CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

May MLTSS AND DUALS STAKEHOLDER WORKGROUP

Date:	May 30, 2024
Time:	10 a.m. – 11:30 a.m.
Number of Speakers:	7
Duration:	1 hour 32 minutes

Speakers:

- Cassidy Acosta
- Anastasia Dodson
- Christopher Tolbert
- Tyler Brennan
- Dr. Laura Miller
- Gretchen Nye
- Kerry Branick

TRANSCRIPT:

Cassidy Acosta:

All right. Good morning, and welcome to today's CalAIM Managed Long-Term Services and Supports, or MLTSS, and Duals Integration Stakeholder Workgroup. We have some great presenters with us today, including Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS. Christopher Tolbert, Health Program Specialist in the Office of Medicare Innovation and Integration at DHCS. Laura Miller, Medical Consultant on the Division of Quality and Population Health Management at DHCS. Tyler Brennan, the Health Program Specialist in the Managed Care Quality and Monitoring Division at DHCS. And then a couple of guest speakers from CMS as well, including Kerry Branick, the Deputy Director of the Medicare Medicaid Coordination Office at CMS, and Gretchen Nye, Health Insurance Specialist in the Medicare Medicaid Coordination Office at CMS. A few meeting management items to note before we begin. All participants will be on mute during the presentation. And as a reminder, the monthly MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions.

Cassidy Acosta:

And we ask that plans that join these calls hold their questions for the multiple other workgroup venues that they have with the Department throughout the month. Please feel free to submit any questions that you have for our speakers via the chat today, and during the discussion if you would like to ask a question, and or provide comments and feedback, please feel free to use the “Raise Hand” function and we will go ahead and unmute you. Just a quick note that the PowerPoint slides, and all other meeting materials will be available on the DHCS website in the next couple of days, and you can find a link to where those will be posted in the Zoom chat. We also want to take a moment to ask you to add your organization's name to your Zoom name so that it appears your name dash organization.

Cassidy Acosta:

You can do this by clicking on the participants icon at the bottom of the window, hover over your name and the participants list on the right side of the Zoom window, click more and then click rename from the dropdown menu. And then enter your name and your organization as you would like it to appear. Next slide, please. So, we have a jam packed agenda for this morning. We're going to start today's meeting with a brief update on the 2025 D-SNP SMAC, or State Medicaid Agency Contract, and Policy Guide. After that, we'll hear an update about the Default Enrollment Pilot with some time for stakeholder Q&A. And then next we'll hear an update on Medicare enrollment data for dual eligible members, as well as an update on the D-SNP Dashboard.

Cassidy Acosta:

After this, there'll be a presentation on the release of the Enhanced Care Management, or ECM, and Community Supports Quarterly Implementation Report. That will also be followed by a Q&A session. And then lastly, CMS will provide some highlights on the

2025 Medicare Advantage and Part D Final Rule. And then of course we'll end today's workgroup with some information on some upcoming meetings. And with that, I'll pass it over to Anastasia to kick us off about the workgroup purpose and structure.

Anastasia Dodson:

Thank you so much, Cassidy. And apologies, I have a bug so I'm off camera today, but really appreciate all of you joining today. We want this workgroup meeting to serve as a collaboration hub for all of us, all of you, to look at ways that we can get feedback, share information, and look at things around policy, operations, and strategy for upcoming changes for dual eligibles, both on Medicare policy as well as Medi-Cal policy. We do have a charter, and again we really value our partnership with you all. We make much better policy and operations by consulting with all of you. Next slide. Okay, so the next slide we're going to just briefly talk about our 2025 SMACs. Those are the contracts that DHCS has with D-SNPs. So, all D-SNPs must have a, acronym is SMAC, a contract with DHCS. And this is in addition to the contracts that D-SNPs have with CMS, the federal government. The contracts that D-SNPs have with state Medicaid agencies, such as DHCS, are focused a lot on care coordination.

Anastasia Dodson:

And every year we update those SMAC templates, we call them, because it is the same contract with almost all of the D-SNPs. And what's in those contracts reflects the feedback from stakeholders, and advocates, and plans, and does also align with CalAIM integration goals for 2025. The actual plan specific SMACs are going to be shared with plans for review and signature in early June. And for those who are not aware, the timeline for SMACs for getting the content of the contracts finalized is in the spring of each year for the upcoming calendar year. So, we are working on, and we have finalized the contract language for contract year 2025, and contract year and calendar year are the same thing for D-SNPs. And we will definitely be posting the boilerplate or the template SMAC that has the language that is for all of the D-SNPs. We will definitely be posting that on the DHCS website. Next slide.

Anastasia Dodson:

So, one more nuance here is that there are two different contract templates or standards. One is for we call EAE D-SNPs, those are D-SNPs that have an aligned Medi-Cal plan in that same service area. We also call those Medi-Medi Plans. And then there are the non-EAE D-SNPs, which right now is a mixture. Some of those are plans that have a Medi-Cal line of business in that same county, some do not, but they do not include, as you can see in the checkboxes here, the non-EAE contracts don't include integrated materials, certain provisions around supplemental benefits, and integrated appeals and grievances. So again, there are EAE and non-EAE SMAC documents that we will be posting, and those are the one-year contracts that we have with all the D-SNPs in the state. And you can see again from this list all the different chapters that are covered in the SMAC. And again, you may all know that there's also a policy guide that is an extension of the SMAC, and we work on the policy guide in conjunction and then a little bit afterwards related to the SMAC for each year. All right, next slide.

Anastasia Dodson:

So, here we have reference again to the SMAC, and then the Policy Guide. Similar to 2024, we will have a 2025 Policy Guide for D-SNPs, and that will contain multiple chapters with detailed requirements and instructions. It's an extension of the SMAC. We have the 2024 and 2023 Policy Guides posted on the DHCS website, and we have actually the initial part, the care coordination part of the 2025 Policy Guide already posted online, because again there's a long runway for when we need to finalize the materials for the Medicare Advantage, D-SNP contract years. Next slide. So, these are the 2025 D-SNP Policy Guide chapters. Again, that care coordination part was released in December. The Integrated Materials and Marketing, we're just about to release that. And again, that's really important for making sure that members for the EAE D-SNPs, the Medi-Medi Plans, that they're presented with their combined Medicare and Medi-Cal plans as one plan. So again, integrated materials, really important.

Anastasia Dodson:

Other chapters that we will be posting around the 2025 D-SNP Policy Guide is Aligned Networks, Medicare Continuity of Care, Quality Metrics and Reporting, Dental Benefits, and Medicare Encounter Data. And those are very similar topics that are already in the 2024 D-SNP Policy Guide. So, nothing significantly new, although I will say we continue to work on adjusting the Integrated Materials based on whatever changes are going on in Medicare, and whatever changes are going on in Medi-Cal to make sure they're totally up-to-date. Next slide. And then this just gives you a detailed layout of the chapters in the D-SNP Policy Guide 2024 compared to 2025. And you can see that mostly they're the same for EAE and non-EAE, and mostly the same from 2024 to 2025. But as we're going to talk about the Default Enrollment Pilot, that's going to be a new chapter coming out for 2024, because we are in 2024. So, we will talk about that in just a few minutes. Next slide. So, should we do questions on this part?

Cassidy Acosta:

Sure. We got a question from Katy, "Could you please go over the ECM eligibility criteria for the D-SNP members?" And Katy, we're actually going to talk a little bit more about ECM later on in this presentation, so we'll come back to that question. But if there are any other questions about the SMAC or the policy guide, we're happy to take them now. And please feel free to raise your hand and we can unmute you as well. All right. Rick, you should be able to unmute now. Let me know if that worked for you.

Cassidy Acosta:

All right, Rick, it doesn't seem like you're able to unmute. Give me one second, we're going to go to Pat and we'll come right back. Pat, you should be able to unmute now.

Pat Blaisdell:

Okay, got it. Can you hear me?

Cassidy Acosta:

We can, yes.

Pat Blaisdell:

Okay, because I got conflicting messages on my screen here. Thank you for this presentation. One of the things I'd like to hear more about, and I don't know whether you'll be able to give me the full picture today, or maybe where I could find it, is around the integrated appeal process. As you know, there's a lot of controversy about access to certain levels of care, particularly within Medicare Advantage, D-SNP and non-D-SNP alike. And what we find from our hospital members is when they're seeking prior authorization, it can sometimes be a little confusing about whether you go to the managed care plan, and when it's a Medi-Cal beneficiary you have a different route than if it's a Medicare beneficiary. So, I'm interested in hearing more about how the integrated appeals would work. If I'm a Medi-Medi that's enrolled in an exclusively aligned D-SNP, how would I appeal a decision about getting into a service that's in one of the D-SNP areas of responsibility? Does that make sense, that question?

Anastasia Dodson:

It sure does, Pat. Great. So glad that you're on, and great question. So, the integrated appeals and grievance process for the Medi-Medi Plans, the EAE D-SNPs is at the plan level only, because Medicare has a plan level process and then it has an external process. And Medi-Cal does as well for a plan level process and then an external process through DMHC or hearings. But an inpatient stay for a dual eligible almost always would be on the Medicare side. And actually, what I will say is yes, we will send you a link to the Integrated Appeals and Grievances chapter. We worked very, very closely with CMS colleagues on this process, and it is no more restrictive on the Medicare side now than on the Medi-Cal side for a particular appeal or grievance. So, there were some slight adjustments and flexibilities that CMS made to accommodate the Medi-Cal process that we have for state statute.

So anyway, but the purpose of the integrated process for Medi-Medi Plans is that the members should not have to try to sort out, okay, how many days, what is the process on the Medicare side? How many days, what is the process on the Medi-Cal side? At least at the plan level, it's integrated.

Pat Blaisdell:

Thank you. I guess maybe when I have a chance to look at all of that, we can have a follow-up. I'm concerned about situations that we know are problematic in MA where it's an MA benefit. Say they're in the acute hospital and they need to go to acute rehab, or they need to go to SNF, and that authorization process can be complicated. It's clearly a Medicare benefit, but it has been problematic at both the Medicare and the Medi-Cal level. So, I'm hoping we can find some way to streamline that so it's not so problematic as it is right now, but I don't want to take too much more time out of this discussion but would be interested in learning more about that.

Anastasia Dodson:

Definitely, yeah. And I will ask the Aurrera team, if you could put a link in the chat to the ... I think there is a matrix that we might still have posted that shows some of the differences between the regular Medicare process and the integrated Medicare process. But Pat, I take your point. Some of it may not be necessarily even about the appeals and grievance process, but about the practices of the plans.

Pat Blaisdell:

Yes, yes, exactly. Thank you.

Anastasia Dodson:

Yeah, and we do have CMS colleagues on, and we can provide referrals there and would be very happy to follow up. It's a very important topic.

Pat Blaisdell:

Thank you.

Cassidy Acosta:

Thanks Anastasia. And Pat, we're grabbing that link and we'll put it into the chat shortly. All right, Rick, I'm going to try to unmute you again. Let me know if this works for you. You should be able to unmute now.

Cassidy Acosta:

All right, Rick, we will come back to you. I don't know what's going on, but you should be able to unmute. Let me know if you can't in the chat, and then we'll try to troubleshoot with you. Anastasia, there is a question in the chat from Katy. "Do the Medi-Medi members have a choice to decline D-SNP enrollment?"

Anastasia Dodson:

Of course, absolutely. And sounds like we should just go ahead and go to the default topic, because that is related to enrollment. But of course, yes, there's many other choices in Medicare, Original Medicare, there's other types of special needs plans. There's regular MA plans, there's PACE. So yes, many choices in Medicare. Next slide. Okay, so this next section is about a pilot that we are undertaking in California. It's something that is in a number of other states. And so, we're following the federal structure for our pilot, but we're doing it on a more limited basis than in other states. We're just starting in two counties, and not all of the plans in those counties. And we are prepared at any time to adjust or pause, et cetera, depending on what happens.

Anastasia Dodson:

So, the structure of default enrollment is that when someone is enrolled in a Medi-Cal plan and they've got Medi-Cal only, but they're just about to become eligible for Medicare, if they're in one of these pilot plans and they are about two months away from becoming eligible for Medicare, then they will get a notice 60 days in advance and then another one 30 days in advance. And if they do not take any action to decline

enrollment, then they will be automatically enrolled into that Medi-Cal plan's Medi-Medi Plan, the integrated D-SNP. But again, if they choose not to, then they can choose any other Medicare option that's already available. So that's the summary, but we have a lot more details and glad to have further discussion. Next slide.

Anastasia Dodson:

So, what populations does this Default Enrollment Pilot not impact? It's all dual eligible members who are already enrolled in Medicare. So, that is the 1.6 million or so folks who are already dual eligibles, this pilot does not impact. Individuals who are already enrolled in Medicare and then who are newly enrolling in Medi-Cal, it does not impact. It's a small number of people each month. For example, we're going to talk about this, San Diego County Community Health Group, 157 members who they've got Community Health Group Medi-Cal right now, and then they will be newly eligible for Medicare in August. Again, 157. So, it's a small number of members, but of course the experience of each member is very important. And following the process and protocol for each member is very important. But just want to make sure that we're clear on what is the scale and how many people are impacted by this pilot. And it will be for San Mateo County, a smaller number than that. Okay, next slide.

Anastasia Dodson:

So again, this is more detail. What exactly is default enrollment? This is a process that's allowed by federal rules that allow states to approve D-SNPs to enroll new dually eligible members of the affiliated Medi-Cal plan into their D-SNP. So, when someone who's in one of these Medi-Cal plans, again is Medi-Cal only and is newly becoming eligible for Medicare, then they will get two notices. And then if they do not respond, then they are enrolled into that Medi-Cal plan's integrated D-SNP, unless they choose a different Medicare option like Original Medicare, or another Medicare Advantage plan.

Anastasia Dodson:

The purpose of this pilot is to support enrollment into integrated care plans for new duals, and also to support the continuity of care with a member's Medi-Cal providers. Again, as you can imagine, folks who have Medi-Cal only, they have a range of providers that they're working with, and when we selected the pilot plans, we selected those that have very, very significant overlap across their Medi-Cal and their Medicare networks, so that barring some rare situation, the member will be able to continue to see their primary care provider, their specialists, et cetera, because those providers will be in both the Medicare and the Medi-Cal networks. Okay, next slide.

Anastasia Dodson:

So just for background context, as of October 2023 there were 12 states and Puerto Rico that were approved to use the default enrollment mechanism. And you can see that list of states there. And again, this is an existing CMS process so there's specific guidance on D-SNP default enrollment in the MA Enrollment and Disenrollment Guidance document. And when we post the slides, you can see that link and we can also put it in the chat. Next slide. So, who are the pilot plans? In San Diego it's

Community Health Group. They're currently approved for the pilot, and the members who are in that cohort of 157 are receiving their first set of notices right now. The 60-day notices must be received by the member June 1st. So, those are probably in people's mailboxes right now. And then there are two Medi-Cal plans in San Mateo County that are pending approval for the pilot.

Anastasia Dodson:

You probably all know who those are, by which county I'm talking about. And Community Health Group and also Health Plan of San Mateo have met with local stakeholders to discuss the pilot. We don't have a confirmed timeline yet for the Medi-Cal plans in San Mateo County, so we're not trying to put details on this slide that might be updated later. We're just saying we are looking, and reviewing, and working with CMS to consider approval for two plans in San Mateo County. But again, looking at the number of new duals in San Mateo, and we know that that number will be a little bit smaller than the Community Health Group number. So again, it's a very modest number of people who are impacted each month. Okay, next slide.

Anastasia Dodson:

The notices. So, in this pilot, the member gets a written notice, 60 days, and then another one 30 days before the month they become eligible for Medicare. So, the federal requirement is a 60-day notice, and then we as a state, per the request of advocates, we added a 30-day notice requirement. The notice comes with a choice to join the Medi-Medi Plan, and then the notice includes information about how the member can decline enrollment prior to the effective date. We have the notices from Community Health Group, we're going to be posting them on our website, the English and Spanish versions. And of course, the notices are being sent in the members' preferred language.

Anastasia Dodson:

Anyway, the notice does include contact information for organizations that can help members make a choice, including HICAP and the Duals Ombuds Program, and of course, Medicare.gov. The member also gets a phone call from their Medi-Cal Plan. So, I should also say that, again, in that local engagement, that Community Health Group and then Health Plan of San Mateo have had, they shared their notices with stakeholders and advocates, and so, they were developed in coordination, extensive back and forth edits across all parties with the local partners. Okay next slide.

Anastasia Dodson:

Just to emphasize, members who are eligible for the pilot, they can definitely choose their Medicare coverage. If they want to be in the Medi-Medi Plan with their Medi-Cal plan, they don't have to do anything, that enrollment in the Medi-Medi Plan starts the month the member becomes eligible for Medicare. If the member does not want to be in the Medi-Medi Plan, they can choose another option, Original Medicare, another Medicare Advantage plan, regular MA. They can choose another Medi-Medi Plan. They can choose PACE, they can choose another type of special needs plans depending on

what their chronic conditions are.

Anastasia Dodson:

There are a variety of options on the Medicare side, and all of those are open to the member. Enrollment in Medi-Medi Plans is voluntary. And so, they have the option to choose which Medicare delivery service they enroll in. And there are multiple Medi-Medi Plans in the counties where they exist. So, it's not just one plan, but there's a choice of plans within the same county. Next slide.

Anastasia Dodson:

Continuity of care. So again, part of how we focused on which plans to participate in the pilot had to do with overlap in the Medicare and Medi-Cal networks. So, members can keep their primary care physician or specialist when they join the Medi-Medi Plan, except for some very rare circumstances like the provider for some reason discontinues with that plan or leaves the area. But usually practice areas don't change as far as practice groups. So, the members, they don't pay a premium. They don't pay for doctor visits or other medical care if they go to a provider that is in their Medi-Medi Plan network. Next slide.

Anastasia Dodson:

And there are other continuity of care provisions for Medi-Medi Plans that already exist. But the main thing we want to emphasize for continuity of care here is that, again, there's that network overlap. So, monitoring and oversight, we are working closely with the plans that are in the pilot and with advocates and CMS to monitor implementation. So, we are having the plans report weekly to us on enrollment results. And of course, anything that where wires get crossed, something totally unexpected happens, we're expecting the plans to let us know right away. And we are also asking advocates, HICAP, and the Duals Ombuds program to let us know. We really want to know if something is working or not working and to get it corrected.

Anastasia Dodson:

And then last resort, if something is really going awry, we can just halt default enrollment at any time. So that is definitely always an option. But we are going to, over the next couple of weeks here with Community Health Group, see how it goes. And again, very limited area, very limited number of members, and close engagement with local stakeholders. So, we think we've set things up to have a good result and a good pilot at any rate. Next slide.

Anastasia Dodson:

Again, CMS, they monitor enrollment cancellations and rapid disenrollments within 90 days of default enrollment. And this just shows some data around what's happened in other states in 2021 and 2022. Around 23% of the eligible beneficiaries cancel their enrollments prior to the effective date. So, they're either choosing Original Medicare with Part D plan or Medicare Advantage prior to that first month they're eligible for Medicare. So again, this is based on other states, 23%. And then after someone has been enrolled

nationally, that data showed about 8% of people disenroll after enrollment in the first 90 days of enrollment. So that's what we've seen in other states, but we will certainly monitor what happens in California. Next slide.

Anastasia Dodson:

Again, just reiterating close communication, frequent reporting, engagement with local partners. And I think these are kind of the same points that we've talked about in the other slides. All right, next slide.

Anastasia Dodson:

Okay, questions. I have not had a chance to look at the chat but looks like there's questions. So happy to talk about those.

Cassidy Acosta:

Right. Thanks so much, Anastasia. The first few questions came in from Jane and Carly, but I believe that you have addressed both of those. So, Jane, Carly, we welcome you to add any other follow up questions that you have to the chat or feel free to raise your hand and we can unmute you. There was a question in the chat from Gwen. It says, "Because this can be very confusing for the member, is there any consideration to use visuals to help members understand the information beyond written instruction? For example, is there a consideration to create videos for the member and their caregivers to help them understand the information or perhaps a QR code leading them to the videos?"

Anastasia Dodson:

Wonderful suggestion. And yes, we have videos and we just have not quite got them posted yet, but we're hoping in the next couple of days. We have a video in English and then the same video in Spanish. And we tried to make them short because who wants to watch a long video? But we would love feedback on the videos. If you all think, "Oh, the video should say something instead." Then we can redo the videos. They're not a huge lift for us at DHCS because they're not special animated or anything. They're just briefly walking through some slides, but they are in a video format.

Cassidy Acosta:

Great, thanks Anastasia. Another question in the chat around default enrollment. Is the default enrollment expected to expand to other counties in 2025 or 2026? Is this a to-be-determined situation depending on data from the pilot program?

Anastasia Dodson:

Definitely to be determined. And we want to make sure that, I mean honestly, we are not making any plans or any thoughts for 2025 or 2026. We're very squarely focused on the next couple weeks. And so, we're happy to come back to all of you and talk further about what we find. We know that this is just a very sensitive issue. So, I don't know, I just want to provide as much reassurance as I can that we have not predetermined what

our next steps will be. We want to wait and see.

Cassidy Acosta:

Thanks Anastasia. And then another question in the chat around default, “Have you determined how long the pilot is going to run before the state makes a decision on whether or not to expand?”

Anastasia Dodson:

Right. So, part of what we are looking at too is we know that we, Medicare open enrollment is coming up, that's annual, in the fall. And because of the kind of 60-day timeline, what have you, we are a little bit nervous, but we're going to have further discussions about what will happen in October, November, December, will these individuals be getting marketing materials from other organizations? So, we want to try this for the next month or two and then also try it, let's see what happens during open enrollment and see if there are differences or what happens, anything problematic or if it's just fine during that open enrollment period.

Anastasia Dodson:

Again, we're going to just take it one month at a time. And then the success criteria, we don't have a predetermined percent of folks who opt out or is that good or bad? We really just want to look at what's the baseline for California. And again, we really appreciate the pilot plans. They're putting themselves out there to try this out. We want to see, okay, did we get any challenges in particular from any particular approach on phone calls or particular phrases in the notices from one plan to the other? That's another part that we're going to look at. Again, really want to support the plans, help them do everything they need to do. But we are curious what the outcomes may be from one plan to the other as well.

Cassidy Acosta:

Thanks so much, Anastasia. And in the interest of time, we're going to move on from this section and move into our Medicare enrollment data and D-SNP Dashboard updates. So, Christopher Tolbert, I'll turn it over to you.

Christopher Tolbert:

Thank you, Cassidy. My name is Christopher Tolbert. I work in the Office of Medicare Innovation Integration at the Department of Health Care Services. Next slide.

Christopher Tolbert:

Today we're going to provide an update on the Medicare enrollment data for dual-eligible, duals, in California. Next slide.

Christopher Tolbert:

Okay so these are the definitions of the services and the type of Medicare Advantage plans and the type of D-SNPs. Next slide.

Christopher Tolbert:

And these are further definitions on other integrated care options including the FIDE-SNP, PACE, and other special needs plans. Okay, next slide.

Christopher Tolbert:

So, this slide right here is showing the overall the percentage of duals across the delivery systems. And as we can see, most duals are in Original Medicare. It's about the same from 2023 at 55%. But one thing that we noticed in January 2024, there has been an increase of duals from 16%, where in 2023 it was 14%. And then another thing that we noticed at the beginning of January 2024 is the non-EAE D-SNPs, like the percentage of their enrollment has decreased from 9% to 7% at the beginning of 2024 from 2023 which, and this aligns with the DHCS goal of integrated care for duals, receiving care from the same organization for both Medicare and Medi-Cal. And then we can go to the next slide.

Christopher Tolbert:

So, this is a snapshot of enrollment for duals across the Medicare delivery system, Medicare Advantage delivery system, and also the types of Medicare Advantage plans, and the PACE organizations. And we also have a Medicare Advantage options for dual eligible beneficiaries webpage, which also lists the definitions. And we also have the quarterly reports on that webpage. And now I will transition this to Dr. Laura Miller for the D-SNP Dashboard update.

Dr. Laura Miller:

Let's see. Okay, I have been able to unmute myself. I am visible and audible and happy to be here. Thank you so much. It's my pleasure to present on the D-SNP Dashboard. So next slide please.

Dr. Laura Miller:

So, as you know, the Department has produced the D-SNP Dashboard for many years. You'll remember, of course, Cal MediConnect. This was the demonstration project that sunsetted in December of 2022, which feels like a very long time ago now. And we've transitioned to the D-SNP Dashboard. This is really a compendium, it's a quarterly report of enrollment, demographics, and quality measures. And so, we've transitioned to a D-SNP Dashboard. And because of the transition, we're of course continuing to look at data from Cal MediConnect and moving forward into our D-SNP times. Because of a lag in reporting, you'll still see Cal MediConnect data with D-SNP data. But as we get our first full year of D-SNP data available, you'll just see D-SNP data. It's a rolling dashboard. Next slide.

Dr. Laura Miller:

So, I'm just going to talk through some of the things that you'll see in the graphics that come. Overall Medi-Medi Plans, MMPs, which is the same as EAE D-SNPs, Medi-Medi, equals EAE, same parent company, does show a significant increase while enrollment

in the non-EAE D-SNPs remains stable. Compared to non-EAE, there is a greater Hispanic presence in Medi-Medi Plans. So, 43% of Medi-Medi Plan members in quarter two were Hispanic compared with 28 people who identify as Hispanic for non-EAE D-SNP members. And that's pretty much consistent with quarter one.

Dr. Laura Miller:

We have received and are analyzing the care coordination measures. We did not publish those in quarter two because of challenges, but with the next dashboard publication of quarter three data, we'll be able to show you quarter one, two, three, care coordination measures, as well as LTSS measures for quarter two and quarter three. So bottom line, stay tuned, quarter three data release will have a lot more richness in terms of the care coordination measures in the LTSS measures. Next slide.

Dr. Laura Miller:

As promised, beautiful graphics. So, you can see here what I was speaking of in that our current graphics for quarter two do have the Cal MediConnect days visible, the navy blue columns here. And you can see a big jump with quarter one of 2023 that's when Cal MediConnect sunsetted and our D-SNP era begins. We've split and color coded EAE and non-EAE. So, the gold portion is the Medi-Medi Plans or EAEs. The blue above it are the non-EAEs. And it's fun because you'll be able to see these marching over time and see the changes and the relative percent changes. Next slide.

Dr. Laura Miller:

This is a graphic representation of race and ethnicity in quarter two, again, comparing Medi-Medi and non-EAE, you'll see the Hispanic population in the top two horizontal bars. And again, Hispanic representation is higher in the EAE or MMP Plans. Next slide.

Dr. Laura Miller:

We show also enrollment by sex for Medi-Medi Plans on your right-hand side, well, it's right if you're a doctor because you reach across the midline to touch the right side of the patient. First, you'll see Medi-Medi Plans 42% male, 58% female. And for the non-EAEs, just a slight variation. I don't think these differences are very, very significant, although the female predominance is notable here. Next slide.

Dr. Laura Miller:

And by primary spoken language, we have primary languages and the representation in the plans. Again, gold is Medi-Medi Plans, and the dark navy is non-EAE plans. And again, we had noted the greater representation of Hispanic folk in Medi-Medi Plans. I think you see that same thing reflected in the Spanish and English percentages period. Next slide.

Dr. Laura Miller:

So, questions. I may have flown through that too quickly, but I super appreciate your attention.

Cassidy Acosta:

Thanks so much Laura and Christopher for providing some updates on the Medicare enrollment data. I think that we only have one question in the chat so far, but welcome others to throw questions in the chat or raise your hand. Oh, great, Pat, we'll get right to you. One question, Christopher, in the chat for you on the pie chart slide, do you have any insight into why Original Medicare is higher than the percentage for duals?

Christopher Tolbert:

I would say that kind of aligns with how people, whether they choose Original Medicare or a Medicare Advantage plan, it's about 50/50. So that may be one of the reasons it's just alignment similar to people that have Medicare as a whole.

Cassidy Acosta:

Thanks Chris. All right, Pat, I'm going to unmute you. You should be able to ask your question.

Pat Blaisdell:

Yeah, thank you. On the chart that shows the percentage of beneficiaries in the various ethnicities where you were pointing out that a large percentage are folks of Hispanic heritage, do we know how those percentages of membership in the D-SNPs correlates to total representation in the population? I don't have the numbers in front of me, but I think you get my point. Is it reflective of the distribution among the general population of the number of folks that are duals? Or do we see a discrepancy that some ethnicities are more likely to be enrolled than others?

Dr. Laura Miller:

Pat, it's a really good question. Can we go back to that slide just so we have the visual in front of us? It is knowable, I can't produce it from my brain right now, but I get your question. We're seeing this sort of, let's go to the ethnicity one.

Pat Blaisdell:

Yeah.

Dr. Laura Miller:

Yeah, this one. So, I can't pull up in my brain right now, ethnicity breakdown in Medicare as a whole or state population as a whole. But we can certainly take that back. Anastasia, I don't know if you can do that off the top of your head, but I totally get your question.

Pat Blaisdell:

So, it would make that number of 43% Hispanic, even more dramatic I would think.

Dr. Laura Miller:

Right.

Pat Blaisdell:

Because I don't know that 43% of all dually eligible Medicare beneficiaries are Hispanic.

Anastasia Dodson:

We can probably look it up during the call and put it into the chat.

Dr. Laura Miller:

Great. Thank you, Anastasia.

Cassidy Acosta:

Thanks Laura. And then Jane, you should be able to unmute now.

Jane Ogle:

Thanks. When I looked on the website, I saw that the non-EAE plan with the largest enrollment is Kaiser. And I'm wondering if that is an artifact of removing the look-alike plans or if that'll be an ongoing thing?

Dr. Laura Miller:

That is a good question. Anastasia, do you want to take that one?

Anastasia Dodson:

Yes. So, in many counties such as Alameda, Contra Costa, other counties that are not the large southern California counties, Kaiser has a D-SNP, they have an MA, but they have a D-SNP, and they also have a Medi-Cal line of business. So that's the category of non-EAE D-SNPs that there is aligned enrollment, but they have not converted to a Medi-Medi status and they won't until 2026. So, as we have talked about standing up, local plans will be standing up their EAE D-SNPs in 2026. Then the Kaiser D-SNPs will convert to Medi-Medi that same year.

Cassidy Acosta:

Thanks, Anastasia. And then a question from Tiffany in the chat for you, Laura. Would DHCS consider disaggregating the AAPI groups to account for smaller subgroups for the race/ethnicity chart?

Dr. Laura Miller:

Let's go to that one as well. Tiffany, I completely get your point that by the grouping, we can blur. I think some of it depends on size of population, but we can certainly take that back and see. There are rules around suppression of data if the group is very small, but we can certainly take that back.

Cassidy Acosta:

Great. Thanks, Laura. I'm not seeing any other questions in the chat or any other hands raised, so I think we're good to move on to our next section. So, I'm going to pass it back over to Christopher to kick us off on the Enhanced Care Management and Community Supports Quarterly Implementation Report release.

Christopher Tolbert:

Okay. Thank you, Cassidy. So, before we get into this section, I like just to call out the different data that DHCS shares with advocates throughout the year may vary. The reporter numbers that Tyler Brennan will present represent the cumulative count of unique dual members who have received Community Supports up through and including the specified quarter. This cumulative total includes all unique dual members who have received services up to that point and encompassing those who have received services in previous years including 2022. And now I will transition to Dr. Laura Miller.

Dr. Laura Miller:

So, it's lovely to be able to present to you our ECM and Community Supports overview. My colleague, Tyler Brennan, will be running the Community Support side, but I'm super happy to represent ECM, Enhanced Care Management.

Dr. Laura Miller:

So, you'll see here a lovely hyperlink. This is to the Quarterly Implementation Report. It was updated in April and does reflect data from January 1, the beginning of ECM, until September 30th, 2023, so the end of quarter three of 2023 and includes total population receiving Enhanced Care Management and CS. So, duals, dually eligible beneficiaries can access all available Community Supports through their Medi-Cal plan regardless of their Medicare status.

Dr. Laura Miller:

That's been an area where we have needed to clarify. So, it's really awesome to be able to put that out completely and clearly. So, duals can get all available Community Supports through their Medi-Cal plan and those should be listed on the website of the plan. If a Medicare Advantage plan offers supplemental benefits comparable to Community Supports, Medicare is the lead. But in general, first go to Medi-Cal.

Dr. Laura Miller:

With regards to ECM and Populations of Focus, we've done a lot of work on this. Dually eligible individuals are most likely to fall into one of the following ECM Populations of Focus and those are as follows, adults experiencing homelessness, adults at risk for avoidable hospital or emergency room use, and adults with serious mental illness and or substance use disorders.

Dr. Laura Miller:

Those were the first three populations of focus that rolled out in January of 2022 and

really, they're the old favorites. They are the populations that were represented in whole person care and health homes. The next ones that I'm speaking of have rolled out more recently, adults transitioning from incarceration, adults living in the community and at risk for long-term care and adult nursing facility residents transitioning to the community.

Dr. Laura Miller:

I've said this before in various settings, I think these last two are really, really important populations of focus when we think about dually eligible members, when we think about our older adult population so super important, those rolled out more recently than the first three and uptake is growing. Next slide. I will pass it to my colleague, Tyler, who can let you know about Community Supports. Thank you, Tyler.

Tyler Brennan:

Hi. Thank you, Dr. Miller and thank you all for having me. I'm happy to be here to talk about Community Supports and the great progress we're making with the program. On screen here we have a map, and this is a little bit dated, but it still represents the current state.

Tyler Brennan:

On the right here, we have the number of elections live as of January 1st of this year compared to on the left what the service picture looked like in July of 2023. So, about a year's difference, six months, the colors are actually getting much more orange. We are seeing a number of additional counties picking up all 14 services, which is great to see.

Tyler Brennan:

I believe at the July 1st, 2024 mark, we will be at about half of California counties operationalizing all 14 services. Now not every plan in every county is operationalizing all 14, but at least one plan in those counties are. So, great to see. It's been a huge leap in progress over the past two years from where we came from, where this map was blank so it's been great to be here and be part of that process. And next slide, please.

Tyler Brennan:

So just to reiterate, a lot of this information is the same as on the previous slide, but we did want to call out that we are now communicating a lot of the public data for Community Supports and ECM publicly via a story maps, ArcGIS Solution. So, on April 4th, we published our latest version of that report and that covered the implementation up for and including Q3 of 2023.

Tyler Brennan:

We anticipate that we'll be releasing the Q4 report sometime in July, so keep your eyes filled for that. But basically, these reports provide key public updates about implementation of the programs. They really enable the Medicare plans, providers, and the public in general to understand the performance relative to their peers. And it really supports local collaboration between stakeholders and just communities in general. We

include state, county, and plan level data and summarize cumulative and quarterly enrollment trends for both programs, including total members and members under age 21.

Tyler Brennan:

We are also exploring adding a duals category. So, we're going to start trying to report more publicly on the dual beneficiaries that are receiving services. So next slide, please. Some numbers; from our latest report we were able to get some clearance to be able to share with you some of the latest information that includes quarter four data.

Tyler Brennan:

So, on screen here, and as Christopher had mentioned at the beginning of the presentation, these are all cumulative numbers, so these are cumulative unique beneficiaries. So, it is possible that the same member would show up if they were receiving services across all eight quarters. They would only be counted once.

Tyler Brennan:

But as you can see here, every quarter, the number gets higher. In the latest quarter, quarter four for which we have data, we saw an additional almost 12,000 members receive services relative to quarter three. And right now, dual eligible beneficiaries represent just over 28% of all members who receive Community Supports in quarter four. Next slide, please.

Tyler Brennan:

And taking a note from the previous slides. I will next time make sure I include some colorful graphs just to make sure I'm living up to the competition here. But on screen, we just wanted to call out the actual numbers of the dual eligible members who are receiving services and just also reflect the general percentage compared to overall members receiving those services.

Tyler Brennan:

So as an example, housing transition over 3,700 duals received that service, which was about 16% of the population. And just going down the list, you can see that dual members are utilizing the services. We do see a lot more utilization in the services where we would probably expect to see older beneficiaries benefit more from, so the community transition services, the nursing facility transition, diversion to assisted living facilities.

Tyler Brennan:

These are low numbers and we acknowledge that. These are also very complex and complicated services to operationalize and deliver, and we are currently hard at work trying to re-clarify some of the more confusing aspects of these services. So, we look forward to relaying that to the market in the, hopefully, very near future. But yeah, it's a great picture and we like to see all the dual beneficiaries being able to benefit from the

program. Next slide please.

Tyler Brennan:

All right, and then demographics. We are seeing numbers that are generally comparable to the overall Medi-Cal population. So, on the left here are just the percentages of the demographics that are receiving Community Supports. So approximately 42% of dual eligible beneficiaries receiving Community Supports were male and 58% were female. And just also call out, all of these percentages reflect only the duals that are receiving services, this isn't everybody receiving Community Supports, but just the duals.

Tyler Brennan:

About 75% of duals were 65 or older, which we would expect to see. And then they represent 28% of the total population. So just some summary information there. Moving into the next slide, I think that might be it. Before I pass things over to Laura, I'm happy to answer any questions if anybody has any.

Cassidy Acosta:

I don't think we have any specific questions on Community Supports just yet, Tyler. So, we'll run through the Enhanced Care Management section and then make sure that we have some time at the end of this to give you and Laura some time to answer questions.

Tyler Brennan:

All right. Dr. Miller, you're up.

Dr. Laura Miller:

Awesome, thank you. There is a question by Barbara on respite CS, but Tyler you can look at that and we'll come back. Next slide. So, this is just a brief overview of ECM, things that you may already know. ECM is a Medi-Cal benefit that supports comprehensive care for members with complex needs. And those are folks who most often engage in multiple delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder, and LTSS.

Dr. Laura Miller:

So, complicated systems to navigate for folks who are vulnerable. ECM is whole person and interdisciplinary intended to be high touch, person-centered and provided primarily through in-person interactions, really meeting members where they live, where they seek care, and where they want to access services.

Dr. Laura Miller:

ECM is part of a broader CalAIM Population Health Management system where Medi-Cal plans will offer care management interventions at different levels of intensity based on member need with ECM really being the highest level. If you think of a pyramid of needs, ECM is the tippy top. Next slide.

Dr. Laura Miller:

Like Tyler, I don't have beautiful graphics on this, but certainly we have numbers. I do want to note that there are some methodologic differences in this data that was taken from an internal dashboard and the information that will later be published on the DHCS webpage. So, there are minor differences, but really this is the ballpark.

Dr. Laura Miller:

So, there was somebody who was asking about disaggregating for duals in populations of focus. So, for individuals experiencing homelessness, dually eligible beneficiaries totaled 2,919 and that is 13.7% of the whole population of focus. For those individuals at risk for avoidable hospital or ED, that raw number was 4,995 and represents 15.4% of the population of focus.

Dr. Laura Miller:

Similarly, for SMI, serious mental illness, and substance use disorder, the raw number is 3,649 representing about 12.1% of the population of focus. So, I think those are helpful numbers. The Justice Involved Initiative is in various stages of rollout. It is currently rolled out in some but not all counties.

Dr. Laura Miller:

And there's pre-release, post-release. I'm sorry, there is post-release ECM for Justice Involved in all counties now. Of the individuals transitioning from incarceration, duals are 140 in raw number, representing about 10.4% of the population of focus. Next slide. At this point, we can flip to questions. Tyler, I don't know if you want to take the respite one that was in the chat and then we can take other questions.

Tyler Brennan:

I don't currently have information for the respite. The respite Community Support is mainly for caregivers of members. I'll make sure to include those numbers next time and we will actually include that data in the upcoming quarterly implementation report. So don't have that available now, but we will follow up in the next meeting and make sure to reflect those.

Cassidy Acosta:

Thanks, Tyler.

Tyler Brennan:

I did see another question too above about the nursing facility transition to a home, and it was asking about, can you explain the 60-day SNF stay as an eligibility criteria. Just to call out that eligibility criteria is only part of the eligibility criteria I believe, and that is for the nursing facility transition part of the service.

Tyler Brennan:

And it really is just there to ensure that the right folks are ones who are being targeted and focused on for transition out of these facilities. The whole concept of Community Supports were formerly known as In Lieu of Services, but these are technically supposed to be diversionary services that are really designed to get members into the right level.

Tyler Brennan:

Generally speaking, a lower level of care than they might currently be residing in that is a higher cost setting. And then the cost savings realized from that transition is essentially funding the program itself. So, happy to elaborate if... Hopefully, that answers your question, but if you have another question, I'm happy to drive off of that.

Cassidy Acosta:

Thanks, Tyler. And I believe that question was asked by Katy. So Katy, I have asked you to unmute so you should be able to unmute now.

Katy Krul:

Thank you. Can you hear me?

Cassidy Acosta:

We can, yes.

Katy Krul:

Thank you. The question was if the person stays in the nursing home more 60 days, then there is a risk of this person of losing his rental because the landlords don't really hold the apartment more than 60 days. So that's what it is. So, if, let's say, a member is ready to be transferred at 50 days or 45, he or she are not qualified, am I right?

Tyler Brennan:

It depends on the service. If it's the transition to assisted living facilities, that is the one that has the 60-day restriction and that was something that was early on made as a decision point. We needed to draw certain lines to be technically eligible for the service. And as I said, speaking in the lens of cost-effectiveness, it was settled on that 60 days. I don't have a good answer for the landlord.

Katy Krul:

My question was about transition to home, not transition to the assisted living. Assisted living, yes, I understand that part. But to home, where maybe the family or the person himself tries to recover from the hospitalization and get back home and he may need a lot of support to transition him. And if he didn't stay 60 days, he's not eligible if I understand correctly, because I'm talking about the home transition and if he is staying longer than 60 days, chances are he has no place to go. So, then he has to stay longer until we find the new housing and so on. That's my point.

Tyler Brennan:

Yeah, we hear that feedback definitely and would encourage you to submit that to... We have a general mailbox where we do accept feedback on the services for potential future modification. Our mailbox is CalAIMECMILOS@dhcs.ca.gov. I'll be sure to put that in the chat as well. We'd love to hear from you for some more details and hopefully we can get back to you in writing.

Katy Krul:

I appreciate it. Thank you so much.

Tyler Brennan:

Of course.

Dr. Laura Miller:

There's a question from Gwen around, “is there measurement indicating the satisfaction from members or caregivers as they come to know CalAIM?” There is not right now, but that patient voice, member voice is incredibly important. We're in the phases of really monitoring plan performance right now looking at the data that we have. But I fully, fully agree with you that really understanding member voice is important. So, I thank you for that question and it's on my wish list as well.

Cassidy Acosta:

Thanks, Laura. I think in the interest of time, we're going to take just a couple more questions around ECM and Community Supports and then move over to our last presentation for the day. Rick, I'm going to see if I can unmute you, but if not, I have your question that you popped into the chat and we'll ask it for you. So, let's see if this works. You should be able to unmute now. All right. Unfortunately, I don't think it's working. But Rick, I'm going to ask your question and then please pop into the chat any other follow up questions that you have. But Laura, Rick's question was, “Does having one or multiple disabilities qualify someone for Enhanced Care Management?”

Dr. Laura Miller:

Great question, Rick. And the answer is, possibly. So just the fact of disabilities does not qualify one, but if there are things like could possibly at risk for skilled nursing facility population of focus might be a fit.

Dr. Laura Miller:

The other possibility that I can think of is the high utilization of hospital or ER, depending on one's history. So, it really is looking at the individual situation and then trying to figure out which population of focus works. People can self-refer to ECM with their Medi-Cal plan. So, we've really emphasized that with the plans that yes, they started out doing data mining to find people in their data who would qualify, but we're really pushing community referrals and self-referrals.

Dr. Laura Miller:

Families can call, members can call, and as we talk to plans about their referral and authorization processes, they're really trying to emphasize no wrong door, come in, ask do you think it's a fit, et cetera. So, I hope that's a reasonable answer to your question. The fact of disabilities just does not, by definition, create ECM eligibility, but there are multiple categories that might be a fit.

Cassidy Acosta:

Thanks, Laura. And then I know that we do have a couple of other questions, but we're going to shift gears and move into our last presentation. If anybody would like to have their questions answered, you can submit them either to the CalDuals inbox or the ECM and Community Supports inbox and we will make sure to include both of those into the chat. But with that, I'm going to turn it over to Kerry and Gretchen from CMS for our next presentation.

Gretchen Nye:

Thanks, Cassidy. Hi everybody. I am Gretchen Nye, I am from the CMS Medicare-Medicaid Coordination Office and I'm going to kick us off in talking about the MAPD Final that was released in April. Last fall, CMS released a proposed rule for public comment with a number of proposals aimed at increasing the number of dually eligible beneficiaries who received their Medicare and Medicaid benefits from the same managed care organization.

Gretchen Nye:

We received thousands of comments and in April, CMS released the Final Rule, which included responses to that feedback that we received earlier in the year. I'm going to talk through a couple of the provisions in the Final Rule, but we largely finalized these provisions as we proposed in the fall. This slide speaks to our changes in the special enrollment periods for dually eligible individuals.

Gretchen Nye:

A Special Enrollment Period allows a Medicare beneficiary to change their Medicare coverage outside of the regular fall open enrollment period or the winter Medicare Advantage election period. As most of you know, dually eligible individuals can currently change their Medicare on a quarterly basis, they can elect any MAPD, D-SNP, or a similar Part D plan quarterly.

Gretchen Nye:

Effective 2025, we are replacing the quarterly SEP with a monthly SEP that allows dually eligible beneficiaries to elect a standalone Part D plan in any month. We also created an integrated care SEP that allows a full benefit dually eligible individual to elect an integrated D-SNP in any month. The integrated care SEP also goes into effect, in 2025. Next slide.

Gretchen Nye:

The combined effect of our new SEPs allows for dually eligible individuals, to leave a Medicare Advantage plan in any month, if it isn't working for them and join Original Medicare with a Part D plan. Dually eligible individuals can also switch between stand-alone Part D plans in any month.

Gretchen Nye:

Full-benefit duals can elect an integrated D-SNP in any month and switch between them in any month. In California, this applies to the Medicare Med-Cal Plans, or the EAE D-SNPs, synonymous as Dr. Miller talked about before, or a SCAN's FIDE-SNP. Next slide.

Gretchen Nye:

This slide provides a bit more detail as to the reasons why we updated the SEPs for dually eligible individuals. We had heard from beneficiaries and enrollment counselors that beneficiary use of the quarterly SEP was difficult to track. We hope the shift to monthly simplifies the enrollment processes for individuals, their families, and enrollment counselors, as they do not need to remember whether or not they used a SEP within their last quarter.

Gretchen Nye:

We also know that dually eligible beneficiaries are subject to intense marketing, from Medicare Advantage organizations and un-integrated D-SNPs. When the new SEPs go into effect in 2025, MA plans and un-integrated D-SNPs will only be able to enroll dually eligible individuals during the fall open enrollment, or during the MA open enrollment period, which we hope will reduce the plan's incentive to market toward dually eligible individuals, throughout the course of the year.

Gretchen Nye:

The new SEPs allow dually eligible individuals to more quickly leave the Medicare Advantage plan if it's not working for them and finally, the new integrated care SEP provides more opportunities for dually eligible individuals, to elect an integrated D-SNP product like the Medicare Medi-Cal Plans in California. Next slide.

Gretchen Nye:

This slide provides a little bit more technical nuance, that I hope is helpful for HICAPs and other sorts of individuals who help members that elect Medicare coverage. If an individual were to make a multiple plan choice in the same month, whichever choice the member made last chronologically, will take effect. For example, if a member selected a stand-alone PDP on May 15th for a June 1st effective date, and then subsequently called a Medicare Medi-Cal Plan on May 20th, so five days later, to elect that plan, the second election would take place. So, the member would be effective in the MMP starting on June 1st.

Gretchen Nye:

As I noted before, regular MA plans can be elected during fall open enrollment and during the MA open enrollment period, or if other SEPs are available to the enrollee. There were no other changes in the rule to existing special election periods. So, the ones that are listed here on this slide are still in effect and can be used if available.

Gretchen Nye:

Finally, CMS is working to update all of our documents, guidance and systems to reflect the new SEP changes, over the course of the next year, because they go into effect on the 1st of 2025. Next slide.

Gretchen Nye:

In the April Final Rule, we also finalized some contracting and enrollment limitations for D-SNPs. These policies are very similar to policies that DHCS already has in place for California. I want to note, at the top, that the biggest impact of these enrollment and contracting limitations, will be in states outside of California.

Gretchen Nye:

In 2027, for plan organizations that operate D-SNPs and Medicaid managed care plans in the same service area and enroll full benefit dually eligible individuals. Those D-SNPs will have to limit new enrollment to individuals who are either already in that organization's Medicaid plan, or who are in the process of enrolling in that organization's Medicaid plan.

Gretchen Nye:

Additionally, these plan organizations will only be able to offer one D-SNP per service area, for full-benefit dually eligible beneficiaries. In 2030, the D-SNPs who already have a Medicaid Managed Care Plan, operating in the same service area, will have to dis-enroll any members that they are also not serving on the Medicaid side. This may sound pretty jargon-y, essentially the plans that focus on serving dually eligible individuals for both Medicare and Medicaid, like the California MMPs, will not be able to offer multiple un-integrated D-SNPs in the same service area. Next slide.

Gretchen Nye:

This slide notes the exceptions to our new rule that an organization may only offer one D-SNP in the service area. So, what I went over on the prior slide. States have the authority from Congress, to define the eligible population service area and other aspects of D-SNPs, in their SMAC contracts. When a state wants to permit a health plan to offer two D-SNPs in the same market, we will allow for that, post-2027, but only if the two plans are clearly distinguished from one another. They need to serve different age groups or have different eligibility or Medicaid benefits.

Gretchen Nye:

CMS will work with these states, as circumstances arise, but this will be more applicable

in other states outside of California, such as Massachusetts, who has different programs for the under 65 and over 65 population in their D-SNPs. The other exception to our rule is in circumstances in which an organization offers a PPO and an HMO D-SNP in the same service area. In that case, the organization can keep both D-SNPs, but the D-SNP that is not aligned with the Medicaid MCO, will be closed to new enrollment, effective 2027. I think I'm turning it over to Kerry for the next slides.

Kerry Branick:

Thanks, Gretchen. Hi, everyone. My name's Kerry Branick. We wanted to highlight a couple of other additional provisions from the 2025 Medicare Advantage Final Rule, that we thought would be of interest to this group. So, this slide highlights changes to the D-SNP look-alike provisions. For some context, several years ago, CMS defined a D-SNP look-alike as a Medicare Advantage plan that is not a special needs plan and where dually eligible individuals comprise 80% or more of the total enrollment. Also, several years ago, through rule-making, we established that CMS would no longer contract with plans that met that definition, as of January 1, 2023.

Kerry Branick:

And we worked with the plans in California that were impacted then, to transition their enrollees to other coverage. We had adopted that regulation, due to concerns about D-SNP lookalikes, circumventing rules for D-SNPs, like the contracts with state Medicaid agencies that Gretchen just spoke of and that DHCS spoke about at the beginning of this call. The minimum integration of Medicare and Medicaid benefits that's required by D-SNPs, care coordination through health risk assessments and evidence-based models of care.

Kerry Branick:

Limiting the D-SNP look-alikes also addresses beneficiary confusion, stemming from misleading marketing practices by agents and brokers that may market D-SNP look-alikes to dually eligible beneficiaries. So, in this rule that was finalized last month, we finalized provisions as had been proposed last fall in the Notice of Proposed Rule-Making, to lower the D-SNP threshold from that 80% that I just mentioned to 70% for 2025 and then it will adjust further to 60% in 2026.

Kerry Branick:

So, we are now actively working with a couple of plans in California, that have been identified to meet this new 70% threshold, to prepare for the transition of their enrollees, where applicable. We'll share more information about that, later this summer, with HICAP, on those specific transitions. There are just a couple of plans in California that are impacted. Next slide, please.

Kerry Branick:

I also wanted to share a little bit about upcoming changes to Medicare Plan Finder. Medicare Plan Finder is an online searchable tool. It's on the Medicare.gov website and it's used by millions of beneficiaries and potential beneficiaries, families, HICAP, et

cetera, to learn more about Medicare health and drug plan options. Beneficiaries can also enroll in a plan using Medicare Plan Finder. Today, when you use the tool, there's limited information about those D-SNPs that also provide Medicaid benefits for dually eligible individuals. So, in the Notice of Proposed Rule-Making last fall, we solicited comments to try to get more feedback to inform future improvements to Medicare Plan Finder, with the goal of making it easier for dually eligible individuals to assess options that cover both Medicare and Medicaid.

Kerry Branick:

So excited to share, we've been working on some updates. We're working to include certain Medicaid covered benefits on Medicare Plan Finder. Those services are available to enrollees through the D-SNP, or through its affiliated Medicaid plan, or Medi-Cal plan. Some of these specific benefits we're targeting, are dental, transportation, certain types of HCBS, Home and Community-Based Services, and there are a few others. So, we are just starting to work with states, to implement this new feature and hope that it will be live for open enrollment this fall.

Kerry Branick:

Second, we're working to improve the order in which D-SNPs are displayed in Medicare Plan Finder. We're changing that ordering, so that the most integrated D-SNPs display first. Then finally, some states like California, have closed some D-SNPs to new enrollment. But without an indicator in Medicare Plan Finder, those plans appear to look like they're open for new enrollment, which can be confusing and frustrating to potential enrollees. So, we're working on adding an indicator to note when a plan is closed for new enrollment. But we still want the plan to display in Medicare Plan Finder, so that existing enrollees can look up information about their plan. So, I think that's all we were going to say, but we're happy to take questions.

Cassidy Acosta:

Thanks, Gretchen and Kerry. Right now, we've got one question in the chat from Janet, but also welcome others to raise their hand, or put other questions in the chat. The question that we have so far is, “Are you able to name the two plans that CMS is working with to move members that meet the 70% threshold?”

Kerry Branick:

I don't know them off the top of my head, but I'm happy to bring that information to a future call.

Cassidy Acosta:

Thanks, Kerry. Any other questions for our CMS colleagues today?

Anastasia Dodson:

Hey Kerry and Cassidy, if I could... Perhaps we can put the link in the chat. I believe there's some information already posted on the CMS website, about D-SNP look-alikes

that we could just highlight to folks.

Cassidy Acosta:

Sure. We're happy to grab that.

Anastasia Dodson:

Great.

Cassidy Acosta:

Then Katy, I see you have a question. You should be able to unmute now.

Katy Krul:

Yes. Thank you so much. My question is about deviation of the Enhanced Care Management and Community Supports, between community providers and the health plan, this new health plan. How the ECM, who provides the ECM services for this new release? Thank you.

Dr. Laura Miller:

That's a really good question and the answer is complicated. As Cassidy and many others well know, for a person who has Medicare/Medi-Cal and their Medicare is with Fee-for-Service Medicare, they would get their ECM through the Medi-Cal plan. For people who are in D-SNPs, the territory has changed over the past several years. Right now, if somebody is newly eligible, newly has say a condition, or newly in a D-SNP, they would get ECM-like Care Management through their D-SNP. It's been an evolution and we've actually done a glide path. Last year, members in EAE D-SNPs, were in that transition period from Medi-Cal ECM to D-SNP ECM-like.

Dr. Laura Miller:

This year, 2024, members in non-EAE D-SNPs are in that transition period. We definitely made a member-centered decision to have folks who are already in Medi-Cal ECM, continue with their ECM provider until they meet graduation criteria, or until the end of the year. But the overall construct is that people who are in D-SNPs will be getting care management that is considered ECM-like. A lot of that decision flowed from the fact that D-SNP care management is pretty high touch.

Dr. Laura Miller:

So, that is the answer. We can put some links in the chat, both the ECM Policy Guide and the D-SNP Policy Guide have a lot of language on this. It's definitely complicated. So perhaps, the team can put those links in the chat.

Cassidy Acosta:

Thanks so much, Laura. Then, turning back over, we got a question in the chat from Tiffany for Kerry and Gretchen. Tiffany's asking, "Will all the proposed MPF changes be

live this fall, or just the first one?"

Kerry Branick:

I was carefully choosing my words on that, because like many of you can probably appreciate, sometimes we come upon unforeseen technical challenges in making these kinds of big system updates. We are trying to have all of these changes live, for the fall. But I hesitate to say that 100%, because we're working through those changes now and you just never know. But that is our goal.

Cassidy Acosta:

Thanks, Kerry. Then I know that we still have a couple of other questions in the chat around ECM, but I did want to address, there was a question in the chat around dental. Anastasia, I know we dropped the link to the provider fact sheet but wanted to see if you wanted to address that any further.

Anastasia Dodson:

Yeah, If the folks who had those questions, or topics of interest, if you want to send an email to the info@calduals inbox, we get various inquiries about dental and the interaction between Medicare Advantage supplemental benefits and so if there's a way that we can kind of clarify either on the policy, or if there's an adjustment we need on our end in the system, or if it is broader policy issue, we want to know. So, we don't have all the right people on the call here today, but please send more information and then we'll figure out how to address it.

Anastasia Dodson:

And then, since I have the mic, I want to really appreciate Kerry and Gretchen for coming on and sharing all that information about the changes coming up for 2025. Really, that's quite some big changes and good changes. We appreciate that at DHCS. So as we meet again with this stakeholder group, we will be working on some scenario slides, to kind of talk through, because depending on what county someone is in and the interaction with the Medi-Cal Matching Plan Policy and all of that, I think it would be a great benefit for members and people in this group to talk a little more about the implications there of what plans can members choose to enroll in annually, versus it can change from month-to-month.

Anastasia Dodson:

We really want to make sure that we are doing as much as we can to support preparations for open enrollment in the fall and that everybody's clear, because it is a change, and it definitely impacts duals. So, we want to give you all the tools that you can use to talk to members. So again, thank you very much to Kerry and Gretchen for talking about the changes coming up for 2025.

Cassidy Acosta:

Thanks, Anastasia. All right, everyone. Well, we have lots of good discussion today. I

know that we tried to answer the ECM and Community Supports questions that were in the chat. If you didn't get an answer to your question, please feel free to email us, either at info@calduals.org, or the ECM and Community Supports inbox and both of those have been placed in the chat for folks to reference. I think we can go to the next slide. So, for next steps, we did want to flag two upcoming workgroups, or excuse me, one webinar and one workgroup.

Cassidy Acosta:

The first is the CalAIM for Individuals and Families Experiencing Homelessness webinar. That's going to be tomorrow at 1:30 P.M. We encourage folks to attend that meeting, if they're interested. Then of course, we have our next MLTSS & Duals Integration Stakeholder Workgroup meeting in August. That's August 29th at 12:00. With that, I thank you all so much. Thank you to our speakers today, for their wonderful presentations and to everyone on the call, for the great discussion. We look forward to seeing everyone in August. Thanks, everyone.