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CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

MEETING TRANSCRIPT

February MLTSS AND DUALS STAKEHOLDER WORKGROUP

Date:	February 22, 2024
Time:	10 a.m. – 12 p.m.
Number of Speakers:	12
Duration:	1 hour 44 minutes

Speakers:

- Cassidy Acosta
- Anastasia Dodson
- Stephanie Conde
- Sean Barber
- Lindsey Wilson
- Derek Soiu
- Lindsey Baldwin
- Candace Anderson
- Kerry Branick
- Gretchen Nye
- Jack Dailey
- Alfie Gonzaga
- Emily Schermerhorn

TRANSCRIPT:

Cassidy Acosta:

Good morning and welcome to today's CalAIM MLTSS and Duals Integration Workgroup. We're going to give it just a second as we let folks enter in from the waiting room and then we'll go ahead and get started. All right. We have some great presenters with us today, including Anastasia Dodson, the Deputy Director in the Office of Medicare Innovation and Integration at DHCS, Stephanie Conde from the Managed Care Operations Division at DHCS. Sean Barber from the Managed Care Quality and Monitoring Division at DHCS, and Derek Soiu with the Medi-Cal Eligibility Division at DHCS. We also have some guest presenters including Lindsey Baldwin and Candace Anderson from CMS, the Centers of Medicare and Medicaid Services, Alfie Gonzaga from San Diego County's Health and Human Services Agency, Emily Schermerhorn with Blue Shield of California, and Jack Dailey with the Legal Aid Society of San Diego. A few meeting management items to note before we begin.

Cassidy Acosta:

All participants will be on mute during the presentation. And as a reminder, the monthly MLTSS and Duals Integration work groups are designed to provide stakeholders with the opportunity to ask questions. We ask that the plans that join these calls hold their questions for the other multiple work group venues that they have with the department throughout the month. Please feel free to submit any questions that you have for the speakers via chat. During the discussion, if you would like to ask a question and or provide comments and feedback, please use the raise hand function and we will come around and unmute you. The PowerPoint slides and all the 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 would like to take a moment to now ask you to add your organization's name to your Zoom name so that it appears your name dash organization. Click on the participant's icon at the bottom of the window, hover over your name in the participants list on the right side. Click more and then select rename from the dropdown menu. Enter your name and add your organization as you would like it to appear.

Cassidy Acosta:

We'll go to the next slide, and we'll go through our agenda for this afternoon. We're going to begin today's meeting with an update on the 2024 transitions, including the Medi-Medi Plan expansion and the Medi-Cal Managed Care Plan transition. After that, we'll hear a brief update on the Continuous Coverage Unwinding, and then next we'll hear an update on Medicare enrollment data for dual eligible members. After this, there will be an update on the 2024 and 2025 Dual Eligible Special Needs Plans, or also known as D-SNP Policy Guide. And then following that we're going to get into our spotlight presentation, and this will be on the Medicare Behavioral Health changes for 2024. This is going to include an overview from DHCS and a presentation from CMS, San Diego County, Blue Shield of California and the Legal Aid Society of San Diego. After the spotlight, we will have dedicated time for discussion with the panel of presenters. And the behavioral health

presentation will begin today around 10:45 AM. We'll end today's work group with some information on upcoming meetings. And I think that's our agenda for today. I'll pass it over to Anastasia to walk through the work group purpose and structure.

Anastasia Dodson:

Great. Thank you so much, Cassidy, and really pleased to say hello to everyone today. We've had a number of these meetings, and we try to focus on topics that are relevant and cross-cutting. And today is definitely the case with behavioral health for people who have Medicare, either broadly Medicare only or people who have both Medicare and Medi-Cal and are dually eligible. We really appreciate the collaboration that this meeting provides in having consumers, advocates, providers, health plans and experts in the field. Again, we'll continue to have these meetings quarterly based on key topics and we do want to allow plenty of time for discussion. Okay. With that we'll go to the next slide. And I think I'm handing it off to Stephanie Conde, is that right?

Cassidy Acosta:

Actually, the first one will be on you, Anastasia.

Anastasia Dodson:

Oh, first one on me. Okay. Thanks, Cassidy. We will talk very briefly about the 2024 Medi-Medi Plan expansion. That's the next slide, and we can keep going to the next slide. As you all know, we did expand the availability for voluntary enrollment of Medi-Medi Plans, which are a combination of Medicare D-SNP and Medi-Cal Managed Care Plans operated by the same organization. Prior to 2024, these types of plans were available in the large Southern California counties, plus San Mateo and Santa Clara counties. And now in 2024, those plans are also available in Fresno, Kings, Madera, Sacramento and Tulare counties. We have been having regular calls with health plans and advocates to make sure that in those expansion counties that everything is going okay. And there are some remaining kind of topics of conversation that we're having in Sacramento County. But so far, as far as the other counties, we're not hearing anything as far as concerns. And we're pleased that enrollment has continued to grow. And even in the case of Sacramento County, we're meeting regularly and continuing to have good dialogue with all parties there. We're paying close attention to this.

Anastasia Dodson:

It's a high priority for the department and of course we'll continue to work on this as we look ahead to 2026 when these Medi-Medi Plans will be statewide. Next slide. Okay. And now I think we transition to Stephanie, right?

Stephanie Conde:

Yeah, good morning, everyone. This is Stephanie Conde with Managed Care Operations Division. I'm going to provide a brief update on our 2024 transition. Next slide please. Some of this is just a recap of some previous presentations, but as a reminder, the scale, approximately 1.2 million members were identified to transition to a new managed care plan on January 1st, 2024. In addition, Kaiser became a prime contract for approximately

800,000 members. This did take place in 21 counties with 14 unique managed care plans. To break that down a little bit, 250,000 members received an enrollment packet to choose a managed care plan because of the county plan model changes. Sorry. 250,000 members received an enrollment packet to choose a plan, and this was due to some of the plan changes in those counties. When members receive an enrollment packet, is because there's more than one plan option in that county. That did impact five counties.

Stephanie Conde:

There were 400,000 members transitioned because of our county plan model change where we transitioned some counties to COHS counties or a single plan county. That impacted 15 counties. We had 500,000 members transitioned from Health Net to Molina in Los Angeles County. And then as noted above, we had 800,000 members transition to Kaiser as a prime contract and that impacted 27 counties. Just as a reminder, a prime managed care plan is a managed care plan that directly contracts with the department to provide coverage services to members within the county or counties specified in their contract. Next slide please. Going through some of our operational readiness, the department required managed care plans to submit approximately 250 operational readiness deliverables corresponding to our managed care plan contract. For example, deliverables included quality improvement utilization, management, network adequacy, delegation oversight, continued care, population health management, enhanced care management (ECM), and community supports.

Stephanie Conde:

We did conduct the deep dive assessments for five managed care plans identified as high priority due to the size and complexity of their expansion into additional counties. Member engagement, there was a lot of member engagement going on including talking with our managed care plans, providers, advocacy groups. Pre-transition, the department utilized various strategies for engaging members, raising awareness about the 2024 transition and their rights and providing contact information. We did this by sending letters, we had call campaigns, text message campaigns, member focused web resources, which included an online interactive map where a member can go in and choose the county and see what notice or changes were impacting them in their county. And then we did send Friday newsletters as well. So post-transition. We are still in the middle of analyzing member call campaign data, grievance appeals, and we send a stakeholder survey for feedback to identify and address any member challenges.

Stephanie Conde:

And then ongoing. The department is collaborating with our managed care plan partners and advocates to ensure effective communication and resolution for any of those identified transition issues. And as a quick reminder, some counties that were impacted are matching plan counties. What this means is if a member was impacted by an exiting plan and they had a Medicare plan that matched a Medi-Cal plan, they were impacted, and they did receive a notice letting them know about the impact. The team will also pop in to the chat box, a link to our matching plan county. But I did want to note that for today's call and I will actually transition this over to Sean for our monitoring approach.

Sean Barber:

Thanks, Steph. Good morning, everyone. Sean Barber, Managed Care and Networks and Access Branch here at the Managed Care Quality and Monitoring Division, and I'm going to talk a little bit about the 2024 Managed Care Plan Transition Monitoring Approach. I'll start with just noting that the Department deployed enhanced protections for members that were transitioning as a result of the 2024 managed care plan transition. The enhanced protections, and really all of the policy governing the 2024 managed care plan transition exists in the Managed Care Plan Transition Policy Guide. Highlighting a couple of the enhanced protections that we put in place were one, we created a robust plan to plan data sharing operation requiring our previous plan partners to share a number of different data files, I think it was about 14 data files on a weekly basis, with their receiving managed care plan partners. And we also deployed enhanced continuity of care protections for the transition, one of which required all of the receiving managed care plan partners to conduct proactive outreach to out-of-network providers that qualify for continuity of care rather than putting the burden on the member to request continuity of care for those providers.

Sean Barber:

How did we monitor the transition? We took a multi-pronged approach. You'll see up on the screen that we've highlighted three of the main components of that approach. One is a managed care plan survey where we require our plan partners to report on approximately 45 to 50 data elements on a bi-weekly basis. That monitoring started in November, will continue bi-weekly through the end of February, shift to monthly in March, and then quarterly thereafter through the end of the year. The Department reserves the right to adjust the reporting schedule for the managed care plan survey in response to any themes that we're seeing in the transition. Right now, things are looking good and we're going to continue on the same path that you see up on the screen there. In addition to the managed care plan data that we're receiving, we're also conducting a monthly stakeholder survey where we send a number of questions out to critical stakeholder partners soliciting their feedback on the transition.

Sean Barber:

We take those responses and perform due diligence to make sure that we're understanding the concerns raised and conduct follow up with either stakeholders, managed care plan partners or other organizations as necessary to make sure we're understanding issues and getting ahead of them to the extent that we can. The plan to plan data sharing operation that I described earlier, the department has taken a keen eye on monitoring that data sharing operation requiring all of our plan partners to share copies of the data files that are going to the receiving managed care plan partners. They're also sending them to the department so that we can make sure that the data sharing operation is going appropriately. In addition to that, we have questions on our survey that ask our receiving plan partners to elevate any issues that they're seeing with the data sharing. Really, the data sharing underpins the transition. We have a very strong focus on that in the later part of 2023, make sure our receiving plan partners have the data they need. Alright. And that rounds out my presentation on the 2024 Managed Care

Plan Transition Monitoring Approach. And I think we're going to pause for questions on anything we've discussed thus far.

Cassidy Acosta:

Thanks so much Sean and Stephanie and Anastasia for your presentations. And yes, we will now open it up for some questions. We have a few in the chat but continue to add them in there. Feel free to raise your hand and we can make sure that you can come off mute. The first question for Anastasia and Stephanie. For Medi-Medi Plans, can FQHCs bill their wrap and is an EOMB required?

Anastasia Dodson:

I'll have to either just in case we have some of the right technical experts from DHCS on or the health plans, they can feel free to chime in, but otherwise we'll take that one back.

Cassidy Acosta:

Sounds great. And then we have a question in the chat from Lorraine. And Stephanie, this one might be for you, but I think that there might be some other venues that we might want to suggest here. But their question is that they're a DME provider to Medi-Cal Children and are not contracted with most medical groups. What can they do to continue services?

Sean Barber:

I think that one is likely actually me, but Steph, let me know if you have a different opinion. We are a durable medical equipment provider to Medi-Cal Children and are not contracted with most medical groups. What can we do to continue services? Lorraine, would you mind hopping off mute and providing a little bit more context around your question? I think one thing I'm interested in understanding is when you say medical groups, my brain immediately goes to, you're seeing children today, but you're not contracted with some potential sub delegate entities that may be delegated risk by our managed care plan partners and have questions about how things might look for you post-transition.

Lorraine Rivas:

Yes. Thank you, Sean, for taking my question. We service G-tube feeding and G-tubes. We provide the children at a facility, and we provide them with the actual G-tube itself and the extension sets. And I was in contact with the owner, and she did make me aware of this transition, but I guess apparently there's a 30-day transition in order for us to continue services. But what can we do since most medical groups or IPAs or what have you have their doors closed to new providers? What can we do to continue service so we're not interrupting what the children need?

Sean Barber:

Thank you. There are durable medical equipment protections in the 2024 Managed Care Plan Transition Policy Guide. I'm sorry, I'm not intimately familiar with that specific

protection right now, but I think perhaps taking a look at the guide and seeing whether or not durable medical equipment providers for the population that you are serving today are qualified for continuity of care for provider would be the appropriate path forward. And apologies that I don't have the answer right here on the call, but essentially when it comes to continuity of care for provider, if the members in a special populations that receiving managed care plan should have reached out to you already, if you're an eligible provider type or if the members that you're serving are not, then the member authorized representative or the provider themselves can reach out to the receiving managed care plan partner and solicit and submit a request for continuity of care provider.

Sean Barber:

I'm going to try and pull up the policy guide right now while we're on the call and perhaps we can go to the next question, unless you have any additional anything to add, Lorraine. And I'll circle back and answer via the chats or confirm whether or not durable medical equipment providers are authorized for continuity care for a provider.

Cassidy Acosta:

Sean. I think we have time for one more question and then we'll move on to the next section. We have a question from Janet in the chat. When will the Medi-Cal Managed Care Enrollment Report for January 2024 be posted to the open data portal?

Stephanie Conde:

Hi, I'll follow up with the internal teams that post the report, Janet, and so we'll have to take that one back and let you know when the ETA is.

Cassidy Acosta:

Thanks, Stephanie. All right, I think we-

Sean Barber:

Real quick, I do have the answer on durable medical equipment. Sorry about that. I pulled up the policy guide. They're not eligible for continuity of care provider, but we do have protections for our members through continuity of care for services, which requires our receiving managed care plan partners to allow members to keep their existing durable medical equipment rentals and medical supplies from their existing DME providers without further authorization for six months after the transition and until reassessment and dependent on the new equipment or supplies being already in possession of the member and ready for use. I might not answer your contracting question, but the members are protected in terms of continuity care for services for the durable medical equipment. And in general, if you're interested in securing a contract with managed care plans that are now serving your members, we recommend that you reach out to the contracting department at that receiving managed care plan.

Cassidy Acosta:

Thanks so much, Sean.

Anastasia Dodson:

Cassidy, I see a question from Rick about conscious sedation dentistry and I'll just flag that we have been getting other questions on that same theme and we are going to be meeting with DHCS to talk about what TA we can provide for duals related to this topic and Regional Centers and other related parties. Thanks.

Cassidy Acosta:

Thanks, Anastasia. All right, I think we're right on time. We can move to the next slide. And Derek, I'll turn it over to you for some updates about the Continuous Coverage Unwinding.

Derek Soiu:

Thank you. Hello, everybody. My name is Derek Soiu. I'm a Health Program Specialist working within the Medi-Cal Eligibility Division. I have some of the Continuous Coverage Unwinding updates for everybody. We are coming close to the end of the Continuous Coverage Unwinding. It's scheduled to end May 31st, 2024. Just a couple more months before the end of the Continuous Coverage Unwinding. For now, we just have some updates with regards to several of the initiatives we've been working on during this time period. The first one that we wanted to share is the extension of Medi-Cal unwinding waivers. On December 18th of last year, the Centers for Medicare and Medicaid Services released an informational bulletin regarding maintaining coverage under Medi-Cal for children. This bulletin though did include an extension of all unwinding waivers and flexibilities through December 31st, 2024, so to the end of this year. Throughout the Continuous Coverage Unwinding period, we've had multiple waivers and flexibilities in place to help individuals maintain their coverage to ease the administrative burden of doing the renewal process for the beneficiary for the Medi-Cal member and for the counties in processing.

Derek Soiu:

These flexibilities have been very helpful to streamline the processes, make them a little bit easier during this time period. And so, the Federal Government has extended the use of these waivers until the end of the year. DHCS did publish by means of its Medi-Cal Eligibility Division Informational Letter, which I'll put in the chat, just the policy direction to the counties on the extension of these waivers till December 31st, 2024. You could go ahead and take a look at that. We're still waiting to hear from CMS on more information with regards to this extension and how it'll look, seeing how it does extend past the end of the unwinding. The next one that we want to talk about is the dis-enrollment survey. During the unwinding, this is when counties have been conducting renewals for all the Medi-Cal members. Individuals have been determined eligible continuing for Medi-Cal, or some have been discontinued for Medi-Cal.

Derek Soiu:

And one of the larger reasons people are concerned about this enrollments is due to procedural dis-enrollments. And this is when an individual is disenrolled, not for an

eligibility criteria like income or residency, but because they didn't complete the renewal process. Maybe they didn't return the renewal packet, they didn't provide the county with necessary information to complete the renewal. DHCS partnered with the California Healthcare Foundation and their grantee, SSRS, to conduct a rolling monthly survey of people who have been procedurally disenrolled from Medi-Cal during the Continuous Coverage Unwinding period. The purpose of this survey is first to develop a better understanding of renewal barriers and reasons for the procedural disenrollments to help DHCS inform real-time changes to help people keep coverage. The second purpose of the disenrollment survey, because it is being extended to all of the individuals that have been procedurally terminated, it kind of queues up to them like, "Hey, you've been disenrolled from Medi-Cal, you need to take action so that you could get back on it."

Derek Soiu:

And if people take that action, if they return the renewal packet, return the information, contact the county within 90 days past being disenrolled, they can be enrolled back into Medi-Cal if they're eligible as if there were no break in coverage. This survey, I'm going to post a link to the survey and the survey results in the chat. You can take a look at it, but particularly with regards to the information we've received from the survey, DHCS is taking multiple actions to help address, maybe help make it more clear to the community about where they can go to get help when they have questions about their renewal packet. We're also looking to outreach to communities that may have higher procedural termination rates. More people are determined ineligible to a procedural reason. We're going to be increasing outreach in those areas. And so, if you're curious as to take a look, that is one of the activities that we've been engaged in to help again, try to understand and help individuals maintain coverage during this time period.

Derek Soiu:

The next update I want to provide is with regards to the unwinding data. If you have been keeping track of the unwinding throughout this time period, DHCS is required to submit regular monthly reports to the Federal Government with regards to the unwinding, but we also publish a data dashboard that helps provide clarity on all the actions taken during the unwinding. That's application enrollment and renewal data. And it is also broken down by county to help not only our partners to have a better understanding of how the unwinding is going in their county, but again, to help with the reporting requirements for the Federal Government and help DHCS keep track of the progress of the unwinding. I'll put a link to that as well. One of the main updates that we wanted to share is that the data that we post is on a month-to-month basis.

Derek Soiu:

But because of what I talked about earlier where individuals who may be dis-enrolled, they have 90 days to submit the information and get back onto Medi-Cal, because there is that three-month lag, we have actually updated some of the data sets to include what the renewals look like for that month three months later. When we reported on the June renewals, that was a point in time what it looked like at June. But then in August, October, early October, we got the data on individuals who may have turned in their

renewal packet in June, July, August and September, and how that affected the June renewals. We updated the dataset to include that information. And so, we just wanted to provide that update to everybody that the updated information is there. And we could go to the next slide. And then one of the other efforts we wanted to share is with regards to our outreach. I'm sure many individuals here are part of the DHCS Coverage Ambassadors group. So, the Coverage Ambassadors is individuals and organizations statewide that help assist in spreading the message about the unwinding throughout California. And so, as we are coming close to the end of the unwinding, we have refreshed our outreach to pivot the messaging.

Derek Soiu:

So, our messaging before was, the unwinding period's going to begin. Renewals are going to start. You need to turn in your information, you may be contacted by the county, make sure that you work with the county to complete your renewal. The shift in the outreach now is to just let people know that the annual re-determination process is an ongoing thing. It is annual. Individuals need to renew their Medi-Cal on a year-to-year basis. So, the shift is to help provide that messaging is like, "Yes, you went through your renewal during the unwinding, but again, it's a year-to-year basis and you want to be mindful of the timing of that as well."

Derek Soiu:

To help with that, we've updated our messaging. We're developing new ads that will prepare people for the return to annual Medi-Cal renewals. The ads will run on digital platforms through television, radio, print media, and out-of-home platforms. The content will be distributed through existing partnerships, including those with Univision and Telemundo for Spanish language television.

Derek Soiu:

And we've developed a new partnership with Crossings TV for Mandarin, Cantonese, Vietnamese, Punjabi, Korean and Hmong programming. Select videos will also be updated to include voiceovers to increase accessibility and exposure to more audiences such as the visually impaired and those who cannot read. And then voiceover videos will also be available in all the threshold languages.

Derek Soiu:

We'll be providing new awareness and renewal outreach materials on the Keep Your Community Covered Resources Hub that will be available for download by our coverage ambassadors. And again, these tools will be available in all 19 threshold languages. And we encourage our coverage ambassadors to take advantage of the updated resources.

Derek Soiu:

And like I mentioned before, part of that survey was to identify individuals, or communities, or locations within California that have higher procedural termination rates. So, part of the outreach will be a focus on those areas to help keep individuals up to date and informed about what's going on with Medi-Cal in those areas. And next slide. I think

those were all the updates I had for the group, so I can take a few questions, see if there's any in the chat as well.

Cassidy Acosta:

We do. Thank you so much, Derek. We've got two questions in the chat from Tatiana. The first is, "Are county workers trained to answer Medi-Cal unwinding questions and other eligibility questions, even those with SSI and Medi-Cal?"

Derek Soiu:

Yes, they are. We actually have a bi-monthly meeting with all the counties. So, all the counties meet together with DHCS twice a month. We go over these kinds of updates. We provide refresher renewal trainings, so information to them about the renewal process and whatnot. And any changes like the updates that we provided today, we keep the county up to date and aware of all this twice a month, those are all the counties.

Derek Soiu:

We also have twice a month a specialized work group with the counties. So, this is just a subset where we can identify any of those additional types of trainings that may be good for all the counties and then to identify what other kind of information the counties need to help them to be successful during the unwinding. So yes, we do.

Cassidy Acosta:

Thanks so much. And then the second question is, "Once renewals are updated in the Medi-Cal system, how long does it take for the Medicare Master File to be updated?"

Derek Soiu:

Unfortunately, I don't have an answer for that. I don't deal with the Medicare master files. I don't know if anybody on... works with that, but unfortunately, I do not. So, I don't have any information for that.

Cassidy Acosta:

Sounds good. We can take that back. I'm not seeing any other questions in the chat, or any hands raised. So, I think Derek, thank you so much and we can move to the next slide and Anastasia, we'll have you jump on in and talk a little bit more about the Medicare enrollment data for duals.

Anastasia Dodson:

Sounds good, Cassidy. Thank you. All right, next slide. So, this is a slide we've shown before. This just gives an overview of the Medicare delivery systems for people who are dually eligible and there's original Medicare and then different types of Medicare Advantage Plans, including, we call them Regular Medicare Advantage and then D-SNPs, different types of D-SNPs. Next slide.

Anastasia Dodson:

As well as we have the SCAN FIDE SNP, we have PACE organizations and there are other special needs plans, C-SNPs and I-SNPs. Again, these are same slides we've shown before and we have this material posted on our website. So, let's go to the next slide.

So, this is the pie chart that we update quarterly, and we are showing as of October 2023 that shows where people who are dually eligible for Medicare and Medi-Cal, where they are enrolled in their Medicare delivery system. So, we see that consistent with prior quarters, a little over half are in original Medicare and then about 18% are in a regular Medicare Advantage Plan. 14% are in Medi-Medi Plans. Those are also known as Exclusively Aligned Enrollment D-SNPs.

Anastasia Dodson:

And then there's still a fair number of folks who are in the Non-EAE D-SNPs. And then other Special Needs Plans and SCAN and PACE. So, the Medi-Medi Plans are at about 14% of Dual Eligible Population are enrolled in Medi-Medi Plans. And then as we're going to see in the next slide, that number has grown, and we expect it to continue to grow. All right, next slide.

Anastasia Dodson:

Oops. Okay. And this slide just shows over time how the enrollment is growing in different types of Medicare Advantage Plans. And we sort of put them all together here. You can see regular MA's at the bottom and then Medi-Medi Plans and so on. So, the numbers continue to grow of course because the population is growing, but also just generally nationwide, statewide, there's a continued trend toward enrollment in different types of Medicare Advantage Plans. Next slide.

Anastasia Dodson:

And then here is the number for January 2024. As far as Medi-Medi Plans, the other slides we were looking at were October of 2023. And we're still working on running the right process in our systems to have that pie chart for 2024. But in pulling just the Medi-Medi Plans enrollment, we see that that's grown. It was around 240,000 or so in 2023, and now it's grown to 293,000 in January.

Anastasia Dodson:

And again, that's related to the expansion of the availability of Medi-Medi Plans in five additional counties. And some people who were already enrolled with Medicare Advantage Plans in those counties, they just seamlessly transitioned over to the Medi-Medi Plans. And then there also is new enrollment. All right, next slide.

Anastasia Dodson:

And then we'll go to the D-SNP Policy Guide. And then I know we're excited to get to our behavioral health section in just a minute. So, as you may know, D-SNPs, which are a type of Medicare Advantage Plan that are just for Dual Eligibles. In California we have policies regarding that D-SNPs must follow. And some of those policies are in the

contract that we have with the D-SNPs that contract is called a SMAC. And the other rules and regulations that we have for D-SNPs are in what we call the D-SNP Policy Guide. And so, we post the Policy Guide, and we post the contract, the SMAC, on our website, and we release chapters and updates as needed.

Anastasia Dodson:

So, the latest updates we have released for 2024, which is the current year, is the Medicare Continuity of Care requirements, so when people newly join a Medi-Medi Plan. In some cases, they're able to continue seeing their other providers that they had been working with, even if the providers are not contracted with the Medi-Medi Plan. We've also updated the quality metrics and reporting requirements and then updated the care coordination requirements for 2024. For 2025, which in the Medicare Advantage structure, there's a much earlier timeframe for when new policies need to be rolled out.

Anastasia Dodson:

In December of 2023, we released the care coordination requirements for D-SNPs for 2025. And those, we did not have significant changes there. We continue to see new improvements and fine-tuning in the reporting that we're getting from the health plans. So, we did major changes for 2024. So, 2025 is just our year to make sure that all the plans are meeting those requirements and continue improving our monitoring and reporting. Next slide.

Anastasia Dodson:

So, for the 2025 care coordination guide, again, this provides specifics for the EAE D-SNPs and the Non-EAE, D-SNPs, risk stratification, risk assessments, individual care plans, interdisciplinary care teams. These are all topics that CMS Medicare also requires D-SNPs to be held accountable for and to have a model of care for. But DHCS has some additional requirements and that those additional requirements include that the D-SNPs provide the equivalent of ECM for their members additional requirements around dementia care as well as palliative care. And those topics, again, were included in 2024, we've carried them over for 2025. And then we do have some additional information on caregiver services within the context of health risk assessments for 2025. Next slide.

Anastasia Dodson:

Here is the State Medicaid Agency Contract update. So, we are working on the 2025 State Medicaid Agency Contract, SMAC with the D-SNP. We do share those drafts with key stakeholders, and we work collaboratively to address concerns. I'm again, glad that someone, Rick had raised the dental issue. We continuing to... We recognize that access and coordination of dental care can be an issue not just for people who are in Original Medicare, but also in any type of Medicare Advantage where there's a supplemental benefit. So, we want to keep looking at that and keep listening to you all to say what particular challenges are coming up and then how can we have an overall approach that improves coordination and access. So definitely dental we're continuing to work on.

Anastasia Dodson:

At any rate, so, we will be finalizing the 2025 SMAC, and having the plan signed in June of 2024. And then we'll post on our website. I think that's... Okay. Next slide. So, I think that's it before we transition over to the behavioral health section.

Cassidy Acosta:

Yeah, I think we're ready to switch over to CMS for their presentation. We can move to the next slide.

Anastasia Dodson:

Cassidy, do we have any questions on the SMAC and D-SNP?

Cassidy Acosta:

We haven't gotten any in the chat.

Anastasia Dodson:

Okay. And thanks Tatiana about the marketing. Yes, another issue that we want to keep our eye on and thank you for the link about how people can report any questionable MA enrollment issues. Thank you.

Cassidy Acosta:

Great. So, Lindsey and Candace, we'll turn it over to you. Just a quick flag for the group today. We do want to make sure that we've got a lively discussion, so please don't hesitate to put questions in the chat and raise your hands if you have any questions that you'd like to have answered by our guest presenters today. So, Lindsey, I'll turn it over to you. Thanks.

Lindsey Baldwin:

Hey, thanks Cassidy. So, hi everyone. Thank you for having me on today. I work in the Center for Medicare, and I'm also joined today by colleagues of mine in the CMS Duals office. I'm going to walk through just a brief update on policies in the behavioral health space that were included in the calendar year, 2024 Medicare Physician Fee Schedule Final Rule. So next slide, please. Okay, this is just a disclaimer, we can jump to the next one.

Lindsey Baldwin:

Okay. So first up is the new Medicare benefit for Marriage and Family Therapists or MFTs and Mental Health Counselors, MHCs. These new benefits under Medicare were authorized by section 4121 of the Consolidated Appropriations Act, 2023, which provides for Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of MFTs and MHCs, allowing these additional practitioner types to be able to enroll with Medicare and bill independently for their services.

Lindsey Baldwin:

One thing to flag is that we also proposed and finalized to allow addiction counselors or drug and alcohol counselors to meet all of the applicable requirements to enroll in Medicare as MHCs. We were excited to have that additional piece here beyond what was in the legislation. MFTs and MHCs were able to begin submitting Medicare enrollment applications after the 2024 Physician Fee Schedule Final Rule was issued back in November. And they're able to bill Medicare for services that are furnished on or after January 1st, 2024.

Lindsey Baldwin:

The statutory benefit for enrolled MFTs and MHCs authorizes them to bill for any services that are furnished for the diagnosis or treatment of mental illnesses and how it was phrased in the legislation and the statute. And that can include substance use disorders. We also made updates to coding under the PFS that describes what we call Behavioral Health Integration, which is Behavioral Healthcare often integrated into a primary care setting to make sure that MFTs and MHCs would be able to bill for those services.

Lindsey Baldwin:

But most of the coding that we use is not prescriptive about what practitioner type has to furnish that service. So, most of the codes that are existing worked as they were. Okay. Next slide please.

Lindsey Baldwin:

Okay, so next is the Psychotherapy for Crisis Services. These updates were based on another section of the Consolidated Appropriations Act, section 4123, which required the secretary to establish new codes under the Physician Fee Schedule for psychotherapy for crisis services that are furnished in certain sites of service, which we defined really broadly as any place of service that is assigned a non-facility rate under the PFS other than the office setting. So that can include the patient's home or a mobile unit. It also includes things like homeless shelter and these codes also took effect on January 1st, 2024.

Lindsey Baldwin:

The CAA specified that these new psychotherapy for crisis billing codes would pay at 150% of the rate that is assigned to the existing CPT codes describing psychotherapy for crisis. Okay, next slide please.

Lindsey Baldwin:

So just a couple of other updates that were included in this final rule. We also finalized an increase in the payment for timed behavioral health services under the PFS. Specifically, we finalized an adjustment to the worker we use for all of the psychotherapy codes that are payable under the PFS. It was a 19.1% increase, which we are implementing over a four-year transition. And then in addition to the psychotherapy codes in response to the public comments we received on the proposed rule, we also finalized applying that increase to psychotherapy codes that are billed along with an evaluation and management visit as well as the HBAI, which is the Health Behavior Assessment and

Intervention codes.

Lindsey Baldwin:

And we stated that we believed those changes will begin to address some of the distortions that have occurred in evaluating time-based behavioral health services over the years. And then lastly, we also finalized a proposal to allow those HBAI services to be billed by clinical social workers, MFTs and MHCs in addition to clinical psychologists who were previously the only practitioner type that could bill for those codes. Okay. Next slide please.

Lindsey Baldwin:

So, these are just some links to the CMS Behavioral Health Strategy, the CY 2024, PS Final Rule and the Fact Sheet that goes along with that rule. I should also flag that there's additionally a page on the CMS website specifically for the new MFT and MHC benefit that has helpful links there about enrollment and billing. So, I can provide that link as well in the chat. Next slide, please. And so that is all for the presentation and we're happy to try to answer any questions folks may have.

Cassidy Acosta:

Fantastic, thank you so much Lindsey. So, we do have a couple of questions in the chat, but we also encourage folks to continue dropping them in. Then also to raise their hand if you'd like to come off mute. So, the first one is from Aziza and their question is, do LPCCs fall under the MHC category?

Lindsey Baldwin:

Yes, Licensed Professional Counselors, Licensed Clinical Professional Counselors, I think I heard an extra C in what was stated there, but the statute identified that professional counselors are included within that definition, that broad umbrella of mental health counselor, so long as they meet all the statutory requirements, which are about education, licensure and clinical supervised experience.

Cassidy Acosta:

Great. Thank you so much.

Anastasia Dodson:

And if I may, I just wanted to offer our sincerest gratitude and thank you to CMS on the Medicare side for making these changes. And I know it was also with Congress and the Biden Administration as a whole, but what a fantastic change this is for Medicare, and we are so happy to be at this moment with you and so grateful to have you on this webinar. Thank you so much. Just had to say that.

Lindsey Baldwin:

Thank you. We're so excited too. I know it was a long time coming, but yes, all credit to the legislation that authorized this.

Cassidy Acosta:

Great. We have another question in the chat from Christine. And the question is, “Is there a gap period that we are allowed to bill Medi-Cal for Medicare eligible services when we are in the process of enrolling the LMFTs and LPCCs?”

Lindsey Baldwin:

That might be one that I call upon my duals colleagues for.

Anastasia Dodson:

Yeah, and we did-

Candice Anderson:

Hi, everyone.

Anastasia Dodson:

Thank you, Candice. I'm just going to say we are going to touch on that in our upcoming slides, but also would welcome your guidance on this as well.

Candice Anderson:

Yes, I was going to bounce it over to you Anastasia, because I want to acknowledge that while CMS has put out guidance to states on how to handle this gap period while providers are enrolling or their applications are working its way through the Medicare system, that there's a couple different mechanisms at play that states can employ. And so that would really be one that we would then hand off to the states to see what the DHCS is guiding.

Anastasia Dodson:

Thanks. Yes, and we will definitely talk about that in the next set of slides.

Cassidy Acosta:

Great. And we do have a couple of other questions in the chat. One is, where can we find information about the changes to the Behavioral Health Integration codes that Lindsey mentioned?

Lindsey Baldwin:

Yeah, the only changes to the codes, we're simply just adding to the code descriptor, these practitioner types. But if you're interested in more information about just those services generally, we do have information on the PFS section of the CMS website on that too under care management. So, I can put that link in the chat as well.

Cassidy Acosta:

Thanks, Lindsey. And we do have another question, and Serina, I might ask you to come

off mute, but the question is, will you provide a resource to any documentation requirements for these services?

Lindsey Baldwin:

And I can just say on that from the Medicare perspective, that we did not establish any particular documentation requirements for billing Medicare for these practitioner types in particular. Just any standard existing rules would apply, but we did not establish anything extra.

Serina Sanchez:

Okay, great. Yeah, I think I was just curious because obviously from a documentation standard, we model majority of our documentation requirements for our service notes specific to DHCS requirements and Medi-Cal. So, we just wanted to see if we're rolling providers to be eligible for reimbursement for Medicare for these services, if there's any changes that we need to make in our documentation requirements to ensure that there'll be reimbursable through Medicare. But it sounds like there are no specific ones currently.

Lindsey Baldwin:

Yeah, there's nothing extra that we finalized. I will say that if you're already familiar with billing Medicare for the services of clinical social workers, the benefit for MFTs and MHCs is nearly identical to the benefit for CSW. So, you could kind of look at that as a model.

Serina Sanchez:

Okay. Is there a link that you could put that in the chat to find that information just so I can compare and make sure we're meeting all the standards?

Lindsey Baldwin:

About documentation specifically?

Serina Sanchez:

Yeah, for the LCSW requirements.

Lindsey Baldwin:

I don't know that there is. Let me look and check.

Serina Sanchez:

Okay, thank you.

Cassidy Acosta:

Thanks so much.

Anastasia Dodson:

One factor... Oh, sorry. I think one thing we also just... the Medicare world and the Medi-

Cal world are both complicated. So, if a member is enrolled in a Medicare Advantage Plan or a D-SNP, then the health plan may have certain requirements that could be separate from, I think what Lindsey is presenting is around original Medicare. Is that right, Lindsey?

Cassidy Acosta:

Yes, absolutely.

Anastasia Dodson:

So that Medicare Advantage might be different.

Lindsey Baldwin:

That's a really great flag that the policies that I work on, and I'm speaking about pertain just to Medicare Fee-for-Service, Original Medicare.

Cassidy Acosta:

Great. And then I know that we have one question from Rick in the chat, “Does this mean UC Davis will accept Medicare in the Department of Psychiatry?” And Anastasia, we wanted to see, since this is a unique situation, if we'd like to take this one back.

Anastasia Dodson:

Yeah. But it's a good question. And Rick, you have really provided really important topics for us to think about over the last couple of years, so I appreciate that and yes, we should find out. And I do think that there'll be a transition period. So, I don't know, Lindsey, if you have thoughts on, do you think it's really a one to two year transition as this kind of rolls out? Or do you think it may be more like six months? Do you have any sense?

Lindsey Baldwin:

I think it's the question about the timeline for how long it takes to get enrolled?

Anastasia Dodson:

Or when might we see maybe a big lift or bump in the number of Medicare enrolled providers in these provider types?

Lindsey Baldwin:

Yeah. I think it's really hard to say, will totally just be dependent, on an individual basis, MFTs and NHCs deciding to enroll and when.

Anastasia Dodson:

Thank you.

Cassidy Acosta:

Great. I think that we have one other question in the chat, but not particularly related to

this topic about the FQHCs. Anastasia, do you want to take now, or would we like to continue on with the DHCS presentation on behavioral health services for duals?

Anastasia Dodson:

Yeah, we'll have to take the FQHC question back, and certainly FQHCs also play into the issue around behavioral health as well. But I don't have the response on that one right now.

Cassidy Acosta:

Great.

Lindsey Baldwin:

I can say that MFT and MHC services are also covered in the FQHC setting under Medicare now as well.

Cassidy Acosta:

Great. All right. No, I'm not seeing any other questions in the chat and no hands raised, so I think that we can go to the next slide and Anastasia, I'll pass it over to you.

Anastasia Dodson:

Okay, great. Thank you, Cassidy. Thank you again, Lindsey and Candice. So pleased to have you on. All right. That was global about Medicare, not specific just to dual members, but let's take a little bit deeper dive for behavioral health for dual eligible members, and I'll say just from the start, this is not going to be comprehensive and there's probably going to be more questions that we won't be able to answer today, but we're working on them. We're having definitely a lot of internal huddles to work on rolling this out on the Medi-Cal side implications here. Next slide.

Anastasia Dodson:

So just as a big picture, dual eligible beneficiaries, they have access to behavioral health services in both systems, the Medicare and the Medi-Cal systems, including mental health and substance use disorder treatment. Of course, Medicare is the primary payer for inpatient and outpatient services and Medi-Cal covers inpatient and outpatient behavioral health but is the payer of last resort. Then on the Medi-Cal side, of course specialty mental health and substance use disorders services are covered through the county, behavioral health agencies. Then non-specialty mental health is through Medi-Cal Managed Care Plans, so I'm sure everybody on the line is familiar, but that's our landscape here in California. Next slide.

Anastasia Dodson:

So, with the 2024 changes on the Medicare side, that includes the licensed marriage and family therapists, licensed professional clinical counselors, also known as mental health counselors. There's a note here of how MHCs are identified as LPCCs in Medi-Cal, and that's pursuant to the California Board of Behavioral Science. So, just a crosswalk there

on terminology. In 2024, Medicare also now covers intensive outpatient services in certain settings.

Anastasia Dodson:

The 2024 changes in Medicare also roll into Medicare Advantage Plans and strengthening requirements around behavioral health for Medicare Advantage Plans, such as looking at networks, having an adequate network of licensed clinical social workers and clinical psychologists, establishing care coordination programs to emphasize coordination of community social behavioral health services, and arrangements with contracted providers to ensure that members have continuity of care. Also, emergency behavioral health services are not subject to prior authorization starting in 2024, and appointment wait time standards apply both for primary care and behavioral health services.

Anastasia Dodson:

So really significant changes across Original Medicare and Medicare Advantage in 2024 for Medicare. Again, we really applaud by the Biden Administration and CMS for taking these wonderful steps and thank you to Congress also for passing these changes, but we just are so supportive of the changes here for 2024. So, we do have a fact sheet published on the DHS website that is oriented to providers and there's a link there and in the chat as well where we are trying to help providers understand what does Medicare cover, how to enroll as a Medicare provider in behavioral health. Then talking about how different ways and strategies to reduce the stigma around getting treatment for mental health and substance use disorder services. These are all ongoing issues that we want to make sure that we're supporting at DHCS, and really partnering with California Department of Aging really for all folks who have Medicare, not just people who are dually eligible, but certainly want to make sure that the care is coordinated for people who are dually eligible. Okay, next slide.

Anastasia Dodson:

So back to the nuts and bolts with the transition of certain provider types to be eligible to be enrolled in Medicare. Again, Medicare is the primary payer. Medi-Cal's the secondary payment there. So just in general, there's coinsurance that Medi-Cal often covers. There are also benefits that are still available in Medi-Cal not yet covered by Medicare. Frankly, don't quiz me on them because I am not an expert. But I know that for the most part, most behavioral health benefits are now covered by Medicare.

Anastasia Dodson:

But again, the co-insurance, Medi-Cal covers, and this is true for both non-specialty and specialty mental health services and substance use disorder services. So, there's still the partnership there for the co-insurance and any remaining services that are not covered by Medicare but are covered by Medi-Cal. So, we are in the process of updating our systems and guidance to Medi-Cal Managed Care Plans and to Medi-Cal providers to account for the 2024 Medicare changes. Let's go to the next slide.

Anastasia Dodson:

So, the bottom line for today, that DHCS, we want to urge Medi-Cal providers that can newly enroll in Medicare, please do enroll. In the chat, we can put the link to the webpage where you can begin the process to enroll as a Medicare provider. As Lindsey said, there's a timeline. It may take a certain number of weeks to get that provider enrollment processed, but of course, as your practice would benefit from being able to access Medicare reimbursement and frankly, provide better access to care for patients by having Medicare coverage. So, we also want to encourage Medicare providers to enroll as Medi-Cal crossover-only providers. There's a special provider type.

Anastasia Dodson:

So, we know some providers may just want to be enrolled in Medicare but not Medi-Cal. Okay. So, to get any coinsurance, anything that Medi-Cal may be able to pay above the 80% or so reimbursement rate through Medicare, then you'll need to enroll as a Medi-Cal crossover only provider. There's an electronic process in PAVE to facilitate that, but we really strongly encourage the Medi-Cal providers to enroll in Medicare and that is really the transition that we, as a state, need to work on to implement, fully implement this benefit, is to have the appropriate providers enrolled in Medicare.

Anastasia Dodson:

We are not... and I don't want to say this the wrong way technically speaking, but we have been processing claims from Medi-Cal providers, and we'll continue to process claims from Medi-Cal providers. We don't have cutoff date that we can say publicly at this point, but in the future as we develop policy, we may have more specific direction either on a cutoff date or there will be a transition.

Anastasia Dodson:

But we want to really make sure that there's continuity of care for people. We don't want any confusion or mass disruption for people who are dually eligible and accessing these provider types. So anyway, that's our bottom line for today and you'll be hearing more from us and there'll be more provider guidance on the Medi-Cal side going out as far as any technical guidance or dates, and I think this is the last of the DHCS slides.

Cassidy Acosta:

I believe so. We do have some questions in the chat, Anastasia, if you'd like to turn it over to those. So, we did get one specifically that was asking for speakers to differentiate between mental health and substance use disorders versus behavioral health as a whole. Is there anything that you can add to that based off of the presentation that you've just presented?

Anastasia Dodson:

So, in the materials, and I think we may have... In that fact sheet that we've put the link to that DHCS published, we talk more specifically about what do we mean by the umbrella term of behavioral health and mental health and substance use disorder services.

Certainly, I know there's been some historical... I don't know, debate or discussion about needing to be more specific. We want to make sure that discussion is helpful, so we're using that term. But certainly, we recognize there's variety of provider types and services. It's a big umbrella and we appreciate all the providers and partners that we have in this area.

Cassidy Acosta:

Great. We also have a question from Christina in the chat. Most of the services they provide are not covered by Medicare but are covered by Medi-Cal, so they have not enrolled into Medicare. The majority of the people they serve are seniors and do have Medicare. They'd like to confirm that with this change, do they need to enroll to make the change to be a Medicare provider or not?

Anastasia Dodson:

Hard to tell, depending on the provider type, but if you are a provider type that can enroll in Medicare, please do. Yes, but I think we need to know what specific provider type it is.

Cassidy Acosta:

She's added Adult Day Health Care.

Anastasia Dodson:

Adult Day Health Care. Okay. That's a different provider type not covered in the presentation we just talked about, but CBAS, as far as I know there's not a Medicare provider type for adult, but there may be, I could be wrong about that, but I know that most of the reimbursement for Adult Day Health, CBAS is through Medi-Cal.

Cassidy Acosta:

Great. Then we have another question from Christine. Can we bill Medi-Cal directly if the provider opted out or decides not to enroll?

Anastasia Dodson:

Christine, I'm not sure. Are you like an IPA, or? Hard to tell from the question. But generally, the provider, I mean, again, probably need more specifics on the provider type, and then-

Christine:

Hi, it would be the new providers that are the LMFTs and the LPCCs. So, we're in a process of sending letters to them regarding the new change. So, if they decide to opt out or not enroll at all, are we allowed to bill Medi-Cal for their services that are Medicare eligible?

Anastasia Dodson:

So, are you like an agency that-

Christine:

Yes, the County, yeah.

Anastasia Dodson:

Oh, I see. The County Behavioral Health Agency.

Christine:

Yes.

Anastasia Dodson:

Okay. So that is a very good question, and I think we should track that and get back to you. There are certain requirements that we talked about as far as to be able to bill Medicare. So, it sounds like we'll need to put a little more thought and make sure we have the detail on that for county behavioral health agencies. Thank you so much.

Christine:

Okay, thank you. I will keep an eye on it.

Anastasia Dodson:

Okay, thank you.

Lindsey Wilson:

If I can just make one comment on that? Lindsey Wilson, I'm with Coordination Benefits with our Third-Party Liability and Recovery Division. So right now, in our systems, there are no what you would call cost avoidance rules to reject claims, but we are working on system changes. As Anastasia mentioned, when those timeframes for anything that would change would roll out, we'll be issuing specific guidance through our provider manuals and such. So more to come, but process as usual right now while we're in the implementation stage.

Anastasia Dodson:

Thank you, Lindsey.

Cassidy Acosta:

Great. Then Rick has his hand up. So, Rick, you should be able to unmute now to ask your question.

Rick Hodgkins:

Hi there. Can you hear me?

Anastasia Dodson:

Yes.

Rick Hodgkins:

I wanted to point out, I did write something in the chat from the very beginning about the County mental health services. No pun intended that the county mental health services, particularly in Sacramento County, they do great work, don't get me wrong, but that if you are IDD, I know that there is one service through Turning Point Community Programs that the Regional Center can pay for, but it's hit or miss there. I'm a patient at UC Davis, so because I have Medicare, thank God now, I should be able to access mental health services through UC Davis. Even if UC Davis does have behavioral therapists, they might only be available through the Mind Institute.

Rick Hodgkins:

I just got referred to the Mind Institute to get some genetic testing and the geneticist told me that because of my neurodevelopmental disorder, which is de Morsier's Syndrome, I'm not going to try and spell that, but they said based on what I was referred for and I could qualify for services in the Mind Institute, I just don't know what all those different services are available, what they're available yet.

Rick Hodgkins:

But I feel I'd be better served through UC Davis or through the same systems I see my other specialists and primary care as opposed to the county. The county is great if you're needing food, clothing, and shelter and not just to see a psychiatrist because the other thing about the psychiatrist that work for the county, you cannot develop a good relationship and good rapport for that psychiatrist because chances are that they're not going to stick around. Psychiatrists that work for the county usually don't stick around. They go from place to place. Thank you.

Anastasia Dodson:

Thank you so much, Rick. Great points. We really appreciate bringing your experience to this group. I think as you have brought up in the past with different providers, the vision is to eventually have more integrated behavioral health across physical health, mental health, substance use disorder services. So, whether it is with UC Davis or with the county and across all of our counties and provider groups, we do want to keep looking at strategies to help everyone be able to work together for patients who need that integrated care.

Anastasia Dodson:

I think that's true in Medi-Cal in general, but then for people who are dually eligible, it's especially true and it is especially complicated. So great points all around, and that is the long-term goal, to have integrated care and not just on physical health but behavioral health as well.

Cassidy Acosta:

Great. Thank you so much. Then we do have one final question in the chat, and I think we have time to move onto our spotlight, but Julianne asked, "Are there also training

resources plans can share with providers on how to use PAVE and billing?" We did pop a couple of useful resources in the chat, but also wanted to see, Anastasia or Lindsey, if you had anything to add?

Anastasia Dodson:

Yes. We want to acknowledge that the guidance from CMS says that we need to be coordinating with our Medi-Cal Managed Care Plans on this enrollment rollout. So, we will be glad to provide further information to the health plans. Lindsey, is there anything more you want to add?

Lindsey Wilson:

No, as I said before, we're in the process of the implementing, so there will be resources once we get just a little bit further along. So just give us a little time. We expect sometime in the Spring.

Cassidy Acosta:

Great. All right. I think that we can move onto our spotlight on coordinating behavioral health for dual eligible beneficiaries. First up is Alfie from the County of San Diego. So, Alfie, I'll pass it over to you.

Alfie Gonzaga:

Good morning, everyone. My name is Alfie Gonzaga, with the County of San Diego Behavioral Health Services. I oversee the health plan administration team in the department. Thank you for having me today. So, if you could hop on to the first slide, please. Next one.

Alfie Gonzaga:

Thank you. So, for the couple of slides that I will be covering today, references to behavioral health plan means the combined specialty mental health plan and the drug Medi-Cal organized delivery system or the DMC-ODS plan. Because in San Diego, specialty mental health services and substance use disorder services are integrated under one behavioral health department. As a behavioral health plan, what we have been doing is working alongside the four Medi-Cal MCPs in San Diego, Kaiser, Molina, Community Health Group, and Blue Shield to align with the state's MOU drivers that are listed on this slide. I want to note that although the state requires one MOU for mental health and the other for the DMC-ODS, many of the required elements are very similar.

Alfie Gonzaga:

In San Diego, these state drivers, these state MOU drivers have helped reconfirm existing care coordination processes that have been in place for several years. Moving onto the next slide, please. For this slide, I want to share some examples of ways that San Diego as a behavioral health plan has been working with the MCPs and quickly highlighting that because San Diego's Behavioral Health Plan target Medi-Cal population, includes persons who are dually eligible, a separate venue with MCPs or D-SNPs to

discuss dual eligible clients specifically has not been called for. Our processes are integrated to include Medi-Medis, or the dually eligible persons.

Alfie Gonzaga:

For many years, what has worked in San Diego to coordinate care for shared Medi-Cal members is a direct contact between liaisons. So, for example, behavioral health clients that require a case conference or a care coordination meeting, the county's liaison would reach out to the MCP liaisons, who would then loop in other staff with their organization, such as the Medicare side when needed. So really quickly, if you click on the top dot point, it'll take you to a public-facing page that includes the MCP's contact information and other references that are primarily intended to assist behavioral health plan providers in coordinating services.

Alfie Gonzaga:

In addition, we have regular twice-monthly meetings in which all of the MCP's participate, allowing for continuous coordination. At these meetings, several reports as part of ongoing monitoring could be discussed. Then in cases where areas of improvement are identified, these meetings could provide a venue to initiate quality improvement activities, if needed. That is super brief but thank you. I hope this gave today's attendees a flavor of how San Diego works with the MCPs to coordinate care for Medi-Cal members, including dually eligible persons.

Cassidy Acosta:

Thanks so much, Alfie. We did drop a link to the San Diego contact cards into the chat, so folks can take a look at those.

Alfie Gonzaga:

Thank you.

Cassidy Acosta:

I will now turn it over to Emily from Blue Shield of California to talk a little bit about the health plan perspective.

Emily Schermerhorn:

Hi. Can you hear me okay?

Cassidy Acosta:

We can.

Emily Schermerhorn:

Okay, great. Thank you very much. This is Emily Schermerhorn. Thank you for the introduction. I am one of the managers at Blue Shield of California, and I manage mostly our commercial Social Workers. One of the teams that I have is our BHCM team and that

is our D-SNP and our Medicare BHCM clinicians. So, we have four licensed clinicians who are working with our members who have had a recent inpatient stay. So, our program elements, like I said, we have the four clinicians. They provide support to our members following an inpatient stay, a BH-related ER visit, SUD-related visit, which is substance use disorder.

Emily Schermerhorn:

And then in general connection to psychiatry, therapy, and other levels of care, general support and resources following crisis, and our clinicians collaborate with our internal UM department. We have Medical Directors that we staff cases with. We work with hospital Social Workers, discharge planners, community providers, county mental health systems, and then also IPAs. If you want to go to the next slide. One more slide, please. Thank you.

Emily Schermerhorn:

So, I just want to put it out there that this is a team, the D-SNP team is one that I have recently absorbed, so I'm still getting familiar with the nuances of working with the D-SNP specifics. So, some of the takeaways that I have learned from our team, strangely we've worked very closely with LA County, San Fernando Valley Mental Health Services. They particularly highlighted a really strong collaboration and one of the things that was pointed out was that a screening tool would be very helpful. Some of the best practices that they mentioned were that the transition between inpatient to outpatient does seem to work better if a hospital is referring to a county clinic versus a Blue Shield employee.

Emily Schermerhorn:

That even if a member of ours is county level of care, that the BHCM support that we are providing them is still very beneficial and helpful. Some of the barriers that we have noticed are sometimes the clinics will say that the referrals need to come from the hospital discharge planner and not from Blue Shield employees. Some of the clinics, we have noticed in our referral attempts, have longer wait times with limited licensed clinicians due to unlicensed not being able to bill Medicare. Next slide, please.

Emily Schermerhorn:

For just an example of one of our stories of one of our D-SNP members, we had a 27-year-old member with diagnoses of schizophrenia, bipolar disorder, ADHD, and hypothyroidism. This particular member had two children, ages two and five, that she had recently lost custody of, so was working with CPS to get her visitation rights reinstated. The member was hospitalized after calling 911 following losing the custody of her children. Next slide, please.

Emily Schermerhorn:

So, post discharge, this was a member that we worked in collaborated with. We worked with her during her stay. She did not want to attend the day treatment program that was recommended following discharge from the hospital. We did assess her needs and connected her to other treatment that she was open to doing. Our clinician utilized

motivational interviewing techniques to understand the member's motivation and needs.

Emily Schermerhorn:

We did collaborate with the County access to find a clinician who could fulfill court-ordered documentation to work towards the visitation reinstatement. So, the impact on this particular patient was that the member is following her court-ordered treatment plan. She did get connected to therapy and psychiatry. The member was connected to a recovery center that has support groups and a DBT group specifically, and member is actively working towards visitation reinstatement. I believe that was the end of my slides. So, thank you very much for having me today. I appreciate it.

Cassidy Acosta:

Thank you so much, Emily.

Emily Schermerhorn:

All right. Sure.

Cassidy Acosta:

I think next, we can go over to Jack Dailey with the with the Legal Aid Society of San Diego to give us the advocate perspective.

Jack Dailey:

Wonderful. Thank you all. Just by way of background, our service, our office rather, has served as the county's Title IX patient rights advocacy program for outpatient services for nearly 25 years now. And for almost 10 years we've served as the ombuds for dual-eligibles. And that's given us a lot of insight into the inner machinations of how duals access care in particular behavioral healthcare. I really appreciate Emily's presentation and the example focusing on a consumer's experience. I also wanted to start my comments by centering on consumer's perspective and experience and how that underscores really the need and importance of meaningful care coordination for the delivery of these behavioral health services. And many on this call, I don't need to preach to folks here on this call that are very experienced in this field, they already understand that patients' symptoms, their care and support needs, their conditions are not static.

Jack Dailey:

They are dynamic, they change with external and internal pressures that they may experience an ongoing basis. A stabilized patient's needs can change, and at times they'll require significant shifts of therapeutic approaches and/or movement up and down the intensity care spectrum, if you will. On the Medicare side, traditionally there may not have been as many behavioral health services covered. As I highlighted today, that's now changing. And so those changes may be coming, those level of care changes, the changes to therapeutic approaches may be coming from currently treating primary care provider, maybe coming from a behavioral health provider. And to a consumer, that may happen when they've been deemed to need a higher or a lower level of care. And that

may necessitate some sort of a transition to a different provider, maybe to a different setting.

Jack Dailey:

On the Medi-Cal side, these changes arise in the context of a determination that a member requires a higher level of care, or a lower level of care, and may need to transition to the county mental health plan for specialty mental health services. Or in reverse, back to the managed care plan for mild to moderate level of behavioral health services. And these transitions and changes from the perspective of the consumer can leave folks feeling very frustrated, and at times with feelings of rejection by their trusted care teams. And even fearful about how they're going to be able to access their medications, their needed services.

Jack Dailey:

And so just for context for our conversation in and around the importance of care coordination and supports to consumers, I thought it was really important to understand that meaningful engagement in these contexts really means meeting the patient where they're at, and with the level of persistence that's needed to effectively provide the support that consumer may need. And I often apologize to my partners when I talk about meaningful care coordination. They hear me say that word so often, meaningful care coordination, because care coordination alone is not going to often be sufficient. Sometimes providing a phone number to obtain a new provider or an appointment at an appropriate level of care is not going to be sufficient. That's not a warm transfer.

Jack Dailey:

We often are talking about the warmest of transfers, really identifying what that consumer needs, meeting them where they're at, and then helping support them along the way as they transition to a different level of care, a different provider, a different treatment or a care delivery system. And it's so important in these transitions because this is where we see the risk of losing patients increase. The patients or consumers falling through the cracks maybe during these different care delivery systems, maybe even within one care delivery system, but falling between the cracks because their care needs to have been escalated to a different provider or a different type of setting. We run the risk of having folks disengage from these voluntary behavioral health treatment services and also exacerbate their symptoms due to some of their frustration with the process.

Jack Dailey:

So just for context, wanted to set that stage. We are talking today about a lot of the new policies with regards to expanded Medicare coverage and highlighting some of the built-in and existing policies in and around care coordination. And from the MMPs and D-SNPs requiring their SMACs, their State Medicated Agency Contracts, already require these plans to establish cooperative working relationships with Medi-Cal managed care plans and county behavioral health plans for both data sharing care coordination. And we've heard some really great examples from my colleagues in the county about how that works on the ground. Same thing for the Medi-Cal managed care plans, they have

requirements for template MOUs that lay out these requirements. However, depending on a plan by plan basis, or a county by county basis, these policy ideals may not always reflect the common experience or practice. And why is that? Well, because we're a very complex system and there's a lot of providers.

Jack Dailey:

And in reality, a lot of these transactions happen at the provider and patient level. On top of that, to add on to the reality of where these transitions are happening and how these policies are being implemented in practice, we have to face the reality that our state has a behavioral health workforce shortage. And the demands on the system to provide adequate providers at each of the level of care is immense. And so that may impact timely access. And if timely access is a challenge, now you have a consumer that's then identified as needing that different level of care being told, "Hey, we're going to do our best to get you in. And maybe we can't get you into that level of care, is there something else that we can get you into or try to support you?" That all requires effective communication, that requires that care coordination piece.

Jack Dailey:

And I think my county colleague Alfie spoke to this, that high level of integration and communication between plans and county behavioral health providers. And I would even say on the Medicare side too, within the Medicare care teams within those D-SNPs, ensuring that folks are collaborating in and around the care needs of the consumer to make sure they're landing where their care is needed. And I noted earlier that these communications often happen between providers and patients, and that's where sometimes we see the inconsistency with regards to the engagement of care team resources and the effectiveness of that particular communication. I fully understand. And by the way, I always have to put this out there, I'm an advocate. People don't call me when things are going great, so they don't call me to say, "Hey Jack, just want to let you know that I really felt supported during this care transition." That's not typically what happens. But what we do see is that when there is a breakdown, it's often that breakdown between a provider and a patient.

Jack Dailey:

And maybe where we see opportunities for best practices to be identified is how to ensure that providers are empowered with information about their care coordination resources that are available to them. The relevant care team members are engaged and aware of how to support folks in those transitioning moments. And I like to point to plan provider portals as being a key opportunity to improve the communication in and around the availability of care coordination services and resources. And so that's something that I think, as we continue to build out policies, is to look at those portals as an opportunity to really support folks in this process. Because providers are busy, they have multiple appointments every single day. They have to move through their day, and they need to be empowered in those moments with the right information at the right time to ensure that they can help their patient land in the appropriate setting. And do so in a way that's effective and efficient for the consumer.

Jack Dailey:

I also want to just note too, on a care coordination point, these instances and maybe where there's patient symptoms, cycling, decompensation, maybe a relapse in the substance use disorder side, these often lead to these care delivery model changes that we're just talking about, transitions of different levels of care. But they're also accompanied by major disruptions to basic life contexts, to basic life Supports and activities. Peoples' housing, employment, family and other support networks can become fractured in these moments. And so, it just underscores this incredible importance of effective care coordination in those moments to make sure those members are being engaged in the variety of supports that plans now have available to them. And I am thinking of some of the Medi-Cal Managed Care Plan community supports that are available to address some of those social determinants of health. Just wanted to underscore here, we're not talking about folks in a laboratory static sense in which we're only focusing on care needs, care needs are within the context of the consumer experience.

Jack Dailey:

And I guess to my last point here about care coordination services really need to wrap around the member regardless of what level of service. I'll take it out of behavioral health for a moment, regardless of what service the individual is receiving. But in particular, around members that are receiving services in a carved out model, in particular highlighting the Medi-Cal Managed Care Plan, carved out especially mental health services that are provided by county behavioral health plans. Care coordinators within both D-SNP, MMPs within Medi-Cal Managed Care Plans, and this could include subcontracted vendor ECM or enhanced care managers, they need to continue to engage folks to help meet those care coordination needs, including transportation, coordination with ongoing medical care, and providers, not just the behavioral healthcare providers. And to help identify where their support, those community supports can be used to address various emerging social determinants of health that are becoming a challenge for the consumer.

Jack Dailey:

I think I'll wrap my comments there. I appreciate the opportunity to come and discuss this with this group, and the ongoing collaboration between all of the partners on the call and the stakeholder group. Thank you.

Cassidy Acosta:

Great. Thank you so much, Jack. And thank you so much to Alfie and Emily for their great presentations. And we do have some time now to open it up for some questions and we have a couple in the chat. I did want to start, Jack, that Janet had a comment in the chat about your election to the co-chair for the Healthy San Diego Medi-Cal Stakeholder Collaborative. And I thought, Alfie and Jack, it might be interesting to hear a little bit from you both about the Healthy San Diego Behavioral Health Subcommittee that exists, and whether or not you all see this as a benefit in the county to help coordinate behavioral health for dual-eligible beneficiaries.

Jack Dailey:

I don't know, Alfie, if you want to speak to that first. I will obviously say yes. And I am going to apologize in advance to our colleagues in other counties around the state, it's often nauseating to hear San Diego folks talk about how well we're coordinating, and we collaborate together. That's by design if you will. When we became a geographic managed care model of delivering Medi-Cal Managed Care services in San Diego, by statute we created a Healthy San Diego collaborative in which plans, providers, consumers, and various stakeholders come together to discuss how we manage multiple Medi-Cal Managed Care Plans operating within the same space and doing that in a way that's effective and collaborative.

Jack Dailey:

And I think it's been a really impressive model. Its legacy was really shaped and formed by our former executive director, Greg Knoll, who unfortunately passed away recently. But through partnerships across all of those stakeholder groups, we've been able to identify barriers and challenges collectively as a group and come up with community solutions. And sometimes that involves community solutions, what we call that local low-hanging fruit. And sometimes that means communicating with state partners and federal partners to say, "Hey, these are challenges that we're seeing on the ground here, and what tools can we be given to address those?" Alfie, any other thoughts? I'm sorry.

Alfie Gonzaga:

No, you spoke very well about the whole Healthy San Diego group. But from the behavioral health operations subgroup, it is likewise very helpful that we have specific subgroups to discuss very specific care coordination case conferences and issues that come up. It is best practice that we would like to share with the other counties if that is available to them.

Cassidy Acosta:

Thanks so much. And then we also have a question from Donna in the chat, who's recognizing that for some folks this is a very new discussion about learning about the Medicare expansion. She's asking, when does it become effective that Medicare is the primary payer for behavioral health services instead of Medi-Cal? And I think this might be a question for DHCS, but we also welcome Jack and Alfie to weigh-in on how you all are seeing this in the county as well.

Anastasia Dodson:

I'll just say first that we thank you so much Donna for joining and for engaging with us on this. We don't have a firm date just yet as far as when will there be an absolute cutoff in claims processing. But would really encourage, like you say, getting started, getting providers enrolled in Medicare. We know that will take some time. And in the meantime, we'll keep you posted, and we'll have more specific guidance on the timeline for any changes that we'll make on the Medi-Cal side.

Jack Dailey:

And I just wanted to add to that, thank you Anastasia, and I know that policies will continue to come out and we'll continue to support those efforts. This is going to create another opportunity and, frankly, need for really clear care coordination. The last thing that we would want to see is a patient referred to a county, especially mental health care provider, only to be told, "Oh, you've got Medicare, they're the primary payer. Go back to your Medicare provider, go back to your Medicare plan." That does happen, unfortunately, even with the best laid plans. In current context where a consumer will get the crossed fingers of, "Hey, go here, go there." And we try to minimize that, and I think we work collectively to do that.

Jack Dailey:

This is just creating one other scenario where that clear communication from the top policymakers within the county behavioral health plans, down to the frontline workers and receptionists at a particular behavioral healthcare clinic or provider have to be on the same exact page with regards to how to handle those instances in which you encounter someone looking for needed care but have other payer sources that are primary. I think it'll be really important that we build out a lot of structures and supports for the clear messaging and communication, not only in our eligibility systems, in our provider trainings, and our consumer-facing materials.

Anastasia Dodson:

Thank you, Jack. We totally agree. Yes, we're absolutely on the same page. And we appreciate the partnership of so many people joining the webinar today. And definitely this is not the last time we'll be discussing this.

Candice Anderson:

To the question earlier around Medi-Cal and Medicare as a payer source for specialty mental health or SUD services. What I understand is that Medi-Cal is the payer of last resort. So other payers first before Medi-Cal for specialty behavioral health services.

Anastasia Dodson:

Yes, absolutely. And again, even before this change on the Medicare side, we know there's sometimes confusion or just need to reiterate the policy that we have at DHCS around county behavioral health agencies being able to bill and transact with Medicare Advantage Plans for services that are covered by Medicare through the Medicare Advantage Plans. And we have some existing guidance, I don't know if it's handy, we might not be able to put it in the chat right now, but we can resurface that. And we do want to make sure all the different scenarios, there are pathways, but they may not be as well-known. That's part of what we're looking to do in the next coming months. And we're especially glad, again, for the Medicare changes. But even before this was a need to better document for dual-eligibles and their providers how to navigate across the payers.

Cassidy Acosta:

Fantastic. All right. I'm not seeing any other questions in the chat, but this is just another call that if you do have any, please feel free to add them or to raise your hand. We'll give

it just another minute and then we'll move on to next steps. Unless Anastasia, you have anything else you'd like to add?

Anastasia Dodson:

I'll just say a couple things, and certainly if there's more people who want to chime in questions, comments, any of it is more than welcome. As I said, we're working on, and I know my wonderful team at the OMII they... Sorry, but I am going to say we are working on a fact sheet, and we will get it done hopefully in the coming weeks to just document even... Again, very glad to have the changes in Medicare, but just across county behavioral health, working with Medicare Advantage Plans, what are those processes? What are the billing rules there? And then trying to weave in, okay, now we have expanded coverage on the Medicare side. Again, what does that mean for dual-eligibles, whether they're in a Medicare advantage Plan or in original Medicare? And we want to check and see, is the existing guidance that we already have sufficient?

Anastasia Dodson:

And maybe what we need to do is, again, resurface some of that existing guidance, or do we need to have new policy letters? We'll be looking into that and looking at ways that we can reach out to specific provider groups, if that is a good way to get more into the detail. And I also, again, just don't want to lose track of, there are other changes that CMS Medicare is putting into play for 2024 in Medicare Advantage Plans around integrated care, integrated behavioral health care. That can be valuable and is very promising. But again, probably more TA work is needed to figure out, how do we have physician offices, medical groups, county behavioral health, or other mental health counselors, how do all the teams work together?

Anastasia Dodson:

And probably that's not necessarily going to be something that we can mandate at the state, but it's going to be up to all of you in the partnerships. Like Alfie was talking about, how can we promote those local partnerships? The billing options are there, but I know it is work for different groups to coordinate. But I think, again, San Diego and Los Angeles Blue Shield, all these great examples. And our wonderful leader, Jack. They're helping us see that there are ways to do it, but it's very, very hard work. I'll leave it at that.

Cassidy Acosta:

Sounds great. And we do have one other question from Susan. Susan, you should be able to unmute.

Susan LaPadula:

Thank you so much. Hello Anastasia, and hello to Jack. Thank you so much, Jack, for your presentation. I just wanted to lift up the topic of behavioral health and Medicare payment provided in a Skilled Nursing Facility. And perhaps Lindsey can speak to this topic. In the Skilled Nursing Facility, we have what we call consolidated billing for our part A residents, and we are not able to bill Medicare for that service. However, the behavioral health is what we call an excluded service, and they're able to bill Medicare directly. And

when you dig in, you dive a little bit deeper, that might be one of the TA items to look at is the setting where this service is provided.

Anastasia Dodson:

Great point, Susan. Great point.

Susan LaPadula:

And Lindsey, I would love to hear your topic on that, because I do sit on the Medicare MAC Provider Education Committee and we're visiting that in our next meeting next month. I know CMS and Noridian are working on giving us coding and documentation all the things we need to have for those providers rendering in our setting, but we're not doing the billing, they're billing direct.

Cassidy Acosta:

Thank you, Susan. And I know that Lindsey had to drop, but I believe that we do have folks on from CMS still, so Candice, Kerry, Gretchen, I welcome any insights that you have here.

Kerry Branick:

Hi, this is Kerry Branick. We'll have to take this one back. Thank you, Susan.

Cassidy Acosta:

Great. All right. Well, then I don't see any other hands raised or any other questions in the chat, so we can move on to our next step. Again, we want to thank you all so much for joining us today and for all these wonderful presentations, and this really great discussion. As a reminder, our next MLTSS and Duals Integration Stakeholder Workgroup will be held on Thursday, May 30th. And so, we want to also remind folks that the materials for this particular work group will be posted to the DHCS webpage soon. Thank you all so much, and please have a great afternoon.