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

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SPEAKERS

Mary Russell
Anastasia Dodson
Amy Peterson
Mariya Kalina

Mary Russell:

Good morning. Welcome to today's CalAIM Managed Long Term Services and Supports and Duals Integration Workgroup. We have some great presenters with us today. Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS, as well as Amy Peterson, the Section Chief of Managed Care Data Support at DHCS. We're also joined by Mariya Kalina, Executive Director of the California Collaborative for Long-Term Services and Supports.

Mary Russell:

A few meeting management items to note before we begin. All participants will be on mute during the presentation. As a reminder, the monthly MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions. So, we would ask that the plans that join these calls, please hold their questions for the other venues, that they have with the department throughout the month. Otherwise, please feel free to submit any questions you have for the speakers, via the chat and during the discussion. If you would like to ask a question or provide comments and feedback, please use the raise hand function and we will unmute you.

Mary Russell:

And a quick reminder that the PowerPoint slides and all meeting materials will be available on the CalAIM website in the next couple of days, and we will provide a link to those in the chat. First, we'll just take a quick second and ask that you add your organization name to your Zoom name, so that it appears, your name dash organization. And once we do that, then we'll take a quick look at the agenda.

Mary Russell:

So, for today we'll begin with an update on the Continuous Coverage Unwinding. After that, Anastasia will share a few policy reminders around Medi-Medi Plans and the Medi-Cal matching plan policy. Next, we'll hear an update on the 2024 State Medicaid Agency Contract template finalization. From there, DHCS will walk through a brief overview of some of the DHCS data on programs for dual-eligible beneficiaries. Then we will hear a report out from Mariya, on the second and third listening sessions that the California Collaborative held at the end of April and May. And then we'll end with some information on upcoming meetings and next steps. Great. So, thank you all for joining. Take a look at the next slide and I'll ask Anastasia to jump in here.

Anastasia Dodson:

Thanks so much, Mary, and welcome everyone. Here at DHCS, all the things that we're doing, we can't do without you. We really appreciate the partnership that we have with you all. Consumers, beneficiaries, caregivers, advocates, community organizations,

providers, and health plans, as well as our partners at CMS. We've gone through a lot of changes, all of us working together locally at the state level and with our federal partners. And we have more things ahead. Of course, the unwinding and resumption of redeterminations, as well as continued implementation of all of the CalAIM initiatives around managed long-term services and supports, integrated care. So, we just really appreciate coming together with you in this venue and in other webinars. Next slide.

Anastasia Dodson:

So, as you know, we've been using these work groups to talk about a variety of topics. We've been meeting less frequently because last year, you're all very familiar, we had some kind of immediate issues, some transition issues that we needed to meet monthly. I think we're meeting either every other month or quarterly, something like that now. And as far as this frequency, that's where we're intending to keep going for the rest of the year. And we're trying to have a mix of what's happening in implementation. Data was a topic that was requested, so we've got some data in this meeting. And then also thinking about, I mean, CalAIM Managed Long-term Services and Supports, but also just thinking about dual eligibles in general. As we've started to take up this work, we see there's a lot of topics that need to be addressed, and we can make progress together.

Anastasia Dodson:

And so, we appreciate the partnership with the Department of Aging as well. We're working together with them on efforts around mental health for older adults that, there's just a wide range of topics. And so, we're going to tackle a few of them today, and just keep having these meetings to give updates, but also to hear from you all. It's been really valuable, the chat and then hearing later from Mariya, getting the details of what's happening locally, and what can be shared as great examples across the state. And then, things that we need to work on at the state level to fix. So, at any rate, let's keep going.

Anastasia Dodson:

So, for the Continuous Coverage Unwinding, these are the standard DHCS slides. And I'll just say right up front, I'm not an expert on the details on the eligibility, and the resumptions of redeterminations. But as a Department, we want to include information in all of our stakeholder meetings about the continuous coverage unwinding. Next slide.

Anastasia Dodson:

So, we do have a plan. All states were required to have plans. We have a plan that was originally released in May, and then updated January. And so, we have unwinding of the Medi-Cal program, flexibilities, and then resumption of normal redeterminations. Next slide. So, this slide here is going to show the beneficiary journey. Next slide. I think we have to, there we go. So, first beneficiary will receive a letter telling them that

continuous coverage is ending. Again, this is for all Medi-Cal beneficiaries. That will happen over a monthly period, monthly timeline over the next 12 months. Next slide.

Anastasia Dodson:

All right, let's keep pushing next. The coverage, continuous coverage ends March 31st, but then there's the unwinding. And in this particular example of someone who has a June renewal month, in April, the ex-parte process starts where the county uses existing electronic information to try to verify whether the person is still eligible. Next slide or next on the button here. And then let's keep pushing next.

Anastasia Dodson:

So, they get a pre-populated renewal form. Again, in the scenario for someone who's got the June renewal month, they get that pre-populated renewal form between April and June. And then there's the eligibility determination. Hopefully, the person returns the information and then can be determined eligible. Next slide.

Anastasia Dodson:

So hopefully, they are able to keep their ongoing Medi-Cal. Next slide. So, that's the month-by-month example for someone that has a June renewal month. We have an outreach campaign, that we want to get renewals as much as we can for people to continue their coverage. And we also want to make sure that we're, as a state and at the county level, getting enrollment going as needed for newly eligible individuals. So, the campaign is about raising awareness about the need to renew coverage and about new Medi-Cal eligibility. And we know for people who are dually eligible, sometimes they may have Medicare and they don't know they're also eligible for Medi-Cal. And that can help them with being able to afford their Medicare coverage. And I see the note, ex-parte in this process means that the county eligibility worker will use the electronic information that they have about an individual's income and use that electronic information to see if their income is within the Medi-Cal limits. And then in that case, they can get a notice that says, "Congratulations, we have verified your income electronically. It is within the Medi-Cal income limits." All right, next slide.

Anastasia Dodson:

Again, you may have seen these slides before. We're working on a data-driven communication campaign. We can see what's happening and we want to equip you, our partners, with information and resources that have messages that are research based. We know that you all, as trusted messengers, are a really important part of the communication system that is needed to get information to people authentically and credibly. We really recognize the diversity of the population in California that has Medi-Cal, and we want to reach people in culturally and linguistically appropriate ways. We're going to talk in this webinar and others about data, and what we know about

beneficiaries. And again, needless to say, we are a diverse group in California. And again, we speak many languages, and particularly people who are dually eligible have an even higher rate than other groups of needing materials in other languages. So, we appreciate the work that all of you do to reach Medi-Cal beneficiaries, dual eligibles, where English is not their preferred language. All right, next slide.

Anastasia Dodson:

So, we have some landing pages that you can go to. KeepMedCalCoverage.org. Next slide, how you can help. Next slide. So, we have materials available in 19 languages and they're on that website. You can use them as you meet with beneficiaries. Next slide. There's outreach materials. We have email and text messages, flyers and snippets, social media posts. And so, we have just lots of material that you all can use. Next slide.

Anastasia Dodson:

We have some videos in English and Spanish. We're also working on them in other languages. Next slide. We have some yes, assets that you can print, or you can order to have print materials. Next slide is a coverage ambassador list that you can sign up for. Also, stakeholder resource page. We would encourage all of you to become coverage ambassadors. Next slide. Okay, questions?

Mary Russell:

Great. We have some time for questions, and I see some hands up. So, Rick, I will ask you to unmute, and you're welcome to chime in with your question.

Rick Hodgkins:

Hello there, I just wanted to, I heard you talk about Medi-Cal and income verification. I would like to point out that for people with disabilities, that whose disabilities occurred before age 26, although the age limit is expected to rise due to legislation, increased. But if you have, if you're disabled and if you have an ABLE, Achieving A Better Life Experience account, particularly if you're working and you get IHSS housing assistance, IHSS or Medi-Cal, you can put your earnings into an ABLE account and it will not count against your Medi-Cal, or your IHSS or SSI, or that type of thing. I get SSDI, but I still have an ABLE account because I get Section 8 housing, I get IHSS, and I get Medi-Cal and Medicare and I don't want those benefits touched.

Rick Hodgkins:

So once again, for those who are disabled that are, that whose disability occurred before the age of 26, although the age limit is expected to increase due to legislation, and you're working, you can put your earnings into an ABLE account. And it might be a

good idea for a future meeting to have Dante Allen come on and explain what the ABLE account does, because it would take me forever. So, I just wanted to throw that out there for any care providers or people with disabilities on the call today. Thank you.

Anastasia Dodson:
Thanks so much Rick. And maybe we can put a link, I don't know, Mary, if your team has a link that you might put in the chat about the ABLE account.

Mary Russell:
Yeah, we will grab that and share some additional resources. Thank you, Rick. I see a question in the chat and I know we also have Bonnie Tran from DHCS on to help with the questions. But a question from Nea Hanscomb, "Are redeterminations required by all existing Medi-Medi beneficiaries, including institutionally deemed consumers of regional centers?"

Anastasia Dodson:
Yes. So, redeterminations, yes. Now with the deemed folks, I don't know if Bonnie wants to chime in on that particular question?

Bonnie Tran:
Was the question, are the deemed individuals also required to do redetermination?

Anastasia Dodson:
Looks like that's the question, right.

Bonnie Tran:
I believe they do but let me take that question back.

Mary Russell:
Sure.

Anastasia Dodson:
I think maybe the question is, is it done through the ex-parte process, or do they actually get something in the mail? Maybe? I don't know if that might be the question.

Mary Russell:

Okay, we can work on some, we can take that question back. Nea, thank you for asking that. We'll work on some follow up. The next hand raised I saw was Susan LaPadula. Susan, would you like to come off mute? You should be able to.

Susan LaPadula:

Thank you, Mary.

Mary Russell:

There you go.

Susan LaPadula:

Good morning.

Mary Russell:

Hi.

Susan LaPadula:
Good morning, Anastasia. Good morning, Bonnie. I was just reviewing four of our counties that next Thursday will go to a brand new system, our CalSAWS, specifically San Diego being a large county. How will we be monitoring and tracking that? My understanding is redeterminations, applications have to be cut off on the 29th of June, and then we have a transition period, but I'm not sure where that will end.

Anastasia Dodson:
Yeah, I don't have the details, but I know that this has been a very carefully, painstaking, detail-oriented process to sequence this appropriately. But I don't know, Bonnie, if you have any other thoughts on that?

Bonnie Tran:

Well, so even with migration, so they'll be migrating over, they will still get their redetermination packet in the month of their normal renewals. We're also doing a text messaging campaign, text, and emails. So, they will also get that notification. We're pulling data every single month for that. So, once they've migrated over, they will receive that reminder, either in a text message or email, if we have that information on file. And it will include the correct link to the portal that their county is in at the time.

Susan LaPadula:

Wonderful. And then will we also be circling back with the members regarding the secondary, or maybe this is a state issue. The secondary address for the beneficiaries didn't originally populate when it went over to the plans. And I think we fixed that and we're working that through. Is that the update? This is for the file that leaves the state with all the addresses and contact information of the beneficiaries, and it's forwarded to the plans.

Bonnie Tran:

I don't have that information, but I can also take that back.

Susan LaPadula:
Wonderful. We were missing things like apartment numbers, suite numbers, whatever, or north, southwest, those kinds of things. And it was really difficult for the plans to reach the members. Thank you, Bonnie.

Mary Russell:

Thanks for that question, Susan.

Susan LaPadula:

You're welcome, Mary.

Mary Russell:

I also see a hand raised from Tatiana. Tatiana, would you like to come off mute?

Tatiana Fassieux:

Yes. Good morning and thank you.

Mary Russell:

Oh, sorry, Tatiana, are you able to unmute?

Tatiana Fassieux:

There we go.

Mary Russell:

There we go.

Tatiana Fassieux:

All right, thank you. Yeah, thank you for the opportunity. And I'm speaking from personal experience, because I'm helping my mom who is in a nursing home. We've been getting both redetermination notices. We got the yellow packet. We also got information from LA Care, which is the Medi-Cal Managed Care Plan. The last text message that I got, and this is where the question is, it says, was on June 15th. "CalSAWS, we processed your Medi-Cal redetermination. Questions, call." How long from the time that they received that redetermination packet, will we get a letter? Because I know my mom has a share of cost at the SNP.

Anastasia Dodson:

So, it sounds like the question is, maybe we can use an example. I don't want to call out your mom per se, but like it is so someone who has a month of June redetermination. Bonnie, can you say again? So, the packet, if it can't be done ex-parte, the packet, I believe it was supposed to be mailed in April?

Bonnie Tran:

Correct. Either April or May. They should have gotten the packet.

Tatiana Fassieux:

Well, yes. No, we've already submitted all of that, and I got a confirmation from CalSAWS that they received and processed that redetermination. So, my question specifically is, and it would apply to anybody that has already submitted their packet, how long from the time that it is acknowledged that it has been processed, does the individual, the dual eligible, know what their new share of cost will be, if it will change?

Anastasia Dodson:

Right. Yeah. Bonnie, so what's the sorry to put you on the spot, Bonnie. Do you know how long the county has to respond back?

Bonnie Tran:

Usually, it's 45 days.

Tatiana Fassieux:

Okay. All right. But once it’s processed, they should be-

Bonnie Tran:
They should be receiving a letter in the mail to give them that new amount, if there’s a new amount.

Tatiana Fassieux:
Okay. And so, the nursing home also gets notice of that? Or the managed care Medi-Cal plan knows that too? Because they’re the ones that approve the long-term care now.

Anastasia Dodson:
So, just the process on the Medi-Cal plan side, it is separate because, and there’s continuity of care provisions, what have you, so it’s ... So, the Medi-Cal eligibility is Medi-Cal eligibility. And then, as far as the managed care plan, I’m not aware of any process that the managed care plan is, they do not need to reaffirm. Just because someone’s Medi-Cal eligibility has been reaffirmed, the Medi-Cal plan, there’s no reason for them to look at another authorization in that light.

Tatiana Fassieux:
Okay. Because I know the plan is also doing outreach to make sure that we've submitted all the documents, obviously, but I just needed to know what to expect in the form of notification of and when, and that probably would be for anybody that has a share of cost. They would like to know what to expect and when to expect that letter.

Anastasia Dodson:
Yes. Sounds like Bonnie is saying 45 days is the standard for confirmation from the county.

Tatiana Fassieux:
Thank you very much.

Anastasia Dodson:
Thank you.

Mary Russell:

Thanks, Tatiana. I think we have time for one more question. I see a question in the chat from Marie, and I'm not sure, Marie, if you want to raise your hand and come off mute, but the question in the chat is, if the program will be able to assist with people discharging from Department of State Hospitals. I'm not sure if that's about enrollment or renewals. But if you'd like to raise your hand, Marie, there we go. Okay. You should be able to unmute if you'd like to add more detail there.

Marie Mohapp:

Yeah. Thank you for making time for this last question. We, at the Department of State Hospitals, have just been noticing so much happening with CalAIM, and inclusion of lots and lots of people that have been at considered high risk before. But there's not a lot of, I don't see a lot of partnership happening with DSH and I'm just wondering, most likely for this program, it looks like it's enrollment. What we would like to be able to do is work towards having our patients provided with as many benefits as they can or set up with eligibility and benefits before they leave us. So, we're just looking for answers about how to really, in terms of helping people discharge or transition successfully back out into the community, does this help us?

Anastasia Dodson:

Yeah, Marie. Yeah, of course. DHCS would be more than happy to work with state hospitals. So, if you wouldn't mind, just message me your email, your state email, and we will absolutely get in touch with you and of course. Yes, absolutely.

Marie Mohapp:

Okay. Who is this? Who should I... who is this?

Anastasia Dodson:

Anastasia Dodson.

Marie Mohapp:

This is Anastasia. Gotcha. Okay. Thank you so much.

Anastasia Dodson:

Yes, of course. Absolutely. And I do see some more questions, so why don't we... Mary, I think we should probably keep going, but I'd want to acknowledge, it seems like there is some questions about regional centers, what have you, and that our eligibility team can maybe take that back and consider if there's other webinars in the coming weeks or so or if there's an FAQ that we can work with DDS on.

Mary Russell:

Great idea. Yep. Great. Thank you all for those questions. I think at this point, we will transition to the next portion. So, Anastasia's going to share some reminders on Medi-Medi Plans and the Medi-Cal matching plan policy.

Anastasia Dodson:

Thanks so much, Mary. Next slide.

Anastasia Dodson:

So, this is just a reminder of what you probably already know, but there may be new people joining. So, we have what we're calling Medi-Medi Plans. They are a type of Medicare Advantage plans in California that are only available to dual eligible members. These Medi-Medi Plans they're required to coordinate all Medicare and Medi-Cal benefits for their members. So, this is the successor program to Cal MediConnect, but based on a federal model that has very specific requirements, again, for the Medicare plan to coordinate all Medicare and Medi-Cal benefits. Right now, they're available in the seven counties listed on the slide. And then starting in January 2024, the Medi-Medi Plans will be newly available for voluntary enrollment in five additional counties: Fresno Kings, Madera, Sacramento, and Tulare counties.

Anastasia Dodson:

So, we have, again, there's the usual process for anybody with Medicare, if they want to join a Medicare Advantage plan, is to, they can contact 1-800-MEDICARE. There's an online process, but also, since these plans are also Medi-Cal plans, they can use the phone number that they normally call for their Medi-Cal plan to request to be enrolled into the Medicare plan. Now, not all Medi-Cal plans have these Medi-Medi Plans. Again, right now, it's just those seven counties and then the additional five counties in 2024. But we've done a lot of work over the last year or two with information about these types of plans and there is information available on our website. Next slide.

Anastasia Dodson:

And then, of course, with Medicare Open Enrollment in the fall, there'll be more information about the specific names of the plans and in 2024 and any supplemental benefits. So more to come when we get closer to open enrollment. But I'll just say we're working with those five counties, with organizations in those five counties to get more information locally to people so they know what Medi-Medi Plan is, what that means and how to enroll and what the options are. Next slide.

Anastasia Dodson:

So, Medi-Cal matching plan policy. Again, this is an issue we have talked about with this group, but reminder that right now, in 12 counties, people can enroll separately from their Medi-Cal plan. They can enroll in a Medicare plan. And in order to reduce complexity, confusion for dual eligibles, we have a matching plan policy so that in those 12 counties that you see listed on the screen, if someone chooses to enroll in a Medicare plan and there is a Medi-Cal plan that's part of that same parent organization, then we will automatically enroll the beneficiary in the matching Medi-Cal plan.

Anastasia Dodson:

So, Medicare is the lead. We understand for people who are dually eligible, Medicare is how they get the vast majority of their healthcare benefits. So, they can choose whether or not to enroll in any type of MA or D-SNP or Medi-Medi Plan. But if they do and there is a Medi-Cal plan that's from that same parent organization, then we'll match them up so that there's less confusion. Two different names, different plans.

Anastasia Dodson:

The update we have is in 2024. We're going to be updating the logic for the matching plan policy to add Kings, Madera, and Tulare counties because those are the counties that we're going to have the Medi-Medi Plans in. So again, Medicare choice, that's primary. It's just the Medi-Cal choice, then, we'll match in three additional counties. All right, next slide.

Mary Russell:

So, we do have some time here for questions on any of those updates or reminders about the matching plan policy. And I do want to acknowledge some of the ongoing conversation in the chat. And so, we're doing some research on the backend to help with some of this follow-up. Any questions at this time? Okay, I think otherwise, Anastasia, we could keep going and we can always come back to this section as needed.

Anastasia Dodson:

So, the next topic is around the State Medicaid Agency Contract Template. This is the contract that DHCS has with the Medi-Medi Plans or D-SNPs. Next slide.

Anastasia Dodson:

So, we have started something new where we have this contract updated each year to improve the way that dual eligibles receive care. Again, being enrolled in a D-SNP, a Medi-Medi Plan is voluntary, but we have, again, some of the terminology here, we're calling them Exclusively Aligned Enrollment Dual Eligible Special Needs Plans, but it’s the same thing as Medi-Medi Plans. And we know that people don’t need more jargon in

their lives, but this page does have a little jargon for the technical folks here. The Medi-Medi Plans, those are the EAE D-SNPs, and they have a contract with DHCS. And then, there are other types of D-SNPs that also have a contract with DHCS.

Anastasia Dodson:

That contract is called a SMAC and that SMAC outlines the care coordination and other requirements that we are holding the D-SNPs accountable for because, again, part of this model is the state, in partnership with the federal government, we say very explicitly our expectations for these Medi-Medi Plans and for all D-SNPs because, again, they have this federal model where they are responsible for all the care coordination for these members.

Anastasia Dodson:

So, for 2024, this slide kind of and the next one will highlight some of the changes. For 2024, DHCS is going to use this SMAC to require that all of the plans have what's called an H-contract, basically, so that when they report their quality measures, their quality measures will only be for dual eligibles so that it's more clear, more transparent to the state, to consumers, to providers the quality ratings, the quality scores for these health plans just for dual eligibles because we know that dual eligibles tend to have more chronic conditions, higher utilization, additional complexity compared to people with only Medicare. It's not every person in every category, but in general, people who are dually eligible have more complex conditions and complex utilization of services. So, we want to have a better understanding of the quality measures. Next slide.

Anastasia Dodson:

So again, we're in a technical journey on these next couple slides. We have separate contracts for the Medi-Medi Plans and then the non-EAE D-SNPs. So, the 2024 contracts focus on some of the care coordination requirements. You've heard of ECM in CalAIM. So, we're making sure that all of the D-SNPs provide the equivalent of ECM for their members. We also have requirements around palliative care. Again, that's a policy that we already have in Medi-Cal, that the Medi-Cal plans have to provide a palliative care benefit and opportunity for referrals for their members. So, this just applies that to the D-SNPs, to the Medi-Medi Plans, and then some more explicit dementia care requirements for the D-SNPs and their model of care. And again, that's things that were already in the 2023 contract, but we're strengthening for 2024.

Anastasia Dodson:

And then finally, greater coordination, more explicit about coordination on Medi-Cal dental benefits. Because, as you probably know, Medi-Cal has a dental benefit for all members and people who are dually eligible, they are also eligible for those dental benefits. But it can be complicated because sometimes, Medicare plans, their

supplemental benefits also include dental. So, it can be complicated there. So, we're requiring better consumer information about how to navigate dental benefits. So, we have these particular contracts. They're posted on our website. And again, this is pretty technical stuff, but for those of you who are in the technical category, this is the update and the link for those contracts is there on the slide. Okay, next slide.

Anastasia Dodson:

And again, this is just more technical stuff to say of these two types of D-SNPs exclusively aligned or Medi-Medi and then the non-EAE, what are the chapters in these SMAC contracts? Next slide.

Anastasia Dodson:

And then there's also a policy guide where we have more details. We have two for 2024. We have two chapters that we've released. And then, we will continue to work on the chapters and they're very lots of details to make sure the plans know exactly what we are expecting, and we start with the language from last year and then make adjustments as needed. So just, I think that gist for those of you who are health plans, you know. You're familiar with these documents and those of you who are consumers, consumer advocates, just in these are some ways that we are giving very explicit instructions to the plans as to what we expect them to do and how we will monitor them. Next slide.

Mary Russell:

Great. Thanks, Anastasia. So again, a few more minutes here for some questions. Anything related to the SMAC or updates for 2024. And great, I see a hand from Susan. Go ahead. You should be able to unmute.

Susan LaPadula:

Thank you, Mary. Hi Anastasia. Did we have an opportunity to look into adding the language for automatic crossover from Medicare to the Medi-Cal plans?

Anastasia Dodson:

We have looked at that and I know that this is on our list. We do not have that requirement in the 2024 SMAC. We have had discussions. We have monthly discussions with the D-SNPs, and we know that is something that many of them are undertaking or already have. Based on our assessment and talking with the plans, it's not quite time to require that, but we know that's exactly how they're all... the direction that they're moving in.

Susan LaPadula:

Wonderful. Thank you so much for the progress. Appreciate it.

Anastasia Dodson:

Sure.

Mary Russell:

Thanks for the question, Susan. A question in the chat from Meredith about D-SNPs and Community Supports. Do you want to speak to this a little bit, Anastasia?

Anastasia Dodson:

Sure. And I wish we had a visual, but it's all good. So basically, people who are dually eligible, they can be eligible for Community Supports from their Medi-Cal plans, just the same as anyone else. So, in all of DHCS instructions to Medi-Cal managed care plans and just also flagging that at this point, almost all dually eligible beneficiaries are enrolled in a Medi-Cal Managed Care Plan. It's absolutely optional to be enrolled in a Medicare Advantage plan, but Medi-Cal, dual eligible beneficiaries are almost all enrolled into a Medi-Cal managed care plan at this point.

Anastasia Dodson:

So anyway, that means by being enrolled in a Medi-Cal plan, the D-SNP, the dual eligible beneficiary can access Community Supports just like any other Medi-Cal Managed Care Plan member. There is kind of a difference among plans as to which Community Supports they offer, but there's no instructions to offer a different set to dual eligibles or what have you.

Anastasia Dodson:

The one other piece of it, though, is sometimes, if someone is in a Medicare Advantage plan, a D-SNP, that D-SNP has supplemental benefits that can be actually the same, defined the same way as some of the Community Supports. It's not 100% overlap at all, but there are certain home modifications that the D-SNP, the Medi-Medi plan can offer. And in that case, it's provided through the D-SNP instead of through the Medi-Cal plan. But from the consumer's perspective, it really should be seamless. That's what our expectation is for the Medi-Medi Plans. And we want people who are in other types of D-SNPs also to have as much as possible a seamless experience where it's the health plan that figures out, "Okay, is this a Medicare benefit or a Medi-Cal benefit?" From the consumer's perspective, hopefully that's not an issue. It's just, "Okay, my health plan is telling me, yes, the home modification or help to such and such at home. Whatever the Community Support benefit is, I've got it. They're helping me access that benefit.'"

Mary Russell:

And Chris is sort of adding on to that with how do the Community Supports benefits get decided and navigated if the ECM provider is in the D-SNP rather than the Medi-Cal plan? Will the D-SNP make that determination?

Anastasia Dodson:

Again, if it's a Medi-Medi Plan, it's the same organization and the federal government, CMS, and DHCS, we are hopefully extremely clear, explicit to the Medi-Medi Plans that their internal process to sort out, "Okay, exactly how are we charging this?" Medi-Cal is the payer of last resort, but from the consumer perspective, it should be seamless, coordinated, combined so that there's no two different organizations that are having to sort of jockey back and forth that the beneficiary needs to work with. For someone who is in another MA plan that's like that plan is different than their Medi-Cal plan, yes, there's going to have to be some conversations hopefully between the plans. Hopefully, the beneficiary is not the one navigating it, but that's why we have the Medi-Cal matching plan. So, it's really in folks' best interest if they're in a Medicare plan to have the Medi-Cal plan be that same organization so that there's not confusion about which plan is covering the similar benefit.

Mary Russell:

Thanks, Anastasia. And Rick, I see your hand up, if you'd like to come off mute.

Rick Hodgkins:

Okay. Can you hear me?

Mary Russell:

Yes, we can.

Rick Hodgkins:

Thank you. I have an observation, not a question, and I just want to redirect and turn everyone's attention back to Thursday, January 23rd of this year. No, I'm sorry, not January, February 23rd of this year, that where we had a meeting mostly devoted to Community Supports, particularly around housing. And at that time, it was stressed that only people that who are homeless and/or that who are coming out of hospitalization that who don't have a place to go that they're the only ones that who can access those Community Supports for housing.

Rick Hodgkins:

Many of you are aware, I sit on the Lanterman Housing Alliance and two of our members that you might be familiar with, Brilliant Corners, who has operations in LA County as well as in San Francisco County and that they're running into a lot of battles because they seem to feel that people who have lived in a place for like, let's say, 15 years as I have or longer should be able to access housing supports as well because what if they can't afford the moving expenses? They're also on a fixed income. So again, I just wanted to make that observation. It was not a question. Thank you.

Anastasia Dodson:

Thank you, Rick. And I do think when we get to Mariya's presentation later in the webinar, let's see how we can fit that in. I'd be curious what Mariya thinks about that as well.

Mary Russell:

Yeah, those are great observations. Thank you, Rick. I'm not seeing any additional questions at this time, so I think, let's see. Tatiana's note that HICAPs are still getting complaints from some duals that their Medicare provider doesn't accept Medi-Cal. Consequently, they're being forced to find new primary care or other specialty provider that they need. Thank you for that, Tatiana.

Anastasia Dodson:

Yes. I just want to acknowledge that and express deep appreciation to the advocates, legal aid folks who have been sending us examples. And we have a very experienced team calling, reaching out to those Medicare providers, explaining that there's no need for them to drop their patients. They can still get the same payment structure. They don't need to change how they're billing Medicare at all, and they don't need to be enrolled as a Medi-Cal plan provider. They can just keep billing Medicare as they have always done for these patients. So, thank you, everyone, for alerting us. Individual providers, we will keep on that outreach because we know that's a really critical issue. Thank you.

Mary Russell:

Yes, thank you. And another note from Lydia that “in our experience with CBAS and the duals transition, we do expect confusion and interruption of service when there's overlap between Medicare and Medi-Cal benefits, even within the same plan because supplemental benefits differ in quantity and eligibility criteria. So, the plan must have clear ongoing training of their UM teams to make the goal of a seamless experience for beneficiaries a reality.” So really appreciate that note, Lydia.

Anastasia Dodson:

Great point.

Mary Russell:

Okay, I think we're ready to transition to the next section, Anastasia.

Anastasia Dodson:

Okay. And I think I'm handing... oh, I'm going to do an intro and then, I'm going to hand off to members of the team. Okay. So, we have heard many of you requesting data, for some time, about what's been the experience, what data do we know about dual eligible beneficiaries and CalAIM initiatives, et cetera. And I'll just say we have many people asking for data in not just around duals, but many parts of CalAIM. And so, we have some data available, and I should also add we have our LTSS dashboard, which, of course, many of the people who are using Long-Term Services and Supports are dually eligible. So, there's a lot of intersections there as well.

Anastasia Dodson:

So, we have been working on data and other parts of our department, all areas looking and thinking about it. And so, with these next few slides, we're going to present what we have available publicly right now, in addition to what we have, again, we have our LTSS dashboard kind of round one that we published in December. We are working very hard on getting additional data out. We want to make sure that it's correct data, so we have a very intensive QA process. So, we're going to keep releasing things week by week, month by month on this data. But today, we're just going to take a little quick trip around the world of the data and show you what we have. Again, more stuff will be released as it's available and perhaps we will do this again, I don't know, maybe December or sometime in the fall to kind of catch you all up on, what new data has been released? What do we know?

Anastasia Dodson:

Next slide. This is just what I was just saying. We have a variety of topics, variety of data. Our open data portal has all kinds of data and the amount of data on that portal has grown so much over the last few years. We also have some published reports that we have done routinely, such as the Cal MediConnect Dashboard that's on a PDF, something that you go to a website, and you click on and it just kind of pulls up a document. Again, folks are asking for additional information and impacts on duals. Some of the data that we have here is kind of ad hoc, and then more of it will get released in the coming weeks and months. Next slide. Let's just talk about the delivery systems.

Anastasia Dodson:

Next slide. In prior webinars with this group, we have talked about how many people are enrolled in Medi-Medi Plans and the MMP you can see is the acronym. We had to fit a lot into this one slide. The orange color to start with is people who have original Medicare, and this is all people who are dually eligible for Medicare and Medi-Cal in California. On this slide you can see again the majority of folks who are dually eligible are an original Medicare. Then the darkest blue is people who have, we'll just say a regular MA plan, and that's approximately 18%. This is preliminary data. The Medi-Medi Plan, about 14% of dual eligibles are in a Medi-Medi Plan. The special type of D-SNP, about 10% of dual eligibles are in other D-SNPs that are not many Medi-Medi Plans and then smaller amounts in other SNPs, the FIDE-SNP and PACE. This is just a big picture snapshot and I'll just add, I don't think we have a slide on it here. But this varies a lot by county, so in some counties it's more like 80% of dual eligibles are in original Medicare.

Anastasia Dodson:

In some counties, the percentage in original Medicare is more like 40% or even less, and there's everywhere in between. Maybe at a future webinar we can kind of do a map or something. But I will say on the Office of Medicare Innovation and Integration website, we have a report that goes county by county for Medicare advantage or enrollment for dual eligibles. If you look, I think somebody could probably put the link to that report in the chat and that will kind of show you county by county. But this is a statewide snapshot and these numbers they have changed a lot. We're going to see further down one of the slides what has happened just over the last year or so. But even between January and April, the enrollment and Medi-Medi Plans has grown.

Anastasia Dodson:

Some of that is sort of catching up on for the technical systems. But then when we get to 2024, we will see this pie chart change again, because of the Medi-Medi Plan expansions, maybe some folks in regular MA plans will join Medi-Medi Plans, maybe some folks in original Medicare. But we'll keep an eye on this pie chart because it will change. Next slide. Now I think I'm... Mary, I'm handing off?

Mary Russell:

Yep, we'll ask Amy Peterson to jump in here for this section.

Amy Peterson:

Hi everyone, I hope you're having a lovely Thursday morning. I'm going to be speaking about the California MediConnect D-SNP dashboard report that's coming out eventually. We're still working on it, as Anastasia said, and we're doing quality assurance on the data. Next slide, please.

Amy Peterson:

As you probably know, for many years, DHCS has been publishing a quarterly report on enrollment and demographics regarding the California MediConnect Demonstration Project. And over the next nine months, we'll be transitioning to the California MediConnect, Cal MediConnect, CMC Dashboard to the D-SNP dashboard. For the coming months there will be a combined Cal MediConnect and D-SNP Dashboard. The data is kind of layered to show data being released about Cal MediConnect plans and D-SNPs due to the data lag for reporting. Again, we're only now getting data in from the beginning of the year. Next slide please.

Anastasia Dodson:

And Amy, maybe I'll jump in a little bit about that data link?

Amy Peterson:

Please do.

Anastasia Dodson:

Maybe folks from Aurrera can put in the chat, the link to the page that has the current or previously published versions of the Cal MediConnect Dashboard. There's a lot of information there that's compiled annually, so we won't be able to get the annual information about the Medi-Medi Plans and the D-SNPs until nine months or so from now or maybe even a year from now. That's why it's kind of this hybrid transition. Anyway, I just wanted to point out about the lag that it's not just because maybe there's a three-month lag or something in the thing, some of it is even annual data.

Amy Peterson:

Thank you for that clarification. I appreciate that too. Next slide please. In figure one, this chart reflects the increase in Medi-Medi Plan enrollments after the CMC to the MMP transition began on January 1st of this year in 2023. This is a good point in time snapshot showing the relatively steady enrollment in 2022 for CMC members and then the significant increase in enrollment from 111,000 CMC members to about 230,000 members as of April of 2023. And please note that the data is preliminary. Next slide.

Amy Peterson:

This is the California MediConnect other and annual count of other grievances. And compared to 2021, the total count for the other grievance category reported for 2022 increased by approximately 18.7%. IEHP and LA Care have a larger beneficiary enrollment and that contributes to a higher number of grievances, when compared to the other CMC plans.

Anastasia Dodson:

Part of what this is showing, this is an example of the annual data. You can see the timeframe it's 2022, it's how Cal MediConnect data, and Amy and her team are just in the process of publishing this data for 2022. Again, this is Cal MediConnect Plans.

Anastasia Dodson:

Like she's saying it's helpful to know kind of well, LA Care and Inland Empire Health Plan, what's going on there? Well, they have a high number of members, but what we'll also be looking at in the coming months is cause traditionally we have published, let's just say if you go and you'll look and see the link we've put in the chat, the dashboard that has the 2021 data, again, there's just volumes and volumes of data that we have. We don't have a “how are things changing over time” measure but some of what we're thinking about in the future is when we put things on the open data portal, if we just put the raw data, then there's some tools there that makes it easier for people to chart trends over time and keep track. Because again, if you look at the link for the Cal MediConnect dashboard, there's a lot of measures, a lot of data. So, we don't have every measure chart over time. Anyway, sorry Amy, keep going.

Amy Peterson:

That's fine. Figure 24 in the next slide and it shows the overall trend of CMC members seeking care in the emergency room for behavioral health services. And that has decreased from 17.8 visits per 10,000 member months in quarter three of 2022 to 13.8 visits per 10,000 member months in quarter four of 2022. From between quarter three and quarter four, that we saw a decrease. I'd like to transition to Anastasia for any more remarks on this slide.

Anastasia Dodson:

This is an interesting example. Part of it is, again, we get data, we do have meetings with the plans to try to better understand what we're seeing in some of these data trends, but this is one that we've just recently compiled and we're looking at and so we will ask the plans, "what do you think is going on?" Then we'll look at the underlying data by health plan to see is this some anomaly with one or two plans? Is it across the board?

Anastasia Dodson:

But again, thinking about the future and how can we make the data more transparent? Should we think about open data portal or other ways that we can get this data out more easily for us and more readily for all of you? Again, just having the data published doesn't mean we understand what it means and so that's another whole topic that we

want to consider as well.

Amy Peterson:

Thank you very much. I think my portions is finished.

Anastasia Dodson:

Thank you, Amy. I know we're going to do. I see questions in the chat, but we'll get through this next bit of data and then maybe do some questions and then I know Mariya's got a good presentation as well. One more piece of data that we are collecting is for D-SNP deeming periods. Next slide.

Anastasia Dodson:

Let's talk about what this means. We have a requirement in our SMAC anyway, and it's a federal requirement that the D-SNPs, both the Medi-Medi Plans and the non-EAE D-SNPs. They have to help members who lose their Medi-Cal eligibility, and this is relevant, of course, we're doing the renewals now. Basically, Medicare allows D-SNPs to voluntarily have their members stay enrolled in that D-SNP for up to six months, even if they lose their Medi-Cal eligibility. That is really important for members to keep access to their doctors, to keep their prescription drug access, et cetera, while they sort out what's going on with their Medi-Cal eligibility.

Anastasia Dodson:

The deeming periods either need to be between three and six months. We have collected information from these D-SNPs about their deeming periods, and we are going to be posting this information on the DHCS website in our pages around integrated care for duals so that all of you as advocates or as consumers, whatever organization you're with. You can look at that data, you can find out if there's a consumer who's lost their Medi-Cal eligibility, hey, they're in this such and such Medicare plan and then be able to work with that plan to say, don't let this person lose their Medicare plan as well. Keep their providers and let's get this Medi-Cal sorted out. Next slide.

Anastasia Dodson:

This is the data that we have so far. Again, this is the parent organization and when we post it, what we will do is also try to crosswalk the specific plan names the Medicare marketing name because that's usually what the consumers will see. But you can see it ranges from, again, three to six months and this is the amount of time that someone, if they lose their Medi-Cal eligibility or there's some kind of issue there, they can stay in the same Medicare plan and then things will get resolved hopefully with their Medi-Cal, and then they can have their full restoration of their Medi-Medi Plan or their D-SNP and with minimal disruption for their Medicare providers.

Mary Russell:

Great. Well, I know that was a lot and there's been some good conversation in the chat. A few questions about the data Anastasia indicating an increase in the Medi-Medi Plans, and just wondering to what that could be attributed to, and maybe that would be marketing efforts by the plans or any insight to share there?

Anastasia Dodson:

Yes. Let's maybe go back to that slide showing the growing enrollment.

Mary Russell:

I think 37.

Anastasia Dodson:

Great. Of course, just about everybody, but not necessarily exactly everybody, but the 111,000 or so Cal MediConnect members they transitioned to Medi-Medi Plans. Then the D-SNP lookalike transition, you may recall, we talked about that a lot last year. That was, I believe it was over a hundred thousand members, some but not all of those folks transitioned to a Medi-Medi Plan. If the parent organization of their D-SNP lookalike, their MA plan also offered a Medi-Medi Plan there was a process, an automated process for those members to transition into other plans and in some cases, it was Medi-Medi Plans.

Anastasia Dodson:

Then there were some D-SNPs that were allowed prior to the transition and if a member was in a D-SNP then that plan also offered a Medi-Medi Plan, then they could transition to a Medi-Medi Plan, so it's a combination of folks. And then yes, of course marketing, the open enrollment period.

Anastasia Dodson:

Again, we think that there's probably a fair amount of that increase from the 218,000 to the 231,000, is probably related to some cleanup, but may have been, again, marketing efforts. I hope that helps is there's several factors contributing to the growth.

Mary Russell:

A comment on the behavioral health slide if we want to go to slide 40. From Chris, just that it's such a broad category that it might be more helpful or informative if it could be broken into SMI, SUD, depression, anxiety. So, in an observation for DHCS.

Anastasia Dodson:

Great point. Yes. There's so much that we can look at. So, appreciate people's engagement on this and thinking about how we should prioritize for the future.

Mary Russell:

Great. Then I know we have some CMS colleagues on, but another question from Chris about payment. Does CMS pay D-SNPs or Medi-Medi, EAE Plans differently from regular MA? I'm not sure if those from CMS would like to comment on that?

Kerry Branick:

Hi, this is Kerry Branick from CMS. They're generally paid the same way.

Mary Russell:

Thanks Kerry. I'm not seeing any other questions on this portion of the presentation at this time. I think if we're ready, we will transition at this time to Mariya Kalina, the executive director of the California Collaborative for Long-term Services and Supports on the CalAIM listening sessions. Actually, just before we flip to Mariya, thanks for being ready. But I did see a hand up from Lindsay. Lindsay, would you like to jump in with a question?

Lindsay Yourman:

Oh, yeah. I'm trying to look for county level data on the Medi-Medi Plans in terms of how many of their members are enrolled in ECM and how many of their members are receiving Community Supports. Is that data within any of these links or is that something I should stop searching for?

Anastasia Dodson:

Yeah, so the Medi-Medi Plans, their model of care is already very similar to ECM. So, we do not have reporting requirements for the Medi-Medi plans or the D-SNPs on how many are getting the equivalent of ECM services, but it is part of essentially their model of care requirements. There is not separate reporting on ECM for Medi-Medi Plans.

Lindsay Yourman:

Got it. Thank you.

Mary Russell:

Thanks for that question, Lindsay.

Anastasia Dodson:

I guess I should add that shout-out to Justice in Aging and the Duals Ombuds program because they have been requesting data around ECM and Community Supports for dual eligible members. We don't have that data published just yet, but very much want to acknowledge that's been a kind of longstanding request and we're sorting that out as part of kind of overall work on community sports and ECM reporting. But that is different than those who are in Medi-Medi Plans, just again, because they get ECM just as part of the whole package of being in Medi-Medi Plan.

Mary Russell:

Thanks. Lydia, did you have a question related to that?

Lydia Missaelides:

Yeah, I had a question I put in the chat. It had to do with people moving in and out of D-SNPs because our experience, particularly in the first few months of the year, was that a number of individuals, particularly in Southern California, didn't realize, beneficiaries did not realize they were in a D-SNP plan and that their Medi-Cal plan changed. They were trying to get out of it and changing plans.

Lydia Missaelides:

Anyway, it caused some tremendous confusion and also lack of authorization for services for our CBAS providers, that our CBAS programs are not intermittent care, they are continuous care for people once they meet eligibility. One question I had was, I can't recall what the rules were for changing plans for duals and are there any restrictions on that?

Lydia Missaelides:

Then secondly, the problem that compounded all of this was that the AEVS system, the online eligibility system for determining if somebody's eligible and what plan they belong to has a huge lag time it seems. People thought they were in one managed care plan, but actually they had already moved to another one but providers that were looking them up on AEVS, obviously that wasn't obvious to them. Just wondering if there's any attention being paid to that. Trying to improve the lag time on the AEVS updates.

Lydia Missaelides:

Then the other question I had was just more on policy. Are there any restrictions on people changing plans in this process?

Anastasia Dodson:

I think I'm just going to do high level on that because I know we're going to get Mariya's presentation.

Lydia Missaelides:

Thank you.

Anastasia Dodson:

Dual eligibles can change their Medicare plans, D-SNPs, MA plans essentially quarterly except in the sort of last part of the year. They are eligible for a special enrollment period, so they can change their Medicare Advantage plans, D-SNPs, Medi-Medi Plans almost quarterly. Then the Medi-Cal plans can be changed monthly but we do have that matching plan policy. And Lydia certainly why I acknowledge, I know there were some disruptions in the beginning part of the year, and it was kind of a compounding issue with the mandatory Medi-Cal managed care enrollment and then the D-SNP transition. But we think we've got that sorted out. So, if it's not, you can email us, DHCS. Then the other thing is that we have the notices and work that we are doing around continuity of care. So, in the future, that type of thing should not happen because we are going to be very clear with our Medi-Cal plans about Medi-Cal services, continuity of care. So, if they do switch plans, then the continuity of care provisions should apply. So anyway, I don't want to shortchange Mariya on her presentation, but good topic and thank you for working with us.

Mary Russell:

Yes, thanks so much, Lydia. Okay, great. So, we'll hold on questions here and we'll let Mariya jump in, and we will probably have time for more questions at the end. Thanks everyone.

Mariya Kalina:

Thanks, Mary. Just a quick background on the CalAIM Listening Sessions, if you haven't heard of these before, the California Collaborative for Long-Term Services and Supports, Insure the Uninsured Project, and Chapman Consulting partnered at the beginning of the year to launch a monthly listening session series, really aimed at specifically hearing from LTSS providers about their experience with the CalAIM transition. And through these sessions, where actively archiving and sharing lessons learned, including both challenges as well as successes and best practices. April through May, our conversations largely focused on enhanced care management and Community Supports provisions. And we heard from organizations who were successful in contracting, those who were working through the process and also from community

based organizations that are just trying to understand how they navigate their way through CalAIM. And so, I'll just start off by sharing some best practices that we've identified.

Mariya Kalina:

One we heard from CBOs active in CalAIM, as well as those working through the contracting process, that building relationships with Medi-Cal Managed Care Plan representatives has been really, really critical. It's a critical piece of this. Plans are integral in advocating for and assisting CBOs and navigating the many complexities of CalAIM and many plans are either patiently waiting or eagerly guiding CBOs through that process by providing technical assistance and collaborating to ensure successful delivery of services.

Mariya Kalina:

Some recommendations for those who may be exploring managed care plan partnership. First, just to acknowledge that CalAIM is new territory for everybody. And so, CBOs as well as health plan partners are still in a phase of learning. Participation is conditional and it'll evolve over time as best practices emerge. ECM programs and services were designed with flexibility in mind. So, work with your partners and mold services and interventions to fit your community.

Mariya Kalina:

And lastly, don't be afraid to negotiate. Plans have as much incentive as CBOs in the success of CalAIM, and what we're hearing is they're oftentimes willing to work with LTSS providers to find common or middle ground. And a really good example of that was a story we heard from Northern California in the Chico area. For rural providers, costa of delivery of services can be slightly higher because of the distance between participants and our rural partners were able to negotiate higher costs with their managed care plan just by demonstrating that it costs a little bit more. Number two, for those onboarding to CalAIM, be sure to leverage existing engagement opportunities. Many CBOs have been around for decades. They're learning and understanding the climate and culture of the communities they serve. And so, leveraging this knowledge and expertise in creating new and building upon existing ECM and CS programs and services is beneficial to all.

Mariya Kalina:

And many of you know, each ECM county service area has a PATH collaborative. They meet on a regular basis to share and troubleshoot and develop localized strategies for advancing the vision of CalAIM. So, it's a great opportunity to begin to build those relationships with plans to learn from local CBOs who are already engaged in CalAIM and start to find your way.

Mariya Kalina:

Number three, there have been substantial investments in CalAIM and there's many resources available to help facilitate the transition. So, if you are a CBO and you're thinking about onboarding to CalAIM, be sure to leverage those state resources and at the same time advocate and be vocal about the needs of your community and your needs as a CBO. And I think that's it for best practices that we've learned about over the last couple of months. So, let's move on to challenges.

Mariya Kalina:

All right, I think I touched a little bit on the flexibility. So that's coming up as a double-edged sword. Enhanced Care Management and Community Supports providers expressed concern and confusion on CalAIM policy guidelines and regulations and how to implement them in the regions they serve. The current policy guide and regulations are subjective and open to interpretation, and that's led to differences in how the policy translates across the regions and among providers and managed care plans. Providers are contemplating what the appropriate way is to get something done and that results in asking the same questions across multiple path collaboratives if they're engaged through that mechanism and getting multiple answers. So, this inconsistent messaging or this flexibility that was built in really has resulted in hesitancy and slower engagement with CalAIM from smaller community-based organizations.

Mariya Kalina:

The second challenge that we identified is that community-based organizations are struggling to navigate the order of steps they need to take to access path funding and subsequently become fully engaged in CalAIM as providers. There's at least a dozen organizations that are unable to get past the attestation stage due to the certification process, and many are struggling to complete the certification process because they're unable to access path funding without attestation. So, it's a chicken and egg problem. So, it would be really helpful to have some clarity and guidance on which process should be completed first, and what are the order of steps.

Mariya Kalina:

Challenge number three that we heard about is, as CalAIM implementation continues, ensuring that there's effecting and meaningful data collection among Medi-Cal managed care plans and CBOs is really critical to the success of CalAIM. But standardized data collection has been slow, and the lack of consistent data flow has resulted in difficulty accessing and extracting best practices. So, the need for accurate data collection is really vital to help equitably identify people who need CalAIM benefits and services to ultimately help improve health outcomes of older adults and people with disabilities and meet the goals of the master plan for aging.

Mariya Kalina:

I think the last challenge that we identified in our last few listening sessions touches on data as well. Many new contracted Enhanced Care Management providers are experiencing difficulties identifying and reaching individuals in their communities. They're at other eligible for ECM services. There's sort of this assumption that's made as part of the contracts. Managed care plans will provide ECM providers the data on eligible Medi-Cal members. But CBOs are reporting that there are challenges with obtaining the timely, comprehensive data and information necessary to identify eligible members within their service area and the services that are already offered and available to those members. And this disconnect in the flow of information across different provider types, including ECM providers, has created a challenge in effective outreach and enrollment. And it's especially true for newly contracted ECM providers. So, a potential solution that we talked about is to use existing local community networks in partnership with managed care plans to conduct better outreach to those that may be eligible for ECM services and utilizing local networks.

Mariya Kalina:

Utilizing those local networks offers ECM providers the capability to identify potential eligible members for their offered services. Building relationships with key stakeholders is critical to increase the number of recipients of ECM and community support services, as well as helping to maintain continuity of care. And I think those are all of the challenges and successes that we've had over the past couple of months or identified over the past couple of months.

Mariya Kalina:

And thanks so much for the opportunity to share. We do have another session coming up next Thursday, June 29th from 10 to 11. We're going to focus the conversation on the long-term care carve-in as well as transitions. I know Lydia, who just spoke, will be joining us. And in case you're interested, I will drop the link in the chat. Please consider it an invitation. We'd love to hear about what you're seeing, what you're hearing, or if you're in a mode of learning, we'll be chatting. So, thank you.

Mary Russell:

Thank you so much, Mariya. I know now we can open it up for questions or further discussion. And I also believe some additional DHCS team members have joined to help with some questions. So, feel free to drop a question in the chat or raise a hand. I think we can actually stay on that last slide with upcoming the dates for the upcoming sessions. Okay, perfect. So, I do see a hand from Katy and I'm not sure Katy, if this was related to one of the earlier topics, but feel free to come off mute.

Katy Krul:

Yes, thank you so much. My question is general question on outreach and of course little bit more clarity on dual eligibles and the eligibility for ECM. Could you please kind of explain in terms if we have someone who is in this D-SNP, does it mean that these organizations that the managed care plans who do this SNP provide ECM for this member? Or we can do that if they don't offer this service? So that's first question. And the second question, if possible, give to help care plans, managed care plans and the community-based providers kind of pinpoint the outreach, self-referrals, make it a little bit more structured if possible.

Anastasia Dodson:

Thank you for that question. So, I'm going to ask the Aurrera team to, if they can on the call or maybe send you a follow-up email. We have a chart on a slide that kind of explains ECM for D-SNP. Right now, in 2023, the Medi-Medi Plans, they provide the equivalent of ECM and the other D-SNP, someone can get ECM through their Medi-Cal plan. That will change in 2024. But I think that the graphic the Aurrera team can provide that or link to that because we have some slides and information on that. But the bottom line is that, if a dual is in a D-SNP, the D-SNP is supposed to be doing the majority of the care coordination. And if there are specific case examples, then we can push the D-SNP to do a better job if needed. And then for your second question, can you kind of repeat that or I'm just wondering if there's others on from DHCS who want to chime in on the second part?

Katy Krul:

Yes, my second question covered outreach and self-referrals and the outreach to participants, because I represent a community-based organization that's for adults and we have a lot of these participants of ours who require ECM. So where are the boundaries, where are the outreach for us, how these people can get assigned, how we follow up with assignment of these people to us or how do we know if they're already assigned to some other organization? So, if we know that they are assigned, maybe we can reach these to this organization and see how we can help this member, how to be successful in ECM. So, we kind of want to have more data on outreach. What is allowable? What do we do? How the self-referrals go? What is the protocol for us reaching out to folks who are not sent to us through managed care plan? So, all that structure if possible.

Anastasia Dodson:

Yeah, and I get what you're saying, and it may or I don't know if it's going to be identical across the state, there may be some differences by plans or even by counties, but I really want to invite other colleagues from DHCS to join, chime in on this question or even Lydia or health plans because I think it's probably just on topic, Mariya, to what you were presenting and if you heard anything kind of related to that in the listening

session as well.

Mary Russell:

And then Katy, there is a link in the chat now to a slide deck that answers sort of the first part of your question. So, feel free to reach out with any questions there. Oh, sorry, Anastasia, you're on mute.

Anastasia Dodson:

Yeah, no, and I know we just have five minutes left, but I just again, would invite any health plans, DHCS team, Mariya, they want to chime in about Katy's question, but my sense is that again, might be different by health plan, not, we hope that it's not kind of dramatically different, but there could be in some cases, certain counties where the health plan is the only health plan in that county if it's a coast county, what have you. So, they may have a kind of integrated process with their particular county.

Mariya Kalina:

Yeah, and I will say through the listening sessions, we kind of roughly touched on outreach. Didn't really do too much of a deep dive on it. There's not really a clear sense whether there is a specific approach. I do suspect, as Anastasia says, that it probably varies a little bit by region. And so maybe connecting with your managed care plan would be helpful.

Anastasia Dodson:

And I see Dr. Miller on. Okay, great. Yes. Oh, you can't get the, oh yeah,

Mary Russell:

I see your note in the chat though. Dr. Miller, she's noted that DHCS has encouraged plans to accept referrals from CBOs for folks to get into ECM. Great. And I know we can continue this conversation and if others have notes to add to the chat. But Rick, I see you have your hand raised as well. Would you like to add or ask a question?

Rick Hodgkins:

Hi there. My question surrounds, it's a two-parter. Do you know about the CBOs like Brilliant Corners? Brilliant Corners has operations in LA and San Francisco. Two of their members are fellow members of the Lanterman Housing Alliance along with me. And that their concern is…my computer is talking because I'm blind. Their concern, and this is also a concern I have, is around housing supports. Currently, as we heard back on February 23rd, housing supports can only be provided to people who are homeless and or those that who are being discharged from hospital facilities.

Rick Hodgkins:

There are people on Section 8 housing for example. They lived in one place for such a long time only because they thought maybe that was the only place they can get into. And they find something better that who also accepts their Section 8 or who will not discriminate against them because they have Section 8, and trouble is that they can't afford financially to move. They found a place but that they can't financially afford the moving expenses, let alone the security deposit and that type of thing. And so, are you familiar with Brilliant Corners? They're a CBO and then you have the East Bay Housing Consortium. I don't know if you know anyone from there, Darin Lounds. Darin Lounds also serves with me on the Lanterman Housing Alliance. Thank you very much.

Anastasia Dodson:

Thank you so much, Rick. And housing is such an important issue. Yes. So not my expertise, but again, really want to acknowledge how important housing is throughout the state and for people with disabilities and that there are many excellent local CBOs and that have wonderful models and innovative ways of serving the people who need those services and supports. So, shout out to all the wonderful CBOs in this area. And then I do hope that as we kind of proceed again, all of us on a journey with CalAIM, and of course the administration makes, is making mental health and housing and homelessness a very high priority, that we can continue to build partnerships and call out great examples and refine the policies because I'm sure things are not perfect. We need to keep, and I see Lydia's come in the chat as we keep this dialogue going. And I'll say there's other forums as well on housing, homelessness, behavioral health. But I think having this one here, particularly for duals is helpful.

Anastasia Dodson:

And Mary, I think we should consider, we want to have a housing topic in the future. I know that's quite ambitious, but it's an important issue. Yeah, I see. Mariya is off mute too.

Mary Russell:

Yeah. Mariya, did you want to add any other closing thoughts?

Mariya Kalina:

No, I mean just housing is absolutely such a critical issue and I'm really thankful that Rick raised it. I think it would be interesting to take a little dive into that.

Mary Russell:

Yeah, agreed. All right, well, thank you all so much and appreciating all the comments in the chat right now. Wanted to just flag for everyone that the next MLTSS & Duals Integration Stakeholder Workgroup will be on Thursday, August 31st at 1:00 PM. So, we will look forward to reconvening then. And in the meantime, of course feel free to reach out via the info@calduals.org inbox. And we really appreciate everyone's participation today. And thank you to our speakers for joining. Have a great rest of your day.