CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

CALAIM MANAGED LONG TERM SERVICES AND SUPPORT AND DUALS INTEGRATION WORKGROUP

Date: March 27, 2025

Time: 10:00 a.m. – 11:45 a.m.

Number of Speakers: 5

Duration: 1 hour 36 minutes

Speakers:

- Cassidy Acosta
- Anastasia Dodson
- Laura Miller
- Tyler Brennan
- Zayden Chen

TRANSCRIPT:

00:00:00 — Cassidy Acosta — Slide 1

Good morning, everyone, and welcome to today's CalAIM Managed Long Term Services and Supports or MLTSS and Duals Integration Workgroup. We have some great presenters with us today, including Anastasia Dotson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS, Laura Miller, Medical Consultant in the Division of Quality and Population Health Management at DHCS, Tyler Brennan, Health Program Specialist in the Managed Care Quality and Monitoring Division at DHCS, and Zayden Chen, Founding Principal at Zeal Senior Living.

00:00:30 — Cassidy Acosta — Slide 1

A few meeting management items to note before we begin. All participants will be on mute during the presentation. And as a reminder, the quarterly MLTSS and Duals Integration Workgroup are designed to provide stakeholders with the opportunity to ask questions. We ask that the plans that join these calls hold their questions for the multiple other workgroup venues that they have with the department throughout the month.

Please feel free to submit any questions you have for speakers via the chat. During the discussion, if you would like to ask a question and or provide comments and feedback, please use the raise hand function and we will come around to unmute you. Just a quick note that the PowerPoint slides and all meeting materials will be available on the DHCS website soon and we'll make sure to include a link to that website in the Zoom chat.

00:01:12 — Cassidy Acosta — Slide 2

So now we'd like to take a moment to ask you all to add your organization's name to your Zoom name so that it appears at your name - organization. So, you can do this by clicking on the participants icon at the bottom of the window, hovering over your name and the participants list on the right side, clicking more and selecting rename from the drop-down menu. And then from there you can enter your name and add your organization as you would like it to appear.

00:01:37 — Cassidy Acosta — Slide 3

This is our agenda for this morning. We'll begin today's meeting with an update on Medicare Enrollment Data for Dual Eligible Members and Dual Eligible Special Needs Plans, also known as D-SNPs. Next, we'll hear about D-SNP updates, which will be followed by stakeholder Q&A. Then we'll hear the latest on the 2026 D-SNP State

Medicaid Agency Contract or SMAC and Policy Guide. After that, we will have a Community Supports spotlight on select service definition updates, which will be followed by the second stakeholder Q&A. And then finally there will be an update on Enhanced Care Management and Community Supports data. And we'll end today's workgroup with some information on upcoming meetings. And with that I can transition over to Anastasia for the workgroup purpose and structure.

00:02:20 — Anastasia Dodson — Slide 4

Thank you so much, Cassidy. And welcome everyone. So, as we usually say in the beginning of these meetings, the purpose of this workgroup is to have a stakeholder collaboration hub for CalAIM MLTSS and integrated care for dual eligible beneficiaries. We want to provide an opportunity for stakeholders across all areas to provide feedback and share information about policy, operations, and strategy for upcoming changes. This is a public meeting. We have a charter, and we really do value the partnership that we have with all of you. Next slide.

00:02:58 — Anastasia Dodson — Slide 5-7

We're going to start by just giving general information about enrollment data for dual eligible members and D-SNPs. Next slide.

We'll start off with Medicare enrollment data for duals. So, this is just a reminder of the different types of Medicare delivery systems for dual eligible beneficiaries, those who have both Medicare and Medi-Cal. On the Medicare side there's original Fee-for-Service Medicare, which about half of dual eligibles are enrolled in. And then there are different types of Medicare Advantage plans. So, half of duals are in some type of Medicare Advantage plans, and those include regular MA plans which are open to anybody that has Medicare, not just people who are dual eligible.

And then there are types of D-SNPs, Dual Eligible Special Needs Plans. In particular, Medi-Medi Plans have integrated member materials, appeals and grievances, and they are aligned where the member is in the same plan organization for their Medicare and their Medi-Cal. We also have some non-EAE D-SNPs, which I know is a mouthful, but those are plans where they have a D-SNP but maybe not all of their members are in their Medi-Cal line of business. And there are some D-SNPs that don't have a Medi-Cal line of business. Non-EAE D-SNPs for 2025 are closed to new enrollment unless they have a Medi-Cal line of business. Next slide.

00:04:56 — Anastasia Dodson — Slide 8-10

This is just a reminder of the different types of Medicare options that dual eligibles have in California. And so, we also have a FIDE SNP in California operated by SCAN Health Plan and that provides integrated Medicare and Medi-Cal benefits, all Medicare and Medi-Cal benefits. And then PACE is also an option. PACE is an integrated care model. Again, combining Medicare and Medi-Cal for dual eligible members. There are also some other Special Needs Plans. Those are I-SNPs and C-SNPs. Next slide.

You can see this pie chart gives you a sense of the relative enrollment. This is a snapshot from last July, but it's about the same as far as the proportion. So, a little less than half of full duals with Part A and B are in Original Medicare, Fee-for-Service. About 20% are in a regular MA plan. About 20% are in a Medi-Medi Plan or an EAE D-SNP. And then there are other percentages for the non-EAE, other SNP, SCAN, and PACE.

Next slide. And I just want to give you a sense now, the other slide gave you the percentages. These are the actual numbers. So as of January, or February, Medi-Medi Plans had 339,000 and there's just for context, about 1.7 million people in California now who are dual eligible, Medicare and Medi-Cal. And so again 339,000 are in Medi-Medi Plans. In the non-EAE D-SNPs there's 118,000 duals. SCAN has about 20,000, and PACE has about 24,000. Next slide.

00:06:56 — Anastasia Dodson — Slide 11-13

So now that we have some table setting with numbers, let's talk about some updates on D-SNPs.

Next slide. As we've talked about with this group before, DHCS has implemented a pilot program for something called Default Enrollment. And you'll see as we talk about it, this is a pilot in just a few counties, and it does not impact people who are already eligible for Medicare. So again, of those 1.7 million dual eligibles, there are some that newly become eligible for Medicare each month. But most people who are dually eligible, they're not new, they have had Medicare for a few years, maybe longer, and the Default Enrollment Pilot does not impact that population that already has Medicare. The Default Enrollment Pilot is just for people who are newly becoming eligible for Medicare and only in certain counties. So, it's a very small pilot.

Okay, so in this pilot, when a Medi-Cal beneficiary becomes newly eligible for Medicare because they're turning 65, or their disability application is approved through SSA Medicare, then the member gets two notices and then unless they opt out, they'll be automatically enrolled into the Medi-Medi Plan that's affiliated with their Medi-Cal plan. And we have talked about this pilot in previous meetings, hopefully this is sounding

familiar, but we'll go through a few more details just to make sure that everybody's tracking and aware.

00:08:58 — Anastasia Dodson — Slide 14

Next slide. So again, the pilot does not impact dual eligible members who are already enrolled in Medicare or people who are already enrolled in Medicare that are newly enrolling in Medi-Cal. So, some people perhaps with disability or over 65, they might already have Medicare and then they're newly enrolling in Medi-Cal. The pilot does not impact them. So, the pilot's only in San Diego and San Mateo counties and only certain plans. So, for example, in San Diego County, the health plan that's participating in the pilot is Community Health Group and there were 157 members newly eligible for Medicare in August of 2024. And that is the largest scope in either of the two counties. San Mateo, the numbers are smaller, so again it's a small pilot, but we are learning a lot from what's happening, and you'll see the data in an upcoming slide but also some technical things that we need to work on here at DHCS. So that's why it's just a pilot and we're going to see how it works.

00:10:17 — Anastasia Dodson — Slide 15-16

Next slide. So, last summer, Community Health Group got approval to start the pilot, and they sent their initial 60-day notices on June 1st, and they are still continuing to send those 60-day notices and enroll people. Then, on January 1st, 2025, Health Plan of San Mateo, they sent their initial 60-day notices and so far, they have enrolled one cohort as of March 1st. And in a future slide we'll show you the data for that. Of course, Community Health Group and Health Plan of San Mateo, they have met with local stakeholders to talk about the pilot. And what we are requiring is that the plans that are participating in the pilot, they must be engaged at a local level. Again, this is not a statewide pilot, it's just a local pilot. So, we want to make sure that anything that comes up, any questions, challenges, wins, improvements, those need to be communicated ongoing at the local level.

Next slide. So right, this is the exact timing and communication process. So, a member, as they are approaching age 65 or approaching when CMS will approve their eligibility for Medicare through disability, they will get a written notice 60 days before the month they become eligible for Medicare, which again you become eligible for Medicare the first of the month. In the case of older adults, it's based on your birthday month. And so, they get a notice 60 days before the month that they become eligible.

And then there's another notice that goes out 30 days before the month they become eligible for Medicare. And the notice comes with a choice to either take no action and

then join the Medi-Medi Plan or they can decline, and they can call or send back something in writing to say, "No, thank you." And they can also join a different Medicare Advantage plan prior to the effective date. There's also information about HICAP, Ombudsman, and Medicare resources and those notices. These plans also make phone calls to the members that are impacted on getting these notices. And of course, the notices were reviewed by advocates and stakeholders.

00:13:05 — Anastasia Dodson — Slide 17-18

So again, you're probably already familiar with this, but there are choices in Medicare and Medicare Fee-for-Service, Original Medicare, and other Medicare Advantage plans. But if the member wants to be enrolled in their Medi-Cal plan's Medi-Medi Plan, they're decent, they don't have to do anything. The enrollment starts the month they become eligible for Medicare. And if they don't want to be enrolled in the Medi-Medi Plan, then they can choose another option, Original Medicare, Fee-for-Service, or another Medicare Advantage plan. Enrollment in the plans is voluntary.

Next slide. There's also continuity of care. So, part of the intent with this pilot is that members already have Medi-Cal prior to getting their Medicare, then they have a provider network already set up with that health plan. So that's where we hope there's benefit to members. They can keep their primary care physician or specialist when they join the Medi-Medi Plan. And members don't pay a premium; they don't pay for doctor visits if they go to a provider that works with their Medi-Medi Plan.

00:14:30 — Anastasia Dodson — Slide 19-20

Next slide. So, here's the data. Very exciting. We can see now that Community Health Group has been implementing this pilot for a number of months. You can see that in the 65 to 70% of members who got a notice, they did enroll with the health plan via default [enrollment]. And then there's an opportunity after they've enrolled in that plan to disenroll within 90 days of their initial enrollment. So, then you can see on the far right, between 3.5 and 13% depending on the month, some members chose to disenroll after they had been default enrolled. So, we will keep bringing this data to you and just so you know, that's the information that we're tracking.

And as we launch in San Mateo County, next slide. We have initial data, but we can see for March, again, similar to what we saw in Community Health Group, a little over 68% of the members who got notices, they did enroll. And then again, the Health Plan of San Mateo pilot has just started. So, we'll keep you posted on the data there.

00:16:04 — Anastasia Dodson — Slide 21-22

Next slide. And I know we're going to pause at some point for questions and I think there were some questions about that in the chat, but we'll come back to that. Okay, so right, this next section is about local plans that are implementing D-SNPs in 2026. So just as a reminder, in California we have Medi-Medi Plans in certain counties, and both counties right now, we are working on an expansion of which health plans in which counties will have Medi-Medi Plans. So, what we're going to talk about here is an overview of what are Medi-Medi Plans and then we're going to have a map to show where those plans are that are expanding. And we have plenty of time to talk all about this.

So, first of all, just table setting. What are Medi-Medi Plans? It's the same name as EAE D-SNPs, but we just say Medi-Medi Plans. It's easier than the acronym mouthful. They are a type of Medicare Advantage plan in California that's only available to dual eligible beneficiaries. We've worked hard with CMS to develop this model. It is the successor to Cal MediConnect and it is the model that is being implemented in other states as well. So, states that had demonstrations, they are shifting to this type of a model or something similar. And even in other states who did not have a duals demonstration, this is the model that is going to be used in a number of other states. And I'll just say there are different nuances or components in other states. So other states are not doing something identical to this, but similar.

So, the way this works is an organization that has both a Medicare line of business and a Medi-Cal line of business. The same organization provides both sets of benefits. So, from a member perspective, they receive coordinated services across both sets of benefits because it's the same organization. And you see on the right-hand side of the slide that we have a little D-SNP plus MCP. Again, they're enrolled in both a D-SNP and a Medi-Cal plan. And together that makes a Medi-Medi Plan and the D-SNP contract, again it's the same organization. But we have to do things in a certain way because of the way we have contracts set up. The D-SNP provides care coordination and Medicare services, hospital doctor visits, prescription drugs. The Medi-Cal plan provides wraparound services, the Medicare cost sharing, long-term services and supports, transportation, etc.

00:19:29 — Anastasia Dodson — Slide 23-24

All right, next slide. So, here's the map. And you can see in orange, that's where the plans are currently available or Medi-Medi Plans in Southern California, some counties in the Central Valley and the Bay Area and Sacramento. And then for 2026 you can see dark blue on the central coast, the north coast, the rest of the Bay Area, and the Sierras,

that's where the Medi-Medi Plan expansion will be taking place. And again, that's starting in 2026. So, Medicare options always go on the calendar year. So, starting January 1st, 2026, the Medi-Medi Plans will be available for enrollment in the counties that are in dark blue and in orange. The lighter blue will be in a later phase.

All right, next slide. So, we are working with 10 [plans]. We're working of course all the time with the existing D-SNPs, existing Medi-Medi Plans, but there are 10 Medi-Cal plans that are going to be newly launching Medi-Medi Plans. And so, we are working very closely with those plans to get ready for January 1st, 2026. We're also of course, partnering with DMHC and CMS. And you can see on the list here, the local plans, the names of those plans that are planning to launch those D-SNPs.

Now there are of course many things that must happen as far as CMS and DHCS for these plans to be approved to launch. So, over the coming months, we hope, and we really are planning for all these plans to successfully meet the CMS and the DHCS requirements, but we'll keep you posted. And they have certain restrictions. They cannot do marketing before a certain time, but they do have local outreach planned. And again, they're working very hard to make sure they're meeting all the federal requirements, as well as the state requirements.

So, in the most recent activity there is that in February they submitted their applications and Models of Care to CMS. DHCS has reviewed those Models of Care. Anyway, in the fall, the Medicare annual open enrollment period, that's October through December, that's when people who are in those counties, dual eligibles, can select to be enrolled in a Medi-Medi Plan in those counties. So that's what we're working toward.

00:22:34 — Anastasia Dodson — Slide 25-26

Next slide. So, what are the criteria for someone to be eligible to join a Medi-Medi Plan? They have to have Medicare Part A and B. They have to have Medi-Cal. They have to be at least 21 years old, and they have to live in one of the counties that offers a Medi-Medi Plan. So, you've seen this number before, 339,000. That's the number of dual eligible members that are currently in a Medi-Medi Plan. That's increased quite a bit since our Cal MediConnect pilot where we had about 113,000. So, we are growing, growing, growing. And again, in 2026 there'll be additional counties.

Next slide. And this is just a reminder about Medi-Medi Plans and their provider network and continuity of care, because you know this is one of the key issues for members to think about, "Is my doctor in this network, how do I access care?" So Medi-Medi Plans, again, they have a Medicare contract, so they have a Medicare provider network of doctors, hospitals, pharmacies, etc. All on the Medicare side. They also have

a provider network on the Medi-Cal side that's existing. But if someone is newly joining a Medi-Medi Plan and their existing provider is not in the network, then that provider can join the Medi-Medi Plan network or the Medi-Medi Plan can help someone, help the member find a new doctor. Again, all that is very structured and we work carefully with our partners at CMS, and we try to make sure in all the stakeholder meetings, we remind folks that for the majority of the providers that these members see, it's providers through their Medicare network.

The other thing that is important is there's continuity of care. If the provider is not currently in the network that's an existing provider, then we do include provisions for the plans to work with the provider to try to come to terms and get that provider in the network.

00:24:55 — Anastasia Dodson — Slide 27

Okay, next slide.

We are working with stakeholders locally to talk about this expansion. We are going to be doing some local meetings in various counties; those counties that were in the dark blue, because we really want to have local conversations. If you have questions though, about any of this and you can certainly email the info@calduals.org.

And then since we already have these Medi-Medi Plans, we have lots of fact sheets and information already on the DHCS website. And then, of course, we're partnering with HICAP and the Duals Ombudsman to make sure they're looped in.

All right, next slide.

00:25:48 — Cassidy Acosta — Slide 28

Fantastic. Well, thank you so much for those presentations, Anastasia. We do have some time now for questions. I've seen a couple come into the chat, but welcome folks to also raise their hand and we can come around and unmute you.

Anastasia, we did get a couple questions in the chat around Default Enrollment. I know that you addressed these in your presentation, but could you just remind folks in the room today what counties the pilot has been launched in and what plans are participating?

00:26:12 — Anastasia Dodson — Slide 28

Sure. We have launched the pilot in San Mateo and San Diego counties. And in San Diego, it's just Community Health Group. San Mateo, it is currently Health Plan of San

Mateo. Kaiser in San Mateo will also be launching, but they have not sent out their first batch of 60-day notices yet.

00:26:38 — Cassidy Acosta — Slide 28

Thanks, Anastasia. And then we do have some conversations happening in the chat right now around Default Enrollment. And so, wondering if you can speak a little bit more to member experience with Default Enrollment.

How they're able to know that they're able to disenroll. It sounds like some folks feel like they're required to have managed care when it comes to Medicare. If there's anything else that you can speak to around member experience with Default Enrollment, that would be helpful, I think.

00:27:05 — Anastasia Dodson — Slide 28

Right, thanks Cassidy. I'll do that. And it looks like some of the chat may have messaged me directly. And just so you know, I cannot look at the chat while I'm presenting, so you need to just message the whole group if you want a response.

The member experience; that notice that went to folks is the 60-day notice and the 30-day notice it was reviewed by local advocates was also reviewed by CMS. And there are certain things that must be included in the notice. And we do have those notices posted on our website and maybe the Aurrera team can put the link in the chat.

Anyway, the notices very clearly say you have a choice, and that is the instruction to the plans as well is when they do their telephone outreach, they talk to the members to explain the choices to them. What we see from the data, you could look at it different ways, but it seems to me that people are exercising their choice.

There are a number of people who are opting out either before the 60 days or after. My sense is that people know they can do that, and they are doing that. The other thing that we have been listening very carefully for is any concerns raised to us by advocates in those counties or the Ombudsman, HICAP.

We have not heard any concerns, so we really want to know if there's any miscommunication. But I think based on the data, what we're hearing from the plans, and what we have or haven't heard from advocates or other local stakeholders, I think that people do know what their choices are.

I think it's perfectly reasonable if people choose to change after that. When they initially start, they try out the plan and then they said, "No, I changed my mind. I want to do something else." The other thing I'll say is, I mean to be just frank with everyone,

Medicare Advantage is a competitive market. There may be reasons that people, they're looking across the different health plan choices that they have, and they can choose certain benefit packages and that's absolutely their choice. I think that's showing us that there are a lot of choices in Medicare and people are exercising those choices.

00:29:50 — Cassidy Acosta — Slide 28

Thanks so much, Anastasia. And then I see that we have Shanti, your hand is raised, so you should be able to unmute now.

00:29:59 — Shanti Ezra — Slide 28

Thank you so much. Can you hear me, okay?

00:30:01 — Cassidy Acosta— Slide 28

We can, yes.

00:30:02 — Shanti Ezra — Slide 28

Okay. Well, thank you so much for the information in this meeting. This is my first time in the meeting but let me quickly introduce myself. Shanti Ezra, and I'm with the California Association of Marriage and Family Therapists. In the state, we represent over 38,000 MFTs [Marriage and Family Therapists]. And as folks on the call are probably familiar with already, MFTs became eligible Medicare providers as of January 1, 2024.

I have a couple of questions I wanted to raise here and I'm happy to put them into the chat. These are questions that are important to our members who are fairly new to billing, both Medicare and Medi-Cal for services rendered to the Medi-Medi patients.

I'm curious, being new to this group, and I saw the inbox and I saw also the webpage there, but any more specific direction that you can point me to would be super helpful. Are there trainings available to help newer providers learn how to navigate the system when working with these Medi-Medi patients?

And then also just in terms of a resource for us going forward, who should providers, and us who represent them reach out to if they have questions on Medi-Medi billing and issues that they might be facing?

00:31:19 — Anastasia Dodson — Slide 28

Great question. Great topic, Shanti. And in fact, a year or so ago we had this group, we did talk about that change in Medicare that we're so excited about, that Medicare expanded what types of benefits for behavioral health that they cover.

Let's break it down a little bit. Of course, you may have questions about how to bill for Medicare and there are existing Medicare training resources on the CMS website about how to bill if it's Fee-for-Service Original Medicare. We do have a fact sheet that we worked on. Maybe Cassidy, or somebody from the Aurrera team can put that link in the chat.

But we at DHCS, unfortunately, we're not experts in how to bill Medicare. But as far as Medicare Advantage plans or D-SNPs or Medi-Medi Plans for duals, that's where each health plan they contract with a network. And so, if providers want to join that network, I'm sure many health plans would be very glad to get more behavioral health providers into their network.

And again, through that, for duals who are in Medi-Medi Plans, that behavioral health benefit through Medicare, it goes through their Medi-Medi Plan. And so, working with those plans to get enrolled in the provider network. And then you guys, there's conversations between plans and providers about rates.

There's probably several plans here on the call. And usually on their website they'll each have information specifically for providers how to join the network, etc. I hope that helps. And as far as DHCS, well let's put it this way, we have the info@calduals email inbox. If you would like to, we're glad to meet at DHCS. But I think looking at CMS and the Medi-Medi Plans on the Medicare billing is probably your best bet.

00:33:36 — Cassidy Acosta — Slide 28

Thanks, Anastasia. And yes, we'll drop that DHCS fact sheet on Mental Health for Medicare in the chat for folks.

All right, we do have some time for a couple more questions. Pat, you should be able to unmute now.

00:33:51 — Pat Blaisdell — Slide 28

Thank you. Pat Blaisdell, with the California Hospital Association. As you are no doubt aware, many of our participants on this call are aware. There've been a lot of concerns on the national level regarding the operations of certain Medicare Advantage plans in general. Issues around prior authorization, in particular around observation services versus inpatient services in the hospital around access to post-hospital acute care such as rehabilitation or skilled nursing care problems with upcoding.

These have been some fairly widespread issues with the MA industry in general. What steps has DHCS taken or is contemplating in your work with the Medi-Medi Plans to

ensure that those that are operating in this arena in California, that those issues are being addressed? What kinds of oversight or reporting are you able to initiate in order to ensure that these concerns that we've seen through the office of Inspector General and other avenues don't occur to the detriment of our California members?

00:35:12 — Anastasia Dodson — Slide 28

Thanks, Pat. Great, great flag. Great question. I guess we have a certain, for sure scope at DHCS, of course, Medi-Cal plans, and then we work on the Care Coordination requirements for D-SNPs. That's absolutely in our swim lane. Some of what you reference is really squarely in the CMS Medicare swim lane, so for the upcoding and prior authorization on the Medicare side, there's not much that we can do at DHCS.

But, there are two more things to think about. In California, we have a lot of local plans that, and I can't vouch in specific for any particular plans, whether they do or do not do upcoding or they have challenges with the Medicare prior authorization. I would say let's give the benefit of the doubt to a certain extent to some of the new entrants, the new plans. I would think that we have a good track record on the Medi-Cal side of looking into and getting concerns like this addressed on the Medi-Cal side.

We would want our plans who are already with us existing D-SNPs and the new plans, we would expect that they would be good partners and hold patient care in really the utmost priority. The other thing is we at DHCS, other states do request MLR reports from health plans. We can at DHCS and are contemplating requesting the MLR on the Medicare side from these plans. There are many things that researchers or leaders have suggested around, “What's in the capitation rate on the Medicare side, what's on the Medi-Cal side, how do those two capitations work together?”

We think about that for the coming years ahead; what should we consider in order to incentivize the most appropriate care and management of care? And you're right, inpatient stays, (what happens there and discharges); that's really at the heart of a lot of where we want to look at. What we're trying to make sure, we have key things handled and then we will certainly look at MLR in the future and possibly other things.

00:37:55 — Cassidy Acosta — Slide 28

Thanks, Anastasia. Susan, I see your hand up. I'm going to take one more question in the chat and then I'll jump over to you. But Anastasia, we did receive a question which is not necessarily around the Default Enrollment or Local Plan Implementation, but I think helpful as we're going to talk about ECM data later in this meeting.

"Does being enrolled in a Medicare Advantage Plan, does that mean that it's an automatic duplication of services from Medi-Cal ECM and similar to D-SNP?" If you could speak a little bit more about the difference between Medi-Cal ECM for folks in D-SNPs versus for folks not in D-SNPs.

00:38:28 — Anastasia Dodson — Slide 28

Right. What we can do at DHCS is set Care Coordination requirements for D-SNPs. And we know that there is a lot of potential overlap for someone who is qualified for ECM through their Medi-Cal plan and then also in a D-SNP. And we don't need to have two different competing Care Coordination teams from the same organization.

We say that Medicare is the lead, the D-SNP model is quite robust. From CMS, they have very specific requirements around Care Coordination. And the other thing that we know is dual eligibles, in addition to having social needs, they have a lot of chronic conditions. Many D-SNPs already per the federal requirement have specific Care Coordination strategies for particular clinical criteria, whether it's diabetes or heart disease, etc.

And so, we have layered DHCS requirements on top of the CMS requirements and together they do provide something that it should be as good at least as what they're getting through ECM. Now, it may not be through a CBO, it might be through a plan-based care manager or it may be through a delegated team with the primary care physician's office. But the idea is that we do hold D-SNPs accountable for providing very intensive care management for their members. And that's in line with the CMS Medicare model.

I don't want to get too into the weeds for members who are in a D-SNP that's not a Medi-Medi plan. We still require those D-SNPs to provide the same kind level of care coordination, that should be the equivalent of ECM, and so does CMS. It's really the D-SNP that's the lead and then the Medi-Cal plan that wraps around.

00:40:33 — Cassidy Acosta — Slide 28

Thanks, Anastasia. And then for non-D-SNPs, so for duals that are not in D-SNPs, are they eligible for Medi-Cal ECM?

00:40:41 — Anastasia Dodson — Slide 28

Right, right, right. Again, there's 400 something thousand duals in D-SNPs. They get their care management through the D-SNP, for all the other 1.3/1.2 million duals, if they meet the criteria, then they can get ECM through their Medi-Cal plan.

Now they may have some other care management team on the Medicare side that's not visible to the Medi-Cal plan. That's a different topic, but, Medi-Cal ECM is for all duals except those enrolled in a D-SNP.

00:41:17 — Anastasia Dodson — Slide 28

Thanks, Anastasia. All right, we've got time for one more question before we need to move on. Susan, you should be able to unmute now.

00:41:29 — Susan LaPadula — Slide 28

Good morning, Anastasia and Cassidy. I'm glad to be in attendance and the presentation as always is spot on. Thank you so much. I'd like to point out Pat and Shanti's point about claims, and I'm very interested in the crossover claims to be automated, especially as we're adding more D-SNPs in the next year. Where are we on that progress? Do we have a listing of the plans that have been testing, and have made it to full production?

00:42:04 — Anastasia Dodson — Slide 28

Right, and we'll just flag that we have existing contract requirements around Medi-Cal plans needing to be participating in all that coordination of benefit processes that already exist across the state and federal processes there. That's a great point, Susan, for the new plans. We will, Cassidy, I think we should think about adding that to one of our checklists for the new Medi-Medi Plans.

But for the existing plans, I know Susan, you have raised this issue a number of times, so I thought we had landed on that, but if we haven't, let us know and we'll go back and revisit that. Thank you.

00:42:52 — Cassidy Acosta — Slide 28-29

Thanks, Anastasia. All right, I think we can move into our next section, which is going to be on the D-SNP, SMAC, and Policy Guide Updates. Anastasia, back to you.

00:43:00 — Anastasia Dodson — Slide 29-30

Okay, great. The way that we make sure we're communicating the policy and holding plans accountable is through what's called a SMAC. That's a contract that DHCS has with the plans and then the Policy Guide is our addendum to the SMAC. Okay.

Each D-SNP must have a SMAC contract with DHCS. And what we do each year at DHCS is we start with the prior year's contract. All of these are posted on our website. We start with, for example, what we did for 2025, which is the current year. And then we go

through and see what we have heard from stakeholders, what is going on at the federal level, what we hear from plans, and what we see in our data. We do collect data from all the plans on various components.

When we look at the data and other issues that have come up, then we will make changes and put them in red line. We've sent out those templates to health plans and key advocates for feedback in February. We got the feedback, we got edits, we've made edits, and then we are working with various partners to finalize those templates for the SMAC. We will have the plans sign those SMAC contracts in June. Again, we have the 2025, 2024, and 2023 SMAC documents on the DHCS website. Okay, next slide.

00:44:50 — Anastasia Dodson — Slide 31

There's a policy guide that accompanies the SMAC. And the same thing we did for 2025; we had a policy guide for '25. We do not have to have the Policy Guide all wrapped up, all chapters by a particular date, except the Care Coordination piece we have to do well in advance. We have multiple chapters of the Policy Guide and you can again see the current version '25, '24, and '23 on our website. And we also have the first chapter of the 2026 Policy Guide also on our website.

We update the Policy Guide chapters based on certain timing and certain needs. And so, we're still updating a place or two in the 2025 Policy Guide. And then we'll keep rolling out updates for '26. And then in the beginning of the Policy Guide we have a section where we say what's new in this version, so that you can see what's been changed since the prior published version. Next slide.

00:46:03 — Anastasia Dodson — Slide 32-34

Okay, so let's talk a little bit more about the Care Coordination chapter. This was released in late 2025 and it provides state-specific care coordination requirements. Again, there's the CMS minimum of care coordination requirements that all D-SNPs that we don't control. That's the CMS decision and they are reviewed by NCQA, etc.

We do some additional requirements on top of CMS requirements around risk stratification, health risk assessments, care plans, care teams, and care transitions. Those are particularly important for care coordination for duals. We also have guidance on palliative care and dementia care that were carried over from 2025.

The most significant change for 2026 is we had previously said ECM-like was our name for the additional state-specific care coordination requirements. And we know that that can be confusing for people. We've renamed it California Integrated Care Management

as the umbrella term for the state-specific care coordination requirements that go on top of the federal requirements.

Again, federal government, they have a very robust set of requirements, and we in California have added a few things on top of that. Technically, for the current year, the care coordination requirements state has for D-SNPs is still under the ECM-like title, but then CICM will be the new title for those additional care management features. And they are really quite similar from '25 to '26, it's just we're putting a new label on them. All right, next slide. Cassidy, is it time to transition to a different speaker?

00:48:08 — Cassidy Acosta — Slide 34

It is. We're ready to pass it off to Tyler from DHCS to get us started on our spotlight for Community Supports.

00:48:18 — Tyler Brennan — Slide 35-36

Hi. Good morning, everyone. Thank you so much for the opportunity to present today. So, my presentation is going to cover some select service definition refinements that we've made in response to stakeholder and market feedback. And later on, we'll look at some updated data on Enhanced Care Management and Community Supports utilization with a focus on dual eligible beneficiaries. We'll also zoom in on some key trends that we're seeing for Q2 and Q3 of 2024 with some possible implications for MLTSS and duals integration.

Next slide, please. DHCS has refined several Community Support service definitions to enhance clarity and standardization. These refinements aim to align with stakeholder feedback and improve service delivery. So today we'll highlight some of those key changes and their expected impact on access and utilization. DHCS has updated definitions for four of our Community Support services and released those in February. And those four services are the Nursing Facility Transition Diversion to Assisted Living Facilities, the Community Transitions Nursing Facility Transition to a Home, Asthma Remediation, and Medically Tailored Meals/Medically Supportive Foods. All of these refinements will take effect on July 1st of this year with select Asthma Remediation components beginning January 1st of next year, 2026. The bundle of refinements is available on our Community Supports website. We do include the updated service definitions and a summary of the changes with corresponding stakeholder feedback for each service.

00:49:48 — Tyler Brennan — Slide 37-39

So, DHCS conducted extensive stakeholder engagement throughout 2024 to refine these service definitions. Input was gathered via implementation advisory group discussions, a public comment period in September of 2024, and direct engagement with managed care plans and advocacy groups. The significant volume of feedback we received on our originally proposed refinements really helped shape the final refinements and ensure alignment with our program goals. Next slide, please. So key refinements include clear eligibility criteria, enhanced service descriptions, and alignment with federal guidance. These changes address concerns raised by MCPs, providers, and advocates regarding implementation challenges and service interpretation.

Next slide, please. So, let's start off by talking about the nursing facility transition and diversion to assisted living facility service, where DHCS is working to boost utilization for duals by clarifying key aspects of the service. Right now, this is one of our least utilized Community Supports with only about 429 members in Q2 of 2024. And stakeholders have asked for more clarity on eligibility, service components, and overlap with other programs like 1915(c) waivers and California Community Transitions or CCT. So, we've made some updates. We're now clearly outlining that the support includes two components: transition services and expenses, plus ongoing assisted living services, both of which must be made available to members. We've also clarified eligibility. Members transitioning from public subsidized housing, or those already in an ALF [assisted living facility] who meet nursing facility level of care can now access this support. And finally, we've spelled out how the service works with other Community Supports like housing transition navigation and the Assisted Living Waiver to avoid overlap and ensure a smoother experience for duals. Next slide, please.

00:51:32 — Tyler Brennan — Slide 40

So, breaking down really what's changing with this service and why these refinements matter. First, eligibility; as I mentioned on the previous slide, is being clarified. Members transitioning from publicly subsidized housing are eligible and so are those already living in an ALF, as long as they meet that nursing facility level of care criteria. And this is important because it expands access to people who might have been unsure whether or not they qualify. Then we're also refining the service components. We're clarifying that there are two distinct but required parts of the service. The first covering transition services and expenses which help members move into an ALF, and the second ensures ongoing assisted living services once they're there. Managed care plans must offer both they can't choose to provide just one or the other.

A big area of focus has been overlap with other programs. Members can receive other Community Supports like housing transition navigation alongside the service but only if the services are not duplicative. This ensures that members get the support they need without unnecessary overlap. That said, when it comes to waivers there are some key distinctions. A member may be eligible for both this community support and the Assisted Living Waiver, or California Community Transitions or CCT program. However, they cannot receive both at the same time since these programs fund similar services. Ultimately these updates aim to remove confusion, improve access, and help Manage Care Plans better navigate how to offer these services. The goal is to ensure members get the right support at the right time without unnecessary barriers. Next slide, please.

00:53:03 — Tyler Brennan — Slide 41

All right, moving to the next one. Let's take a look at Community Transition Services or also known as Nursing Facility Transition Home. Specifically, how we're refining the support to improve clarity and utilization. Right now, it's also one of the least used Community Supports with only about 240 members accessing it in Q2 of 2024 which tells us there's room to improve both awareness and understanding of how the service itself works. So, one of the biggest areas of confusion has been around eligibility and allowable expenses. So DHCS is making key clarifications here. The service is made up of two core components. One, Transition Services, which helps members move from a nursing facility back into the community. And two, household set up expenses which now have a clearly defined $7,500 lifetime cap to assist with essential one-time costs.

So, what counts as an allowable household set up expense? This could include things like security deposits, utility setup fees, pest eradication, one-time cleaning services, or even essential appliances like heaters and air conditioners. Basically, the things a person might need to safely establish a home after living in a facility and leaving that facility. Another key clarification is how this service interacts with other Community Supports. Members may also be receiving housing transition navigation, housing deposits, or home modifications but these services must be distinct and non-duplicative. This update makes it a little bit easier for managed care plans to understand where this fits into the broader housing-related supports. Ultimately here, the goal of these revisions is simple, make sure members and managed care plans fully understand how the service works, what expenses are covered, and how it complements other supports so that more people can take advantage of it. Next slide, please.

00:54:42 — Tyler Brennan — Slide 42

So, building on the refinements to the Community Transition Services, we're also clarifying some key details around eligibility, service components, and overlap with other programs. First, eligibility; we've made it explicit that members transitioning to public subsidized housing qualify for the support. That's an important clarification because it ensures that those moving into these settings have access to the resources, they need for a successful transition. In terms of service components, this Community Support continues to include both transition services and expenses to support the move itself, and one-time household set of expenses which help establish or reestablish a home. We've also aligned the allowable one-time set of expenses with the December 2024 CMS Informational Bulletin ensuring consistency with federal guidance. Just to be clear, the $7,500 lifetime cap only applies to a set of expenses, not the Transition Services component.

On overlap with other Community Supports, members can receive services like housing transition navigation, housing deposits, or home modifications alongside this service as long as each service, as I said, remains distinct, necessary, and non-duplicative. Lastly, when it comes to waivers and demonstration programs, a member may be eligible for both community transition services and programs like California Community Transitions or the HCBA Waiver. However, they cannot receive both at the same time, if the services are duplicative, which ensures that funding isn't being used for the same activity twice. These refinements help clear up who qualifies, what's covered, and how the support interacts with other programs, ultimately, hopefully, making it easier for members of managed care plans to navigate. Next slide, please.

00:56:21 — Tyler Brennan — Slide 43

All right. Next up, Asthma Remediation. So DHCS envisions this Community Support being a wraparound service focused on physical modifications and supplies, and really complementing the already available Asthma Preventive Services benefit or APS. So, when Asthma Remediation launched it included assessments, self-management education, and home remediations. But as the program matured and July 2022 came there began to be this overlap with the APS benefit which started covering the education and in-home trigger assessment components. So, since Community Support should supplement and not replace state plan services we've made some changes in that line of thought. Starting January 1, 2026, we'll phase out assessments and education from Asthma Remediation leaving those to the APS benefit and focus Asthma Remediation solely on those physical modifications and supplies for our members. To make the transition smooth, DHCS encourages MCPs to collaborate with providers. And

we'll be diving deeper into this during our Managed Care Plan Technical Assistance session that we're actually having later today with them. Next slide, please.

00:57:32 — Tyler Brennan — Slide 44

All right. Finally, let's talk about Medically Tailored Meals and Supportive Foods. We've heard loud and clear from stakeholders that we need to improve standardization and quality so we're refining this Community Support to align with national standards. When Medically Tailored Meals and Medically Supportive foods first launched, we didn't really have specific descriptions for what Medically Tailored or Medically Supportive really meant. That led to inconsistent interpretations across the state which made it tough for managed care plans to really oversee their providers effectively. Stakeholders also pointed out that the original eligibility criteria were too broad and vague and left room for varying interpretations by managed care plans and providers which wasn't really serving our Medi-Cal population, including duals, as well as it could.

On top of that, CMS released an updated Health Related Social Needs Framework in December of 2024, which I believe has since actually been rescinded but we're still somewhat abiding by, pushing states to set clear protocols. This ensures managed care plans and providers deliver high-quality tailored services that really address nutrition-sensitive health conditions for duals. So, we're working to tighten up these standards making sure that all of our members, including duals accessing Medi-Cal, get consistent, evidence-based nutrition support that meets their needs. Next slide, please.

00:58:48 — Tyler Brennan — Slide 45-46

So, diving into some of the revisions that we've made to the service. Our goal is to boost the evidence-based services for members, for duals, or any member that has a nutrition-sensitive condition that could potentially be impacted by receiving the service. We've streamlined the eligibility to focus purely on whether or not a member has a condition that MTM or MSF can directly help with. So now both Medically Tailored and Medically Supportive service packages need to be designed specifically for those targeted conditions. Medically Tailored Services, we're requiring that an individual nutrition assessment by a registered dietitian/nutritionist be done to create a tailored plan which ensures that the services meet at least 2/3 of a member's daily nutrient and energy needs and address their specific condition.

On the Medically Supportive side, food packages must follow evidence-based guidelines with oversight from an RDN or another clinician. One keynote is that nutrition education cannot be offered any longer as a standalone service, at least through this Community Support. Finally, we've laid out clear oversight requirements for managed care plans to

ensure that providers are delivering high-quality effective services that really make a difference for our members. And with that, I believe I'll be transitioning things over to Zayden Chen for an advocate perspective.

01:00:15 — Zayden Chen — Slide 46-47

Thank you, Tyler, for providing the updates on the definitions. And thank you for inviting me to speak on this very topic that is so close to my heart. Because I've been personally implementing this program at our company in San Diego County as a provider. And I want to start by commending the Department of Health Care Services for recent updates. This is so much clarity.

For context, we've been providing Assisted Living Waiver program services at our assisted living facility for the elders for five years. We continuously face the challenge of limited beds. So, the stake and the challenge with that, the negative impact on that is the whole community. When we don't have beds available for dual members to move from a skilled nursing facility to our facility, the skilled nursing facility has a backlog, limited beds, and then that has a downward impact on hospitals, and then the hospitals cannot discharge patients into rehab, then the emergency room has a backlog. So, it's a whole community-statewide issue. So, thank you again so much for updating this definition. Because now that the MCP and the providers have a clear path to allow us to get reimbursed when elders move into our facility on a monthly basis, to receive the services that they need. I look so much forward to when these definitions get implemented in July. So, I see that there is a question in the chat that says "Has DHCS received concerns about the processes on contracting and services?" I want to jump a little bit more into that. Can we go to the next slide, please?

01:02:46 — Zayden Chen — Slide 48-49

This is a flow chart on what I just talked about. Before we were not getting paid if somebody moves into us under the current Community Supports program, so you see that, overcrowded hospitals, hospital backlogs, and now the Assisted Living Waiver program approval, it takes eight months if we set up a new facility for more capacity. So, we can go into detail later. But the contracting process needs to be refined later. Could we go to the next slide?

Okay, great. Again, this is the benefits and the opportunities for everyone. Why do we use Assisted Living Facilities? Or in California we call it RCFE, Residential Care Facilities for the Elderly. This is great for dual members, more than ever, they're 65 years old. And then we want to avoid institutionalization, so Assisted Living Facilities are great. They offer personalized, cost-effective, quality care for seniors. The cost for long-term care in

a skilled nursing facility, it ranges from $500 a day to $800 a day. When in assisted living that's 50% or sometimes 1/3 of that. And then the opportunity for a managed care plan statewide is to boost satisfaction, independence, and resources used by funding ALFs. And this ultimately provides preventative care. In the community setting, seniors move into a community like ours, they get more personalized care, medication management, attention, activity, life enrichment. And then that, of course, gets better quality of life and a holistic win for residents and providers. And this ultimately aligns with our goal for the whole state to, as what Tyler said, provide a quality of services on a timely manner. So, finally my ultimate recommendation is that as we roll out these new definitions, I would love to be participating in the MCP Technical Assistance support to learn about what the challenges might be because I have been contracted with a MCP implementing this specific program, and we have helped, so far, only two members. Unfortunately, I personally know that there are more than 100 members that are currently being held at the SNF level because of this specific technical challenge in how to approve the hours, what the processes are, and how to define services provided. So, there's a whole list of implementation issues and clarification that I would love to see how we can address.

If we use the previous number $800 bucks, that's 100 members, that's $6 million a month. And then every month that goes, let's say, 1000 members that's $60 million. If a year goes by, these things don't get resolved, that's hundreds of millions of dollars that taxpayers are spending unnecessarily. This is a topic that's dear to me because I see these elders every day. I get calls from the family members, I go into skilled nursing facilities, and I hear them say, "I've been here for five years or six years, thank you so much for telling me this is possible for me to get out of here." I mean, don't get me wrong, skilled nursing facilities are great but sometimes not all members are fit to be there because they already got the rehab, they want to be part of the community again. So anyways, I don't want to drag this too long. I look so much forward to what we can do as a great working group together. I would love to hear some questions. So, Cassidy, can you help me transition here?

01:07:50 — Cassidy Acosta — Slide 50

Absolutely. Thank you so much, Zayden, and thank you Tyler for those presentations they were fantastic. We do have some time now for some questions. I think the first one will be for Tyler. But Zayden you just spoke to this and so it would be interesting to get Tyler’s perspective on whether or not DHCS has heard of any concerns or questions from MCPs or the ALF, RCFE providers about the contracting and billing processes? Is there anything else that you can speak to that Tyler?

01:08:26 — Tyler Brennan — Slide 50

We do have relatively frequent contacts with a number of interested stakeholders in this space, a number of RCFE providers who keep us updated on their contracting progress, working with certain MCPs in different areas. A lot of that was the stimulus for why we looked at the service early on and really saw a lot of opportunity to improve and clarify some of the included parts of this service. The original service definition was written somewhat using ambiguous wording and language and could have been interpreted in different ways by different plans and providers. We really tried to button that up a little bit, make it more clear what the expected components of the service are.

We also engaged with these stakeholders throughout the entire revision process, so they had a number of additional edits or comments or suggestions, that they made which we factored in. We're hoping we landed in a good place with all of this. But we know that there will continue to be questions as this is new to a lot of folks operating in this space. I hope that it helps answer your question. Happy to answer any follow-ups.

01:09:37 — Cassidy Acosta — Slide 50

Thanks, Tyler. I think that leads into the second question here which is around DHCS offering support to both the facility providers and to MCPs about how to navigate any challenges. I know that we've invited you out here to talk at this stakeholder work group, but any other work groups or any other work that DHCS is doing to support plans and providers?

01:10:00 — Tyler Brennan — Slide 50

Yeah, we've got the PATH CPI and the learning collaboratives. A lot of this new info trickles down and sort of reaches the market participants through PATH CPI. We have a number of work groups that we are contributing to, and are included in where we offer as much guidance as we can around these changes, around why we're making these changes, what the process behind it may be, where they came from, and what we're seeking defining the long-term vision for why we're making these changes. And most of our work is engaging with the plans or plan representatives themselves, less so providers. But we really do encourage the Managed Care Plan partners we work with to make sure that they're educating and sharing all of this new latest and greatest information with their providers.

01:10:51 — Cassidy Acosta — Slide 50

Thanks, Tyler. All right. Brianna, you should be able to unmute now.

01:10:57 — Brianna Moncado — Slide 50

Thanks so much. Is now a good time to ask a question about Medically Tailored Meals?

01:11:01 — Cassidy Acosta — Slide 50

I think so, yes.

01:11:03 — Brianna Moncado — Slide 50

Okay, great. Thank you guys so much. Just wanted to clarify. So, this is on the MLTSS side. Right now, duals are eligible for Community Supports, specifically for Medically Tailored Meals. And just wondering if this is something that might be integrated into MLTSS, or if the member would be eventually eligible for HCBS and Community Supports for Medically Tailored Meals, if there are going to be Medically Tailored Meals as a part of MLTSS? So that's a separate question, curious about that. So today it's a 12-week service typically with the option, if medical necessity, to continue. So, for these individuals, typically it's a long-term situation that they're in, right? Keeping them out of that facility is going to be a long-term process and so cutting off meals after 12 weeks is probably not going to be helpful for them. They're going to need something more long-term. So that's something we're running into. And just curious if you guys have thought about that or if there's any plans to change that once MLTSS goes live in 2027?

01:12:23 — Tyler Brennan — Slide 50

I'll say we are very adept at evolving the policy and pivoting things based on new developments. We do not have any plans to modify the 12th week basic inclusion as part of the service with the ability for managed care plans to authorize, extend the service beyond that. So right now, there's no future plans for that, but we will make sure we update the policy to accommodate any non-duplication that we have to factor in.

01:12:56 — Brianna Moncado — Slide 50

Great. I don't know if anyone has this answer or if they've thought about it, if there might be meals as a part of the benefit that might be offered for HCBS waiver recipients. We see that in other states today. That's why we're curious, but, usually it's food insecurity, so it would be a totally different eligibility criteria than what is Community Supports today.

01:13:40 — Cassidy Acosta — Slide 50

Thanks, Brianna. I don't think we have the right folks on the call for that one, but we'll take that back.

01:13:43 — Brianna Moncado — Slide 50

Okay. Thanks so much.

01:13:46 — Cassidy Acosta — Slide 50

Thank you. All right. Looking into the chat Tyler, I know you mentioned PATH and so we do have a question in the chat from folks. Are providers receiving TA support for duals under PATH or are the MCPs working directly with those providers?

01:14:01 — Tyler Brennan— Slide 50

I have less visibility on that actually from where I sit, I know that the plans should be receiving that technical assistance support. I'm not sure if it's specific to duals, but it certainly could include a specific TA just around the dual population. But we work with our managed care plans, and we really just disseminate guidance around dual members and how to engage and the appropriateness of offering these services to dual members as much as we can. So, while I can't really specifically answer that question, I hope that at least helps a little bit.

01:14:37 — Cassidy Acosta — Slide 50

Thanks, Tyler. And then a clarifying question around the Asthma Remediation. So, someone mentioned that the services typically require a doctor's order and historically the CBO has worked with the member to obtain that during home visit services. "Is the APS provider now responsible for obtaining that document?"

01:14:55 — Tyler Brennan— Slide 50

Well, that is a very specific question. We scaled back that requirement a little bit, I know. I believe the diagnosis, or the history of untreated asthma or unmanaged asthma does suffice at this point. But I just encourage you to read. We include a summary at the beginning of the service definition where we dive into this a little bit and talk about the pathway towards members being able to access the service.

So, members do need to receive that in-home trigger assessment through the APS benefit or at least starting in January of 2026. That's been historically done under the Asthma Remediation Community Support. So, there will be some shifts there. And we're working closely with stakeholders like RAMP [Regional Asthma Management and Prevention], who's actually helping us co-present later this afternoon to our MCPTA audience around what it looks like contracting with both APS providers, Asthma Remediation providers, and possibly looking at the same providers doing both. So really

keeping that all under one roof and streamlining that authorization and approval process.

01:16:04 — Cassidy Acosta — Slide 50

Thanks, Tyler. All right, I'm not seeing any other questions in the chat, or any other hand raised, but I do want to just offer Zayden and Tyler if either of you have any last words that you'd like to share around the Community Support, and Select Service definition updates.

01:16:24 — Tyler Brennan— Slide 50

I think that's it. I would just really encourage anybody if they're interested at all, to go check out the service definition package that's available on our website. It really gives a detailed summary and dives into more than I can speak to on this call there. So, all of the fine print and the details are in that document and encourage anybody with questions beyond that to reach out to us at our CalAIM ECM ILOS mailbox and we can get back to you there.

01:16:52 — Zayden Chen — Slide 50

Yes, thank you Tyler. This is very exciting. I'm sure that utilization will go up from there. Thank you. Take care.

01:16:58 — Cassidy Acosta — Slide 50-51

Thank you both. All right, I think we can transition into the next section of our work group today, which is going to be on Enhanced Care Management and Community Supports data and I will pass it over to Dr. Laura Miller.

01:17:11 — Laura Miller — Slide 51-52

Great, thank you so much. It's a pleasure to be here. I'm going to be giving a brief report on essentially numbers of duals in Enhanced Care Management. So, let's go to the next slide.

Just as an overview, we have a really strong commitment to data transparency. So, you'll see the link here for the ECM and CS quarterly implementation report. It is updated quarterly. It was updated in December and reflects data from January 1, 2022 to June 30th, 2024, and includes the total population of those receiving ECM and CS.

The next update will be coming quite soon. I believe that we will be including Quarter 3 by the end of March or perhaps early April because the end of March is quite soon.

As you know, duals can access all available Community Supports through their Medi-Cal plan regardless of enrollment in Original Medicare or MA. If an MA plan does offer supplemental benefits that are comparable to Community Supports, Medicare is indeed the lead.

So, looking at ECM, dual eligible beneficiaries are most likely to fall into one of the following ECM populations of focus. And as you know, ECM is rolled out via population of focus. So, these are adults experiencing homelessness, adults at risk for avoidable hospitalization or ED utilization, adults with serious mental illness or substance use disorder, adults transitioning from incarceration, those living in community and at risk for long-term care institutionalization, and lastly adult nursing facility residents who are transitioning to the community. Next slide.

01:19:16 — Laura Miller — Slide 53-54

So again, this is a bit of a review, but it always helps to say it out loud. ECM is a Medi-Cal benefit to support Comprehensive Care Management for members with complex needs. We know that these members often engage with several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder, and LTSS. The more complex a person's medical, behavioral, and social situation, the more systems they need to interact with. So, it's in some ways a catch 22, the more complicated the issues that one has, the more complicated the systems that one needs to interact with.

ECM is really intended as a whole person interdisciplinary approach to care. It is high-touch, person-centered, and provided primarily through in-person interactions with members where they live, seek care, and prefer to access services. It's not telephonic primarily. Telephones obviously can be used, but really the idea is to have in-person care, in-person connection, and relationships where members live and seek care.

ECM is part of the broader CalAIM Population Health Management System design through which Medi-Cal plans are offering Care Management interventions at different levels of intensity based on member need, with ECM being the highest intensity level. Next slide.

So, I'm going to go through some data on the representation of dual eligible members within ECM. First, we'll start with Quarter 2, 2024 and then Quarter 3. So next slide.

01:21:10 — Laura Miller — Slide 55

So, this is just walking through the populations of focus or POF. So, in Quarter 2 of 2024 of the individuals experiencing homelessness, dual eligible beneficiaries represented

about 5,000, 4,956, which is about 15.9% of that population of focus. Similarly, for those at risk for avoidable hospitalization or ED utilization, the total number of duals was 5,979, representing about 14% of that population of focus.

For those with serious mental illness or substance use disorder, duals were at a total of 5,545 representing 13.5% of the population of focus. And for members transitioning from incarceration, there were 164 duals representing about 10.1% of the population of focus. I will note that for members transitioning from incarceration, this is the newest population of focus and has really been going since, I want to say January of 2024, it is our most recently launched population of focus. So really not at full steam yet. Next slide.

01:22:50 — Laura Miller — Slide 56

So, continuing on for Q2 '24. For those living in community and at risk of long-term care, there were 5,931 duals in that population representing 45.4% of the population of focus. And I think that's really, really significant. These people in this POF are primarily older adults. These are the people in my primary care practice. About 77% of duals are 65 or older in this population of focus. So, an incredibly important POF for older adults.

For those transitioning out of a nursing facility, we have 294 duals and that's about 36.1% of the population of focus. And similar to the other population of focus above those living in community at risk for LTC, 72% are aged 65 or older in that population of focus. I will note if you go to the hyperlink for the ECM and CS Quarterly Implementation Report, there are some slight differences those really have to do with timing in the data. Next slide.

01:24:15 — Laura Miller — Slide 57

We'll move on to Quarter 3 and it's really the same rundown. So, for the population of focus of people experiencing homelessness, there were 6,284 duals, about 16.6% of that POF. For those at risk for avoidable hospitalization or ED, there were 6,610 representing 14.5% of the POF. Those with serious mental illness and SUD were totaling 5,932 duals representing 13.5% of the POF. And transitioning from incarceration, 185 folks representing 9.9% of the POF. Next slide.

01:25:02 — Laura Miller — Slide 58-59

For the other POFs, those living in community and at risk of LTC were 7,169, about 47% of the POF. Again, the proportion of those 65 and older is about the same. And for individuals in an adult nursing facility transitioning to community, there were 359, about 42% of the POF.

So that's ECM by the numbers. Of course, there are always human stories behind these, and I think that the high representation of older adults in these two POFs that are on this particular slide is a really important area of focus and really getting the word out in the community that these services are available.

I believe that is my last slide, yes. And at this point I will pass it to Tyler for his update on similar numbers for Community Supports.

01:26:14 — Tyler Brennan— Slide 59-60

All right, thank you, we can move to the next slide please.

Okay, so taking a look at the data that we have on dual eligible beneficiaries receiving Community Supports from 2022 until now, as you can see on screen here, you can see a clear upward trend in utilization over time, starting with just about 3,000 members in Q1 of 2022, jumping to nearly 38,300 by the end of 2023, showing how much this program has grown for duals accessing Medi-Cal.

In 2024, we did see a bit of a dip in Q1 to just under 30,000, and this is likely partly due to the turmoil that was caused by the managed care plan transition at the beginning of last year. But then we saw a steady climb back up to almost 36,000 by Q3. Q4 is still in validation. What stands out to us is that duals make up about 26% of all members receiving Community Supports in Q3 of 2024. So, they are a significant part of this program. Breaking it down by age for Q3, we've got about, a little over 10,000 members, aged 21 to 64 and over 25,500 members, aged 65 and older. Really highlighting how critical these supports can be for our older duals population. Next slide please.

01:27:25 — Tyler Brennan— Slide 61

So, we actually have two different sets of slides here. We are presenting data for both Q2 2024 and Q3 2024. The slide layouts are very similar. So, starting with Q2 2024 and seeing how duals utilize Community Supports, Medically Tailored Meals leads the way with nearly 25,000 duals making up 31% of the total, which really shows how critical nutrition support is for this group.

Housing Transition Navigation Services come in strong with almost 5,000 duals, about 16% of the total. Housing Tenancy and Sustaining Services Support over 2,000 duals around 22%. Personal Care and Homemaker Services are a big one with 1,800 duals, representing about over 50% or 58% of the total. And Respite Services help almost 500 duals, which is again over 50%, about 55%.

On the transition side, Nursing Facility Transition to Assisted Living Facilities supports 335 duals, which is a hefty 74% of the total there. And Community Transition Services to Home reach almost 200 duals or 81% of that total.

Environmental Accessibility Adaptations, also known as Home Modifications, that assist over 400 duals, which again is a majority, 71% of that total. While smaller numbers use services like Housing Deposits, Recuperative Care, and Short-Term Post-Hospitalization Housing, which are each around 12 and 16% of the total members receiving those services. Next slide please.

01:28:49 — Tyler Brennan— Slide 62

On this slide, we just have a demographic breakdown of the duals population. So, within the duals population of members receiving Community Supports services, this is their demographic makeup. We also show the male/female breakup, the age breakup, and the number of members at the bottom right who receive both ECM and at least one of the Community Support services. Next slide please.

01:29:18 — Tyler Brennan— Slide 63

All right, so again, this is one quarter advanced Q3 of last year, so July through September. But Medically Tailored Meals remains at the top with almost 25,000 duals. This share does dip slightly to 30% of the total, but we are seeing that percentage, I won't say plateau, but it's starting to stabilize.

Housing Transition Navigation Services did grow as well, still at 16% showing steady demand. Housing Tenancy and Sustaining Services dropped a bit to about 1,900 duals or around 21% while Housing Deposits actually rose to almost 500 duals and is holding at about 16% for that service.

Personal Care and Homemaker Services increased, now 59% of the total and Respite Services see a big jump to over 1,000 duals now, which is up to 61%. The Transition Services/Nursing Facility Transition to ALF, that grew to about 77% of the total. And then Community Transition Services/Nursing Facility Transition Home saw another slight increase to 204 duals and stayed relatively stable at around 80%.

Environmental Accessibility Adaptations rose, all of the share or proportional share dipped to about 69%. Recuperative Care ticks up to almost 500 duals and Short-Term Post-Hospitalization Housing grew, both hovering around 13 to 14%.

And then comparing to Q2, we are seeing growth in key areas like Respite and Personal Care, which again for us really underscores the evolving needs of duals in Medi-Cal.

01:30:53 — Tyler Brennan— Slide 64-65

Then the next slide includes a bit of a breakdown of demographics, age, and sex breakdown of the members receiving services in Q3 of last year. The percentage of members who received ECM and at least one Community Support rose slightly to about 13%, but we just wanted to include all of the data here pertaining to duals that we had available to us.

I believe that's it for me, but just maybe jumping into the next slide to make sure that I don't have anything else. Yep. I think that's someone else.

01:31:26 — Cassidy Acosta — Slide 65 [Went back to refer to Slide 64]

Yes. Thank you so much. Tyler. I know that we don't have a dedicated Q&A section here, but we do have a little bit of time. So, I have a couple of questions for you if you don't mind. The first is just to ask whether or not the data sets that you presented on for Community Supports are available on Open Data Portal or other locations on the ECM or CS DHCS webpages.

01:31:46 — Tyler Brennan— Slide 64

Yeah, all the duals data, it might be somewhat embedded in the Quarterly Implementation Report that we released publicly through the ArcGIS StoryMap solution. Most of the granular data on duals, we first share here with this Workgroup, and we are always available upon request. If people have questions about any of these numbers or anything pertaining to duals and Community Supports or ECM, we do accept those questions in our mailbox and are happy to get back to folks there.

01:32:21 — Cassidy Acosta — Slide 64

Thanks Tyler. A couple of other questions around our Community Supports data. One specifically around the potentially low utilization of Asthma Remediation, which was not covered, I think, in the previous slides. And they were curious if they were just so low that it was not highlighted on those slides or if you can speak to why it wasn't included.

01:32:42 — Tyler Brennan— Slide 64

Yeah, I think generally we were just trying to highlight some of the services that had more proportional representation of dual members accessing those services. I can get back to you on the Asthma Remediation. I'm not, offhand, knowledgeable about why we left that one off from there, but it's possible that the percentages really just weren't very high. We were just trying to highlight the services that duals were most likely to access.

There's also been some ongoing confusion with the APS that we're just now resolving with these revised service definitions. So, we're hoping to see not only dual membership grow for that service, but also Medi-Cal membership overall.

01:33:23 — Cassidy Acosta — Slide 64

Thanks, Tyler. Then can you also speak to whether or not the numbers presented for Q2 and Q3 are those unique numbers?

01:33:33 — Tyler Brennan— Slide 64

They are unique members within that quarter. If you were to take both of those quarters and layer them on top, there would absolutely 100% be duplication. So, the same member will be likely represented across both of those quarter counts if they were receiving that service in both quarters.

01:33:53 — Cassidy Acosta — Slide 64-65

Thanks, Tyler. And then I see that Jacqulene is in the chat and has also shared a little bit more information about ECM and Community Supports QIR information. So, I think that is a wrap. So, I think we can go to the next slide.

Anastasia, any final words before we move into our next steps in closing?

01:34:13 — Anastasia Dodson — Slide 65

Well, just that it's really been a great time. I've appreciated this meeting, and I really am very glad for the people who are joining this meeting for the first time because this is a wide-ranging set of topics and yet everybody knows that we have a population focus that lots of different topics will impact. So, we really appreciate everybody who's joined the call today, and also to think about the topics that you bring up; the behavioral health is a great one.

We can think about sending out reminders on some of the materials because we do have a lot of fact sheets. We have a fact sheet on dental for duals. We have a fact sheet on DME for duals. So, we will take your suggestions about all these different topics, and we can send a reminder out on what we have, and any future meeting topics, we would love your suggestions. We do consult with a group of key stakeholders around these meetings and what topics to include. But you are all more than welcome to email info@calduals.org.

Tell us what you want to see out of these meetings, and we'll try to meet those goals. Okay. So that's it for me. Thank you so much, and thank you Cassidy for facilitating and thank you Tyler, and Laura, also and Zayden for presenting.

01:35:30 — Cassidy Acosta — Slide 65

Thanks so much, Anastasia. I think that we can close out today's meeting. So, thank you again to all of the speakers for the wonderful presentations and to everyone that was able to join us today for such a great discussion. And this is just a final reminder that the next MLTSS and Duals Integration Work Group will take place on Wednesday, June 25th at 11:00 AM. We'll see you all there. Thanks everyone. Have a good afternoon.