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

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

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**SPEAKERS**

Mary Russell
Anastasia Dodson
Bambi Cisneros
Jillian Davis
Sara McDonald
Stephanie Conde
Derek Soiu
Bonnie Tran
Mariya Kalina

Mary Russell:

Well, good afternoon. Welcome to today's CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup. Thank you all for joining. This is Mary Russell with Aurrera Health Group supporting DHCS. And we have some great presenters with us today. Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS. Bambi Cisneros, Assistant Deputy Director in the Health Care Delivery Systems Division at DHCS. Stephanie Conde from the Managed Care Operations Division at DHCS. Jillian Davis and Sara McDonald with the Medi-Cal Eligibility Division at DHCS. Derek Soiu and Bonnie Tran with the Medi-Cal Eligibility Division at DHCS. And Mariya Kalina, who is the Executive Director of the California Collaborative for Long-Term Services and Supports. Thank you all for being here. A few meeting management items to note before we begin. All participants will be on mute during the presentation.

Mary Russell:

As a reminder, the monthly MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions. We'll just ask that for today, the plans that join these calls hold their questions for the other workgroup venues they have with the Department throughout the month. Please feel free to submit any questions you have for the speakers via the chat. And during the discussion, if you'd like to ask a question and or provide comments or feedback, please use the raise hand function and we will unmute you. The PowerPoint slides and all meeting materials will be available on the DHCS website in the next couple of days, and we'll provide a link to where those materials will be posted in the Zoom chat.

Mary Russell:

Next slide, please. Before we jump in, we'll ask that you take a minute to add your organization's name to your Zoom name so that it appears as your name dash organization. You can do this by clicking on the "Participants" icon at the bottom of the window. Hover over your name and the "Participants" list on the right side of the Zoom window. Click "More" and select "Rename" from the drop-down menu and enter your name and organization as you would like it to appear.

Mary Russell:

And let's take a quick look at the agenda, which is pretty packed for today. We'll begin today's meeting with an update on the 2024 Medi-Cal transitions with some time for stakeholder Q&A. After that, we'll hear a brief update on the continuous coverage unwinding, then a few reminders and updates on the Dual-Eligible Special Needs Plan policies. Following that, there'll be a brief update on outreach and collateral materials for Medi-Medi Plans. In the next section, we'll hear an update about Enhanced Care Management, Community Supports, and Long-Term Services and Supports dashboard data. And we'll also hear an update on end stage renal disease Medicare enrollment outreach. Then we'll hear a report out from Mariya on the second and third listening sessions that the California Collaborative held at the end of June and July. And finally,

we'll wrap up with some information on upcoming meetings and next steps. Thank you all for joining. For now, I'll hand it over to Anastasia Dodson.

Anastasia Dodson:

Thank you so much, Mary. A packed agenda, but there is a lot going on. And of course, there's so much that we gain from the conversations and dialogue that we get with you all in this meeting. Just a reminder, what is this particular stakeholder meeting? We designed it as a stakeholder collaboration hub for CalAIM Managed Long-Term Services and Supports and integrated care for duals. We want your feedback. We have a charter. We really value the partnership that we have with everyone. And again, this forum is super valuable for us. Next slide.

Anastasia Dodson:

For 2023, these are the topics that we have been focusing on. At our next meeting, we'll probably have a preview of what we intend to focus on in 2024, but then again, in collaboration with you all. And it's not a one and done. Many of these topics, we start working on, we get feedback, we make some iterations, and then we check in with you all again. Some of these topics, we'll keep going, but again, just for 2023, these are the key areas that we've been working on, and we do have data. Really pleased to be sharing data with you all today, and again, want your feedback. Next slide.

Anastasia Dodson:

We're going to start with the transitions that we have for 2024. And I'll hand it back to Mary and the great team we have.

Mary Russell:

Great. Thank you. We'll start looking at 2024 transitions impacting dual-eligible beneficiaries with an update from Bambi Cisneros, Assistant Deputy Director in the Health Care Delivery Systems, on the intermediate care facility carve-in and subacute carve-in. Thanks for being here today, Bambi. I'll hand it over to you.

Bambi Cisneros:

Great. Thank you, Mary, and thank you, Anastasia. Thanks for having me on this call this afternoon. And so, what I wanted to cover were two upcoming transitions that are happening in managed care on January 1st, 2024, when it comes to the long-term care transition. And so, we'll go through that in the slides.

Bambi Cisneros:

When we say long-term care carve-in, we're really thinking about three kind of sets of benefits. The first one was about skilled nursing facilities, and that has transitioned to be a managed care plan responsibility on January 1st, 2023. That has occurred. And we did release an All Plan Letter, APL 23-004, linked on the slide, in March to give guidance to the managed care plans on implementing that benefit. And what I'll cover for this topic today is about two upcoming transitions occurring in January. And one has to do with intermediate care facilities for developmentally disabled as well as the

habilitation portion of the ICF/DDs and nursing, so ICF/DD, ICF/DD-H, and ICF/DD-N.

Bambi Cisneros:

We have convened a stakeholder workgroup to talk about policy development specific to this population. And one of the outcomes of that was an All Plan Letter which we released on August 18th specific to the ICF/DD carve-in. And then the other or the third part of the long-term care carve-in that's occurring is going to be for subacute care facilities, so adult and pediatric subacute care facilities, which is also occurring in January. And so, as we talk through these and go through the slides, really the carve-in really means that Medi-Cal members will need to be mandatorily enrolled in managed care, residing in the ICF/DD homes and subacute care facilities. And we'll talk about member protections and notification. And so, we just want to make sure that the information is out there about these transitions that are happening and then the policies surrounding these two carve-ins. We can go to the next slide, please.

Bambi Cisneros:

The long-term care carve-in goal is really to standardize benefits and coverage under managed care across the state. We have various plan model types within California. And currently, there's different benefits offerings, depending on the plan model type. And so, what this carve-in is really intended to do is to make sure that no matter where the member goes or where they live, whichever county in the state, that their benefit coverage would be the same. And it helps the Department with that administrative oversight as well, having that same benefit structure across the board. And so, we are really aiming to have this transition be as seamless as possible. And so, one of our top line goals is to ensure that members don't experience any disruptions in access to care or services. And so, we are going to be working closely with our managed care plans to make sure that they are understanding these policies and are forming the relationships with these new provider types as well as we continue on in this work.

Bambi Cisneros:

One thing I wanted to note, and we'll dive into the ICF/DD policy particularly, is that for ICF/DD homes particularly, there's some existing infrastructure in place when it comes to their interactions with the regional centers and the ICF/DD home model itself for individuals with developmental disabilities. And so wanted to just say upfront that that will stay the same. And so, this includes the Lanterman Act protections and the roles and responsibilities of the regional centers as it exists today.

Bambi Cisneros:

We can dive onto the next. And we can go onto the next. Thank you. First, we'll go through the ICF/DD carve-in and talking about what is an ICF/DD home. And so, you may have heard of ICF/DD homes as facilities, but they really are more homes. They're typically located in a residential neighborhood and have four to six beds and it's where someone lives. And typically, they live there for quite a long time. And so, what this living option does is provide 24-hour care, specialized habilitation, developmental and supportive health services for those individuals that are referred from the regional

centers.

Bambi Cisneros:

Go to the next slide, please. As I have mentioned, the regional centers do play a key role for individuals with developmental disabilities, and that is established in the Lanterman Act. There are 21 regional centers that are serving approximately 400,000 individuals with developmental disabilities throughout California. And then after ICF/DD services are carved into managed care, regional centers will continue to perform the functions they do today. You'll see this as a depiction on the slide, which includes intake and assessment. They do eligibility determinations, case management, developing individual program plans, or IPPs, and also purchasing other necessary services and supports. And so that's what the regional centers do today, and they'll continue to do that even after the carve-in, the ICF/DD carve-in happens in managed care. And so, per the Lanterman Act and Department of Developmental Services, the regional centers, they do this person-centered planning in IPP and then they work with the individual and the home to determine placement because one of the utmost provisions of Lanterman Act is that where the member resides is really upon individual choice and preserving that choice.

Bambi Cisneros:

And so, once a member is enrolled in a managed care plan, they will still have the same relationship with their regional center who will continue to develop their IPPs as they do today.

Bambi Cisneros:

Go to the next slide, please. Thank you. In terms of authorizations, so to preserve the regional center's role as determined by the Lanterman Act, the regional center, along with the attending physician there, is responsible for making the determination for the member to be admitted or continue to stay in the home. Then managed care plans are then to use that determination and recommendation that's already been made by the regional center to then authorize the services in an ICF/DD home. Really, this is not going to be a change to services, but a change in payment. The ICF/DD homes today, they send their claims and invoices to fee-for-service Medi-Cal.

Bambi Cisneros:

And then after January 1st, 2024, that will be sent to the managed care plans for payment, after January 1st. And authorizations per regulations are up to two years. And historical claims information show that services generally stay the same for that duration. And then for services that are outside of the ICF/DD per diem rate, managed care plans are required to authorize the request for services for 90 days after the member's enrolled in the plan or until their reassessment is completed. Can we go on to the next slide, please?

Bambi Cisneros:

As mentioned, the regional centers will make the eligibility determinations for ICF/DD

home services and then they will submit the referral packet to the ICF/DD home for review. And so, after the home receives a referral, the home will then complete and submit the documents that are required for authorization to the member's managed care plan. And so, our goal is really to use the authorization forms that are used today, which is listed here on this slide. And the guidance that we have issued to the managed care plans is that they must accept these forms as evidence of the regional center's determination that the member meets the ICF/DD home level of care because the idea is it was per member choice to have the IPP developed along with the regional center and the regional center's physician has made the determination that would be the appropriate level of care. And so, we just wanted to honor that.

Bambi Cisneros:

Go to the next slide, please. Thank you. And one of the member protections for this transition is continuity of care. The Lanterman Act provides for the member's right to choose their living arrangement. And so, in alignment with this, we established continuity of care requirements for managed care plans so that members can stay in their home automatically for at least 12 months while the managed care plans work to bring their ICF/DD homes in-network. And so, this protection is automatic and does not require any action from the member or the representative. And if the home still does not have a contract with the member's managed care plan after that initial continuity care period, there is an option to request an additional 12 months. But, that second 12-month period, the member and or the representative will be the one to request that continuity of care.

Bambi Cisneros:

The automatic provision is for the first 12 months, and the additional 12 months is going to be per member request. And so, this continuity of care protection is for the member to stay in their home, but there's also continuity of care for services. And so, this may require switching to the managed care plan's in-network provider to continue receiving these services, but the goal is that members will still have access to those services. And examples of those services are non-emergency medical transportation, non-medical transportation, and care coordination. Members will still continue to receive those services under the plan.

Bambi Cisneros:

You can go to the next slide, please. Thank you. To provide members information about the transition of ICF/DD services to managed care, DHCS will be mailing out notices to members starting in November and we will be publishing our notices on the DHCS website as well. And so, we will be sending these notices to the member as well as if the member has an authorized representative on file within MEDS, which is the Medi-Cal Eligibility Data System, then we would be sending notices to their authorized representative as well. And so, these notices will provide information about the transition, information about managed care plans and the services that they provide and include a contact with questions.

Bambi Cisneros:

And then within the letter, there will be a link to a Notice of Additional Information that has a little bit more detail. It's in a question and answer format on just the carve-in, working with the plan, and things of that nature. And so, we will also be posting that on our website as well. And then lastly, Health Care Options. We'll be conducting a member call campaign from November to January 2024. We just want to make sure that members are receiving this information, and hopefully they would get their member notices, but I think the call campaign would help bolster and make sure that members are getting the required information for this transition.

Bambi Cisneros:

We can go to the next slide, please. And so, we just talked about the member information. We do also have several upcoming webinars to further inform and educate the homes, regional centers, and managed care plans about the transition. And so, we have, between now until December, a slew of topic focused and open office hours to be able to answer some questions, provide technical assistance. And so, although this is kind of directed to the homes, regional centers, and managed care plans, they are open to the public as well. And we will be posting the meeting materials on our website. We do highly encourage you to join to keep abreast of the latest information.

Bambi Cisneros:

Next slide, please. Next, we will transition to talking about the subacute care carve-in, which is also occurring on January 1st. And so, we can go to the next slide, please. Here we talk about subacute care as a level of care for individuals that are medically fragile and require special services, and just that it typically requires a longer length of stay than at a skilled nursing facility. Go to the next slide, please. Here on the slide, we have an outline of the All Plan Letter, or APL, guidance that we have sent out for public comment in late June that we are finalizing based on stakeholder feedback received. And so, if you are familiar with the skilled nursing facility All Plan Letter, you'll note that most of the policies in the subacute care APL are mainly near the same policies that were in the skilled nursing facility APL, which is APL 23-004. And so, we don't have an APL number for the subacute care policy APL. We're still working on finalizing that, but we'll be posting that once it's final.

Bambi Cisneros:

Go to the next slide, please. In terms of benefit requirements, there are sections of the All Plan Letter that talks about the adult and pediatric subacute care services, the plan's responsibility for pharmacy benefits, as most pharmacy benefits are carved out to Medi-Cal Rx, and then the coverage of additional non-long-term care medically necessary services, so things like case management, care coordination, et cetera. And so, in terms of the provision of services, managed care plans are required to cover all medically necessary services for members that are residing in or getting care in a subacute care facility, which includes facility services, professional services, and ancillary services. And then of course, as managed care plans do, they also provide the appropriate level of care coordination, including for carved out Medi-Cal services.

Bambi Cisneros:

The next slide, please. Thank you. Similar to ICF/DD homes, we have put into place continuity of care protections for subacute care facility, for the transition for the subacute care facilities. And so, similarly, for a member to stay in the facility, continuity of care is automatic, so the member doesn't need to request it. And then after the 12 months, members or their authorized representative may request an additional 12 months.

Bambi Cisneros:

Moving on to member notices. Again, similar to the ICF/DD transition, the Department will be sending 60 and 30-day notices to members to explain the transition to managed care, member options, and continuity of care for residents. And so, these notices explain what changes are happening, the transition to mandatory managed care, information on managed care plans, and contact information on health plan options, and then the choice process. And again, similar to the ICF/DD home notices, if we have an authorized representative on file within MEDS, we will also be mailing the notices to the member's authorized representative.

Bambi Cisneros:

And again, similar to the ICF/DD notices, the notices will also include links and the QR code that takes you to an online version of the Notice of Additional Information, again, is a document that has a lot more detailed information about the transition, plan choice, continuity of care, and things of that nature. And so, we will be posting the notices and the Notice of Additional Information on our website as well. That's a really good source of information.

Bambi Cisneros:

Go to the next slide, please. We also have some upcoming webinars that will be open to the public for the subacute care transition. And again, though it's targeted towards managed care plans and subacute care facility providers, they are open to the public, so would highly encourage you to join. And so, we will be posting information on how to register for these webinars on the subacute care facilities carve-in webpage that we're working to develop. We'll have that available soon.

Bambi Cisneros:

Go to the next slide, please. And then the last thing I want to cover, which will apply to all of the long-term care transitions, so skilled nursing facility, ICF/DD homes, and the subacute care facilities, we have asked plans to have an identified LTSS, or Long-Term Services and Supports, liaison. And so, we see this individual to be a single point of contact for providers in the LTSS community. And so, the idea is that the liaison is well versed in the long-term care policies, and they can help address claims and payment inquiries as well as care transitions for what the member needs. And so, we have worked on gathering that information from the managed care plans but are asking the plans to then share that information with their network providers, and then of course, keep that information updated and maintained when there are changes to their identified LTSS liaison. And I think that takes me through all of the slides, so I will pause here.

And Mary, should I turn it back to you?

Mary Russell:

Thanks so much, Bambi. Yep. Anastasia's going to jump in here next for this next section.

Anastasia Dodson:

Great. And then we do have 15 minutes for all these sections in the first hour, we'll have 15 minutes for questions. Very brief slide, and then I'm going to keep going. Next slide. Just to flag everyone at a future meeting, we do want to talk about the impact of the Medi-Cal targeted provider rate increase on Medicare crossover claim payments for the Medicare providers who are serving dual-eligible patients. We know that this can be kind of a complicated area, and its good news for those providers, but we want to walk through what that means and hope that all of you, as you learn about it, can help us get the word out to Medicare providers on the impact of the Medi-Cal rate increase for Medicare providers serving dual-eligible. That's a little teaser. Sorry, we're not going to go into detail today. But next slide.

Anastasia Dodson:

Another, just brief update, and then we're going to get into some more substantive stuff. You all, I believe, are pretty familiar. We've talked about the Medi-Cal matching plan policy that is currently in 12 counties. We know that people's Medicare is really their primary health care when they're dually eligible. And so, if they choose to be enrolled in an MA plan, then they will automatically be enrolled into the matching Medi-Cal plan, if there is one, in those 12 counties that are listed on the slide there. Again, Medicare is the lead.

Anastasia Dodson:

The update here is that in 2024, we're going to be updating our logic in our systems for Medi-Cal plan assignment to add Kings, Madera, and Tulare counties. Again, if someone chooses an MA plan in those counties, and there is a corresponding Medi-Cal plan in the same parent organization, then their Medi-Cal plan will match their Medicare plan for better coordination. And that's part of also having our Medi-Medi plans available in the five counties in 2024. Fresno, Kings, Madera, Sacramento, and Tulare counties. And Fresno and Sacramento were already part of the matching plan policy.

Anastasia Dodson:

Let's go to the next slide. We're going to hand it off to our eligibility colleagues. And again, we'll have 15 minutes for all these sections for questions, so we'll get to the questions, for sure.

Jillian Davis:

Hi, everyone. Jillian Davis from Medi-Cal Eligibility. I'm going to give a couple updates on a couple of our expansions. The first one is the Older Adult Expansion. It was launched on May 1st, 2022. The initiative extended full scope Medi-Cal benefits to

California residents who are aged 50 or above regardless of their immigration status so long as they satisfied all other Medi-Cal eligibility criteria. This policy expansion ensured that California's growing population of older adults can access the health care services they need. On the rollout date, DHCS transitioned 247,522 individuals from restricted scope Medi-Cal to full scope Medi-Cal. These policy changes were effective from May 1, 2022. As of June 2023 month of eligibility, the expansion has had notable success with over 362,500 individuals now receiving full scope benefits. For more information on the Older Adult Expansion, you can find policy guidance in ACWDL 21-13. There's also additional information and resources available on the DHCS Older Adult Expansion webpage. And both of those links are in the PowerPoint. Next slide, please.

Jillian Davis:

The next expansion is the age 26-49 Adult Expansion. We also refer to this as the Adult Expansion. It is set to implement on January 1, 2024. This initiative will extend full scope Medi-Cal to all California residents irrespective of their immigration status, provided that they meet all other Medi-Cal eligibility criteria. This expansion represents a significant move towards inclusive health care, making full scope Medi-Cal coverage accessible to all eligible Californians.

Jillian Davis:

Estimates from the Governor's 2022 to 2023 budget projected that the Adult Expansion population will benefit approximately 707,000 individuals. For comprehensive policy guidance concerning this expansion, you can go to ACWDL 23-08, then the link is here. DHCS recently published the eligibility and enrollment plan on the adult expansion webpage. The plan includes a general information outreach notice, the notice of action snippets, managed care enrollment notices, and an FAQ.

Jillian Davis:

DHCS will be hosting a webinar specific to the adult expansion on October 3rd. Registration information will be posted on the Adult Expansion webpage in the coming weeks, and I did go ahead and link that in the PowerPoint as well. That is all I have.

Mary Russell:

Thanks so much, Jillian. I believe next we are going to transition to Stephanie Conde. Oh wait, I'm sorry. Go ahead Stephanie.

Stephanie Conde:

Afternoon. Do we have one more presenter prior to me?

Mary Russell:

Yep. I was just about to say, I'm sorry. Sarah, are you ready to jump in on this one?

Sara McDonald:

Yes.

Mary Russell:
Thank you.

Sara McDonald:
Hi everyone. My name is Sara McDonald from Medi-Cal Eligibility and I'm going to present quickly on the asset limit increase and elimination for non-MAGI programs. So, our Assembly Bill 133 was signed into law by the Governor on July 27, 2021. And this included a two-phased approach to eliminating the asset test that is used to determine eligibility for non-MAGI Medi-Cal programs. So, the first phase of this implementation went into effect on July 1st, 2022. This phase increased asset limits to $130,000 per individual and an additional $65,000 for each additional household member up until 10 members.

Sara McDonald:
Previous limits were $2,000 for one person, $3,000 for two people, and then an additional $150 for each additional household member. So, this increase does apply to all non-MAGI Medi-Cal programs, which includes our long-term care population and Medicare savings programs. Next slide please.

Sara McDonald:
On July 14th of this year, the Federal Centers for Medicare and Medicaid Services approved our State Plan Amendment to completely eliminate the asset test, which was phase two of AB 133. Phase two is scheduled to implement on January 1st, 2024. So, this phase will completely eliminate the asset test entirely for non-MAGI programs, again, including our Long-Term Care Population and Medicare Savings Programs. And that is all I have, so I'll turn it back to you. Thank you.

Stephanie Conde:
Good afternoon, Mary. I can just jump in. This is Stephanie Conde with Managed Care Operations Division. We're going to transition back over to Medi-Cal Managed Care transition for 2024. We will do a quick overview and then I'll go into member enrollment, including some information on our exiting plan enrollment freezes, and then our noticing that we will be sending out to our members. And then finally, I'll get into an overall noticing timeline, which goes into the notices that are going out from the transition I'm presenting on, and then a few of the other transitions that folks covered today already. Next slide please.

Stephanie Conde:
Okay. So overall, DHCS is transforming Medi-Cal Managed Care through multiple channels. So, we have these three main buckets. One is the new commercial managed care plan mix. This is the contracts with commercial managed care plans announced in December of 2022. Operational readiness process is underway and has been since the beginning of this year. The second channel is our model change in sub-counties. So, in 17 of our counties, we're changing to a new managed care model type. This does include a new single plan model and our COHS expansion counties. And then last is our

direct contract in 32 counties with Kaiser Permanente.

Stephanie Conde:

And then just to note, we restructured our contract. It is more robust, and it's implemented across all of our plans in all these model types that either are existing or new. Next slide please. This transition does impact approximately 1,200,000 members who could be having to choose a new plan effective January 1, 2024. And this is just a little snapshot of the unique plans in counties where there is a transition or impact.

Stephanie Conde:

Next slide please. So, the MCP transition principles. DHCS is applying the following principles to guide the planning, implementation, and oversight of the 2024 transition. We are planning for a smooth and effective transition, minimize service interruptions for our members, especially for vulnerable groups, most at risk for harm from interruptions in care, provide outreach education and clear communications to members, providers, managed care plans and other stakeholders. And then proactively monitor our managed care plans implementation of the transition responsibilities. Next slide please.

Stephanie Conde:

So, getting into a little bit of the policy and process for our exiting managed care plans. So, I'll first cover our choice counties. So that does include our GMC, Two-Plan, and regional models. Members enrolled in a managed care plan that will continue to operate in 2024 will remain in their managed care plan unless they do opt to change their managed care plans as they're allowed to do today.

Stephanie Conde:

Mandatory managed care members enrolled in exiting a managed care plan will need to enroll in a new managed care plan. Our dual eligible members and Medi-Cal Matching Plan counties will be automatically enrolled in a Medi-Cal Managed Care Plan that matches their Medicare Advantage plan where relevant. This speaks to a little bit of what Anastasia covered a few slides previously.

Stephanie Conde:

Other exiting managed care plan members will receive a 90, 60 and 30-day notice and a choice packet with their 60-day notice default assignment. If a member does not make an active choice, they will be enrolled in a managed care plan based on the following assignment hierarchy. First, provider linkage, plan linkage and family linkage. Absent members meeting the linkage criteria, their default managed care plan will be based on an auto assignment in such a program algorithm, which does include quality and other adjustments to an annually defined ratio for auto assignment among managed care plans in each county.

Stephanie Conde:

In our COHS and Single Plan counties, the right-hand side, right-hand box, members enrolled in a continuing managed care plan. For example, Alameda Alliance for Health

or Contra Costa Health Plan or Kaiser will remain in their managed care plan. Members enrolled in an exiting managed care plan will be automatically enrolled either into a COHS, Single Plan, or Kaiser where applicable. Kaiser will receive a default assignment for exiting managed care plan members in our COHS and Single Plan counties where it participates on the basis of plan and family linkage. And then of course, our Medi-Cal Matching Plan policy. Again, where applicable. Next slide please.

Stephanie Conde:

The new enrollment freeze for exiting managed care plans. We will stop new enrollment in exiting managed care plans both for active choice and to default assignment, three months prior to January 2024. Exiting managed care plans will retain their existing membership through the end of this year in Two-Plan, GMC, and Regional model counties. New Medi-Cal members in late 2023 will have the choice of all the managed care plans operating in their county in 2024.

Stephanie Conde:

In our COHS and Single Plan models, our dually eligible members in Medi-Cal Matching counties and our new Medi-Cal members in late 2023 will be automatically enrolled into a managed care plan for 2024. If the new member chooses or is assigned to a 2024 plan that is not yet operating in that county as a prime managed care plan, they'll access care through the fee-for-service delivery system until that managed care plan is available, effective January 1st, 2024. Next slide please.

Stephanie Conde:

So, our noticing plan for our members. Members in our exiting managed care plans will receive a 90-day notice from their exiting plan. So, their current plan will send a 90-day notice. 60-day and 30-day notices from Health Care Options, the Department's enrollment broker. A choice packet will also be sent following the 60-day notice, and then a welcome packet from the new managed care plan in January of 2024. Our notices will include a QR code that will go to a Notice of Additional Information, which provides more detail, frequently asked questions for that member. Members can request a print copy or alternative format from Health Care Options or their managed care plan. We did send our notices through stakeholder feedback and through the Center for Health Literacy. And then we will have our notices posted early September for our stakeholders to review closely to see what's going out to our members.

Stephanie Conde:

Next slide please. Here's a quick noticing timeline. I'm going to go through it quickly because in a couple of slides, I have an overarching timeline that I'd like to present on in a little bit more detail. So, in October, the Transition Member Notice will be in hand 10/1. This is our 90-day notice from our exiting plan. November and December, the member will also receive an additional notice. And then as noted in January, the new plan will send a welcome packet to our transition members. Next slide please.

Stephanie Conde:

This is a resource page. So, all members on this call should have the presentation slide

deck. These are very good resources to understand what's going on, all the different changes that are happening in 2024, along with those resources like the FAQ, Notice of Additional Information, and our actual notices for our members. Next slide please.

Stephanie Conde:

So overall, our January 2024 Medi-Cal transition noticing timeline. Next slide. I want to go through real quick the transitions that are occurring at the Medi-Cal Managed Care Plan transitions that I just presented on, select Medi-Medi Plans, which is the pink purple box that Anastasia did present on. So, San Diego, San Bernardino and Riverside Counties impacts beneficiaries in some health plans in these counties, which will no longer have a Medi-Medi Plan in 2024. And then what Bambi presented on at the top of the call for our Intermediate Care Carve-In and Subacute Care Carve-In. Next slide please.

Stephanie Conde:

This is an overall representation of the noticing that will go out. So, I'll start in September. The Medi-Medi Plans exiting San Diego, San Bernardino, and Riverside Counties. Members will receive an Annual Notice of Change and a cover letter, and this will be sent on 9/30, so September 30th. Then in October, the Medi-Cal Managed Care Plan that is exiting, we'll send a 90-day notice in November. Our Long-Term Care Carve-In members, so both the ICF/DD and Subacute Care Carve-In members will receive a 60-day notice. And then our members, that part of the Medi-Cal Managed Care Plan transition, the presentation and the changes I presented on will also receive a 60-day notice, along with in applicable choice counties, a choice packet.

Stephanie Conde:

And then following in December, we will be sending a 30-day notice for both those populations. So, our Long-Term Care Carve-In impacted members and also our managed care plan transition members. Both those member types will receive a 30-day notice. In our Long-Term Care transitions, and I believe Bambi noted this, we will be mailing the same notice to the member’s authorized representative that we have recorded in MEDS. Next slide please. And I think this is our 15-minute window for questions. Maybe not that long.

Mary Russell:

That’s right. No, thanks so much Stephanie. That’s right. So, we do have time now for questions. I know we covered a lot of content, but we will pull a few from the chat and feel free to add to the chat or raise a hand with a question. And I will try to direct these to the appropriate DHCS people on the call. And thank you Bambi. I see you’ve been active in the chat responding directly as well.

Mary Russell:

So, a question from Jason Murillo. "In regard to the MCP transition, what is the projected number of people that would move from a current MCP to Kaiser now that there will no longer be a subcontract?" Stephanie, is that something you can speak to?

Stephanie Conde:

I don't have that number at the top of my head. My team will have the actual number closer to the end of the year, but I don't know if anyone on the call has the estimated number.

Mary Russell:

Or that could be something we note for follow up. Thanks. Okay. And then a question, let's see, a question from Tatiana. "Since Medicare AEP is arriving soon, will dual eligibles enrolled in a Medicare Advantage Plan that is not renewing also receive a notice from their county or their MCP about options?"

Anastasia Dodson:

I'll take that one, just to flag. So, if it’s a change in their Medicare Plan, then that notice follows the Medicare rules. So, like if the health plan is leaving a market, they send that Annual Notice of Change. And in the case of a few counties, a couple of plans, because they're not continuing as Medi-Cal plans, they have to change the structure of their D-SNP somewhat. And so, they're going to send a cover letter attached, again, to the Medicare Annual Notice of Change that the Medicare Advantage Plan sends. And on the DHCS side, on the Medi-Cal side, we wouldn't necessarily send something different unless the Medi-Cal Matching Plan rule was triggered because if they're changing their Medicare plan, then yeah, we might have to change their Medi-Cal plan. But the notice about the Medicare plan change, that comes from the Medicare plan.

Mary Russell:

Great. And then a quick reminder to everyone that the slides and materials will be distributed after this meeting, so we've shared the link to where that will be posted. Okay. Other questions in the chat. And it's been so great in the chat, some have already been addressed.

Anastasia Dodson:

Mary, I see one about someone wanting to change their address and so we can... I wonder if Stephanie or others know, could the Medi-Cal Managed Care Ombuds help with that a little bit if it's really been a difficulty or did any of the eligibility folks have suggestions there?

Stephanie Conde:

I don't see the question, but it is a county. The county does have to update that. So, I don't know if Jill's on. I'm not sure if it's her shop though.

Sara McDonald:

I can take that. If they have a particular case number and case name and county, they can always email eligibility and we can be a liaison on how to fix that.

Anastasia Dodson:

Fantastic. Is there a particular email address for them to mail that to?

Sara McDonald:
You can send it to me since I'm here.

Anastasia Dodson:
Oh, yeah. Or is there a Medi-Cal now or something like that?

Sara McDonald:
We do have an inbox. I will get that and then I can put it in the chat.

Mary Russell:
That would be great, Sara. Thank you.

Sara McDonald:
No problem.

Mary Russell:
A question from Maricris at L.A. Care. I believe this is also for Stephanie but, "When will the NOAI be available on the website?"

Stephanie Conde:
It'll be top of September and we'll send an email out to our stakeholders when it's posted, but it's very, very close. So top of September.

Mary Russell:
Great. All right. A question from Jerri. Let's see. "So earlier, the eligibility asset levels have gone up. Is this for people at home on Medi-Cal where the asset level is from 2,000 to 3,000 to 130,000? Just looking for a little more explanation on the changes to the asset limits." And Jerri, if you'd like to raise your hand, I can unmute you if you'd like to speak through that. Jerri, would you like to raise your hand? Okay. Maybe we can try to come back on that. Okay. I see Alisa responded to Carolyn's question. Great. Okay, great. Jerri, would you like to come off mute and ask your question about the asset limits?

Jerri Ollett:
Yes, I would. And thank you very much for taking my call. This has been a great presentation. Thank you for everybody. So, the asset going up from 2,000 for a person, 3,000 for a couple, it's now 130,000 for somebody living at home.

Sara McDonald:
Yes, that's correct. 130,000 for one person who's at home. And it also extends to all those populations, so long-term care and Medicare Savings Programs.

Jerri Ollett:
Thank you.

Sara McDonald:
You're welcome.

Mary Russell:
Great. Thanks for the question, Jerri. Thanks Sara. Let's see, I'm not seeing any new questions or raised hands at this time. We do have other opportunities for questions further on. Oh, great. Janine, would you like to unmute and ask a question?

Janine Angel:
Sure. Just on the asset limits, I just want to clarify because I don't know if maybe it's just me because I'm die-hard Medicare, but even though the asset limits are going up, that doesn't automatically mean the member is a full benefit dual eligible, right? If they make more money or they have higher assets, even though there's no limit anymore, they still could have a share of cost. Is that correct?

Sara McDonald:
That is correct. Assets are different than income. So, if they have income over the limit for free Medi-Cal, they could still have a share of cost.

Janine Angel:
Okay. Great. Thank you so much. Appreciate it.

Sara McDonald
You're welcome.

Mary Russell:
Thanks Janine.

Anastasia Dodson:
Yeah, let's go to the redeterminations because I bet this wonderful group here will have some other good questions for us on the redeterminations.

Mary Russell:
Great. All right, so now I'll ask Derek and Bonnie to jump in and take us through this next section.

Derek Soiu:
Thank you, Mary. My name is Derek Soiu. I'm a Health Program Specialist with the Department of Health Care Services. I'm going to do a couple of updates with regards to the Continuous Coverage Unwinding. So, we are a couple of months into the

Continuous Coverage Unwinding. What this is that now that the continuous coverage period has ended, the pandemic has ended, counties can begin redeterminations of individuals' Medi-Cal. And the counties need to complete all redeterminations within the next 12 to 14 months. And so, during this time period, individuals, they're going to go through the redetermination. They may be continuing eligible, or they may no longer be eligible and be discontinued from Medi-Cal. So, during this time period, one of the key focuses of DHCS right now is maximizing the continuity of coverage for Medi-Cal beneficiaries. So, this means we're looking for ways that we can help individuals maintain their eligibility if applicable.

Derek Soiu

And so, some of the ways that we've been doing that is through our waivers. Next slide please. So, we've gone through a couple of months of the unwinding, and we have data available publicly for the first month of unwinding, where we saw that 21% of individuals who had a renewal were discontinued, with a large portion of those being due to procedural reasons. We anticipate that due to individuals being able to turn in their paperwork within three months after receiving that discontinuance that they could be renewed back to that date. We anticipate that the number will go down to 17%. But even still, DHCS has committed to try to improve these numbers and to try to help individuals retain their benefits. And so, we've done so by these waivers and flexibilities.

Derek Soiu

On this slide, you can see multiple ones that we've done, but some that may be of notice for this group is the zero income waiver and the income at/or below 100% of the federal poverty level waiver. What these waivers do is they allow the counties to take verification of income that was previously attested at zero income or income at/or below a 100% and utilize that for the renewal without having to reach out to the beneficiary for verification. So that means that they may be able to renew their Medi-Cal without contacting the beneficiary, without a renewal packet being sent. And so that can help with the procedural discontinuances that we see where individuals they could just be renewed without receiving that packet.

Derek Soiu

If we go to the next slide, we have a couple of more flexibilities that we're looking to implement. They're in the approval process, but one that we wanted to focus on is the stable income waiver. So, this is waiving income verification requirements for individuals that have stable income sources that are not subject to change, such as Social Security or pension income. So again, if they have these forms of income, stable forms of income, this waiver will allow counties to process the redetermination without seeking the verification from the individual. So, they won't need to contact them, they won't need to send a renewal packet based upon the need for income.

Derek Soiu

But of course, these are only some of the measures DHCS has done. I'm going to turn it

over. Oh, actually, the next slide please. I forgot about this one slide. So, in order for us to track the effectiveness of not only these waivers, but of course to understand the redeterminations and applications and renewals for the entire population. We track the data and report it to federal sources, but also, we share it publicly. And so here on this slide and within the slide when you get it, there's a link to the unwinding dashboard. This is a publicly available dashboard that gives you all the information on these redeterminations that are happening during the unwinding, so that you can have a better understanding of what's going on with the population as a whole and is stratified down to the county level as well. So, this is a helpful tool for you to see what's happening overall, and then county specific with regards to redetermination. So, it's an effective tool for all people to look at.

Derek Soiu

But again, these tools and these waivers are helpful to an extent. And so, we have an extensive outreach campaign. I'm going to turn it over to my colleague, Bonnie Tran, and she'll go over some updates in regard to the outreach we've been engaged in to help people retain their coverage.

Bonnie Tran:

Hello, my name is Bonnie Tran, and I am a Health Program Specialist with the Department of Health Care Services. So, if you haven't done so yet, we encouraged you to sign up to receive up-to-date information about what is going on and become a DHCS coverage ambassador. We are holding webinars every other month, so if you sign up, you'll get this information to sign up for the webinars. We are also sending out emails every two weeks with updates to include any of our new outreach materials when they become available.

Bonnie Tran:

So, our last webinar was held last week, and we had another webinar today that was a Train The Trainer webinar. So, the slides for this were posted on our social press kit. The slide deck is meant for our DHCS coverage ambassadors to use. It has information of all levels of knowledge, and it can be used and adapted broadly in communities. It's meant to use as a tool to help present this information out to the community. So, we encourage our partners in the public as well as the private sectors to reach out to Medi-Cal members to help them with information that they need to complete their renewals. Next slide.

Bonnie Tran:

This is the resources hub that I was referring to. We are using the social press kit to house all of our outreach materials. It's very user-friendly and easy to use. You're able to share from this page or you can download it and put it on your own platforms if you choose to. And if you scroll down, once you reach this page, you can choose what materials in other languages that you need. Next slide.

Bonnie Tran:

So, all of our partner resources are available in all of the 19 threshold languages. So, if you click on the link there, it'll be available, and you can scroll down and pick whatever materials that you want. Next slide. These are the toolkits that we have in development. Many of these are already completed now and available for download, and some of these are still in development. The ones that are completed and posted, some of those are available in other language right now, but we are still translating because as you know, that takes a long time. But once they become available, we will put it into the emails that we send out for updates. Next slide.

Bonnie Tran:

We also have many videos that were developed that you can download, or you can share directly from our DHCS YouTube page. Right now, we have the Take Care videos as well as the Keep Covered videos in different links. We also have the How-To videos, which cover the top three things to know about Medi-Cal renewals, and those are also available in all the languages, and you can share those directly from our YouTube as well. Next slide. There are also flyers and other print materials available for download. We did provide an opportunity in the beginning of our campaign for DHCS coverage ambassadors to order free copies of print materials. We are looking into providing more print materials in the future, but we will have to evaluate if we have the resources to provide this.

Bonnie Tran:

Next slide. We have also created the Medi-Cal website, so this is the Medi-Cal member facing webpage. We use this URL in our outreach material, so Medi-Cal members can easily get to the correct page. It's easy to navigate and we have buttons on there that they can easily click as well as an FAQ on the side if there's questions that they are looking for answers for. Next slide.

Bonnie Tran:

We are also sending email and texts to our Medi-Cal members when it's time for them to complete their annual renewals and to remind them to complete their packet. These messages are only sent out to the people who are sent an annual renewal packet that need to complete the packet. Our Medi-Cal Managed Care Plans and our navigators are also receiving monthly renewal data so they can conduct their own targeted outreach as well. Next slide. So that is it for our portion of the presentation. I will transition back to Mary to facilitate the question and answer.

Mary Russell:

Thank you so much Derek and Bonnie, that was so helpful, and I know there's been some great conversation in the chat. Wanted to grab a question about auto-renew from Janine. What about members with a permanent disability? Would those members get auto renewed?

Derek Soiu:

The waivers that we have in effect are based off of income or resources, not the other

eligibility requirements. So, they would not be auto-renewed just based off of disability, but if they had. Like we talked about with stable income sources, so, if they had disability income that was considered stable income source, they may have that verified automatically as part of the renewal process.

Mary Russell:

Thanks, Derek. I also just wanted to point out that Sara McDonald with DHCS was able to provide the contact information to respond to the previous question about updating change of address or contacting the county. So, you'll all see that in the chat. And Derek, thank you for responding to the question about some additional stats. Thank you, Bambi, for that response. And I do see a note from Nea asking how the HCBA waiver is involved in all of this. Wondering if maybe Bambi would like to speak to that.

Anastasia Dodson:

I think Bambi had to sign off for another meeting, but back to Derek's point about-As far as the renewals based on income, based on income threshold, it sounds like not necessarily a particular role for folks who are in HCBA waiver or assisted living waiver. Is that right, Derek?

Derek Soiu:

That's correct.

Mary Russell:

Thanks, Anastasia and Derek. Any other questions at this time about renewals or the unwinding? Let's see. And we are noting a few questions for follow-up as well.

Anastasia Dodson:

I see there's Tatiana's question about timeframe for Medi-Cal beneficiaries who are enrolled automatically in Medicare. I'm having trouble sorting through that. I think that's irrespective of eligibility renewals, right? That's more the broader question around when someone who they were Medi-Cal only and then they gain their Medicare, then I don't know if it's one month or three months or four months by the time they actually have their Part B premium covered. I don't know, Derek, if you have a sense of how long that takes?

Derek Soiu:

I haven't been part of the buy-in program for a couple of years. I don't know if Sara's still on board, but based off of my previous understanding is that buy-in kicks in the month that they're eligible. But it does take a couple of months for the individual to see that reflected in their social security check or to receive the premium refund as well. The Medicare Savings Program, depending on the program itself that has a timeframe for when that kicks in according to eligibility. Oh, Sara is there. Sara, am I saying this all correct still?

Sara McDonald:

Yes, you are. Yes. We usually tell people that it takes about three months for buy-in to kick in and they'll see a refund if the premiums were taken out for a certain amount of time. They'll get that money back a little bit later. But there's a lag, unfortunately.

Mary Russell:

Thank you, Sara. Thanks, Derek. Okay, thank you for that note, Tatiana, that's helpful. Okay. I think at this time, Anastasia, we can transition to you to take us through some reminders and updates on D-SNP policies.

Anastasia Dodson:

Great. Thank you again to all the wonderful presenters on the 2024 transitions. I know there's a lot to take in, but good policies and things we have to do to comply with federal requirements, so we're really glad to be working with all of you. Now we're going to shift gears and talk about the delivery systems. And again, it was like what order do we put things in on this agenda? And many of you are experts, but some of you, maybe this is helpful to get this background and context. Medicare delivery systems for dual eligible beneficiaries are kind of in two buckets. There's original Medicare, also known as fee-for-service or regular Medicare. And then other type, there's a whole set of Medicare Advantage type of plans. And about half of dual eligible beneficiaries are in original Medicare. And then about half are in some type of Medicare Advantage plan.

Anastasia Dodson:

Within that MA umbrella, there's regular Medicare Advantage, that's what we just call it regular, that those MA plans don't have written agreements with DHCS. And then there are D-SNPs, Dual Eligible Special Needs Plans. And then within the D-SNP category, there are Medi-Medi Plans where it's the same organization for Medicare and Medi-Cal, so they can work together. And then there are some Non-EAE D-SNPs that might have a Medi-Cal plan, but it's not in that county or they just do not have a Medi-Cal line of business. So, these are some of the main categories. There’s also PACE as well. Okay, next slide.

Anastasia Dodson:

And so, you can see here we have one FIDE-SNP in California scan that also provides integrated Medicare and Medi-Cal benefits. And there are actually additional benefits that are combined within that including dental. And then PACE also is combined across Medicare and Medi-Cal and includes benefits that are not necessarily part of the Medi-Medi Plans. And then there are other special needs plans, a C-SNPs and an I-SNPs. There are a lot of choices for dual-eligible beneficiaries and for all Medicare beneficiaries really among all the MA plans. Next slide. So, this... Yay, it's a pie chart. It's not just words. So, I think this is a really helpful visual to just put things in perspective. Again, about half of dual eligibles are in original Medicare and then of those who are in some type of Medicare Advantage, so not in the orange, the largest group there is in a regular MA plan that doesn't have any kind of care coordination requirements specific to duals.

Anastasia Dodson:

And then those EAE D-SNPs the Medi-Medi Plans, that's what transition from Cal MediConnect. And that's at 14% of the dual population. Non-EAE D-SNPs also. But both of those D-SNPs they have to have a contract with DHCS for care coordination. There's other special needs plans and then the SCAN, FIDE-SNP, and PACE small but mighty as far as the percent. And those are of course important options too. Next slide.

Anastasia Dodson:

This gives just a snapshot between January and April to see the growth in overall any type of Medicare Advantage plan. And quarter by quarter it grows because dual eligible beneficiaries, they can change their Medicare plans once per quarter during the first nine months of the year. And then in the last quarter of the year they can. If they make a change, it will be effective January 1st. And then of course some people become newly eligible every day, every month become newly eligible for Medicare. And so, we expect that we will probably see these numbers grow. And of course, the overall number of dual eligibles does grow. With the caveat that as redeterminations happen, there may be some folks who lose their Medi-Cal, but I do want to just flag also that there is a cure period for people who lose their Medi-Cal. They can go back, send whatever documents are needed, or respond as needed to the county and very quickly get their coverage back.

Anastasia Dodson:

I don't think we have a slide on it, but there is what's called a deeming period for people who are in D-SNPs so that they can keep that Medicare plan while they're curing their Medi-Cal coverage. Anyway, the overall, you see the growth across really all of the options for dual eligibles. Next slide. Again, Medi-Medi Plans, for those of you not familiar, they're a type of Medicare Advantage plan that's only available to dual eligible members and they're required to coordinate all Medicare and Medi-Cal benefits for their members. It doesn't mean that they're financially responsible for all of the Medi-Cal benefits, it's just that they're there to provide the care coordination. And Medi-Medi Plans is our global term, and each Medicare plan may have their own marketing name. As of January 2023, there are seven counties that have these Medi-Medi Plans. You can see Southern California plus San Mateo and Santa Clara.

Anastasia Dodson:

And then starting January 2024, Medi-Medi Plans will be newly available for voluntary enrollment in five additional counties, Fresno, Kings, Madera, Sacramento, and Tulare. And just like any Medicare beneficiary, they can call 1-800-Medicare to select the plan. Or they can also contact their Medicare plan in those counties to say, "I would like to be enrolled in your Medi-Medi Plan." And they can be selected in the fall during Medicare Open Enrollment. And thank you, Tatiana, for flagging about HICAP. Great, excellent resource. So, this is getting into a little bit of the technical stuff. Some of you may be familiar with this, but as far as how do we communicate our policies to D-SNP plans, we have a contract with them that we have posted on our DHCS website. We also have what's called a policy guide. And just to update everyone for 2024, which is the

upcoming year, we have some chapters that have been released and posted on our website around Care Coordination, Integrated Materials, and Dental Benefits.

Anastasia Dodson:

There are a few more chapters coming up that we will be working on in the coming months to post. And again, those of you who are health plans, you're very familiar with this, we've covered this in other venues. Just for everybody to know that D-SNP policy guide is on the DHCS website. We want to make everything as transparent as possible and in key areas. We really appreciate the feedback that we get from working with all of you, whether it's around dementia care or dental benefits. There's been a lot of really great feedback and we try to incorporate that as much as possible. Next slide.

Anastasia Dodson:

Again, very technical. We won't spend much time on this slide just to say in 2023, we had certain chapters for certain types of D-SNPs, and then in 2024, we are applying more of those policies to all D-SNPs. The only thing that doesn't apply to those Non-EAE D-SNPs is the Integrated Materials, but we're trying to make our Care Coordination requirements consistent across all the D-SNPs, again to the 25 or 30% of the Duals who are in those D-SNPs. We want them to have as good care coordination as possible and help navigating across the different sets of benefits. Next slide. And I do want to just. Yes, dental. We have heard great feedback from all of you from key advocates about the need to provide more technical assistance and clarity around coordination of dental benefits across Medicare and Medi-Cal because Medi-Cal does offer a comprehensive dental benefit, but then sometimes Medicare plans, they also offer a dental benefit, and it could be with a different provider network than the Medi-Cal benefits.

Anastasia Dodson:

We have then put in some additional requirements starting in 2024 for D-SNPs around coordinating dental benefits and including language about the Medi-Cal Dental benefits in the member materials, just as a reminder to members that they do have those Medi-Cal Dental benefits. And then we're working on a fact sheet which really is oriented toward dental providers. When we were talking about members or beneficiaries. Curious, wanting to know about Medi-Cal Dental benefits, we do have that Smile California portal webpage that is oriented to members because you don't need to know all the technical behind-the-scenes billing stuff, but we want you to know what dental benefits are available through Medi-Cal and how to find a provider. And again, being in a D-SNP, the D-SNP should help with that process as well. Next slide. Okay, so I think we're shifting gears here and I think this is probably still me.

Anastasia Dodson:

Yes. Okay, so we have... Thank you, Mary. We have outreach and collateral materials around those five additional counties and really about Medi-Medi Plans in general and D-SNP policies. So, there's that reference to the dental benefit fact sheet. And then we are working on putting them in multiple languages because we know that particularly

dual eligible beneficiaries are more likely than the overall population and more likely even than just Medi-Cal-only folks to have limited English proficiency or have a primary language other than English. So, we will keep putting those fact sheets under on our website and the Medi-Medi Plan webpage. Next slide.

Anastasia Dodson:

Here, this is the link. So, once we post these slides, of course, the links will go exactly to those. And then just a reminder, we do have information about... Well, we have fact sheets oriented to providers. We have a fact sheet about palliative care. We have a fact sheet about deeming periods, balanced billing, durable medical equipment. We're going to keep building our library there. Next slide. Okay, so before we go to Enhanced Care Management, Mary, you were probably going to say about Tatiana's question, I guess.

Mary Russell:

Yeah, I was just going to say we have a couple of minutes. We could take a quick pause here for questions before we dive in on the ECM and Community Supports elements. But yeah, did you want to address Tatiana's question about duals and fee-for-service Medicare who may travel to another state or need non-emergency health care and if they have to get a prior auth from their Medi-Cal plan and the provider?

Anastasia Dodson:

That's a good question. Of course, Medicare is primary for duals. So, the Medicare fee-for-service network of course is nationwide. And so, if it is a hospitalization, if it's an emergency room visit or labs, pharmacy, any of those main Medicare benefits, there's no approval needed by the Medi-Cal plan at all. I suppose if it is a long-term skilled nursing facility stay, then we'll have to take that back because that would be eventually Medi-Cal coverage question. And I don't know about out-of-state skilled nursing, or long-term skilled nursing facility stays, but if it's a Medicare benefit, Medicare has all kinds of information about that. And certainly, if they're in fee-for-service, it's a nationwide network and Medicare fee-for-service.

Mary Russell:

There's one comment in the chat from Cynthia that I wanted to flag, and Cynthia, if I don't represent this correctly, feel free to raise your hand and you can come off mute. But Cynthia is noticing that on the DHCS site, there's the 2023 D-SNP policy guide and available chapters of the 2024 policy guide as well as the SMAC. For new EAE plans, these materials may serve as guidance in the development of downstream provider contracts, which may be time-sensitive. And while she understands that the 2023 policy guide is available for reference, there may be additional changes once the 2024 D-SNP policy guide is finalized that may pose a risk or require a rework to downstream provider contracts. So just asking DHCS if there are any insights or considerations for this timing. I know the Department is very aware of that timeline, but any additional comments there, Anastasia?

Anastasia Dodson:

Maybe we can flip back a couple of slides just to examine the sections that are still not

published because I don't think there'll be...

Mary Russell:

Yeah. Maybe slide 71.

Anastasia Dodson:

Right. Or maybe... Yeah, one more back perhaps. Okay. Aligned network guidance, that's just reporting for the plans. If that means that the plans have to contract with more providers. I don't know if there's an impact on provider contracts, but we're not at the point yet to publish the 2024 version of that. For continuity of care, we don't expect to have a big change on the Medicare side there. Quality metrics and reporting requirements, sure. But probably we're in the same boat as CMS as far as... I don't expect that we would necessarily have those all nailed down in August or September. It will take us a little more time. But that kind of aligns with what happens on the Medicare side for quality metrics and reporting. And then Medicare Encounter Data, we're going to be aligning with what CMS requires for the health plans for Medicare plans. So, I don't think there will be... There should not be any additional requirements other than what already happens because of Medicare requirements for.

Mary Russell:

Okay. Thanks, Anastasia. And hopefully, that helps Cynthia. A question from Danielle. Will a member who wants to stay in their D-SNP be able to stay in that plan past 2024 if the D-SNP does not have a Medi-Cal plan?

Anastasia Dodson:

Yeah, thanks for asking that question. And just in the interest of time, we did not get a whole section on this, but there's two plans in San Diego County and then one plan in Riverside and San Bernardino where they're exiting as a Medi-Cal plan, but the D-SNP contract continues. So, if a member in one of those plans and one of those counties wants to stay, that's just fine. And in fact, the notice that they get on the Medicare side from the Medicare plan from the D-SNP says, "Okay, here's your plan for the upcoming year. Unless you actively make a change, your plan will continue. And it's just that it will not be a Medi-Medi Plan, but it will still be a D-SNP. So, we'll still have to meet the same care coordination requirements and many of the same other requirements that Medi-Medi Plans have to meet." Hopefully, that answers the question.

Mary Russell:

Great. And then I see a raised hand from Yasmin with Justice in Aging, would you like to ask her a question?

Yasmin Peled:

Yeah, thanks so much, Anastasia. Actually, she just answered my question. I just wanted clarification on the change happening in San Diego, San Bernardino, and Riverside, but you just covered that, so thank you.

Mary Russell:

Good. Great. I think we're ready for you to head into the next section, Anastasia.

Anastasia Dodson:

Okay. And of course, I wish we had a whole hour for the ECM and Community Supports Data discussion, but we're just going to go quickly through these slides and I'm sure we can have much more continued conversations in future meetings about these topics as more data comes in, but okay, next slide. The key point in all of this section is that we did have a release from DHCS on ECM and Community Supports for all of Medi-Cal about a month ago. And this data that we're going to talk about here is around dual eligibles for ECM and Community Supports, because we know we've been working with some of you and you've said, "Hey, we need to see the data specifically for dual eligibles." So that's what we're doing here. And we'll just quickly go... One little point I'll make on here is just that for Community Supports, they're available for dual eligibles, just the same as Medi-Cal beneficiaries for the most part, and absolutely without any caveats in 2024.

Anastasia Dodson:

But if a Medicare Advantage plan offers a supplemental benefit that is comparable to Community Supports, then Medicare is the lead. Medi-Cal is the payer of last resort. There are some nuances here that unfortunately we don't have time to get all the way into, but what we're going to do is just walk through some key data for 2022. This is not 2023 data, just 2022. And so, you will not see the populations of focus that relate to long-term services and supports in ECM that of course, we all expect we'll have a high prevalence of dual eligible. So, this is just 2022 data. Next slide.

Anastasia Dodson:

The big takeaway here is that when we look across all the population in Medi-Cal that received Enhanced Care Management and then what percent were dual eligibles, dual eligibles were about 15% of the total ECM population. Which is good because we wanted to make sure that there's not some kind of misunderstanding or system issue where dual eligibles are not getting ECM. So, dual eligibles are approximately 11% of the total Medi-Cal population, but they tend to be higher utilizers. So that would make sense as to why they're about 15% of the ECM population. We are going to go through in a minute to the other slides that show language breakout. And then on the Community Supports, again, duals were accounted for about 22% of the total Community Supports population. We'll also look at race and ethnicity data. And again, the last couple of bullets around Community Supports that focus on LTSS, vast majority are dual eligibles, which of course makes sense because we know 75% of IHSS, 80% of long-term skilled nursing facility care residents are dual eligibles.

Anastasia Dodson:

Next slide. This gives the enrollment and dis-enrollment in ECM for dual eligibles. And you'll see that there's a rationale for why some people would be disenrolled, but it's not that people are sort of moving quickly through, they're getting an ongoing benefit to help

them stabilize and get the services they need. And just a reminder, again, dual eligibles include folks who are under 65 with a disability, including people with more serious mental illness or substance use disorder services. That can be a different type of population than folks who need long-term services in sports. And sometimes there's overlap there too. But the populations of focus for ECM in 2022 or primarily transitioning from Whole Person Care, which is not so much the long-term services and supports population. Next slide.

Anastasia Dodson:

This does give the demographics race and ethnicity, sex, age... You can see that that age where 59%, age 65 and over, 41%, age 18 to 64. And that again, that 18 to 64 group is kind of more likely to have been in 2022 getting ECM because of their set of diagnoses and services they already getting under Whole Person Care. Next slide.

Anastasia Dodson:

We do have information here about individuals experiencing homelessness getting ECM. Again, duals are represented there. Avoidable hospitalization or ED utilization, 15% there, serious mental illness, substance use, duals are represented there. And then transitioning from incarceration. That group is not statewide in 2022, but again, dual eligibles are also there. Next slide. For Community Supports, again, there's a lot of representation among dual eligibles among folks getting Community Supports. You can see the numbers there on the slide. And then you'll notice at the bottom, those that are focused on long-term services supports duals are a high majority there. Next slide. This is the cumulative number of duals who receive Community Supports and overall, well-represented. Next slide.

Anastasia Dodson:

Again, overall well-represented. Next slide. This gives some demographics, race and ethnicity, sex, age, and then overall, you see well-represented among the population receiving Community Supports.

Next slide. Okay, so Mary, should we do questions on ECM and Community Supports now, or wait?

Mary Russell:

I'm not seeing any in the chat, so I think we could continue, and then pause after this section.

Anastasia Dodson:

Okay. Because we do have our team from ECM and Community Supports if there are any questions. Great. So Long-Term Services and Supports Dashboard. Again, going to just go quickly, but the slides will be posted, and then you can digest these further. We did publish in December of 2022 an initial version of the LTSS dashboard with all kinds of data, a huge amount of data, but we knew even then there was more we wanted to do. So, we are getting ready to post more. Again, it's an Excel file right now, and then we are working on a better way to display it. But for now, we know some folks are

sophisticated in what they can do with the spreadsheet. So, we're going to keep posting updates on that LTSS dashboard page. And there's a lot of important reasons and purposes that people can use this data to better understand and improve the quality of long-term services and supports.

Anastasia Dodson:

Next slide. So that initial release included data from 2017 through 2021, and then the future release is going to include California Community Transitions, home health, and the programs administered by DDS. So, we have some preview data around the crossover between IHSS and DDS programs. And so, we'll go ahead to the next slide.

Anastasia Dodson:

So, one piece that we are also scheduled to release is around share of cost. And you all are getting a preview of the data. Don't really have time to go into the details around share of cost, but I think we talked about it earlier. If someone's over the income limit, forget about assets, but if their income is over the limit, they can still get Medi-Cal. And in particular for people who are in skilled nursing facilities, because of the high cost of skilled nursing facility care, the SNF residents they generally meet their share of cost on the first day of the month.

Anastasia Dodson:

And so, folks who are in the community are less likely to meet their share of cost than folks who are in skilled nursing facilities. Because again, they may pay a certain amount and then the rest is covered by Medi-Cal. Next slide. So, part of what we're going to show you in one second is because when we released the initial version, there was a lot of difference by age, race and ethnicity, and primary language spoken for people who had home and community-based services in the community, versus folks who were getting skilled nursing facility care in an institution. And so, we scratched our heads about that. And we think that part of it, and of course, this can be a future conversation to try to understand, but it is that some folks who are in skilled nursing facilities, they have higher incomes, but they are meeting their share of cost every month because the skilled nursing facility cost is high.

Anastasia Dodson:

So, we will show you, let's just go ahead to the next slide. And this shows in the orange, those are the folks that have no share of cost, and again, they're at the lowest income level. And then there is a group then that has a share of cost, and you can see in the yellow, of $1,000 to $2,000. And then in that lighter blue, another group with over $2,000 as their share of cost. And that means their income is higher. But of course, because the cost in a skilled nursing facility per month is many thousands of dollars, then these folks are able to have Medi-Cal eligibility. And so again, all we know is what this data tells us. And then when we look at the race and ethnicity breakout of that group with the yellow and the light blue, we see that it is different than the other categories. So that leads us to think that accounts for the difference in race and ethnicity and language spoken among skilled nursing facility residents, and Medi-Cal

and home and community-based services.

Anastasia Dodson:

Next slide. So, this is the folks with no share of cost that you can see. And then next slide. And so again, we will post those slides. Sorry, I know we're going along quickly, but I know that there's some questions in the chat, so we'll keep going. Mary, should we keep going on this section here?

Mary Russell:

Yeah. And then we'll pause right after.

Anastasia Dodson:

Okay. This is a count of folks who are getting IHSS or DDS programs or IHSS and DDS programs both. I mean, I don't think, probably people who are familiar with the populations and working in the service programs, this may not be a surprise, but we're proud of the fact that we have this data and we're publishing it. And again, some of these numbers they do not line up exactly with what the numbers that are published by DDS and CDSS for DD and IHSS program. That's because this is how many people were ever in the program in a given year, rather than the point in time for a given month. But we just wanted to show that we have that overlapping data. It's been really an important set of work to be able to have that. And so, with our next release of the LTSS dashboard, we will publish that data. Next slide.

Anastasia Dodson:

And this just gives you the numbers, of close to 15% of Medi-Cal members getting IHSS. Also, we're getting programs through DDS in 2022. And then on the other side, 42% of Medi-Cal members getting a DDS program service also received IHSS. So, the overlap is more distinct when looking at the population getting DDS services. And I believe we have folks from those Departments online, in case there are questions there.

Anastasia Dodson:

Okay, next slide. So yes, so we should probably pause and go back one slide, Mary, and see if there's questions about that and the ECM Community Supports.

Mary Russell:

Yeah, let's do that. So, a few things have come in through the chat, and of course, feel free to raise a hand if you have another question to ask. But from David Panush, "How many Duals have been enrolled who were not grandfathered through Whole Person Care?" I'm not sure we have that breakdown.

Anastasia Dodson:

We do not.

Mary Russell:

Okay. Sorry about that, David. And then a couple of questions from Yasmin at Justice in Aging. "Does DHCS have plans to target outreach based on the data released or adjust policies in an effort to reach more dual-eligibles?"

Anastasia Dodson:

Yeah, there are others on who might want to speak to that, but I think because this is 2022 data, and now we're starting to get the 2023 data in, and even having conversations yesterday with the health plans, I said, "I'm going to be at the stakeholder meeting." They said, "Tell them that there's various systems issues or learning issues," back to Mariya's work that she's going to talk about. But they're very hopeful that the numbers are going to grow significantly in the coming months. And even just the last part of even the quarter that we're in right now should be a big increase.

Mary Russell:

Yep. And actually, thank you so much, Tyler, right. As we got to that question, it looks like Tyler was able to add some additional detail. So, I think that will be very helpful for everyone. And then a question here from Nina. "Was the share of cost changed to 138% of the poverty level enacted, or is it going into effect? Or does it still need budget allocation?"

Anastasia Dodson:

I wonder if we have our eligibility experts still on.

Mary Russell:

I'm not sure they were able to stick with us.

Anastasia Dodson:

Okay. Yeah, I think that if I'm understanding the question correctly, I think that is still pending, but I really don't know. So, we should have the eligibility folks answer that.

Mary Russell:

Okay. We can take that. Okay. Any other questions at this time about any of this ECM or Community Supports data? Okay. Oh, thank you, Laura, for that note as well, that the inclusion of the long-term care population of focus as of January 1st, 2023 will very likely increase the duals representation. Thank you for that. Okay. I think at this time, Anastasia, you have a couple more slides, and then we will shift gears to Mariya.

Anastasia Dodson:

Great. And I appreciate in the chat, too, so even I'm going to talk about ESRD, but you all can feel free to keep chatting about ECM and Community Supports Dashboard. Okay. So next slide, and this is really changing gears, but for you all who are on, I think you're just the right audience to talk to about this for just a minute or two. So, folks, individuals who are diagnosed with end stage renal disease are eligible for Medicare, regardless of age, if they meet certain eligibility requirements. And there’s clinical

criteria, and there's also you must be on dialysis for at least four months. Or the first four months are not covered, but then they will get covered by Medicare. So, what we are seeing in the data and hearing from partners is that there may be a misnomer, that folks who have ESRD and who are going to dialysis, they may think that they are not eligible for Medicare because they're not 65 yet.

Anastasia Dodson:

And of course, there are people who are on dialysis who are 65 and older. But what we are seeing in data is that it seems like there are more folks who are Medi-Cal only getting dialysis than there needs to be, and that we want to work with partners, including dialysis centers and other folks, to look at outreach strategies for this population. We know that Medi-Cal provides a robust benefit package. And so there may be a sense that folks who've got to go to so many different medical appointments, and there are certainly steps in the process to apply for Medicare, it may be not the top of their priority list. But again, having the more comprehensive set of benefits across both Medicare and Medi-Cal can be helpful to folks. And so, we do want to flag that for all of you.

Anastasia Dodson:

Again, we've looked at the data. We do see at least several thousand folks who we think maybe have sufficient immigration status. They have at least four months of dialysis. So just a flag for you, and then if you hear from us, if we knock on your door asking you to help on this, you'll have a little background. Okay, next slide. Great.

Mary Russell:

All right. Well, thank you so much to Mariya Kalina for joining today. I'm going to ask her to jump in and take us through some lessons learned from June and July's LTSS Listening Sessions. Thanks, Mariya.

Mariya Kalina:

Thank you so much, Maria. And apologies, I'm switching gears here. Okay, so good afternoon. My name is Mariya Kalina. I'm the executive director of the California Collaborative for Long-Term Services and Supports. And we are a statewide coalition of nearly 60 state and regional organizations, working to advance the dignity, health, and independence of California's older adults and adults with disabilities. And earlier this year, the Collaborative partnered with Insure the Uninsured Project and Chapman Consulting to facilitate monthly CalAIM Listening Sessions to hear from plans and LTSS providers across the continuum about their experience with the transition. So, these sessions focus on teasing out systemic challenges, as well as best practices. And I'm really honored to join you all today and share some of our lessons learned from the June and July sessions.

Mariya Kalina:

I think we're okay to go to the next slide. Our June session focused on the long-term care carve-in, and more specifically on transitions from hospital to facility-based

settings. We heard from hospitals, they're elevating challenges in getting accurate and comprehensive data to support the transition of eligible members to in-network facilities, and in-network facilities that offer accommodating services. For example, a beneficiary may require oxygen therapy upon discharge. However, not all facilities offer oxygen therapy. And so. it's not just finding a facility, but also finding a facility that matches the care needs of the individual.

Mariya Kalina:

Staff are having to comb through provider directories and conduct numerous layers of outreach to identify proper placement. As managed care plans are responsible for the quality of their provider network, we feel like they can provide relief by including an additional layer of oversight through verification confirmation and routine updates to provider network databases, as well as services that are offered in facilities.

Mariya Kalina:

The other major challenge that we identified in transitioning individuals from the hospital-based settings has to do with unexpected payment delays, issues with reimbursements and continual reauthorizations while Medi-Cal determination and eligibility verifications are occurring simultaneously. So long-term care facilities are reliant on timely payments, and unanticipated delays have discouraged proactive transfers and impeded on continuity of care.

Mariya Kalina:

We heard a clear concern and need for meaningful engagement and relationship building, and this is really a theme that has been absolutely central in every single listening session. It seems to underpin the success of CalAIM. Often, the flow of communication starts with ensuring that partners have access to a dedicated plan representative, and relationships develop over time as plans get to know their CBO partners, who they are, what services they provide, how they operate, and as CBO partners get to understand some of the inner workings of plans. It's also crucial to continue to improve administrative processes and conduits of communication over time, increasing uniformity, and standardizing approval processes to create regional uniformity and improve efficiency with transfers.

Mariya Kalina:

I think that's on the next slide. Thank you. In July, we highlighted a publication by the California Health Care Foundation and the Center for Health Care Strategies that explored the unintended consequence of over-relying on cost and utilization data in identifying individuals with complex needs. The discussion centered largely on equity in CalAIM. Studies show that Black, Latino, American Indian, and members of other underserved populations may not access health care as much as they need to due to a number of factors. For example, lack of trust in providers, or lack of available health care services in under-resourced communities. So. By strictly looking at utilization data, where these populations are likely underrepresented, we’re surely to miss individuals

who may benefit from more comprehensive services and supports. And this results in poor health outcomes among certain racial and ethnic groups. What's needed is a more holistic view of beneficiaries, which can be achieved by utilizing multiple data sources, including qualitative data that speaks to lived experience.

Mariya Kalina:

So as managed care plans refine their approaches to determining eligibility, consider leveraging the expertise of CBO partners who often have deep roots in their communities. They can offer insights about existing or new data sets that could be used to identify individuals with complex needs. The system would also benefit from disaggregating data by race and ethnicity, sexual orientation, and other markers to really understand the scope of disparity, develop targeted solutions, and to track progress on equity metrics over time. CalAIM is a very complex systems-level transformation, as you all know, and the way that we communicated about it at the policy and program level doesn't translate to beneficiaries. Many beneficiaries are largely unaware that California is in the midst of a monumental Medicaid transformation, or of new benefits that may be offered to them through CalAIM. And this hinders their ability to self-advocate and meaningfully engage in the system.

Mariya Kalina:

And we can't achieve whole-person care without the person. In order to center equity as a core principle in health and social services care delivery, we have to operate in a way that includes and emphasizes the beneficiary perspective, but particularly of beneficiaries from underserved communities. To meaningfully engage beneficiaries, managed care plans need trusted partners in the community who are well-positioned to engage directly with consumers. This could be faith-based institutions, libraries, food banks. CBO partners are particularly well positioned for this role and can help to bridge the power imbalance. CBOs can serve as conduits for health plans to better serve their populations of focus.

Mariya Kalina:

However, there's a challenge there, too, with many CBOs expressing that they're challenged with prioritizing equity while simultaneously building capacity and addressing procedural barriers and adapting to new processes. And so, it's really important to keep that in mind that CalAIM is a multi-year effort and an immense lift for all involved. But building a responsive and equitable system doesn't happen overnight. And this will progress and become better over time, so long as we place emphasis on communication, inclusive of transparency and compassion, and recognize the various factors that influence implementation, like historic workforce shortages and burnout.

Mariya Kalina:

And the other component to this is that in order to build an equitable system, you have to be intentional about building an equitable system. And that means being intentional in

investing in equity and investing in that system. So, these were a summary of our lessons learned from the past two sessions, and definitely has given us a lot of food for thought and the path ahead. For those that are interested, I think on the next slide, on September 7th, from one to three, our project partners are co-hosting a Virtual Policy Forum to share lessons learned from the full six months of Listening Sessions. So, in addition to an overview of key takeaways, the session will feature a stakeholder panel that will build and expand on these themes, and we'll close with some reflections from DHCS on early learnings, as well as next steps. So really hope you all can join us. And I think I'm transitioning back over to Mary for Q&A.

Mary Russell:

Thanks so much. These are such interesting insights. And I wonder, we can probably stay on that last slide for a little bit, and just open it up for more questions or comments. If people would like to raise a hand and maybe share some additional insights with Maria, we have some time for that. We can also pivot to additional questions on any of the other presentation content today.

Anastasia Dodson:

Mariya, I will ask a question. So were the listening sessions focused, would you say, more on ECM, more on Community Supports? Any particular area? I know there were some slides about the long-term care carve-in.

Mariya Kalina: Yeah, I would say that given that these listening sessions are really targeted to LTSS providers, they've heavily focused on enhanced care management and Community Supports, with some intersectional topics coming up. And I think that the collaborative ITUP and Chapman recognize that CalAIM is an evolutionary process, and so we really want to engage stakeholders in trying to understand what is valuable to you as we move forward, how can we continue to add value to your organizations? And so, we do have a survey out in the field, and I can put both the link to that and the Virtual Policy Forum in the chat for those that are interested. The survey is really kind of geared for people who have been tuning into these listening sessions, but certainly, you can skip ahead and just give us your thoughts on what might be helpful.

Anastasia Dodson:

Great. I'll give one more question, and then certainly, if other questions are coming in, go to there. But what about the regional differences? Did you hear anything about that? Without naming names too much, or whatever you're comfortable with.

Mariya Kalina:

It's really interesting. We actually haven't heard too much about regional differences, and I think that has to do a lot with the focus of the conversations. This is the systemic statewide challenges, what are folks hearing and experiencing? So that hasn't come up.

Mary Russell:

Thanks. And just want to acknowledge Nea's comment in the chat, and the thought of sending them the link to this webinar and getting some additional eyes and awareness on this process. So, I think that's a great idea. Thanks.

Mariya Kalina:

Great. And I absolutely will drop those links.

Mary Russell:

Great. Other thoughts, insights, or questions for today's group? Okay. Just see a question from Rosalind at Molina, and this is going back to the 2024 MCP transition. And I'm not sure who from DHCS, we still have on the line who might be able to speak to this. So, if we don't have the right person, we can definitely take it back. But "If the member continues services with the same provider, and continuity of care is not needed, the plan would not need to send a written notification, as this would cause member confusion. Can DHCS confirm our understanding of the member notification requirements is correct in this situation, when a member stays with its PCP and providers for continued services?" Anastasia, do you think we have the right people on the line for this?

Anastasia Dodson:

I'm not sure. I'm sure if we do, they would raise their hand, but I think I'm not totally understanding that. But we should take it back and get it to the right folks.

Mary Russell:

Sure. And Rosalind, we'll take that back and follow up with you via the inbox as well. And I see a raised hand from Susan LaPadula. Susan, would you like to unmute?

Susan LaPadula:

Hi, Mary. Hello, Anastasia.

Mary Russell:

Hi there.

Susan LaPadula:

I was looking at the 2024 conversion of the long-term care billing claim form, and as you know, that's been aligned with the ICF DD and Subacute Carve-In date for February 1st. I'm wondering if we're going to be doing any beta testing for the new claim form, hard copy and electronic.

Anastasia Dodson:

Yeah, I do not know, but I don't know, Mary, if anybody else might be on to-

Mary Russell:

I know Bambi had to drop, so I think this would be something for us to take back,

Susan.

Susan LaPadula:
Okay, wonderful. And I have shared it with Bambi as well.

Mary Russell:
Okay. Okay.

Susan LaPadula:
But it does affect all long-term care providers, so those residents that are in skilled nursing today, as well as those residents in subacute care today, as well as ICF DD, all three levels. So, it's a big change for us.

Mary Russell:
Got it. Okay. Thank you.

Susan LaPadula:
Thank you so much. Thank you.

Mary Russell:
Great. And thanks, Mariya, for dropping those additional links in the chat.

Anastasia Dodson:
Yeah, I just want to again, appreciate the work that Mariya and the collaborative, the regular LTSS collaborative and then the collaboration with ITUP and Chapman and CHCF for that work, because it's really valuable and interesting to see. And we really appreciate the dialogue there. And just to reiterate what you've seen on many slides and heard already is that we're at one phase in a multi-phase effort, multi-year effort around CalAIM. And CalAIM is many, many pieces. And so, we want to get all the feedback we can from all of you, troubleshoot, raise up great examples, and then keep iterating and growing across community organizations, health plans, et cetera, because it's across a variety of partners, not just one set of organizations.

Mary Russell:
Thanks, Anastasia. Let's take a look at our next slide. Just a reminder for everybody that the next MLTSS and Duals Integration Stakeholder Workgroup will be in November on the 30th at 10:00 AM. So, we have provided that link in the chat for registration. And just want to thank everyone and appreciate everyone's time today. Anastasia, any closing thoughts?

Anastasia Dodson:
Well, we know open enrollment is coming up on the Medicare side, and of course, then, the transition with the Medi-Cal plans, too. So, just as last year, if things come up before the next meeting, of course, please do not hesitate to reach out. You know how to get

us. Info@CalDuals and many other inboxes. We want to hear from you. We don’t always know everything that’s going on around the state, but when we hear about things, we put the pieces together, and we do try to get things addressed. So, thank you very much.

Mary Russell:

Thanks, everyone. Have a good afternoon. Take care.