Public Webinar: 2024 MCP Transition

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Emma Petievich – 00:00:42	Hello. Hello and welcome. My name is Emma and I'll be in the background answering Zoom technical questions. If you experience difficulties during the session, please type your question into the Q&A. We encourage you to submit written questions at any time. Finally, during today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat. With that, I'd like to introduce Susan Philip, deputy director of Health Care Delivery Systems at DHCS.
Slide 1	Susan Philip – 00:01:23	Great. Thanks, Emma. Good afternoon, everyone. First, I just want to take a moment to welcome everyone today. The objective of this webinar is to provide an overview of the policies related to the transition of managed care plans, participating in Medi-Cal, and those changes that will become effective January 1, 2024. I also wanted to also acknowledge our DHCS team as well as our plan partners for all the hard work and efforts as it relates to this transition. It is a big undertaking, and we are all very much wanting to ensure that our Medi-Cal members have a smooth transition. That is our priority. So it takes a lot of work and focus, planning, effort, and implementation. Also want to thank many of our stakeholders and providers and others who've really been helpful in providing input, flagging key issues for our consideration along the way. It's been incredibly helpful and valuable in shaping our policy development and our planning efforts.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 2	Susan Philip – 00:02:29	We can go to the next slide. So the agenda for the next little bit is packed, but we'll try to get through it all efficiently and leave some time for Q&A. So first we'll provide a brief overview of the transition plan for 2024. And then we want to spend a bulk of the time really focusing in on the 2024 transition policies, which are included in the current version of the 2024 Transition Policy Guide. And we will be walking through the chapters of that transition Policy Guide. So that includes Member Enrollment and Noticing, Continuity of Care, Enhanced Care Management and Community Supports transition, Protections for American Indian and Alaska Native Members, and we'll also walk through expected forthcoming content that we plan to put out also. Okay. And I also do want to mention that this slide deck will also be posted online after the webinar.
Slide 4	Susan Philip – 00:03:31	We can go to the next slide, and the slide after. Great. Okay. So this is a reminder. So Medi-Cal, as most of you know in California is administered primarily through managed care, and come 2024, 99% of our Medi-Cal beneficiaries will be receiving their Medi-Cal benefits through managed care plans. So DHCS of course wants to ensure our members have access to managed care plans that really demonstrate and are committed to delivering high-quality care to our members. So over the last couple of years, we've been working on really a multi-pronged approach to consider the managed care plans that DHCS partners with. And we've also done quite a lot of work to revamp our contract with our managed care plans. So first, we've restructured and revamped our model contract to really move from one model contract across all plans in all model types in all the counties. And that updated contract really contains more robust provisions. And those provisions are really intended to enhance how care is delivered to Medi-Cal members, provisions that are focused on advancing health equity, quality, access, accountability, and transparency of our healthcare delivery system.

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Slide 4	Susan Philip – 00:04:55	The next major effort that we started again a couple of years ago is related to the county plan model changes. Counties really had an opportunity to consider the managed care plan model that operates in their county and changed that. So 17 counties expressed a desire to change their Medi-Cal managed care model type and change it to a Single Plan or County Organized Health System. And those were approved by DHCS late in 2021.
Slide 4	Susan Philip – 00:05:25	The next effort is really related to our managed care commercial procurement efforts. At the end of 2022, we announced that we will directly contract with five commercial managed care plans to serve Medi-Cal members in 21 counties. So that was another major undertaking.
Slide 4	Susan Philip – 00:05:43	And then finally, with AB 2724, DHCS is entering into a direct contract with Kaiser, which will allow Kaiser to be a managed care plan in 32 counties. I do want to mention that as of June 26th, DHCS did receive CMS approval for our 1915(b) waiver to allow the Single Plan and County Organized Health System changes as well as the Kaiser Direct Contract. And this approval letter is available on our website. Okay. We can go to the next slide.
Slide 5	Susan Philip – 00:06:20	This slide is just to show you that we have a webpage that lists out all the counties in which there will be changes. Actually, it lists out all the counties. And it points to the counties and the plan type of all the counties now, and in 2024 if there's a change. It also lists all the plans in the counties now, and the plans that will be there in 2024. So it's a nice crosswalk. I also do want to mention that all our plan partners are really undergoing a rigorous operational readiness review. So that really involves producing deliverables, really providing evidence of readiness, and those are materials that our DHCS team have been really busy in conducting those reviews, and that operational readiness process is happening right now.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Susan Philip – 00:07:11	Okay. We'll go to slide six now. Okay. So as we discussed, there will be changes for members come 2024. And I wanted to just start with clearly stating our principles that really guide the planning, implementation, and the oversight of the 2024 transition. First, we're working to plan for a smooth and effective transition. Our goal is to minimize any service disruptions for all members, especially for vulnerable groups, most at risk for harm from interruptions in care. So that's really important to us.
Slide 6	Susan Philip – 00:07:49	We also want to make sure we're providing outreach, education, clear communication to members, providers, managed care plans, and other stakeholders that are affected by the transition. I will note that not every county will be experiencing changes. So we want to make sure we strike the right balance in communicating. So if folks actually affected by the transition are receiving appropriate information and that we're not necessarily alarming folks who won't be experiencing changes, so trying to strike that right balance for communication.
Slide 6	Susan Philip – 00:08:20	And then finally, it's really important for us to ensure that we are monitoring the managed care plans implementation of the transition activities. We really want to make sure, again, that we are really minimizing disruption as much as possible.
Slide 7	Susan Philip – 00:08:36	We can move to the next slide. So to help us and to help in the effort for our partners, DHCS has developed a 2024 Transition Policy Guide. And the intent of this guide is really, I think of it as a one-stop shop for managed care plans who are entering or exiting the market or would otherwise have some changes to their membership. The Policy Guide is really intended to function as a requirements document for the transition activity. It incorporates links to existing or applicable All Plan Letters, APLs, and is really supposed to be, again, a one-stop shop for all the relevant requirements for managed care plans. And the idea is really for the Policy Guide, it allows us to have kind of a nimble approach to respond to feedback, any feasibility challenges, and really make sure that we're updating policies as needed. Okay, go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 8	Susan Philip – 00:09:46	This slide shows an overall structure of the Policy Guide. As you can see, it's organized by chapters. We have released chapters related to member enrollment, Continuity of Care, transition policies related to Enhanced Care Management and Community Supports, and we'll really take a bulk of the time on this call today to do a deep dive of these chapters. And we can go to the next slide.
Slide 9	Susan Philip – 00:10:13	But I do want to point out that we also did release a All Plan Letter. So the All Plan Letter, it really simply ties the Policy Guide to the contract. So this really serves as a document that really points to the Policy Guide and points out that if there's needed updates and policies and procedures, that those are to go through the typical process and working with the managed care operations division contract manager. And this APL was released a couple of weeks ago along with the latest iteration of the Policy Guide. Okay. And so without further ado, we'll get to the first chapter, and I will turn it over to Michelle Retke, our division chief for Managed Care Operations Division. Michelle?
Slides 10-11	Michelle Retke – 00:11:08	Thank you, Susan. Good afternoon, everybody. As Susan mentioned, Michelle Retke with the Managed Care Operations Division. And we're going to spend a little bit of time going over some of the main points of the Policy Guide specific to the enrollment process and noticing. Before we move into the slides with the details, we do hope that the Policy Guide is helpful. We tried to structure it in a way that folks can kind of know and understand whether they're at the plan level, a stakeholder that we work with, a member can really know and understand what's happening in their county. One really helpful tool that I'll probably mention a few times, is within the Policy Guide there's an appendix that's a county-level MCP transition kind of chart that really outlines by county what is happening. And to Susan's point, some counties may have less impact than others. We really wanted to make sure it was helpful for all of those that maybe use the Policy Guide as a good tool. So you might hear some of this referenced a few different times today. Okay, we can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Michelle Retke – 00:12:27	Most of this... There's a lot of details in the Policy Guide. And believe it or not, as robust as that Policy Guide is, that is a condensed version for all of you to be able to digest and kind of know and understand what's happening. But we tried to make these slides a little bit higher level to really point out some main points. So on this particular slide, we're talking about member noticing for transitioning members. So if a plan that a member is in, is leaving a county, we want to make sure we are explaining how that impacts a member. So members of an exiting managed care plan will typically receive a 90-day notice from that managed care plan that is exiting the county. And then there will be a 60-day notice and a 30-day notice that will be sent from the state, from DHCS, and most of the folks are aware that our enrollment brokers, so through our Health Care Options program, that is who will be sending the notices to those members at the 60-day and 30-day mark.
Slide 12	Michelle Retke – 00:13:33	And along with that 60-day notice, when appropriate, a choice packet will also be sent so that the member in that particular county knows what options they have, now that a particular plan is exiting. And then, per normal process, a welcome packet from the new managed care plan will be sent to the member once they are enrolled with the plan, so in early January. Additionally, these notices will include a QR code for additional information. We call it Notice of Additional Information that will provide additional details, and that will be posted on our website. members can choose to view it there or actually call and request it in print if that is what they would prefer. Having it online allows for the information to be current and really helps members know what's happening in their particular county.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Michelle Retke – 00:14:33	These notices, probably many of you on this call provided feedback on the notices and on the Notice of Additional Information, so just to pause and say, thank you. I know it's a rigorous process to review all of the notices out from the department, and so we really appreciate the feedback that we received. It's really helpful for us to make sure that we are making them, the notices and the information, as helpful as possible. So all of those notices received stakeholder feedback, and then also were reviewed by the Center for Health Literacy and various feedback from the Center for Health Literacy is actually incorporated into the notices as well.
Slide 12	Michelle Retke – 00:15:14	And then as mentioned again within the Policy Guide, there is an appendix that really walks through county by county what is occurring. And eventually, once all of the notices are finalized and in print, we will actually have those posted on our website. There will be a link within the Policy Guide to those notices. And the goal is to actually have a link within that particular county row, if you will, within the Policy Guide. So if somebody that lives in Alameda County can click on the Alameda County information and then know and understand what type of notices are occurring within that particular county. Right, we can go to the next slide.
Slide 13	Michelle Retke – 00:15:59	There's a lot of information on the slide. And some of it, I may just be reading to you, but as folks mentioned at the top of the call, the slide deck will be available for you after the call. So in Choice Counties, the GMC, the Two-Plan, and the Regional model counties, members that are enrolled in a managed care plan that will continue to operate in 2024, we want to make sure it's really clear that folks know and understand that they will remain in their managed care plan unless of course they opt out to choose another plan just as they do today.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Michelle Retke – 00:16:37	Mandatory managed care members enrolled in an exiting MCP will need to be enrolled in a new managed care plan. So similar to the previous slide that I was walking through, most members will receive a choice packet with their 60-day notice, but the bullet here does indicate that dual eligible members that are in a what we call a Medi-Cal Matching Plan county, which we talked a lot about during the 2023 transition, they will be automatically enrolled in the managed care plan that matches their Medicare Advantage plan where relevant. And there's a lot of information that we have in our Policy Guide and also on our DHCS website that helps explain that as well.
Slide 13	Michelle Retke – 00:17:23	Default assignment, if a member does not make an active choice, if they received a packet for example and they do not make an active choice, then they will be enrolled into a managed care plan within their county based on a hierarchy. So we want to make sure we first look at if there's any prior provider linkage so that we can put them with a plan that possibly works with a provider that they're used to working with, their primary care provider. If that isn't available, we also look at plan linkage if they have any prior affiliation to a managed care plan in that county. And then we also look at family linkage, so if somebody within their home already is enrolled with a plan, we want to make sure we connect them to where their family already receives services. Absent any of that linkage criteria, then that member will be defaulted into a plan using what many of you probably know of as the Auto-Assignment Incentive Program algorithm, which then puts a certain percentage of members within each plan.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Michelle Retke – 00:18:26	Going over to the other side of the slide, in the COHS expansion or Single Plan counties, so that's where there will be changes occurring at the county level. And there's actually an appendix at the end of the slide deck if I remember correctly, that shows a map of California, that kind of shows what types of plan models are operating within each county. So members enrolled in a continuing managed care plan, for example, Alameda Alliance for Health, Contra Costa Health Plan, Kaiser will remain with their managed care plan. These are really specific to those COHS expansion and Single Plan counties on the slide deck.
Slide 13	Michelle Retke – 00:19:08	Members enrolled in an exiting managed care plan will be automatically enrolled into that COHS or Single Plan or where relevant Kaiser. Kaiser will receive default assignment for those exiting managed care plan members in COHS and Single Plan county where they are participating, and that would be based on that plan and family linkage process as well as the Medi-Cal Medicare Matching Plan process that I described.
Slide 13	Michelle Retke – 00:19:42	I know there's a lot of information on this slide and the Policy Guide hopefully will be a good resource to be able to attack and tie to some of this information that we're talking through today. We can go to the next slide.
Slide 14	Michelle Retke – 00:20:01	When it comes to new enrollment and making sure that we're really thinking about our members and making sure that they're not joining a plan that would potentially be or that would be leaving at the end of the year, DHCS will stop new enrollment into exiting managed care plans. And that's both based on somebody choosing that plan or defaulting into that plan. That stop will be three months prior to January 1, 2024. And what that basically means is that the last enrollment into an exiting managed care plan would occur during September 2023. And new enrollment, there wouldn't be any new enrollment into that plan starting in October. So that's really what that first bullet is pertaining to.

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Slide 14	Michelle Retke – 00:20:50	Exiting managed care plans will retain their existing membership through December 31st. So a member that's already in a plan that is exiting that market, they will stay with that plan and then go through that noticing process or plan assignment process that I described on the prior slide.
Slide 14	Michelle Retke – 00:21:12	New Medi-Cal members in late 2023, so folks that are new, maybe not already in a plan. In counties with an exiting managed care plan, so in a county where particular plans are exiting, those new members, they will be offered, or in a COH Single Plan, Medi-Cal Managed Care Plan county will be automatically enrolled into a managed care plan that will operate in 2024. So one of the key points here on this slide is if a new member chooses to be assigned to a managed care plan that isn't yet operating in that county or in the COHS scenario, if that plan is not available yet, because it's not available until January 1, 2024, those new members will be in that Fee For Service delivery system until that managed care plan is available in January 2024. And again, we have some details that are outlined in the Policy Guide for this, but hopefully, this slide kind of lets folks know what's occurring when we talk about the new enrollment freeze with new members entering into Medi-Cal and needing to choose a new plan or be assigned to a new plan.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Michelle Retke – 00:22:32	We can go to the next slide. Okay, this slide tries to encompass all of the details around the Kaiser Direct Contract when it comes to enrollment. So in 2024, Kaiser is expanding as a Medi-Cal prime plan, participating through a direct contract with DHCS as many of you know and have been tracking. Eligible members may actively choose to enroll in Kaiser in any county where Kaiser operates, but we do have eligible members. So on the slide deck, it does indicate what an eligible member means and there are certain eligibility requirements and if that member meets those eligibility requirements, then they would be available to be choosing Kaiser. A couple of key points, members already in a Kaiser subcontract, so members that are already assigned to Kaiser in a county where Kaiser currently operates as a subcontracted plan, they will stay with Kaiser. They will receive a 90, 60, and 30-day notice from Kaiser letting them know of the transition.
Slide 15	Michelle Retke – 00:23:49	We talked a little bit about the Medi-Cal Matching Plan Policy, which really is about keeping the member with the Medi-Cal plan that is also affiliated to their Medicare Advantage plan. And so that would be the case here. So the policy will apply to Kaiser. Kaiser Medicare Advantage members in relevant counties will be automatically assigned or transitioned to Kaiser Medi-Cal Managed Care Plan that matches. When it comes to default assignment, again, new members who do not make an active choice, or in the case of a COHS or Single Plan county where Kaiser participates, members may be defaulted into Kaiser.
Slide 15	Michelle Retke – 00:24:31	There is the plan family linkage. So members who have a history of enrollment with Kaiser or family members that are enrolled with Kaiser, members can be default-assigned. And then there is the auto-assignment. So new members in certain counties may be assigned to Kaiser as part of the Auto-Assignment Incentive Program as well. There are... I think that was my last slide. Again, I know that there's a lot of information. Hopefully, the Policy Guide along with some of these slides help folks tack and tie that information together. But we're definitely going to be taking questions as needed as well.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Michelle Retke – 00:25:20	All right. I didn't see Dana. I think Dana's on. I was going to...
Slide 16	Dana Durham – 00:25:24	Yeah, I am.
Slide 16	Michelle Retke – 00:25:25	Oh, there you are. Okay. I lost your video for a second. Okay, Dana. I'm going to hand it over to you to get us going on the Continuity of Care requirements for 2024.
Slides 16-17	Dana Durham – 00:25:35	Thanks so much, Michelle, and really excited about the protections that we have put in place to make sure that care is not disrupted. So I'm going to go over our Continuity of Care policies. Next slide, please. So in looking at the principles that we have, this Transition Guide does outline our goals, which is to make sure that no service is interrupted for members that are required to transition on January 1st. And so we're taking those groups that are most at risk for harm or disruptions in care and making sure that they really are protected. And this is to avoid member, provider, and manage care confusion. We are trying to look at reducing the administrative burden as much as possible, but we do understand that there are some administrative things that must be considered when we look at Continuity of Care overall. The 2024 policy largely aligns with the current policy for Continuity of Care but with some additional protections. Let's go to our next slide, please.
Slide 18	Dana Durham – 00:26:58	Some of those policy lovers, all members required to transition to managed care plans are eligible for Continuity of Care using the following policy lever. Continuity of Care for Providers, the member can keep their provider even if the provider is out of network for the receiving managed care plan. There's Continuity of Care for Covered Services and that means the member can continue an active course of treatment and the receiving managed care plan must honor prior authorization from the previous managed care plan. Continuity of Care and coordination and care management information. Previous managed care plans and receiving managed care plans should work together to transition any information that would help to support an individual such as if their care plans or any information that's available for ECM or Community Supports that information should be shared.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Dana Durham – 00:28:03	And then additional Continuity of Care protections for all transitioning members. So all members are eligible for additional protections related to DME or Durable Medical Equipment, rentals and supplies, transportation, so the non-emergency medical transportation as well as the non-medical transportation and scheduled appointments. And these levers are currently deployed in policies through the Knox-Keene Act. So the 2023 letter on Continuity of Care, as well as the Policy Guides for ECM, and Community Supports are the three in which the[inaudible 00:28:46] can be found. And really the idea behind this is we want to make sure that an individual who is forced to change plans that there is as [inaudible 00:28:59] disruption as possible. Next slide, please.
Slide 19	Dana Durham – 00:29:06	We have identified some Special Populations. All members required to transition managed care plans on January 1st have the ability to ask for Continuity of Care, but some members will have enhanced protections and that's really meant to minimize the risk of harm. And Special Populations are those populations that are generally living with complex or chronic conditions. Transitioning members will be identified using either DHCS or previous managed care plan data and that includes our program enrollment data, pharmacy claims, Durable Medical Equipment claims, screening and diagnostic codes, procedural codes, or aid codes. The receiving managed care plan will receive this data in advance of the 2024 transition.
Slide 19	Dana Durham – 00:30:08	And a couple of the just high-level examples of populations are adults and children who receive Enhanced Care Management services and Community Supports, children and youth enrolled in CCS, members who are either receiving treatment for end end-stage renal disease, or receiving a hospital inpatient care, or those who may be living with hospice or palliative care. And the goal is just to make sure that these very vulnerable members really are taken care of.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Dana Durham – 00:30:49	And as we continue to look at this, the managed care plans are required to take proactive steps to implement Continuity of Care on these Special Populations. They'll do outreach to members and providers and there'll be that data transfer between managed care plans. And the goal is to make sure that, that provider relationship is not disrupted at all. So DHCS will monitor the Continuity of Care for those Special Populations as part of the monitoring that will happen during the transition overall. We feel like this is really important because it really does help us know who is eligible for Continuity of Care and make sure those who are most vulnerable, those are the ones that we're really working to protect as much as everything. In the appendix, there is a list of all the Special Populations and as you get the slides we'd encourage you to look through that. Next slide, please.
Slide 20	Dana Durham – 00:32:00	Continuity of Care for Providers. So all members required to transition managed care plans will be eligible to keep their out-of-network providers for 12 months when transitioning to the receiving managed care plan. And those, as I talked about, those additional enhanced protections that apply to Special Populations are really the plan, we'll reach out to offer that Continuity of Care. So if you're a member who is not one of those Special Populations, then you can ask for that continuity of provider. But if you're in that special population then it's important that you know we're doing everything to make sure that relationship is not interrupted at all. So for all members, members of previous managed care plans can continue to see their out-of-network providers for 12 months, and during that 12 months, the hope is that a contract can occur between the managed care plan and your provider.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Dana Durham – 00:33:13	It's kind of a holding pattern if they're working on contracting. There are a few things that must be in place. There has to be a relationship between the member and the provider. The provider has to be willing to accept the contracted rates or the Medi-Cal Fee For Service rate. And the provider must meet professional standards as well as there being no quality of care issues. And finally, the provider should be state-plan approved or enrolled through the state pathway.
Slide 20	Dana Durham – 00:33:49	And as I talked about those enhanced protections for Special Populations, the MCPs will contact the provider treating... Apparently, I can't speak today, sorry about that. Treating Special Populations to initiate the process for entering into that Continuity of Care agreement. And extended Continuity of Care really is eligible for certain populations. So looking at that, if you're part of a special population, the plan, as I said, will initiate that process for entering the Continuity of Care agreement. Next slide, please.
Slide 21	Dana Durham – 00:34:28	The Continuity of Care for Covered Services. The policy for continuing active course of treatment outside of Knox-Keene is relatively new and is the expectation for the managed care plan to outreach to providers treating the Special Populations. The policy for continuing authorizations is not new. Continuity of Care Policy for services for all members required to transition managed care plans, including those Special Populations. Some members can keep their existing authorizations for covered services for six months following the members' transition to the receiving managed care plan from the previous managed care plan. They can also continue their active course of treatment without authorization for six months. Any active course of treatment is expected to be documented prior to January 2024. And finally, active course of treatment is defined as a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Dana Durham – 00:35:55	You'll see in red that we do anticipate it going to 90 days, I mean, six months from 90 days as a finalization from our negotiations with CMS over the special terms and conditions. So previously, it'd been 90 days. And in talking with CMS, it looks like they're going to have us have those protections in place for six months. The enhanced protections for Special Populations, following the transitions, members can keep their existing authorization for six months until the receiving plan assesses clinical necessity for ongoing services. And during the six-month Continuity of Care for Services, the receiving managed care plan must look at the utilization data of the special population to identify any active course of treatment that requires authorization and contact those providers to establish any necessary prior authorizations.
Slide 21	Dana Durham – 00:37:03	And also, if you look at those Special Populations that are accessing the transplant benefit, the receiving managed care must start reassessments for clinical necessity no longer than six months after their transition date. And the reassessment applies to adults and children for transplant performed to treat conditions that are not medically eligible for the California Children's Services Program or as we often call it CCS. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Dana Durham – 00:37:40	Continuity of Care Coordination and Care Management Information. The care coordination and care management information will travel with members to the receiving managed care plan. This really isn't a current expectation under the 2023 Continuity of Care Policy and this really applies only to Special Populations. So the proposed Continuity of Care Policy provides that the previous managed care plan provides contact information for the plan level contact and care managers to the receiving managed care plan. If a member changes care managers, the receiving managed care plan contacts the member's previous managed care man, and/or care manager to obtain that supportive information. And it should be including but is not limited to results of assessments, the member's care plan, and ad hoc communication and coordination between incoming and outgoing care manager. The information transfer must be complete before January 1st, 2024, or within 15 calendar days of the member changing to a new care manager, whichever one is later. And next slide, please.
Slide 23	Dana Durham – 00:39:06	And I'm going to turn it over to Randy. Just making sure, Randi Arias-Fontenot, and she will go over Enhanced Care Management for us.
Slide 24	Randi Arias-Fontenot – 00:39:18	Thank you so much, Dana. My name is Randi Arias-Fontenot. I'm one of the nurse consultants here with the Quality Population Health Management. And we're here to just speak a little bit about the ECM transition policy for the 2024 MCP transition. As it's previously been mentioned, our goal is to make sure that during this transition period, our members experience the least amount of disruption possible in that process. Currently, our transition policy for ECM builds on and aligns with the ECM Policy Guide and with the Continuity of Care section within the Policy Guide. All of our members that are authorized for ECM, regardless of whether they're actively receiving ECM at the time of transition, as long as they're authorized, are considered one of the Special Populations.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Randi Arias-Fontenot – 00:40:22	As a result, the receiving managed care plan must honor all of the previous managed care plans authorizations for ECM. So again, if that member is authorized, even though they may have not actively been in ECM care as long as they're authorized, we are expecting that the receiving managed care plan will treat that member as though they are an ECM member, participant, excuse me. And then to ensure that there is no interruption for the transitioning member receiving ECM, DHCS will require a mandatory overlap of the previous managed care plans and the receiving managed care plan providers to the maximum extent possible. So to the maximum extent possible, services that that individual would've received, we are requesting that that individual receive them from the new providers. And next slide, please.
Slide 25	Randi Arias-Fontenot – 00:41:35	I'm going to go ahead and now transition this over to Ms. Vickshna Anand. Oh, excuse me, back to Dana.
Slide 25	Dana Durham – 00:41:45	I think this one's me.
Slide 25	Randi Arias-Fontenot – 00:41:45	All right. Back to, Dana.
Slide 25	Dana Durham – 00:41:45	I think this one's me.
Slide 25	Randi Arias-Fontenot – 00:41:49	Sorry about that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Dana Durham – 00:41:51	I'm going to talk about Community Supports, the transition policy for the 2024 transition and it really aligns and/or builds upon the Medi-Cal Community Supports, or In Lieu of Services, Policy Guide that exists already, and the Continuity of Care provisions that are in that guide. So when both managed care plans offer the same community, the receiving managed care plan must honor the community support that was authorized by the previous managed care plan. And that's in alignment with the Community Support Policy Guide. So if the previous managed care plan's authorization exceeds the state-defined Community Support, the receiving managed care plan is strongly encouraged to honor the greater Community Support which has been authorized. And if the receiving managed care plan does not offer a Community Support that's offered by the previous managed care plan, DHCS really strongly encourages the receiving managed care plan to authorize to honor the previous managed care plan authorization for the Community Support for those members determined eligible at the time of transition.
Slide 25	Dana Durham – 00:43:17	If for any reason the receiving managed care plan does not continue the previous managed care plans authorization for our members' Community Support, the receiving managed care plan must really look at the needs that were addressed by that Community Support and coordinate all services necessary to make sure that the needs of the individual are honored and that includes Enhanced Care Management, ensuring an appropriate transition of care, and doing everything possible to prevent the need for higher acuity services. So just in general, if the new managed care plan offers the same Community Support, that Community Support will be authorized as long as the authorization is enforced, and we will do our best to make sure that...

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Slide 25	Dana Durham – 00:44:22	Most plans are doing that already. We're doing our best to work with plans to make sure that those stronger timeframes are offered if for any reason the authorization timelines don't sync. Now if a managed care plan does not offer Community Support, many of them are continuing to offer the Community Supports that we're previously authorized. If for any reason they don't, we do have a plan in place so that they come up with a plan of care for a member, and that would include everything that addresses all needs that were being met by that Community Support. Next slide, please.
Slide 26	Dana Durham – 00:45:04	At this point, we will be transitioning to Vickshna. And Vickshna, I don't know that you have talked to group before, so I will let you introduce yourself.
Slide 27	Vickshna Anand – 00:45:26	Thank you so much, Dana. Hi, my name is Vickshna Anand. I'm with the Office of Tribal Affairs. And I'll be going over the protection for American Indian and Alaska Native members. The 2024 managed care plan transition does not change existing protection for American Indian and Alaska Native beneficiaries voluntarily enrolled in managed care under both Federal and State Medi-Cal policy. Managed care plans must provide for American Indian and Alaska Native members enrolled in managed care to receive services from an Indian Health Care Provider of their choice. Regardless of whether the Indian Health Care Provider is a network or out-of-network provider, all of these protections will remain in effect for American Indian Alaska Native members in managed care regardless of whether or not they're required to transition to a new managed care plan on January 1st, 2024.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Vickshna Anand – 00:46:24	And American Indian and Alaska Native members of managed care plans who are accessing care from non-Indian Health Care Providers are subject to the same Continuity of Care protection as all managed care plan members. Members of managed care plans who are not American Indian and Alaska Native and who are accessing care from Indian Health Care Providers are also subject to the same Continuity of Care requirements. For additional information regarding protections for American Indian and Alaska native members, please reference All Plan Letters 9-009, All Plan Letters 17-020, and All Plan Letter 21-008, with their attachment. Thank you. Next slide, please.
Slide 28	Vickshna Anand – 00:47:12	Thank you so much, and I will hand it back over to Michelle Retke to go over the forthcoming managed care plan transition policy.
Slide 29	Michelle Retke – 00:47:28	Okay. Thank you. Just briefly to kind of share with you the Policy Guide that has been posted, as we've mentioned, there will be various chapters and information that will be included along the way. And so this is really just to let folks know that there will be forthcoming policies in Quarter 3, related to data transfer, oversight and monitoring, and ongoing education and communication. So I know, even in some of the questions coming in, that we've been seeing have asked for example around data transfer and so there will be a chapter that is forthcoming in Q3 really specific to that area. Next slide.
Slide 30	Michelle Retke – 00:48:17	Okay. So I know that we're probably going to take a little bit of a pause to get moving on some of the Q&A that have been coming in. So I'll hand it over to the team that is helping with the Q&A response.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Kier Wallis – 00:48:42	Thanks, Michelle. This is Kier. So, let's start. We're going to walk through some of the questions that came in, and thanks everyone for your great questions and comments that have been coming in through the Q&A. The team has been responding to some live, and we'll try to get through as many as we can today, and we'll follow up on others if we're not able to get to them all. So let's start with some of the more general questions and Michelle, maybe while we have you, some of the questions around member enrollment and noticing. So what is the transition plan around sub-delegated plans that may be exiting? For example, Health Net in Riverside, folks are curious whether sub-delegated plan exits are addressed in the Transition Policy Guide.
Slide 30	Michelle Retke – 00:49:38	I'm sorry. I couldn't get off mute. If a sub-delegate is terminating a subcontract with a prime plan, that is handled really specific through normal termination process. So APL 21-003, outlines the requirements of what managed care plans need to do if they are terminating, I'll say a subcontract with another plan that they currently subcontract with. And so those aren't... That's not like specific to enrollment for 2024, but there are processes and policies that plans adhere to when a subcontract is being terminated. I guess the only kind of caveat there I would just say is what we've already talked through with Kaiser being a delegate in many of the counties and now becoming a prime plan. That obviously is outlined in our Transition Policy Guide.
Slide 30	Kier Wallis – 00:50:51	Thanks, Michelle. And another one that came in that I think was answered maybe privately in the chat, but I assume I think a lot of folks might be interested in, you mentioned the member notices, and thanks, everyone, for giving feedback on those, when will those notices be final and posted?
Slide 30	Michelle Retke – 00:51:09	We're targeting late summer and we will post them, I'm going to say late August and we will do our best to post them and then obviously let folks know that that information is available. So we're targeting to post on the DHCS website in August.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Kier Wallis – 00:51:36	Great. And what about foster youth? There are a few questions in the chat about how or whether foster youth will be affected by the model change and whether foster youth that are affected would be automatically enrolled in MCP.
Slide 30	Michelle Retke – 00:51:49	Definitely, thank you. A few things. One, we will make sure that we have, in one of the next iterations of our Policy Guide, in the chapter around and enrollment and noticing, more detail and specific information around children and youth that are part of our foster care program. And so that information will be outlined a little bit better, a little bit more specifically to give those details. As with today, in COHS, County Organized Health System counties members that are part of the foster children and youth are enrolled into the managed care plan. And you may be tracking on recent trailer bill that has been posted for those Single Plan counties. The mandatory enrollment of foster children and youth is outlined to say no sooner than January 1, 2025, in that proposed language. And again, further detail in a subsequent Policy Guide will be outlined to make sure it's really clear for folks.
Slide 30	Kier Wallis – 00:53:00	Great. One or two more on enrollment. And then, Dana, we'll go to Continuity of Care, where we've got a lot of questions as well. Michelle, who sets the Kaiser default enrollment ceiling and what is it?
Slide 30	Michelle Retke – 00:53:15	Yeah, so per the memorandum of understanding the MOU between DHCS and Kaiser, which is based on AB 2724, hopefully, I got my numbers, Kaiser provides those numbers annually to the department. And so we actually have already posted those numbers for 2024 for those relevant counties on the D DHCS website, on the MCP transition webpage that I know is linked in a couple of places and we'll make sure to link that out again. So it is something that Kaiser submits based on their projected capacity to the department annually.
Slide 30	Kier Wallis – 00:53:56	Great. And the last one, Michelle, for you. For now, where can listeners today find a summary by county of exiting plans and new plans in each county?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Michelle Retke – 00:54:10	Yeah, I think there's actually two resources. Both of them when we send out the slide deck will be linked. There's a resource that's part of the Policy Guide, the appendix that I had mentioned where there's a lot of details by county of what is happening from an exiting standpoint as well as new plans entering. And then there's also a simplified chart that's literally just who's operating today in 2023 and who's operating, I'll say tomorrow for January 1, 2024. And both of those are great resources to use.
Slide 30	Kier Wallis – 00:54:48	Great. And we'll make sure that the deck that gets posted has all of the links to those resources as well, all in one place. And those are the links from the Policy Guide. Great.
Slide 30	Michelle Retke – 00:54:59	Thanks, Kier.
Slide 30	Kier Wallis – 00:55:00	Thank you, Michelle. Okay, Dana, a few questions around Continuity of Care. A question around the 2023 APL 22-032 and whether or how the Continuity of Care requirements in that APL, apply to the 2024 transition.
Slide 30	Dana Durham – 00:55:23	Yeah, that's a really good question. So the protections do apply. But that policy doesn't necessarily talk about transitioning from one managed care plan to another. It talks about transitioning from Fee For Service to a plan. So we've taken those Fee For Service protections and made them available for this transition from when you're transitioning from a managed care plan to another managed care plan because of a change that wasn't requested by the individual. So I think it's important to note that. And also we've gone one step further and said their populations that are incredibly vulnerable and we want to make sure those vulnerable populations and we're calling them Special Populations get protections. So in theory, the same protections apply and they're enhanced even further. So I hope that answered the question.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Kier Wallis – 00:56:27	Great. And let's pull the thread on Special Populations a bit, Dana. There's a question about when more detail will be available on the Special Populations. For example, detail on what members exactly are included in the Special Population receiving specialty mental health services. I know the department's planning to put out some more information, and maybe you can talk a bit about that.
Slide 30	Dana Durham – 00:56:54	Yeah, we are working towards when we will be able to supply that information, but we won't. And we're looking at mid to late July when we will be running that out. But it will be a description of the populations and more kind of the specifications of the populations. We won't outline specific individuals, of course. I assume that was in your question. But it's more specifications on how we identify the population than who actually is in those populations.
Slide 30	Kier Wallis – 00:57:35	And one of those Special Populations, I think, because members receiving DME, and there was a question about for members who are receiving or requiring DME such as complex rehab technologies, how does the policy minimize disruption to DME? I think there are more details in the Policy Guide in the appendix of the slide deck that will go out. But Dana, do you want to talk about the DME policy for a moment?
Slide 30	Dana Durham – 00:58:02	Yeah. Yeah. We do think people who are receiving DME are vulnerable. And so the goal... Well, the direction is that they get to keep the DME for no less than, and as I said, we're still working with CMS right now. The policy says 90 days. We think that policy will end up saying six months. So you get to keep that DME for six months. And during that six months, the plan and the provider should be working out the relationship with each other to come into contracting. That is the hope with any Continuity of Care that we have or any policy that we have.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Dana Durham – 00:58:44	And then only after that time period, if that DME is approved for that time period, then would the plan reassess what the need is. So if it's a long-term DME that has an approval for over six months, that approval will be continued to be offered for that time period. And then only when an individual's reassessed will that approval be looked at again. And our hope is, during that time period, where the person is newly in that plan, that relationship can be worked out. Thank you for the question. We do feel like that's an especially vulnerable population, and really want to make sure that the loss of equipment does not happen for that population, little disruption as possible.
Slide 30	Kier Wallis – 00:59:40	Great. Great. And seeing that we are at time here at the top of the hour, I want to acknowledge that there are several questions that came in about when the data transfer specifications and timelines will come out, questions about the intersection with incentive programs, as well as communication and outreach messaging forthcoming for members. Those will all be addressed in forthcoming chapters of the Policy Guide as Michelle mentioned toward the end of the webinar today. And also, DHCS will also be taking into account the questions that came in this afternoon in future iterations of the Policy Guide to ensure that stakeholders have the clarity they need as we approach the 2024 transition. So I think with that, Emma, shall we wrap up?
Slide 30	Emma Petievich – 01:00:38	I think we're all set. Thank you for joining. You may now disconnect.