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

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SPEAKERS

Mary Russell
Anastasia Dodson
Mariya Kalina

Mary Russell:

Good morning, and welcome to today's CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup. We have some great presenters with us today. Anastasia Dodson, the Deputy Director in the office of Medicare Innovation and Integration at DHCS, and Mariya Kalina with the California Collaborative for Long-Term Services and Supports. A few 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 work groups are designed to provide stakeholders with the opportunity to ask questions. We ask that the plans that join these calls hold their questions for the multiple other work group venues they have with the department throughout the month. Please feel free to submit any questions you have for the speakers via the chat.

Mary Russell:

During the discussion if you'd like to ask a question or provide comments and feedback, please use the raise hand function and we will come around and unmute you. A reminder that the PowerPoint slides and meeting materials will be available on the CalAIM website in the next few days, and we will provide a link to those in the Zoom chat. So, a quick ask that you take a minute now to add your organization's name to your Zoom name so that it appears your name - organization. Click on the participant's icon on the bottom of the window. Hover over your name and the participant's 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. And that will just help us, as we are facilitating the discussion today. We'll take a quick look at our agenda for today where we'll start with an update on the continuous coverage unwinding.

Mary Russell:

After that, we'll hear an update on the 2024 Medicare Medi-Cal Plan expansion counties. We'll also hear about the Medi-Cal Managed Care for dual eligibles crossover claims and balance billing. Next, we'll walk through stakeholder and plan feedback on the 2024 State Medicaid Agency Contract templates. Then a brief overview of palliative care, followed by an overview of Enhanced Care Management and Community Supports. And finally, our last topic of the day will be a report out on the first listening session that the collaborative held at the end of March. And we'll end the call with some information about upcoming meetings and next steps. So, thank you all for being here. And with that I'll transition to Anastasia Dodson.

Anastasia Dodson:

Thanks so much, Mary. Really glad to be here with you all and glad to be, again, thinking about the ways that we can all work better together. We want this work group to have to be a collaboration hub for CalAIM Managed Long-Term Services and Supports, which is people who are Medi-Cal only and dually eligible, and also integrated care for dual eligible beneficiaries. Really glad to have Mariya Kalina later on. Today we do not

have sort of brand new policy issues to present, but we do want to make sure that everybody's on the same page about some of the work that we've done. We've been talking about expansion of the Medi-Medi Plans in certain counties, but we are happy again to have Mariya later on. Thinking about the spirit of this work group, any and all questions are welcome. Mary and her team are going to facilitate that. Next slide.

Anastasia Dodson:

So just in general, again, for 2023, we want to use this workgroup to talk about implementation, data, results, opportunities, and challenges for the CalAIM initiatives around MLTSS for all Medi-Cal members. Again, implementation, data, results, opportunities, challenges for integrated care for dual eligibles, and then flagging any related efforts. And so, when we talk about continuous coverage, unwinding, of course, that affects all Medi-Cal members. And then there's so many topics we can talk about here and you all are welcome to suggest topics for future meetings, even if we've covered it in the past. Maybe there's a good reason to revisit some of the topics. Integrated care across behavioral health, IHSS, thinking about quality measures, all of these are really good topics, really fair game, I think, for future meetings.

Anastasia Dodson:

All right, next slide. So first today, let's talk about the continuous coverage unwinding on Medi-Cal, and all states are working on this. Next slide. And these are the kind of standard DHCS slides. And I am not intimately familiar with all the details, but I think I'll do a good enough job covering this. And then there are other venues that DHCS has for super detailed discussion about these items. But at any rate, so we had a Medi-Cal COVID Public Health Emergency and Continuous Coverage Unwinding plan that was originally released in May 2022, and then updated January 2023, to incorporate federal requirements. We have both the unwinding of Medi-Cal program flexibilities and the resumption of normal Medi-Cal redeterminations. Next slide.

Anastasia Dodson:

So, the beneficiary journey is here, and you can see, as the individual progresses, first, an individual who's got Medi-Cal will receive a letter telling them that continuous coverage is ending and that redeterminations are going to start. March 31st is the official day that marked the beginning of those letters going out. And then for someone who has a month of eligibility redetermination month of June, in April, we call it the ex parte process, where existing data is used to try to verify that the individual's income meets the Medi-Cal limits. And then there's a pre-populated renewal form that's sent. And then based on any additional information, and that ex parte information, there's an eligibility determination made in June. And then hopefully that person will continue their ongoing Medi-Cal eligibility. Next slide. So, we have an outreach, DHCS has an outreach campaign, for folks getting their redeterminations.

Anastasia Dodson:

So, we want the Medi-Cal renewals too, of course, we want people to maintain coverage if they're eligible, and we want enrollment for newly eligible individuals to

continue as well. So, we want to raise awareness about the need to renew Medi-Cal coverage and encourage folks to take the steps that are needed to do so. Again, some people, their income may not have changed much, especially older adults and people with disabilities, if they're on a fixed income. But we know that sometimes things do change, and especially if people's addresses have changed or if they have changed who they're living with as far as if they're married, not married, et cetera. Some of those can play into the eligibility based on income. So, we want to raise awareness about new Medi-Cal eligibility. Again, the expansion that we undertook in 2022, for older adults, regardless of immigration status, as well as the changes that we've made around the asset limit. And we can talk about that and it's just a sec. But we also want to engage our partners, all of you, to increase the outreach and amplify the messaging around keeping your Medi-Cal coverage. Next slide.

Anastasia Dodson:

So, we do have some data driven communications that DHCS is rolling out to raise awareness and drive action. We want all of you, as partners, to be equipped with information and resources that can leverage research-based messages. We want to enlist trusted messengers, like you all, to convey information authentically and credibly. And we absolutely recognize the diversity of Medi-Cal population and all of California. So, we want to be able to reach people in culturally and linguistically appropriate ways. Next slide. So, we have some landing pages. KeepMediCalCoverage.org and MantengaSuMediCal.org. And those are great landing pages. Again, thinking about the audience, so feel free to make referrals to those web pages. Next slide.

Anastasia Dodson:

All right, how you can help? Next slide. So, there are partner resources in 19 languages on our continuous coverage unwinding webpage at DHCS. Next slide. There's outreach materials, scripts for call center staff, emails, and text messages, flyers, IVR, interactive voice response, scripted messages, social media. And we're going to have some additional tailored materials for IHSS recipients, travel communities, provider schools, and senior centers or community centers for older adults. Next slide. There's some videos, 30 seconds, 15 seconds, English and Spanish, other languages coming. Next slide. Downloadable assets. You can see great pictures there. And then you can order print materials on that link. And again, all these slides will be posted, and you can find this on the DHCS website, of course. Next slide. And coverage ambassadors. Again, signing up to be a coverage ambassador. And then you can get email reminders, there's FAQs to assist with outreach efforts. So, lots of effort that we want to make sure that people can keep their coverage. Next slide. Okay, any questions about this first item?

Mary Russell:

Anastasia, I see a question in the chat from Julianne at Blue Shield asking when DHCS changed the asset limit mid-last year, there was a look-back period to reassess those who were denied Medi-Cal coverage before the asset limit change, in case they were now eligible. Will this same process be implemented in 2024, and if so, how far back will that lookback go?

Anastasia Dodson:

Thank you for raising the question about the asset limit change. And in fact, we did get a waiver from the Federal Government to be able to make it a little bit easier for people with regards to assets, because technically the 2024 asset limit change, which is the elimination of the asset test, does not officially go into effect until January 2024. But for renewals, we have federal waiver that allows certain latitude when looking at data and being able to use existing information about assets. But as far as another look back, I don't think that is planned, but we can take that back to our eligibility team. We think that most everyone who would've been eligible under the new rules, but wasn't under the old rules, probably got identified in that lookback, the first lookback that we did. But we can take that back.

Mary Russell:

Great. And another question from Tatiana. How will duals and SNFs be notified about redetermination if there's no POA on file?

Anastasia Dodson:

That is a great question. I will ask the team, the backup team here, if during this meeting can they look if that's on the FAQs for continuous coverage unwinding, because I think that question has come up before. And if we don't have it in the FAQs, then we will definitely track that because that's an important question.

Mary Russell:

Yeah, we can help take that back and track.

Anastasia Dodson:

Thank you.

Mary Russell:

Okay, great. I see Susan LaPadula’s question about not all 58 counties use the BenefitCal, can DHCS provide a listing by county statewide within the respective system?

Anastasia Dodson:

Yeah, I believe there's just two. So again, hoping the team can put the answer in the chat. And I believe this question is about the consumer portals that Medi-Cal beneficiaries can use to respond, provide information, et cetera, back to the counties so people, at their option, they can sign up to use the online portals to work with their county eligibility office. So hopefully the team can put those links in the chat. But again, we have been consolidating, counties have been consolidating, as far as eligibility systems. So, I think there's just two portals at this point.

Mary Russell:

Got it. Okay. And the question specific to duals, if someone has dual Medicare Medi-Cal

eligibility and loses Medi-Cal but retains Medicare, how will that affect their access?

Anastasia Dodson:

What a great question. So, if someone, again, has dual eligibility and, for whatever reason, their income is now above the Medi-Cal income limit, and I would say for some people do they need to clarify with the county? We think that people's income is relatively stable if they have Medicare, but there may be some significant change in their income. And then if they lose Medi-Cal, they still have Medicare, if their Medicare is based either on age or disability, they can keep their Medicare systems. If they're enrolled in a Medi-Medi Plan, there is a period of time they can keep that enrollment. But at some point, if their income is just too high for Medi-Cal, then they will need to transition to a different Medicare plan or to original Medicare.

Anastasia Dodson:

But original Medicare and Medicare Advantage plans are widely available for people who do not have Medi-Cal and just have Medicare, and all the Medicare providers that serve dual eligibles also serve people with just Medicare. So, we don't think there should be an access issue on the Medicare side, I guess the question of can they retain, for example, CBAS or IHSS, if they lose their Medi-Cal, that can certainly be challenging. But again, if their income goes above a certain point, there are different ways that I'm sure the HICAP folks can help with. If their income is just above the Medi-Cal income limit, there are ways to be able to access your Medi-Cal benefits through the share-of-cost program.

Mary Russell:

Thanks, Anastasia. And it looks like Tatiana is adding a little bit to that in the chat as well. And then Jack Dailey is adding a little bit with regard to Julianne's question earlier. There's also a question here, Anastasia, about how beneficiaries are protected from questionable outreach.

Anastasia Dodson:

I assume that's with regard to the renewals. So, all the same provisions around what is and is not allowed for anyone, as far as Medicare information agents and brokers, et cetera, that's irrespective of the Medi-Cal Continuous Coverage Unwinding. So, I have not heard of any problems with regard to people taking advantage, but Tatiana, if you have examples, you can certainly send them to us, and we'd like to hear about that.

Mary Russell:

Great. And we've added some additional reference links in the chat as well and appreciate the additional discussion on this.

Anastasia Dodson:

And I see another one from Diana. Yeah, major issue with some newly covered services in California that are resulting in members being wrongly advised. Mary, do we have time to have Diana come off mute maybe?

Mary Russell:

Sure. Diana, if you want to raise your hand, we can unmute you. You'd like to share more about that.

Diana Heineck:

Okay. Am I on? Can you hear me now?

Mary Russell:

Yes. We can hear you.

Diana Heineck:

Okay. I'm sorry, I'm new at this. Yeah, I'm giving you some background. I've been in the medical field for over 35 years. Actually, in our county, I have the distinction of contracting the first, when we went from the fee-for-service model to PMPM, and Cal Optima was developed in Orange County, I actually authored some of our first contracts. So, I'm kind of a little familiar with this animal. And I noticed that we were fortunate enough to expand coverage, which included some things like glasses, hearing aids, this and that. And for somebody that is a dual eligible or a full dual or a QMB or what have you, I'm finding that we're having some major issues. It's a relatively small area, but it's financially significant, in that you're having a problem with hearing aid providers seeming to think that they're still eligible to balance bill patients above their benefit limits.

Diana Heineck:

And unfortunately, one of the biggest carriers and providers we have, we don't want to disbar these people, but it's just ridiculous. It's really ridiculous. I can't believe that they're actually, they're saying, no, it's a benefit limit. No, that's the same thing as saying you balance billing people, but okay. So that's what we're up against, and that's significant, because they're asking for people to pay from $250 a year to 1,750 a year per item, and it's a fully dual eligible member. There's no excuse for this. So, I'm letting you guys know this isn't an issue, and I can talk off camera with somebody else in a more particular manner.

Diana Heineck:

But I've been dealing with this company now some time, I don't want to embarrass anybody, but there's some educational issues that are really. I can remember when we changed from worker's compensation a million years ago and implemented a 93 fee schedule went from CRVs and we had gap fill, and there was a lot of unhappy people, because we were telling people that used to bill $3,000 for MRIs, sorry, you're going to get 900 bucks. So there was growing pains then, and this is what you're going to have now. But my concern is people aren't going to get the help because they're going to be under the impression that they're due, they have to pay this, and don't, when they are dual eligible.

Anastasia Dodson:

Yes. That's a great example. I know we have been thinking about that also with regards to dental, because the balance billing prohibition applies to Medicare Part A and Part B benefits and services. And I know with hearing aids, there's maybe a little bit of complexity of what's covered by regular Part A and part B, versus what are additional benefits that Medicare Advantage plans.

Diana Heineck:

No, it's very clear that when Medicare and or when Medi-Cal covers it, you see that's the difference, that's what's changed. The law hasn't changed, the coverage has changed. That law has been in effect for a very long time. And I was aware when I was a billing manager, so that's what's changed. And they're trying to mix and match it to hand wave on it. That law hasn't changed. What's changed is now that Medi-Cal is allowing for that, now you can't go in and go, okay, guess what? Now we're going to balance bill you for the co-insurance. Now we have to accept that. And that's an issue, really, between the plan and the provider now, at this point. Only, they're just kicking and screaming, going, and I'm sorry, but that's growing pains. And what's unfortunate is some of these plants have a really generous benefit, several thousand dollars. I'm sorry, but if you can't get a decent pair of hearing aids for three, $4,000 for a disabled or elderly person, that's the whole reason we started Managed Care.

Anastasia Dodson:

Yeah.

Diana Heineck:

So, I'm concerned because I know that what I'm doing and I've been fighting it for months, and I bet there's people that really need that help and haven't been able to get it.

Anastasia Dodson:

Right.

Diana Heineck:

And I understand we need providers too. So, it’s a kind of bailiwick here. But should not be promoting that.

Anastasia Dodson:

Yeah. Thank you, Diana. So, I know Tatiana has a good point in the chat, and this issue is coming up even more in dental, but I could see also with hearing aids. So, we’re working on a fact sheet for dental benefits for dual eligibles, how to navigate for providers, and then thinking about for beneficiaries too. And so, we will next tackle the hearing aid issue because you’re right, it should not be so hard. Yeah.

Diana Heineck:

And I think I'd like to work on that ambassador program. Give me something else to do,

because frankly, now that I'm not working, I'm bored anyways.

Anastasia Dodson:
Well good. We can use your help. Absolutely.

Diana Heineck:
Thank you. I'd be happy too.

Anastasia Dodson:
Wonderful. Thank you.

Diana Heineck:
Thank you, everyone. Sorry I bothered your meeting.

Mary Russell:
Thanks, Diana.

Anastasia Dodson:
Glad to have you.

Mary Russell:
Great. Well thank you for those thoughts and those questions. I think Anastasia, at this time we should transition to the next slide and get into the Medicare and Medi-Cal plans in 2024 Expansion Counties.

Anastasia Dodson:
Okay, terrific. Good. So, this is, again, nothing brand new, but if you were not at the last meeting, or just as a refresher, we'll talk about the Medi-Medi Plans and what we're going to do for 2024. Next slide. So, people who have Medicare and Medi-Cal dual eligibles, as you all well know, often have high rates of chronic conditions, functional impairments, more likely to report being in poor health. So, we had a demonstration for a number of years, Cal MediConnect, and we transitioned that to a model that CMS is helping to support as far as a way to have a broader reach. We're calling them Medi-Medi Plans in California. It's again an integrated approach for dual eligibles. And these Medi-Medi Plans, they deliver all the Medicare and Medi-Cal Managed Care covered benefits to members, and they also coordinate for any other Medi-Cal benefits that are outside of the Medi-Cal Managed Care Plan, like dental or home and community-based services. Next slide.

Anastasia Dodson:
So, for these Medi-Medi Plans, again similar to the Cal MediConnect approach, there's a financial incentive for better care because one entity is financially responsible for both Medicare and Medi-Cal benefits, including skilled nursing facility care. It also incentivizes Community Supports for dual eligible beneficiaries. There are integrated

member materials, there's benefit coordination, unified plan benefit package, plan level integrated appeals, and integrated beneficiary and provider communication, as well as simplified care coordination across both Medicare and Medi-Cal benefits. Next slide.

Anastasia Dodson:

And then looking for 2023, we just, a couple of months ago, thanks to all the hard work of health plans, CMS, DHCS teams, we transitioned the Cal MediConnect members into Medi-Medi Plans in those seven counties, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. And in addition to the folks who transitioned there, those plans are open to new members, those Medi-Medi Plans. And we are, with all of you, working to enable those Medi-Medi Plans to be available in all the rest of California's counties by 2026. So, we have a multi-year plan to roll out the availability of these plans. Next slide.

Anastasia Dodson:

So, for 2024, which is the next contract year coming up, we are going to be expanding those Medi-Medi Plans in five counties, Fresno, Kings, Madeira, Sacramento, and Tulare. In those counties, the dual eligible beneficiaries then will have a new choice as far as integrated care, all of the D-SNPs and Medi-Cal plans in those counties, all the Medi-Medi Plans, they already have experience as Medi-Medi Plans in other counties. So, we have confidence in the technical processes that they will know how to, for the integrated materials, integrated call centers, having one card, integrated appeals and grievances, et cetera. All of that should be something that is, again, they're already successfully doing in other counties. But we know that it's still something new for providers and beneficiaries in those counties. So, we'll keep talking about this so people can become more familiar with this type of integrated care in those five counties.

Anastasia Dodson:

And then, so starting in the fall, for open enrollment, for 2024 on the Medicare side, that's when dual eligibles, in those counties, can select those plans. And again, you have to have both Part A and Part B to enroll in a Medi-Medi Plan. But we definitely have lessons learned and technical knowledge from the Cal MediConnect transition, so we'll make sure that, again, the technical pieces should work just fine. And it's really then about outreach providers, members, et cetera, community groups so that people know. And then it's really at people's option whether they want to enroll or not. But there's other choices. There's pace, of course, in some counties, in some regions, some zip codes, and then other Medicare Advantage plans, and there's original Medicare which anyone can select or remain in.

Anastasia Dodson:

All right. Next slide. So, this is a little update on the first one. So, these are numbers, enrollment numbers, for dual eligibles. As far as different types of Medicare Advantage or PACE programs for January. There were about 218,000 people enrolled in the Medi-Medi Plans in the seven counties in January. And that number, as of April, has gone up to 228,000. And again, there's still over 800,000 dual eligibles in regular Medicare,

original Medicare fee for service. So, we know that the options are many for dual eligibles as far as Medicare plans and integrated options, but people can certainly choose if that works best for them, for their providers, et cetera, to choose or stay in original Medicare. Next slide. Okay. Questions again?

Mary Russell:

Great. Yeah, so we've had some good questions added to the chat. So, a few that are relevant to Community Supports. Rick has asked what Community Supports are incentivized in the MMP plans? And then there's also a question about will covered Community Supports include assisted living, ADL care? I wonder if you want to share a little bit more on Community Supports.

Anastasia Dodson:

Sure. So yeah, how does it incentivize Community Supports? Because again, especially for skilled nursing facility care, so that and hospital care, they're both very expensive and managed care plans, D-SNPs, Medi-Medi Plans, they need to be mindful of quality ratings, respecting patients' wishes, but also, they need to think about the payments that they get, the capitation payments. And so, if there are less expensive services instead of a hospital stay, or a skilled nursing facility stay like Community Supports or other home and community-based services, those plans have an incentive to provide those less expensive services to avoid an ER visit or a hospital stay, or a skilled nursing facility stay.

Anastasia Dodson:

So, Community Supports and other home and community-based services are appealing to the health plans. Of course, they have medical criteria that they need to confirm and other eligibility criteria. But in general, the principle is that if there are less expensive services that can be provided to help people remain in the community at home and avoid a hospital or nursing home stay, they will look for that. And I'll just say, but it's really also in the choice in the hands of the members as well, because none of us is one size fits all. So, depending on someone's living situation, their medical home needs, family support, et cetera, all of those play a factor in what services they need and want.

Mary Russell:

Great, thank you. A few comments in the chat about enrollments and a note from Susan, with DaVita, noting that they've seen lower than anticipated uptake in their patient population and selecting a D-SNP plan when they are dual eligible. And curious if it would be due to marketing opportunities or additional DHCS thoughts on that. And also asking if there might be additional education for members or beneficiaries on these plans.

Anastasia Dodson:

Yeah, I don't know exactly what that may be about. It might depend on folks considering if there's certain providers that may or may not be in that plan network. It could be about just people being concerned about, okay, again, we know that having provider networks

set up and not abruptly changed, is very important to people with Medicare, all people with Medicare as well as people with Medicare and Medi-Cal. So I think, and others can certainly chime in the chat, but thinking about how to make sure that if there is a change, selecting a Medi-Medi Plan that the person is comfortable with the provider network and understanding if their providers are in that network, great, but they still maybe want to be in that plan. They don't mind changing providers because it offers additional benefits or care coordination. It's up to each individual to make that choice. And certainly, HICAPs and providers can help them think that through as well as the health plans.

Mary Russell:

Great. And a comment from Janine at Wellcare. Interested to understand if there have been any issues with the EAE matching plan policy and if the ombuds have any feedback there. Jack Dailey has added a little bit in the chat, but I'm wondering if either Janine or Jack, you'd like to come off mute and share a bit more on that. Feel free to raise a hand if you'd like to. And thank you, everyone. Some other interesting comments here in the chat, a question from Kevin Hamilton, will this group be eligible for all full scope Medi-Cal services?

Anastasia Dodson:

Right. People who are eligible for Medicare and Medi-Cal, Medicare pays first. So, if they go to the hospital, go to a doctor visit, Medicare pays first, and then Medi-Cal. There's a crossover billing process there. For CalAIM programs in Enhanced Care management, we're going to get to that a little bit later. If they're in a D-SNP or a Medi-Medi Plan, then it's actually that Medi-Medi Plan or D-SNP responsible for Enhanced Care Management. But most of, I think, for behavioral health, that's another complex area. We probably don't have time to walk through all the details here today, but in general, though, no one who is a dual eligible is missing out on anything that's available through Medi-Cal and CalAIM. Is it their D-SNP Medicare plan that might be providing it or is it their Medi-Cal plan? And there's a lot to untangle, and as we saw in the data, there's a lot of people who. There's different Medicare types of Medicare plans that folks are in and that can really drive some of the CalAIM pieces.

Mary Russell:

Great, thank you. And then looping back to the previous comment, Janine and Jack, you should be able to unmute at this time.

Janine Angel:

Sure. Thank you so much. I think maybe my question is if we have gotten some questions or concerns, specifically, how can the health plan support any of that? I know the noticing goes out from the state in terms of the member being reassigned to the matching plan. So, I guess maybe it's what is the concern and is that something that we on the Medicare side can do a better job in our communications, or in the materials or how do we help alleviate that confusion at all?

Anastasia Dodson:

Right. I see Jack has his hand up.

Jack Dailey:

Hi, thanks for unmuting me. Sorry about that. It is a great question, and just really generally, I think we certainly have continued to receive questions about matching plan policy. I think to respond to your direct question, and thank you for adding a little more clarification, I think, really important, is that all member services have consistent messaging about these matching plan policies and provide some real clear guidance regarding how this shouldn't impact folks' access to their providers. But that certainly referring folks over to the ombudsman, if they are having difficulty accessing a provider, if their providers are communicating something different to them about whether or not they can continue to work with them or not, I think is also really important as well.

Jack Dailey:

So, I think that the challenge that we found with some member services is that there's some inconsistent messaging out there about how the matching plan policy will work and what the implications are for consumers. And so, I think as long as we can all stay on message with regards to the implementation of that policy, the impact to consumers, what consumers' continuative care protections are, and how cross-claiming works. All these protections for consumers being messaged consistently, I think that messaging is really important.

Janine Angel:

Got it. Well, definitely, I can put a plug in for our member services teams to make sure that they're all messaging everything correctly. The one thing that I can tell everyone that we have experienced here is that we did have members who were matched, and they have the continuity of care to continue seeing those providers, but the challenge was that their Medi-Cal provider was not willing to accept the terms of the Medicare, the pricing. So, we weren't able to actually get a single case agreement with that provider.

Janine Angel:

It wasn't our health Medi-Cal provider, so we weren't able to come to an agreement. It was a different health plan that the member had for their Medi-Cal side. So, we ran into that, and I'm not sure if it warrants maybe some additional education to the Medi-Cal provider community that explains what are those rights that the member has. But the policy, it does depend on that provider willing to accept the Medicare rates for that 12 months or to get them contracted with us or whatever it is in our network. So that is one thing that we have come across that I just wanted to share on that note.

Anastasia Dodson:

Thanks, Janine. I think, and I do see more questions, and it sounds like lots of really important topics. One thing I am noticing from the chat is that there's a stream of people asking questions about fundamental or just general questions, and then there's a stream of people with more complex knowledge, more complex topics. So, I want to

bring it back to just making sure that people, the fundamental questions are getting answered here and then this topics about what can plans do, continuity of care. We can definitely take that back and talk with a smaller group of how to keep improving there.

Mary Russell:

Agree. And we've been tracking the discussion in the chat and some questions for follow-up. Anastasia, were there any that you wanted to address or I think we might be ready to transition to the next section?

Anastasia Dodson:

Yeah, let's just briefly, I want to acknowledge the points about CBAS and I want to emphasize that, yes, there were hangups, gaps, problems with getting the CBAS authorizations made, but as far as we know, with the transition to D-SNPs, and with the matching plan policy at the delegate level, et cetera, so we believe that the authorizations are caught up on CBAS, and we appreciate the collaborative discussions we've had with CBAS providers about those issues. And we certainly are thinking, as we look ahead to 2024, making sure that does not happen again. It is again, communication with DHCS and the health plans reminding them of that. And then again, we've been reminding all the Medi-Cal plans about CBAS because there are referrals that can be made to CBAS and with the turnover in staff, et cetera. So, I just definitely want to acknowledge the CBAS comments. And Mary, I see a lot of different things in the chat, but I know we have Mariya coming shortly.

Mary Russell:

Yeah, let's move to the next section, and we can continue to address these and also flag a few that we can take back and assist with after session.

Anastasia Dodson:

Okay. So, on this topic, some of the topics we've been talking about, Crossover Claims and Balance Billing. Just to briefly talk about the slides here. Next slide. So, most Medi-Cal beneficiaries, including duals, are enrolled in Medi-Cal Managed Care Plans. There was a recent transition, January and February, for dual eligibles in 31 counties, Central Valley and the Bay Area, to transition into Medi-Cal Managed Care enrollment. And we are still getting email inquiries from providers, members, et cetera, about this. So, I want to just read these slides and emphasize to everyone again that enrollment into a Medi-Cal Managed Care Plan, for a dual eligible, does not impact their Medicare provider access or their choice of original Medicare or Medicare Advantage. So, for someone who has Medicare and Medi-Cal, they can choose the Medicare delivery system that they want, original fee-for-service Medicare, regular Medicare or a Medicare Advantage plan, which includes a Medi-Medi Plan, a D-SNP, et cetera.

Anastasia Dodson:

And being in a Medi-Cal Managed Care Plan can be independent of that choice. So, if you've got original regular Medicare and you've been enrolled into a Medi-Cal Managed Care Plan, you can still keep your original Medicare and all of your Medicare providers

that you've been working with. Also, those Medicare providers do not need to be enrolled in the Medi-Cal plans to continue billing Medicare as usual. And we are still getting inquiries about this, so I really want to emphasize to Medicare providers, you can keep seeing your patients, even if they enroll in a Medi-Cal Managed Care Plan. Medicare providers can keep seeing their patients even if the patients enroll in a Medi-Cal Managed Care Plan.

Anastasia Dodson:

Medicare providers don't need to be enrolled in the Medi-Cal plan in order to submit a claim for crossover billing to the Medi-Cal plan. And that is something, again, it might sound contradictory because providers are used to needing to be enrolled in a health plan in order to submit a bill, but there is this special rule for Medicare providers, they can submit that crossover billing to a Medi-Cal plan, and they don't need to be an enrolled provider in that Medi-Cal plan. We have outreach materials and notices. Let's go to the next slide.

Anastasia Dodson:

And for the technical folks, again, this is the same slide we've used before for original fee-for-service Medicare. The provider, they bill the Medicare administrative contractor, that's known as Noridian, and then Noridian processes that claim for the Medicare payment and then forwards the claim automatically to the Medi-Cal plan for the secondary Medi-Cal payment. We have a way to upload information about people's Medi-Cal plans that gets to the Noridian folks. There may have been a lag the first few months of the year, but hopefully by now or in the next month, all the systems should be caught up. And then that secondary can automatically go to the Medi-Cal plan. For folks who are in some type of Medicare Advantage plan, including a D-SNP, the provider bills the MA plan for their Medicare payment. And then depending on if the Medi-Cal plan is the same or different from the Medicare plan, then the provider may need to send that secondary crossover billing to the Medi-Cal plan.

Anastasia Dodson:

Just depends on whether the Medi-Cal plan is the same as the Medicare plan, but that first scenario, original Medicare, fee-for-service Medicare providers, that's the one that we really think has been just new information for some providers. So, we want to continue to emphasize that. Next slide. And we do have a toolkit document that spells all of this out again and explains and lists the contact information for all the Medi-Cal plans for the crossover billing. So, if you hear of any providers that need this information, feel free to send them a link to that crossover billing toolkit.

Anastasia Dodson:

And we also have been communicating to the Medi-Cal plans that we want them to help members and providers with this transition and make sure that they're really explaining to their members and providers if they call about this, that again, there is an existing process that's been used in other counties, Los Angeles, the large Southern California counties, Santa Clara, San Mateo counties. So, it's not a brand new process, it's new

for some providers in some counties. I see folks are asking for the link for that crossover billing toolkit, and I'm sure that the Aurrera folks will put that in shortly. Good. Okay. Next slide.

Anastasia Dodson:

Balance billing. We talked about this earlier. Dual eligibles should never receive a bill for their Medicare Part A and Part B services. It's called improper billing or balance billing, and it's illegal. Beneficiaries should not be paying for doctor visits or other medical care when they get services from a provider in their MA network. Again, if you're in an MA plan or a D-SNP and you go to medical providers outside of that network, that's a different story. But if you're in any type of MA plan, you see the providers in your network, you should not get a bill if you're dual. And then if you're in Original Medicare, again, you should not get a bill for Part A or Part B services. Next slide. We've got so many different things, but I really want Mariya's discussion to get enough time.

Anastasia Dodson:

So quickly going to do some updates on our 2024 State Medicaid Agency Contract for D-SNPs. And there's a lot of terminology here, but I think we'll just go ahead and skip this slide. This is technical stuff. But the State Medicaid Agency Contract, that's the way that we put in the state's care coordination requirements for D-SNPs. So the new policies that we have for 2024, it's coming up, are that for Enhanced Care Management, we'll talk about that in just a sec, D-SNPs are essentially providing the same thing as Enhanced Care Management. We have a new requirement for them to provide palliative care and dementia care, and there was already dementia care requirements in the 2023 contract, but we're beefing those up, so to speak, for 2024.

Anastasia Dodson:

We shared some drafts with stakeholders of these contract documents. Next slide. So, we're working on responding to those comments. There's also a policy guide that is a companion to the SMAC contract. Next slide. The policy guide. We have just the first chapter posted for the 2024 policy guide, but we will keep updating those chapters and publishing them as needed. Next slide. Again, policy guide. I think you guys, those of you who are paying a lot of attention to all these details, you can look at that website link and see more about what is in the policy guide versus the SMAC. But again, the major changes that we are making for 2024 are around the palliative care, Enhanced Care Management and dementia care. Next slide. And Mary, I don't know if we have time for questions on this piece.

Mary Russell:

I wonder if we want to just continue to the next section and then we can capture questions at that point.

Anastasia Dodson:

Yeah. And again, I really, really appreciate the chat, everybody putting their questions there. And it's giving us important topics that we either need to convene ad hoc groups

or address in the next meeting. So, for palliative care, next slide. The main point I just want to get across is that palliative care is not the same as hospice, and it is based on the needs of the patient, not their prognosis. It can be appropriate at any age in any stage in serious illness. But palliative care is for people with serious illnesses. And again, hospice is well known, but palliative care, sometimes people think of it as just pain management, but it's much broader. It's about having a team of doctors, nurses, other specialists, who work together and provide an extra layer of support, and can help with all of the issues that come up when someone has a serious illness. Next slide.

Anastasia Dodson:

So, this is the criteria that we set up on the Medi-Cal side for palliative care. And we are using the same set of minimum criteria for D-SNPs for their palliative care programs. So, you can see on the slide, patient is likely to or has started using the hospital or emergency department to manage late stage disease. They're at a late stage of illness and they're either not eligible for or they decline hospice. Their death within a year would not be unexpected, based on their clinical status, and they are receiving appropriate, patient desired, medical therapy. So again, those are very important, complex topics that we developed several years ago based on a long stakeholder process, and based on many clinical experts. Next slide.

Anastasia Dodson:

And then these are additional requirements for the palliative care program so that the patient and family, they're willing to attempt in-home residential based or outpatient disease management, instead of first going to the emergency room. And they're willing to participate in advanced care planning discussions. There's also a more general and disease-specific criteria for certain conditions. And all of that information is in the program guide for palliative care for D-SNPs. So again, serious illness is an important time for a patient, for their providers, for their family. And so palliative care is meant to help support patients and families during those difficult times, and have a team-based approach to reduce suffering, help people navigate across all of the different complexities of serious illness. Next slide. Okay, there's the webpage with additional information. Next slide. So, we'll keep going. Next slide. Enhanced Care Management very briefly in Community Supports. So, I know we're shifting gears really fast here. Next slide.

Anastasia Dodson:

For Enhanced Care Management. That is a CalAIM Medi-Cal initiative. Next slide. It's intended to support comprehensive care management for members with complex needs that often engage several delivery systems, primary specialty care, dental, mental health, substance use disorders, and long-term services and supports. Next slide. And you'll see similarities here when we talk about Enhanced Care Management, it's very similar to the D-SNP model, to the Medi-Medi care model. So, when we look at the Enhanced Care Management program, there are populations of focus, there's definitions there, and you can see on the page for folks who are at risk of long-term care institutionalization, skilled nursing facilities, we develop these in conversation with all of you, these particular definitions. Next slide.

Anastasia Dodson:

And then there's another category of populations of focus for nursing facility residents transitioning to the community. So, the previous slide was people at risk, and then these are folks who are in nursing facilities who are interested in moving out of the institution and able to reside continuously in the community with specific definitions there. So, we know that these are two of the Enhanced Care Management populations of focus, and they are particularly relevant for people with disabilities, older adults, including dual eligibles. Next slide, Community Supports. Next slide. Those are services that the Medi-Cal plans are strongly encouraged, but not required, to provide as substitutes for other services or settings like the substitute for hospital and skilled nursing facility, and to avoid discharge delays or ED use. Different Medi-Cal plans offer different combinations of Community Supports.

Anastasia Dodson:

Next slide. And this is the list of the pre-approved DHCS Community Supports as part of CalAIM. Next slide. And when we think about members in long-term care populations of focus, there are particular Community Supports that can help them either stay at home or return to home community, the nursing facility transition and diversion to assisted living, transition to home, environmental accessibility adaptations, respite service, and personal care, and homemaker services. Next slide. So, this is just background, and for Mariya's discussion. Next slide. Good. Okay. So, we have a half an hour, I think, for Mariya's discussion. So, thank you all so much and hand it back to you, Mary.

Mary Russell:

Well, I actually wondered, I know we are going to pass the mic to Mariya in just a moment, but there were a couple questions that came up in the chat that we might want to just regroup on before we hand off. And I know some of them, we've been able to address or flag that we will take back via the inbox. There is an interesting question from Susan LaPadula related to the SMACs and also crossover billing guidance and checking in on the automation of crossover billing, and if that was able to be included in the SMACs for 2024.

Anastasia Dodson:

Okay, I think I see that. Did the automation of crossover billing contract language? I don't think so, but that is a great flag. Right. So, we will check back and see. Yeah, you're right, Susan. I know it's one of the topics on technical assistance that we have been talking to Medi-Cal plans and Medicare plans about, but great flag, should we put it in the SMAC and require it? Right.

Mary Russell:

Great. Okay. And I'm just browsing a few others or others feel free to raise a hand and we can unmute you, but thank you. Some really helpful input and discussion in the chat for today. All right. I think with that, I'll ask Mariya to come off mute. You should be able to unmute, and we're looking forward to your presentation today. Thank you for joining.

Mariya Kalina:

Great. Thank you so much. Mary, let me know if I should say next or just roll with the slides.

Mary Russell:

Sure, yeah, feel free to say next slide and we will facilitate for you.

Mariya Kalina:

Okay, fantastic. Well, I know this audience is very familiar with CalAIM, so I won't spend too much time on doing the background. I feel like Anastasia probably did a fantastic job of that before I was able to join. Just a couple of personal reflections that I wanted to share. Really, CalAIM is a monumental overhaul of care delivery in California. And for years the LTSS community and the health policy community have been in discussion about person-centered care and social determinants of health. And it's really an exciting time to see California take this ambitious leap forward, really taking that vision and making it something tangible. And at the same time, I just want to recognize that change is hard, and the bigger the change, the harder it is. So, there's absolutely going to be growing pains, but I think as long as we're working towards that common vision, as long as we're collaborating and communicating, I have absolutely no doubt that CalAIM will be successful.

Mariya Kalina:

The California Collaborative for Long-Term Services and Supports, by nature, is really interested in understanding how CalAIM will impact older and disabled Medi-Cal and dual legible adults. We know that for individuals with complex health and social needs, access to services and continuity of care is absolutely critical. So as California works to deliver on this promise of CalAIM, having mechanisms in place to monitor the rollout such as stakeholder groups and regional collaboratives and listening sessions, and probably much more than that, and then having mechanisms to be able to collaboratively address barriers, gaps, systemic challenges, all of that will really be vital to preserving the health and well-being of this vulnerable population.

Mariya Kalina:

So, the California Collaborative has partnered with Insure the Uninsured Project and Chapman Consulting, and with funding support from the California Health Care Foundation. We launched a monthly CalAIM listening sessions that are really aimed at creating a unique space for peer-to-peer connection and collaboration across the state. They're focused on identifying systemic challenges, and also best practices, sharing wins, sharing successes. And it's not entirely all about listening. I think that third prong is really about working with our state health plan and provider colleagues to elevate themes, to develop solution oriented recommendations, and lift up those successes that we hear.

Mariya Kalina:

So, we meet the last Thursday of every month from 10 to 11:00 AM. So far, we've only

had one session, but I think it was really interesting to hear some of the themes that came out of this first session we had. The first session we had was pretty well attended. We had a range of LTSS providers, including those that are currently engaged in CalAIM, as well as organizations that are still trying to feel their way around and see how do they really fit into this big picture, this big transition. We were joined by association representatives, hospitals, health plans, adult day healthcare centers, advocate groups from across the states. And what we heard was three pretty clear themes that emerged during the conversation. One is the need for clear transparent communication. As CalAIM implementation continues, clear and open communication among managed care partners is critical to ensuring success and well-being for older adults and dual eligible populations.

Mariya Kalina:

And lack of clear and timely communication, information, and notification of changes has resulted in disruption to continuity of care. And then adding to this complexity, challenges faced by key health stakeholders vary by provider type. So that further contributes to the lack of transparency in communication channels. As Medi-Cal Managed Care Plans extend their reach into more diverse set of community providers, it'll be vital to establish clear conduits of communication, from both the managed care partners to providers, and from DHCS to stakeholders, to ensure there's access to updated guidance and information and consistent messaging on what the expectations are for plans and providers alike.

Mariya Kalina:

The second theme that we spent quite a bit of time discussing is difficulty navigating care coordination because of inaccessible information. And this one really for me strikes right at that core of data conversations that have been taking place. We heard about hospitals and other Enhanced Care Management and Community Supports, providers, that are experiencing significant difficulties in identifying which individuals are associated with which managed care plan, whether they're accessing Enhanced Care Management services, who the ECM provider is, what other services are they connected to, that big picture of what kind of care they are getting and where. And this lack of a centralized database and source of information has resulted in immense challenges in navigating Medi-Cal members to the correct resources. So based on the discussion, we do believe that clarity on what the criteria is for access to certain services, what areas of the criteria are standardized, what areas of the criteria for access are at the discretion of managed care plans would be helpful in easing this transition and coordination amongst various entities.

Mariya Kalina:

And the third theme that emerged was lack of support for non-health CBOs. There are many non-traditional healthcare providers and community-based organizations that are facing obstacles in being included and integrated into CalAIM as part of the healthcare delivery system. We heard from several community-based organizations that shared and expressed that the contracts, the questions, the agreements that are currently being used are really designed for the medical healthcare community, and are designed

through that lens, that leaves social services and other non-traditional healthcare CBOs challenged with confusing and exhaustive administrative work. So, without being fully integrated into the system, these community-based organizations are essentially unable to access funds and are left with minimal supports and resources. Many have voiced concerns about the need for relationship building as they require investment and time to curate over time. So, we really look forward to continuing these discussions, and digging in a little bit deeper to gain a full understanding of exactly how CalAIM implementation is impacting our providers, our plans, and our consumers alike.

Mariya Kalina:

Our next meeting is scheduled for this upcoming Thursday, April 27th. I guess that's next Thursday from 10 to 11. And we're really hoping to continue to explore these topics, again, dig a little deeper and catch up on other topics as they emerge. These sessions are scheduled through August, and then at that point we're going to reassess the frequency need and format. But all are welcome. I'm happy to share the link with Mary and maybe she can share it out with you all if you'd like to join these conversations, and just listen in or participate, just an open call for that. So, Mary, I think I will pass it off to you to facilitate questions.

Mary Russell:

Thank you so much. That was so helpful, and I know there's a lot of excitement around this. We already had that question in the chat about how people could join or register, so feel free to drop that link in the chat or send it to us and we can also circulate it. Any other questions for Mariya or Anastasia that you want to-

Anastasia Dodson:

I'll just jump in quickly for the item number two about confusion about which Medi-Cal plans people are enrolled in. And thank you for flagging that. So, we are looking at changes to our AVES system, that some providers use to find out which Medi-Cal plans people are in. There may have been some lags in the updates or there may have been issues with Medi-Medi Plans showing up correctly in the AVESsystem. So anyway, duly noted and thank you for that.

Mary Russell:

Great. Other questions or comments for Mariya? Thank you again for that presentation, and appreciate the link in the chat for others to sign up.

Mariya Kalina:

Absolutely. We'd love to see you all there. Thanks everybody.

Mary Russell:

Thanks so much. All right, well thank you all to our speakers today for the wonderful presentations and for this great discussion. I know there were a number of questions that we will plan to take back and we're able to discuss today. And wanted to remind everyone that the next MLTSS and Duals Integration meeting will be in June on

Thursday, June 22nd at 10:00 AM and we'll provide a registration link in the chat. Anastasia, any thoughts to close us out for today?

Anastasia Dodson:

Right, I was thinking that the Mariya discussion might be a little bit longer, so if there's anything else from the chat that is really pressing, I just want to scroll through and see. Again, back to that, how do people know which Medi-Cal plan someone is enrolled in? That should be in the AVES system, but if there's others, and there's definitely some known issues there. But if you have suggestions, comments about that, feel free to put them in the chat. And Mary, are there any other hot topics in the chat that we should look at?

Mary Russell:

I think it was great to cover that CBAS item that you shared a bit more about. I wondered if you wanted to loop back on Julianne's comment from Blue Shield about the HCO choice form as a result of the matching plan, and that is causing some provider selection or change issues because they need to enter provider IDs on the Medi-Cal choice form. So, thank you Julianne for flagging that for additional conversation. I'm not sure if we have the right people on today.

Anastasia Dodson:

Right. Yes. Definitely, we'll take that back and look into it.

Mary Russell:

Yeah. And we do have some raised hands. Rick, would you like to come off mute and ask a question?

Rick Hodgkins:

Can you hear me?

Mary Russell:

Yes.

Rick Hodgkins:

I turned my video on so you can also see me. For people that have anxiety about going to the dentist, particularly if they have to get dental work done, whether it's a filling or any more serious dental work done. This is particularly the case, people like myself in the IDD community. My dental plan, Liberty Dental, that while they offer Smile Time Dental, that where I will go starting next month, that while they offer things like conscious sedation, while they offer things like this, it is not covered and has to be paid out of pocket. I had a question in the chat about the dental managed care plans should cover this rather than having us pay out of pocket, the other thing I said in the chat earlier on is that when it comes to people with disabilities of working age, up to age 26, even though Congress is trying to raise the age, but that you still have to be born with a

disability.

Rick Hodgkins:

And that is that in order for you not to lose your Medi-Cal and still work, you have to apply for what is called a CalABLE, and CalABLE is an abbreviation for California Achieving a Better Life Experience. So, in order for you not to lose your Medi-Cal, if you were born with a disability, you have to apply for a CalABLE account and ABLE is nationwide, although each state, each and every state has their own ABLE, program and there are some strings attached. I have an ABLE. When I started working, I applied for an ABLE program. It allows you to keep your Medi-Cal IHSS and in the like, and even though I don't get SSI anymore, I received SSDI, but I have it so I can keep my IHSS and housing and whatnot. But it allows you to keep those benefits and continue to work so you can save for the future, and take vacations, and buy a home and whatnot. So, thank you.

Anastasia Dodson:

Thank you so much, Rick. Yeah, and I think it would be an interesting topic for the future to consider how does the change in the asset limit intersect with capable accounts? And so great point. Thank you.

Mary Russell:

Thanks so much Rick. And I see Tatiana has a hand raise as well. Would you like to go ahead?

Tatiana Fassieux:

Yes. Hi, can you hear me?

Mary Russell:

Yes, we can.

Tatiana Fassieux:

Okay, great. Yes, regarding the question of how does one know what plan the beneficiaries in as far as the Medi-Cal plan, the 1800 Medicare CSR, if there is a crossover from the Medi-Cal plan to the Medicare, whether it be fee-for-service or managed care Medicare, they do have that information. So, for those that do not have access to the Medi-Cal system, we had HICAP, for example, do call the 1800 Medicare back door because we have access to the backdoor and they can tell us which Medi-Cal plan that individual is in.

Anastasia Dodson:

What a great point, Tatiana. Thank you.

Tatiana Fassieux:

Thank you.

Mary Russell:

Thank you for that. Other questions or comments? I don't see any other hands raised at this time.

Anastasia Dodson:

Well, we certainly have some good homework, and I don't mean to minimize it. It's very important issues and things that we can work on both in separate groups, and then for our next meeting, back to hearing the point about hearing aids, crossover billing, balance billing there, as well as comments that Rick made about dental and folks in the chat. Reminder to folks about CBAS, and the availability, and to make sure that the plans are getting the billing and coordination correct there. Looking at automation of crossover billing and the SMAC. And again, just thinking about ways that we can improve our systems that providers use to look at, to find out which Medi-Cal plans folks are enrolled in. So, we will keep working away at these pieces and really appreciate your partnership. We can't do it without you at all. So really appreciate the collaboration.

Mary Russell:

Agree. Thank you all so much and thanks for joining today. Have a good afternoon.