CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

August 31, 2023

How to Add Your Organization to Your Zoom Name

- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window and click “More.”
- Select “Rename” from the drop-down menu.
- Enter your name and add your organization as you would like it to appear.
  - For example: Mary Russell – Aurrera Health Group

Agenda

- Welcome and Introductions
- 2024 Medi-Cal Transitions and Stakeholder Q&A
- Continuous Coverage Unwinding
- Reminders and Update: Dual Eligible Special Needs Plan (D-SNP) Policies
- Update: Outreach and Collateral Materials for Medi-Medi Plans
- Update: Enhanced Care Management (ECM), Community Supports, and Long-Term Services and Supports Dashboard (LTSS) Data
- Update: End Stage Renal Disease (ESRD)
- California Collaborative for Long Term Services and Supports (CCLTSS) CalAIM Listening Session Report Out
- Next Steps and Closing

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for CalAIM MLTSS, and integrated care for dual eligible beneficiaries. Provide an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for upcoming changes for Medicare and Medi-Cal.
- Open to the public. Charter posted on the Department of Health Care Services (DHCS) website.
- ***We value our partnership with plans, providers, advocates, beneficiaries, caregivers, and the Centers for Medicare & Medicaid Services (CMS) in developing and implementing this work.***

CalAIM MLTSS & Duals Workgroup: 2023 Topics

- Discuss implementation, data, results, opportunities and challenges of CalAIM initiatives for MLTSS, for all Medi-Cal members
- Discuss implementation, data, results, opportunities and challenges of CalAIM initiatives for integrated care for dual eligible beneficiaries (both Medicare Advantage and Original Medicare)
- Flag related DHCS efforts for Medi-Cal members who are older adults or people with disabilities

2024 Medi-Cal Transitions

DHCS

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and Subacute Care Services Transition to Managed Care

CalAIM Long-Term Care (LTC) Carve-In

- On January 1, 2023, MCPs in all counties began covering the LTC benefit in Skilled Nursing Facilities (SNFs).
  - APL 23-004 was released on March 14, 2023.
- On January 1, 2024, MCPs in all counties will cover the LTC benefit:
  - Intermediate Care Facilities for Developmentally Disabled (ICF/DD), ICF/DD-Habilitation (H), ICF/DD-Nursing (N)
    - APL 23-023 was released on August 18 for the ICF/DD carve-in.
  - Subacute Care Facilities and Pediatric Subacute Care Facilities
- Enrollment in Medi-Cal managed care will be mandatory for all Medi-Cal members residing in ICF/DD Homes and Subacute Care Facilities.

LTC Carve-In Goals

- Standardize LTC services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in ICF/DD Homes and Subacute Care Facilities.
- Facilitate a seamless transition for ICF/DD Home residents and Subacute Care Facility members with no disruptions in access to care or services.
- For ICF/DD Homes, maintain the existing infrastructure of ICF/DD Homes and Regional Centers, which includes Lanterman Act protections and the roles and responsibilities of Regional Centers.

ICF/DD Carve-In to Managed Care: Key Policies

What is an ICF/DD Home?

- An ICF/DD Home is a community home that provides 24-hour care to people with a developmental disability.
- ICF/DD Homes are licensed by the California Department of Public Health and certified by the Centers for Medicare & Medicaid Services (CMS).
- Effective January 1, 2024, all managed care plans will become responsible for the full LTC benefit at the following Intermediate Care Facility (Home) Types:
  - Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
  - Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H)
  - Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N)

*Note: ICF/DD-Continuous Nursing Care (ICF/DD-CNC) Homes are **not** included in the LTC Carve-In.*

Regional Centers' ICF/DD Carve-In Role

- Regional Centers are governed by the Lanterman Act, providing lifelong services and supports to assist those served to lead the most independent and productive lives in their chosen communities.
- The Regional Centers will continue to serve members in the following ways under the ICF/DD Carve-In, as required by the Lanterman Act:

Intake and Assessment	Eligibility Determination	Case Management	Individualized Program Plan (IPP) Development	Purchase of necessary services and supports

Enrollment into a MCP will not change a Member's relationship with their Regional Center. Access to Regional Center services and to the current IPP process will remain the same.

Authorizations

MCPs **must utilize the determination** and recommendation from the coordinating Regional Center and attending physician for a Member's admission to or continued residency in an ICF/DD Home.

- Effective January 1, 2024, MCPs are responsible for approving any new treatment authorization requests for ICF/DD Home services for up to two years.
- MCPs are responsible for all other approved authorization requests for services, outside of the ICF/DD Home per diem rate, for 90 days after enrollment in the MCP, or until the MCP is able to reassess the Member.
- MCPs must turnaround routine authorizations in five days.

Overview of TAR Process

- Regional Centers will continue to submit a referral packet, which includes all relevant diagnostic information, to the ICF/DD Home for review.
- After receiving a referral packet from the Regional Center and confirming bed availability and capacity, the ICF/DD Home completes and submits the following information for authorization to the MCP:
  - Certificate for Special Treatment Program Services form (HS-231)
  - Treatment Authorization Request (TAR) form (LTC TAR 20-1)
  - Medical Review/Prolonged Care Assessment (PCA) form (DHCS 6013A)
  - **ICF/DD-N Homes Only:** Individual Service Plan
- MCPs must utilize these forms as evidence of the Regional Center's determination that the Member meets the ICF/DD Home level of care.

Regional Centers will continue to develop an IPP for each individual with intellectual and developmental disabilities based on their person-centered goals and needs.

Continuity of Care

MCPs must automatically provide 12 months of continuity of care for the ICF/DD Home placement of any Member residing in an ICF/DD Home that undergoes a mandatory transition into an MCP after January 1, 2024.

- This protection is **automatic** – Members do not need to request to stay in their facility.
- Following the initial continuity of care period, Members or their representatives may request an **additional 12 months** continuity of care.
- Continuity of care provides continued access to the following services but may require a switch to in-network providers:
  - Facility, Professional, and Select Ancillary Services
  - Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
  - Appropriate Level of Care Coordination

Member Communications

- DHCS will be mailing member notices directly to the affected beneficiaries beginning in November.
  - Member notices will also be mailed to authorized representatives documented within the Medi-Cal Eligibility Data Systems (MEDS).
- The Notice of Additional Information (NOAI) will be posted on the DHCS and Health Care Options (HCO) websites and accessible through a Quick Reference (QR) code in the notices.
- DHCS will also publish a member-facing plain language version of the member notice.
- Member notices and resources will be published on ICF-DD LTC Carve-In Member Information webpage.
- HCO will conduct a Member call campaign from November-January 2024.

ICF/DD Upcoming Webinars

Topic*	Audience	Date and Time
ICF/DD Carve-In 101 for ICF/DD Homes	ICF/DD Homes & Regional Centers	August 21, 2023 2:30-3:30pm
Office Hours	ICF/DD Homes, Regional Centers, and MCPs	September 8, 2023 10:00-11:00am
Promising Practices	ICF/DD Homes, Regional Centers, and MCPs	October 6, 2023 10:00-11:00am
Billing and Payment	ICF/DD Homes, Regional Centers, and MCPs	November 17, 2023 1:00-2:00pm
Office Hours	ICF/DD Homes, Regional Centers, and MCPs	December 1, 2023 1:00-2:00pm
How Medi-Cal Supports ICF/DD & Subacute Residents	ICF/DD Homes, Regional Centers, Subacute Facilities and MCPs	December 15, 2023 2:00-3:00pm

**These topics may be subject to change based on the needs of ICF/DD Homes, Regional Centers, and MCPs*

Subacute Care Services Carve-in to Managed Care: Key Policies

What is Subacute Level of Care?

- Subacute patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.
- **Adult subacute care** is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury or exacerbation of a disease process.
- **Pediatric subacute care** is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

Subacute Care Policies

- The Subacute Care APL is modeled off the SNF APL, but tailored to the subacute care population and set of services.

- **Subacute APL Topics:**
  - Benefits
  - Network Readiness
  - Leave of Absence or Bed Holds
  - Continuity of Care
  - Treatment Authorizations
  - The Preadmission Screening and Resident Review
  - Facility Payment
  - Population Health Management
  - Long-Term Services and Supports Liaison
  - MCP Quality Monitoring
  - Monitoring and Reporting
  - Policies and Procedures

Benefits Requirements

Effective January 1, 2024, Medi-Cal MCPs in all counties will cover adult and pediatric subacute care services under the institutional LTC services benefit for approximately 1,700 Medi-Cal members currently in FFS.

- Services include coverage of adult and pediatric subacute care services, which are provided by a licensed general acute care hospital with distinct-part skilled nursing beds or a freestanding certified nursing facility.
- Coverage of pharmacy benefits not carved out into Medi-Cal Rx.
- Coverage of additional (non-LTC) medically necessary services.

Continuity of Care

MCPs must automatically provide 12 months of continuity of care for the Subacute Care Facility placement for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care after January 1, 2024.

- This continuity of care protection is **automatic** – Members do not need to request to stay in their facility.
- Following their initial continuity of care period, Members or their representatives may request an additional 12 months of continuity of care.

Member Notices

- DHCS will mail targeted notices to members to explain the transition to managed care, member's options, and continuity of care for residents.
  - 60 and 30-day notices explain LTC benefit changes, transition to mandatory managed care, information on MCPs, information on health plan options, information on continuity of care and includes the member's assigned health plan (if a member does not make a choice).
    - If a member does not make an active choice to enroll in a plan, DHCS will complete provider linkage to ensure the member is assigned to the Managed Care Plan that works with the beneficiary's existing provider to avoid any disruption to care.
- Member notices will also be mailed to authorized representatives documented within the Medi-Cal Eligibility Data Systems (MEDS).

Member Communications and Outreach

- Notices will include a Quick Reference (QR) code which links to an online Notice of Additional Information (NOAI) that will provide more details.
  - DHCS will publish member notices and NOAI on the Subacute Carve-In Member Information webpage.
- Health Care Options will conduct a member call campaign starting in November 2023 through January 2024.

Subacute Upcoming Webinars

Topic	Target Audience	Date and Time
Subacute Care 101 for MCPs*	MCPs	September 13, 2023, 10 – 11am
Subacute Carve-In 101 for Subacute Care Facilities	Subacute Care Facilities	September 15, 2023, 9:30 – 10:30am
Billing & Payment	Subacute Care Facilities and MCPs	November 29, 2023, 3 – 4pm
How Medi-Cal Supports ICF/DD and Subacute Care Facility Residents	Subacute Care Facilities and MCPs	December 15, 2023, 2 – 3pm

*Webinar will leverage a DHCS MCPC call and not be open to the public

Long-Term Services and Supports Liaison

MCPs must identify an individual, or individuals, to serve as the liaison to the Long-Term Services and Supports (LTSS) community for the LTC Carve-in (skilled nursing facilities, ICF/DD Homes, and subacute care services).

- The LTSS Liaison must serve as a single point of contact for service providers in both a Provider representative role and to support care transitions.
- The Liaison is intended to assist service providers with:
  - Addressing claims and payment inquiries.
  - Care transitions among the LTSS provider community to support Members' needs.
- MCPs will share their LTSS Liaisons' contact information to their Network Providers and update Providers regarding any changes to LTSS Liaison assignments.

Medi-Cal Provider Rate Increases and Impact on Medicare Crossover Rates

Medi-Cal Targeted Provider Rate Increases – Impact on Medicare Crossover Claims

- DHCS is developing targeted provider rate increases for primary care, obstetric, and non-specialty mental health services that will be effective for dates of service on or after January 1, 2024, in the Medi-Cal fee-for-service and managed care delivery systems.
- At a future meeting of this workgroup, DHCS will discuss the impact of the Medi-Cal rate increases on Medicare crossover claim payments, for Medicare providers serving dual eligible patients.

Update: Medi-Cal Matching Plan Policy

Update: Medi-Cal Matching Plan Policy

- 2023: In 12 counties, dual eligible beneficiaries who are enrolled in a MA plan must be enrolled in the matching Medi-Cal managed care plan **if a matching plan is available**.
  - Medicare is the lead plan.
  - The 12 "Medi-Cal Matching Plan" counties are: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus.
- **2024: DHCS is updating the Medi-Cal Matching Plan County logic to add Kings, Madera, and Tulare counties.**

Older Adult Expansion
and
Age 26-49 Adult Expansion

Older Adult Expansion

- The Older Adult Expansion implemented on May 1, 2022, and provides full scope Medi-Cal to California residents 50 years of age or older, regardless of immigration status, if they meet all Medi-Cal eligibility criteria.
- DHCS transitioned 247,522 individuals from restricted scope Medi-Cal to full scope Medi-Cal with eligibility effective May 1, 2022. As of the June 2023 month of eligibility, there are over 362,500 individuals receiving full scope benefits because of the expansion.
- Policy Guidance is posted in ACWDL 21-13
- Additional information and resources available on the DHCS Older Adult Expansion webpage

Age 26-49 Adult Expansion

- The Adult Expansion will implement on January 1, 2024, and will provide full scope Medi-Cal to California residents, regardless of immigration status, if they meet all Medi-Cal eligibility criteria.
- With this expansion, full scope Medi-Cal coverage will be available to all otherwise eligible Californians, regardless of immigration status.
- The Governor's 2022-2023 Budget estimates the Adult Expansion population to be 707,000 individuals.
- Policy guidance is posted in ACWDL 23-08
- Additional information and resources available on the DHCS Age 26-49 Adult Expansion webpage

Asset Limit Increase & Elimination

Asset Limit Increase

- Assembly Bill 133 was signed into law by the Governor on July 27, 2021, and included a two-phased approach to eliminating the asset test used to help determine eligibility for Non-MAGI Medi-Cal Programs.
- Phase I was implemented on July 1, 2022.
- This phase increased asset limits to **$130,000** per individual and **$65,000** for each additional household member (up to 10).
- The increase applies to all Non-MAGI Medi-Cal programs, including Long-Term Care and Medicare Savings Programs.

Asset Elimination

- On July 14, 2023, the federal Centers for Medicare & Medicaid Services approved DHCS' State Plan Amendment to eliminate the asset test.
- Phase II is scheduled for implementation on **January 1, 2024**.
- This phase will eliminate the asset test entirely for Non-MAGI Medi-Cal programs, including Long-Term Care and Medicare Savings Programs.

Medi-Cal Managed Care Plan Transition

Medi-Cal Managed Care Plan Transition Overview

- 2024 Managed Care Plan (MCP) Transition Overview
- Member Enrollment in Managed Care
  - New Enrollment Freeze for Exiting MCPs
  - Noticing for Transitioning Members
- Noticing Timeline

DHCS is Transforming Medi-Cal Managed Care Through Multiple Channels

New Mix of High-Quality Managed Care Plans Available to Members

New Commercial MCP Mix

- Contracts with commercial MCPs announced in Dec. 2022, operational readiness process has been underway since January 2023

Model Change in Select Counties

- Conditional approval for 17 counties to change their managed care model
- Includes a new Single Plan Model and expansion of COHS model

Direct Contract with Kaiser

- In 32 counties in which Kaiser operates
- Based on provider / plan linkage or population-specific criteria for active choice / assignment such as Dual-eligible or foster children

Restructured and More Robust Contract Implemented Across All Plans in All Model Types in All Counties

Improved Health Equity, Quality, Access, Accountability and Transparency

Managed Care Plan Transition

- Approximately 1.2 million members will transition to a new MCP on January 1, 2024
- These transitions will take place across 14 unique MCPs and 21 counties:
  - Alameda
  - Alpine
  - Butte
  - Colusa
  - Contra Costa
  - El Dorado
  - Glenn
  - Imperial
  - Kern
  - Los Angeles
  - Mariposa
  - Nevada
  - Placer
  - Plumas
  - Sacramento
  - San Benito
  - San Diego
  - Sierra
  - Sutter
  - Tehama
  - Yuba

MCP Transition Principles

DHCS is applying the following principles to guide the planning, implementation and oversight of the 2024 transition:

- Plan for a smooth and effective transition
- Minimize service interruptions for all 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
- Proactively monitor MCPs' implementation of transition responsibilities

Member Enrollment Process for Counties with an Exiting MCP

In "Choice" Counties (GMC, Two Plan and Regional Models):

- **Members enrolled in an MCP that will continue to operate in 2024** will remain in their MCP unless they opt to change MCPs, as they are allowed to do today
- **Mandatory managed care members enrolled in an exiting MCP will need to enroll in a new MCP:**
  - Dual-eligible members in Medi-Cal Matching Plan counties will be automatically enrolled in a Medi-Cal MCP that matches their Medicare Advantage plan, where relevant
  - Other exiting MCP members will receive 90/60/30 day notices 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 MCP based on the following assignment hierarchy: (1) provider linkage, (2) plan linkage, and (3) family linkage. Absent a member meeting any of the "linkage" criteria, their default MCP will be based on the Auto-Assignment Incentive Program algorithm, which includes quality and other adjustments to an annually defined ratio for auto-assignment among MCPs in each county

In COHS Expansion and Single Plan Counties:

- **Members enrolled in a continuing MCP** (i.e., Alameda Alliance for Health, Contra Costa Health Plan, Kaiser) will remain in their MCP
- **Members enrolled in an exiting MCP** will be automatically enrolled into the COHS, Single Plan or – where relevant – Kaiser
  - Kaiser will receive default assignment for exiting MCP members in COHS and Single Plan counties where it participates on the basis of plan / family linkage and Medi-Cal Matching Plan policy (where relevant)

New Enrollment Freeze for Exiting MCPs

- DHCS will stop **new** enrollment into exiting MCPs (both for active choice and default assignment) three months prior to January 1, 2024
- Exiting MCPs will retain their existing membership though December 31, 2023
- In Two-Plan, GMC, and Regional model counties, new Medi-Cal members in late 2023 will have the choice of all MCP operating in their county in 2024
- In COHS and Single Plan model counties—dually-eligible members in Medi-Cal Matching Plan counties—new Medi-Cal members in late 2023 will be automatically enrolled into an MCP for 2024.
  - If the new member chooses or is assigned to a 2024 MCP that is not yet operating in the county as a prime MCP, they will access care through the fee-for-service delivery system until the MCP is available in January 2024

Noticing for Transitioning Members

- Members of exiting MCPs will receive a:
  - 90-day notice from their exiting MCP
  - 60-day and 30-day notices from Medi-Cal Health Care Options (HCO), DHCS's enrollment broker
  - A choice packet will be sent with the 60-day notice when appropriate
  - Welcome packet from their new MCP in early January 2024
- Notices will include a QR code to an online Notice of Additional Information that will provide more details, which members can request to receive in print or alternative format
- The notices received stakeholder feedback and were reviewed by the Center for Health Literacy
- Notices will be posted on the DHCS Transition member webpage

2024 Medi-Cal MCP Transition Noticing Timeline

October 2023	November 2023	December 2023	January 2024
Transition Member Notice in hand by 10/1/2023 (90 Day Notice)	Transition Member Notice in hand by 11/1/2023 (60 Day Notice)	Transition Member Notice in hand by 12/1/2023 (30 Day Notice)	2024 MCP Transition Live
	Choice Packet (when appropriate)		Welcome Packet from new MCP in early January 2024

MCP Transition Resources

- MCP Transition webpage: MCP Transition (ca.gov)
- MCP Transition Member webpage: 2024 MCP Transition Member Information (ca.gov)
- MCP Transition Policy Guide
  Inbox: MCPTransitionPolicyGuide@dhcs.ca.gov

January 2024 Medi-Cal Transitions Noticing Timeline

January 2024 Medi-Cal Transitions

Medi-Cal Managed Care Plan Transitions

- **Statewide**: Impacts beneficiaries currently or newly enrolling in certain Medi-Cal MCPs

Select Medi-Medi Plans

- **San Diego, San Bernardino, and Riverside Counties:** Impacts beneficiaries in some health plans in these counties which will no longer offer Medi-Medi Plans in 2024

Intermediate Care Facility Carve-In/ Subacute Care

- **Statewide**: Impacts beneficiaries in ICFs
- **Statewide**: Impacts beneficiaries in Subacute Care Facilities

Combined Transition Noticing Timeline

Medicare Annual Enrollment: Opens October 15 and closes December 7

September 2023	October 2023	November 2023	December 2023
Medi-Medi Plans Exiting in San Diego, San Bernardino, and Riverside Counties **Annual Notice of Change (ANOC) and Cover Letter (sent by 9/30)**	Medi-Cal MCP Transition **90 Day Notice**	LTC ICF/DD and Subacute Care Carve-In **60 Day Notice** Medi-Cal MCP Transition **60 Day Notice & Choice Packet, when appropriate**	LTC ICF/DD and Subacute Care Carve-In **30 Day Notice** Medi-Cal MCP Transition **30 Day Notice**

*Notices will be mailed to members and authorized representatives. There are four versions of the Enrollment Notices that differ depending on the county the member lives in and whether the member is a part of the Medi-Cal matching plan policy.

Questions?

DHCS Medi-Cal Continuous Coverage Unwinding

DHCS

Medi-Cal Continuous Coverage Unwinding

- DHCS Continuous Coverage Unwinding Guiding Principal:
  - **Maximizing Continuity of Coverage for Medi-Cal beneficiaries**
- Ensuring individuals have timely and correct redeterminations based upon their current information
- Implementing innovative policy and waivers to relieve the administrative burden on County Eligibility Workers and beneficiaries.

Medi-Cal Temporary Waivers and Flexibilities

Waiver or Flexibility	Authority	Letter
MAGI Medi-Cal Reasonable Compatibility Threshold Increase	MAGI Verification Plan	ACWDL 22-17
Reasonable Explanation	MAGI Verification Plan	ACWDL 22-22
Partnering with Managed Care Plans to Update Beneficiary Contact Information	1902(e)(14)(A)	MEDIL I 22-20E
Partnering with Program of All-Inclusive Care for the Elderly (PACE) Organizations to Update Beneficiary Contact Information	1902(e)(14)(A)	MEDIL I 22-45
Partnering with the National Change of Address (NCOA) Database and United States Postal Service (USPS) In-State Forwarding Address to Update Beneficiary Contact Information	1902(e)(14)(A)	MEDIL I 22-45
Maximize the Number of Non-MAGI based Individuals Renewed Without Requesting Additional Information.	1902(e)(14)(A)	MEDIL I 23-19
Zero Income	1902(e)(14)(A)	MEDIL I 23-21E
State Fair Hearings Waiver Flexibilities	1902(e)(14)(A)	MEDIL I 23-26
Ex Parte Renewal for Individuals With Income at or Below 100 Percent of the Federal Poverty Limit (FPL) and No Data Returned	1902(e)(14)(A)	MEDIL I 23-40
Renewing Medicaid Eligibility, Based on Available Information, Establishing a New Eligibility Period When Contact is Made with Hard-to-Reach Populations	1902(e)(14)(A)	MEDIL I 23-40

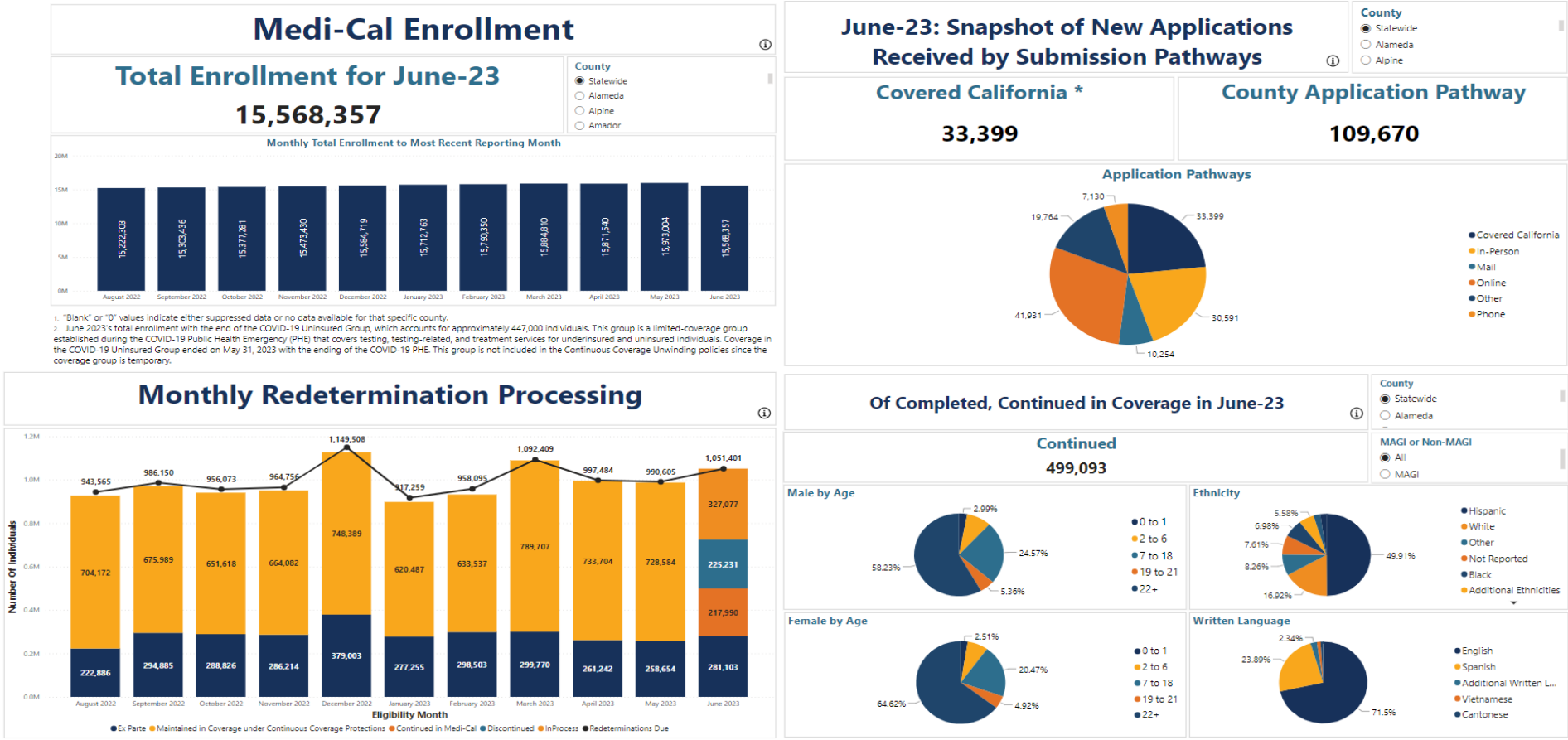
Medi-Cal Waivers and Flexibilities: Pending Approval

The waivers listed below have been submitted, but are pending approval by the Centers for Medicare and Medicaid Services (CMS). Once approved, DHCS will release a policy guidance letter.

Waiver or Flexibility and Description	Authority
Medical Support Enforcement Waiver: Waiving the requirement for a Medi-Cal applicants to apply within 90 days of approval of benefits for medical support (if available and at no cost) from a non-custodial parent that is not in the home.	1902(e)(14)(A)
Unconditionally Available Income Requirement Waiver: Waiving the requirement for a Medi-Cal applicants to apply for income within 90 days of approval of benefits that is available to the applicant if applied for at no cost (also referenced as 'unconditionally available income'), such as unemployment or Veteran's benefits.	1902(e)(14)(A)
Stable Income Waiver: Waiving income verification requirements for individuals that have stable income that is not subject to change, such as Social Security or pension income.	1902(e)(14)(A)

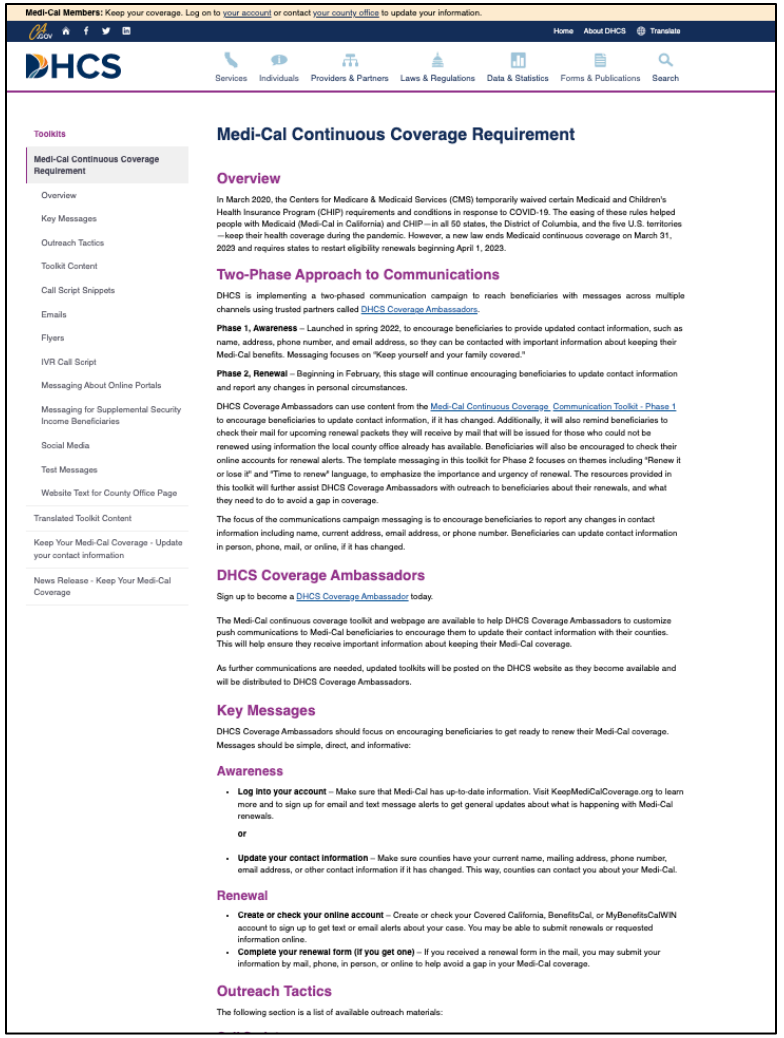
Medi-Cal Continuous Coverage Unwinding Dashboard

» [Continuous Coverage Unwinding Dashboard]



Become a Coverage Ambassador

- Check the stakeholder resource page for up-to-date content and resources
- Become a DHCS Coverage Ambassador (in English and Spanish)
  - Currently, we have 3000+ DHCS Coverage Ambassadors signed up to help DHCS spread the word on the Continuous Coverage Unwinding Efforts
  - DHCS developed FAQs for our Coverage Ambassadors to assist with outreach efforts
  - Sign up here



Medi-Cal Members: Keep your coverage. Log on to your account or contact your county office to update your information.

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Toolkits

Medi-Cal Continuous Coverage Requirement

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Messaging for Supplemental Security Income Beneficiaries
Social Media
Test Messages
Website Text for County Office Page

Translated Toolkit Content

Keep Your Medi-Cal Coverage - Update your contact information

News Release - Keep Your Medi-Cal Coverage

Medi-Cal Continuous Coverage Requirement

Overview

In March 2020, the Centers for Medicare & Medicaid Services (CMS) temporarily waived certain Medicaid and Children's Health Insurance Program (CHIP) requirements and conditions in response to COVID-19. The easing of these rules helped people with Medicaid (Medi-Cal in California) and CHIP—in all 50 states, the District of Columbia, and the five U.S. territories—keep their health coverage during the pandemic. However, a new law ends Medicaid continuous coverage on March 31, 2023 and requires states to restart eligibility renewals beginning April 1, 2023.

Two-Phase Approach to Communications

DHCS is implementing a two-phased communication campaign to reach beneficiaries with messages across multiple channels using trusted partners called DHCS Coverage Ambassadors.

Phase 1, Awareness – Launched in spring 2022, to encourage beneficiaries to provide updated contact information, such as name, address, phone number, and email address, so they can be contacted with important information about keeping their Medi-Cal benefits. Messaging focuses on "Keep yourself and your family covered."

Phase 2, Renewal – Beginning in February, this stage will continue encouraging beneficiaries to update contact information and report any changes in personal circumstances.

DHCS Coverage Ambassadors can use content from the Medi-Cal Continuous Coverage Communication Toolkit - Phase 1 to encourage beneficiaries to update contact information, if it has changed. Additionally, it will also remind beneficiaries to check their mail for upcoming renewal packets they will receive by mail that will be issued for those who could not be renewed using information the local county office already has available. Beneficiaries will also be encouraged to check their online accounts for renewal alerts. The template messaging in this toolkit for Phase 2 focuses on themes including "Renew it or lose it" and "Time to renew" language, to emphasize the importance and urgency of renewal. The resources provided in this toolkit will further assist DHCS Coverage Ambassadors with outreach to beneficiaries about their renewals, and what they need to do to avoid a gap in coverage.

The focus of the communications campaign messaging is to encourage beneficiaries to report any changes in contact information including name, current address, email address, or phone number. Beneficiaries can update contact information in person, phone, mail, or online, if it has changed.

DHCS Coverage Ambassadors

Sign up to become a DHCS Coverage Ambassador today.

The Medi-Cal continuous coverage toolkit and webpage are available to help DHCS Coverage Ambassadors to customize push communications to Medi-Cal beneficiaries to encourage them to update their contact information with their counties. This will help ensure they receive important information about keeping their Medi-Cal coverage.

As further communications are needed, updated toolkits will be posted on the DHCS website as they become available and will be distributed to DHCS Coverage Ambassadors.

Key Messages

DHCS Coverage Ambassadors should focus on encouraging beneficiaries to get ready to renew their Medi-Cal coverage. Messages should be simple, direct, and informative:

Awareness

- **Log into your account** – Make sure that Medi-Cal has up-to-date information. Visit KeepMediCalCoverage.org to learn more and to sign up for email and text message alerts to get general updates about what is happening with Medi-Cal renewals.

  or

- **Update your contact information** – Make sure counties have your current name, mailing address, phone number, email address, or other contact information if it has changed. This way, counties can contact you about your Medi-Cal.

Renewal

- **Create or check your online account** – Create or check your Covered California, BenefitsCal, or MyBenefitsCalWIN account to sign up to get text or email alerts about your case. You may be able to submit renewals or requested information online.
- **Complete your renewal form (if you get one)** – If you received a renewal form in the mail, you may submit your information by mail, phone, in person, or online to help avoid a gap in your Medi-Cal coverage.

Outreach Tactics

The following section is a list of available outreach materials:

Social Press Kit

Keep Your Medi-Cal

CAMPAIGN

Keep Your Medi-Cal

DESCRIPTION

The California Department of Health Care Services (DHCS) is conducting a statewide public information, education, and outreach campaign to raise awareness about the return of the annual Medi-Cal eligibility renewals and encourage Medi-Cal members to take steps to keep themselves and their families covered.

To promote collaboration with community groups in this effort, DHCS created the Keep Your Community Covered Resource Hub with outreach materials in **English**. Simply select from the tabs below to download and share graphics, flyers, videos, and access specific audience resources. These materials can be customized and are designed to help Medi-Cal members take steps to keep their health coverage.

Important: clicking on the file names will immediately begin downloading the files.

General Messaging Resources	Social Media Graphics	Print Materials
Media Outreach Resources	For Uninsured Group	Videos

ADDITIONAL DOWNLOADABLE ASSETS & HOUSED MEDIA

ENG Communications Toolkit

ENG Renewal Message Guide

Partner Resources

- **Available in 19 threshold languages**
  - English, Spanish, Arabic, Armenian, Cambodian, Mandarin, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese
  - https://socialpresskit.com/keep-medi-cal-coverage

Toolkits in Development

- IHSS
- Employers
- Tribes
- Providers
- Insurers
- Schools
- CHIP/MCAP/MCAIP
- Seniors

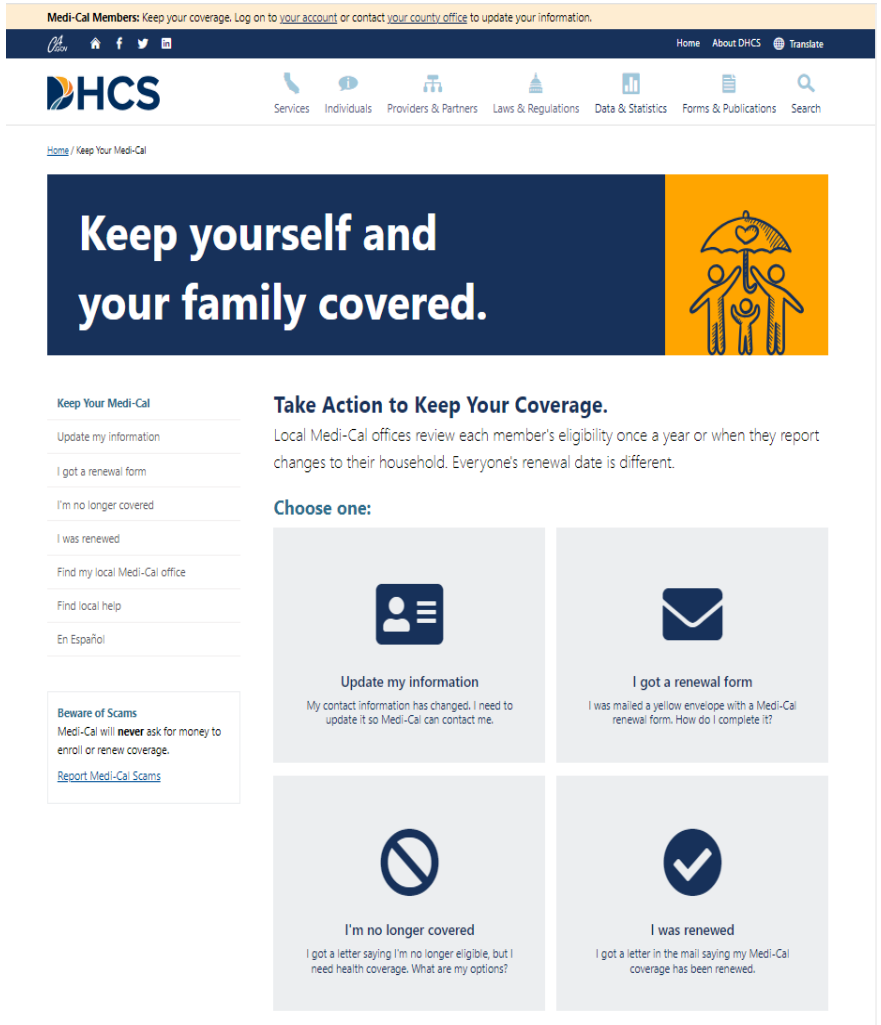
Videos

- "Take Care" and "Keep Covered" :30s, :15s, :06s videos
  - Available in all threshold languages
- How-To informational video
  - Step-by-step explanation of the renewal process
- Translated to all threshold languages
  - Will be made available on Social Press Kit

Downloadable Assets

- Print materials in all threshold languages are available for download
- https://socialpresskit.com/keep-medi-cal-coverage

Medi-Cal Member Website



» KeepMediCalCoverage.org

MantengaSuMediCal.org

Direct Outreach

- DHCS sends targeted messages through email and text to Medi-Cal members when it is time for them to complete their annual renewal.
- Medi-Cal Managed Care Plans and Medi-Cal Health Enrollment Navigators receive monthly renewal data to conduct targeted outreach with Medi-Cal members about their annual renewal.
- The direct outreach is only sent to Medi-Cal members that were sent an annual renewal packet.

Questions?

MCED.COVID@dhcs.ca.gov

DHCS

Reminders and Update: Dual Eligible Special Needs Plan (D-SNP) Policies

DHCS

Reminder: Medicare Delivery Systems for Dual Eligible Beneficiaries

- **Original Medicare (Fee-for-Service):** The original system where Medicare pays providers for each service rendered.
- **Regular Medicare Advantage (MA):** Plans serve both dual eligible and Medicare-only members and are not required to have written agreements with DHCS for benefit and care coordination.
- **Dual Eligible Special Needs Plans (D-SNPs):** Medicare Advantage plans that provide specialized care and wrap around services to members that are dually eligible for both Medicaid and Medicare. D-SNPs must have a State Medicaid Agency Contract (SMAC) with the state Medicaid agency, DHCS, in California.
  - **Medicare Medi-Cal Plans (Medi-Medi Plans aka EAE D-SNPs):** These plans meet integrated D-SNP care coordination requirements with integrated member materials, integrated appeals & grievances, and membership is limited to dual eligible members who are also enrolled in the Medi-Cal MCP affiliated with the D-SNP.
  - **Non-EAE D-SNPs:** These plans either have an affiliated Medi-Cal MCP but are not in counties that offer Medi-Medi Plans yet or are do not have an affiliated Medi-Cal MCP.

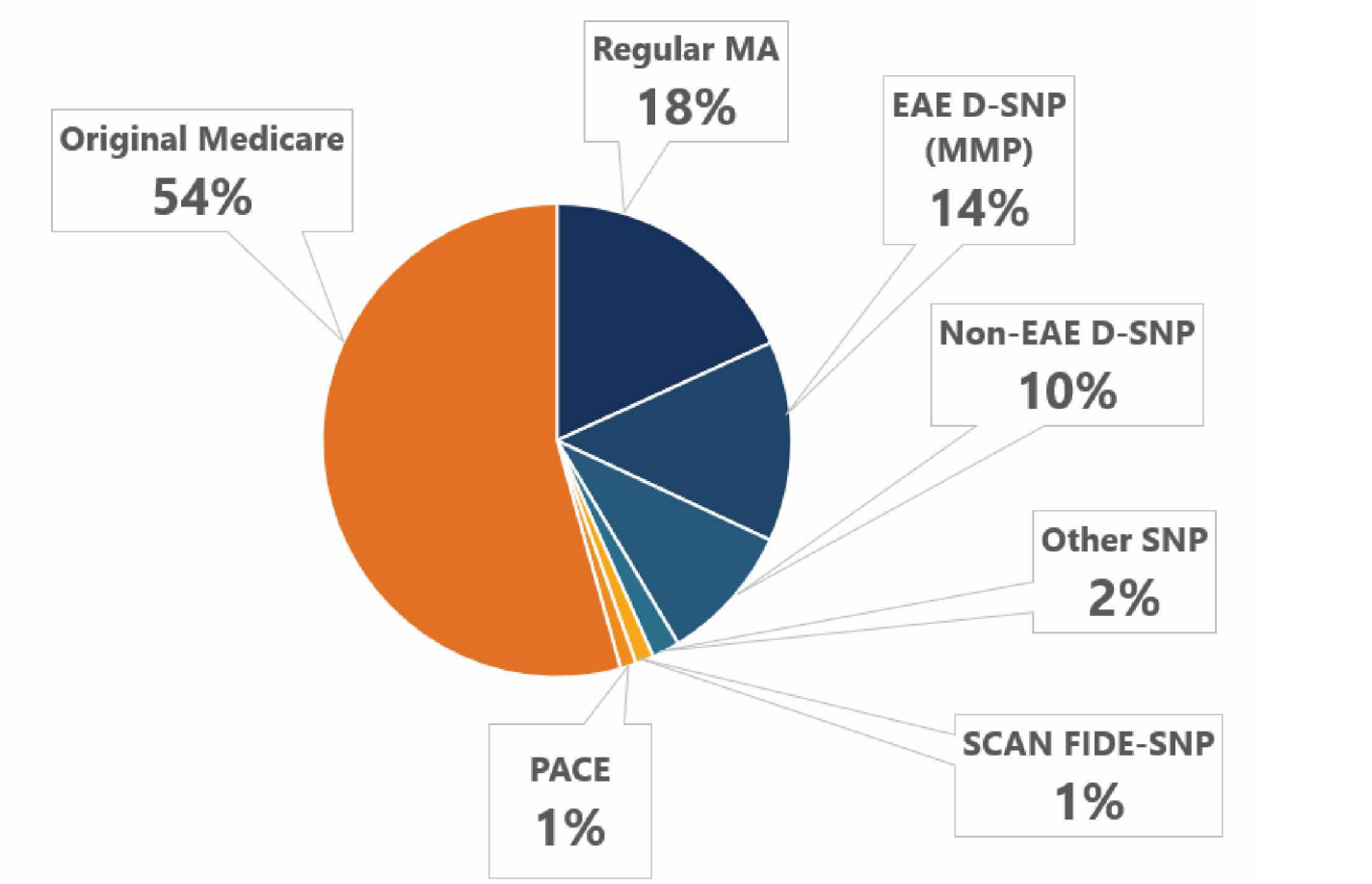
Medicare Delivery Systems for Dual Eligible Beneficiaries (cont.)

» Other Integrated Care Options

- **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP):** California has one FIDE SNP operated by SCAN that provides integrated Medicare and Medi-Cal benefits to dually eligible members.
- **Program of All-Inclusive Care for the Elderly (PACE):** PACE is an integrated care model that provides medical and long-term services and supports to individuals aged 55 and older who meet the criteria for a nursing facility level of care, most of whom are dually eligible. California has a number of PACE organizations.
- **Other Special Needs Plans (SNPs):** Examples include Chronic Conditions Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs).

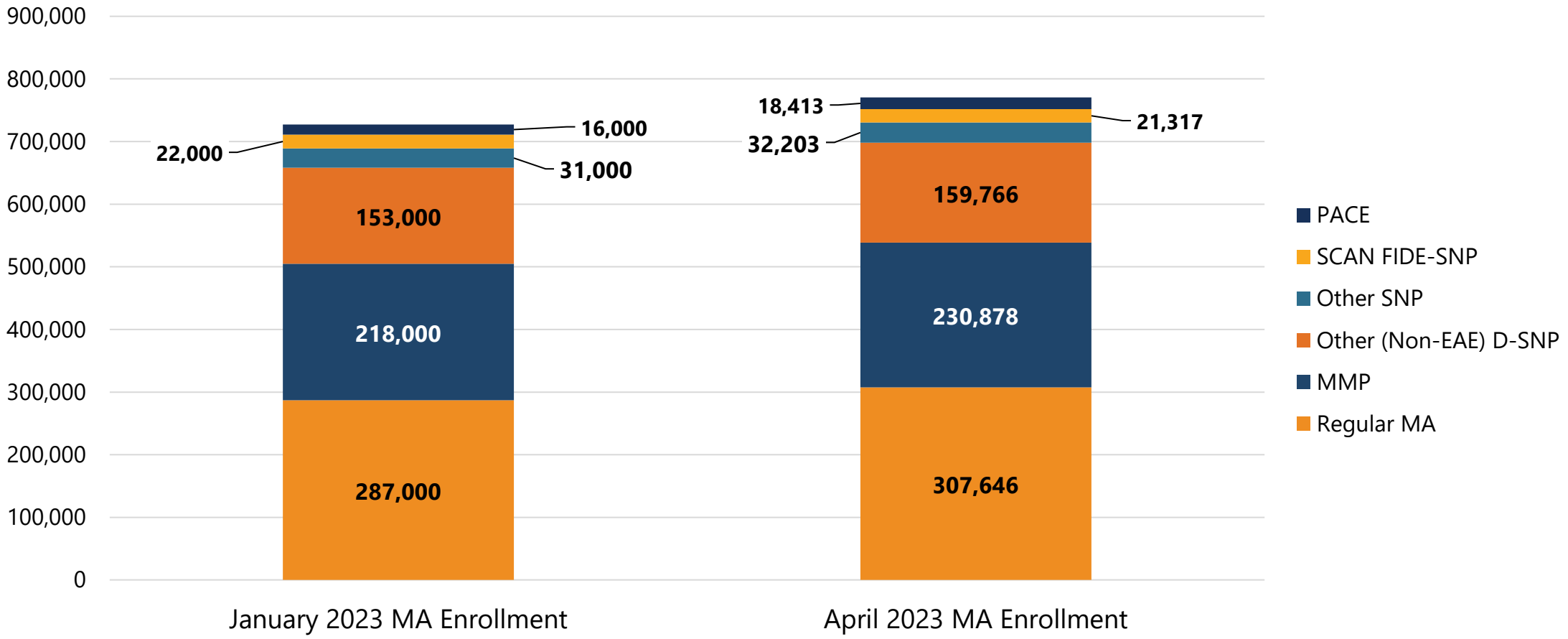
Medicare Delivery System Enrollment for 1.7 million Dual Eligibles in California (April 2023)

Note: Data is preliminary



- Original Medicare – 54%
- Regular MA – 18%
- EAE D-SNP (MMP) – 14%
- Non-EAE D-SNP – 10%
- Other SNP – 2%
- SCAN FIDE-SNP – 1%
- PACE – 1%

Point-in-Time Medicare Advantage Delivery System Enrollment



Medi-Medi Plans

- Medicare Medi-Cal Plans (Medi-Medi Plans) are a type of Medicare Advantage plan in California that are only available to dual eligible members. Medi-Medi Plans are required to coordinate all Medicare and Medi-Cal benefits for their members.
  - Medi-Medi Plans is the California-specific name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).
- As of January 1, 2023, Medi-Medi plans are available in the following counties:
  - Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara
- Starting January 1, 2024, Medi-Medi Plans will be newly available for voluntary enrollment in five additional counties:
  - Fresno, Kings, Madera, Sacramento, and Tulare
- To enroll, a beneficiary can contact their Medi-Cal plan or 1-800-MEDICARE.
  - Medi-Medi Plans in the expansion counties can be selected starting in the fall during Medicare Open Enrollment (October 15 – December 7, 2023).

Proposed 2024 D-SNP Policy Guide Chapters

DHCS intends to release chapters on a rolling basis.

- Care Coordination (released January 2023)
- Integrated Materials (released June 2023)
- Dental Benefits (released July 2023)
- Aligned Network Guidance
- Medicare Continuity of Care
- Quality Metrics and Reporting Requirements
- Medicare Encounter Data
- The D-SNP Policy Guide is available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx

2023 v. 2024 D-SNP Policy Guide Chapters

Section	2023		Proposed 2024	
	EAE	Non-EAE	EAE	Non-EAE
Care Coordination	✓		✓	✓
Information Sharing	✓	✓	SMAC	
Aligned Network Guidance	✓		✓	✓
Enrollment and Disenrollment	✓		N/A	
Medicare Continuity of Care	✓	✓	✓	✓
Quality and Reporting Requirements	✓	✓	✓	✓
Integrated Materials	✓		✓	
Integrated Appeals and Grievances	✓		SMAC	N/A
Medicare Encounter Data Submission	Pending	Pending	✓	✓
Dental Benefits	N/A		✓	✓

2024 Dental Benefits D-SNP Policy Guide Chapter

- The Dental Benefits chapter details the requirements for all D-SNPs to:
  - Coordinate dental benefits
  - Include language about Medi-Cal Dental in the D-SNP's member and marketing materials
    - DHCS provided recommendations for D-SNPs to consider when developing member and marketing materials.
- The D-SNP Policy Guide will be updated in the future to the Dental Benefits Fact Sheet, which is in development, as an appendix. The Dental Benefits Fact Sheet will provide an overview of Medicare, Medi-Cal, and Supplemental Dental Benefits.

Update: Outreach and Collateral Materials for Medi-Medi Plans

DHCS

Outreach and Collateral Materials

- DHCS has been working on creating and revising outreach and collateral materials around D-SNP policies and the Medi-Medi Plan expansion.
- DHCS is developing a fact sheet answering common questions on dental benefits. Future fact sheet topics may include transportation and hearing benefits.
- Once final, the fact sheets can be found on the DHCS Medi-Medi Plan Webpage under **Additional Resources**.

Fact Sheets

- **New/Updated Materials:**
  - Beneficiary Fact Sheet: English and Spanish
  - Provider Fact Sheet
  - CalAIM MMP Fact Sheet
  - Palliative Care Fact Sheet (Located on the DHCS Palliative Care Policies Webpage)
  - 2023 Deeming Period Handout (Located on the DHCS D-SNPs in CA Webpage)
- **Other Materials:**
  - Balance Billing Fact Sheet
  - DME Member Fact Sheet
  - DME Provider Fact Sheet

Update: CY 2022 Enhanced Care Management (ECM) and Community Supports (CS) Data for Dual Eligible Beneficiaries

DHCS

Enhanced Care Management and Community Supports Overview

- The ECM and CS data was published on August 3, 2023 for Calendar year (CY) 2022 and includes the total population receiving ECM and CS.
- Duals can access all available CS through their Medi-Cal plan regardless of enrollment in Original Medicare or a Medicare Advantage (MA) plan. If the MA plan offers supplemental benefits comparable to CS, Medicare is the lead.
- The ECM Populations of Focus (POF) included in CY 2022 data summarized here for dual eligible beneficiaries are the following:
  - Individuals Experiencing Homelessness
  - Individuals At Risk for Avoidable Hospital for ED Utilization
  - Individuals with Serious Mental Health/and or Substance Use Disorder (SUD) Needs
  - Individuals Transitioning from Incarceration
- Other ECM POF were launched in 2023 and are not included in the current ECM and CS report.

Key Findings of ECM and CS for Duals, for CY 2022

- In Q4 CY 2022, 16,630 dually eligible beneficiaries received ECM and accounted for 15% of the total ECM population.
- The Primary Language for duals receiving ECM in 2022 was approximately 75% for English and 18% for Spanish and 7% for Other.
- In Q4 CY 2022, 7,863 dually eligible beneficiaries were enrolled in CS and accounted for 22% of the total CS population.
- The percentage of Duals that are Hispanic and Black/African American receiving CS in CY 2022 was less than the total population receiving CS.
- Dually eligible beneficiaries receiving Nursing Facility Transition/Diversion to Assisted Living Facilities is 196 in CY 2022 and represents about 79% of the total population receiving that CS.
- Dually eligible beneficiaries receiving Community Transition Services/Nursing Facility Transition to a Home is 134 in CY 2022 and represents about 80% of the total population receiving that CS.
- *Please see Appendix A of this presentation for more specific enrollment data.*

Duals Active Enrollment and Disenrollment in ECM by Quarter, for CY 2022

- Active Enrollment by Quarter:
- Q1 – 10,118
- Q2 – 8,416
- Q3 – 9,578
- Q4 – 8,117

- Disenrollments by Quarter:
- Q1 – 1,084
- Q2 – 1,868
- Q3 – 1,507
- Q4 – 1,644

Duals Enrolled in ECM by Demographics, for CY 2022

- Hispanic – 29.6%
- White – 25.8%
- Black/African American – 21.7%
- Other – 7.8%
- Asian/Pacific Islander – 7.3%
- Unknown – 7.2%
- American Indian/Alaska Native – 0.5%

- Approximately 52% of duals in ECM were Female and 48% were Male.
- 59% of duals receiving ECM were age 65 and older and 41% were ages 18-64.
- Dually eligible beneficiaries represent about 15% of the total population receiving ECM.

Dual Eligible Beneficiaries who Received ECM by Population of Focus (POF), for CY 2022

- Of the Individuals Experiencing Homelessness dually eligible beneficiaries total 5,049 and represent about 14% of the POF.
- Of the Individuals at Risk for Avoidable Hospital or ED Utilization dually eligible beneficiaries total 8,982 and represent about 15% of the POF.
- Of the Individuals with Serious Mental health and/or Substance Use Disorder (SUD) Needs dually eligible beneficiaries total 5,415 and represent about 13% of the POF.
- Of the Individuals Transitioning from Incarceration dually eligible beneficiaries total 575 and represent about 12% of the POF.

Duals Receiving CS, for CY 2022

- Dually eligible beneficiaries receiving Housing Transition Navigation Services was 2,515 and is about 16% of the total population.
- Dually eligible beneficiaries receiving Housing Tenancy and Sustaining Services was 3,775 and represents about 25% of the total population.
- Dually eligible beneficiaries receiving Recuperative Care (Medical Respite) is 388 and represents about 16% of the total population.
- Dually eligible beneficiaries receiving Nursing Facility Transition/Diversion to Assisted Living Facilities is 196 and represents about 79% of the total population.
- Dually eligible beneficiaries receiving Community Transition Services/Nursing Facility Transition to a Home is 134 and represents about 80% of the total population.
- *Please see Appendix A of this presentation for more specific enrollment data.*

Dual Eligible Beneficiaries who Enrolled in CS, for CY 2022

- Cumulative numbers of Duals members who received CS:
- Q1 – 3,139
- Q2 – 4,510
- Q3 – 5,856
- Q4 – 7,863
- Dual eligible beneficiaries represent about 22% of the total members who received CS in Q4.

Duals Receiving CS by Demographics, for CY 2022

- Hispanic – 20.4%
- White – 30.2%
- Black/African American – 27.5%
- Other – 6.9%
- Asian/Pacific Islander – 6.2%
- Unknown – 8.3%
- American Indian/Alaska Native – 0.6%

- Approximately 53% of duals receiving CS were Male and 47% were Female.
- About 59% of duals receiving CS were age 65 and older and 41% were ages 18-64.
- Dually eligible beneficiaries represent about 22% of the total population receiving CS.

Long Term Services and Supports (LTSS) Dashboard Update

DHCS

Background and LTSS Dashboard Goals

- Growing need for long-term services and supports (LTSS) to support older adults and people with disabilities.
- Wide array of LTSS home and community-based services (HCBS).
- Need for more publicly reported data on the provision of LTSS in California to track and understand programs.
- Publish utilization, cost, and quality data on Medi-Cal LTSS, including long-term care (LTC) and HCBS data.
- Increase accessibility to accurate, timely, and meaningful data.
- Inform regulators, policymakers, advocates, and the public on efforts to expand, enhance, and improve quality of LTSS in all home, community, and congregate settings.

Initial Release and Upcoming Data

- Initial Release in December 2022 included data from 2017-2021 for IHSS, Program of All-Inclusive Care for the Elderly, Long-Term Care, and most Home and Community-Based Services (HCBS) Waiver programs.
- A future release in coming months will include California Community Transitions, Home Health, and programs administered by DDS.
- Today's presentation includes key new data points for beneficiaries accessing IHSS, DDS programs, and concurrent enrollment in IHSS and DDS programs.
- Today's presentations includes the following programs administered by DDS:
  - HCBS-DD Waiver
  - DDS Targeted Case Management
  - 1915(i) SPA
  - Self-Determination

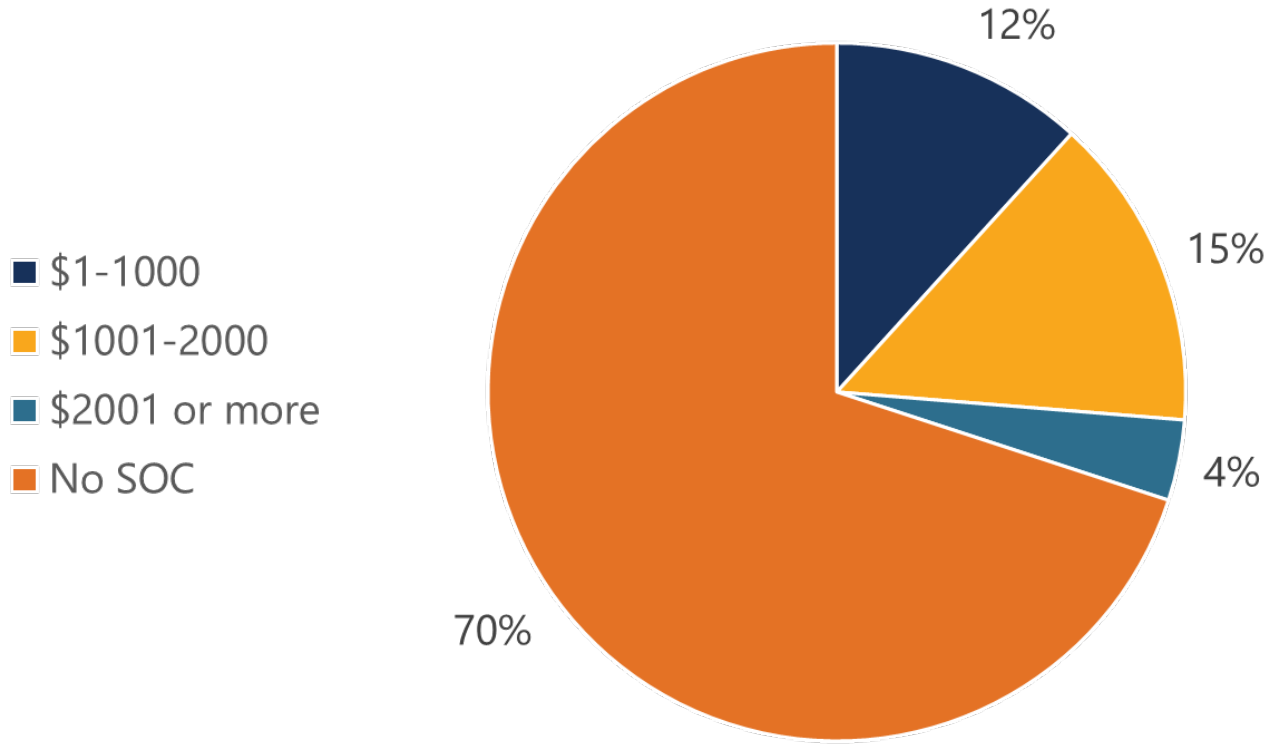
Share of Cost (SOC) Overview

- When a person applies for free Medi-Cal and is over the income limit, they qualify for SOC Medi-Cal.
- SOC is the amount the Medi-Cal member is obligated to pay or are billed for their medical expenses before their Medi-Cal coverage starts that month.
- Once they use medical services and meet the full SOC amount, they are "certified eligible" and Medi-Cal will cover all other costs for that month.
- For Medi-Cal Skilled Nursing Facility (SNF) residents with income, such as Social Security, the SOC is usually all the resident's income above $35 per month.
- Medi-Cal SNF residents meet their SOC on the first day of the month. Medi-Cal SOC beneficiaries in the community are much less likely to meet their SOC than Medi-Cal SNF residents.

Share of Cost (SOC) and LTSS Populations

- In the initial release of the LTSS dashboard, the Fact Sheet showed significant differences in the Home and Community Based Services (HCBS) and Long-Term Care (LTC) populations by age, race/ethnicity, and primary spoken language.
  - For example, about half of Medi-Cal HCBS beneficiaries had English as their primary language, and close to 80 percent of Medi-Cal LTC beneficiaries had English as their primary language.
- It is possible that some of these differences may be related to the additional Medi-Cal SOC population in SNFs (also called LTC), who have higher incomes and meet their SOC on the first day of each month. Many Medi-Cal SOC beneficiaries in the community do not consistently meet their SOC, and are not included in the Medi-Cal HCBS population as certified eligible.
- About 19 percent of Medi-Cal beneficiaries in SNFs in 2021 had a monthly SOC (and income) above $1000 per month. Medi-Cal SOC beneficiaries in the community with a SOC above $1000 per month usually do not meet their SOC and are not certified eligible.

Share of Cost (SOC) Unduplicated by Month in CY 2021 for Medi-Cal SNF Residents



Data is from the DHCS Data Warehouse, accessed 3/3/2023. One member may be in multiple SOC categories throughout the year.

Percent of Medi-Cal SNF Members in each Race/Ethnicity Group with No SOC (2021 Monthly Average)

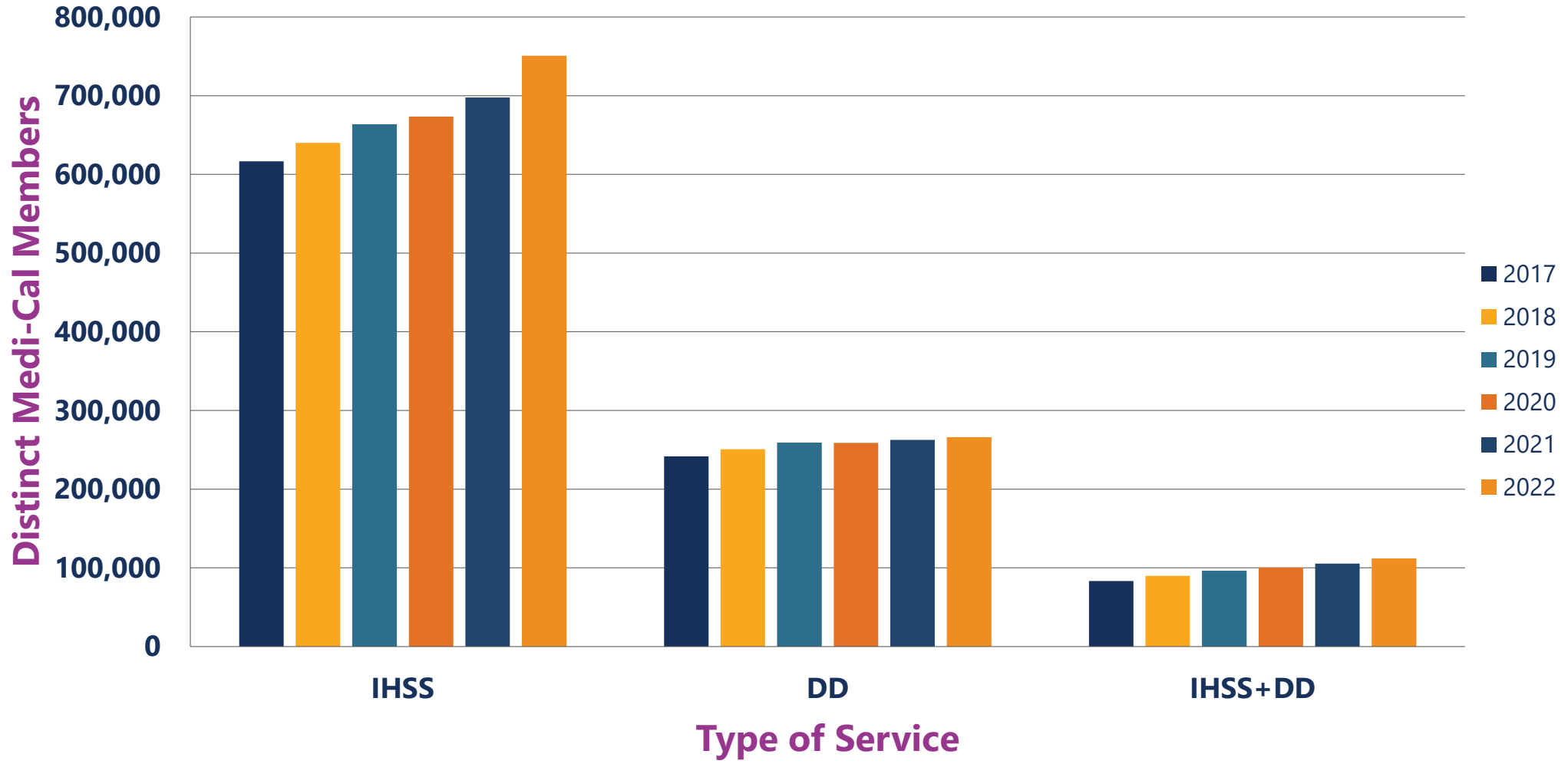
- American Indian/Alaskan Native – 66.3%
- Asian – 65.9%
- Black/African American – 63.7%
- Hispanic – 69.4%
- Native Hawaiian/Other Pacific Islander – 87.8%
- White – 47.9%

Individuals Accessing In-Home Supportive Services (IHSS) and Programs Administered by the Department of Developmental Services (DDS)

2017 - 2022

DHCS

Count of Medi-Cal Members Receiving IHSS, DD Programs, or IHSS and DD Programs, by Year



The data were pulled from the Management Information System/Decision Support System (MISDSS) DHCS Data warehouse
Dates Represented: 2017-2021 | Date Downloaded: 8/17/2023

Concurrent Enrollment in In-Home Supportive Services and DDS Programs (CY 2022)

- 14.9% of Medi-Cal members receiving In-Home Supportive Services also received Developmental Disability services in 2022.
- 42.1% of Medi-Cal members receiving Developmental Disability services also received In-Home Supportive Services in 2022.

Update: End Stage Renal Disease (ESRD)

DHCS

ESRD and Medicare

- Individuals diagnosed with ESRD are eligible for Medicare, regardless of age, if they meet certain eligibility requirements. However, some Medi-Cal only members with ESRD and sufficient immigration status or citizenship are not enrolled in Medicare.
- DHCS is working with partners, including dialysis centers, to consider outreach strategies for this population.

CalAIM LTSS Listening Sessions:
Lessons Learned

June – July 2023

Mariya Kalina
Executive Director
California Collaborative for Long-Term Services & Supports (CCLTSS)
Marya@CCLTSS.org

Listening Sessions are funded by the California Health Care Foundation

Long-Term Care Carve-In

Transitions from Hospital to Facility-Based Settings

Identified Challenges:

- Lack of accurate and comprehensive data about in-network providers.
- Unanticipated problems with reimbursements, payment delays, and continual reauthorizations.
- Historic workforce shortages.

Potential Solutions to Ease Transitions:

- Additional layer of verification, confirmation, and routine updates to provide network databases.
- Increased uniformity in approval and administrative processes.
- Great communication and transparency.

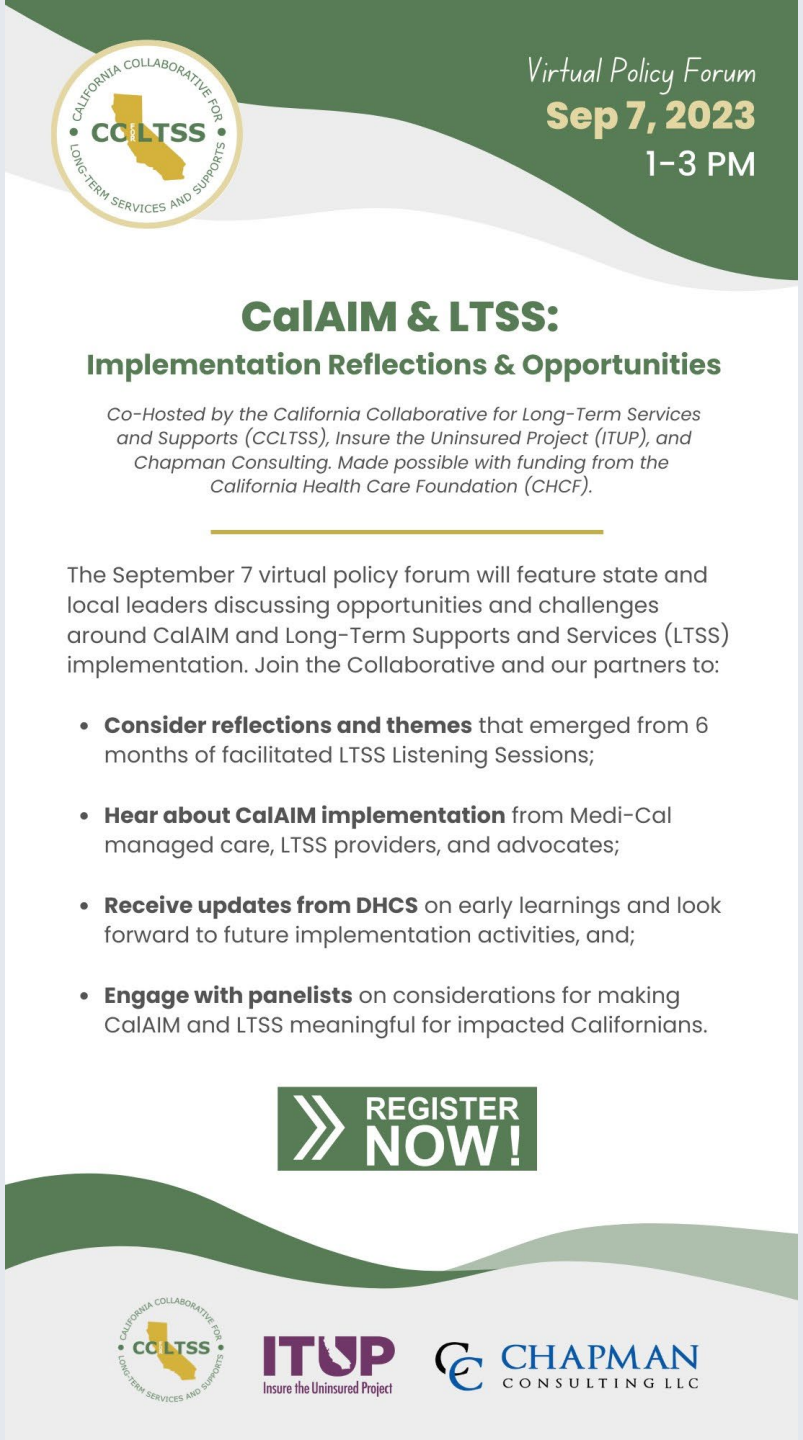
Centering Equity in CalAIM

Identified Challenges:

- Over-reliance on cost and utilization data.
- Beneficiaries lack awareness of new benefits, hindering their ability to self-advocate.
- Prioritizing equity while navigating a range of other transitional challenges and new processes.

Potential Solutions to ensure equitable access to care:

- Re-examine additional data sets that can be used to identify eligible beneficiaries.
- Disaggregate data based on race and ethnicity to build a responsive system.
- Leverage CBO expertise to inform beneficiary outreach and engagement strategies.
- Recognize that CalAIM is an immense lift for all involved.



Upcoming…

Virtual Policy Forum
September 7 | 1 – 3 pm

- Consider reflections and themes from 6 months of LTSS Listening Sessions.
- Hear about CalAIM implementation from MCP, LTSS providers, and advocates.
- Receive updates from DHCS on early learnings and look ahead to future implementation activities.
- Engage with panelists on considerations for making CalAIM and LTSS meaningful for impacted Californians.

Questions?

DHCS

Next Steps

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, November 30th at 10 AM**