Medicare Medi-Cal Plans, those are similar to the Cal MediConnect approach. Health plans can have integrated member materials and they will do that. Benefit coordination is much better. Their unified plan benefit packages, coordinated benefit administration, unified process for authorizing durable medical

equipment, and there's also plan-level integrated appeals and grievances, integrated provider communications, and of course simplified care coordination so that one coordinator can help across both sets of Medicare and Medi-Cal benefits. Next slide. So, any questions on this transition?

Mary Russell:

Thank you, Anastasia. Just a reminder, people can drop questions into the Q&A box or raise their hand and we will unmute you. It looks like we have a raised hand from John Tanner. And John, are you able to come off mute now?

John Tanner:

Sorry. That was an accident. I didn't mean to do it.

Mary Russell:

Okay.

John Tanner:

Thank you.

Mary Russell:

No problem. There was a question that came through about materials, so those will be made available shortly. There was a question from Michael Aguilar that came through about any potential confusion with the name change for beneficiaries between old MMPs and the new change from EAE D-SNPs to MMPs. So, Anastasia, any comments on that?

Anastasia Dodson:

Yeah, we thought about that. We spoke with the Centers for Medicare and Medicaid Services, and we took a look at materials. We don't think that there will be confusion because the Cal MediConnect name was what was used in most materials, or Cal MediConnect plus the health plan specific name was what was used in most beneficiary materials. And probably it's not too much of a challenge actually if the MMP was already sort of a familiar acronym to beneficiaries, and then this would still be a familiar acronym because it is essentially the same type of integrated plan. But thanks for flagging that.

Mary Russell:

Yes, thank you. There is a question from Stephanie Fajuri. "Just to confirm. For enrollment into the MMP for folks who are not currently CMC members, will any of that be done via health care options or can the beneficiary simply enroll into the D-SNP and then their Medi-Cal Plan will be auto assigned?"

Anastasia Dodson:

What a great question. Yes. So, it's the latter where there's currently processes for all types of Medicare Advantage Plans, where beneficiaries work with that plan to enroll.

And there's also 1-800-MEDICARE and other venues there on the Medicare side. So, the same thing will be true for the MMPs. And you are correct that if someone chooses to enroll in an MMP, then on the state side, the Medi-Cal side, we will get that information and then automatically enroll the beneficiary in the Medi-Cal Plan that matches their MMP.

Mary Russell:

Thanks, Anastasia. Let's go to Susan LaPadula next. I see your hand raised, Susan. Susan, are you able to come off mute?

Susan LaPadula :

Yes. Thank you, Mary. Thank you, Mary. Good morning, and good morning, Anastasia.

Anastasia Dodson:

Hi Susan. Thanks for joining.

Susan LaPadula:

Thank you. It's always a privilege and a pleasure. Thank you for having me. I have two questions for you today. One is in reference to the acronyms. Is there a way we could get a listing so that we're all on the same page? And the second question is in reference to end-stage renal disease. Regardless of age, someone could be entitled to Medicare because they've been diagnosed with an end-stage renal disease, how will they be provided in this upcoming transition? And thank you so much.

Anastasia Dodson:

Sure. On the acronyms question, good point. Well, in the beneficiary materials, of course, there are, I don't know if it's called a glossary, but there's a list of terms that are in those materials as a standard practice. Of course, right on the screen there you have CMC and MMP, and then of course, we've been talking about D-SNPs and MAs, Enhanced Care Management, ECM... There are definitely some acronyms that we've been throwing around. Hopefully we are defining them in the slides as we go, but we can take that back and make sure in future presentations we're spelling things out more often. Thank you. And then for end-stage renal disease, there's no restriction on enrollment for people who have end-stage renal disease as far as enrolling in MMPs. So, that is an important change, and it goes along with changes in the last couple years around Medicare Advantage enrollment for ESRD. So, we have no restrictions on that population to enroll in MMPs. And you make a good point about that population. There's been research that really good outcomes are available through Medicare Advantage.

Susan LaPadula:

Thank you so much.

Anastasia Dodson:

Thank you.

Mary Russell:

Thank you, Susan. I'm not seeing any other hands raised at this time. Let's see. A question just came through, Anastasia. This is about, "If a beneficiary is attributed to an ACO or the ACO REACH model, are MMP members excluded from ACO enrollment?"

Anastasia Dodson:

Another great question. Well, essentially yes. So, a beneficiary that is in Original Medicare may have a provider that is enrolled in an ACO REACH model. A beneficiary is, I believe the term is attributed, to an accountable care organization, but it's not the same type of an enrollment choice that a beneficiary would make for a Medicare Advantage Plan. The Medicare accountable care organizations, again, are provider-based groups that work with CMS Medicare to deliver care, provide care coordination, improve health outcomes. But it's transparent to the beneficiary. They may or may not know that their provider is participating in the ACO REACH model. So, with that said, Medicare Advantage members who sign up for a Medicare Advantage Plan or an MMP, they cannot be included in the beneficiaries that are attributed to a provider participating in an ACO model. So, they are two separate groups. Beneficiaries are either in a Medicare Advantage Plan or original Medicare not related to an ACO, or they may be an original Medicare related to an ACO but they don't necessarily know that on the front end.

Mary Russell:

Thanks, Anastasia. Any other questions at this time? Okay. Thanks, everyone. I think with that, and we will have additional opportunities for questions and answers later on, but I think we will transition to the CMC dashboard. And this update will be from Ken Pham, the Research Data Analyst with DHCS. Go ahead, Ken.

Ken Pham:

Thank you. Yes, this is Ken Pham. I'm with the Data Reporting Unit under DMAD, which is the Data Management Analytics Division. Next slide, please. And this is the recently published 2022 CMC Dashboard, and that's the link that you can get a copy of that from. Next. And this is the first figure from the CMC Dashboard, it's a statewide enrollment in CMC increase from 112,803 members in January 2021 to 115,700 in December 2021. Next slide. This is Figure 8. Figure 8 shows the percentage of members with a health risk assessment completed within 90 days of enrollment, and that increased from 97% in quarter three of 2021 to 98% in quarter four of 2021. Next slide.

Ken Pham:

This is Figure 12, and this shows the percentage of members with an individualized care plan completed within 90 days of enrollment, which increased from 82% from quarter three of 2021 to 85% in quarter four of 2021. Next slide. Final slide. Figure 24 shows the rate of CMC members seeking care in the emergency room for behavioral health services. Utilization has decreased from 17.2 visits per 10,000 member months in Q1 of 2021 to 13.0 visits in Q4 of 2021. Thank you. I think that's the last slide. So, if

you have any other questions...

Mary Russell:

Thank you so much, Ken. Yes, we are available for any questions or answers on Ken's presentation. Please feel free to raise a hand or submit it via the Q&A. Great. Okay. Thank you so much, Ken.

Ken Pham:

Thank you.

Mary Russell:

And next we will transition to Shel Wong, the Staff Services Manager at DHCS for an overview of CalAIM Community Supports. Thank you, Shel. Go ahead.

Shel Wong:

Hey. Thank you. So, my name is Shel Wong. As Mary just said, I am the Unit Chief over Community Supports here at DHCS, and we can go to the next slide please. And so let's start and talk about, what our Community Supports? So, Community Supports are medically appropriate and cost-effective services or settings that Managed Care Plans and Cal MediConnect plans can offer as a substitute or to avoid traditional Medi-Cal benefits like ED visits, hospital admissions or skilled nursing facilities stays. And all Community Supports are optional for the plans to offer and optional for the members to accept. And while Community Supports are not benefits, the department strongly encourages plans to offer a robust selection of Community Supports as they focus on addressing the combined medical and social determinants of health needs and avoiding more costly, higher levels of care. And we can go to the next slide.

Shel Wong:

So, the foundation for Community Supports really came from leveraging the design learnings and successes of other DHCS programs, specifically the Whole Person Care pilots and Health Home Programs. Plans are also encouraged to contract with local community based organizations to provide Community Supports. This is because these local CBOs generally have that expertise of providing the services included in Community Supports and understand the needs of the local members. And we can go to the next slide. And so currently there are fourteen pre-approved Community Supports that plans can offer, ranging from housing-related services, recuperative care services, transition and diversion services from skilled nursing facilities, all the way to medically tailored meals, asthma remediation, and sobering centers. So, I won't go into detail on all fourteen Community Supports, but I can give you a high-level overview of a few.

Shel Wong:

So, some of the housing-related services include housing navigation to help locate and apply for housing, housing deposits to assist with the setup costs, and housing tenancy and sustaining services, which help those who have found housing stay housed. The transition and diversion Community Supports both provide assistance in keeping

members who would otherwise be placed in skilled nursing facilities, in the community. And medically tailored meals provide medically appropriate meals or groceries to members who may have chronic conditions or maybe were recently discharged from a hospital. The benefits include improved health member outcomes and lower hospital readmission rates. So, plans can also submit proposals to offer new Community Supports outside of the fourteen that were pre-approved, but they're just subject to DHCS and CMS approval. And we can go to the next slide.

Shel Wong:

So, who's eligible for Community Supports? Eligibility for each Community Support varies, and the specific criteria for each Community Support can be found in the Community Supports Policy Guide, which is linked on our website and also right here. The DHCS Community Support Spotlight Series also highlights the eligibility for each Community Support and a webinar recording series that's hosted by DHCS. And if you want to look at recordings of past webinars or maybe have a registration link to future webinars, that can also be found on our website. And members in Managed Care Plans, or CMC plans, may be eligible for Community Supports in their county. Community Supports are optional for the member to receive, and if the member does decline the Community Support, they are still entitled to the state plan benefits the Community Support was offered in lieu of. And because Community Supports are optional for the plans to offer, and plans don't have to offer the same Community Supports in all counties where they operate, the availability of Community Supports can vary. Next slide please.

Shel Wong:

So, here is a map that shows how many Community Supports are currently offered in each county. As of July 1st, sixteen counties offer more than ten Community Supports with some plans in Riverside and San Diego County's offering all fourteen. So, plans do have the ability to add more Community Supports every six months, and many plans are phasing in additional Community Supports through 2024. As I mentioned at first, Community Supports can vary by plan and by county, and we encourage you to look at the Community Supports final selections grid link linked at the bottom of this slide, or members can also reach out to their plan to see what Community Supports are available in their area. Next slide please.

Shel Wong:

So, here are some of the Community Supports that are currently offered by Cal MediConnect or CMC plans. So, currently ten plans offer housing transition, housing tenancy and sustaining services, as well as housing deposits. Nine offer medically tailored meals and recuperative care, which is also known as medical respite. Seven plans offer personal care and homemaker services as well as sobering centers. Six offer community transition services, asthma remediation, environmental accessibility adaptations, and respite services, which unlike medical respite is caregiver respite. And about four to five plans offer short-term post-hospitalization housing, nursing facility transition or diversion, and day habilitation programs. As I mentioned at first, members should reach out to their plan to see what Community Supports are offered in their

county. And we can go to the next slide.

Shel Wong:

And Community Support providers. So, Community Support providers deliver those critical medical and social services that are typically not funded by Medi-Cal. This includes those housing navigation services, recuperative care, medically-tailored meals, and community transition services. The allowable providers do vary by Community Support, and specific examples of providers can be found in that policy guide that was referenced earlier. Some of the providers the plans can choose to contract with include, but are not limited to, community-based organizations, health, home, or respite agencies, home-delivered meal providers, and affordable housing and supportive housing providers. And we can go to the next slide.

Shel Wong:

And so this is just some of our resources. We really encourage anybody who is interested in Community Supports to visit the DHCS Enhanced Care Management and Community Supports website, and all of the other resources that are listed here can also be found on our website. So, I will now toss it back to Mary.

Mary Russell:

Thank you so much, Shel. That was really informative. We do have a few minutes to pause here quickly for questions before we get into our case study with Tracee at IEHP. So, I see one raised hand from Sarah. Sarah, would you like to come off mute and ask your question?

Sarah Gonzaga:

Oh, sorry. I accidentally hit the button. I don't have a question at this time.

Mary Russell:

Okay. No worries. Just wanted to check. Looks like Susan. Susan, did you have a question you want to jump in with?

Susan LaPadula:

Thanks, Mary. Yes. I'm wondering, once we transition to CalAIM, will we have a dashboard of sorts to let us know how many members or beneficiaries will migrate and transition in January and then follow it through thereafter each month?

Anastasia Dodson:

Hi. This is Anastasia. I'll take that one. Yeah. So, good point. We have a dashboard, but there's a lag because of the types of indicators that are on the current dashboard. But we also do publish information on our open data portal monthly and with a pretty short turnaround about enrollment information. So, yeah, we are looking at how we can provide enrollment updates. We know that that will be of great interest to folks. How is the transition going? How many people have transitioned? And so we will look to

provide that in a timely manner, either just directly at one of these meetings or certainly also on our website.

Susan LaPadula:

May I make a suggestion, Anastasia?

Anastasia Dodson:

Sure. Yes. Go ahead, Susan.

Susan LaPadula:

May I make a suggestion?

Anastasia Dodson:

Yes. Go ahead.

Mary Russell:

Susan, it looks like you're on mute. Oh, there you go.

Susan LaPadula:

Is that better, Mary? Thank you. I'm thinking perhaps we could get more granular and do an LTC carve-in, review the skilled nursing facility as one branch of the movement, then the second would be ICF-DD, and then perhaps the third subacute. Because I believe, if I understand our plans currently, ICF-DD and subacute are on hold until July 1st, 2023. But those are going to be very important to monitor, especially for a traditional skilled nursing facility in the state of California. They may provide two out of three of those levels of care, and some may provide more than that.

Anastasia Dodson:

Sure.

Susan LaPadula:

Perhaps we could take that back and discuss it. And then, one other point might be the COHS, so our County Organized Health Systems, will migrate differently, right? Orange and San Mateo, which are two of our COHS of seven CCIs, which it's important to watch their migration differently from LA, Riverside, San Bernardino, and Santa Clara. And then of course, San Diego is its own unique GMC model. So, maybe delineated by the type of structure in that county, if that makes sense to the masses.

Anastasia Dodson:

Yeah. And some of that is captured in reporting. Let's go back to Community Supports though, because we're in this really important, interesting topic. And the enrollment transitions, those are important as well, but back to Community Supports. One flag. Shel, thank you so much for that great presentation. One thing I wanted to flag for you all is that, so you saw in the presentation Cal MediConnect plans can offer Community

Supports. There are also, as we proceed to 2023 with our MMPs, the Medi-Cal Plan, which is, the MMP is technically the name for the Medicare plan and beneficiaries that will still have a Medi-Cal Plan and they can still receive, then, Community Supports. Technically it's under the authority of the Medi-Cal Plan, but that coordination across Medicare and Medi-Cal will still be there.

Anastasia Dodson:

And to the extent that there are supplemental benefits offered by the Medicare plan that are similar to the Community Supports, that's where, again, it's really wonderful to have individuals in an MMP that's got an affiliation with a Medi-Cal Plan so that they can directly coordinate across both sets of benefits and help beneficiaries really maximize what's of best use for them. And so I just wanted to add that little technical note, but not to take away the rest of the time. I know we have Inland Empire also going to present on this.

Mary Russell:

Thanks, Anastasia. Thanks, Susan, for those questions. Yeah, let's transition now. We are excited to have a speaker from IEHP today, Tracee Roque, the Community Supports Manager, to share a little bit about this plan's efforts and community support so far. So, Tracee, go ahead.

Tracee Roque:

Good afternoon. Thank you for having me. As Mary stated, I am Tracee Roque, the Manager of Community Supports for IEHP. Next slide please. So, Community Supports are cost-effective alternatives to services or settings that are already available to our members through the Medicaid plan. DHCS pre-approved fourteen services under this umbrella of Community Supports. IEHP chose to run with eleven of those services effective January of this year. This is a link that you all are more than welcome to visit. It'll give you more information on each one of these services. But you can see you have housing services available, recuperative care, asthma remediation, sobering centers, this long word that simply means home modifications, but it's classified as environmental accessibility adaptations. And we also have medically tailored meals. We are planning on an additional three services, so the remaining three that DHCS had approved, which are respite care, day habilitation, and personal care and homemaker services. Those will most likely not be rolled out until next year, around July is the aim. Next slide please.

Tracee Roque:

So, Community Support Services and IEHP Members. As you know, we serve San Bernardino and Riverside counties. These services are offered throughout both of the counties with only two exceptions. So, for example, for sobering centers, we currently only have it available in Riverside, and for community transitions we only have it available in San Bernardino. We are currently working with our county entities and other community-based organizations to fill these gaps, and so we do hope to have a sobering center that will cover San Bernardino and then community transitions for

Riverside as well. The blue box is simply just giving you more information on the initiative. I'm sure everyone is well aware of the purpose of CalAIM. It really was to improve the quality of life and health outcomes of our members and Medi-Cal beneficiaries. So, one of the key features I have the joy of putting together and overseeing is the Community Supports program.

Tracee Roque:

So, they are available for all lines of business. Medi-Cal, Cal MediConnect, which would be your dual choice members, and Medi-Medi members. Interestingly, 12ur IEHP members may self-refer as well. So, just a little tidbit of information on our members. Another helpful bit of information is that our members' assigned PCP, they're assigned specialists, and/or their behavioral healthcare provider, all these providers have access to refer members for Community Support services. So, our members do not have to be in the room with PCP and PCP refer. They can be seeing a specialist, they can be seeing behavioral health, and they too have the opportunity to refer. Last but not least, for members enrolled in Enhanced Care Management, known as ECM, care teams are also able to assist with connecting member to Community Support. So, we work very closely with our internal and external partners to make sure that they are aware of these services and make sure that they know they have the ability to refer for them. Next slide please.

Tracee Roque:

So, I thought it would be interesting to share some of our data. I like to think of this as our success data because it was completely new in January and we didn't really know where it would go or how it would take off. So, here in this first gray box, you will see the number of Community Support services. These are actually approved authorization. So, you're looking at approvals here. I thought it was funny that it dips a bit in February and May because in my world I feel like it's consistently grown, but you will see that the numbers have in fact gone as high as 759 for one month. In the other box alongside this, you will see a breakdown of those authorizations just to give you a sense of those that tend to be more used. You'll see housing services are a big one and then followed by medically tailored meals.

Tracee Roque:

And third place would be recuperative care. We have not seen any referrals, therefore no approved authorizations for asthma remediation, but we are attempting to work more with the community member-facing forums to really get this service in front of people. And last but not least, this is the number of successfully housed members. This data was from January 1st through the end of April. You'll see Riverside County, we successfully housed eight members. And for San Bernardino County, we successfully housed seven members. We do expect these numbers to grow, of course, seeing that the authorizations have grown as well. But it is a process and it does take time. Next slide please.

Tracee Roque:

So, I also wanted to share with you our support services data for our CMC members. So, for our “Dual Choice”. This is data as of January of this year to current. So, you will see the same goes for previous data, the top running three are housing, but the most approved service is medically tailored meals for that population followed by transition navigation services. So, I thought that would be helpful to see where we're at for that specific population. Next slide, please. I think we might be getting close to the end. How to refer a patient member for Community Support services. You can always visit the link below. This is going to give you access on how to refer, a kind of blast fax that we originally sent out when this first took off. Key contacts, myself, with my phone number, email if you ever have any questions. And then my director, which is Anita Holmes, you'll find her contact information here as well.

Mary Russell:

Thank you so much, Tracee. That was so informative and we really appreciate you joining for today. Any questions for Tracee or Shel? I know we also have Neha on the line who can jump in. Anything related to Community Supports. Sure, Susan. Would you like to come off mute and go ahead?

Susan LaPadula:

Sure, Mary. Thank you. This question's for Tracee. Thank you, Tracee. It was a wonderful presentation. Are there any Community Supports that you would recommend for a subacute level of care or the traditional skilled nursing facility as well as perhaps a little lower level of care like an ICF/DD? Thank you.

Tracee Roque:

Yeah. No problem, Susan. So, I would say that the majority of services that are provided are provided by CBOs and/or provider office types. However, we do work with our skilled nursing facilities. We do offer one service, which is our nursing facility transition diversion to assisted living facilities. So, for example, we work with somebody who will look at our members that are ready to transition to a lower level of care and they will provide assistance in placing them to an RCFE. So, we have a network of contracted RCFEs. They will look and see which RCFE best meets member's needs, and they will assist us with those transitions as well as member. Another one would be community transition services. So, this includes nursing facility transitions to a home. The volume has not been very high there so unfortunately I'm unable to really speak to that success or even give any pointers on how this is working for us, but we do have a contracted provider to provide those services.

Susan LaPadula:

That's excellent. Thank you for walking us through that.

Mary Russell:

Thank you, Tracee. A couple questions that have come in for you. Wondering if you can speak to the average age groups for the authorized Community Supports.

Tracee Roque:

That is a very good question. And unfortunately, I don't have that data in front of me now, but I can certainly get it and I can share it with Mary. And then if it's at all possible to connect everyone to what I share with her, that would be great.

Mary Russell:

Sure. And another question. How are you defining successfully housed?

Tracee Roque:

So, these would be members that were either homeless, or at risk of homelessness, who have now since been permanently housed.

Mary Russell:

Thank you. I see a hand raised from Tiffany. So, Tiffany, would you like to come off of mute and ask your question?

Tiffany Huyenh-Cho:

Yeah. Thank you, Mary. Thank you, Tracee, for your presentation. I was just wondering, do you know or have a breakdown of how members are referred for Community Supports? Is it mostly through identification through ECM, providers, or if it's self-referral? If there's anything you can share on how-

Tracee Roque:

Oh, yeah, no, that's a very good question. And it makes me want to go back and pull that data so I can see the breakdown. We actually do have the data. I shouldn't say we don't. But I would like it right in front of my face, and I'd have to go dig. I can tell you that the majority of referrals do come from our internal teams. So, we have internal care teams that are working with members, either from a behavioral health perspective or otherwise, and they make the connection to Community Supports. Our goal is to really get our PCPs on board, our specialists, our behavioral health doctors, so that they are just as comfortable with submitting those referrals and can increase that volume as well. We do have self-referrals, but the volume is not huge. And the services I really see where we get the most self-referrals for would be medically tailored meals because they usually hear about it from someone that they're acquainted with that has the same health plan, and the other one would be housing.

Mary Russell:

Great. Thank you, Tracee. Any other questions at this time on Community Supports? This has been really helpful. Thank you so much. Okay. I'm not seeing any other hands raised. All right. Thank you again to our speakers for that session. Next, I'm going to transition to Anastasia to talk us through the Public Health Emergency Unwinding.

Anastasia Dodson:

Thank you, Mary. And thank you again, Tracee. That was really great. And Shel as well.

I know there's been other presentations on different forums about the Community Supports, but I think really this is important to think about it in the context of Cal MediConnect plans, dual eligibles, and then our MMPs. It's really an important piece of the array of services and their coordination. So, the next topic is about the Public Health Emergency Unwinding. Nothing new here. These are the same slides we've shown in other meetings. So, we don't know when, but eventually the federal public health emergency for COVID-19 will end. And when it does, then there will need to be redeterminations of Medi-Cal eligibility. So, the top goal of DHCS is to minimize beneficiary burden and promote continuity of coverage for our beneficiaries. We have a DHCS Coverage Ambassador program with a toolkit and a mailing list. Next slide.

Anastasia Dodson:

So, right now we're encouraging beneficiaries to keep their contact information up to date with their Medi-Cal plans and with the counties. So, when the county eligibility offices need to send out those renewal packets, they will have the correct contact information so that we don't want packets mailed to people and then returned to the county undeliverable. That can lead down a path of eventually disenrollment. And so, once the public health emergency ends, there will be renewal packets in the mail. We'll anticipate that the counties would send those renewal packets sixty days prior to the end of the public health emergency. So, we'd ask that you remind beneficiaries to watch for those renewal pack packets in the mail.

Anastasia Dodson:

And again, keep that contact information updated with the county office if that's not already been done. We do not have any estimated date for termination of the public health emergency yet. So, we will certainly keep you posted, and the ambassadors list is a good way to get updates there. I think that's it. Right. Next steps. We have information on the Coordinated Care Initiative on our website, including the enrollment and quality data and toolkits. And then we're going to have a meeting again on August 18th. And Mary, I think I took your points, sorry about that.

Mary Russell:

That's okay. You did great. Yep. Just want to make sure everyone is in the loop. Our next MLTSS and Duals Integration Stakeholder Workgroup will be on Thursday, August 18th. Of course, we have the website here and the inbox for any questions in the meantime. And please feel free to reach out. And I think that will do it for today. Although I do see one last hand raise from Susan. Susan, did you want to jump in?

Susan LaPadula:

Thanks so much, Mary. Anastasia, today, this morning, CMS held their Public Health Emergency Unwinding update, and the CMS expert mentioned that each state in the United States determines if they will keep the months of redetermination for the beneficiary. So, for example, if a beneficiary renewed in March that going forward it would continue remaining March of each year. Do we know for California what the call will be on that, and then specifically how will that roll down to each county? Should we

start with our beneficiary family members, and how should we teach that, please?
Thank you.

Anastasia Dodson:

Sure. Yes, it will. We will continue with the monthly redetermination process back to the original redetermination month that's already in effect for beneficiaries with the counties. So, we don't think it's a good strategy to batch people all at once. We'll just do it month by month according to their regular eligibility renewal month.

Susan LaPadula:

Thank you for that. You're helping the industry as well. Thank you so much.

Anastasia Dodson:

Thank you.

Mary Russell:

All right. Thank you all so much for joining today. Enjoy the rest of your afternoon.