CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

CALAIM MANAGED LONG TERM SERVICES AND SUPPORTS AND DUALS INTEGRATION WORKGROUP

Date: November 14, 2024

Time: 12:00 p.m. – 2:00 p.m.

Number of Speakers: 12

Duration: 1 hour 58 minutes

Speakers:

- Cassidy Acosta
- Anastasia Dodson
- Christopher Tolbert
- Barbara Brown
- Rick Hodgkins
- Susan LaPadula
- Jan Walsh
- Joseph Billingsley
- Tyler Brennan
- Melen Vue
- Laurie Schwartz
- Laura Miller

TRANSCRIPT:

00:00:00 – Cassidy Acosta – Slide 1

Good afternoon and welcome to today's CalAIM Managed Long Term Services and Supports and Duals Integration Workgroup. We have some really great presenters with us today, including Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS, Christopher Tolbert, Section Chief in the Office of Medicare Innovation and Integration at DHCS, Joseph Billingsley, Assistant Deputy Director with the Health Care Delivery Systems at DHCS, Patricia Rowan, Principal Researcher at Mathematica, 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, as well as Melen Vue, Program Manager in the Systems of Care at Health Net, and Laurie Schwartz, the Director of CalAIM Provider Relations at Roots Food Group.

00:00:47 – Cassidy Acosta – Slides 1-2

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 Workgroups are designed to provide stakeholders with the opportunity to ask questions, so that we ask the plans that join these calls to 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 the 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 unmute you. The PowerPoint slides and all meeting materials will be available on the DHCS website soon, and you can find a link to those in the Zoom chat. Next slide please.

00:01:27 – Cassidy Acosta – Slides 2-3

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

00:01:56 – Cassidy Acosta – Slide 3

And here's our agenda for this afternoon. So, we will begin today's meeting with an update on Medicare Enrollment Data for Dual Eligible Members and the D-SNP Dashboard. Next, we'll hear the latest on the 2025 State Medicaid Agency Contract and Policy Guide. Then we'll hear an update on the EAE D-SNP Default Enrollment Pilot, which will be followed by an opportunity for stakeholder question and answers. Following that, we will have an update on the 2026 Local Plan Implementation. Next, there will be a reminder about the Medicare Special Enrollment Period changes for 2025, followed by another opportunity for stakeholder Q&A. Following this, there will be a presentation on the Medi-Cal Gap Analysis and the Multi-Year Roadmap Project, which will be followed by another opportunity for Q&A. And then after that we will have our Community Supports spotlight on Medically Tailored Meals, which will be followed by stakeholder Q&A. And finally, we'll hear an update on Enhanced Care Management and Community Supports. And we will end today's work group with some information on upcoming meetings. And with that, I'll turn it over to Anastasia to talk us through the Workgroup purpose.

00:02:53 – Anastasia Dodson – Slide 4

Thank you so much, Cassidy. So, this meeting is our collaboration hub for CalAIM MLTSS and integrated care for dual eligibles. We like to have this meeting for all stakeholders to give feedback and for us to share information about policy, operations, and strategy for Medicare and Medi-Cal. Of course, it's a public document, and we really do value our partnership with you all; plans, providers, advocates, beneficiaries, members, caregivers, we also have CMS that joins this call. Thank you very much for joining today. We have a lot of things to talk through, some of them are new, some of them are things we've talked about before, but we just want to keep you all up to date on where things are at. So, I think with that we can go to the next slide and first presenter, Christopher.

00:03:50 – Christopher Tolbert – Slides 5-9

Thank you, Anastasia. If you go to the next slide. So, this is going to be an update on the Medicare enrollment data for dual eligible members. Next slide. These are the definitions that we've seen before, people in Original Medicare and different types of Medicare Advantage plans. Go to the next slide. And these are other definitions of other integrated care options, the FIDE SNP, PACE and other SNPs, which include Chronic Special Needs Plans and Institutional Special Needs Plans. Okay, next slide. So, this slide right here is showing the overall enrollment for duals, as we can see,about 50% of duals,

they're in Original Medicare and there's continuing to be an increase of duals and Medi-Medi Plans.

00:04:46 – Christopher Tolbert – Slide 10

Next slide. So, this slide is an overall snapshot from October 2023 to July 2024 enrollment. And as we can see in the middle here, Medi-Medi Plan enrollment continues to increase, as well as increase in PACE organizations.

00:05:10 – Christopher Tolbert – Slides 11-12

Okay, next slide. So, these are going to be slides about the D-SNP Dashboard, the annual measures. These measures are similar to the Cal MediConnect annual measures. So, these measures will be available for publication shortly. These state-specific measures are also in addition to the federal Medicare measures that are published by CMS, such as the STAR ratings. And we do have the D-SNP Dashboard, the August version, available on the website.

00:05:44 – Christopher Tolbert – Slide 13

Okay, next slide. And as I talked about earlier, these are similar annual measures that were Cal MediConnect. I'm just going to read through these here. Percentage of members with documented care goals is 90% of members have those discussions in Medi-Medi Plans, 76% have those in non-EAE D-SNPs. And then the next measure is about the number of members to the care coordinators like the ratio. So, the statewide average for Medi-Medi Plans is 231 and then for non-EAE D-SNPs is 329. And then the next annual measure was about the annual count of emergency room behavioral health services utilization per 10,000 member months. The statewide average for Medi-Medi Plans is 135 and then the statewide average for non-EAE D-SNPs is 160.

00:06:43 – Christopher Tolbert – Slides 14

Okay, next slide. So, this slide is about our new requirement for the D-SNPs in 2023 to report on a mild cognitive impairment for members that are aged 65 and above. And as we can see, Medi-Medi Plans, like their providers, for 6% of the eligible members, they did a cognitive assessment, and the non-EAE plan providers, they did a cognitive assessment for 4% of their eligible members. Additional details on this reporting requirement, including the tools, exclusions, the eligible population, is in the 2023 D-SNP Reporting Requirements Technical Specifications. Okay, next slide.

00:07:37 – Christopher Tolbert – Slide 15

So, these are the measure specifications. This is the percentage of people aged 65 and older who had their cognition assessed within the last calendar year. And then the numerator is patients who had their cognition assessed at least once during the measurement period, which is a year. And then the denominator is patients aged 65 and older. There are some exclusions where if they had a prior diagnosis of mild cognitive impairment or dementia, they're removed from the measure. And then there's allowable exclusions where they may decline a cognitive health assessment, or they're unable to participate in one, or they previously had a cognitive assessment, and the prior results were noted. And there's a full list of exclusions in the technical specifications. Okay, next slide.

00:08:41 – Christopher Tolbert – Slides 16-17

So, these are the screening tools. D-SNPs are encouraged to reference and direct providers to the Dementia Care Aware website and associated resources. And then the Cognitive Health Assessment is a readily accessible tool for screening. And the American Academy of Neurology has those tools listed below that are validated objective tools that providers could use to screen for dementia. Next slide. I'll pass it back to Anastasia.

00:09:17 – Anastasia Dodson – Slides 17, 10

Thank you so much, Christopher. And I'm just going to add a couple more points, but very well done. Well said, Christopher. You may recall that we have a D-SNP Dashboard that is published in a PDF format. So that was how we did it for many years in Cal MediConnect, and we continued that for the beginning of this D-SNP and the transition there. We are now transitioning to the VI type of platform, a more interactive dashboard that you have seen for other aspects of CalAIM. And so, the measures that Christopher was walking through, those annual measures, those three annual measures, that data that was on the slide. And maybe we'll just kind of go back a few more slides where we talk about those three measures. Keep going back please. It should be slide 13, I think.

00:10:27 – Anastasia Dodson – Slide 13

There we go. Those measures will be the measures that we will eventually publish in the new VI platform. But you'll see again, these measures were the same ones that were used in Cal MediConnect. So, then we can look across and see, did the plans maintain the same level for these measures as they did under Cal MediConnect. So anyway, I just want to make the point about the format of how we will be publishing this data. And we

do have plan-specific data that we will publish. This is just the average across all of the plans.

00:11:11 – Anastasia Dodson – Slides 13, 17-18

Okay. So now we'll keep going to the SMAC and Policy Guide updates. All right, next slide. So for the 2025 SMACs, those are the contracts between D-SNPs – the health plans – and the state. We published those contract documents on our website. And we did take feedback last year from stakeholders, health plans, et cetera, to make any needed adjustments for contract year 2025. And as you probably all know, the contract year is the same as a calendar year. So, the 2025 contracts start January 1st, just a few weeks from now. Next slide.

00:12:09 – Anastasia Dodson – Slides 19-20

And this is a table that shows we have two types of contracts with D-SNPs. One is the EAE D-SNPs, those are the plans that have an aligned Medi-Cal plan. And then non-EAE, those plans do not have an aligned Medi-Cal plan in most cases. And most of the sections of the SMAC are the same for both. Next slide. Okay. And then we do have a Policy Guide that provides more specifics based on the framework that's in the SMAC. And the Policy Guide has multiple chapters. And similar to 2024, we'll have a Policy Guide for 2025 that we release on a rolling basis, and that's on our website. Next slide.

00:12:59 – Anastasia Dodson – Slides 21

So, this is just to kind of keep up with where we're at. So, in September we released the Network Overlap section and the Medicare Continuity of Care section, very similar to the prior year. Coming up, we're working on the quality metrics and reporting requirements for 2025, and really being cognizant now that the measures that plans submit to CMS, most of them are now specifically related to D-SNPs in California. So going forward, we'll be able to use what plans are submitting to CMS for most of our reporting. And then the Medicare encounter chapter needs to be done. Next slide.

00:13:44 – Anastasia Dodson – Slides 21-24

And this just shows in the Policy Guide for 24 and 25, which sections are in EAE and non-EAE. And of course we have Integrated Materials, Coordination with Dental, those are important chapters as well. Next slide.. This is just going to be talking about the recent chapter that we published. Again, CMS Medicare monitors the Medicare network of the D-SNPs and DHCS monitors the Medi-Cal network. But we have a requirement, we want to have many of the providers in both networks. So, we have a way that we keep track and set a goal for the overlap, so we hope that 90% of the Medi-Cal

providers from a health plan are also in the Medicare network for that health plan. And that's our overlap goal; 90%. Next slide.

00:15:02 – Anastasia Dodson – Slides 25-26

Now we're going to updates on the Default Enrollment Pilot. Next slide. Okay, so over the summer we started the D-SNP Default Enrollment Pilot in San Diego County. And we'll get to the name of the plan and latest data in just a sec. But the concept of Default Enrollment is that when a member is enrolled in one of the Medi-Cal plans that's participating in this pilot, and they just have Medi-Cal, but they are going to become eligible for Medicare because of their age, they're turning 65, or their disability, they're going to meet the Medicare disability requirements to get Medicare under age 65. As that individual becomes eligible for Medicare, if they're in one of those Medi-Cal plans that's in the pilot, then they're going to be automatically enrolled in the D-SNP that's affiliated with that Medi-Cal plan, unless they choose a different option. So that's why we call it Default Enrollment, so that if they take no action, they will be enrolled in the D-SNP, but they can choose a different Medicare option.

00:16:31 – Anastasia Dodson – Slide 27

Next slide. Dual eligible members who are already enrolled in Medicare; this pilot does not impact them. Also, people who are already enrolled in Medicare and then who are newly enrolling in Medi-Cal, does not impact them either. So vast majority of the 1.7 million dual eligibles, this pilot does not impact. It's only a few hundred individuals each month in specific counties in specific health plans. So, for example, San Diego County, August 2024, there were 157 members newly eligible for Medicare. They previously had Medi-Cal only. And so that's just an idea of the scope of this pilot. It is very small and intentionally so. Next slide.

00:17:31 – Anastasia Dodson – Slide 28

Okay, so starting June 1st, Community Health Group in San Diego sent their initial 60-day notices to individuals that would be becoming eligible for Medicare August 1st. And then starting December 1st, 2024, Health Plan of San Mateo, they will send their initial 60-day notices for people who have Medi-Cal only, but they're becoming eligible for Medicare on February 1st. Those 60-day notices are sent 60 days prior to when the person will be newly eligible for Medicare and a newly dual eligible individual. Both Community Health Group and Health Plan of San Mateo have met with their local stakeholders to discuss the pilot and are keeping them apprised, and we are making sure everybody knows what's going on. And if somebody doesn't, we would love to make sure that anybody who needs to be is looped in. Next slide.

00:18:38 – Anastasia Dodson – Slide 29

So, this is some initial data for the first three months of the Community Health Group pilot. So, you can see for the first cohort, the first group that became eligible for Medicare August 1st, 78% were enrolled in the plan. In the next month, September and then October, numbers have gone down. And when we look sort of behind the scenes at the data, what we're seeing is that there are not very many individuals who decline Default Enrollment, but there are a fair number who choose a different Medicare Advantage plan. But we are not seeing large numbers of people who either call or fill out a form or anything that says, no, thank you, I want to stay in Original Medicare. It's that they choose a different Medicare Advantage plan, which certainly they have every right and that is definitely their option. So, for what it's worth, that's what we're seeing in this pilot so far. And then folks who are enrolled through this process, they can disenroll. And within 90 days, you can see it's 3.3, 3.5%, so again, very few are disenrolling, but we do see in advance some folks are declining and going to a different Medicare Advantage plan. Next slide.

00:20:18 – Anastasia Dodson – Slides 30-31

Okay. Again, this is just for either of the plans where this is effective. There's a 60-day notice and then there's a 30-day notice. There's information in those notices about where they can get help for their information. They also get a phone call from the plan. And the notices were reviewed by advocates, CMS, et cetera. Next slide. Again, if a member is eligible for this pilot, they can choose if they want to be enrolled in that Medi-Medi Plan, in that D-SNP, they don't have to do anything. And if they don't want to, they can choose another option, Original Medicare, another Medicare Advantage plan, another D-SNP. And beneficiary enrollment in Medi-Medi Plans is voluntary. They have the option to choose which Medicare delivery system they can enroll in.

00:21:15 – Anastasia Dodson – Slide 32

Next slide. And we also have continuity of care provisions. So, in most cases, members can keep their primary care physician or specialist when they join that Medi-Medi Plan. Members don't pay a premium or pay for doctor visits or other care if they go to a provider that works with their Medi-Medi Plan. All right, next slide.

00:21:44 – Cassidy Acosta – Slide 33

Great. Thank you so much, Anastasia. So, we do have some time now for questions. I see a couple coming in through the chat and I see one hand raise. So, we'll go to questions in the chat, and then Barbra, we'll come back to you. So, the first question in the chat,

Anastasia, is what is the percent of members in the Default Enrollment that choose a different Medicare Advantage plan?

00:22:01 – Anastasia Dodson – Slide 33

Right. We don't have that exact number broken out. For example, if 66%, I think was the number around that for the October cohort, then that means about a third of those folks either chose a different MA plan or declined, and then were in Original Fee-for-Service Medicare. But again, behind the scenes, most of the people who didn't enroll with the pilot plan chose a different MA plan.

00:22:36 – Cassidy Acosta – Slide 33

Thank you, Anastasia. And then Barbra, you should be able to unmute now.

00:22:45 – Barbra McLendon – Slide 33

Hi, can you hear me?

00:22:46 – Cassidy Acosta – Slide 33

We can.

00:22:47 – Barbra McLendon – Slide 33

Fabulous. Just a couple of questions, Anastasia. So, I know you just sent out a draft update for care coordination. Do you have a date by which you expect that document to be finalized?

00:23:02 – Anastasia Dodson – Slide 33

We really want to get it out very soon and we appreciate your feedback on that. Thank you.

00:23:09 – Barbra McLendon – Slide 33

Okay. Yes, thank you. And then to the measure about screening, just to make sure I understood the data on the slide. So, what we were seeing was that of the population 65 and over, depending on whether it was aligned or non-aligned, 6% of that population was screened for cognition, or 4%.

00:23:37 – Anastasia Dodson – Slides 33, 15

There were quite a few exceptions, exemptions. So, let's go back to that slide. I think it's slide 15. So, people that already had a diagnosis are not included in the measure, if they decline, unable to participate. So that measure specification has exclusions there.

00:24:01 – Barbra McLendon – Slide 15

Right. I'm just wondering how much you're digging into that, because the data that we've seen is that of this population who are dually eligible, it's almost a quarter of them that are probably living with some kind of cognitive impairment. So, I would be surprised if the exclusions explained the big gap between the percent of people who were screened and what we would expect to see for prevalence in that population. And to be honest with you, that's what we thought we'd see in this data. We thought we'd see a number that was lower than it should be. And of course, everyone who's on Medicare over 65 is supposed to be getting a cognitive screen as part of their annual wellness exam. So, there's just a lot of numbers that don't add up, which again is what we expected. And so, we just look forward to what I'm sure is technical assistance you guys are going to be providing for plans to get that where it needs to be and just want to be a partner to you in that process in whatever way we can be.

00:25:08 – Anastasia Dodson – Slide 15

Thank you so much, Barbara. Yeah, we agree. And I think part of measuring this measure, requiring this measure, is to see what do we start out with, and we can talk with experts like you and others nationally as far as what should the baseline be or the goal. Is the goal 60%, is it 40%, is it 80%? I don't know. But yeah, we should work on that.

00:25:40 – Barbra McLendon – Slide 15

I'd love to have that conversation. Thank you so much.

00:25:42 – Anastasia Dodson – Slide 15

Thank you.

00:25:44 – Cassidy Acosta – Slide 15

Thanks, Barbra. All right. Rick, you should be able to unmute now.

00:25:50 – Rick Hodgkins – Slides 15, 33

Yes, I have a question. Earlier this year I talked to someone who represents some of the Special Needs Plans, the Medicare Advantage plans, including Dual Special Needs Plans in some of the counties. And the Medicare Advantage plans, and Dual Special Needs Plans do provide additional benefits outside of health, like extra expenses for food and that type of thing. But that what I found out is that they would not work in my case, because I get a lot of my care at teaching hospitals, like Stanford, UCSF, UC Davis. And I understand that when it comes to any Medicare Advantage plan, that whether it's a D-

SNP or not, I would have to stay in the county. I would have to give up all the specialists I see at the teaching hospitals. I would not be able to go out of my county at all for anything. Is that the case?

00:27:15 – Anastasia Dodson – Slide 33

Thanks so much, Rick, and I see what you're saying. I know that, yes, it is true that if anybody signs up for a Medicare Advantage plan or a D-SNP, they have to, for the most part, stay in network. There are certain exceptions, but the idea is that these plans have a network of providers and part of the agreement is-

00:27:43 – Rick Hodgkins – Slide 33

What are the exceptions?

00:27:45 – Anastasia Dodson – Slide 33

Well, I don't think we have all the right people to go through every single exception, but the idea is if there's someone that a new member has been seeing in the past, we expect the plan to work with the providers that are outside of their network to come to an agreement hopefully for 12 months. But for the most part though, it is that network of providers and the way that the care coordination works with the D-SNPs is the providers have agreed to when they're serving these dual members to report certain things, like screening for dementia, et cetera, and there's a whole care coordination team that works with the provider.

00:28:37– Rick Hodgkins – Slide 33

I'm only disabled, I'm not elderly. I'm 46 years old, so, I don't know. I'm not ready for dementia yet.

00:28:48 – Anastasia Dodson – Slide 33

It is up to you to decide what works best for you, for your health care, and you do not have to join a Medi-Medi Plan, but I think it's pretty cool that you talk to them to see what you think, but really no pressure either way. We want people to get the health care that they need through the provider networks that they need. We want the D-SNPs to build a robust network of providers. But it is your choice, and we totally respect that.

00:29:21 – Cassidy Acosta – Slide 33

Thanks, Anastasia. We have a couple more minutes for questions. So, Susan, you should be able to unmute now.

00:29:28 – Susan LaPadula – Slide 33

Good afternoon, Anastasia and DHCS. How are you?

00:29:32 – Anastasia Dodson – Slide 33

Good, thanks. How are you, Susan?

00:29:35 – Susan LaPadula – Slide 33

I'm doing well, thank you. I just had a question regarding the SMAC Medicare coordination piece, and I was hoping we could propose a listing of the managed care plans that have successfully made it to production with CMS and are out of the testing phase for that coordination of crossover and deductibles.

00:30:03 – Anastasia Dodson – Slide 33

Thank you. No, I know that that has come up in the past. We will check with CMS colleagues on that. Great idea. And I know there was a thread going, but I have not seen the latest email thread on that, but we will follow up.

00:30:19 – Susan LaPadula – Slide 33

Thank you so much. I appreciate it.

00:30:23 – Cassidy Acosta – Slide 33

Thanks, Susan. And then I think we have one more question in the chat, Anastasia. This one seems to be about current beneficiaries and D-SNP look-alikes in Ventura County and if a beneficiary can stay in their current plan or if they'll need to make a change in the new year.

00:30:39 – Anastasia Dodson – Slide 33

So, anybody who is in a health plan that was categorized as a look-alike got a notice. And I think they probably went out at the end of September that said, "Okay, if you do nothing, here's what will happen. You will be enrolled into such-and-such different Medicare Advantage plan if you were in a plan that was a look-alike." But sometimes in certain counties if that D-SNP look-alike plan did not have another plan they could crosswalk the member into, then they may have just discontinued that plan. But open enrollment on the Medicare side is right now, and people can choose to stay in their existing plans, they can choose new plans, they can switch over to Original Medicare. That's what people can do during Medicare open enrollment, which is right now. And that will be effective January 1st of 2025.

00:31:42 – Cassidy Acosta – Slide 33

Great. Thanks so much, Anastasia. I think now's a good time then to move into our next section on 2026 local plan implementation.

00:31:52 – Anastasia Dodson– Slide 34

Great. And I did get a message about my voice being muffled. I can try to fix that.

00:31:59 – Cassidy Acosta – Slide 34

I can hear you loud and clear.

00:32:01 – Anastasia Dodson– Slides 34-35

Okay. All right. So, you all probably know Medi-Medi Plans are available in 12 counties right now, but they will be available in additional counties coming up for 2026. So, that's what this next section is about. And again, we've talked about on this with this group, Medi-Medi Plans. They are a D-SNP plus a Medi-Cal plan. Same organization offering both sets of benefits through one plan to the member. Next slide.

00:32:37 – Anastasia Dodson– Slides 36

So, we've been working with 10 local Medi-Cal plans to have them fill out all the forms, develop their provider networks, everything else, in preparation for January 1st, 2026. Those 10 plans will be again standing up D-SNPs, Medi-Medi Plans, January 1st, 2026. We're doing a lot of work with them to make sure that they get all the technical assistance they need. And next year at this time, dual eligibles that are living in the counties where those 10 local plans operate will be able to enroll in one of the new D-SNPs, one of the new Medi-Medi Plans again a year from now. Next slide.

00:33:33 – Anastasia Dodson– Slide 37

So, what are the rules for joining a Medi-Medi Plan? Dual eligible beneficiaries if they have both Medicare Part A and B and Medi-Cal, and are age 21 years or older, and live in one of the counties where the Medi-Medi Plans are being offered. That's the requirements for joining a Medi-Medi Plan. We see that in the 12 counties where Medi-Medi Plans are in place that about a quarter of all dual eligible beneficiaries are enrolled in the Medi-Medi Plans, so a little over 300,000 members.

And you can see in the middle of the slide, that gives the names of the counties, those 12 counties where Medi-Medi Plans are currently available. At the bottom of the slide, those are the lists of the counties. There are 30 additional counties where Medi-Medi Plans will be available in 2026. There are some counties that are on a little bit of a longer

timeframe, but by the time we get to January 2026 there will be Medi-Medi Plans available in almost all counties, in 42 counties and certainly all of the large counties. Next slide.

00:34:53 – Anastasia Dodson– Slide 38

And here's the map. So, we have updated this map to show you, in orange, those are the counties where Medi-Medi Plans, the special type of D-SNP, are currently available. In the dark blue, That's where the counties that will have new Medi-Medi Plans newly available in 2026. And then in the medium blue in the northeast part of the state, those counties will have Medi-Medi Plan options eventually, but not in '26. They'll be phased in later years. All right. Next slide.

00:35:33 – Anastasia Dodson– Slides 39-40

So, now we're going to switch to a different topic, but still related to enrollment and eligibility. And this has to do with people who already have Medicare and they have what's called a Special Enrollment Period to change their plan or go to Original Medicare. And there are some changes in the rules on the CMS side that will occur starting next year. So, right now we're still in 2024, and some of this will be true in 2025 as well.

People who are duly eligible, they can change their Medicare Advantage Plan, Medicare drug coverage for any reason. There are certain usual times to make changes. The Medicare open enrollment period, which is right now, or the Medicare Advantage Open enrollment period, which is in the beginning of the year each year, those are the usual times. There are also Special Enrollment Periods where duals can make changes at other times of the year. There's a long list of different scenarios, different situations that allow people to make changes outside of the usual times. There is, of course, a phone number, 1-800-MEDICARE. They can answer all the questions about these open enrollment and Special Enrollment Periods. Let's go to the next slide.

00:37:06 – Anastasia Dodson– Slide 41

So, starting January 1st, 2025, there will be some changes in the Special Enrollment Periods. So, Medicare is going to allow folks who are duly eligible to switch to Original Medicare with a standalone Part D plan once per month. In 2024, there is a quarterly Special Enrollment Period, but that's going away. So, instead there is a Special Enrollment Period that allows duals to switch to Original Medicare once per month. So, more frequently than current. There's also a new type of Special Enrollment Period for

integrated care that allows duals to choose a Medi-Medi Plan or SCAN Connections, and really PACE as well, in any month of the year.

So, that any month of the year for Medi-Medi Plans, SCAN, PACE is new. What is going to be discontinued is the quarterly Special Enrollment Period. And the other change is that duals will not be able to enroll in or change regular Medicare Advantage plans or other Special Needs Plans outside of those usual times. So, in 2024, there was a quarterly opportunity and duals could change even into a regular Medicare Advantage plan on a quarterly basis. But that's being changed. And so now someone who wants to go into a regular Medicare Advantage plan or other Special Needs Plan has to use that usual time. We have a webpage, a DHCS webpage, where we have a lot of information about this. Let's go to the next slide.

00:38:59 – Anastasia Dodson– Slide 42

So, we have a full list of the 2025 integrated D-SNPs that can use this integrated care SEP or that beneficiaries can opt into. It's on the CMS.gov website, but for California that means PACE, SCAN Connections, and the Medi-Medi Plans. There's also a resource newly released by CMS to help people visualize this and make choices. Next slide. Okay, so now we're at questions.

00:39:41 – Cassidy Acosta – Slide 43

Great. Thanks, Anastasia. So, Jan, we'll get to you in one moment. I just want to flag that there is a question in the chat around ECM that we're going to hold on until we get to our ECM and Community Supports data updates later on. But Jan, you should now be able to unmute.

00:39:57 – Jan Spencley – Slides 43, 41

Thank you, Anastasia and everybody. There's been some confusion about this, a lot of confusion, in terms of what this means. And it would be helpful if we went back to that slide where you're showing what that change is. If you also added that there are special Medi-Cal SEPs besides the monthly one. One of them is new to Medi-Cal or a change in their Medi-Cal status, meaning going from share of cost of full scope, which gets them into a better situation. And both of those, as I understand it now, didn't in the beginning, both of those allow them to choose any plan. Because they are new to Medicare. That's a separate SEP. But a lot of people are very confused about that. And I am hoping that you will make it clearer in these slides. Because it's a huge access issue. I've said this over and over. It's a huge access to care issue.

If there were Sharp doctors in San Diego, the doctors that are not directly D-SNP, but that's where their doctors are and that's where their access is. And so, I'm happy to send you a couple, because I've actually studied all of the health plans that we work with here. I've looked at their SEP list that you look at each time. So, other than the usual and customary times when you can change, there's if you're new, meaning you're new to Medi-Cal, or you lose Medi-Cal, or you change your Medi-Cal status, are separate SEPs. And I think it'd be helpful, since they're specific to Medi-Cal, if you started including them on your slides.

Because they have a choice to go outside of a D-SNP or a Medi-Medi Plan. Well, outside of a D-SNP. I can be honest, we encourage them to do D-SNPs when that's in their best interest, but not when that would disrupt their continuity of care. Because those plans are much better in terms of benefits and coordination. But the fact is, their doctors may be someplace that they can't get to a D-SNP. So, that's my request is to please clarify that. I've been in very large gatherings of folks and they're all confused, including the compliance people and everybody. And I'm going, "No, no, no, no. That's not what it is." And they're like, "Yes, yes." So, I would appreciate that clarification on your slides as well.

00:42:42 – Anastasia Dodson – Slide 41

Thank you, Jan.

00:42:43 – Jan Spencley – Slide 41

That's it.

00:42:44 – Anastasia Dodson – Slide 41

Yeah, absolutely. No, great point. We will do that and we can put that on the webpage that we have. We do try to be careful because we're not CMS, so we don't want to misstate anything, but we can just copy and paste the language from CMS, put it on our slides. Absolutely. Thanks for all the work that you're doing, Jan, to help educate people.

00:43:09 – Cassidy Acosta – Slide 41

Thanks, Jan. All right, Susan, you're up next. You should be able to unmute.

00:43:14 – Susan LaPadula – Slide 43

Thank you. Another question for you, Anastasia. My understanding is we have something new in California starting January 1st, 2025, regarding an automatic buy-in for Medicare Part A for Medi-Cal members who are currently without Part A coverage. And I've been interested in how this will unfold in two ways. One is the current long-

term care resident that is here with us that only has Part B. Does that mean January 1st of 2025 they would now be entitled to Part A? And then how would that unfold for new Medi-Cal members just applying for Medi-Cal?

00:44:08 – Anastasia Dodson – Slide 43

Oh, that is a great topic, Susan. I am going to go off script and yes, let's talk about the Part A buy-in, even though I will say my colleagues in the Eligibility Division and Third-Party Liability, they are really the experts. So, I'm going to say what I know. It may not satisfy you with all the technical details, but they are working on... They've been sending notices to members, and we can work on pushing more information out. But-

00:44:38 – Susan LaPadula – Slide 43

Can we also perhaps consider adding it to your website, because going to need it and we're going to need it soon?

00:44:47 – Anastasia Dodson – Slide 43

Yes, there is a webpage, and we are working on it. But here goes, and this could be of interest to a lot of people. So, right now there are 100,000+ people that have Part B Medicare, but they do not have Part A. So, they are enrolled in Medi-Cal Managed Care Plans. So, the Part A type services, like a hospital stay, et cetera, is covered by Medi-Cal, and then their doctor visits are covered by Medicare. And it's really kind of frustrating, difficult system for them to have that Part A type services through Medi-Cal, and then Part B through Medicare.

And there's various reasons why this population exists; complicated eligibility rules. The bottom line is, yes, we are working with CMS, the federal government, and they are going to execute certain transactions, computer system updates to have certain people, not all of them, but certain groups will be able to get their Part A Medicare automatically. Those folks got notices from DHCS. They either have or will get a notice from, and I don't know all the technical details, but I think they'll get a notice from the Social Security Administration.

And we have been reaching out to our Medi-Cal Managed Care Plans to give them a heads-up, and to the D-SNPs, so that they know that these folks will show up in certain systems as, soon to have Medicare Part A. There's ways that they can identify them. Because the main thing is we want to make sure that everybody's access to care is not interrupted with this transition. So, that if they are in the hospital, if they're in a skilled nursing facility, what have you, there's no confusion about access to care. Behind the scenes their source of coverage is changing, but their access to care should remain.

The one thing I do want to just mention is that CMS does not do this all the time. This is a very special event happening for California. Most states already do this automatic Part A buy-in thing. And so we're working very closely with CMS, meeting with them several times a week to make sure all the technical stuff works out. We're not 100% sure that all the technical pieces are going to line up perfectly. So, there may be people that we expect to get their Part A automatically on January 1st and they don't.

But they will still have their Medi-Cal, so they're not going to lose access to care. But we are working very much with CMS, with SSA. Going to be talking to HICAPs in December. But we are still working on the technical things, so we don't want to put information out there that we have to retract later. But we are very excited about this transition. And the most important thing is to make sure people don't lose access to care.

00:48:32 – Cassidy Acosta – Slide 43

Thanks, Anastasia. I know that there are a couple of other questions, but in the interest of time, we're going to move on to our next section. And so, we'll turn it over to Joseph and Patricia to kick us off. And just flagging that we do have a couple of other opportunities throughout the presentation for additional stakeholder Q&A. So, Joseph, Patricia, I'll turn it over to you.

00:49:12 – Joseph Billingsley – Slides 44-45

So, we can go ahead and get started. So, yeah, thank you for moving to the introduction slide. And I just want to take a moment to thank everyone for inviting us to join today and speak with you related to the work that the Department of Health Care Services has been doing on our ongoing statewide Medi-Cal home and community-based services and managed long-term services and supports Gap Analysis and Multi-Year Roadmap Project, which aims to identify and help close gaps in California's home community-based services, and long-term services and supports programs and provider networks.

00:50:11 – Joseph Billingsley – Slides 45-47

So, I look forward to the opportunity to provide you an overview of this project and stakeholder engagement opportunities, and also get to have a chance to hear questions and comments that you have. Just to start with introductions, I'm Joseph Billingsley. I'm Assistant Deputy Director for Integrated Systems at Department of Health Care Services.

00:50:45 – Joseph Billingsley – Slide 46

I'm also joined by Patricia Rowan, who is the Principal Researcher with Mathematica. DHCS has engaged Mathematica to conduct the HCBS MLTSS Gap Analysis and also

Multi-Year Roadmap. So, Patricia is joining me today in case any questions come up that she could assist in responding to. So, next slide please.

00:51:25 – Joseph Billingsley – Slide 47

So, just to briefly walk through our agenda for today, we've already covered introductions, and next I'm going to provide an overview of the Medi-Cal Gap Analysis and Multi-Year Roadmap Project. Then we'll walk through the timeline for major activities and stakeholder engagement related to the Gap Analysis and Multi-Year Roadmap. We also want to take time to discuss the transition to managed care for select home and community-based services programs with you. And then finally, we have prepared several discussion questions for you to help us prepare for additional stakeholder engagement related to the Multi-Year Roadmap development, and also in preparing toward the work to integrate selected home and community-based service programs into our managed care delivery system. Next slide please.

00:52:38 – Joseph Billingsley – Slide 48

So, the goals of the department's Medi-Cal Gap Analysis and Multi-Year Roadmap are first to identify and analyze opportunities to close gaps in access to home and community-based services, or HCBS, as we also refer to it as. Then based on that information to develop strategies to close identified gaps through transitions to managed care for select home and community-based services programs. With the end goals of this effort being to improve health outcomes, consumer satisfaction, and health equity for Medi-Cal members who use home and community-based services in California. Next slide please.

00:53:27 – Joseph Billingsley – Slide 49

So, just to provide a high-level overview, the final Gap Analysis report is currently under review. So, Mathematica has completed that initial Gap Analysis report phase of this project, and the final report is going through internal review at Department of Health Care Services with an expected public release in early 2025. And the Gap Analysis focused on five objectives. Objective One is reducing inequities in access and services. Objective Two is meeting client needs. Objective Three is program integration and increased coordination. Objective Four is quality improvement, and Objective Five is streamlining access.

So, this report was informed by analyzing data and extensive stakeholder input on gaps in access to home and community-based services, and suggestions for addressing those gaps. So, in addition to performing or conducting an analysis on extensive data that was

available through DHCS, that is collected by DHCS, as well as data obtained by DHCS from other departments that participate in providing Medi-Cal funded home and community-based services programs, through this Gap Analysis effort Mathematica also worked to obtain information through other venues, including four public stakeholder meetings that were held during the course of the Gap Analysis effort.

Also, they conducted 16 listening sessions with over 150 Medi-Cal home and community-based services recipients and their caregivers. Also, over 50 interviews were conducted with providers, waiver agencies, and Managed Care Plans to obtain input from those different entities. And then also we conducted a statewide survey of home and community-based services providers. Next slide.

00:56:11 – Joseph Billingsley – Slide 50

So, currently we're using the findings from the Gap Analysis report to develop recommendations to address those gaps and increase Medi-Cal members access to home and community-based services. As part of the CalAIM initiative, California has a stated goal of moving several of its Medi-Cal home and community-based services programs from a fee-for-service service delivery system into a managed care delivery system. And so currently the Department of Health Care Services has convened an internal work group of the different teams across the Department of Health Care Services that will be impacted that need to provide input in relation to options for HCBS integration into managed care, with the goal of identifying and discussing potential approaches to transition select home community-based services programs into managed care, and to inform the development of a road map with specific steps and associated timelines. And recommendations from this internal work group will be vetted with Department of Health Care Services senior leadership in January of 2025, and then the development and implementation of the road map will be informed by continued engagement and input from stakeholders. Next slide.

00:58:00 – Joseph Billingsley – Slide 51

So, this slide provides a high-level overview of major milestones for the DHCS Gap Analysis and Multi-Year Roadmap Project. As you can see on the slide, we identified that the final Gap Analysis report is going through review by DHCS and is planned for release in Quarter 1 of 2025. Also, want to note that again, we've started that process here in late 2024 of the road map development, which is being informed through an initial process that I just discussed, which is the internal work group that DHCS is conducting to identify options and recommendations for the integration of select home community-based services programs into managed care.

And then noting that towards the end of Quarter 1 of 2025 and the beginning of Quarter 2, DHCS will be kicking off additional and more focused stakeholder engagement, including putting together a focused work group of different impacted stakeholders to continue to help inform both the development of the roadmap as well as planning toward MLTSS or home and community-based services integration into managed long-term services and supports.

And so really recognizing that the goal being to initiate strategies for applicable waivers to achieve better managed care integration of the selected home care-based services. And when looking from a timeline perspective, recognizing the work and planning that needs to be done towards being able to effectively complete that, or implement that, that integration that we do not anticipate actual integration implementing any sooner than 2028. And that is not a hard timeline, we are just looking at ensuring that we have appropriate runway for the planning process. And so looking downstream at integration of select home care-based services beginning no sooner than 2028. Next slide.

01:01:29 – Joseph Billingsley – Slide 52

With this slide, we're just wanting to highlight that since this project has launched in late 2022, approximately 1500 stakeholders have been engaged so far through the different activities. And again, that includes four public stakeholder meetings, updates that we've been providing for existing stakeholder forums, small group consultations, the 16 consumer listening sessions that I previously noted. And then we are currently preparing for the additional ongoing stakeholder engagement that I mentioned that will begin in early 2025 and have developed discussion questions for you today to inform those conversations. Next slide.

01:02:21 – Joseph Billingsley – Slide 53

So, just again, want to clearly state that DHCS has not established the set timeline or transition date for managed care integration, and are currently, again, anticipating that we will not begin any actual integration sooner than 2028. We're currently holding early-stage cross-department internal discussions and exploration, and the programs that, when I keep referring to select home services programs, the programs that are currently being considered for managed care integration are specifically the Home and Community-Based Alternatives Waiver, the Assisted Living Waiver, and the Multipurpose Senior Services Program Waiver. So, three of the 1915(C) Home and Community-Based Services Waivers that are administered in California through either Department of Health Care Services or sister departments in collaboration with Department of Health Care Services.

Also, want to clearly state that neither the In-Home Supportive Services Program, nor the waivers administered by the California Department of Developmental Services are currently being considered for integration into managed care.

And as I've mentioned a few times before, key design options will be discussed with stakeholders for input and feedback in early 2025. And again, as we continue to go through this process, it's why I'm here speaking with you today. There's additional standing stakeholder forums that will be joining in the interim to continue to provide updates on where we're at in the process, what we're doing, and how we're working towards establishing a dedicated stakeholder process to again inform the development of the road map and plan towards integration of the select home and community-based services programs into managed care downstream. Next slide, please.

01:04:50 – Joseph Billingsley – Slide 54

So, we would like to spend the next few minutes hearing from you to help us prepare for additional stakeholder engagement in 2025. We've identified three discussion questions here for you, and they are specifically, what topics would be most beneficial for stakeholder discussion and input related to managed care integration and implementation? What are your biggest questions about the managed care transition, the integration of HCBS into managed care? And what additional forums should Department of Health Care Services use to provide updates and receive input? So, would definitely like to take time to pause here, and hear any input you have on these questions, as well as respond to any questions that you have.

01:05:52 – Cassidy Acosta – Slide 54

Thanks, Joseph. I'm not seeing any questions in the chat yet, but do you want to give folks an opportunity to raise their hands, or drop questions in the chat, or any responses to these discussion questions in the chat before we move on to our next section? So, we'll give it a couple of seconds.

We have one response in the chat that says, "MCP readiness is critical, as operationally our CBAS experience is informative when these transitions take place."

01:06:16 – Joseph Billingsley – Slide 54

Thank you for that comment, Lydia. I completely agree that as part of this process, our planning process, identifying all of the required readiness components and having a clear readiness process in advance of the transition will be essential to ensuring that we are transitioning services effectively and appropriately, and that it's not impacting member access to the services.

01:07:09 – Cassidy Acosta – Slide 54

We also have a question from Jan in the chat. "Will there be standardized screening and other tools to ensure HCPs have parity of services approved and provided?"

01:07:19 – Joseph Billingsley – Slide 54

Again, that is a great question. I appreciate you raising that. Those are things that we are going to be looking at as we go through this planning process, and we're appreciating input from stakeholders, providers, managed care plans, all of the different impacted entities to understand what needs to be included in the readiness process, where and when standardization is necessary. So, we appreciate your continued input in raising up items for consideration.

01:08:03 – Cassidy Acosta – Slide 54

And then Jan, I know you have a follow-up in the chat, please review the IHSS and the transition and not transition. Do you want to come off mute and explain that one a little bit more? If you raise your hand I can unmute you.

01:08:15 – Jan Spencley – Slides 54, 53

There we go. Okay, I'm not trying to share. It's telling me just that I'm trying to share. But if you go back to the page before it went pretty quick, and you said that there were certain IHSS services that would not be included, neither the IHSS program nor the waivers administered by the California Department of Developmental Services. So, that's for developmentally disabled individuals. Is that what you're talking about? You're talking about regular IHSS going into plans much like SCAN has now?

01:09:06 – Joseph Billingsley – Slides 53

Thanks for raising that question, because I want to make sure we're being really clear on how we're presenting information. What we're trying to convey here in this slide is clearly identifying the scope of what we're meaning by transitioning select home and community-based services programs into managed care. And so that is a limited scope. We're not speaking to transitioning all home and community-based services programs into managed care. We are very specifically evaluating the integration of three of our 1915(c) waivers, which are the Home and Community-Based Alternatives Waiver, the Assisted Living Waiver, and the Multi-Purpose Senior Services Program Waiver into managed care.

Other HCBS programs, which include the In-Home Supportive Services Program, administered by Department of Social Services, and then the two 1915(C) Home and

Community-Based Services administered by the Department of Developmental Services, which are the Home and Community-Based Services for the Developmentally Disabled Waiver, and then the Self-Determination Program Waiver, as well as the corresponding 1915(i) State Plan Option for individuals with developmental disabilities. Those are not being transitioned into managed care. So those will remain as standalone programs.

01:10:38 – Jan Spencley – Slide 53

Joseph, you just covered a lot of different types of waivers. So really, I'm asking very straightforwardly, are IHSS services being transitioned? And I guess that would be for no matter what, are any IHSS services being transitioned?

01:11:00 – Joseph Billingsley – Slide 53

The In-Home Supportive Services Program administered through Department of Social Services and at the county level, those services are not being transitioned into managed care.

01:11:11 – Jan Spencley – Slide 53

Thank you. Then see, you just took a full thing right off my list. It's just because there's so many implications for families.

01:11:22 – Joseph Billingsley – Slide 53

I'm glad you asked that question; I want to make sure we're being very clear.

01:11:23 – Jan Spencley – Slide 53

Thank you.

01:11:24 – Joseph Billingsley – Slide 53

Thank you.

01:11:26 – Cassidy Acosta – Slides 53-55

Thanks, Jan. And then a couple of other comments are coming through the chat, but in the interest of time, I think we're going to move on. Rick, I do see that your hand is up. We will get to you during the next Q&A section. But if we want to move through these last few slides, and then Joseph and Patricia, welcome you both to respond to questions in the chat as they come in. But any other last comments, Joseph, on the resources slide, before we move into our spotlight?

01:11:54 – Joseph Billingsley – Slide 55

Yeah, just like for folks that we've provided some links here that will be in the PowerPoint that is posted, where you can access additional information. And also, an email address where you can provide questions and feedback. Thank you all.

01:12:11 – Cassidy Acosta – Slides 55-57

Thanks so much, Joseph. All right. I think with that, we can transition into our spotlight on Medically Tailored Meals and I will turn it over to Tyler to kick us off.

01:12:24 – Tyler Brennan – Slides 57–59

Hi, good afternoon, everyone. My name is Tyler Brennan, I'm a Health Program Specialist here at the Department, in a Managed Care Quality and Monitoring Division. Here to talk to you a little bit about Medically Tailored Meals, one of our 14 Community Support services. And we can jump right into the next slide, and actually, why not go another one?

01:12:41 – Tyler Brennan – Slide 59

All right. So, Medically Tailored Meals... I'm sorry, you can go back whichever one this is, I guess we're starting here. A little bit about the history of Medically Tailored Meals and where this all comes from. But back in 2018, the Department had a Medically Tailored Meals pilot program that was launched in eight counties. That pilot program focused on beneficiaries that had a diagnosis of congestive heart failure, and an aim to reduce hospital and emergency department readmissions. We also had under the Whole Person Care pilots managed care plan involvement in offering managed Medically Tailored Meals. That was actually done through the counties who were operating as the lead entities for that particular pilot program.

And through that and through the myriad of services, and types of Medically Tailored Meals programs that we saw through that, the evaluation found evidence of reduced hospital stays and health care costs. So seeing the successes of both the Medically Tailored Meals pilot program, as well as the Whole Person Care pilots, really encouraged as a Department us to offer and include Medically Tailored Meals as a part of CalAIM, and a part of In Lieu of Services, which we call Community Supports. We can go to the next slide.

01:13:50 – Tyler Brennan – Slide 60

So, a little bit about what Medically Tailored Meals are. The Medically Tailored Meals, as I said, is a Community Support service that's available through California's CalAIM

initiative. The program provides meals that are specifically designed to meet the nutritional needs of individuals that have complex health conditions. Meals are crafted under the guidance of registered dieticians to ensure they align with medical requirements, like low sodium for heart disease, or carbohydrate-controlled meals for diabetes. And then by addressing specific dietary needs, Medically Tailored Meals really aim to support better health outcomes and improve the quality of life for individuals with conditions that can be impacted by their diet.

And some of our services and subcomponents of the services are here on-screen, but really Medically Tailored Meals are designed to support health stabilization, reduce hospitalizations, and decrease the need for emergency care by providing the right nutrition to those who need it most. So, when people with chronic conditions have consistent access to meals that align with their medical needs, they can better manage their symptoms and reduce complications that lead to more intensive care. In the long-term, the service aims to improve overall health and reduce health care costs by supporting preventative care through nutrition. And some of the subcomponents of the services you see on screen. Meals that are delivered to the home after hospitalization are included. They must meet unique dietary needs; registered dietitian involvement is always present throughout the process. Supplementary, medically tailored groceries are also available and sort of a subcomponent of the service itself is medically supportive food, which is sort of inclusive of those. Healthy food vouchers is the same as well as food pharmacies.

And then an important component of all nutrition interventions is the behavioral cooking and nutrition education component that is essentially included with any of the interventions. So, jumping to the next slide, please.

01:15:58 – Tyler Brennan – Slide 61

There are a few service limitations that we have as part of the service. So, services are inclusive of up to two meals per day for up to 12 weeks. That can be extended for longer periods if the managed care plan, or functions determine that to be medically necessary for the individual. Meals that are eligible for or reimbursed by alternative programs are not eligible. And then meals are not covered solely to respond to food insecurities that members may be experiencing. That can certainly be a secondary factor, but it cannot be the primary factor. Jumping to the next slide, please.

01:16:14 – Tyler Brennan – Slide 62

All right. And so why do Medically Tailored Meals matter? The service is really intended for Medi-Cal beneficiaries with complex health needs, particularly fragile, and who have

been recently discharged from a hospital, or who are dealing with chronic conditions like diabetes, heart disease, or renal failure. Eligibility often prioritizes individuals who may not have stable access to nutritious food due to social determinants of health like food insecurity or limited mobility, which can make it difficult to maintain a healthy diet. The services itself aligns with CalAIM's goals of integrating health-related social needs into the health care system, addressing factors outside traditional clinical settings that impact health. The service can certainly complement other Community Supports, like Recuperative Care is one example, by providing meals during recovery periods. And it also aligns with MLTSS by helping individuals avoid institutional care settings when possible. The program typically covers, as I said, a period of around 12 weeks, but there is that potential for extensions based on individual needs and eligibility, although ongoing access, regular permanent access, is limited due to the program constraints.

And just on screen here you see some of the highlights. This is really why we feel that healthy nutrition is paramount to encouraging people to remain healthy. Jumping to the next slide, please.

01:17:34 – Tyler Brennan – Slide 63

A little bit of a data highlight here, and this is specific to dual eligible beneficiaries who receive medical-tailored meals, or medical-supported food. But we are seeing these numbers continue to grow and grow rapidly. So, as you can see here on screen, we are just tracking the growth and visualizing the growth for you over the last year and change. So back in Q1 of 2023, we had just over 4,000 dual members receiving services. As of Q1 2024, so as of the end of March of this year, that number was up to almost 22,000, which represents about almost a 450% increase in just that 15-month period. And with that, and acknowledging the time, I think that is it, but I'm happy to pass things off to our next presenter who is going to continue talking a little bit more about Medically Tailored Meals.

01:18:20 – Melen Vue – Slide 64

Thank you, Tyler. And good afternoon, everyone, and thank you for having me here today. Again, my name is Melen Vue, on the System Secure Team at Health Net, and I'll be sharing with you our Medically Tailored Meals and Medically Supported Foods. Next slide, please.

01:18:44 – Melen Vue – Slide 65

So, there's a lot on this slide, but this slide provides an overview of Health Net's landscape. And more than 85% of our members have coverage through a government

sponsored program. I'd like to direct you to the center of the slide where we have more than about 148,000 Medicare members in 23 counties, and those counties are listed on the right. And I also like to highlight here that Medicare will no longer cover post-acute meals effective 1/1/2025. However, if your members or individuals you're working with are duals or D-SNP members, they will be eligible for Medi-Cal services, like what Tyler had mentioned, Medically Tailored Meals in the Community Support services initiative. Next slide, please.

01:19:33 – Melen Vue – Slide 66

And a quick high-level overview of CalAIM, which I'm sure many of you are familiar with, and you all probably know already, CalAIM stands for California Advancing and Innovating Medi-Cal, which is a huge game changer here in California. There are two significant programs within CalAIM that began in January of 2022 to support Medi-Cal members, Enhanced Care Management and Community Supports. I won't go into Enhanced Care Management, I will focus specifically on Community Supports, really highlighting our Medically Tailored Meals program.

But just high-level overview on Community Supports. It is being implemented by the managed care plans as a service. These services are not yet a benefit, and these services are designed to provide health related services as an alternative covered benefit. So, Community Supports programs will be integrated into care management for members at high level of risk and are intended to address SDOH in a way that is cost-effective. So, instead of more expensive services such as going to the ER, or skilled nursing facility, members would be referred to one or more of the community support services based on the members identified needs. And these services are available for all Medi-Cal members, including duals who meets the program eligibility criteria. Next slide.

01:21:05 – Melen Vue – Slide 67

DHCS has defined specific responsibilities for the managed care plan and Community Supports. MCPs are responsible for establishing a provider network, and that's a network within our 14 Medi-Cal counties to deliver the services, as well as provide oversight and monitoring for all community, 14 Community Support services. Next slide, please.

01:21:31 – Melen Vue – Slide 68

For Community Supports, as I previously mentioned, their primary responsibility is delivering Medi-Corporate and cost-effective alternatives, which are typically not funded by Medi-Cal, such as our housing bundle, the Recuperative Care, Medically Tailored

Meals, and pretty much all of the 14 community support services that are available today. And here as well, CS providers must also meet certain contractual requirements, such as having a process in place, or a system for billing and data sharing. Next slide, please.

01:22:08 – Melen Vue – Slide 69

And Medically Tailored Meals was one of the very first CS services that went live on January 1st, 2022. And this service was implemented across all of our counties at the time. The primary goal of this program, which many of you are probably familiar with, is to improve our members' overall health, reduced hospitalization, re-admission rates, ensure that our members maintain a good nutritional health and increase member satisfaction. As Tyler mentioned earlier, it's important to note here that the MTM program is not designed to address food insecurities. There are specific eligibility requirements similar to all of the other CS services, and a member will qualify for MTM services if a member has a chronic condition, in addition to one of the following, either being discharged from a hospital or skilled nursing facility, or the member is at risk of hospitalization or nursing facility placement. Or that the member needs extensive care coordination needs. Next slide, please.

01:23:15 – Melen Vue – Slide 70

MTM services. It now includes an initial assessment, which is required and must be conducted by a registered dietician, or other certified nutrition professional before any mail request can be made. And the assessment that's completed must also be submitted with the authorization request. The meals or food boxes will be delivered to the member's home. And again, the assessment is crucial for tailoring the member's meal to ensure that the meals or the food boxes that are being delivered meets the member's dietary needs, and their chronic condition. For medically supportive foods, such as medically tailored groceries, must be selected to align with the nurse nutritional requirements and dietary needs as well. And MTM also includes behavioral education, cooking classes, and/or nutritional education. Next slide, please.

01:24:14 – Melen Vue – Slide 71

For this service, there are restrictions and limitations. Members are eligible to receive up to two meals a day, or weekly grocery boxes up to 12 weeks. And if medically necessary and extension can be requested, members can extend their services up to an additional 14 weeks, which is a total of 26 weeks in the program.

Under Health Net, this service is covered for a duration of up to 90 days. Again, if medically necessary, extensions are allowed after the initial 90 days. And this program, again, it's not designed or respond solely to food insecurities, this program is really focused on individuals with high-risk conditions that are being discharged from the hospital and is a short-term support for them to increase stability and education for members to really get them on the right path again.

So, what I just shared on Medically Tailored Meals, it's very specific to Health Net. Each health plan has their own eligibility and restrictions. So, if you're working with other health plans, we ask that you reach out to your plan partners to identify what conditions they cover, their eligibility and restrictions that they may have put in place for this service. Next slide, please.

01:25:32 – Melen Vue – Slide 72

Again, here these are the key elements of our MTM program. Meals are provided to the member's home, especially for individuals who may have issues with transportation. Critical to highlight again, the importance of the registered dietitian support around doing a really good nutritional assessment and personalized care plan depending on the member's needs. Services can be extended beyond the 12 weeks. And if you're interested in more information on the program, you can go to the Health Net website, which is linked on this slide. Next slide, please.

01:26:08 – Melen Vue – Slide 73

And as of this month, we have successfully contracted with 17 providers. We do have a full network across all of our 14 Medi-Cal counties, and we have more than one contracted provider in each county. So, we have a fully operational network at this time with 12 local community-based organization, and five multi-county or statewide providers offering this service. And these are our contracted providers on the slide. Next slide, please.

01:26:42 – Melen Vue – Slide 74

These are the steps when referring individuals to Community Support services. At Health Net, there is a no wrong door approach. With the referral process, we'll accept referrals from ECM providers, PCPs, any entities serving members, including the member themselves, family members, guardians, and pretty much anyone who's in need of this service. But also, who then meets the eligibility criteria. There are several referral pathways for CS services, including FindHelp, which is the preferred pathway when making a referral for any member. Members can also call Health Net's member services,

which is the number on the back of their ID card, or they can simply ask the doctor to make a referral. We also have a provider directory on our website as well where you can look up a CS provider and make a referral directly there. Once the referral is made, the CS provider will review the referral, determine if the member is eligible for the services, submit an authorization, which usually takes up to five business days, and then render care. Next slide.

01:27:52 – Melen Vue – Slide 75

And as part of our implementation, as I mentioned earlier, we expanded our partnership with FindHelp to track referrals for all of our Community Support services. And FindHelp is the access point for all Community Supports providers. So, we developed unique links for our health plans in California. The first link is tailored to Health Net and Community Health Plan of Imperial Valley, and the second link in specific to CalViva Health. And right below it are the steps to making a referral into Community Supports. Next slide, please.

01:28:29 – Melen Vue – Slides 76-78

So, before I close, I'd like to leave you with a member story. I'd like you to meet Juan. He's a 64-year-old Hispanic man who is a member of Health Net. He lives with type two diabetes and continues to struggle with managing his uncontrolled diabetes. He also has other related health issues. Juan was referred to Project Angel Food by Eisner Health. And Project Angel Food was able to quickly engage with Juan and enroll him into their MTM programs where Juan began to receive MTM services in April of this year.

And since then, he has shown remarkable improvements. He's following advice from the registered dietitian, and he has reduced his intake of sugary beverages. He's also made dietary changes to adopt a healthier eating habit, which has increased his energy and physical activities, and he's sleeping better now than he did before as well. Juan reported that his recent lab results show significant progress in managing his A1c. And I quote from Juan, "The meals have helped me stabilize my sugar and I've adopted healthier eating habits." So, this was an actual member story that was provided to us by Project Angel Food. Next slide.

I know I just whizzed right through our programs and our services, but I will definitely be available for Q&A.

01:28:29 – Cassidy Acosta – Slides 78-79

Thanks so much, Melen. And with that, I think we can turn it over to Laurie, and then we'll have a Q&A section afterwards.

01:28:29 – Laurie Schwartz – Slides 79-80

Great. Good afternoon, everybody. My name is Laurie Schwartz. Melen and Tyler did an amazing job at setting me up for our program. I'm the Director of Provider Relations and Partnerships with Roots Food Group. Supporting Healthy Outcomes through Food as Medicine is kind of our tagline.

So, a little bit about how our program actually integrates. So the meals, they're ready to heat, our meals are flash frozen, they're designed by dieticians. We send like what's stated, 12 weeks of meals, so they get two meals per day, 168 meals consisting of breakfast and an entree. The meals are shipped every two weeks to the patient's house. And we ship on dry ice, so the patient actually does not have to be home. They will just leave it on the doorstep and it's good for up to three days in that packaging. There's also no age requirement for our program. Next slide please.

01:30:59 – Laurie Schwartz – Slide 81

We really want to integrate into the community. So, we span all of California right now, serving pretty much the entire state, minus a few counties. And we love to get out in the field, we will table at community events. This is one of our dieticians, Andrea, from our intake team. We want to work with patient populations directly, we have a great operations and customer service team. And as we hire people, we make sure that community events is high on their priority because we really want the visibility. So, when we're working with providers or FQHCs, we're always asking where we can participate and be a part of their programs. Next slide.

01:31:53 – Laurie Schwartz – Slide 82

This is a little bit about our food. As we expand our company, we're getting more and more sophisticated with our meal selection and hopefully have even more diversity coming in Q1. But we offer a general wellness bundle. And then if screened by our dieticians, there's dietary restrictions or preferences. We offer pork-free, dysphagia, kosher, Halal, gluten-free, breakfast only, which tends to be a little bit of a preference for our pediatric patients. And then we also offer vegetarian breakfast only. And for the managed care plans that will provide produce grocery boxes, we can supplement that as well. Next slide.

01:32:38 – Laurie Schwartz – Slide 83

So, eligibility, again, it's dependent on managed care plan. Melen kind of walked through Health Net, we are contracted with Health Net. And like she stated, we need a diagnosed chronic condition that hospitalization or risk of hospitalization. And then extensive care coordination needs. We are working with our managed care partners, as well as DHCS, to really get this clearly defined. So as the eligibility requirements get a little bit more ironed out, if you will, then we kind of relay that back. And then we have a wonderful intake team that tries to get as much information to the managed care plans to really facilitate that authorization. Next slide.

01:33:26 – Laurie Schwartz – Slide 84

These are some commonly covered conditions that would constitute chronic disease including diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, HIV cancer, gestational diabetes, chronic or disabling mental behavioral disorders. Again, this is not an all-inclusive list and again, they also need to have extensive care coordination or a recent hospitalization or at risk. Next slide.

01:33:56 – Laurie Schwartz – Slide 85

So, I think I'm safe to say our referral process is the only medically tailored meal company that has a portal to directly input referrals. Don't a hundred percent quote me on that, but I haven't heard of another one. But our providers really love our HIPAA secure portal, which gives them access and it also gives them a dashboard to see the referral process in real time. So, they're able to very securely enter all the patient information to us. Then our team goes to work at getting that authorization and all the supplemental information over to managed care. Then that patient on their end, we'll pop up into an approved pending, or from pending to approved. And then when they finish their 12 weeks, they're alerted and they become inactive with the option to refill if it's medically justified and necessary.

It's a really great streamlined program. We can also take referrals through FindHelp through the managed care programs. And then we have a good old-fashioned fax form for some of those offices that just want paper. And we also will take those self-referrals. We have patient facing brochures with QR codes and phone numbers that they can call and give us their information. We can help assess them and qualify them on our end. Next slide.

01:35:22 – Laurie Schwartz – Slide 86

So, dietician support, we've got two RDs on our sales and outreach side. And then we've got a number on our intake. Again, our meals are all reviewed by our dieticians. And the dieticians reach out and do that nutritional assessment with every patient, regardless if it's a requirement from the managed care plan or not. There are a few touch points with our dieticians and the patient through the process to really solidify education, answer any questions. And then very importantly, screening for dietary allergies and food preferences. So, we've got huge support on that. And the nutritional counseling, I think, is a crucial part of the program. We can send food, but to really understand how it's benefiting their chronic disease, we've been told by our members really helps them commit to the program, essentially. Next slide.

01:36:21 – Laurie Schwartz – Slide 87

So, for people that would want to sign up as a provider with us to get that portal access, we would just need name, email, phone number, and company name. This would be sent to us. We have to initiate portal access for that online referral. This is the Medi-Cal flyer with the QR coding that would be patient-facing. So that QR code will take you to a landing page on our website. And for those that aren't that tech-savvy, there is an 800 number down at the bottom. So again, the patient can call and see if they're part of one of our managed care plan partners, whether they're chronic disease and status of hospitalization all constitutes them to be eligible. For those that want portal access, they get a link to create a personalized login. It's HIPAA secure, it does send your cell phone a code to get in. And then it's just start referring, add in those patients. Next slide.

01:37:30 – Laurie Schwartz – Slide 88

And that completes our slide deck. Again, supporting healthy outcomes through Food as Medicine. Melen and Tyler did a great job at explaining the origins of MTM and our program within CalAIM. This is my contact information, and I know we're a little behind on time, so I'll turn it over to questions and I'm here to answer any.

01:37:52 – Cassidy Acosta – Slides 88-89

Thank you so much, Laurie. So, we do have a couple of questions coming in the chat, but I know that Rick, you have had your hand up, so I'm going to ask you to unmute and ask your questions.

01:38:12 – Rick Hodgkins– Slide 89

Can you hear me?

01:38:13 – Cassidy Acosta – Slide 89

We can, Rick.

01:38:17 – Rick Hodgkins – Slide 89

Okay, I had a question carried over from when Anastasia was talking about earlier. Shouldn't the D-SNPs and the SMACs have the same plans across all 58 counties? Shouldn't all the networks have the same providers? Including the teaching hospitals and whatnot.

And then when we get into Joseph's talk about managed care plans having home and community-based services, you said that services which DDS provides and Regional Center provides will not be in managed care plans and neither will IHSS. Can you tell me which Home and Community-Based Services, which waivers will be under managed care?

And also, now that we're in medically tailored meals, I have type two diabetes myself, but I don't have type two diabetes and obesity because of my lifestyle. I have type two diabetes because of a rare form of obesity known as hypothalamic obesity. I have Panhypopituitarism. So, are people required to have medically tailored meals? Because if that's the case, what if they get pre-made meals that they don't like? Are they told by the dietitian or their doctor, well you're not allowed to have A, B or C. You're only allowed to have X, Y, or Z. And if you don't like it, then I guess don't eat. So those are my questions. Sorry it took so long to ask my questions because I kept on getting passed over. Thank you.

01:40:28 – Melen Vue – Slide 89

So, I can respond to that real quick. So MTM services, Rick, is not a required service. So, it is an optional service. If this is a program that you feel that would help or support your A1C or your diabetes, and that's where we would then refer you to. One of our Community Supports providers who will then evaluate your needs and if the meals are not to your liking, our Roots Food Group and our Community Support providers with their dietician onboard will reevaluate and make sure that you are getting the appropriate meals that will meet your needs. And making sure that you also like them, as well, but also making sure that it also meets your dietary needs, as well. I don't know if, Laurie, if there's anything else you'd like to add to that.

01:41:21 – Laurie Schwartz – Slide 89

Yeah, I mean we have to get the permission. And again, you're absolutely right. If somebody complains or doesn't care for the meals, then we try to offer them something

else and other options. Even other MTM companies; food is so subjective. But there's no force on any of it from any of us.

01:41:44 – Cassidy Acosta – Slide 89

Thank you both. Anastasia, anything else you'd like to add to Rick's questions?

01:41:49 – Anastasia Dodson – Slide 89

Right, fair question about aligning D-SNP and SMAC policies statewide. We do have requirements that are consistent, but there are certain flexibilities that each D-SNP has with regards to supplemental benefits, the provider network that is up to the Medicare rules. So fair point and we can keep thinking about it and looking at it in the future. And then I assume Joseph may have had to sign off, but I don't know if he is still on.

01:42:29 – Joseph Billingsley – Slide 89

I'm still on.

01:42:30 – Anastasia Dodson – Slide 89

Oh, okay, great.

01:42:36 – Joseph Billingsley – Slide 89

Yeah. Rick, I just want to make sure I got your question right in that, again, being clear that the 1915(c) waivers that are administered through the Department of Developmental Services for individuals with developmental disabilities, those waivers are not being considered for integration into managed care. Also, In-Home Supportive Services is not being considered for integration into managed care. Specifically, being considered and evaluated for integration into managed care are three 1915(c) waivers, which are the Home and Community-Based Alternatives Waiver, the Assisted Living Waiver and the Multipurpose Senior Services Program Waiver. And so, we're looking at the services offered under each of those waivers and evaluating the appropriateness of transitioning those waivers and services into managed care.

01:43:46 – Cassidy Acosta – Slide 89

Thanks so much Anastasia and Joseph. I think we have a couple more questions in the chat for Melen and Laurie. The first asks whether clinicians and health care providers can refer clients to medically tailored meals via Epic using FindHelp? Or if they would need to go through a separate portal to submit a referral.

01:44:09 – Melen Vue – Slide 89

You would have to go through a separate portal to FindHelp to submit the referral. If you are interested in an interoperability opportunity, there's also that as well. Where we can connect you to FindHelp so that you can integrate your system so that way you're not having to go into one system and then having to leave that system into another system. We know that that becomes a little bit of a challenge. And it becomes a lot of administrative challenges there. So, there are rooms where we can support you with an interoperability integration system and we can get you connected to FindHelp.

01:44:45 – Laurie Schwartz – Slide 89

Yeah, I would love to see an Epic integration where a physician can just type in, medically tailored meals. We haven't quite gotten there. You can actually pull our company up, but it doesn't go anywhere. So hopefully that comes in the future because we do miss a lot of opportunity at a clinician level that are used to just sending orders through Epic. And for Roots Food specifically, we can create an intake sheet that the patient can fill out in the office and can be faxed into us if portal access directly to us seems too difficult. Or just a handout that that patient can then take it upon themselves to qualify and contact us either via the QR coding or 800 number.

01:45:37 – Cassidy Acosta – Slide 89

Thank you both so much. I know there was one other question in the chat, but it looks like Tyler got that one. And so, with the interest of time, I know that this is our last opportunity for stakeholder Q&A. We do want to circle back to a question that we had received earlier in the work group around ECM. Laura, we'll ask you to chime in here. But we did get a question around whether or not D-SNP members will be disenrolled from ECM by December 31st of this year and how those transitions will occur. But Laura, happy to turn it over to you to answer this question.

01:46:10 – Laura Miller – Slide 89

Yes, we were literally just talking about this sort of continuity of care issue. As you may recall for this year, 2024, people who were coming into D-SNPs and had Medi-Cal ECM basically had continuity of care for 12 months throughout 2024. There were not a very large number of those people across the state by my recall. And Anastasia may remember the number better than I. So, in the course of 2024, those folks may have graduated. But if they have not, yes, their Medi-Cal ECM would be sun-setting after 12 months of continuity of care. And they can continue care manage or they can move

their care management to the D-SNP. So, we'll be looking to get more firm word out about this, we're working on this now.

01:47:24 – Cassidy Acosta – Slide 89

Great. Thanks so much, Laura. And then I think with that, I will actually pass it back over to you to kick us off on our next section, which is going to be on Enhanced Care Management and Community Supports data updates.

01:47:35 – Laura Miller – Slide 90

Awesome. Thank you so much.

Again, I think I know this crowd. I'm Laura Miller, Medical Consultant with Quality and Population Health Management and Primary Care Internal Medicine Doctor and I do a lot with ECM. Let's do the next slide.

01:47:51 – Laura Miller – Slide 91

So, we're going to go over some of the data from both ECM and Community Supports. The highlighted link here is a wonderful resource. It's the ECM and CS Quarterly Implementation Report. It was last updated in August and takes us all the way through from the beginning of ECM and CS in January of '22 to December of '23. And it includes lots of information including the total population receiving ECM and CS. Dual eligible beneficiaries can access Community Supports through their Medi-Cal plan regardless of their Medicare enrollment, be it Fee-for-Service or Original Medicare or Medicare Advantage. If an MA plan offers supplemental benefits that are comparable to CS, Medicare is the lead. But in general, one would go to Medi-Cal first.

And with regards to ECM, dual eligible folks are more likely to fall into the following ECM Populations of Focus. I won't read them out here. But as you know, ECM is both for children and youth and adults, and these are really focusing on more of the adult Populations of Focus. Next slide.

01:49:17 – Laura Miller – Slide 92

Again, as you may know, ECM, Enhanced Care Management, is a Medi-Cal benefit that supports comprehensive care management for members. Most of the members engage in multiple delivery systems that are challenging. And so, ECM plays a key role in a whole-person interdisciplinary approach to care. It is absolutely intended to be high-touch, person-centered and provided primarily through in-person interactions with members where they live, seek care, and prefer to access services. I think that's one of the hallmarks of ECM is that it is outside the four walls of plans and clinics.

ECM is part of a broader CalAIM population health management system design, redesign. And within it, Medi-Cal plans offer care management interventions at different levels of intensity based on member need. And ECM is indeed the highest intensity level. Hence that piece about being in-person and where people live. Next slide.

01:50:33 – Laura Miller – Slides 93-94

I'm going to go through some numbers here. We'll go to the next slide please. And I do want to note if you go to that link that I spoke of prior, these numbers and percentages may differ a little bit, there are just some calculation issues that cause that difference, but they're relatively minor.

So, what we're looking at here is of the ECM population of focus, what percentage are dual eligibles? In the first one, across the state for quarter one 2024, there were 3,894 people in the Population of Focus for people experiencing homelessness. And of those, dually eligible beneficiaries were 14.8%. So that's how to think about these numbers as they're going through. In the POF for avoidable hospitalization or ER, the total members were 5,484 and duals are about 15.8%. Similarly for serious mental illness, the total number across the state was 4,331 and duals represent 12.3% of the Population of Focus. And for those transitioning from incarceration, the total number as of Q1 '24 with 146 and duals represent 10.4% of that Population of Focus. Next slide.

01:52:21 – Laura Miller – Slides 95-96

Now these two Populations of Focus I think are very important for the duly eligible population. These are my heart and soul POFs. So, the first Population of Focus is individuals living in community, in the community and at risk of long-term institutionalization. Total number of duals is 4,809 and that is 45.3% of the Population of Focus. Of note, of the 77% of dually eligible beneficiaries are age 65 or older in this POF. And of individuals in adult nursing facility transitioning to the community, duals total 244 and represent 35.7% of the Population of Focus. So again, duals are very highly represented in these two populations of focus. Next slide.

Does Tyler get to narrate this? Thank you, Tyler.

01:53:38 – Tyler Brennan – Slides 96-97

I do indeed. No problem at all.

So yeah, on the Community Supports side, wanted to share some data that we have been seeing over this past year. And on screen here, I know the slide looks busy, I tried to make it as sort of clearly as communicated as I could. But over the course, since the beginning of implementation, which started in January 1, 2022, we can see the

continuing progress in terms of the number of duals who are receiving services through Community Supports. As we see at the very beginning, the first quarter we only had about 3,000. And up to Q1 of this year, which ended March 31st, we're now up to almost 30,000. That is inclusive of the number of members who receive Medically Tailored Meals. I believe that number is around 23,000. So, the majority, vast majority are receiving Medically Tailored Meals. But we are seeing duals access a number of different services as time progresses, as managed care plans sort of program implementations mature.

So right now, dual eligibles, they represent about 28.5% of total members who received Community Supports in Q1 of 2024. I have another break down here at the bottom just to show you different age groups in that category. And then we still have data coming in. We just got the Q2 data in a few months ago, we're still processing that. Because of the 2024 managed care plan transition, there were a number of difficulties associated with that that sort of made reading some of the data a little bit more challenging. So, we're working through those challenges and hope to have some more information publicly released very soon. Moving to the next slide.

01:55:18 – Tyler Brennan – Slide 98

On here is just another breakdown, just sort of showing the number of dual members who are receiving various services. Kind of picked out the services nine, I believe nine of the 14 services that are somewhat most appropriate for dual members to be receiving. And we had about almost 4,000 members receiving housing transition, we had 300 housing deposits, 2,600 housing, tenancy and sustaining services, recuperative care, seeing a lot of access with 380 dual members. Personal care and homemaker services, duals actually represent the majority of membership receiving that particular service. Same is true and as we sort of expected to see for the nursing facility transition services, where you can see about 77 and 82% of the totals there are represented by dual members. And then medically-tailored meals, I was a little off, it's about 22,000 members or about 33% of the overall membership. And then home modifications, they also represent a majority of the members there as well. And again, all of this is as of March 31st, 2024. And these numbers are continuing to rise and we'll look forward to reporting back in our next meeting. We can go to the next slide.

01:56:29 – Tyler Brennan – Slide 99

So, just while we were in there, we wanted to sort of communicate this demographic breakdown we're seeing. No real surprises, no real flags. It generally aligns with the Medi-Cal membership. But just in the era of communicating as much as we possibly can,

we wanted to share this with this group. So happy to answer any questions. On the bottom right there, you can see that about 2,600 dual members received both ECM and at least one Community Support service.

01:57:09 – Tyler Brennan – Slide 100

We do have a number of resources available on our website, which is here on screen. We also are happy to answer any questions. Please forgive the time it might take us to respond. We are very busy this time of year, but we do try to get back to everybody as quickly as we can. So CalAIMECMILOS@dhcs.ca.gov is our mailbox. And next slide. Great.

01:57:35 – Cassidy Acosta – Slide 101

Great. Thank you so much Laura and Tyler, we really appreciate it, and for closing us out today. And thank you to all of our other speakers who were able to join for their wonderful presentations. And to all of you for participating in such great discussion today. This is just a reminder that this is our last MLTSS and Duals Integration Stakeholder Workgroup of the year. The next DHCS MLTSS and Duals Integration Stakeholder Workgroup will be in 2025, and the webpage will be updated to reflect the 2025 Workgroup cadence soon. Thank you all so much again, and we look forward to seeing you in the new year.