CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

NOVEMBER MLTSS AND DUALS STAKEHOLDER WORKGROUP

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Number of Speakers:	8
Duration:	1 hour 33 minutes

Speakers:

- Mary Russell
- Anastasia Dodson
- Stephanie Conde
- Tyler Brennan
- Konitha Tek
- Jordan Hoiberg
- Derek Soiu
- Bonnie Tran

TRANSCRIPT:

Mary Russell:

Good morning, everyone. Welcome. We will wait just one more minute as we let others connect. Thanks for joining. Okay, great. Good morning. Welcome to today's CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup. We're excited to have some great presenters with us today. We have Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS, Stephanie Conde with the Managed Care Operations Division at DHCS, Tyler Brennan with the Managed Care Quality Management Division at DHCS. Konitha Tek, a Behavioral Health Specialist with Inland Empire Health Plan, and Jordan Hoiberg, the Director of Housing Services with the Illumination Foundation, as well as Derek Soiu and Bonnie Tran with the Medi-Cal Eligibility Division at DHCS.

Mary Russell:

A few quick meeting management items to note before we begin. All participants will be on mute during the presentations. As a reminder, the MLTSS and Duals Integration Workgroups are designed to provide stakeholders with the opportunity to ask questions. So, we'll ask that plans that are on these calls hold their questions for the other workgroup venues that they have with the department. For others on the call, 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 or provide comments and feedback, please use the raise hand function and we will unmute you. The PowerPoint slides and meeting materials will be available on the DHCS website, and you can find a link to where those will be posted in the Zoom chat.

Mary Russell:

A quick reminder on adding an organization to your Zoom name, we just ask that you take a minute to do this, that will help us better facilitate the discussion. To do this, click 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 select "Rename" from the drop-down menu. And there you can enter your name and add your organization as you would like it to appear.

Mary Russell:

Let's take a quick look at the agenda for today. It is pretty stacked, so we're excited for these discussions. So, we'll start with an update on 2024 Medi-Cal Transitions and noticing that impact dual eligible members, and we'll have some time for stakeholder Q&A after that. From there, we'll have a brief update on Medicare enrollment data for dual eligible members, followed by some reminders on dual eligible special needs plans or D-SNP policies. From there, we'll have an update on Medi-Medi Plan outreach and following that there will be a spotlight presentation on the Recuperative Care Community Support, which will include an overview from DHCS and presentations by Inland Empire Health Plan and the Illumination Foundation. And we'll have time for discussion with the panel of presenters. Finally, DHCS will present an update on the Continuous Coverage Unwinding with some time for Q&A. And then we'll end today's workgroup with some information on upcoming meetings. So, thank you all for being here.

Mary Russell:

We'll take a quick minute just to share as a reminder the workgroup purpose and structure. As you all know, the CalAIM MLTSS and Duals Integration Workgroups serve as a stakeholder collaboration hub for this effort. They include health plans, stakeholders and the Centers for Medicare and Medicaid services, our CMS colleagues. The workgroup provides an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for the department's transition plan for dual eligible individuals, as well as the CCI transition within the CalAIM initiative. And a reminder that this is open to the public, there is a charter that is posted on the DHCS website, and DHCS truly values the partnerships with plans, providers, advocates, beneficiaries, caregivers, and CMS in developing and implementing this work.

Mary Russell:

At this point, I will transition to Anastasia Dodson with the OMI team at DHCS. Anastasia, feel free to jump in. Oh, sorry. I think Anastasia is still connecting. So, I'll just share quick highlights of the topics that have been covered on the 2023 workgroups. I know at the end of this meeting we will take a look towards 2024. But as you all that have participated in the workgroups from 2023 know that this venue has been a time to discuss the implementation data, results, opportunities, and challenges of CalAIM initiatives for MLTSS for all Medi-Cal members. This has also been a place to discuss the implementation data, results, opportunities, and broader challenges of the initiatives for integrated care for eligible beneficiaries from both the Medicare Advantage and original Medicare perspective. And it's also been a really great space for partners to flag related DHCS efforts for Medi-Cal members who are older adults or people with disabilities. So, I know we thank you all for your participation thus far and look forward to continuing this workgroup series in 2024.

Anastasia Dodson:

Thank you so much, Mary. Great job covering that. And again, we really appreciate the partnership and the participation of so many of you on this call today and in this workgroup series generally. Thanks, Mary.

Mary Russell:

Great. I think at this time we will transition to Stephanie Conde with DHCS. Stephanie, are you ready to jump in?

Stephanie Conde:

Good morning. Hi everyone. Thanks Mary. Stephanie Conde with Managed Care Operations Division. I'm going to go through a few slides. The first one, just a quick update on our Medi-Cal matching plan policy. Next slide please.

Stephanie Conde:

So, in 2023, there were 12 counties with dual eligible members who were enrolled in a Medicare Advantage plan, and they had to be enrolled in their matching Medi-Cal Managed Care Plan if there was a match available. Again, as a reminder, our Medicare plan is our lead, and then we have the list of the 12 matching counties below, we have Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus. And then we have some changes impacting our plans in 2024, we will be updating our policy to include Kings, Madera, Orange, San Mateo, and Tulare counties. Next slide please.

Stephanie Conde:

I'm going to talk a little bit about our Medi-Cal managed care plan transition. We have talked about this before, but just as a reminder, beginning in 2024, so at the top of next year, Medi-Cal Managed Care Plans will have new requirements to advance quality, access, accountability, and transparency. That means in some of our counties, we actually are transitioning some members, 21 counties actually. The member... I'm sorry, I lost my train of thought here. The member transition is not happening in all of our counties. So again, just our 21 counties. And this does not impact the member's Medi-Cal eligibility or coverage of their benefits. Next slide please.

Stephanie Conde:

So, I wanted to provide some resources for these Medi-Cal Managed Care transitions. If you go to this page specifically, this slide deck will be released or has been released. There are some great resources on the DHCS website including a county lookup tool where a member or a stakeholder can go to this tool, type in the county of interest, and it will pop out with the impact to that county. It's such a great resource, so I do encourage folks who are impacted to go to this tool and see how your county is impacted, what plans are available, what plans are exiting, and then what type of notice is actually deployed to the member who is impacted. There is also a member FAQ, a continuity of care. There's that continuity of care policy for these transitioning members. As stated, our notices are also up on the website. And then just a contact us page, so an extra resource of if you have some questions on who to reach out to. Next slide please.

Stephanie Conde:

So, I want to go into a little bit of our transitioning timelines. So, the Medi-Cal Managed Care Plan transition, as I noted to the 21 impacted counties is January 1, 2024. Our Select Medi-Medi Plans who are impacted in San Diego, San Bernardino and Riverside counties, the impact there, some beneficiaries in our Medi-Medi Plans, the Medi-Medi Plans will no longer be offered in those counties just based on the transitioning plans. And then our ICF/DD and Subacute Care Long-Term Care Transition is also in effect on January 1, 2024. So that impacts beneficiaries in an ICF/DD and our beneficiaries in a subacute care facility. Next slide please.

Stephanie Conde:

So, the noticing, the impact for that member and how they are outreached by either the managed care plan or the department. So, in September, our Medi-Medi Plans and exiting county San Diego, San Bern, and Riverside Counties received an annual notice of change, an ANOC, and a cover letter. And that was deployed on September 30th. So then in October, our exiting plans did mail a 90-day notice. In November, the department mailed a 60-day notice and choice packet to our managed care transition members. We also mailed a 60 -day notice to our Long-Term Care members who are impacted. So, our ICF/DD and our subacute members who were impacted received a 60 notice from the department. And then in December in hand, any day now for December 1st, is also a 30-day notice for both those Long-Term Care transitionary members and our managed care plan transition members. And then note that Medicare annual enrollment opened October 15th through December 7th.

Stephanie Conde:

I do want to make one note for the Long-Term Care members, we did mail notices to our Long-Term Care members and their authorized representatives as documented in our eligibility system. And then folks in a matching plan county, these are just a few of the notes at the bottom of the slide, members in our matching plan counties did not receive choice packets as those members will be automatically transitioned into a plan based on their Medicare enrollment. Next slide please. I will pause for some questions.

Mary Russell:

Thank you, Stephanie. Yeah, so we have a few minutes here for any questions on these updates or any general questions on this policy that Stephanie touched on. So, feel free to drop it in the chat or you can raise a hand and I can unmute you. Okay. Thank you so much, Stephanie. And just... Okay, great. Quick question from Janine about change requests going to HCO?

Stephanie Conde:

Hi Janine. I need a little bit more information for a change request. A Managed Care Plan change request? Oh yes, contact Healthcare Options, that's our enrollment broker. And if a member needs to change a plan, they either can go online to the customer service portal, they can call Healthcare Options or they complete their Choice form.

Mary Russell:

Great. Thanks Janine. Great. All right, so I'll ask Anastasia to jump in now and take us through some updates on Medicare enrollment data for duals.

Anastasia Dodson:

Great, thank you Mary. Thank you, Stephanie. Great. So, this is not any new policy, but just an update on some data that we have. Next slide.

Anastasia Dodson:

So, this is a slide that we have presented on before, it just gives the array of the Medicare delivery systems that are available for dual eligible folks to choose from. Original, also known as Fee-for-Service or regular Medicare. And then a Medicare Advantage plan that is not a D-SNP, sometimes we call those regular MA plans. Dual Eligible Special Needs Plans, D-SNPs, which are a type of Medicare Advantage. And again, Medicare Advantage is an umbrella term that includes different types of health plans. And then within the D-SNP family we have Medi-Medi Plans where the same health plan manages both the Medicare and the Medi-Cal plan. And then non-EAE D-SNPs, which is where the Medicare plan is maybe different than the Medi-Cal plan someone is enrolled in. Next slide.

Anastasia Dodson:

And then we do have a SCAN. The SCAN Health Plan operates a FIDE SNP. And then there are PACE organizations that are available for dual eligibles that meet the level of care criteria. And then there are also what's called C-SNPs and I-SNPs for people with specific chronic conditions or in institutional care. So those are the range of options in the Medicare side for people who are dually eligible. Next slide.

Anastasia Dodson:

So, this is, as you can see, a pie chart. And it's a similar pie chart that we presented at our last meeting in, I think it was late August, but this has been updated for July enrollment. So, there are approximately 1.7 million people who are dually eligible for

Medicare and Medi-Cal in California. And as of July of 2023, a little more than half of those individuals were enrolled in original regular Medicare. And then 18% or so were in a Medicare Advantage plan that is not a D-SNP, not a special needs plan, so we just call it a regular MA plan. And then about 24% of dual eligibles were in some type of D-SNP. A little more than half of those were in a Medi-Medi Plan. And then 2% were in other special needs plans, the C-SNP or I-SNP. And about 1% were in SCAN's FIDE-SNP and 1% were in PACE organizations. So, as you can see, there is really an array of Medicare options for dual eligibles. And so, when we think about policies, we need to be mindful of the delivery systems that folks are in. Next slide.

Anastasia Dodson:

And this shows over time what we're seeing, the patterns. And we will certainly post the slide so you can study this more carefully, but the bottom line is that enrollment in our Medi-Medi Plans where we have that acronym MMP for them, which is in blue, is continuing to increase, a little over 240,000 as of July. And then overall, any type of Medicare Advantage across the whole spectrum, the overall numbers also continue to increase. And that's consistent with what we see in other states, national trends, et cetera, partly from the growth in people who are becoming eligible for Medicare and dually eligible, and then due to demographics and then also because of the continued strong interests in Medicare Advantage, D-SNPs sort of overall among all Medicare beneficiaries. All right, so let's go to the next slide. And Mary, I'm going to keep going on these, right?

Mary Russell:

Yep, go ahead.

Anastasia Dodson:

Okay. So, some reminders about our D-SNP policies, and again, not much brand new here, but want to make sure we're keeping everybody up to speed on where things are at. Next slide.

Anastasia Dodson:

And many of you are really familiar with this, but maybe some people are new to this. So just want to restate Medi-Medi Plans are a type of Medicare Advantage plan in California that are only available for people who are dually eligible for Medicare and Medi-Cal. We call these Medi-Medi Plans and they are required to coordinate all Medicare and Medi-Cal benefits for their members. Medi-Medi Plans are a type of D-SNP, which is sort of the national terminology for these types of plans. As of January 1st,

so still in this current year, 2023, Medi-Medi Plans are available for enrollment in seven counties, primarily in the large Southern California counties, plus San Mateo and Santa Clara counties. And then next year in 2024, Medi-Medi Plans are going to be newly available for voluntary enrollment in five additional counties, Fresno, Kings, Madera, Sacramento, and Tulare Counties. And for all the existing seven counties and then the five additional counties, again, it's voluntary for dual eligibles to decide if they want to enroll. And the health plans that are in the seven counties plus the five counties that are offering these Medi-Medi, those same organizations also have Medi-Cal Managed Care Plans and so they combine both sets of benefits. It's presented as one plan to members.

Anastasia Dodson:

To enroll in a Medi-Medi Plan, a beneficiary can contact their Medi-Cal plan, which offers the Medi-Medi Plan. They can also call 1-800-MEDICARE. And right now, as you probably know, we are in the Medicare open enrollment period from October 15th through December 7th. So, we know there's a lot of discussion, mailings, commercials, activities around this open enrollment period. And just a reminder about these Medi-Medi Plans being available. And for folks who are in those five additional counties, they can make their choices now for the 2024 contract year. Next slide.

Anastasia Dodson:

As part of our structure for providing policy and setting requirements for the Medi-Medi Plans and other D-SNPs, we have a D-SNP Policy Guide. We have different chapters of the Policy Guide, and again, this is guidance and requirements for the Medi-Medi Plans themselves. And so, for the 2024 contract year, which is coming up, we've already released a number of chapters around care coordination, integrated materials, dental benefits, network guidance. We are still in the process of finalizing and releasing the Medicare continuity of care requirements, but we have that same policy that we've had in prior years where if someone is newly entering one of these plans and they've already been seeing some primary care providers, they can continue to see those providers if there's an agreement that can be reached with the plan and the provider. So, we will be publishing that continuity of care requirement shortly.

Anastasia Dodson:

There's also quality metrics and reporting requirements that we'll be publishing for contract year 2024, and many of those are similar to what we had in 2023, but we have learned some things. We're improving and modifying some of those quality measures and reporting requirements. So that will be published soon. Medicare encounter data requirements we'll also be publishing for the plans to submit that to DHCS. And then we

have the Policy Guide available on the DHCS website. And that's for contract year 2024, which is coming up shortly. Next slide.

Anastasia Dodson:

This gives you an idea for those of you who have been following along these many months, what's in the 2023 Policy Guide, what's in the 2024 Policy Guide. Again, this is a slide that we have shared often with various groups. But you can see the array of topics that we include in our requirements to D-SNPs. And again, dental benefits, integrated materials. Some of these are just for the Medi-Medi Plans, but most are for all D-SNPs. Next slide.

Anastasia Dodson:

Good. So, let's talk about outreach, next slide. So, for our Medi-Medi Plan outreach, in particular for those five counties, we have been working on materials. We have fact sheets, we have videos, and then we did publish, I think in the last couple months, our fact sheet on dental benefits. And we're also working on a fact sheet now around hearing benefits. We appreciate your patience. We know that was a topic that was raised on this call months ago.

Anastasia Dodson:

And so now that we've got the dental fact sheet out, and it's really for all duals, not just those in Medi-Medi Plans or D-SNPs, it's a fact sheet aimed at providers because we know that we have to make sure that the dental providers understand how to navigate, and they can help their patients. But anyone is welcome to look at that fact sheet and we can put the link in the chat. But we do have other fact sheets and videos just generally on Medi-Medi Plans. We want to try to provide tools for all of you or for the people that you are supporting. Next slide.

Anastasia Dodson:

So, here's the link. We have that, again, the dental benefits. We have an updated landscape of D-SNPs in California for the beneficiary fact sheet. For the Medi-Medi Plans. We have it posted in several languages. We have a short video. So, we hope that these materials are helpful. And even after open enrollment, we know people will still have questions and dual eligible beneficiaries can change plans and enroll quarterly in Medi-Medi Plans, D-SNPs so we know that it's not just for discussion in this open enrollment period we're in now, but really ongoing throughout the year. Next slide. Okay, Mary.

Mary Russell:

I think we're going, yeah, let's pause on that last slide and we'll take a few questions. I see a few things that have come in via the chat, but just a reminder, again, if you have a question, feel free to raise a hand and we can unmute you. And I think we still have Stephanie Conde on the line. So, Katie, I see your question about the Medi-Cal Matching policy and does it apply to subcontracted plans under a prime plan or only the prime plan. Stephanie, do you want to address that?

Stephanie Conde:

Our Matching Plan Policy only matches at the prime level, not our subcontracted level in matching plan counties. Sorry, Anastasia, it's been a minute since I've...

Anastasia Dodson:

Sure, sure. And I think it looks like the example they're talking about is around Kaiser, and we know that, yeah, delegated plan for 2023 in most counties. But then in 2024 it'll be a direct contract. So, what happens in 2023, and then what will happen in 2024? And then I do want to say, if anybody is from a health plan perspective also, we have separate calls for that topic, but glad to help consumers on this call.

Stephanie Conde:

Yeah, thank you. And there is expansion of those Kaiser prime contracts. And so, folks can go to those resources that were provided to see where Kaiser is having a prime. Thanks, Anastasia. I didn't have the scenario in front of me.

Mary Russell:

Thank you, both.

Anastasia Dodson:

Yeah, and like Stephanie is saying, the scenarios are really important because in some counties like San Diego, okay, Kaiser is already a prime. And so, look to your county to make sure it's got the right, and you can get the right information.

Mary Russell:

Great. Other questions on these topics? Jeanette, I see maybe the beginning of a question, but also if you... Okay. Jeannette's question is to confirm Medi-Medi Plans can change every three months.

Anastasia Dodson:

Yeah. So, people who are dually eligible for Medicare and Medi-Cal, they are actually able to change their Medicare plans, Medicare Advantage, and D-SNPs, once per quarter. The exception to that is the last quarter of the year when there is this open enrollment period, then any choice that they make is effective January 1st. But yes, it's called a special enrollment period for people who are dually eligible, and they can change their Medicare delivery system once per quarter.

Anastasia Dodson:

And the plans themselves, the many, many plans, and their specific details for that health plan as far as any supplemental benefits, and features of the plan, that changes once per year. So, the plans themselves get refreshed every year, but beneficiaries can enroll once per quarter.

Mary Russell:

Great. Other questions at this point? All right. Well, I think we're really looking forward to our next section of the agenda, which is on our spotlight. So, we will transition at this point and ask that Tyler Brennan with DHCS jump in to provide an overview of the DHCS Guidance. Tyler, are you ready to jump in here?

Tyler Brennan:

Yeah. Hi there, everybody. My name's Tyler Brennan. I'm a Health Program Specialist with the Department of Health Care Services. Here to talk to you a little bit about Recuperative Care and share some of the recently highlighted data that we have available on duly eligible beneficiaries receiving services. The slides are a little bit mixed up here, so I'll ask that you go maybe forward two or three just to get to the guidance part first. There we go. So, we're going to be highlighting Recuperative Care, or Medical Respite, which is one of our Community Supports that we offer, one of fourteen. It is essentially short-term residential care for individuals who no longer require hospitalization, but who still need to heal, and need a safe place to do so. It helps address housing instability and does promote recovery after members receive acute levels of care and allows patients to continue accessing healthcare and social services through their connected networks and coordinators that they establish through both Community Supports and potentially even ECM, Enhanced Care Management. Next slide, please.

Tyler Brennan:

So, in context, what Recuperative Care is really designed to do is bridge between the hospital and emergency departments, and homeless shelters that do not offer medical

care, but who create opportunities for members to receive services more in the social services' sphere. It's part of the continuum of care for homeless services. There's a lot of program diversity in the Recuperative Care world. There are over 130 Recuperative Care programs in the United States, and 41 of those can be found in California. We work closely with a lot of the organizations around Recuperative Care and have ongoing work actually with them to try and ensure that we have Recuperative Care programs available in all 58 California counties. I believe there are still a couple of them that are missing Recuperative Care programs, but we are looking at those over 2024 and hoping to address those gaps. Next slide, please.

Tyler Brennan:

So Recuperative Care service offerings can vary but really include a number of minimum things and then some additional services above and beyond the base foundational layer. So, the basic aspect of Recuperative Care is the inner housing, the meals that can be provided either through the service itself or through the medically tailored meals Community Supports, which is another service we have available. It also includes medical and behavioral health monitoring to ensure that members health statuses are being maintained. Additional services on top of that, layered on it can include short-term assistance with ADLs, and IADLs, can include coordination for transportation, proposed discharge appointments or other healthcare appointments, and ongoing connection to other services, housing and benefits support and case management stabilization. Next slide, please.

Tyler Brennan:

Okay. And then just some of the highlighted benefits. This is from the historical literature that's available on Recuperative Care programs, but those have seen generally a 28% average reduction in hospital days for chronically homeless individuals, or reduction in overall healthcare costs of $62,500500 per person per year, relative to the $26,000 that they would normally... The costs for Recuperative Care versus the cost for what they would normally be receiving in utilizing other healthcare services.

Tyler Brennan:

So there really is a large, estimated savings that can be had through this service in particular, estimated between $18,000 and $48,000 dollars per patient. And going to the next slide, I think that might be the last one. Oh, just talking about some of the eligible populations. So yeah, so eligibility for the service, it's pretty broad, and we do encourage plans to really outreach to individuals who they think can benefit most from receiving it. But the base layer eligibility is for members who are at risk of

hospitalization, or are post-hospitalization, those who live alone with no formal supports, members who face housing insecurity or otherwise have housing that would jeopardize their health and safety. Then individuals who may be high definitions of homeless or at risk of homelessness, and who are receiving ECM. Or have a chronic condition. Next slide, please.

Tyler Brennan:

So, some of the limitations for the service. It must be necessary to achieve and/or maintain medical stability and prevent hospital readmission. There is a 90-day limitation on the continuous duration for the service. So, members can only be receiving lease for the service for three months continuous duration. It cannot include funding for building modification or building rehabilitation, although we do have other Community Support services that may be able to assist with those things. And also, the service itself has been determined to be inherently time sensitive. So DHCS has subjected this particular Community Support to expedited authorization and mandates that managed care plans have those policies in place for expedited authorization. Next slide, please.

Tyler Brennan:

All right, and allowable providers. We do include a list of the available providers in the Community Support Policy Guide. It's a list of recommended providers, but we do take into consideration potentially other non-traditional providers being able to offer the service so long as they've demonstrated their capabilities to do so. But interim housing facilities with additional onsite support, shelter beds with additional onsite support, converted homes with additional onsite support, and county-directed, operated or contracted Recuperative Care facilities. So, facilities can look a number of different ways, but they should all be essentially taking care of the same basic member level needs for Recuperative Care. And next slide, please.

Tyler Brennan:

All right. These are some of the citations. NIMRC is one of the organizations nationwide that we work with to sort of identify gaps and see what additional technical assistance and guidance we can provide in this area. So, we did include a slide for you here just in case you wanted to look at some of the resources. Going to the next slide.

Tyler Brennan:

Okay. And before we get to questions, I want to jump back about six or seven slides to the data, just to highlight some of the dual specific data that we're seeing for Community Supports over the past year. So, on the left I included some numbers for the

2022 year, and then on the right we've got 2023. So, you can see there is sort of an upward trajectory. And I think Q2, we saw our largest single quarter jump in number of members utilizing services. We do see that dual eligible beneficiaries are utilizing Community Supports. They represent about 25% of the total population of those receiving Community Supports as of quarter two 2023. And next slide, please.

Tyler Brennan:

And then just highlighting some of the specific services where duals are really utilizing Community Supports. Of course, we've got the housing trail, the housing transition navigation services and the housing tendency and sustaining services. Those are the most highly utilized by duals outside of the medically tailored meals. So, you can see about 2,700 duals for transition navigation, of almost 3,000 for tendency and sustaining, medically tailored meals is the biggest player here. Almost 7,000 members in quarter two of 2023 received that service. And then we also wanted to highlight Recuperative Care and the nursing facility transition services, which are the other three services really that are most highly utilized by the duals population. Next slide, please.

Tyler Brennan:

And then just wanted to highlight some of the demographics we're seeing overall, I think it follows a similar trajectory to the overall Medi-Cal population, but it is something that we are monitoring through the data, and just wanted to present that information as we had it available. So that's just sort of an overall informational slide. And with that, I'd be happy to take any questions, or Mary, if you'd like to lead us through that part.

Mary Russell:

Thanks, Tyler. Yeah, we are opening it up right now for any questions on the DHCS policy and guidance around this Community Support before we dive into some discussion with our health plan partner and others. So, any questions on Tyler's presentation here? Maybe while people are brainstorming their questions, I do see this note from Serena in the chat. And Stephanie, while we still have you, do you want to weigh in and respond to this question about Sacramento County?

Stephanie Conde:

Hi again, folks. Yeah, so members who are in Kaiser today as a subcontracted member, they will move over to Kaiser as a prime contract. Those members are part of Kaiser's network today, and so we're able to provide that rollover to the Kaiser prime contract for 2024.

Anastasia Dodson:

Stephanie, I'm just going to add that since Sacramento is already a matching plan county, if a dual eligible in Sacramento County right now already has Kaiser MA, and they're dual eligible, they should already be enrolled in Kaiser on the Medi-Cal side. It's automatic process that should have already happened for this current year already. Nothing new. And same thing for 2024.

Stephanie Conde:

Yep, got it.

Mary Russell:

Great. Thanks for weighing in on that question. And I see a few things in the chat related to Tyler's content. So, Tyler, a question from Maureen, are the facilities providing Recuperative Care licensed?

Tyler Brennan:

I believe they are. And we do have all of the details, the finer point details and available in the Community Supports Policy Guide. Let me get back to you real quickly on that, because I just don't know off the top of my head.

Mary Russell:

And we can provide a link to that Policy Guide as well. And a question from Carly Roman, "Do we know what share of beneficiaries who get the Recuperative Care Community Support are housed at day 100?"

Tyler Brennan:

We do not have that information readily available, but I think we are exploring ways to sort of better track that information using some of the coding schema.

Mary Russell:

And a question from Fabiola Wallace in Tulare County, "Can a link be provided for further information on Recuperative Care, looking for more information on allowable providers and eligibility?" And so, some of these slides will be shared, but Tyler, any recommendations of other resources?

Tyler Brennan:

Yeah, I'll drop in some links in the chat specifically to our Policy Guide, but also to our resources page where we have a lot of other documents and guidance available,

including webinars that we've given in the past, presentations that we've recorded, et cetera. So lots available. I'll make sure those links are included.

Mary Russell:

Great. Thanks, Tyler. And Barbra, I see your note and would ask you to just hang tight because we do have some good speakers coming up next during this meeting, and hopefully that will help provide the information you're looking for. Any other questions on the DHCS policy at this point?

Tyler Brennan:

Real quick, just to confirm, the facilities for Recuperative Care are unlicensed.

Mary Russell:

Thanks for clarifying, Tyler. All right. So, at this point, let's transition to our health plan partner who has joined us today. We are going to be hearing from Konitha at Inland Empire Health Plan. So Konitha, if you're ready, feel free to come off mute and jump in.

Konitha Tek:

Good morning, everyone. My name is Konitha Tek, I'm the specialist team lead for Community Supports team. I'm very excited to share with you how Recuperative Care program has been working for IEHP and our members. Hey, next slide, please.

Mary Russell:

Oh, okay. Thanks for your question. Thanks for just getting it set up. There we go.

Konitha Tek:

Oh, can you move to the agenda? Yes, right there. Thank you. Okay, so today we will cover IEHP Fun Facts, Community Supports overview, what is Recuperative Care, Recuperative Care success stories, and the impact of Recuperative Care. Next slide, please.

Konitha Tek:

The one up above. There we go. Thank you. So, here's some fun facts about IEHP. IEHP is a top-ten largest Medicaid health plan, and the largest not-for-profit Medicare, Medicaid plan in the country. We have 1.6 million members, over 7,000 providers, and over 3,000 team members. Our mission, we heal and inspire the human spirit. Our vision, we will not rest until our communities enjoy optimal care and vibrant help. And our values, we do the right thing by placing our members at the center of our universe,

unleashing our creativity and courage to improve health and wellbeing, bringing focus and accountability to our work and never wavering in our commitment to our members, providers, partners, and each other. Next slide, please.

Mary Russell:

So sorry, I think we're having some PowerPoint issues, but...

Konitha Tek:

It's okay.

Mary Russell:

Thank you.

Konitha Tek:

Thank you. So Community Supports is a part of the Department of Health Care Services, also known as DHCS. With our CalAIM program, DHCS encourages Managed Health Care Plans, or MCPs, to offer a robust menu of 14 Community Support services that have been pre-approved by DHCS to comprehensively address the needs of our members. These are members with the most complex challenges affecting their health, such as homelessness, unstable and unsafe housing, food insecurities, and all other social needs.

Konitha Tek:

So, a key goal of Community Supports is to allow members to obtain care in the least restrictive setting possible, and to keep them in the community as medically appropriate. And because IEHP is the health plan with the heart, we offer all 14 Community Support services. Next slide, please.

Konitha Tek:

There we go. There we go. One up, please. There we go. Thank you. So, you may ask, what is Recuperative Care? Recuperative Care is a short-term... Oh, you know what? I believe we're on the wrong slide. Is it one up, or one down? There we go. Thank you. So Recuperative Care is a short-term residential care for members who no longer require hospitalization. However, they still need to heal from injury or illness and whose condition would worsen in an unstable living environment. The service includes interim housing with a bed, meals, and ongoing monitoring of medical or behavioral health condition. Next slide, please.

Konitha Tek:

Thank you. So, when asked how Recuperative Care is working for IEHP, I think the testimonies from our Recuperative Care staff and members are the best validations of how successful Recuperative Care is working for IEHP and our members. This is a quote from a staff member at Helping Hearts Recuperative Care. "I truly believe that Recuperative Care is very helpful in getting homeless and house members get back on their feet, whether it's taking medications, finding jobs, reunification with families, replacing missing necessary documents, such as ID, social security card, birth certificate, needed for housing. We help them with their sobriety and recovery care after hospital discharge as well." Next slide, please.

Konitha Tek:

We also have multiple success stories to share with you. Success story number one. "Member was homeless and needed a place to stay. Member was diagnosed with bipolar disorder. Our Recuperative Care connected member through their psych mobile and members started taking his medications. They assisted the member on utilizing their computer to look for a job. As a result, member found a job in California Conservation Corps in Stockton, California. His employer provided the member with a bus pass to get to work." So that worked out very well for the member. Next slide, please.

Konitha Tek:

Okay. So, success story number two. "Member came from Jackson House in Temecula. Our Recuperative Care accepted the member and got him back connected with a psychiatrist and started taking his medications. They helped him get his ID, which he needed to apply for a job. Member found a job and was hired at Major Drilling America in Utah. The employer had sent member a plane ticket, which was verified by Recuperative Care manager, and the staff dropped off the member at the airport and member made it safely to his new job and home in Utah.

Konitha Tek:

Success story number three, please. Okay. So, for this one, "Member was with our Recuperative Care program twice. The member was originally discharged to his family. Member reached out to us asking for help. Since he left our facility, the member stopped taking all of his psych medications. We accepted the member back and connected him to Psych Mobile. Member started taking his medications again and is now stable. Member found a job at Landscape Maintenance of America as a lead driver and are helping other homeless in his encampment. He comes to us three to four times a month just to let us know he's doing great and telling others who need help to reach

out to us. Since then, he had recommended two people, which he met in the encampment to join our Recuperative Care program." Okay. Can we go to the next success story, please?

Konitha Tek:

Okay. So, this one, "Member was with our Recuperative Care before and had completed the program and was discharged. Our Recuperative Care accepted the member back and help him get all the necessary documents needed for his housing. The member finally got his voucher for an apartment and was able to purchase a car." So that was truly remarkable. Can we have the next slide?

Konitha Tek:

So far, we have listened to the staff's testimony and member success stories, but what is the impact that Recuperative Care has made on our members? Since IEHP started offering Recuperative Care services in January of 2022, 301 authorizations have been approved for Recuperative Care, and we have helped 204 members recover and get back on their feet. We have assisted numerous members recover from injury wounds, find jobs, maintain their sobriety and reunite with family members. Thank you to all the hard work of our Recuperative Care providers. These members are living better, more productive lives. Thank you so much for that. You can take any questions.

Mary Russell:

Thank you so much, Koni. And again, thanks for your patience with some of our issues on the back end.

Konitha Tek:

No problem.

Mary Russell:

... And again, thanks for your patience with some of our-

Konitha Tek:

Oh no problem.

Mary Russell:

Issues on the back end. Those are amazing stories. Thank you so much for sharing them. And we're going to save some time for a little bit of a panel discussion, but right now I will ask for our provider perspective to jump in. I know we have Jordan with the

Illumination Foundation who is going to pick up on the next section. So, Jordan, are you ready to jump in here?

Jordan Hoiberg:

Yes. Thank you for the introduction, Mary. So, my name is Jordan. I'm here today on behalf of Illumination Foundation. Illumination Foundation is a homeless service provider operating in the southern California area. We offer wraparound services to our clients, really trying to accompany them from the streets all the way into permanent supportive housing, providing those tenancy supports as well. So, trying to follow them each step of the way. But our organization started with Recuperative Care 15 years ago, so it's really at the heart of what we do as an organization. Next slide.

Jordan Hoiberg:

So today I'm going to cover a little bit of general background about what Recuperative Care is without hopefully repeating too much from the previous speakers. Talk in more detail about what some of the services provided at Recuperative Care look like. Talk about some of the benefits and challenges we see in serving dual-enrolled members and talk about some of the innovative practices we're trying to implement at Illumination Foundation that we think benefit dual-enrolled members in particular. Next.

Jordan Hoiberg:

So, what is Recuperative Care? Recuperative Care really started with the Whole-Person Care days for people who were admitted to the hospital and when it came time to discharge them, they would have no place to go. And as a consequence, many of them would end up discharged back to the streets or other places not meant for human habitation. And that home health that's part of their discharge plan, there's no home for them to go into for the home health. Wound care, those connections couldn't be made. And as a consequence of the day-to-day survival of those people being discharged from the hospital to the streets or their environments, there was really low compliance with discharge planning.

Jordan Hoiberg:

So Recuperative Care was designed to be a place for those people to go, people who could handle their activities of daily living. So, it's not like a skilled nursing facility or an assisted living facility, but people who really need somewhere safe to stay with the degree of medical coordination and other social supports to be able to comply with that discharge planning and see the full recovery that they need before transitioning to other services.

Jordan Hoiberg:

Recuperative Care also changed with the rollout of CalAIM. So CalAIM has allowed us to take community-based referrals, which has greatly expanded the eligibility for Recuperative Care. And depending on the managed care plan and how we're able to work with them, we're able to work with some people who have very poorly managed chronic health conditions, people with mental health conditions as well. So CalAIM has done a great job in promoting the use of Recuperative Care and also increasing the eligibility for Recuperative Care, which has driven up its use in the past two years.

Jordan Hoiberg:

Recuperative Care is for 90 days, and it's really designed to stabilize that client before they make the next step towards housing, which there are other Community Supports to help address that, like short-term post-hospitalization. Next slide.

Jordan Hoiberg:

So, this gives a good general overview of the services provided at Recuperative Care. On the left side, you could see a general overview of the services that we'll go into greater detail on, particularly at our Fullerton Navigation Center, which is our flagship facility. The right talks about our Illumination Foundation Medical Group for our Orange County Recuperative Care clients and other clients, we actually have a medical group on site at our Fullerton Recuperative Care that provides primary care, therapy, behavioral health, so including psychiatry and dental care. Right. And because that medical group is specifically working with our Recuperative Care clients on site and other people experiencing homelessness in the community, they're able to really provide culturally competent services to our clients. And having that medical expertise on site at the Recuperative Care helps us ensure that our clients are receiving good quality of service as well.

Jordan Hoiberg:

So, diving into greater detail with the services, we could move on to the next slide. I wanted to give a rundown of each service and what it looks like to help people understand. So, one of the major backbones with Recuperative Care is case management. Every client that comes into our Recuperative Care facility is assigned a case manager to work with. Upon intake, that case manager assesses the clients to address their social determinants of health and determine what their needs are for service connections. They'll develop an income plan that can include connections to benefits including SSDI, which can help with that Medicare connection. So, we see a lot

of people get dual-enrolled with Medi-Medi while they're with us at Recuperative Care. We help the clients obtain vital documents, which IEHP went over. We coordinate connections to substance use and behavioral health connections. We assist clients in addressing legal barriers. The case manager is the main point of contact for our clients at Recuperative Care as they develop a care plan for their 90 days with us and work towards that. Next slide.

Jordan Hoiberg:

Medical coordination is the other major backbone for Recuperative Care. Of course, all of our clients coming to us have discharge plans from the hospital they're coming from or are coming to us with health needs that put them at significant risk of hospitalization. So, our Recuperative Care staffing model includes medical assistants and LVNs that report up to a registered nurse. And then we also have the medical group on site, which I mentioned as well. Medical staff review the clinical documentation received during the intake and assess the client to determine their medical needs. They regularly assess the client vital signs and complete facility rounds at regular intervals. I believe every two hours to check in on the clients they collect and dispense client medication to ensure compliance with their medication. Next slide.

Jordan Hoiberg:

The medical staff coordinate medical care including primary care and specialist appointments, wound care, home health, occupational and physical therapy, and any other services that are ordered by the primary care practitioner or are indicated in the client's discharge plan from the hospital. We also find that a lot of our clients that come to us may have some difficulties with their activities of daily living or because of the chronic health conditions they might face, their ability to handle their activities of daily living can sometimes for the deteriorate with us while at Recuperative Care. So, the medical staff will work with the case managers when appropriate to coordinate transitions to higher level of care such as assisted living facilities, memory care, boarding care, skilled nursing facilities as needed to help also ensure a smooth discharge from hospitals and free up those beds for people who really need them.

Jordan Hoiberg:

And then one of the other key components to medical coordination is really educating clients on how to manage their chronic health conditions. A lot of our clients coming to us may be newly diagnosed with a chronic health condition or may have not been managing it properly in the past. So, educating them on how to manage that chronic health condition when they’re no longer under our care is a key component of

Recuperative Care so that hopefully they're not coming back to us and they're able to manage their conditions when they're no longer under our care. Next slide.

Jordan Hoiberg:

We also try to connect our clients to a number of different Community Supports while they're with us at Recuperative Care to really provide that wraparound. So, all our clients at Recuperative Care are connected to Community Supports Housing Navigation and Deposit Assistance as needed. So, everybody at Recuperative Care has a housing case manager that they work with who develops a housing plan with them to find secure, safe, and stable housing. We do operate in the coordinated entry system and as an organization we also have a number of different contracts with government agencies or a continuum of care to provide housing directly to our clients and other community members. Next slide.

Jordan Hoiberg:

And then we also provide substance use counseling on site at Recuperative Care. So, every client that comes to our Recuperative Care is assessed on intake by a substance use counselor to determine if they have a substance use disorder and need a care plan related to their substance use disorder. If they indicate interest in that service, the substance use counselor can provide regular one-on-one counseling with the clients. They can work with the clients for any needed referrals related to their substance use disorder. So that can include medical detox, sometimes inpatient or outpatient programming, sober livings related to client discharge plans from Recuperative Care, and the substance use counselors can also work with the clients to help resolve any legal barriers that they might be facing when they come to the facility related to their substance use. Next slide.

Jordan Hoiberg:

And then day habilitation is another one of the Community Supports that we work to integrate into our Recuperative Care programming. So, day habilitation is basically independent living skills programming or life skills programming. We offer programming with day habilitation that covers a range of topics from budgeting skills to credit recovery to some behavioral health related modules like stress management and effective communication to skills that are really going to help ensure that clients are set up to live independently when they're no longer under our care, including emergency medical planning, cleaning and organizational skills when living alone, trying to prevent hoarding. Really those kind of foundational skills that our clients are going to need when they're no longer having a case manager working with them on a regular basis.

Jordan Hoiberg:

One thing I like to highlight with day habilitation is that everybody that participates, if they graduate, they get a little certificate that they could take with them and a gift card. So, we really try to promote participation in that life skills programming as well. Next slide.

Jordan Hoiberg:

This just goes over our holistic model at Illumination Foundation. We call it a hub and spoke model where our Recuperative Care and navigation centers are really considered our hubs. We want to get our clients into our hubs, get them stabilized, and get them set up with staff that they could work with regularly to make that transition to our spokes, which are the housing programs that we offer. Because one of the big barriers with Recuperative Care is that if we're not resolving the underlying housing issue along with the health conditions that the clients are facing, it's very likely that they're going to end up back in the hospital and back with us again. Next slide.

Jordan Hoiberg:

And this goes over the different Community Supports that we try to integrate into our Recuperative Care. And I think as you could see from the overview of the services, we really try to provide a holistic model that's not just looking after the client's health situation, but really understanding those social determinants of health and gearing our programming to addressing those in a way that's going to result in client self-sufficiency and independence when they leave the programming so that we're hopefully not having people cycling in and out of the system. Next slide.

Jordan Hoiberg:

So now I wanted to talk a little bit about some of the benefits and challenges you see in serving dual-enrolled members. So first I would note that our homeless population in California is quickly aging. As a consequence of that, and I think we saw this in Tyler's data as well, the number of people that we're serving as a homeless service provider who are dual eligible or dual-enrolled has significantly increased over the past several years and is likely to further increase.

Jordan Hoiberg:

As a consequence, though, we see that these dual-enrolled members that we serve tend to be higher acuity and more medically frail than our straight Medi-Cal recipients. We believe this is due to the eligibility criteria related to Medi-Medi, and eligibility criteria

that are age-related disability-related or related to chronic renal disease. So, by definition, those Medi-Medi members are going to have greater needs. Another thing I would note in particular with that 65-age eligibility requirement with Medicare is that multiple studies have demonstrated that people experiencing homelessness also experience premature aging. So, our Medicare recipients who are over 65 also actually tend to present with a medical age that is 15, 20 years older. So, a lot of health needs that we'd see with a more geriatric population when we're serving people that are dual-enrolled.

Jordan Hoiberg:

And this presents some difficulties for us as a Recuperative Care provider in that the reimbursement for Recuperative Care is coming from Medi-Cal and not Medicare at all. So even though we have dual-enrolled members who tend to be higher acuity, our reimbursement rates are the same for our Medi-Cal or dual-enrolled members. So being able to provide the quality of care that these dual-enrolled members need at the reimbursement rates can be a bit of a challenge. Another challenge we've noticed with dual-enrolled members is that some dual eligible clients have Medi-Cal spend downs because of some of the particularities with eligibility criteria for Medi-Medi members. Sometimes they'll have that Medi-Cal spend down and that can pose a costly barrier to services that we've had to work sometimes with our managed care plans and also internally to be able to try to overcome for our clients that need this service. It's not a common one we run into, but it has come up a couple times.

Jordan Hoiberg:

So, I say those as some of the key difficulties we face in serving dual-enrolled members, and I think that those difficulties are just going to be exacerbated over the coming years as our homeless population in California continues to age.

Jordan Hoiberg:

Some of the benefits we do see in serving dual-enrolled members are that the Medicare reimbursement rates for our Illumination Foundation Medical Group primary care are higher than the Medi-Cal reimbursement rates. So those Medicare reimbursement rates for the dual eligible members help sustain the work of that medical group when they're working with a high acuity population where each patient needs a lot of time and a lot of hands-on care. And then we've also found that those dual-enrolled members are easier to transition to higher levels of care when needed. So, for our straight Medi-Cal clients, we find ourselves having to work with the living waiver system a lot, and that of

course can be difficult and time consuming to navigate. So being able to transition to higher level of care for our dual-enrolled members has been a benefit. Next slide.

Jordan Hoiberg:

And then I just wanted to close by talking about a couple of the innovative practices we're trying to implement that I see as helping dual-enrolled members. So, I wanted to highlight our Unity House, which is a twenty-bed Recuperative Care facility for women located at the St. Jude Hospital campus in Fullerton. So that Recuperative Care is specifically for women. All the staff there are women. I visited once or twice, so we'll have occasionally staff on-site that are visiting that are male, but everybody there on a day-to-day basis is a woman. And we think that's really important for our population because women experiencing homelessness experienced gendered violence including sexual assault at disproportionate rates. So, being able to provide a more trauma-informed setting for them has been really helpful to bring some people who might be more resistant to care into the services and engaging with our services. Next slide.

Jordan Hoiberg:

And I wanted to highlight also our learning collaborative and partnership for action with the California Healthcare Foundation, which includes the Orange County Healthcare Agency and CalOptima Health. We've worked with them to be able to secure housing choice vouchers, so section eight from the Orange County Housing Authority, and to use claims data from the managed care plan to identify which of our Recuperative Care clients are high utilizers of emergency services. So have five or more emergency department visits or three or more in-patient stays in the past six months and target them for these housing opportunities. And that really allows us to ensure that there is a rapid connection to housing opportunities for those highest utilizers of medical services, which makes sure that the Recuperative Care services more effective and leads to that housing outcome at the end and helps ensure that our members aren't going back to the hospital, coming back to Recuperative Care in that vicious cycle. So next slide.

Jordan Hoiberg:

And this just goes over the goals a bit. We actually housed a bit over 40 high utilizers in our first year through this Partnership for Action. Next slide. Another innovative strategy I wanted to highlight were our Senior Microcommunities. Our Senior Microcommunities are single family residential homes that Illumination Foundation master leases. We then sublet private rooms in those homes to seniors who are 55 plus experiencing homelessness. The rents are traditionally around $500 to $750 depending on the property. So, they actually aren't subsidized. We're just able to find these houses at

slightly below market rates that we can master lease some of them through relationships that we have. But that's compared to the thousand plus dollars for most private room rentals in Orange County.

Jordan Hoiberg:

And what we find is a lot of our seniors that we serve are on fixed income. They don't really have the ability to develop income and as a consequence, their income is going to be set from $1,000 to $2,000. And when you're making $1,000 to $2,000 and your room rental is a thousand dollars, that's your entire paycheck. So, lowering that rent burden to $500 to $750 still could leave those households slightly rent burdened, but is a more feasible number for them to work with. And also allows for quick housing connections in an environment where housing subsidies are very scarce.

Jordan Hoiberg:

And also, one of the benefits with the Senior Microcommunities is that the residents there receive case management services, and we work with nursing students from a local college to assist them. And we believe that the shared living model needed through the service really helps address the social isolation that a lot of our seniors face as well. Next slide.

Jordan Hoiberg:

And this just goes over some general referral information for anybody who's working with people who need Recuperative Care or short term post hospitalization And I think that's it on my end.

Mary Russell:

Thank you so much, Jordan. That was so informative and so interesting. And we do have some time now to pose some questions to our panelists today. And again, we're happy to take questions from the chat or if you'd like to raise a hand, but we'll start with a couple questions that I'll just throw out to Jordan and Koni and Tyler if any of you can weigh in. But I thought this would be an interesting way to just continue this conversation. So, starting off, I know Jordan, you just had a slide on some referral processes, but can you or Koni speak to the referral process, particularly for dual eligible members to be included in the Medical Respite/Recuperative Care, Community Support? And Koni, you should be able to unmute, but feel free to raise your hand if you're having issues.

Jordan Hoiberg:

I'll start with our end then. So, for the Illumination Foundation in particular, we have a 24-hour referral line that's operated by an in-house referral team, and anybody can call that number. So, all our hospital partners, the health care plans we work with, some of the community partners we work with call into that line. Community members themselves who need Recuperative Care services are able to call that referral line. There is clinical documentation that we need to gather to determine eligibility for Recuperative Care. So, if people are calling in and they're not a clinician, we may have to have them connect with their primary care practitioner or another clinician to be able to complete some of the intake documentation we need and to gather the supporting clinical documentation that the referral team needs to determine eligibility.

Jordan Hoiberg:

But at that point, once we have everything we need, we're able to process the referral same day. And the managed care plans have been great at working with us to set up either prioritized access to authorizations or presumptive eligibility periods for Recuperative Care, which allows us to feel really confident in trying to take people into Recuperative Care as quick as possible. But the process for our dual-enrolled members and for just straight Medi-Cal recipients is the same.

Mary Russell:

Got it. That's really interesting. Thanks. Koni, anything you'd like to add from the IEHP perspective?

Konitha Tek:

Yes, so like Jordan mentioned, the referral process is the same both for our Medi-Cal and for our dual members. Providers and specialists, they can submit the referral through our provider portal as well. So, there's definitely a different means of submitting the referral.

Anastasia Dodson:

I wonder if I could just ask a follow-up question on about the referrals as far as the clinical conditions that are most common and even for the referrals, I know Jordan, I think you said it can come from hospital discharge planners perhaps, or individuals themselves, but what are the most common. Who's making the referrals and what are the chronic conditions that folks tend to have?

Jordan Hoiberg:

Yeah, so most of our referrals are still coming directly from hospitals or from health plans. It's still pretty rare that we're getting people just directly calling in for Recuperative Care. Some of the reasons, I think are the barriers I mentioned, to gather the documentation needed for eligibility. As a consequence, I think we see a lot of the conditions that people are traditionally in the hospitals with people who are like post-op surgeries. A lot of people with cellulitis. But we do see now with CalAIM some more people I think with poorly managed chronic health conditions. So, we've had some people with edema, COPD, and I think we even had somebody with severe hypertension recently. So, it has been good to be able to work with some of those poorly managed chronic health conditions too.

Anastasia Dodson:

Thanks so much. Konitha, do you happen to have any information at your fingertips on source of referrals and then the chronic conditions that folks may have or the acute conditions?

Konitha Tek:

Yes, unfortunately I'm provider facing, so I deal mainly working with potential providers getting on board. So, I don't have the clinical aspect, so I'm not able to provide you with that information unfortunately. But I can definitely touch base with some of the clinical managers to get their input and get back to you.

Anastasia Dodson:

Thank you. And sorry to put you on the spot.

Konitha Tek:

Oh, no worries.

Mary Russell:

That's great. The next question here, just sort of thought starter and open to your input here, but what strategies are used to help dual eligible beneficiaries enroll in the Medical Respite/Recuperative Care Community Support? Anything unique or specific for this population?

Konitha Tek:

Yeah, so for IEHP, these services are open to any member who has Medi-Cal eligibility, and we follow the same process. The members may call into the health plan and request

the services. If the member is in an inpatient setting, the review nurse at IHP would assess for these services at discharge.

Mary Russell:

That's great. Thanks for sharing that.

Konitha Tek:

No problem.

Mary Russell:

And I think that both of you have touched on some of these elements throughout your presentations, but any other thoughts on challenges of enrolling dual eligible members into the Medical Respite Community Support, or how can other members learn more about these options available through their plan?

Konitha Tek:

Yes, for IEHP, the barriers are finding facilities that would accept members with behavioral health issues. Also, members of a history of drug abuse that may not be accepted. Those would be our biggest challenges.

Mary Russell:

Jordan, any thoughts from your perspective there?

Jordan Hoiberg:

I don't think I have any particular input on that.

Mary Russell:

Okay. Well, there's some nice kudos in the chat, but other questions from today's group, feel free to raise a hand or drop it into the chat. And Anastasia, welcome any other thoughts from your perspective as well? Fabiola has a question about Recuperative Care providers in Tulare County, and I'm not sure we have anyone on the line who can answer that right now, unless Tyler, you can speak to that, but we can certainly take that back.

Tyler Brennan:

I can provide a response in about 30 seconds, so let's hold onto that one.

Mary Russell:

Okay, we will come back to you. Thanks Tyler. And I see Susan, you have a hand raised, would you like to come off mute?

Susan LaPadula:

Hi Mary, happy holidays. Jordan, Koni, it was a wonderful presentation. I'm interested in the counties specifically where you operate. So that question's for Jordan as well as for Koni, please.

Jordan Hoiberg:

For Illumination Foundation, we operate in Los Angeles County, Orange County, San Bernardino County, and Riverside County.

Mary Russell:

Great, thanks for that question, Susan.

Konitha Tek:

For IEHP, we serve Riverside Counties and San Bernardino Counties.

Mary Russell:

Great, thanks Koni.

Tyler Brennan:

To follow up real quickly on the Recuperative Care in Tulare County, it's currently available through HealthNet, but starting in January, it should be available countywide by all of the local managed care plans.

Mary Russell:

That's great, thank you.

Tyler Brennan:

I'll also post a link to our elections grid in the chat here, so you guys can, or anybody who wants to, can see which services are available in which counties.

Mary Russell:

Great, thanks Tyler. Tyler, a question for you of broader Community Supports, but this is a question from Joan Chang. Are there wait lists for Community Supports, housing transition navigation services, and if so, what can be done to address those wait lists?

Tyler Brennan:

So generally, plans, they must have processes in place to avoid wait lists whenever possible. However, they are running into some provider capacity issues, especially with the housing trio services. And given the sort of complexity of those services and housing navigation in California currently with sort of a lack or dark housing stock and just overall challenges finding affordable housing for folks, there might be some delays relative to how the program should normally be operating. I know that the managed care plans are aware of these issues and are working through them and we're working closely with them and trying to provide that technical assistance to help them navigate and get around those things.

Mary Russell:

Thanks, Tyler. Jordan, did you want to chime in?

Jordan Hoiberg:

Yeah, yeah. We also provide the trio of housing services and it's varied from county to county we operate. And some of them do currently operate wait lists, but I think it's really... PATH, I think did a great job in giving us the funding to be able to initially scale up, but it's been really difficult I think to hire and train and scale the support staff at the rate that's needed to keep up with the inflow of clients. So, to give you an idea, in the IE with IEHP, we increased our referral pipeline from them to a hundred members a month for housing navigation services, which means we're having to onboard three new housing navigation staff a month, continue to hire all the support staff, train them up, come up with all the office space for them. So, hiring three staff a month comes out to 36 new housing navigators a year. So, it is I think been very difficult from the provider's end to be able to adequately scale up to meet that demand while ensuring the quality of service and the scale that we're operating with the housing supports, I think requires the whole organization to kind of scale up and move to the next level as well to meet that kind of demand. So, it's been difficult.

Mary Russell:

Thanks for sharing that perspective. Other questions? I see a few more comments in the chat. Thanks Greg and Pam. This has been really interesting and really helpful. Anastasia, any other thoughts here?

Anastasia Dodson:

I'll just add that, I mean obviously just wonderful, wonderful presentations all around from Tyler, Konitha, Jordan and really showing what's possible through CalAIM and also acknowledging that expansion is not just turning a knob, that it's hiring people and

making sure that got the networks in place, et cetera, but really showing an example of that this can be done and it's making a meaningful difference for people, improving their care and having these examples I think is really helpful and hopeful. So just really so much appreciation for all of you and your work on this and for dual eligibles, I think there were questions last year and earlier this year of how will these programs work for people who are dually eligible and it's working and I'm sure that there's different combinations of people, different medical provider groups, different health plan examples, but it's working. So really thank you so much for the work that you're doing and for sharing it today.

Mary Russell:

Agree. Thank you all so much. We're going to transition here in a moment, but again, as others have questions or think of additional notes they want to share, feel free to drop that into the chat. And at this time, I will ask Derek and Bonnie with DHCS to jump in and take us through the Medi-Cal Continuous Coverage Unwinding updates.

Derek Soiu:

Thank you, Mary. Hello, my name's Derek Soiu, Health Program Specialist with Medi-Cal Eligibility Division within the Department of Health Care Services. Going to provide some brief updates on the Continuous Coverage Unwinding for Medi-Cal. Next slide please.

Derek Soiu:

So, we are about six months in. We're finishing the sixth month of the Unwinding, the 12-month Unwinding period. So, we're about halfway through and DHCS continues to be committed to implementing policies and strategies to help individuals maintain their coverage during this time period and ongoing. We've done so successfully with multiple different waivers and flexibilities that have been offered to us through the federal government, but also through our community partners, ideas on what kind of flexibilities we could possibly implement. And so, we wanted to provide a brief update on some recently approved federal flexibilities that we've adopted that again assist our beneficiaries to maintain their Medi-Cal, their benefits, and then to help the counties in processing their renewals again during this 12-month time period.

Mary Russell:

Derek, can you hear me? You might have frozen a little bit.

Derek Soiu:

… administrative processes at the county level. So, the county with regards to processing medical support enforcement and then also for beneficiaries, they do not need to apply for unconditionally available income during this time period. One of the other flexibilities that's really large and really helpful for our populations is the Stable Income Waiver. So, this is for individuals who have sources of stable income either through social security or retirement benefits where their income doesn't realistically change that drastically from year to year. The counties will be able to process their eligibility during their renewal without having to verify that income again because it's what we consider a stable source of income.

Derek Soiu:

And then we also have some flexibilities with regards to when an individual has to return their renewal packet where the information provided, many times if there's any discrepancies, the counties will have to reach out to the individual and clarify the information. But some of these flexibilities help so that the counties can just take the information as either self-attestation if it meets the requirements and then also if the county has all the information they need, even though they send out a packet, then they won't need the packet returned. So again, just some flexibilities that make it easier for the beneficiaries and easier for the counties. Next slide please.

Derek Soiu:

And then one of the things that really helps the counties is automation of these waivers. They determine eligibility based in the CALSAWs system. So, automation really helps them to just process these a lot easier. And so, we recently published a MEDIL where we're automating some of these waivers so that the counties, they won't have to do the processes manually, but they'll be automatically applied. So that's very helpful for everybody involved. And then just wanted to let everybody know during this time period, counties are processing renewals on a month-to-month basis. And they're currently working all outstanding renewals during this time period. And DHCS is currently focused on helping counties to address all the outstanding renewals at this time period and to make sure that they complete them within their 12-month unwinding period.

Derek Soiu:

As we continue to work with them on this through the rest of the Unwinding, we're also going to be focusing on the policy and what decisions need to be made to help counties transition out of the Unwinding. We have a lot of these flexibilities that they have now, but they're going to have to go back to what we call normal business

operations. So, we'll be focusing on that as we move through towards the end of the Unwinding. Of course, outreach is important, a continued outreach to beneficiaries. We still have great many that have their renewal upcoming. So, I'm going to turn it over to Bonnie who's going to talk about our continued outreach to our beneficiaries. Go ahead, Bonnie.

Bonnie Tran:

Hello, my name is Bonnie Tran with the Department of Health Care Services, and I will be presenting on outreach and also the resources help that we have available. Next slide.

Bonnie Tran:

So, we currently have over 4,000 people who are signed up to be DHCS Coverage Ambassadors to help us spread the word on the Continuous Coverage Unwinding efforts. If you have not signed up, we highly recommend that you join in order to receive the latest updates as well as have access to all of the resources that are available. We are also holding webinars for ambassadors every other month, and we are also sending out emails every two weeks with updates to include any new outreach materials as well as upcoming webinar information. Next slide.

Bonnie Tran:

So, this is our Keep Your Community Covered Resources Hub. We launched this hub in order to support the collaboration in this effort. It's a one-stop shop to download and share the latest communication resources. The resources were created based on feedback from navigators, ambassadors as well as community partners. The hub is updated regularly with the latest and ready to share resources in all of the 19 threshold languages. There are sections for each language, so you can scroll down and there are tabs in each section so you can download whichever resources that you wish. Next slide.

Bonnie Tran:

These are just some of the social media graphics that we have. There is a tab for social media graphics that you can directly share from the Resources hub on your channels. You can also download the graphics if you don't want to share from the Resources hub. It also has a company post copy, so you can copy and paste that when you share the social media graphic. And just want to note that the sharing function is only operational for English and Spanish, and this is to avoid any translation losing integrity because some of the languages read different directions and it may not show up correctly. So, we only have this available in English and Spanish for the sharing function. Next slide.

Bonnie Tran:

These are some of the print materials that we have. There are customizable flyers and posters and palm cards that are available in 19 languages. The customizable flyers have a section where you can add a logo and your contact information where you can save it and then you can print it out that way or share on your platform as well. Next slide.

Bonnie Tran:

We do have videos that are available. So, these are some of the videos that we have are detailed how to videos explaining step-by-step renewal processes. This is for use in lobbies as well as waiting rooms. You can just have it playing on a screen there. We also have short videos that are made for social media. This includes six-second videos as well as one-minute videos. All of these videos are available in all the 19 languages. These are also available on our YouTube channel. So, you can either download them and share them on your own platforms or you can use the link from our YouTube to share these videos. Next slide.

Bonnie Tran:

And these are just some of the tailored resources that we have. We have outreach materials that are for in-home supportive services, managed care plans, providers, schools, and families, and also for older Californians about Medi-Cal. These all include key messages as well as frequently asked questions that you can use. There's customizable flyers as well as social media posts that you can use. So, you can download whatever resources that you would like to share with the population that you wish to share with. Next slide.

Bonnie Tran:

And these are just some pages that we have to bookmark. So, the first link is keeping your community covered. This is where you can sign up to be a Coverage Ambassador. The link after that is the Resources hub. So, this is where you can click to download any of the resources that we have available. And we also have two medical member facing pages, and these are pages that our outreach materials are linked to. And you can also share this with medical members. This is where they can click, and they can find frequently asked questions if they have questions about what they need to do when they get a renewal or things like that. They can find that information on these pages. Next slide. And so that is the end of my presentation. We can go into any questions that we have.

Mary Russell:

Thanks so much, Bonnie. Thank you, Derek. Yeah, happy to open it for questions now, either in the chat or feel free to raise a hand. Thanks for these updates. Okay. Not seeing any for now, but of course feel free to continue to use the chat if anyone has a question they'd like to pose for Derek or Bonnie. And Anastasia, I think I will transition to you for the next slide to close us out here and talk about our next meeting in 2024.

Anastasia Dodson:

Thank you so much Mary and thank you Derek and Bonnie. I'm really pleased that we had such great participation today, such diversity of presenters and topics and also so many people dialing in. So, this particular workgroup is a public workgroup open to everyone, and it meets quarterly. Our next meeting will be, as you can see on this screen February 22nd, and we want to continue to have this type of meeting format where we're giving updates on what's happening with enrollment transitions redeterminations, but then also looking at practical, operational, what's the result of these CalAIM policies. There's other stakeholder meetings that are also going on around the ICF/DD transition as well. But again, we'll try to keep this format where we're looking ahead and also looking at right now the things that are working well and things that we can improve. So, thank you so much for joining the meeting. And yes, happy holidays and we just really appreciate your partnership. Thank you so much.

Mary Russell:

Thanks everyone. Take care.