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

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

DATE: Thursday, September 22, 2022, 10:00 AM to 12:00 PM

NUMBER OF SPEAKERS: 4

FILE DURATION: 1 hour 40 minutes

SPEAKERS

Mary Russell
Anastasia Dodson
Lindsey Wilson
Dr. Laura Miller

Mary Russell:

... Anastasia Dodson, the Deputy Director of the Office of Medicare Innovation and Integration at DHCS; Lindsay Wilson, the Assistant Branch Chief in the Third Party Liability and Recovery Division at DHCS; and Dr. Laura Miller, a Medical Consultant with the Quality and Population Health Management team 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. We ask that plans that join these calls hold their questions for the other venues, where we can prioritize plan questions and discussions. Please feel free, though, to submit questions you may have for the speakers via the chat. And during the discussion if you would like to ask a question or provide comments and feedback, please use the raise hand function and our team 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. We will provide a link to those materials in the Zoom chat.

Mary Russell:

Alright, and now we'd like to ask that you would take a minute 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 dropdown menu. Enter your name and add your organization as you would like it to appear. We'll take a quick look at the agenda, which is jam packed for today. We will begin with a walkthrough of the summary of the January 2023 enrollment changes, followed by time for questions and answers. Next, we'll hear an update on the DHCS communications and outreach materials, then an update on crossover claims and balance billing. Then we will transition to an overview of the 2023 D-SNP quality metrics and reporting requirements and have some time for Q&A there.

Mary Russell:

We'll have a few notes on upcoming meetings and next steps and I think that will do it for today. And just a quick reminder, there are some additional background slides available in the appendices. With that, I will hand it over to Anastasia to get us started. Thanks, everyone.

Anastasia Dodson:

Thank you so much, Mary, and thank you everyone for joining. Very excited to be talking with you all today. We've been doing these meetings every month and for the last year and a half or so, and every time I’ve learned something. And we've had a variety of formats. Sometimes we do breakout groups, sometimes we talk about clinical patient care issues. More recently, we've been talking about enrollment issues and

that's going to be quite a bit of what we talk about today, but we do have some other topics as well. And I just want to express the appreciation of the Department, for all of you, for continuing to participate in these meetings. We know that they're frequent, and your time is valuable, but the comments that you all have been providing are really helpful. And we're excited that we're on the edge of the Medicare open enrollment period coming up and we've done a lot to get ready and you all have done a lot to get ready.

Anastasia Dodson:

So, again, we're just really pleased to be at this spot with all of you together. And we know that the next few months are going to be very busy for all of you. It'll be busy for us, and we'll keep working together, communicating whatever might come up. We will address, pivot, communicate out, look for your thoughts and suggestions on what we can do to help, what plans can do to help, what might be good for folks to communicate about. And then in 2023, once some of these changes are implemented, there'll still be more work to do to work together, really, on thinking about what's working, what can be improved. So anyway, with that, just, again, the purpose of this Workgroup is to get input from all of you, share information and get great ideas that can be translated into policy and improved care. Next slide. So, we're going to start the first half of the meeting is going to be about enrollment changes. And there are no new policies in all of this.

Anastasia Dodson:

And I know many of you have been faithfully coming to these meetings every month, but we're trying to make sure that those of you who have not been participating in these meetings, if this is your first time joining this meeting, welcome. We're really glad to have you here. And we want to make sure that we're explaining the information for these upcoming transitions in a way that's not overly technical. So, again, as Mary was flagging, health plans who we've been working with all along for many months, you may have technical questions. We're going to just try to keep it at a high level on these policies and enrollment changes that are coming up so that everybody can understand what's happening and where it's happening. And then we will have time for questions. We have more than an hour for these topics in this meeting. And, again, encouraging the folks who have not participated.

Anastasia Dodson:

And this is not new information, please feel free to ask your questions here. And we have other webinars, other resources, other ways to get engaged on these changes. Next slide. The first one I'm going to talk about is Medi-Medi plans the name that we're calling for the transitioning Cal MediConnect plans. Next slide. So as a just overall reminder for people who have Medicare, whether they're dual eligibles or just Medicare only, enrollment in a Medicare Advantage Plan is voluntary. If you have original or Fee-for-Service Medicare, you do not have to take any action to remain in original Medicare

or Fee-for-Service Medicare. Enrollment into a Medicare Advantage plan or a D-SNP of any kind is always voluntary.

Anastasia Dodson:

We do have a type of Medicare Advantage Plan, we call them Medi-Medi plans and those combined Medicare and Medi-Cal benefits into one plan. Those are going to be available in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. Those are the seven counties where we already have Cal MediConnect plans. The Medi-Medi plans are very similar to Cal MediConnect plans, and the folks who are already enrolled, over 100,000 dual eligible beneficiaries that are already enrolled in Cal MediConnect plans, they will be automatically enrolled into the Medi-Medi plan that is affiliated with their Cal MediConnect plan. So, the same plan organization that already has Cal MediConnect will be transitioning to a Medi-Medi plan. No action is needed by the beneficiary to keep essentially their same health plan organization. So, if you have a Cal MediConnect plan XYZ, it will seamlessly transition to Medi-Medi plan XYZ. Next slide.

Anastasia Dodson:

So, as I said, there's about 113,000 Cal MediConnect beneficiaries. That will be automatically transitioned January 1st. No action needed. There'll be no gap in coverage. The networks should be substantially similar. That's something that CMS, the federal government, is looking at. And there are continuity of care provisions for folks who are already working with providers. And in the unlikely event that the plan does not continue with that same provider, then there's continuity of care provisions that the state is requiring so that beneficiaries can continue to access those providers. Health plans are communicating with their members about these changes. So, any Cal MediConnect members, September 30th they will be getting some official notices, but they may already have been getting some communication from their plans about these changes. But the official notices will go to beneficiaries by September 30th. Next slide. Then these Medi-Medi plans, I know we're changing the terminology here a little bit, instead of Cal MediConnect it will be Medi-Medi plans, or the long name is Medicare Medi-Cal plans.

Anastasia Dodson:

There are many opportunities and benefits of this type of a plan. Similar to Cal MediConnect, this is tried and true, this is not something that we're starting brand new. It's a type of plan that's already been successful, high consumer satisfaction by Cal MediConnect beneficiaries. There are simplified care coordination processes and teams to help members access services across Medicare and Medi-Cal, so that beneficiaries do not have to take the burden on themselves or their families to figure out “What can I get through Medicare? What about Medi-Cal? How do the services work together?” There's care coordination provided by these plans to help with that navigation. There's also integrated member materials. So, again, the same plan is providing both Medicare

and Medi-Cal and they can provide a single document instead of two separate documents. There are supplemental benefits available through many Medicare Advantage plans, including the Medi-Medi plans.

Anastasia Dodson:

And each plan, you'll see in Medicare plan finder and in the materials, you'll see each plan supplemental benefits may be slightly different. But, just like many other Medicare Advantage plans, these Medi-Medi plans offer supplemental benefits, and they are coordinated with the existing Medi-Cal benefits. Because many of the Medi-Cal benefits are actually very similar to supplemental benefits you'll see in Medicare Advantage plans. So, these Medi-Medi plans can help coordinate across all of those benefits. And, again, that goes to that next bullet on the page here about benefit coordination. So, there's a unified plan benefit package that looks across all Medi-Cal and Medicare benefits. Same organization is coordinating and administering both sets of benefits. And then there's integrated beneficiary and provider communications. So, again, many of you may have heard about this many times, but for those who are new this is what the benefit and the opportunity is here with these Medi-Medi plans. That will be in seven counties starting in 2023. They are plans that are basically building on what we have in Cal MediConnect plans already. Next slide.

Anastasia Dodson:

So that's all the slides that we have on the Cal MediConnect and the Medi-Medi plans, but we have a lot of materials on our website, and I'm sure the team is putting that in the chat. And there will be opportunities for questions, we're going to go through a few more slides, and then plenty of time for questions. The next transition that is effective January 2023, but beneficiaries will start to see notices sooner than that, is for D-SNP look-alike plans. Next slide. So, D-SNP look-alike plans are a type of Medicare Advantage plan that have been marketed to people with both Medicare and Medi-Cal, but these look-alike plans do not have the same type of care coordination requirements across Medicare and Medi-Cal, as true D-SNPs do. So, in order to be a true D-SNP, a type of Medicare Advantage plan oriented toward dually eligible beneficiaries, there needs to be an agreement with the state and there's certain care coordination requirements that true D-SNPs need to meet. These look-alike plans, the majority of their members are dual eligible beneficiaries, but they don't meet those federal and state D-SNP integrated care requirements.

Anastasia Dodson:

For complex market reasons, enrollment in these plans has increased quite a lot in the last few years. There are about 140,000 beneficiaries that are in the D-SNP look-alike plans. And as we'll see on the next slide, those folks will be transitioned effective January 1st, 2023, to plans that are the same parent organization. Next slide. So, CMS, the federal government, because of these sort of plans not being true D-SNPs and not meeting the full intent of D-SNP policy, they are going to be not renewing the contracts

for those D-SNP look-alike plans. I think we can just go ahead to the next slide. So, the impact is that CMS, the federal government, is working with the Medicare Advantage plans to have a good transition so that members can have continuity of care. They can continue to have their cost sharing protections and better options for care coordination. So, there is going to be a crosswalk of plans from D-SNP look-alike plans to either regular MA plans or true D-SNPs.

Anastasia Dodson:

And CMS and the health plans themselves will implement those transitions. So, September 30th, again, there'll be a notice that goes out to individuals whose plans are D-SNP look-alike and they will be seamlessly transitioned into either a regular MA plan, or a true D-SNP. And no action is needed for them, but they do, just like with the Cal MediConnect transition, during the open enrollment period, any Medicare beneficiary can choose any other Medicare plan. But, again, this is designed to be seamless and make sure that beneficiaries can continue to access their providers as much as possible. Next slide. So, here's another transition we're going to talk about briefly. And, again, there's materials on our website and we can answer questions. Next slide. And this is about Medi-Cal. Those first two transitions were about Medicare. This is about Medi-Cal. So Medi-Cal actually has two different primary delivery systems. One is called Medi-Cal Managed Care, and the other is Medi-Cal Fee-for-Service.

Anastasia Dodson:

And Medi-Cal Managed Care means that there is a health plan that a beneficiary enrolls in, and that health plan administers certain Medi-Cal benefits. In January of 2023, dual eligible beneficiaries, beneficiaries that have Medicare and Medi-Cal, in 31 counties will be transitioning into Medi-Cal Managed Care. And we're going to talk in subsequent slides about what are the benefits of Medi-Cal Managed Care for people who have both Medicare and Medi-Cal. But first and foremost, I want to reassure everyone that being enrolled in a Medi-Cal managed care plan does not impact anyone's Medicare provider access. So Medi-Cal Managed Care, those plans do not enroll Medicare providers in a Medi-Cal network. So, Medicare providers, they can enroll in a Medicare network. Medi-Cal providers can enroll in a Medi-Cal network. Sometimes providers are in both Medicare and Medi-Cal, but if you have both Medicare and Medi-Cal, and you're using certain Medicare providers, those Medicare providers do not need to be enrolled in your Medi-Cal health plan for you to continue to see those Medicare providers.

Anastasia Dodson:

So, we will be happy to answer further questions about that, but, again, want to just reassure folks that this change in Medi-Cal Managed Care enrollment will not impact access to Medicare providers. Next slide. So, over 70% of dual eligible beneficiaries are already enrolled in a Medi-Cal Managed Care plan. This change is going to impact about 325,000 people who are mostly in the 31 counties that you see in that third bullet. And in those counties, dual eligible beneficiaries will be enrolled in a Medi-Cal Managed

Care plan. Again, I don't want to get too technical. If those beneficiaries are already enrolled in a certain type of Medicare Advantage plan that has a Medi-Cal affiliated plan, then they'll automatically be enrolled in that matching Medi-Cal plan, but for everybody else, and that's definitely a majority of folks, they will get a choice packet in the fall that gives them the list of Medi-Cal plans that they can choose from. All right, next slide.

Anastasia Dodson:

And why does it matter for dual eligible beneficiaries to be in a Medi-Cal plan? The role of Medi-Cal plans for dual eligible beneficiaries, one of their major roles is to coordinate long-term services and supports. So CBAS, skilled nursing facility care, community supports, et cetera, those are provided through Medi-Cal Managed Care plans. And so, having the Medi-Cal plans be able to coordinate that transportation to medical appointments will help dual eligible beneficiaries be able to coordinate and navigate amongst those programs. Next slide. Again, a reminder we have a Medi-Cal matching plan policy. I know some of you policy experts are well aware of this. It basically means that in these 12 counties, a beneficiary's choice, if they choose to enroll in a Medicare plan, that's the lead plan. And then if there is a Medi-Cal plan that's run by the same organization as a Medicare plan, then the beneficiary will be enrolled in that matching Medi-Cal plan automatically in those 12 counties.

Anastasia Dodson:

Okay, next slide. So, I know that's a lot of information. We'll just keep going and then we'll have time for questions. So, one other change that's coming for January 2023 is around skilled nursing facilities and in those same 31 counties. Next slide. And this is the topic of many other workgroup meetings, and this is a very important topic that I'm not going to do it justice in one slide, but just flagging that January 1st, 2023, that's when Medi-Cal plans in all counties will begin covering skilled nursing facility as a Medi-Cal Managed Care benefit. Again, for most beneficiaries, for most parts of the state, this is already the case. This is just in those 31 counties that the transition is happening. And there'll be notices and choice packets for beneficiaries. All right, next slide.

Anastasia Dodson:

So, this is about the noticing timeline for all of these changes. Next slide. You can see we've got it color coded here to try to follow the patterns. Cal MediConnect to Medi-Medi plans, that's in purple, the D-SNP look-alike Transition in orange there, the Medi-Cal Managed Care Enrollment in those 31 counties, that's in yellow. And then the Skilled Nursing Facility Carve-In through Medi-Cal Managed Care in the bluish purple. Next slide. And then this layout shows you, here we are in September, so by the end of this month there will be notices that go out around the look-alike transition. That's in the Annual Notice of Change, and then Cal MediConnect members will also receive their Annual Notice of Change. Then around that same time the Cal MediConnect transition 90 day notices will be received by beneficiaries. And you can see across that light blue

across the top ‘Medicare Annual Open Enrollment,’ that's October 15th through December 7th.

Anastasia Dodson:

And we know that's a time when Medicare beneficiaries get a tremendous amount of mail, and there's a lot of advertising to promote Medicare Advantage plans. So, we're very cognizant of that and some of these transitions that impact Medicare plans are designed to be concurrent with that time period because of the Medicare Advantage plan structure. In November and December, you can see in the blue and the yellow, that's when notices and packets will go out to beneficiaries. Primarily in the 31 counties, but also in other counties as needed for the enrollment into a Medi-Cal Managed Care plan. Again, those purple and orange, that has to do with Medicare plans. And then the yellow and the blue, that's for Medi-Cal plan enrollment, we put it on one slide so you can see the timeline. Next slide. And there's outbound calls. So, in October, the Cal MediConnect plans will make phone calls to their transitioning members.

Anastasia Dodson:

And then in December, DHCS Health Care Options will make phone calls to members who, individuals who are being enrolled, and need to choose a Medi-Cal Managed Care plan. All right, next slide. And then lastly, before we go to questions, I want to flag a couple of other Medi-Cal changes that happened in 2022 because, and let's go to the next slide. We know that many of you have networks, speak with beneficiaries, or speak with others who speak with beneficiaries and need to know this. For people who are not dually eligible, but now Medi-Cal is available to older adults aged 50 and older, regardless of immigration status. And so, some of the same older adult populations that you may be serving as Medicare beneficiaries or dual eligibles, they are now newly eligible for Medi-Cal. If they have not had coverage before, they're not eligible for Medicare, they can be eligible for full scope Medi-Cal, regardless of their immigration status, if they meet the income limit.

Anastasia Dodson:

So, probably you're all familiar with that, but I just want flag because as a group of older adults, some of them if they are not eligible for Medicare, they could be eligible for full scope Medi-Cal. The other big change in Medi-Cal that I think you're probably all aware of, but I want to remind you, is that effective July 1st, 2022, the Medi-Cal asset limit increased to $130,000 for one person, and then additional $65,000 per an additional person in the household. That is a really big change that can help many people who previously, even though they were within the Medi-Cal income limit, if they had a certain type of property, bank accounts, et cetera that put them over the Medi-Cal asset limit, they were not eligible.

Anastasia Dodson:

So, we're really proud and pleased for this policy change, and we hope that all of you as you're talking to beneficiaries who maybe they just have Medicare, they don't know that now they can also get Medi-Cal, and Medi-Cal can help with cost sharing, and you're going to hear from Lindsey in a few moments about that. And that this is a really really important financial benefit to folks that have Medicare only, and that can help them make their Medicare and their healthcare more affordable to enroll in Medi-Cal now that we have a much higher asset limit. And then in 2024, the asset limit is scheduled to go away entirely. So, again, really want to emphasize that for folks to share with your networks. Next slide. Okay, so we've got through a lot of slides, the transitions, many of you have heard this before, but maybe some of you have not, so I'd be happy to answer any questions.

Mary Russell:

Great. Thank you so much, Anastasia, for doing that walk-through. There have been some conversations in the chat so far, and so the team has been adding in some links and responding to a few questions. If there are additional questions, please feel free to add them to the chat or raise a hand we can unmute you. I'll start with a question from Trong Le, “In the seven CMC counties, for individuals who will turn 65 next year and become eligible for dual benefits, will they be enrolled automatically into the Medi-Medi plan, or will they have the option to choose Fee-for-Service, or another MA plan?”

Anastasia Dodson:

So, beneficiaries can always choose original Medicare, Fee-for-Service Medicare. We do not have, at this point, any... so it sounds like this question is about 2024. For 2023, there's no automatic enrollment. One policy that is in place in some other states is around folks as they're turning 65 and they already have Medi-Cal. Is there an automatic process?

Anastasia Dodson:

We're not working on that right now. What we're working on right now is the transition of Cal MediConnect and making sure that the Medi-Medi plans are doing their best, and that we have the right program design. And we can have future conversations in future years about as people turn 65 how what opportunities do they have to enroll in a Medi-Medi plan. But for 2023, there's absolutely no policy for any kind of automatic enrollment for people who are not already in Cal MediConnect plan. And people can always choose original Medicare.

Mary Russell:

Great. Thank you. And there have been a few other questions in the chat that our team has tried to answer just about voluntary nature of the transition. There is a question from Sophie, and I think this would be directed Stephanie Conde, who I think is on the call, about the Medi-Cal Matching Plan policy. And so, I wonder, Stephanie, if you want to

come off of mute, or Sophie, if you want to raise your hand, and we can unmute you, if you want to raise this question?

Stephanie Conde:

I'm here. If Sophie doesn't come off, can you read it for me, please?

Mary Russell:

Yes. It looks like... okay. Go ahead, Sophie.

Sophie Exdell:

Thank you. Let me see if I can explain it well. Maybe I'll just read it out loud here. Okay. So, there's a slide about the Medi-Cal matching plan policy, and that's the requirement that the Medi-Cal plan has to match with the Medicare Advantage plan if there is a matching plan. I've just heard so many different answers to my question that I wanted to ask one more time, because I'm getting different answers from different sources.

Sophie Exdell:

So, I saw a presentation that said that that policy has been in effect for years, and I also heard earlier this year that the policy just started in January, and then on a different occasion, I heard that the policy is not going to be implemented until 2023. And we just haven't really seen any clients who are being automatically put in the matching Medi-Cal plan, so I'm trying to understand if that has started yet, or if it's not started yet?

Anastasia Dodson:

It's ongoing, yes. That policy has been in place for quite some time, and so... but I think some of the complexity is if people... we are updating the alignment to make sure that we're properly implementing that policy, that we have... Medicare plan codes change from year to year, and so we need to make sure our system is correctly matching the Medi-Cal plan to the correct Medicare plan. But, Stephanie, I don't know if there's anything else you want to add about that.

Stephanie Conde:

No, you got it. There are updates, Sophie, to the 2023 processes and policy, so there are updates to that. We will be presenting on this. Mary might have to help me on the date for the next call. We will be presenting a little bit more on the matching policy, though, on the next monthly call.

Sophie Exdell:

Okay. Great. Thank you so much.

Mary Russell:

Great. Thank you, Sophie. I just wanted to flag another couple great questions in the chat about outreach and education efforts, and we do have some slides coming up in this presentation, so hopefully that will answer your question or at that time, we welcome you to jump into the conversation at that point. Let's see. Mariam, I believe your question... oh. Go ahead.

Anastasia Dodson:

Yeah. Let's take Teri's question about what efforts have been made to inform insurance agents and HICAPs about these transitions. So, we have actually been meeting with the HICAP local groups for over a year now. And in fact, this afternoon, this week, the HICAPs are having their, I think it's quarterly or semi-annual training, and then we'll be presenting, and we've been meeting specifically with the HICAP groups in the CCI counties.

Anastasia Dodson:

So, hopefully, we are answering all the questions from the HICAPs. And then also, health insurance agents and brokers, we actually had… there was a conference in LA last week that our team attended, and we are looking at ways we're going to do a special webinar. We have a list of all the agents and brokers emails in California, so we're planning to send an email blast there and have specific webinars for those folks. Because we know that that is an important group that has a lot of contact with dual eligible beneficiaries. So, great question, Teri.

Mary Russell:

Thanks, Anastasia. I see Rick has a question in the chat, and also his hand raised. Rick, would you like to come off mute and ask your question?

Rick Hodgkins:

Yes. About a week ago, last Monday, on the 12th, I contacted consumer services at UC Davis Medical Center because as it currently is, I receive... I see a primary care physician at one location at UC Davis Medical Center, and I see an endocrinologist at the neurosurgery clinic over on Folsom Boulevard. And I'm being told that at one location, they don't take any Medi-Cal managed care plans.

Rick Hodgkins:

At UC David Medical Center, it doesn't matter whether I have Medicare or not. I'm being told by... it depends on the people I talk to at UC Davis. Some people think my Medicare will be affected if I go into a Medi-Cal managed care plan, other people tell me it won't be affected if I go into a Medi-Cal managed care plan. I checked with Stanford and

UCSF and happy to say, my Medicare won't be affected. But it seems at UC Davis, some people tell me it will be affected, some people tell me it won't be affected. I'm confused.

Anastasia Dodson:

Rick, thank you so much. So, we will talk to... we will do a specific outreach to UC Davis Medical Center and make sure that the teams there are aware. And you're right. What we need to keep doing more of is talking to provider groups, because it should not make a difference on the Medicare side, but we will need to keep doing more and more provider education.

Anastasia Dodson:

And not just in the CCI counties, but also in the other counties where people are going to be in a Medi-Cal managed care plan. So, thank you so much for flagging that. So, sounds like UC Davis Medical Center is going to be on our list and if other folks hear about other large provider groups that could use a refresher... and Lindsey's going to talk a little bit more about the crossover billing and all that, and we would also want our Medi-Cal managed care plans to be talking to provider groups as well. So, we will continue to increase our efforts there. Thank you very much for flagging that.

Rick Hodgkins:

All right. And I even sent them... they even gave me an email address so I could invite them to this meeting.

Anastasia Dodson:

Oh.

Rick Hodgkins:

Yeah.

Anastasia Dodson:

Okay, super.

Rick Hodgkins:

They normally don't give out email addresses to anyone, but I was able to somehow pry them and talk to them. I don't even know if they made it to this meeting, but I don't know if anybody is on this call from UCDMC, but if they are, great. If they're not, then they must be scared. Because I think all the administration cares about is just getting their money.

Anastasia Dodson:

Well, we will make sure that we outreach to them, and then start thinking are there other large Medicare providers that we need to touch base with. And so, thank you. That's a great flag.

Rick Hodgkins:

All right, thanks.

Mary Russell:

Great. Okay, next let's go to Susan LaPadula with your hand up. Go ahead, Susan.

Susan LaPadula:

Good morning, Mary and Anastasia. Thank you for this meeting, and congratulations on your Innovation Award to the whole Department. Quite an accomplishment.

Anastasia Dodson:

Thank you, Susan.

Susan LaPadula:

You're welcome. I have a question, and I would like to follow up on Rick's point. Perhaps all our UC systems need to be contacted. We have tremendous research and development UC Healthcare, and perhaps you'll look at that statewide.

Anastasia Dodson:

So, I think what's happening is in the counties where dual eligibles are already enrolled in Medi-Cal managed care, I think the UC's there probably have worked this out. I will say probably in Southern California, it's worked out. It's just probably in the Central Valley and maybe the Bay Area where the UC's medical centers are that we can do more outreach. And there's probably other medical groups and medical centers there in Central Valley, Bay Area, we can look at more outreach there. Thank you.

Susan LaPadula:

Wonderful. Thank you for that. My question is something else. May I proceed?

Anastasia Dodson:

Oh, sure. Sorry.

Susan LaPadula:

Oh, good. Thank you. Would the Department consider moving forward a central hub for providers and stakeholders to report implementation issues as we go? And I'm thinking about this in reference to the Medi-Cal Rx and all the hurdles and speed bumps that came with implementation. Perhaps if we have a centralized location to give you the feedback from boots on the ground, we could actually assist in this implementation to keep it smooth for all of the beneficiaries and their family members.

Anastasia Dodson:

Yes. We do have that email inbox, the info@calduals. So, really, that's the best single point, and we're using that for the Long-Term Care, the Skilled Nursing Facility Transition as well. So, keep sending comments there. Thank you.

Susan LaPadula:

I have used that in the past, but if they get overwhelmed, you don't hear back from them.

Anastasia Dodson:

Yeah. Sometimes what happens, if we see patterns... yes. I'm sure there are going to be days where we, and weeks probably, where we get many more emails than we can directly respond to. But if we look at the patterns of what's coming in, that also is helpful for us to pivot and say, "Okay. This provider or this set of health plans, or this set of consumers, we need to do more for those groups."

Susan LaPadula:

Wonderful. Well, thank you for that opportunity. The better we can communicate, I think in my opinion, the smoother it will be for our beneficiaries and their family members.

Anastasia Dodson:

Thank you, Susan.

Susan LaPadula:

You're welcome.

Mary Russell:

Thank you. Another question in the chat from Mariam, “Are congregate living health facilities who are part of home and community-based services going to be affected?”

Anastasia Dodson:

Good question. Though there's other parts of CalAIM, community supports, enhanced care management, that we're asking the Medi-Cal plans to look at opportunities there to partner more with assisted living providers, but that's a different topic not for this webinar. So, there's no specific changes for payment structures or carve-in or carve-out for congregate living facilities, aside from skilled nursing facilities for January 1st.

Anastasia Dodson:

But, again, for other parts of CalAIM, we are asking Medi-Cal plans to build out the network of partnerships that they have with community-based organizations to do community support, enhanced care management, and they can in some situations, they may partner or contract with assisted living or other types of facilities.

Mary Russell:

Thanks, Anastasia. And I think we'll take one more question on this section before we head into the next section of the presentation, but along similar lines, a question from Jennifer about ECM for D-SNP members. She is saying back in May, she read that MCPs are exempt from providing ECM to aligned D-SNP Medi-Cal members. These D-SNPs will be providing ECM-like services via the D-SNP and non-EAE D-SNP members will receive ECM services through their MCP. Didn't catch if there was a distinction on the slide that talked about benefits for dual eligible beneficiaries. So, great question.

Anastasia Dodson:

Oh, good question. And yeah. We should cover this, then probably in October in more detail, but yes. So, dual eligible beneficiaries, if they meet the criteria for enhanced care management or community supports, they are eligible. But what we know is that D-SNPs and particularly the Medi-Medi plans, they are providing essentially the equivalent of enhanced care management through their models of care.

Anastasia Dodson:

So, in order to not cause confusion by having duplicate care managers and duplicate requirements, we're saying that the Medi-Cal plans that are affiliated with those Medi-Medi plans, they do not have to provide ECM on top of what beneficiaries would already be getting, the equivalent of enhanced care management, through their Medi-Medi plan. So, beneficiaries are not losing out on benefits in any way through that policy. That's for 2023.

Anastasia Dodson:

In 2024, we need to get information out to the other types of D-SNPs, the ones that are not affiliated with Medi-Cal plans, because our expectation for 2024 is that per the

federal model for D-SNPs, they should be providing essentially the equivalent of enhanced care management for duals in all D-SNPs. So, we know that that is going to be a transition for those types of D-SNPs to understand what is the ECM model, the partnerships with CBOs. So, we will be working on that this fall for preparation for 2024.

Mary Russell:

Great. Thanks for that question. I see Rick's hand is up. Rick, did you want to jump in with another question?

Rick Hodgkins:

Someone in the chat, because my computer was talking, someone in the chat had a question about the City of Hope. I don't know if you saw it. Thank you.

Mary Russell:

Thanks for that flag. Oh, yeah. It looks like Jackie is saying, “What about some of the hospitals that don't even take Medicare such as City of Hope?”

Anastasia Dodson:

Yeah. That's probably beyond our scope right now about which providers are Medicare providers, but what we do want to make sure is the Medicare providers know that dual eligible beneficiaries, when they're in a Medi-Cal plan, their reimbursement to the provider won't change. It's just where do they bill that secondary payment? So, there should be no impact on Medicare provider access, but again, as Rick pointed out a good example, and I'm sure there's many others, we want to make sure that Medicare providers know about this transition, and that it should not impact their reimbursement. And okay, I'll leave it that. Because I know we have other questions and topics.

Mary Russell:

Great. Thanks. Okay. And a hand raised from David. David, go ahead.

David Fein:

Hi, good morning. I just had a quick question. I typed it in early in the chat, but I'm hoping Anastasia or somebody at the Department can elaborate a little bit on the timing of the transition for the Medi-Medi’s. Just given the fact that the state is working through a re-procurement for commercial Medi-Cal plans, and those are implementing in 2024. I'm wondering why we're choosing to move Medi-Medi Plans in 2023 and then almost a year later, many of those folks will have to select a different Medi-Cal plan based on the changes from the procurement. Is that something that the Department has thought about? Or is it just the way it is? My organization, we represent the medical product suppliers and DMEs throughout the state, and we're in communication with our patients

and clients, and we're trying to figure out how best to message what's changing to them, and we just wanted to try and get some insight, with respect to the timing.

Anastasia Dodson:

Mm-hmm. Well so, David, thanks for flagging that. Yeah. We certainly are aware and tracking. The folks who are going to be choosing a Medi-Cal plan for 2023, it's only a subset of those folks that would potentially change Medi-Cal plans again in 2024. It's not a huge overlap. And the broader re-procurement for Medi-Cal plans, and really, it's accompanied by additional requirements on Medi-Cal plans broadening the expectations that we have for them, improved quality. So, again, a lot of people who are, and will be enrolled in Medi-Cal, are enrolled in local plans that won't change or in commercial plans that won't change either. So, we don't want to alarm people to say, "Oh, everybody's going to have to change." No. It's just a subset, and again, people will have choice in their Medi-Cal plans, or if it's transition to a single plan, those models are community-based. And again, the vast majority of people will be enrolled in a plan that will continue.

Mary Russell:

Great. Well, I think at this time we will transition to the next portion of our agenda, which is DHCS communications and outreach materials. So, go ahead, Anastasia.

Anastasia Dodson:

Great. So, we know that... this is such a good conversation we need to have materials available on our website, and then different conversations, different opportunities, different venues. So, we're going to outline some of that. Next slide. So, again, we have resources on our website and continuing to post those, and we'll give you a snapshot of what that webpage looked like. And then we have health plan communications. So, the Medi-Cal plans and the Medicare plans, because remember we're talking also about D-SNP look-alike transition, the Cal MediConnect, the MMPs. So, health plans communicate with their members and with prospective members, about the transitions. DHCS Healthcare Options is a key partner support for all of this. There is full detailed healthcare options, DHCS Health Care Options website, that allows beneficiaries to see which Medi-Cal plans are in which counties and walks them through the process to choose a Medi-Cal plan. There's also a very extensive phone team that Health Care Options manages, and they can answer all kinds of questions about Medi-Cal plans, and even Cal MediConnect plans, and that transition.

Anastasia Dodson:

So, those phone numbers, website, fully staffed, ready, and there's also in-person Health Care Options, DHCS Health Care Options folks available throughout the state at many locations. Again, to help with Medi-Cal managed care questions. There's beneficiary notices and phone calls. We've talked about, there are additional webinars.

So, in addition to this monthly big public open to all, we have many specific webinars, different groups that we've been meeting with. Again, I mentioned the HICAP group later today. Yesterday, meeting with Area Agencies on Aging. Last week, the Collaborative for Long-Term Services and Supports. So, multiple meetings every week at this point to meet with folks.

Anastasia Dodson:

And we have a dedicated in-person team in Southern California that goes and meets with provider groups. So, anyone that wants to suggest a meeting with us, with DHCS, Aurrera, and the Health Care Options team, we're ready and willing. And then, we were also partnering with community-based organizations in the Central Valley and Bay Area Counties about that Medi-Cal managed care enrollment change. And we'll be posting the list of CBOs in a few weeks, and those are mini grants to help those CBOs be able to answer questions along with, again, all the Health Care Options resources. Next slide. This is just a little snapshot of what the webpage looks like. We're trying more and more for materials about integrated care for dual eligibles.

Anastasia Dodson:

We're putting the Medicare card, the Medi-Cal card and the plus sign to indicate this is for people who have both, they're dually eligible and flagging this is information available that's pertinent to them. On this webpage, you'll see we've got enrollment information, policy resources, workgroup information, and then another link to outreach materials. Next slide. On the outreach information, the live page actually looks a little bit different because we keep adding more and refining the level of information, but you'll see again, that those two cards, Medicare and Medi-Cal together for dual eligible beneficiaries. And then we have materials that are targeted specifically for providers, agents and brokers, and beneficiaries. And of course, anyone could look at any of these materials and use them anytime. Next slide. We also are posting the notices that are being sent to beneficiaries. So, you'll see, there's a webpage called The Future of Cal MediConnect. On that page, there's a section, “how will I be notified?”

Anastasia Dodson:

And we have the beneficiary notices posted right there. So, there's no mystery, you can see exactly what the notices will look like that beneficiaries will receive. Of course, these notices are being sent by the plans. So, the plans that you'll see certain bracketed, or what have you, areas where the plans fill in their name, but essentially these are the templates that plans are using. So, really glad that we have that. And then soon, we will also post the notices that beneficiaries will be receiving from DHCS on Medi-Cal managed care. It'll be on a different page, but those will be posted. Okay. Any questions on that communications and outreach?

Mary Russell:

And we have added a link in the chat so people can access that easily, and definitely encourage people to check that out frequently. They're having a lot of new updates and the information is being added very frequently. A question from Tiffany, "Will the ANOC for Cal MediConnect be posted on the transition notices page?"

Anastasia Dodson:

I think so. We certainly can. I mean, unless Stephanie, or is there anybody else, is there a reason that it's so heavily tailored that it would be confusing to-

Stephanie Conde:

Not sure, the Medicare requirements might stop that, but we can look into it, Tiffany.

Mary Russell:

Yeah, we can look back on that, Tiffany. And then a question from Jill, "Is that ANOC the only communication that will go out these look-alike members?"

Anastasia Dodson:

Yes. As far as I recall, unless anybody else has something different, I think that's it. And then, oh, what I should flag also is that in the first week in October is when we will post on a DHCS website the crosswalk between the plans, because I know many of you have been asking, "Well, what are the official names of the new Medi-Medi Plans or the what's the crosswalk for the look-alikes?" And those plan names, et cetera, that has to be finalized by CMS. And of course, they're extremely careful to make sure everything is properly executed before they let those names go out and those contracts be fully confirmed. So, we will wait patiently for CMS and their process, and then we will post that information.

Mary Russell:

Thanks, Anastasia. Thank you for those questions. Anything else-

Anastasia Dodson:

And somebody sent me a direct chat talking about the ANOCs are specific to the plans so we could post links to the plans. Certainly, we can do that once we have all the official names.

Mary Russell:

Great point. Okay. I'm not seeing any further questions or hands raised at this time, so I think we can transition to our next portion of the agenda, which will be crossover claims

and balance billing with Lindsey Wilson, the Assistant Branch Chief with TPLRD. So go ahead, Lindsey.

Lindsey Wilson:

Hi, good morning, everyone. My name is Lindsey Wilson, and I am happy to be speaking to you today about crossover claims and balance billing. We could go on the next slide please. So, balance billing. Medicare is the primary payer for services for dual eligible beneficiaries, which means dual eligible beneficiaries are going to be seeing their Medicare providers first, and then the payment will then cross to Medi-Cal for their co-insurance or deductibles. Dual eligible beneficiaries should never receive a bill for their Medicare cost sharing. This is called improper billing or balance billing and is illegal under state and federal law. Beneficiaries will not pay a premium or pay for provider visits and other medical care when they receive services from a provider in their Medicare Advantage provider network. They may still have a copay for some prescription drugs. We do have a new website that is addressing balance billing, you can find it at the links below. Next slide please.

Lindsey Wilson:

So, our current crossover claims policy for beneficiaries that are in Medi-Cal plans. Medicare should be billed as usual. Medicare will pay around 80% of the Medicare fee schedule. And then the 20% copay cannot be billed to the dual eligible beneficiaries. Instead, these crossover claims must go to the patient's Medi-Cal plan, which will pay any amount owed under the state Medi-Cal law. In Fee-for-Service, this will go to our fiscal intermediary and then DHCS is responsible for processing the secondary payment. For the pharmacy billing supplies, they would go through our Medi-Cal Rx system. So, billing dual eligibles, just to reiterate, violates both federal and state law. This is also in our new D-SNP SMAC contracts. They are prohibited from imposing cost-sharing requirements on dual eligible members, and we are currently working to have upcoming guidance on crossover claims that will be directed at our Medi-Cal managed care plan through an all plan letter as well. I can take any questions at this time.

Mary Russell:

Thank you, Lindsey. Yeah. Any questions on this? Feel free to raise a hand or drop it in the chat. Susan, I see your hand. Go ahead.

Susan LaPadula:

Thank you. Good morning, Lindsey. Any chance in the SMAC contract that the language includes automation of the crossover claim from Medicare to Medi-Cal?

Lindsey Wilson:

I don't know, Anastasia, on the-

Anastasia Dodson:

Yeah, I know Susan, you have such a good question and we have not got there yet, but frankly, we have to make sure we get these enrollment transitions done, but you're right. Automated crossover billing is a best practice, and we know some Medi-Medi Plans and some D-SNPs have that, some don't. Again, we have to get these eligibility transitions done, enrollment transitions done correctly, but then we want to provide learning opportunities. And at some point, maybe for the 2024 SMAC, perhaps that could be a requirement and I think we should consider that but want to explore it a little bit more with plans to see if there's any, or if we do make it a requirement, exactly how is that requirement phrased.

Susan LaPadula:

We do have the codes to work off of because they've been doing it for years and we do have some of the larger plans already working on it. So, maybe it's just a matter of reaching out and getting some feedback. It would be fabulous to have it in a current SMAC instead of waiting, but I understand you have a lot going on.

Anastasia Dodson:

Thank you, Susan, but it's an excellent issue. And it would help providers, help our healthcare system be more efficient. Absolutely.

Susan LaPadula:

It would help our beneficiaries and our family members too, because they will not receive a balance bill. It will eliminate that. It's incredible what that automation will do for our industry statewide.

Anastasia Dodson:

Thank you.

Susan LaPadula:

Thank you both. Thank you, Lindsey. Thank you, Anastasia.

Mary Russell:

Great. A question in the chat from Jennifer, "Will DHCS provide specific guidance regarding crossover claims for long-term care settings and the difference between a long-term care setting and a hospital inpatient?" And she's noting that in the past, there have been issues with MCP denying crossover claims for LTC applying the hospital guidance.

Lindsey Wilson:

Yes. In our current APL, there is some guidance specific to long-term care as well, but we plan to issue updated guidance and it will go into detail about the difference in long-term care, especially the first 100 days.

Mary Russell:

Great. Thanks, Lindsey. And a question from Jack, "Can you speak to the oversight tools DHCS has if it learns that an MMP's network providers are inappropriately billing consumers?"

Anastasia Dodson:

Yeah. So, the SMAC is very clear. So good question about oversight tools. And to be honest, again, we've been so focused on making sure these enrollment transitions go smoothly, but that is an important question. What steps would DHCS take and what steps perhaps would CMS take? Great point, so we'll look into that. Yeah.

Mary Russell:

Thanks for that question, Jack, and appreciate your collaboration and help on this topic as well. I'll go to Rick next. Rick, would you like to unmute and ask your question?

Rick Hodgkins:

Yes. What if you live in a GMC county, such as Sacramento, that's where I live, or San Diego and you have to go out of that county or either a specialist at Stanford or UCSF such as myself? And again, I have Medicare. So again, my Medicare should not be affected, but then they also have to bill the Medicare managed care plan. Will that be an issue? I mean, Medicare being the primary, Medi-Cal being the secondary. Again, I'm stressing that the, again, Sacramento County where I live is one of two counties, with San Diego being the second county, the only other county that is a GMC, geographic managed care. Thank you.

Lindsey Wilson:

Yeah. So, I mean, a Medicare provider, if it's within the contracted service, should be billing the Medi-Cal plan, then managed care plan for the co-insurance. If they were to receive some denial for a carved-out service for our Medi-Cal managed care plan, then they could bill in a Fee-for-Service setting through DHCS. But, either way, you should not be receiving a bill. So, whether it goes through our managed care plan or Fee-for-Service route for the co-insurance and deductible, as long as it's a Medicare covered service, you should not be receiving a bill. So, is that happening? I think we'll provide some contact information in the slides, reach out to us.

Anastasia Dodson:

And Lindsey, I think part of the point is that we talked about earlier where Medicare providers don't have to be in the Medi-Cal plans network, but it can be confusing for providers and beneficiaries, but Medi-Cal plans can get secondary claims from Medicare providers that are not in their network and that's okay, right?

Lindsey Wilson:

They don't have to take Medi-Cal at all, but they still have to bill appropriately.

Anastasia Dodson:

Yeah. And if there's a plan that's on the line here that wants to chime in about, how do they process those secondary claims from a totally different county, feel free or you can put that in the chat. Because Rick, you're not alone. There's definitely other beneficiaries that have the exact same scenario and Medi-Cal plans, especially those that have had the dual eligibles enrolled for many years, they are successfully able to process those types of claims. So again, Medi-Cal plans, feel free to chime in on the chat on this.

Mary Russell:

I'll keep an eye out. And if anything comes, then we can flag that for the group. Great. Any other questions or? I'm not seeing any other raised hands at this point. All right. Well thank you so much, Lindsey. Appreciate you joining today. At this time, we will transition to Dr. Laura Miller to discuss D-SNP quality metrics and reporting requirements for 2023.

Dr. Laura Miller:

Okay. I am off mute. Thank you so much to Mary, Anastasia, Lindsey. It's a pleasure to be here. My name is Dr. Laura Miller. I'm a primary care internal medicine physician, and I've recently joined DHCS in the Quality and Population Health Management Division. Next slide, please. So, the quality metrics and reporting requirements, that's what I'll be speaking with, the quality metrics that we are going to be asking the plans to report out. That guidance was released in August, and there is a link to the policy guide on this slide. And these new quality metrics and reporting requirements will go into effect January 1, 2023. So, state specific reporting requirements are part of a larger quality strategy with DHCS, including the Comprehensive Quality Strategy, the Long-Term Services and Supports dashboard, and the Master Plan for Aging. And it's really all about greater visibility and improving the care for elders across the state. So, next slide please. So, I want to briefly walk through some of the differences between the reporting requirements for the Cal MediConnect plans and D-SNPs. First of all, both D-SNP and the Cal MediConnect plans report on both Medicare Parts C and D quality

measures. The Cal MediConnect plans are also required to submit both federal and state reports specific to the demonstration.

Dr. Laura Miller:

The Cal MediConnect plans report at the plan or county level, while the D-SNPs report at the CMS contract level, which can include information about other Medicare products in the state and region in the same report. So, DHCS has built upon promising practices and quality reporting metrics from the CMC plans, particularly as statewide and plan specific performance has been a helpful benchmark to evaluate member's experience in the Cal MediConnect plans. And I do think, again, evaluating member experience is incredibly important. We have clinical outcomes, and we also really want to understand how are people experiencing their care and the care coordination. Next slide, please. So, these are considerations that DHCS used when determining the reporting requirements for 2023 for the D-SNPs. We wanted to look at the overall quality and integrated care goals for D-SNPs. We wanted to look at clinical value and also wanted to align with Medicare and Medi-Cal goals and measures. We certainly wanted to look at existing data already sent to CMS that DHCS can receive, not wanting to reinvent the wheel or add administrative burden. We certainly wanted to look at existing data that DHCS has that can be analyzed, and we also looked at Cal MediConnect measures for the initial enrollment transition monitoring. So again, the goal was to avoid overburdening plans with new reporting requirements, while also ensuring that the plan benefit package level data is being captured to make sure we are delivering high quality care in alignment with both Medicare and Medi-Cal goals. So next slide, please.

Dr. Laura Miller:

This slide shows the additional requirements for the plans. The D-SNPs must start submitting the following measures to the state at the plan benefit level starting in 2023. They also most internally validate all the data and quality measures submitted to DHCS, and the D-SNP performance rates must be evaluated by an external entity prior to submission to DHCS. And again, the use of an external entity is common, it's well understood, so that's not a new requirement at all. For a reminder on how we got here, the measures for 2023 were shared with this group with the MLTSS and Duals Integration Stakeholder workgroup, and with advocates for comment and discussion before the state finalized them. All of that happened before I arrived on the scene, but again, I do think this stakeholder involvement is incredibly important. Next slide, please. So, we've included both measures from HEDIS, the Healthcare Effectiveness Data and Information Set, as well as other measures. So, all of the HEDIS measures are broken down by race and ethnicity and will be reported on to DHCS on an annual basis by the plans. So, in terms of access and availability to care, there is a HEDIS metric measuring adults' access to preventive and ambulatory health services. That is on the list. And there's the category of effectiveness of care. We'll be looking at controlling high blood pressure, poor hemoglobin A1C control. You probably all know that hemoglobin A1C is one of our main measures for diabetes. So, an A1C greater than nine is not good, and we want to be really tracking that and able to report out on that. Also, another HEDIS

metric that we're looking at is follow-up after emergency department visit for mental illness.

Dr. Laura Miller:

Again, super important to take into account the behavioral health needs of members. And we're also looking at plan all-cause readmission. Again, super important, looking at if somebody is hospitalized, do they end up getting readmitted? We don't want readmissions; we want people to remain outside the hospital. So those are the five HEDIS metrics that we're looking at. Next slide. And then the other bucket of measures that are continuing are taken from the current Cal MediConnect reporting requirements. Those fall into three areas, care coordination. So, looking at folks, who've had a care plan completed, looking at those who have an individualized care plan, and a documented discussion of goals of care. Again, Anastasia was referring earlier to the interrelationship with ECM, meant a lot of these measures have a flavor of ECM, really looking deeply at the patient, what their own goals are. And that's something that the Cal MediConnect plans have been doing, and we are continuing those as the D-SNPs come on the scene. We're also looking at care coordinators. How many care coordinators are there to a member and what is their training to support patient self-directed care? So, not the care coordinator saying, "You must do this," but really wanting these goals to be patient-centered so that patients get a chance to state what are their goals. Then the third bucket is looking at Long-Term Supported services, which include Community-Based Adult Services, In-Home Supportive Services, the Multipurpose Senior Services Program, and Long-Term Care. So, making sure that all of those are being reported upon. And then next slide, please.

Dr. Laura Miller:

Our final requirement is the Alzheimer's/Dementia Quality of Care, which is a cognitive health assessment that will be reported annually. This is the one measure that is not a continuation of prior measures. It is new. It also goes hand-in-hand with a department initiative in concert with UCSF, on Dementia Care Aware. They're a series of trainings that are being rolled out across the state. I've actually taken the training. It's quite good. So, we will require plans to report the percentage of patients over 65 who've had their cognition assessed. This is, again, super important. Dementia is a very pervasive and very challenging diagnosis, and we really want to make sure that people are getting screened, and people are getting screened across the race ethnicity spectrum, so that's very, very important. I've given a brief, fast overview here. There is more detailed information about the reporting requirements in the appendix, and certainly glad to pass the baton back to Mary for any questions. Thank you.

Mary Russell:

Thank you so much, Dr. Miller. There are a few questions in the chat that I want to just flag for the DHCS team. A note from Andy, "Are there any requirements for providers to utilize ICD-10 social determinants codes, especially those regarding housing stability for

beneficiaries? These codes are highly underutilized because they're not billable, but SCOH reporting seems key for Medi-Medi's especially for ACM clients, et cetera." So, any comments there?

Dr. Laura Miller:

To my existing knowledge, no requirement around those codes, although I absolutely agree with you that it is incredibly important to document social determinants status, housing, transportation, all of those elements. Certainly, the understanding of the impact of the social determinants is woven into CalAIM, but in terms of requirements on those codes, I do not know. We can certainly take that back, or if anybody else from DHCS on the call is aware, I'd certainly be welcome to be enlightened. I do see a comment in the chat.

Mary Russell:

Yeah, I was just going to flag. Andy had sort of a follow-on to that about a way for DHCS to report out on folks who are experiencing housing instability, that might make them candidates for CalAIM community supports, but who are not eligible because they currently lack complex medical conditions. So, I think that's a great question to take back. I'm not sure we have the right people on this call to discuss that, but thank you for that flag, Andy.

Dr. Laura Miller:

Important.

Mary Russell:

And an additional question from Jennifer, "With IHSS and MSSP carved out, MCPs are having to rely on data external to the plans, which can be challenging for reporting purposes. For Cal MediConnect reporting, some of the IHSS and MSSP reporting tabs were removed in 2022 on the reporting templates. Any thoughts about this for D-SNPs?"

Anastasia Dodson:

I'll just chime in that we... This is important to know what's going on, but we are also working on our LTSS dashboard. So, what we might do... A lot of what we did in looking at these measures back in the spring, even actually at the very beginning of 2022, was think, "Okay, what do we want to know, especially in the beginning of 2023?" Because some of these measures, as Dr. Miller was saying, they will be reported by the plans in mid-2024, because of the structure of certain quality measures. But some of these administrative measures are available sooner, and they can be sort of part of our monitoring, to see what is happening in the early months of these plans, the MMPs, the Medi-Medi plans. We don't think there should be really any substantial change in things

like IHSS or CBAS enrollment. I mean, maybe there would be an increase, I don't know, but there's... Of course, we really acknowledge workforce challenges in those programs as well.

Anastasia Dodson:

So anyway, either through some combination of the measures that are reported by the D-SNPs for IHSS, CBAS, et cetera, or through our dashboard work, we are going to keep an eye, especially in the first six months or so, to make sure that there's no drop-off... I mean, there shouldn't be, but we want to make sure we're looking at that information. And I think after we kind of get the first few months of MMPs, Medi-Medi Plans, and look at what we've got in our dashboard, then consider how much of the administrative measures should be continued to be reported by the MMPs, or is it available through the dashboard just as well, you know? Sorry, Laura. I don't mean to steal your thunder.

Dr. Laura Miller:

No, thank you. Perfect. Much appreciated.

Mary Russell:

That's a great point. Thanks, Anastasia. Rick, would you like to come off mute and ask your question?

Rick Hodgkins:

Yes. I don’t really have a question, but a follow-up comment. I could see why someone would question that whether it ought to be a requirement or not to look at the ICD code for social determination, because… Can everyone hear me?

Dr. Laura Miller:

Mm-hmm.

Rick Hodgkins:

Okay.

Mary Russell:

I can, yes.

Rick Hodgkins:

I can see why someone would question whether it ought to be a mandate or a requirement to look at the ICD code, to look at the social determination or not, because I would add, finances, financial stability in addition to housing stability, because let's just face it, let's be clear who wants to... In addition to housing stability, financial stability. Who wants to shop at Walmart? Because Walmart, you might be able to save money shopping at Walmart for groceries, but you're definitely not going to be healthy. I question where their produce comes. My guess would be not from California. That's just a hypothetical. Thank you.

Mary Russell:

Thank you, Rick. Okay. Great. I see some other comments in the chat as well, and Jack did have a question about the additional dementia screening related metrics, if those will also be requirements for MCPs in PACE programs, or if they currently already report on these elements. I do not have that answer off hand. I believe it is no, but Anastasia or Laura, do you know?

Anastasia Dodson:

No. And for the Medi-Cal plans, since they do not contract for Medicare providers, and mostly it'd be Medicare providers that would be doing the screening. But it's a fair question though, because of the expansion of Medi-Cal to all older adults, regardless of immigration status. I think Dr. Miller, it's probably a fair question of put that in the hopper to consider for that population, at least.

Dr. Laura Miller:

Absolutely. It's important.

Mary Russell:

And then I did see a raised hand from Jennifer, but I think it was lowered. Feel free to re-raise your hand if you'd like to ask a question, Jennifer. There's a question in the chat for the link to the D-SNP policy guide, and yes, we will definitely provide that shortly. Great, I see Jennifer Schlesinger. Go ahead, Jennifer.

Jennifer Schlesinger:

Hi, everyone. Jennifer Schlesinger from Alzheimer's Los Angeles. First just want to thank the Department for having a quality measure around dementia screening and diagnosis. We applaud these efforts, and the intersectionality with Dementia Care Aware. Regarding that measure, two questions. One is, will the plans be getting any baseline data by pulling ICD-10 codes to see where they currently are when it comes to dementia diagnoses? And if not, whether that's something worth considering, so we have some baseline and can see progress. And my other question is whether that quality measure will also be on the dashboard. Thank you.

Dr. Laura Miller:

Great questions. I'm going to take a stab at it. To your first question around baseline, my sense of it is that this is going to serve as the baseline. There's specific screening tools that aren't always correlated exactly with an ICD, so it's really about the presence of the screening. Certainly, ICDs could be pulled, but this is really about screening. And to your second question, which was what? Can you just refresh me? I'm sorry. Jennifer, you had a two-part, and I lost the second part.

Jennifer Schlesinger:

Sorry, I was trying to unmute myself again. If it will be reported on the dashboard.

Dr. Laura Miller:

Oh, thank you. Yeah, the dashboard at present is utilization measures, really just doing counts of people in programs. But it's a great idea, and as we iterate the dashboard, moving forward, that can... We will absolutely fold that into our thinking, thank you. It's a great question.

Jennifer Schlesinger:

Dr. Miller, if I may, can I ask a follow-up question? Are we looking at people over 65 who are screened, or who are diagnosed?

Dr. Laura Miller:

The measure itself is for screening, percentage of those who are screened. Okay, yeah. In part in recognition that we aren't catching people early enough at all, and that's absolutely something I see in the community where I practice. So, I think that's the major intent of Dementia Care Aware, I mean one of the intents of Dementia Care Aware and this measure, is to really put a push on screening.

Jennifer Schlesinger:

Thank you so much.

Dr. Laura Miller:

So clinically, we can intervene.

Mary Russell:

Great. Thank you. Thank you for those questions. Any other questions, feel free to add to the chat or raise a hand. Thank you so much, Dr. Miller. Appreciate you walking us through this. At this time, we will transition to the next portion of the agenda, which is

the upcoming skilled nursing facility long-term care webinars, and I will pass it back to you, Anastasia, to take us through these slides.

Anastasia Dodson:

Great. Thank you so much, Mary, and thanks to Dr. Miller. You know, she just started here a couple months ago, so boy, just jumping right in the deep end of the pool and doing so much good work for the Department. And Lindsey as well. I'm so pleased with the team here at DHCS, because they are taking on issues that... These are not new issues, but we as a Department are really plunging in and trying to tackle some very complex and tricky issues, so I really want to thank my colleagues and thank the Aurrera team as well for supporting us. And thank all of you for asking us and pressing us on these challenging issues, because I do think we're making some good progress at least, in fleshing them out, but we have a lot continued more work to do on all of these areas, and you help us sort through how best to navigate and share information among all of the partners here on the call. So, speaking of, long-term care carve-in. This is, again, the policy where Medi-Cal managed care plans will be covering skilled nursing facility care, long-term care in 2023. It's January 1, 2023, for skilled nursing facilities, and that is already the policy in most of the state, for most beneficiaries in skilled nursing facilities, but it is a change in 31 counties, and it's a very... Of course, that population is fragile, at risk, et cetera, and the facilities, because of the pandemic, workforce issues, this continues to be a challenging time, so we want to make sure that this policy is implemented very carefully, and that there are working models, successful models, already, in many counties, that health plans, and providers, beneficiaries, partners can learn from.

Anastasia Dodson:

So, this is not something brand new that's not been tried before in the state. It's an existing model, and we're expanding it, but we will have a number of webinars coming up to share the information that we already know, and that plans know, providers know, beneficiaries, and advocates, and families know, to make sure that it's implemented successfully in the remaining parts of the state. The webinars, I think we can go to the next slide. These are the webinars that are coming up, and we are in the process of updating the DHCS webpage. We have a dedicated page just for this long-term care carve-in and skilled nursing facility carve-in, so we'll put those dates and times and registration links, et cetera, on that webpage shortly. But again, trying to make sure that we're correctly assessing where's the knowledge gap, where's the sort of operational need, and targeting those webinars for those needs. So, having a long-term care carve-in 101 for skilled nursing facilities, promising practices for contracting, billing and payment, care transitions, care management. Again, it's not just about the contracts or the dollars. It's about, then, what are the Medi-Cal managed care plans doing? How do they work with all of the providers, the hospitals, nursing homes, other providers?

Anastasia Dodson:

We know that a large majority of Medi-Cal beneficiaries in skilled nursing facilities are dually eligible, Medicare and Medi-Cal, but not all. There are still quite a number of Medi-Cal only beneficiaries, so making sure that all the right people are hearing all the right information, to know what models have worked elsewhere. What do they need to consider in their county, for their plan, for their facility, for their types of members and individuals that they are working with? Okay, and so again, really, we are very well aware that our job at DHCS, and frankly, the job of the Medi-Cal plans, and the work that is done in facilities does not start or end January 1st or December 31st. This is going to be an ongoing effort that we have in the Department, and when we think about our population health management strategy, when we think about CalAIM Enhanced Care Management and Community Supports, we know that individuals who are in skilled nursing facilities or at risk of placement in facilities, short-term, long-term, are a vulnerable population, and a population that there are alternatives, if they choose and if it's appropriate for them to be in a home or community-based setting.

Anastasia Dodson:

And sometimes it is, sometimes it's not. So, again, I want to acknowledge the full range of experiences, and conditions, and situations that people are in, and make sure that we're having our Medi-Cal plans do the best that they can and providing them the tools. And then, supporting providers and families as well. Next slide. Okay, so with that, we can talk about the next upcoming meetings. Again, we started out talking about we have a lot of these enrollment transitions that we are... a lot of the focus of the last few meetings has been on. Today, we got a nice intensive set of time on those enrollment transitions, and then it was good to think about quality measures, so that we know that these meetings are not always going to be just about enrollment, eligibility issues, but also about quality, and then let's go to the next slide. You know, we talked about crossover billing. Again, that's not going to be solved. We still need to keep talking about it before and after January 1st, and Jack brought up a good point. How will the department react, enforce, et cetera, those requirements, educate providers, et cetera? I think that will be kind of ongoing for quite some time.

Anastasia Dodson:

And then thinking about what are we doing for the 2024 SMAC? I know we just haven't started our 2023 calendar year yet, but it's already time to think about what requirements to put in for 2024. Health equity, addressing health disparities, always an important issue. When we talked about those quality measures, we're going to find ways to look at them by race and ethnicity. It's complicated. It's complicated when we look at how does Medicare define certain racial and ethnic groups? How does the state do that? You know, trying to sort all that out so that we have good health equity data that we can provide, and then look at how do plans use that data? Again, population health management, thinking about the ways that we can continue to improve care for dual eligible beneficiaries.

Anastasia Dodson:

We will have updates as we launch our LTSS dashboard. There's CalAIM Housing Supports, that we know housing is a very important issue for many, if not all Californians, but especially for folks who are low income. Housing instability can be linked to so many other health issues, and we can find ways to help with that housing issue through CalAIM, so we can highlight that. Again, it affects dual eligibles. It affects people with disabilities.

Anastasia Dodson:

And then local examples. Starting at the top there, what are we seeing? What's working? Where is there opportunity for improvement? How to keep all of us learning. And it's not just health plans talking to health plans, but really, all of us talking as a community, about things that are working well, and how can we keep learning across all of the different partners here? Next slide. These are the upcoming meetings that we will have. Again, there's that long-term care carve-in webinar October 7th. We will meet again with this large group October 19th. By then, notices, the initial batch on the Medicare side will have gone out to folks, and open enrollment will have started, so we'll look forward to hearing anything that you all can share about what's working, and new information, and what you might be finding. And of course, please, if something, if you have a question or something comes up, no need to wait for October 19th. Email our info@calduals inbox and we... Also, like on our CCI webinar and other places, we want to flag that we know that flu and COVID vaccinations, now is the time, so hopefully we'll hear some updates on how that's going.

Anastasia Dodson:

We want to encourage, of course, all of us, and particularly vulnerable beneficiaries, to get those vaccinations. We are aware that there's still many people who are contracting COVID, hospitalized, and dying, and we want to acknowledge that as well, and that we don't know what will happen in the next few months there, but it's an issue that's present for all of us, and acknowledge that. So, we're looking forward to partnering with all of you as we continue in this journey in the next few months, and then looking forward to the success of these changes thanks to the partnership and the hard work that all of you are putting into this.

Mary Russell:

Great. Thank you so much, Anastasia, and thank you to all of you for being part of today's discussion. A quick reminder, any questions, feel free to send them to the info@calduals.org email address, and that the materials from this meeting and slides will be available on the website in the next few days.

Anastasia Dodson:

Great. And it looks like Rick has his hand up. I would love to hear Rick, any additional thoughts that you might have.

Rick Hodgkins:

Yes. I just wanted to flag one other thing. Someone said in the chat, someone had one question in the chat from earlier, from the very earliest slide, and that, when we were talking about balance billing and crossover claiming. If the managed care plan denies to pay, will there be a way for Medi-Cal Fee-for-Service... I guess they're worried that even if... I guess they're worried that even for the Medi-Cal... They're worried that the Medi-Cal managed care plan might not pick up the slack. So, thank you.

Lindsey Wilson:

If it's a covered service for the Medi-Cal managed care plan, they should not be getting denials though. I mean, if that's something of issue, we'll need to address that with the managed care plan. But there are some services that are carved out of managed care, and those would be appropriate to bill in a fee-for-service fashion. We'd have to get back to you. I think we said we would take this back and provide some more information on what kind of billing codes the plans would be providing to the providers, and that circumstance to let them know to bill appropriately. But to be communicated back to the provider in some fashion, that this is the carve-out bill, in Fee-for-Service, or however. Again, we'll take that one back and provide more detail.

Mary Russell:

Great. Thank you, Lindsey, and thank you for that comment, Rick. Okay, Anastasia, any further thoughts?

Anastasia Dodson:

Thank you to everyone, and just let us know whatever you need, whatever you're hearing. We'll work with you on it.

Mary Russell:

Great. All right, looking forward to connecting with you all soon. Take care and have a great rest of your day.