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

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

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SPEAKERS

Mary Russell
Anastasia Dodson
Stephanie Conde
Bambi Cisneros

Mary Russell:

Good morning and welcome to today's CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup. We are excited to have some great presenters today. We have Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS; Stephanie Conde, the Branch Chief in the Managed Care Operations Division at DHCS; And Bambi Cisneros, Assistant Deputy Director with Health Care Delivery Systems at DHCS. A few quick meeting management items to note 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. So, we would ask that plans that are on these calls, hold their questions for the multiple other venues that we have throughout the month. Please feel free to submit any questions you have for the speakers via chat. And during the discussion, if you would like to ask a question or provide comments and feedback, please use the 'raised hand' function, and we will unmute you. And a quick reminder that the PowerPoint slides and all meeting materials will be available on the CalAIM website in the next few days. And we'll provide a link to those materials in the Zoom chat, so you can find them.

Mary Russell:

We'll ask you to take a quick minute now to add your organization's name to your Zoom name so that it appears as ‘your name – organization’. To do that, click on the 'Participants' icon at the bottom of the window. Hover over your name in the 'Participants' list on the right side of the zoom window. Click 'More' and select 'Rename' from the drop-down menu. Enter your name and add your organization as you would like it to appear. And then we'll take a look at the agenda for today. So, we'll start with a walkthrough of the summary of the January 2023 enrollment changes followed by some time for Q&A. Next, we'll have a presentation on the 2023 Medi-Cal matching plan policy scenarios, also with some time for questions. Then there'll be an update on the 2023 transition notices. And we'll follow that with an update on the recently released, 2023 D-SNP policy guide information sharing chapter. And finally, we will hear an update on the 2023 Skilled Nursing Facility Long-Term Care Carve-In transition. And we will also have some time for questions there. We'll end the call with some information on upcoming meetings and next steps. And as a reminder, when the slides are posted, you'll see that there are additional background slides in the appendix for reference. And at this time, I'll hand it over to Anastasia Dodson. Thanks, Anastasia.

Anastasia Dodson:

Thank you so much, Mary. Very excited to be here and talking with you all today on this really important stakeholder group. An important time as we are proceeding through the transitions. So, this workgroup has been a wonderful collaboration hub for all, a lot of different partners in our work around the transition of Cal MediConnect and the launching of Medi-Medi Plans, as well as the enrollment of dual eligible beneficiaries

into Medi-Cal managed care, and the carve-in of Long-Term Care into Medi-Cal managed care. And then, as we think about the next couple of meetings, we'll continue to focus on these upcoming transitions. But then in the new year, we'll transition more to some broader topics, because as we get these enrollment transitions and then also some of the additional populations of focus for Enhanced Care Management that will go into effect January 2023, then we can start to think about... What is happening as far as implementation and operations? And what are we learning? And how are these pieces all working together to provide comprehensive benefits across medical and long-term service and supports? And finding ways to provide the best set of services across all of those areas to meet people's needs.

Anastasia Dodson:

But for today, we're going to continue to focus on the enrollment processes and transitions, and make sure those are done as smoothly as possible and communicating very clearly with all of you about them. And then we'll talk a little bit about the 2024 and 2023 SMAC documents around D-SNPs. But again, today's focus will be about enrollment. And then at future meetings, as we get through the enrollment changes, we'll be talking about broader care coordination topics. Next slide. So, let's start, and there's no new policy here for those of you who've been joining these meetings all along. But if you are new to the meetings, we will start with a reminder and walkthrough of the transitions, and the enrollment changes in Medi-Cal. And particularly those for dual eligibles that will be implemented as of January 2023. And notices have already gone out and some have been received in people's mailboxes at the beginning of this month, and some are going to be toward the end of this month. So, we're going to walk through all of those and make sure that everybody knows what's going on and answer any questions. Next slide.

Anastasia Dodson:

So, the first section is about, these are a type of combined Medicare and Medi-Cal plan and the transition of Cal MediConnect into what we're calling Medi-Medi Plan. Next slide. So, first of all, any enrollment in any Medicare Advantage plan, including a D-SNP, is strictly voluntary. Medicare beneficiaries can remain in Medicare Fee-For-Service, also known as original Medicare, and do not need to take any action to remain in Medicare Fee-For-Service. Medicare Medi-Cal Plans or Medi-Medi Plans, those are available starting in 2023, and they combine Medicare and Medi-Cal benefits into one plan. These Medi-Medi Plans are going to be available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. Those are the same counties and the same health plan organizations that currently offer Cal MediConnect plans. Cal MediConnect members, currently enrolled in 2022, will be automatically transitioned to the corresponding Medi-Medi Plan, operated by their same organization. And no action is needed by the beneficiary to remain enrolled with the same organization. But they will transition automatically from a Cal MediConnect plan to a Medi-Medi Plan. And there is no gap in coverage. Very likely, no transition of providers, no transition of benefits, et cetera. It should be a very smooth transition. But

we certainly want to hear if there's any questions, or topics that people are hearing that they want to talk about with that transition. Next slide.

Anastasia Dodson:

So, the opportunities and benefits of the Medi-Medi Plan. First of all, it's not a brand new approach. It's similar to Cal MediConnect, which has a high consumer satisfaction level. There's simplified care coordination to help members across services, so that there is no need to figure out, "Who I call for Medicare? Who I call for Medi-Cal." All the same organization. There are integrated member materials, so that the required materials that go out to beneficiaries for explaining benefits, et cetera, are combined together, so they don't have to compare across two sets of materials. These Medi-Medi Plans offer supplemental benefits similar to other types of Medicare Advantage plans, and also Community Supports, and Enhanced Care Management are available through Medi-Cal, in that same organization. So basically, for a beneficiary in Medi-Medi plan, they're getting Medicare Advantage type of benefits and services. And then additional care coordination, across with the Medi-Cal managed care benefits all from one organization. There's also integrated beneficiary and provider communications as well.

Anastasia Dodson:

Next slide. And just a reminder, again, there are about 113,000 members in Cal MediConnect plans, and those folks are going to be automatically transitioned in to the Medi-Medi Plan that are operated by that same parent company, the Cal MediConnect plan. There's no gap in coverage. The networks will be substantially similar, and there's continuities care provisions for any beneficiaries seeing providers who are not in the new plan. But again, the networks will be substantially similar. The first set of notices went out to beneficiaries by September 30th, and those should have been received. And there are phone calls that are being made in the month of October, to members, about this transition. All right, next slide. And then, so we're going to go through a couple more transitions and then we will pause and have questions on all these topics. The next topic is about D-SNP look-alike plan transitioning.

Anastasia Dodson:

So, look-alike plans are a type of Medicare Advantage plans that are marketed particularly to people who are dually eligible for Medicare and Medi-Cal. But these look-alike plans, they don't have the same care coordination requirements as true D-SNPs. So, these are plans that have 80% or more of their members eligible for Medi-Cal. So, they mostly serve dual eligible beneficiaries. And we've seen quite an increase in enrollment in these plans in certain counties, due to certain marketing efforts. Next slide. So, CMS, the federal government, is limiting enrollment into Medicare Advantage plans that are D-SNP look-alike plans. And you can see on the slide that there were some changes in 2022. And then starting in 2023, CMS will not renew contracts with Medicare Advantage plans with 80% or more dual eligible, unless they're a true D-SNP. Then we'll go to the next slide.

Anastasia Dodson:

So, what this means is, for 2023, Medicare Advantage organizations are transitioning their D-SNP look-alike members. There's about 140,000 in California. And again, this will be an automatic transition. Seamless to the member. They'll be transitioning into another Medicare Advantage plan, and, potentially, it could be a true D-SNP, or a regular MA plan offered by that same organization. So, because it is the same Medicare Advantage organization, that transition is designed to ensure continuity of care with providers and cost-sharing protections for dual eligible beneficiaries. And also, this provides better options for people who are currently enrolled in a look-alike plan, because then they would be, hopefully, in a true D-SNP that has the care coordination across all Medicare and Medi-Cal benefits. CMS has been working with the Medicare plans to facilitate a crosswalk enrollment of members from D-SNP look-alike plans to true D-SNPs or other MA plans. And we do have a link to that crosswalk list on the DHCS website.

Anastasia Dodson:

It's a page that... And we may be able to put the link in the chat, but I know many of our HICAP partners have been curious and supporting this effort. So, we've sent the link to the HICAP folks, and we do have a call with HICAP folks later today. So, if there's questions in the chat from HICAP folks, I would just suggest maybe we have our call later today. But if you do have questions, and you're a beneficiary or you're a member, or other folks, and you have questions about Medicare options in your county, you can contact your local HICAP. And they have great expertise in helping people figure out across the different Medicare Advantage plans what are the pros and cons if you want to choose a Medicare Advantage plan. And which one you might want to choose, and as well as Part D plans. So, I think we're not going to spend too much time on the D-SNP look-alike transition. But again, for those of you who haven't been calling in, in recent months, there's definitely more information available about D-SNP look-alike transition and the broader Medicare Advantage open enrollment period that we're in right now. Next slide.

Anastasia Dodson:

All right, so the next topic here is about is not about Medicare, but I will make sure that we all have the right context for how it impacts people who have Medicare. Next slide. So, this topic is about Medi-Cal managed care, and again, dual eligibles have Medicare and Medi-Cal. This topic is about Medi-Cal, and how people who have both Medicare and Medi-Cal, get their Medi-Cal benefits. So, you can see from this map the kind of darker purple, those are called County-Organized Health System counties. And in those counties, Long-Term Care Skilled Nursing Facility services, and people who have Medicare and Medi-Cal, they are automatically enrolled in a Medi-Cal managed care plan. The light purple. We have been calling those Coordinated Care Initiative counties. Those are the large Southern California counties plus Santa Clara and San Mateo. In those counties as well, all people who have Medi-Cal, including people that have

Medicare and Medi-Cal, are already enrolled in a Medi-Cal managed care plan, or should be. That is the policy in those counties.

Anastasia Dodson:

So, what's new here for January 2023, is that in the kind of bluish color, you can see in many Central Valley counties, some Bay Area counties, Alameda, Contra Costa, San Francisco, as well as Imperial County, all Medi-Cal beneficiaries, with very few exceptions, starting in January, will need to be enrolled in a Medi-Cal managed care plan. This does not mean that individuals with Medicare will need to enroll in a Medicare plan. This is only about Medi-Cal managed care. So, as we go through the next slides, we'll just make sure that we're saying it very clearly but try to remember this map when you want to think about which counties does this policy impact. The kind of darker purple and pink colors, those counties, they already have this policy in place. Almost all beneficiaries in those counties are already enrolled in a Medi-Cal managed care plan.

Anastasia Dodson:

The change that we're talking about is just for individuals in those dark bluish colored counties. And that's what we'll be talking about in the next slide. Right, next slide. So, right now in Medi-Cal, there are some people who get their Medi-Cal benefits through Medi-Cal Fee-For-Service, and some through Medi-Cal managed care. And it depends, as we talked about in the county. So, in 31 counties, in January, dual eligible beneficiaries and other Medi-Cal beneficiaries will be transitioning into Medi-Cal managed care. This change on the Medi-Cal side does not impact Medicare provider access or someone's choice of original Medicare or Medicare Advantage. Medi-Cal change does not require anyone to enroll in a Medicare plan. Medicare providers do not need to be in the Medi-Cal plans in order to continue seeing patients, submitting claims, et cetera. There are fact sheets and notices now available on the DHCS website. There's a particular page we can put in the chat, related to this transition. And we will be putting more materials there. We're working on provider specific materials. Go to the next slide.

Anastasia Dodson:

So again, for context, over 70% of people who are dually eligible with Medicare and Medi-Cal are already enrolled in a Medi-Cal managed care plan. This transition, again, some Central Valley and Bay Area counties, affects about 325,000 dual eligible beneficiaries, and also a number of people who are Medi-Cal only. And you can see here, the list of the counties. Beneficiaries are going to be getting notices very soon, and they'll also be getting materials to choose a plan, depending on which county they live in, and if they're already enrolled in a Medicare plan. But again, I don't want to get too deep in that. Let's just stay high level for the moment. Next slide.

Anastasia Dodson:

So, the benefits, and why are we doing this? So Medi-Cal plans, they coordinate long-term services and supports. This is particularly for people who are dually eligible for Medicare and Medi-Cal. For people who are dual eligibles, their physician visits, their hospital stays, labs, X-rays, pharmacy, are all through Medicare. But on the Medi-Cal side, people who are dually eligible, they get long--term services and supports, including nursing facility care, Community-Based Adult Services, which is Adult Day Health. Community Supports such as home modifications, transportation to medical appointments, Enhanced Care Management, all those are Medi-Cal benefits. And those benefits, some of them are only available through a Medi-Cal managed care plan. So having all dual eligible beneficiaries, or virtually all of them enrolled in a Medi-Cal plan, then is helpful for beneficiaries, so that they have a health plan representative that can help them navigate through these benefits and coordinate across with their Medicare benefits. Next slide. Okay. I'm going to pause for one sec, and then we're going to walk through some changes and go to questions. Mary, can you start looking at the questions? And I will be right there.

Mary Russell:

Yep. Great. So, we have received some questions via chat and also encourage everyone to 'raise a hand' if there is a question, you'd like to come off mute and ask. And also, just a reminder, we know that a lot of this content is a review, and it's mostly just to make sure everybody is working with the same context and background. So yes, some of it may seem repetitive, but it is just making sure everyone has the same baseline information. So, there is a question in the chat from Joanne Cannon, Anastasia. And I think this is a good opportunity to remind everyone about the voluntary nature of the transition. But Joanne is asking if she can choose to keep original Medicare? And what changes would she have to make in this transition?

Anastasia Dodson:

Yes, absolutely. So, anyone who is already in original Medicare, they do not need to do anything to keep original Medicare. So, if you live in one of those counties that we listed out, you will receive information about joining a Medi-Cal plan. No matter what you choose on the Medi-Cal side, you can stay in original Fee-For-Service Medicare. And Mary, does that answer the question? Was there any part of it that we need to clarify?

Mary Russell:

Well, let us know, Joanne. We did have some dialogue in the chat, so hopefully that addresses it, but feel free to 'raise a hand' if that raises other questions. A note from Peter Hansel asking if you would clarify that PACE plans are also an alternative for duals providing integrated care.

Anastasia Dodson:

Right, yes. So, PACE programs. PACE organizations are available around the state, and they are also a combined Medicare and Medi-Cal option for people who need a higher level of care. And there is information about joining PACE in the notices and materials. And again, that is kind of a special exception, if you join a PACE program that includes your Medicare and your Medi-Cal. But all of the other, and I'll just say also SCAN has a certain type of special needs plan. Again, that combines Medicare and Medi-Cal. Those are integrated care options alongside the Medi-Medi Plans. So Medi-Medi Plans, PACE organization, and a certain type of SCAN health plan, are integrated across Medicare and Medi-Cal. All other options are either original Medicare or Medicare Advantage plan, and then separate Medi-Cal plan.

Mary Russell:

Great. And a question from David Fine, which I think we'll get into further detail on shortly. But “When will beneficiary notices be mailed out to non-CMC duals informing them of their health plan options?”

Anastasia Dodson:

So, there's two sets of notices. But the second set, and Stephanie Conde’s on, she can also clarify. The first one is informing people of this change. The second one is going to include a choice packet, depending on which choices you have available in the county that you're in. And there is a little bit of a wrinkle on that. For people who are already enrolled in a Medicare Advantage plan, we have a matching plan policy that Stephanie's going to talk about. But we will get to that in a few minutes. So, let's just stay on our overall level at this point.

Mary Russell:

Great. Okay, great. Thank you. And a question from Kristen Smith, which is interesting here, “Since ECM and MSSP are duplicative, is there a preferred direction or vision for how eligible duals will receive this type of care coordination?”

Anastasia Dodson:

So, for Enhanced Care Management, this again is a kind of special type of care management for people that have very complex needs, starting in January 2023, with expanded populations of focus, the Medi-Cal plans primarily are the organizations that are administering the Enhanced Care Management benefit. For people who are enrolled in Medi-Medi Plans in 2023, we have said, we don't want both the Medi-Cal plan and their Medi-Medi Plan to both be providing Enhanced Care Management, that's duplicative. So, the Medicare side of the house is responsible for Enhanced Care Management. In that case, it's not a duplicative requirement. But again, it should be very seamless to beneficiaries, to members. So, for those of you who are not steeped in that policy area, the point is that we want to make sure that it's very clear to members, to providers, and to the health plans, that there should not be duplication for Medi-Medi

plans. If it's a requirement on the Medi-Cal side, and it's a requirement on the Medicare side, then, in most cases, the Medicare plan will be doing that coordination. And the Medi-Cal plan will fit right in.

Mary Russell:

Great. Let's go to Lydia next. Lydia, feel free to unmute yourself and ask your question.

Lydia Missaelides:

Hi. Thank you, Mary. Hi Anastasia. Really, really helpful overview. I can't get enough of these summaries actually, so thanks for doing that. This is reminding me of the CCI transition that many of us went through. And what it brought to mind, and I am not at all expert on this, and I'd have to refresh my memory and go back to my notes for specifics. But I do recall, that even though someone is on Medi-Cal now, and they're receiving their managed care benefit through whatever mechanism they have chosen, the fact that there's a transition from Fee-For-Service Medi-Cal to managed care, confused providers in the medical community. And I'm wondering if the fact sheet you referred to, has to do with educating that very important group of providers for continuity of care. It caused an immense amount of confusion at CCI because Adult Day Healthcare, at that time, was really the only LTSS benefit where beneficiaries were required to be enrolled in managed care. And so, I'm just having visions of that again, as you listed out the counties that are affected, it's actually quite a few. It's a high population. So, wondering if you can just reflect on that a little bit, Anastasia, and what's been put into place to avoid those kinds of problems. Because it did affect continuity of care. There were specialists and even primary caregivers that were saying, "Well, we don't deal with Medi-Cal managed care. We're not going to continue to serve you as a patient if you do that." Well, now they have no choice. So, wondering if you can just put my mind to ease a little bit. Again, I'm not an expert on all the technicalities of share-of-cost and billing and all those things. That might worry those folks. Thank you.

Anastasia Dodson:

Right. Yeah, thank you so much, Lydia. So, first of all, the fact sheet that we have right now posted on that webpage, is beneficiary oriented. And we are in the process of developing a little bit longer fact sheet for Medicare providers. So, we have been reaching out to medical associations in the affected counties. And for example, for Alameda Contra Costa, we're working with them. Going to be doing probably a webinar in conjunction with the Medi-Cal plans in those counties. Just the other day I spoke with Butte-Glenn Medical Society, and they recorded that. Now they'll make that available to their members. We have also been reaching out to many of the health systems. We had a very productive call the other day with UC Davis Medical Center, and we're going to be reaching out to other key health systems and hospitals. Because you're right, there is some confusion. Or we need to continue to provide clarity to Medicare providers. And so, I'll take this opportunity to say, if you are a Medicare provider, if you're an individual provider, or a facility, a specialist, you do not need to be enrolled as a provider in the

Medi-Cal plan that your patients are in, in order to continue seeing them and submitting claims to CMS on the Medicare side. There are backend processes.

Anastasia Dodson:

Both on the CMS side and then working with the state and then working with the Medi-Cal plans in order to make sure that the claim is processed fully and correctly. But the Medicare payment process for that claim remains the same. On the backend, there's, again, some technical stuff that happens when someone has Medi-Cal Managed Care versus Medi-Cal Fee-For-Service. But in most cases, it doesn't change how much a provider is paid because the payment policy that Medi-Cal has for dually eligible folks, we have a lesser policy. That will be more detail for the provider fact sheet, but the main thing that we want to emphasize to specialists, primary care providers on the Medicare side is that your patients, you do not need to be enrolled in the Medi-Cal plan that your patient enrolls in. You will still get the same Medicare payment regardless of which Medi-Cal plan your patient is enrolled in.

Anastasia Dodson:

If you're seeing a dual eligible patient right now and then they join a Medi-Cal plan, there's no change in where you bill on the Medicare side and there's no change in the Medicare payment. There may be a change on the secondary, you may not be getting an actual payment, it just could be a $0 adjudicated claim that you'll continue to get that type of claim. It's just a matter of working with the Medi-Cal plan versus DHCS. I'm breaking my own rule, I'm going way too much into the technical details, but thank you for the question, Lydia. We're definitely doing outreach to providers, and we will have a fact sheet and we know that it's very important for patients, beneficiaries to hear from their providers in the front desk when they go to make their appointments with a specialist that just because they're joining a Medi-Cal plan, it doesn't mean there's going to be any new restriction or hang-up on seeing their Medicare providers.

Mary Russell:

That's right. Thank you for that question, Lydia, and thank you, Anastasia. I think that was a really helpful response. I'm going to take a couple more from the chat and then I think we'll move on to the next section where we will have some more time for Q&A later. But an interesting question about care coordination from Joe Garbanzo, so, "On the question on the Cal AIM contract with managed care payers and delegated providers, network providers who have a delegated contract with payers, who is accountable for care coordination outcomes?"

Anastasia Dodson:

I'm not the technical expert on that, but as far as people who are dually eligible for Medicare and Medi-Cal, if they are in a D-SNP, a Dual Eligible Special Needs Plan, then that D-SNP is really ultimately responsible for care coordination across all

Medicare and Medi-Cal benefits. Not all people who are dually eligible are enrolled in D-SNPs by any means, but of those who are, it's that D-SNP plan that's accountable for care coordination. For people who are in original Medicare, Fee-For-Service Medicare, the Medi-Cal plan, depending on the circumstances of the individual, if they're in a skilled nursing facility, if they're transitioning out of a hospital stay to some kind of long-term care, long-term services and supports, we do have new rules around Medi-Cal managed care plan responsibility, around supporting that member in their transition out of the hospital for transitional care. But it's an area of opportunity for sure, because sometimes the Medi-Cal plans, they may not have the full picture of what's happening on the Medicare side, so we are working on ways to provide additional information about what's going on in the Medicare piece to the Medi-Cal plans. So, it's an area of opportunity, but if someone's in a D-SNP, in a Medi-Medi Plan, there's absolutely no question, it's that Medi-Medi Plan, it's the D-SNP that is required and accountable for care coordination across all benefits.

Mary Russell:

Great, thank you. A quick follow-up from Lydia that, "It would be helpful to set up a troubleshooting desk for these types of problems that we were discussing previously." She's grateful that you're meeting with the medical groups and doctors and just again, wanting to do what we can to reduce confusion with continuity of care in the future. I know there…

Anastasia Dodson:

For sure. Yeah, Mary, I'll just add that what we've also noticed in looking at the data for people who are making the transition to Medi-Cal Managed Care is that there's a significant number of folks in San Francisco County who have Cantonese listed as their primary language. So, we're looking at recording a webinar in Cantonese for folks and if folks think it would be helpful, we can do that in Spanish. We also have a contract with California Coverage and Health Initiatives, and they are subcontracting with CBOs in some of the larger counties that have this change. We are doing quite a bit and so we'll be happy to do more and certainly the info@ CalDuals inbox , people can send questions there. But also, I want to flag Health Care Options is our contractor that helps with Medi-Cal managed care enrollment and they also, they have an 800 number, and they have people out stationed in all of these counties in person who can help people understand their Medi-Cal choices and that it won't impact their Medicare.

Mary Russell:

Great. Anastasia, why don't we wrap up this section before we hand it over to Stephanie, but I think there's... Did you want to touch on one more slide here?

Anastasia Dodson:

Yes, just a couple more things to make sure everybody's aware with the larger context here that we also have this Older Adult Expansion. Everyone's probably very familiar, just a reminder there, and that the Medi-Cal asset limit did increase effective July 1st. We do have a page now on the DHCS website around Medicare Savings Programs where the asset limit also applies there. We don't have time today to talk in-depth about Medicare Savings Programs, but just to say there's really a variety of programs that are available at income levels that... People may not know that they're eligible for Medi-Cal, I think is the bottom line here. Even if it's just to pay the Part B premiums and the co-insurance, it can be really a great help for being people being able to afford their healthcare. Just again, all of you community leaders, keep encouraging people. They may not know that they're eligible, but now with the asset limit increase, they may be eligible, or they could be eligible for a Medicare Savings Program, which can be helpful in and of itself, just even for the Part B premiums and copays. With that, we'll go to the next slide. We talked about the questions, so I'll hand it off, Mary, to you, and then to Stephanie.

Mary Russell:

Great. All right. Thanks so much, Anastasia. We're going to turn it over to Stephanie Conde, the Branch Chief in the Managed Care Operations Division at DHCS to walk us through the 2023 Medi-Cal Matching Plan Policy Scenarios. So, take it away, Stephanie.

Stephanie Conde:

Good morning, everyone. Stephanie Conde with Managed Care Operations Division. Happy to be here today. I'm going to walk through the Medi-Cal Matching Plan Policy Scenarios. This is not necessarily new information. We have walked through this before, but what we've done is put it in a little bit different scenarios or communication in a way to make it a little bit easier to understand because it's a little bit complicated as its new to all of us. Next slide please. All right, so Aligned Enrollment, or the Medi-Cal Matching Plan policy, dual eligible beneficiaries who are enrolled in a Medicare Advantage plan must be enrolled in a matching Medi-Cal managed care plan if one is available. Our Medicare Advantage plans are the lead plans. The 12 Medi-Cal matching plan policy operates in Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus. In all the other non-COHS counties, aside from these 12 counties, there is no matching policy. Next slide please.

Stephanie Conde:

The difference between primary and delegate. A Primary Plan is a managed care plan that directly contracts with the Department of Health Care Services to provide Medi-Cal services. Primary Plans are responsible for ensuring that delegate health plans and provider groups are and continue to be in compliance with all applicable Medi-Cal state and federal laws and contractual requirements. The Primary Plan is responsible for

enrolling beneficiaries into subcontracted, or Delegate Plans. A Delegate Plan is a subcontractor with a Medi-Cal managed plan that provides Medi-Cal services. DHCS does not enroll beneficiaries into subcontracted, or Delegate Plans. The enrollment process is the responsibility of the Primary Plan. Next slide please. So, what does this mean, the difference in the primary and delegate? In our 12 Medi-Cal matching plan counties, Medicare plan choice determines Medi-Cal plan enrollment. Like mentioned on the slide before, for all 12 Medi-Cal matching plan counties, aligned enrollment occurs at the Medi-Cal prime level.

Stephanie Conde:

In the following counties, aligned enrollment extends to the Medi-Cal delegate level for matching Medicare Advantage plans, including our MMPs, our Medicare Medi-Cal Plans. So, in our former CCI counties, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, the extension of the matching plan policy goes to the delegate plan level. Next slide please. Like I mentioned, this is not new. We had presented on this before, but we did change up our slides and our scenarios just a little bit to give a better picture of some of these scenarios that a beneficiary would go through. Scenario 1 is an example of a member who has original Medicare. They can be enrolled in any Medi-Cal Managed Care Plan.

Stephanie Conde:

Next slide please. This slide for Scenario 2 is an example of when a beneficiary has requested to change their Medi-Cal managed care plan. If a full benefit dual eligible is currently enrolled in a Medi-Cal plan that matches their Medicare plan but wants to change their Medi-Cal plan to one that does not match their Medicare Advantage plan, the enrollment is not allowed, and we will direct that beneficiary to change their Medicare Advantage plan enrollment first. Should the beneficiary need an urgent or medically necessary disenrollment, particularly during the last quarter of the calendar year, Health Care Options can directly facilitate the immediate disenrollment. What this means is that there will be a mismatch for a very short period of time while that beneficiary updates their Medicare enrollment to then match their Medi-Cal managed care plan choice. Next slide please.

Stephanie Conde:

In Scenario 3, this is an example of when a beneficiary changes their Medicare Advantage plan to a plan that no longer matches their Medi-Cal managed care plan. If there is a matching Medi-Cal managed care plan to their Medicare Advantage plan choice, then the beneficiary will be automatically enrolled into that matching Medi-Cal managed care plan. The beneficiary will then receive a confirmation letter from DHCS to explain the change in their Medi-Cal managed care plan. If there is not a matching Medi-Cal managed care plan to their Medicare Advantage plan choice, no action is taken, that beneficiary is allowed to be misaligned. Next slide please. Then lastly, this Scenario number 4 is an example of when a beneficiary becomes newly eligible for

Medi-Cal managed care. The beneficiary will be automatically enrolled into the Medi-Cal managed care plan that matches the Medicare Advantage plan that they're currently enrolled in. The beneficiary will receive from DHCS a letter or confirmation letter explaining the enrollment into the matching Medi-Cal plan. A lot of information, but the slide deck has been shared, so it's just a good reminder, these scenarios, of the beneficiary experience as we roll out our 2023 Medi-Cal Matching Policy. Next slide. I will take any questions.

Mary Russell:

Great. Thank you, Stephanie. I am checking the chat right now and I know our team has been able to provide some additional resources in the chat as you've been presenting, but please feel free to add a question in the chat or raise a hand and we can unmute you. Okay. Yeah, Lydia, go ahead.

Lydia Missaelides:

Hi Stephanie. Really helpful overview, those slides. I'm going to have to study them a little bit more, but super, super helpful. It went by kind of fast, but you talked about one of the slides where there could be mismatch temporarily. Anytime I hear that, I worry about the beneficiary and a disruption in their care and I'm again very sensitive to Adult Day Health Care, CBAS, because these are folks who are receiving services on a weekly basis or daily basis, so any disruption in that continuity of care really causes quite a lot of havoc for everyone. Wondering if you could just address that a little bit more or how, if a beneficiary or provider experiences that, what's the best way to get a quick resolution? Is there going to be unbilled services where people aren't going to be paid for services provided and so on? If it's too long of an answer today, then I'd be happy to talk offline with you.

Stephanie Conde:

No, it's a great question and I should have backed up and said this is only when a beneficiary calls in to make the request and it's medically necessary. It's a disenrollment that will allow for a short period of time, in order for that beneficiary to go to their appointment, because they've requested that enrollment, they have an appointment scheduled and they need to see that provider. So, it's only when that beneficiary does call in to Health Care Options requesting that disenrollment, or change in Medi-Cal plans, because of an appointment they have on calendar. We would allow that disenrollment and explain to that beneficiary in those 120 days, allowing them as such that they need to go work on changing their Medicare plan to match. So, then the policy does come into effect after the 120 days, that match will occur. So, it is a short period of time, but is only when that beneficiary has requested a mismatch and it's medically necessary. Does that help a little bit in explaining kind of that beneficiary experience or how that scenario may play out?

Lydia Missaelides:

A little bit? Again, I'm going to have to study this a little bit more and just think of some examples, but I appreciate you leading me to that kind of scenario. Appreciate it.

Stephanie Conde:

Yeah, please email me or the team and it can get over to me. I've had to study these myself and that's why I say we're trying to make them a little bit simpler even for our thought processes and how we're designing the systems to respond to this and help our beneficiaries as we move into this policy, so happy to take questions and work with you on any clarifying points to these slides.

Lydia Missaelides:

Thank you, Stephanie.

Mary Russell:

Thanks, Stephanie. The next hand I see is Susan LaPadula. Go ahead, Susan, you can come off mute.

Susan LaPadula:

Thank you, Mary. Hello. Good afternoon, Stephanie. Hope you're doing well. My question for you in the 12 matching plan counties is will we have automation of crossover claims?

Stephanie Conde:

I am going to pause for an additional SME. I'm not the expert there. Anastasia, or I don't know if our folks from Third-Party Liability are on to really dive deeper into that one.

Anastasia Dodson:

Yeah, we are definitely looking at all the different aspects of crossover billing. I mean, thank you Susan for raising that longstanding issue, and we're thinking of ways to... First of all, we're making sure that we have our technical teams fully documented, the current process and then looking at ways to work with the Medi-Cal plans to make sure they understand the process and the opportunities there. We agree that having an automated process is much cleaner, smoother, less complicated, efficient. Definitely on our list and we were meeting on it even just this morning, our technical team. So, more to come and thank you for raising that. And I should also flag, for those of you on the phone, advocates, community leaders, we have a fact sheet also on our website about balance billing, related issues, related to crossover. Dual eligible beneficiaries should never receive a bill related to their Medicare Part A or Part B services, so providers should not be billing beneficiaries who are dually eligible. Medicare providers should not be billing beneficiaries, and so we have a beneficiary fact sheet and again, as we work

on a more detailed fact sheet for providers that will address the crossover billing issues, we'll make sure that all that is clarified. Thank you.

Mary Russell:

Great, and we'll provide a link to that fact sheet in the chat for reference as well. Great. Okay, I see Rick Hodgkins has a hand up. Go ahead Rick.

Rick Hodgkins:

Yes, I am very busy today, have multiple simultaneous different meetings going on. But I wanted to ask. I know we have one more… I don't know how many more meetings we have after this one this year, but I would like to ask, will you be able to educate UC Davis Medical Center? Because as it stands now, depending on which UC Davis Medical Center location that you go to, some will not take... They all Medicare, but some will not be able to take Medi-Cal, or straight Medi-Cal, or Medi-Cal Managed Care Plans. So, thank you.

Anastasia Dodson:

Thank you, Rick. Thank you so much. I just really want to say how much I appreciate you bringing this up to us. We did meet with UC Davis Medical Center. We met with about 20 of their billing managers and they asked a lot of questions. We explained the policy to them, and we have an email chain following up with them. So just from the bottom of my heart, thank you so much for alerting us to that, and we are going to be reaching out to UCSF, to all of the other major health systems in the Central Valley and Bay Area and make sure that they understand the policy. It is our really... a shared goal across the whole department here to make sure that there's no disruption for people who have Medicare and Medi-Cal, and just really appreciate you alerting us to that. Please keep us posted and anything that you are hearing that sounds confusing, let us know. We will keep following up on it. We're not going to let go of this until it's clear to everybody. Things are not going to be perfect, but we're just going to keep at it and make sure that all the information is pushed out to all the providers. Then as issues come up, we're going to address them, and we do really want to make sure that you can access all of your Medicare providers and have no disruption. So, thank you again.

Mary Russell:

Thanks Rick. Oh, sorry. Do you want to unmute so we can hear your-

Rick Hodgkins:

Now unmuted.

Mary Russell:

Go ahead. Okay. Just let us know, Rick, if you want to unmute again, but thank you for that question.

Rick Hodgkins:

Thank you very much. Bye-bye.

Mary Russell:

All right, I see a question in the chat from Debbie Wickersham for you, Stephanie. "Are you going to address beneficiaries who are currently on Fee-For-Service Medi-Cal in a CCI county, and will they be transitioning to an MMP?"

Stephanie Conde:

Hi, Debbie. Yeah, for any reason that beneficiary in a CCI County is not already Medi-Cal managed care plan mandatory and they become mandatory based on the presentation and Medi-Cal mandatory managed care transition that's happening this year, they will transition based on their Medicare enrollment. So, if that beneficiary has a Medicare Advantage plan and has a matching Medi-Cal plan, there will be a transition to the matching Medi-Cal plan that happens on January 1st. So, it'll be January 1, 2023, forward and they will get a confirmation letter explaining why there's a change in their.... may be a change in their Medi-Cal managed care plan based on this policy.

Mary Russell:

Thank you, Stephanie. I think Lydia, did you have another question? Feel free to unmute.

Lydia Missaelides:

I do, yes. You can tell I care about this a lot. What I'm wondering about is, given that it's open enrollment season for Medicare and there potentially could be a lot of changes and people on the ground that are delivering services may not be aware of this. Again, I'm just picturing a lot of areas of risk for the beneficiaries going forward. I'm wondering, I put this in the chat earlier, Anastasia, is there a way to set up some sort of a help desk? To Rick's question, for example, where beneficiaries or providers who are serving beneficiaries do encounter these areas where somebody is clearly confused. We understand the rule, it's not being understood. Is there a way we can get a quick intervention then by someone at the Department of Health Care Services? Because I don't know that people in the community would know how to resolve these. Who do they go to resolve this now that we have so many entities involved? So just putting that out there, you don't have to answer it today, but if you've thought about it or if you can think about it, I just feel like that would be super, super helpful. Thank you.

Anastasia Dodson:

Right. No, you're right, Lydia. We have the info@CalDuals.org and we do get a number of questions in there and the team watches that and they forward to me or to other folks in the Department. Beneficiaries can contact Health Care Options. Stephanie, chime in, but I think that Health Care Options, they should be able to work with beneficiaries on a lot of this.

Stephanie Conde:

Yeah, they absolutely can, but also their managed care plan for all these transitions, we set up at least a two-week monitoring period where we have a very quick triage from DHCS to the managed care plans and Health Care Options. At all times, we have direct communication with them, but with the managed care plans, we do have the plans report daily on any access to care, any of these scenarios that may come up, we monitor those. To Anastasia's point, we are monitoring all these transitions very closely with our partners.

Mary Russell:

Great. I think we are good to transition to our next section. Thank you so much, Stephanie. I will hand it back to you, Anastasia, to take us through the January 2023 transition notices.

Anastasia Dodson:

Right. Okay. Next slide. Good, I see more in the chat about the Cal MediConnect or the Duals Ombuds program, and so there are many resources. Again, there are these four streams. We didn't talk yet about the Long-Term Care Skilled Nursing Facility Carve-In, but we are going to get to that a little bit later. But these are the four main transitions. You'll see the Cal MediConnect to Medicare Medi-Cal plans, the D-SNP Look-Alike transition, Medi-Cal Managed Care enrollment in those 31 counties, and Skilled Nursing Facility Carve-In again in those 31 counties. Next slide. So, September has come and gone, and materials notices have already been sent on the Medicare side from the Medicare plans to Cal MediConnect members and folks who are enrolled in a D-SNP look-alike, and they got information about those upcoming transitions in October. Again, that 90-day notice has already been sent out and should have been received. Now we've started the Medicare annual enrollment period.

Anastasia Dodson:

Upcoming are the notices in… November 1st, so some of those may already be in the mail, probably are for Medi-Cal managed care and the Long-Term Care Carve-In. Those are 60-day notices that folks will get by November 1st from the Department of Health Care Services. Again, in the purple, around the Cal MediConnect transition, there are 45-day notices that will be arriving in mid-November to beneficiaries. Then in December, well, December 1st, there'll be 30-day notices for both the Long-Term Care Carve-Ins, Skilled Nursing Facility Carve-In, and the Medi-Cal managed care. Again,

those are primarily in those 31 counties, and that packet by December 1st will also include information about which health plans, a choice packet. Again, we have that little asterisk because in certain counties, if a beneficiary has voluntarily enrolled in a Medicare Advantage plan, and that Medicare Advantage plan has a matching Medi-Cal plan, then the beneficiary doesn't necessarily need to choose a Medi-Cal plan because they've already chosen a Medicare plan. If they have a matching Medi-Cal plan, that's where they're enrolled. This is the noticing timeline that we're halfway through, and so you all can see what... I'll also want to flag that just in the last 24 hours or so, we have posted the beneficiary notices for the Long—Term Care Nursing Facility Carve-In, as well as the Medi-Cal managed care enrollment policy.

Anastasia Dodson:

Both of those notices are posted on the DHCS website. There is a page specifically for the Long-Term Care Skilled Nursing Facility Carve-In. And if you go to that page, and I'm sure the team will put that link in the chat, you'll have to scroll about two-thirds of the way down and then you will see the 'Beneficiary Notices' in English. On the Medi-Cal managed care enrollment, there's a different page there. That page, if you scroll a little way down, you will see the beneficiary notices. So, those notices are posted there. Of course, the versions that will go to beneficiaries have their name, et cetera, filled in and it's in the correct language. So, of course we are sending these notices to people in the language that they have checked off as their preference. We're posting the English versions. And other versions, like the people who would like to get a copy of the Spanish version, for example, we can make that available as well. Next slide.

Anastasia Dodson:

Okay. And there are outbound calls. So, right now the Cal MediConnect Plans are making telephone calls to the members to make sure they're aware and if they have any questions about the automatic transition to Medicare Medi-Cal plans. And then in December, the California Department of Health Care Services, DHCS, Health Care Options, will be telephoning the beneficiaries who are being transitioned to Medi-Cal managed care plans, either because of being dually eligible or Medi-Cal only, and certain categories who need to choose a Medi-Cal plan. Next slide. So, these next few slides focus in-depth on the types of notice that are being sent. So, we don't need to probably go into great detail, but these slides will definitely be posted. For the D-SNP look-alike, there's an Annual Notice of Change that the Medicare Advantage plans have sent out, and that's a routine mailing each year. And then it does explain the new plan that they're going to be transitioned into. All right. Next slide.

Anastasia Dodson:

For the Cal MediConnect to Medicare Medi-Cal Plan transition, again, it's an Annual Notice of Change and then also a 90-day notice with some inserts. Those materials, those notices, are available on a different webpage, The Future of Cal MediConnect. And we do have a webpage called Integrated Care for Dual Eligible Beneficiaries. I think

that's what it's called. Anyway, it's a hub. And then from that landing page you'll find the links to all of these other web pages that have the notices, et cetera. But again, this is about the Cal MediConnect transition, the 90-day notice, the additional notice and notice of additional information. Next slide. And that's the page, 'The Future of Cal MediConnect' and there are the 90-day notices and the 45-day notices. Next slide. For Medi-Cal managed care, we've been talking about this quite a bit. There's a 60-day notice and then a choice packet and a 30-day notice. And again, this is for essentially the remaining dual eligible beneficiaries that are not already enrolled in a Medi-Cal managed care plan. And just a reminder, over 70% of people who are dually eligible are already enrolled in a Medi-Cal plan. It's just the remaining 20-something percent, about 325,000, that this change will impact. Next slide. And then this is for folks who are in a skilled nursing facility in the 31 counties. Folks who are, if they're not already enrolled in the Medi-Cal Managed Care Plan, then they will be enrolled. And Bambi Cisneros is going to talk more about that transition. But there are specific notices for individuals in skilled nursing facilities about this transition, and we've been having a number of meetings and work groups and we have other webinars about that transition. Next slide. Okay, so questions on these notices?

Mary Russell:

Great. And yeah, just a few notes in the chat. We've had some dialogue. We've been able to share some additional resources. There have been a couple questions related to the SNF transition, which I know we will get to shortly on our agenda, so I'm actually going to hold those questions for when Bambi is on the line. So, additional questions related to the notices or the noticing process, feel free to raise a hand or drop it in the chat. Otherwise, Anastasia, I think you could continue on to the policy guide section and then we could loop back if any transition questions come up.

Anastasia Dodson:

Sounds great. Okay. Well, we have been talking about a lot of enrollment policies and notices and transitions. So, this topic is related to the actual rules around care coordination and policies once people are enrolled in a dual special needs plan. Now, before we dig in too deep, I just want to remind you that in the world of Medicare Advantage there are D-SNPs, which are Medicare Advantage plans specifically oriented to people dually eligible. And of those D-SNPs, some of them are, we've been calling them exclusively aligned enrollment, but Medi-Medi Plans, where the same organization manages Medicare and Medi-Cal benefits for the member. Again, those are Medi-Medi Plans that will start in January. There are some D-SNPs that are not Medi-Medi Plans. They do offer care coordination, but they don't have the same Medi-Cal benefit wraparound. So, we have a policy guide that lists our requirements for both types of D-SNPs. And so, let's go to the next slide.

Anastasia Dodson:

We have recently made some changes. And this policy guide, again, we've talked about this about six months ago. And you have to clear out the cobwebs a little bit to say, "Okay, what did we talk about six months ago?" We talked about the State Medicaid Agency Contract. That is the contract between the Department of Health Care Services and the D-SNP, and it has the care coordination requirements. And then the policy guide provides additional detail beyond what's in the State Medicaid Agency Contract. So, I know some of this terminology is not something we've been talking about for a long time. This is somewhat new terminology, but it is a national model. The federal government has been working on regulations and a process to transition all of the Financial Alignment Initiative demonstrations like Cal MediConnect. There are other demonstrations in other states, and we are on the same path as other states in transitioning our demonstration to a type of D-SNP that has the coordination across Medicare and Medi-Cal.

Anastasia Dodson:

So, again, the State Medicaid Agency Contract, that's a standard contract between the state and the D-SNP. And then the policy guide has additional information, additional requirements that the state has for D-SNPs that give even more detail of how we want them to have care coordinated, information sharing, many other aspects. Some of those policy guide provisions are for all D-SNPs. Some are just for the Medi-Medi Plan type of D-SNPs. All of the policy guide information and the SMAC contracts are posted on the DHCS website. Next slide. So, why are we bringing up all this? Why, in the midst of the enrollment stuff? We wanted to make sure you knew that we have updated the policy guide for 2023 around information sharing. And again, those of you who are community organizations or healthcare providers, you may find this very interesting. The federal government has a policy that requires states to require D-SNPs to make sure that for dual eligibles, when they get admitted to a hospital or skilled nursing facility, that the Medi-Cal or the Medicaid plan for Long Term Services and Supports is notified.

Anastasia Dodson:

So, of course, that is a very good strategy for care coordination because the Medicare Advantage plan and the D-SNP, while they do fund the hospital and physician visits, they don't necessarily fund the long-term care stay, especially if it's a custodial type stay. So, having that information sharing where there's a hospital admission, the hospital notifies the Medicare plan, and then this policy now is expanding that notification for the hospitals to make to also include either the D-SNP or the Medi-Cal plan. And then same thing for nursing facilities, requiring nursing facilities to notify the D-SNP, of course, of the admission, and then either having a D-SNP or the nursing facility notify the Medi-Cal plan.

Anastasia Dodson:

Sometimes we think of the internet and information-sharing interoperability, isn't that already being done? In some cases, yes, but not all cases. For some facilities or some

combination of health plans, that information sharing is not already happening. So, we have strengthened the requirements, again, to comply with federal requirements around that information sharing. Next slide. So, this has a little more detail, but one thing also we want you to know is that there are existing requirements for hospitals as far as notification when there is a hospital admission or a discharge. And so those are federal requirements and so our policy tries to fit in as closely as possible with those existing federal requirements for notification. And it basically just says, when the hospital is making that notification already to the patient's primary care provider, for example, on the Medicare side, they also then notify the Medi-Cal plan or the D-SNP and then the D-SNP would notify the Medi-Cal plan.

Anastasia Dodson:

But basically, making sure that the Medi-Cal plan is in the loop for both hospital and nursing facility admissions, discharges, and transfers. And this is, again, in many cases it conforms with existing practice, but in some cases, it is something new. And so, we know that there's a lot of other pieces around interoperability and data exchange going on at the state level. We are pushing ahead in some ways with this policy for D-SNPs and their contracted providers, but we want to make sure that it's fitting in with those existing other initiatives. So, we have to put the policy in place at the federal requirements, but we're certainly welcoming feedback on how we can improve it in future years. And we know that, again, there's a lot going on in this space of information sharing. Next slide. Okay. So, that's it for the policy guide update. Again, I appreciate everybody switching gears because that is a totally different topic than the enrollment we were just talking about. But I'll be available to answer any questions.

Mary Russell:

Great. Anastasia, there is one question related to the policy guide update you shared. So, from Jennifer Breen, "Does the notification information sharing requirement also apply to beneficiaries who are not in a D-SNP, for example, Fee-For-Service Medicare when admitted to a SNF?"

Anastasia Dodson:

It does not. So, this is only a policy around people who are enrolled in a D-SNP. We are certainly looking at this area for people who are not in D-SNPs, but we don't have the same avenue right now for the folks who are not in a D-SNP. And I'll take a quick second to say, part of the complexity of all of this, as you all well know, is that there are different ways that people get their Medicare. They're in original Medicare or they're in Medicare Advantage plan. Maybe it's an integrated type of plan like PACE or Medi-Medi Plan or SCAN. There's these different combinations on the Medicare side. On the Medi-Cal side we're hopefully simplifying. So, just about everybody is in a Medi-Cal managed care plan. And nursing facility stays soon will be more consistent across all counties carved into Medi-Cal managed care.

Anastasia Dodson:

But there are still some pieces that are outside of Medi-Cal managed care like IHSS and specialty mental health, et cetera. So, part of, again, the goal having integrated options for dual eligibles is even though there are some pieces that are carved out of Medi-Cal managed care, at least having the single entity that, through a D-SNP, through a Medi-Medi Plan or a PACE or SCAN, some care coordinator whose main job it is to help the beneficiary navigate across all those systems, that is something we think can be very appropriate for people who choose to enroll in something like that. But even then, there's a lot of people who are in original Fee-For-Service Medicare, and absolutely that may be the best choice for them. But then again there's just the complexity of all the different delivery systems. So, we were working on ways for people who do not choose to enroll in any kind of integrated system, ways that we can improve the information sharing across all of the providers and plans. And we can certainly talk more about those in the coming months.

Mary Russell:

Great. Thank you so much, Anastasia. And thank you for all the questions and discussions so far. At this point we're going to transition over to Bambi Cisneros, Assistant Deputy Director with Health Care Delivery Systems at DHCS to walk us through the CalAIM Skilled Nursing Facility Long-Term Care Carve-In. Go ahead, Bambi. Thanks for joining today.

Bambi Cisneros:

Great. Thank you very much, Mary. Can you hear me, okay?

Mary Russell:

Yep. You sound great.

Bambi Cisneros:

Okay, perfect. Thank you so much. So, thanks for having me here this afternoon. Again, I'm Bambi Cisneros. I'm with Health Care Delivery Systems here at the Department. And I'm going to talk to you a little bit today about the work that was done with the Long-Term Care Carve-In Workgroup specific to the Skilled Nursing Facility transition and where we landed on the All Plan Letter, APL 22-018, as a result of that work. Okay. So, we can go on the next slide, please. Okay. So, the next few slides we will discuss just a brief reorientation to the CalAIM Long-Term Care Carve-In goals including this current state of the Long-Term care benefit today and what is changing in 2023. And then we will quickly recap the Long-Term Care Carve-In Workgroup and then the outcome of that APL. We'll also talk a little bit about post-transition monitoring efforts and how the Department will oversee the implementation and then we'll have some time for some

Q&A. And then you'll see later in these slides, we did provide some resources and contact information in this slide deck just so you have it as well.

Bambi Cisneros:

Okay. So, effective January 1, 2023, the Department will be making the Long-Term Care benefit available under all managed care plans statewide regardless of plan model. And we are doing this really to ultimately improve the member experience. By standardizing coverage no matter where the member lives in the state, the healthcare delivery system is less complex to navigate for the member. And this will also provide the member with the benefits that managed care plans offer such as care coordination and care management. And so, as you've seen in the pretty massive CalAIM proposal, CalAIM has various initiatives. And this particular initiative is part of what is described as Benefit Standardization. And so, what this means is that CalAIM is standardizing benefits in coverage under managed care across the state. And this standardization of benefits really helps to ensure that regardless of the county that the member lives in, their benefits will remain the same.

Bambi Cisneros:

So, again, really just ultimately to improve the member experience. And so, in today's environment, institutional long-term care services are only covered under Medi-Cal managed care in the 27 COHS and CCI counties. And then for those plans and those COHS and CCI counties, these plans are responsible for all medically necessary long-term care services, regardless of the length of stay in a facility. And then for all other counties that are in non-COHS and non-CCI, managed care plans are responsible for medically necessary, long-term care services, that are provided from the time of admission into the facility and up to one month after the month of admission. And so, after that time period, they're required to disenroll the member to Fee-For-Service. Okay. You can go to the next slide, please.

Bambi Cisneros:

Okay. So, this map illustrates the counties where skilled nursing facilities services are carved in today already. So, the dark pink is for managed care plans and the light pink is for the CCI counties, and then the non-COHS and non-CCI counties are in blue. And so, you'll see here for effective January 1, 2023, the Long-Term Care benefit for skilled nursing facilities will be carved in those counties in the blue, making skilled nursing facility coverage statewide in Medi-Cal managed care. And you'll see here that we are estimating the impacted population to be about 28,000 members, most of which are dual eligible members. Okay. Next slide please.

Bambi Cisneros:

And this slide is just a list format of the blue counties on the previous slide, which is a list of the non-COHS and non-CCI counties and plans where the skilled nursing facility

carve-in will take effect on January 1, 2023. So, what is changing? So, starting January 1, 2023, managed care plans will cover skilled nursing facility services for their enrolled members statewide. And so, what this means is that beneficiaries who enter a skilled nursing facility and would otherwise have been disenrolled from the plan will remain enrolled in the plan ongoing. And so, this means that they do not need to be disenrolled to fee-for-service in order to receive the skilled nursing facility benefit. So, same as what happens in the COHS and CCI counties today. And so, in addition to that, Medi-Cal only and dual eligible beneficiaries in the fee-for-service system that is residing in a SNF on January 1 will be enrolled in a managed care plan effective Jan 1, 2023.

Bambi Cisneros:

And I would say there's two dates here because we have January 1, 2023, for members that make a plan choice. And for those members that do not make a plan choice and are then put in the default enrollment path into a plan, that change will be in effect February 1st, 2023. So, just wanted to make that distinction there. And so, this change will include most Medi-Cal beneficiaries, which include the Medi-Cal only, dual eligible beneficiaries, so those who have Medicare and Medi-Cal, Medi-Cal beneficiaries with other health coverage including private coverage and share of cost Medi-Cal beneficiaries in the long-term care aid codes.

Bambi Cisneros:

Okay. Thank you. So, next we'll dive in a little bit on the All Plan Letter. And so, we developed, finalized and posted an All Plan Letter based on the great feedback that was provided by our Skilled Nursing Facility Carve-In Workgroup. And so the group met between December 2021 to September of this year and did discuss a variety of topics which included network readiness, continuity of care, planning data, what communications would look like between plans and facilities and some education and training needs there, as well as informing our policy guidance and the APL, and then other pieces that would not be memorialized in an APL would then be codified through other venues such as promising practices that's currently under development. And so, we will talk about it in later slides how we've incorporated this feedback either in the APL or the forthcoming FAQ or through continued provider and plan engagement through training webinars. So, I think the bulk of the work is done there, but we are continuing to have those communications about this policy because we think that's really important.

Bambi Cisneros:

Okay. So, the SNF All Plan Letter touches on topics that include benefits and the plan responsibilities for the provision of those skilled nursing facility services. We talked about network readiness and what that looks like. The leaves of absence or bed hold requirements. We talked about continuity of care requirements, requirements for treatment authorizations, the plan's responsibility for payments to facilities and population health management and where this Long-Term Care Carve-In fits in as part

of that larger picture. And then policies and procedures that managed care plans are required to submit to the Department to demonstrate that they are in compliance with the policy of this APL. And one thing I wanted to point out is that this APL is specific to the Skilled Nursing Facility Carve-In. So, we are beginning, or we've actually just relaunched our stakeholder process on the ICF, or Intermediate Care Facility, for the developmentally disabled population and Subacute Facility Carve-In, which takes effect July 1, 2023. And so, we are developing a separate APL on those policies with the stakeholder process that's currently ongoing now.

Bambi Cisneros:

Okay. So, continuity of car is what we'll tackle next. And continuity of care for this population really has three specific aspects. So, there is continuity of care to services. There's continuity to the provider, and then continuity to the facility. And so, when it comes to continuity of care to services, plans are required to provide a continuity of care for all medically necessary long-term care services, non-contracting long-term care facilities for members residing in a skilled nursing facility at the time of enrollment. And so, the services in those facilities include all the supplies, drugs, equipment and services necessary to provide that level of care, which also include personal hygiene items and therapy services. And you'll see here that we did link to the provider manual, which does have additional information and detail on what's included and excluded services when it comes to these SNF services.

Bambi Cisneros:

And so, one thing to point out here is that this policy applies to members who are already residing in a skilled nursing facility on January 1, 2023, and that were previously in Fee-For-Service Medi-Cal. So, that's what this is speaking to. And then we can go onto the next slide please. I'm seeing some questions which we'll get to. Okay. So, to continue on, Skilled Nursing Facility Continuity of Care, members can stay in their current SNF as long as certain conditions are met. And so that includes that the facility is licensed by the Department of Public Health, that the facility meets quality standards, which includes the plan's professional standards, and that the plan and the facility agreed to work together on payment and rates. And so, if all of those conditions are met, then this continuity of care protection for the skilled nursing facility is automatic.

Bambi Cisneros:

And what that means is that the member does not have to request to stay in their facility. If these conditions are met, then the plan must honor that. And again, the goal of this policy is really to minimize disruption and movement of members. And so that's why we have this in place. And after 12 months, the member can request an additional 12 months of continuity of care, but that portion would not be automatic. They'd have to request to have that additional continuity of care. And if for some reason the plan is unable to offer continuity of care, the plan is required to provide the member with a written Notice of Action, or we also call it a Notice of Adverse Benefit Determination.

And the plan is also responsible for finding the member alternative placement just to ensure that they have somewhere to go. And we can go on to the next slide please.

Bambi Cisneros:

Okay. So, this slide pertains to continuity of care as it applies to providers. And unlike continuity of care to the facility, which is automatic, to stay with their providers members have to make a request to keep seeing their provider or a member's authorized representative or provider can make this request on the member's behalf as well. And similar to the continuity of care policy for facilities, there are certain conditions that must be met for the plan to then honor the continuity of care request. And those conditions are: the member, the authorized representative or provider makes the request, and the member has a pre-existing relationship with the provider, which we're defining as having seen the provider or specialist at least once during the prior 12 months for a non-emergency visit, and of course that there are no quality issues that the plan has with the provider and that the provider's willing to work with the plan and agree on payment and/or rates.

Bambi Cisneros:

And one thing to note is that, as currently written in our Continuity of Care APL, these continuity of care provisions exclude Medi-Cal providers of durable medical equipment, transportation, ancillary services, as well as carved out services. We are working on updating this policy for 2023, which will include ancillary providers such as physical therapy and occupational therapy for the full 12 months of protection as well as for DME providers for the first 90-days after a beneficiary transition. So, that work is currently ongoing and we're looking to issue that policy as soon as possible as well. And so, one thing I wanted to flag for this group is that for dual eligible members, Medicare providers, including primary and specialty care providers and hospitals, do not change for the member and do not have to be in the plan's network. So, what we're talking about here is strictly the Medi-Cal policy and the requirements that plans have for the provision of skilled nursing facility services come January 1, 2023.

Bambi Cisneros:

Okay. The third aspect of Continuity of Care applies to other Medi-Cal services, and so for prescription drugs, Continuity of Care allows members to maintain their current drug therapy, which includes formulary drugs, until the member is evaluated or reevaluated by their network provider. I think you probably have seen this policy as per Medi-Cal Rx, in which the claim type really determines the financial responsibility. If the drug is dispensed by a pharmacy and is billed on a pharmacy claim, it's carved out of the plan's responsibility and is covered by Medi-Cal Rx or Magellan, and if the drugs are furnished by the skilled nursing facility and billed on a medical or institutional claim, then the plan is responsible.

Bambi Cisneros:

Then managed care plans may also choose to cover drugs that are not covered by Medi-Cal Rx, which includes over-the-counter drugs and other therapies that are otherwise not covered here by this policy. As I mentioned, there are other services that we're working on updating our Continuity of Care APL to enable members to keep their provider for DME, medical supplies for the first 90 days and some ancillary providers for up to 12 months. We are working on that, but for other services, we do have that Continuity of Care provides continued access to transportation providers. So, for non-emergency medical transportation and non-medical transportation, as well as some ancillary and medical supplies, but although Continuity of Care does apply to continued access to those services, it could require that the members switch to an in-network provider. So, it's not necessarily continuity to the provider, but it is to the service, and then we can go onto the next slide, please.

Bambi Cisneros:

Okay. So, the next couple slides kind of deal with leaves of absence and bed holds. So the leave of absence, or a bed hold, is a period of time when a facility resident may leave the facility for a short period of time, and still having the ability to return to the facility, and so this policy is really dictated in state regulations and the state plan, and are based on the Medi-Cal provider manual, and so if you have seen our All Plan Letter and see kind of the policy that we've laid out for Leaves of Absence and Bed Holds, you'll kind of see that it tracks to those regulations, the provider manual and state plan. One thing I wanted to just point out here on the slide is that plans may require prior authorization for bed holds and leaves of absences, but I'm not required to, and so I think this may be different from plan to plan.

Bambi Cisneros:

Okay, I think we can go to next slide. Thank you. So managed care plans are required to ensure bed holds and to ensure that this policy is utilized if the member takes a leave of absence, and what this means is just that members must be allowed to return to the skilled nursing facility that they were previously staying in, and the managed care plan is responsible for the coordination of that transition, and so the managed care plan is responsible for notifying, or working with, their skilled nursing facilities to then notify their members in writing of this right to a bed hold. Because again, as established in statute and regulations and the provider manual, and so the plan, as set forth in the APL does have some responsibilities there just to ensure that their members and their skilled nursing facilities and providers are aware of this policy. And also, to ensure that the skilled nursing facilities and providers that they're contracted with have appropriate training on these kind of Leave of Absence requirements.

Bambi Cisneros:

Okay, the next slide please. Okay, so moving on to authorizations. So, starting January 1, 2023, managed care plans are responsible for Treatment Authorization Requests that are approved for skilled nursing facility services that are provided under the per diem

rate, and that period is a period of 12 months after enrollment in the plan, or for the duration of the TAR, so whichever is shorter. Also, plans are responsible for all other DHCS approved treatment authorization requests in a skilled nursing facility, exclusive of the per diem rate for a period of 90 days after enrollment in the plan, or until such time that the plan is able to reassess the member and determine what other medically necessary services they are required to be connected to.

Bambi Cisneros:

Then when it comes to service authorizations, we do consider prior authorization requests for members that are transitioning from an acute care hospital to a SNF to be considered an expedited request. We don't want them kind of languishing in the hospital longer than they need to, and so that means that the managed care plan is required to respond within 72 hours, that's the expedited authorization timeframe, and that timeframe does include weekends as well. Okay. So, when it comes to care management and care coordination, one of the plans' contractual requirements is that they provide care coordination and care management to support their members in skilled nursing facilities. And so, care coordination is really personalized and scaled to member needs. But for members that are in a skilled nursing facility, those services would likely include a comprehensive assessment of the member's condition, determining what other benefits and resources are available that would be helpful to offer to the member, as well as developing a care management plan with the member's care team. And that care management plan includes performance goals that the member and the family would like to meet, monitoring and follow up as well would be documented there. And then, managed care plans also are required to assess and provide additional care coordination services if it's medically necessary, and as part of that is Enhanced Care Management and Community Supports, as well as Complex Care Management within the tiers of care management programs as required by Medi-Cal.

Bambi Cisneros:

So as part of the broader Population Health Management program, managed care plans are required to provide transitional care services for all members across all settings. This really helps to ensure that members are supported from discharge planning and are connected to all needed services and supports. There's some language in the APL to that end, as well as the managed care plans ensuring that they have a single point of contact that can assist members throughout their transition and ensure that all of the required services are provided for, and the members connected to the services that they need.

Bambi Cisneros:

We can move on the next slide. So, I think next, we will briefly review our next steps, including our continued stakeholder engagement. So, we can move on to the next slide, please. Thanks. So again, I think if you had the opportunity to take a look at our All Plan

letter, we did specify some of the readiness requirements there for the managed care plans, which includes ensuring that they meet network readiness, which includes the requirement that they update member facing materials, there's data sharing requirements, policy requirements, and other considerations. Network readiness really just includes a complete network submission for the Department to review in order to certify as part of our network certification that the managed care plan has an adequate provider network, and so what we did was we bumped up data from the facilities that are licensed by Department of Public Health, and provided that to the managed care plans, and to just get a status of their contracting efforts with those facilities that are available for contracting purposes.

Bambi Cisneros:

Additionally, the Department will also be reviewing and approving updated plan member facing materials, and so those materials include: the member handbooks, the member welcome packets, as well as website mockups for how this information would be displayed on the plan's websites. And then, when it comes to data sharing, the Department will be providing data to the managed care plans that will kind of help to show and provide understanding of the population that is transitioning to the plan. And so, the plan is aware of what the member needs are so they can use that information for continuity of care and transition planning purposes. Then finally we have that our managed care plans must have some processes in place to ensure that they're sharing this data as needed with their contracted providers in a way that's timely and consumable. And so that they're sharing this information, what is necessary, downstream to their providers, again, with a goal to ensure that the members are getting the services that they need and that their care is coordinated.

Bambi Cisneros:

So, moving on to member communications, and here's our timeline from November until February of 2023. In under a month's time, communications to members regarding the carve-in will begin, so all members will receive notices, but the information in the notices will differ based on their coverage. And so, we do have that all members will receive two sets of notices from the Department. So, they'll get a 60 day notice and a 30 day notice, and both of those notices will include the same information that talks about the Long-Term Care benefit changes and mandatory managed care enrollment and what that means. The notices also include instructions and how to contact the Department, the Long-Term Care Ombudsman, the Medi-Cal helpline, Health Care Options. So just kind of providing them other resources and tools.

Bambi Cisneros:

Then the notices, each of the 60 and the 30-day notices will be accompanied by... We're calling it a Notice of Additional Information. It's kind of an FAQ format, and this FAQ has common questions that members will have regarding the changes to their long-term care benefit, and so that would all be included in the notice packet. Then by the end of

November, Choice Packets will also be mailed to beneficiaries that are not part of the Medi-Cal matching plan policy, and again, the Medi-Cal matching plan policy applies to beneficiaries in the 12 counties who are already enrolled in a Medicare Advantage plan, who will also be enrolled in the matching Medi-Cal plan under the same parent organization, if there is such a match. Then lastly, Health Care Options will begin a member call campaign in December that will continue through February. So, I guess we really just want to ensure that members are aware of the changes that are happening and how they'll continue to receive their benefits and services. So that is the point and the goal of all of the various pieces here of member communications.

Bambi Cisneros:

Then just touching quickly on oversight and monitoring, is that we have what we call a post-transitional monitoring process here at the Department. So, in the near term, we will be working with the plans on a pretty frequent basis to get an understanding of any kind of access concerns, any kind of operational concerns. And we'll be monitoring for network access, grievance and appeals, continuity of care and the authorization requests… And what's happening there for both the TARs, the Treatment Authorization Requests, and the service authorizations. And then longer term, we're thinking through ways of leveraging existing monitoring processes for ongoing monitoring. And so, currently today, we do look at certain domains, including access quality, data quality - which includes encounter data and provider data quality - as well as other compliance monitoring indicators such as grievances and appeals and continuity of care. And so, we'll continue to leverage those processes there and work with our managed care plans on any areas of concern or potential areas of concern.

Bambi Cisneros:

Okay, so we will continue ongoing stakeholder engagement on the Long-Term Care Carve-In, even though the APL has already posted, and the Long-Term Care Skilled Nursing Facility Carve-In Workgroup has concluded. We'll do that by sharing updates on calls, such as this, or the monthly MLTSS Workgroup calls, as well as... We have regular weekly calls with the managed care plans and the associations, and so we'll continue to leverage those forums. And what we started this month is monthly educational webinars for the carve-in, and these webinars, they're open to the public, but are mainly geared towards the managed care plans and the skilled nursing facilities and their providers. Especially for those in the counties where this is new to them, and so we're working on gathering some subject matter experts who've done this before and really excelled in this space to give some best and promising practices there.

Bambi Cisneros:

Then as I also mentioned earlier, there are other policy documents that are being teed up and, in the queue, right now, which includes FAQs and additional resources that we will be releasing and posting soon. Then we had the ICF/DD Workgroup as kind of like a subgroup of the Skilled Nursing Facility Workgroup, but we've decoupled that. And so,

what we did was relaunch the ICF/DD Workgroup as a separate workgroup to really focus on issues specific to this population, and also because their implementation date is July 1st, 2023. So, we're turning our attention there and working on those population-specific topics to the ICF/DD and Subacute Workgroup, and we'll be working on policy-specific to those topics next.

Bambi Cisneros:

So, on this slide is just what I had mentioned earlier, which we will be having monthly educational webinars. So, here's the list, who our targeted audience members are. We've already had a few, a couple, so we're looking forward to our next one on November 4th. We will be talking about Promising Practices for Contracting, and we have a link here on the slide that we'll keep current and will have information about these webinars and also the registration links if you are so interested in joining.

Bambi Cisneros:

Again, just providing additional resources and contact information here. We are working diligently on additional policy documents. As I mentioned, FAQs, additional resources for plans, and then we are providing links here to the webpage where we are posting all of this great information that came from this workgroup. And the webinar information we're keeping current there. So, I would encourage that if anyone has any follow up questions, we did include the email here at info@calduals.org, our Aurrera team is helping the Department facilitate those questions. I think depending on the type of questions and the level of interest will help us determine what additional policy guidance we need to issue moving forward. So, I think that was all the updates for the Skilled Nursing Facility Carve-In for this afternoon. So maybe I'll turn it over to you, Mary?

Mary Russell:

Sure, thank you so much, Bambi. I think we do have a couple questions, but first really appreciate you joining and sharing that deep dive. I hope you have a glass of water nearby, because that was very extensive. A couple questions I'll just pull out of the chat. A clarification about the February 1st start date. There was a question if that is new or if you could explain a little bit more about February 1st.

Bambi Cisneros:

Oh yeah, no, not new. I think when we talk about the January 1st date, it's really for those that make a plan choice. So, the February 1st date is just for those members that don't make a choice to enroll in a plan, and they go down the default enrollment path that is when their transition begins. So hopefully that helps to clarify, but it's not new policy, just kind of part of the... I don't know, I guess noticing... Default enrollment noticing process.

Mary Russell:

Great, okay, and then a question from Jennifer Breen, "In carve-in areas for new SNF stays starting in October, which are expected to be long term, will members still be disenrolled after the first/second month, which would be December, then re-enrolled in January? Is there a cutoff date by which disenrollment due to long term SNF admission will stop before January 1st, 2023?"

Bambi Cisneros:

Thanks, Mary. I'm trying to look for the question.

Mary Russell:

Yeah, it was a bit ago from Jennifer Breen. Do you see it?

Bambi Cisneros:

Yeah. So, I mean our goal was not to disenroll, and enroll, and disenroll members. So, there would not be a disenrollment and then only to have them re-enroll in January. I think the cutoff date, Jennifer, is something that we may have already provided to you. It just really depends on when that plan choice is made, and that's something that we were going to clarify in the FAQ as well. So hopefully that helps.

Mary Russell:

Okay, great, and then a question from Tatiana. "For those residing in a SNF under custodial benefits, will the Medi-Cal plan determine eligibility based on need or time, for example, three months or longer?" Then there's a second part to that question that I can wait, if you'd like to take one at a time.

Bambi Cisneros:

Yeah, the plan definitely has to make that assessment and determination, and of course, work with the member and the family on the care plan to determine what is the best needs for the member, and of course, that would be kind of personalized and depending on the need.

Mary Russell:

Yep. Okay, and then the follow up to that is, "When a person lives in a SNF, the beneficiary's primary care provider usually defers to the medical director of the facility to get Medicare covered services. If in a Medi-Cal managed care plan, will the beneficiary be assigned a PCP by the Medi-Cal plan?"

Bambi Cisneros:

Yeah, I don't know if others on my team are on, but I don't think that there would be a change here. I don't think there's an assignment to a PCP by the Medi-Cal plan today, and so I think that same process would apply, but I'm happy to hear feedback from team members if they're on.

Mary Russell:

Thanks Bambi, and then this is a broader question, so Anastasia might want to chime in here, or other DHCS team members, but a question from Beth Garver about transportation for dialysis patients when they transition into a plan and there isn't time to get prior authorization for the first few weeks in CalAIM. Any thoughts there?

Anastasia Dodson:

Bambi, do you have thoughts on that? Otherwise, we can take it back.

Bambi Cisneros:

Yeah, sorry Mary, would you mind repeating the question again?

Mary Russell:

Yeah, the question is around the issue of transportation for dialysis patients when they transition into a plan, and there isn't time to get a prior auth for the first few weeks in a CalAIM transition.

Bambi Cisneros:

Yeah, I think we may have to take that one back, because there's lots of discussion on what we're doing for 2023 versus existing state today, and I definitely don't want to give you bad information. So, let's take that one back, and then we'll follow up with this group, if that's okay.

Mary Russell:

That sounds good. Great. Well, thank you so much, Bambi, and thank you everyone for all these questions. At this time, I am going to transition it to Anastasia to help close us out, and I think we'll take a quick look at future meeting topics.

Anastasia Dodson:

Yeah, thank you again, Bambi. What a great presentation, and really, so timely. All of this is very well informed by stakeholders and the questions that we're getting. So, we appreciate all the partnerships across so many areas. Okay, next slide. We have been talking a lot today about enrollment changes, but we know that as those are sorted out, notices, the transitions, any troubleshooting we need, there are other topics that we

want to talk about with this group. Local examples and discussions about integrated care. How is it working? What are some of the promising practices? What are some glitches and opportunities? So those types of topics are all of interest, and I'll just flag... We have our CCI quarterly webinar coming up, I think, next week, and again, talking about flu shots, COVID vaccination, of course COVID and then flu, some of you are keeping those in mind.

Anastasia Dodson:

The transitions, of course, we've just been talking about crossover billing. We know this is a key topic, and we, again, are working on ways to make the process more transparent and make sure that there's changes that we need to make on the backend that we can look at making those changes. There's other types of Medicare Advantage benefits some plans are offering, some are not, or particular benefits. So that's a new emerging area. The 2024 State Medicaid Agency Contract will have some provisions that we're working on around care coordination and other iterations on these policies. Strategies to improve health equity; Now that we are getting all of these various contracts and structures in place, then we'll be better positioned to identify and look at strategies and incentives to improve health equity. We have our LTSS Dashboard that we've been working on with other departments as well. I'm going to try to get that posted hopefully in the next six to eight weeks, and so we'd love to share that with this group when it's ready, and then continue iterating.

Anastasia Dodson:

In previous meetings, the topic has come up around assisted living, assisted living for memory care, CalAIM housing supports. Of course, the continued efforts that we have around dementia and Alzheimer's and screenings, different ways that we can support that population and caregivers and providers. So, this is just a little bit of a snapshot. There's so many topics that we can all work together on. It's a really exciting time. We know that in California and in the nation, the demographics are changing as we proceed through these years. There's a transformation. We are shifting to having more older adults in our communities, and all of us are aging, and as we think about these topics and the makeup of the population in California, we're an extremely diverse state, we have a high longevity rate, and so all of these topics are really important and will be for many years to come. So, the discussions we're having in these meetings, and the policy changes and operational changes, are really important building blocks for many years ahead. So, we appreciate your partnership. Next slide. So, these are the upcoming webinars, and Mary, I'll hand it back to you, but thank you everyone for joining today.

Mary Russell:

Yep. Great. So yes, thanks everyone for your participation. Just some quick reminders that next week on Wednesday, October 26th, we'll have our Quarterly CCI Stakeholder Webinar at noon. The next SNF LTC Carve-In webinar is Friday, November 4th at 1:00 PM, and then the next meeting of this workgroup will be on Thursday, November 17th at

10:00 AM. Links to register for these meetings are being added to the Zoom chat right now, and of course, if there are questions, please feel free to email the inbox at info@calduals. The slide deck and meeting materials will be posted in the next few days. Thanks everyone, we look forward to seeing you again soon, and enjoy the rest of your day.