Department of Health Care Services
California's Coordinated Care Initiative

**TITLE:** Coordinated Care Initiative Quarterly Stakeholder Webinar

**DATE:** Wednesday, June 30, 2021, 12:00 PM to 1:00 PM

**NUMBER OF SPEAKERS:**

**FILE DURATION:** 48 minutes

**SPEAKERS**

Hilary Haycock
Anastasia Dodson
Jacqulene Lang
Autumn Boylan
Jim Elliott
Anna Edwards

Hilary Haycock:

Good morning, everyone. Welcome. We're going to get started in just a minute. Good morning. We're still having folks join. So we're just going to get started here in a couple, just a few. Great. We'll go ahead and get started this morning. Well, good afternoon and welcome. Thank you all for joining us for the June quarterly Department of Health Care Services, Coordinated Care Initiative, stakeholder update webinar. We are so pleased to have you join us today. Today we're going to hear some presentations from some great guest speakers as well as from the Inland Empire Health Plan, as well as from the Department of Health Care Services. A few housekeeping items before we begin, all participants will be on mute during the presentations and please feel free to submit any questions you may have for the panelists via the chat feature on Zoom during the Q&A portion at the end of the webinar if you would like to ask a question or provide a comment or feedback you can use the raise hand function at that time and we will unmute you and call on you.

Hilary Haycock:

But of course you can always enter questions in the chat throughout the presentation as they come to you and we will be collecting and answering those at the end. Go to our next slide with today's agenda. We are going to start with some updates from the Department of Health Care services, including an update on the budget, the June Cal MediConnect dashboard, the Multipurpose Senior Services Program carve out, the durable medical equipment, DME benefit. And then we are going to hand it over to Inland Empire Health Plan IEHP to give a presentation on some great work that they have done recently improving individualized care plan completion rates. As you may know or may not know that has been a key focus of the Cal MediConnect Program over the last year working very closely with all of our Cal MediConnect plans to try to improve ICP completion rates.

Hilary Haycock:

And so we're excited to hear from them on how that's going. Particularly for folks who are been tracking other activities in terms of the transition. It's a very timely update on how care coordination is working and being improved as we speak in the Cal MediConnect program. To get us started, I am very excited to hand it over to Anastasia Dodson from the Department of Health Care Services associate director for policy to lead us off with some DHCS updates.

Anastasia Dodson:

Thank you and good morning everyone. I'm pleased to be here today as we look at what we have right now in our Cal MediConnect program in the context of where we are on addressing the pandemic and health equity and the state budget. And we're also looking ahead as we have in our other work groups been discussing with stakeholders, all the changes that will be coming in 2023 around the transition of Cal MediConnect to a D-SNP aligned enrollment model.

Anastasia Dodson:

But for today, the purpose of this call is to talk about some strengths and status on where we are with the Cal MediConnect Program. And I want to start out by saying how much we value and appreciate all of our partners in Cal MediConnect, all of the health plans, providers, community-based organizations, caregivers, beneficiaries, researchers, because this program has been a wonderful opportunity for the state to provide integrated care to dually eligible beneficiaries. And we're really pleased that we're sustaining the enrollment levels and continuing as you'll see in the dashboard to provide updated information and highlight some of the best practices and promising practices that you'll hear from the Inland Empire Health Plan, as well as I also want to emphasize that all of the plans and the providers continue to work on ways to address the COVID pandemic, including getting members vaccinated.

Anastasia Dodson:

And we know that that's a concern in many dimensions and particularly for health equity. We want to encourage all of you to get the vaccine and to continue to work with all of your partners to get as many people vaccinated as possible. Again, in our other stakeholder meetings, we are talking about that in details about how we're going to be transitioning, Cal MediConnect to a D-SNP aligned enrollment. And I want to flag that the budget trailer bill will contain more statutory provisions around that and we expect that will be passed soon, and that will give us as part of the CalAIM initiative that will give us more specific structure around how we will make that transition to a D-SNP aligned enrollment structure and just flagging that there are also interactions with that transition and for dually eligible beneficiaries, other parts of CalAIM for example, enhanced care management in lieu of services, population, health management, and the carving of long-term care and dual eligible beneficiaries statewide.

Anastasia Dodson:

Again, we're focused today on current status of Cal MediConnect. We have our eye on the future and we know that we will need all of you in the coming months to help us as far as the overall care plan and care management structure of the new model and learning from what we have successfully done in Cal MediConnect, as well as the enrollment details and noticing what's the content of those notices. All of that is coming up in the next few months, but we do also want to make sure that we're talking with all of you and hearing any feedback on the current status and anything we can do to help with, as I said, vaccinations, health equity, improving the care management of dual eligible beneficiaries because they are, as you know, a population that is vulnerable and really stands to benefit greatly from integrated care.

Anastasia Dodson:

And if we can continue to improve integrated care and Cal MediConnect, even before the D-SNP transition we want to continue to do that. I'm excited about the DME component of the presentation today and the other components as well. I think it's a great presentation. Thank you.

Hilary Haycock:

Thank you so much Anastasia. I appreciate that presentation. Next we will move to Jacqulene Lang, the CGS data reporting unit chief to walk through a few findings and our most recent Cal MediConnect dashboard. Jacqulene I'll hand it over to you.

Jacqulene Lang:

Thank you so much. Hilary. Thank you, Anastasia. I was going to try and put my video on, but I think that function may be disabled for me right now, but that's okay. See if I can get it going for you guys. Again, good afternoon. My name is Jacqulene Lang. I am the data and reporting unit chief in the managed care quality and monitoring division at DHCS. And I'm just here to share a few updates for the Cal MediConnect based on the Cal MediConnect dashboard, June release, and as always you can access the dashboard at the link there on the PowerPoint slide at our DHCS external website. Next slide please.

Jacqulene Lang:

Okay. For the first slide that I'm going to be sharing out today, it's concerning enrollment and demographic figures for figures one through six of the dashboard. And so statewide enrollment and how many connect it did increase from 106,188 members in January, 2020 to 114,977, excuse me, in December of 2020. In Q4 of 2020, 52% of enrollees spoke English and 34% spoke Spanish as their primary language with 38% of our enrollees identifying as Hispanic. Males and females aged 65 and older represent 30% and 45% of the total CMC population respectively. Next slide please.

Jacqulene Lang:

Okay. This slide shows care coordination trends and that is figure eight. And so this figure shows that the quarterly statewide percentage of members willing to participate in a health risk assessment, who the plan was able to locate and has an assessment completed within 90 days of enrollment remained at 94% in Q2 Q3 and Q4 of 2020. Next slide, please. Thanks. For individualized care plan data, figure 10, this table indicates that the percentage of members with an ICP completed within 90 days of enrollment actually did increase from 72% in Q1 of 2020 to 86% in Q4 of 2020. Figure 11 indicates that in five of the 10 plans, which are Anthem, blue shield, health net, Cal Optima, and HPSM. The percentage of members with an ICP completed within 90 days of enrollment is below the statewide average of 86% for Q4 of 2020.

Jacqulene Lang:

And lastly, for this slide, individualized care plan performance, it will continue to be a focus of DHCS program improvements in the coming year and that includes potentially enhancing or modifying quality measures and addressing low performance through plans, specific core performance improvement plans. And for my next and last slide for the CMC dashboard. This depicts behavioral health emergency room utilization figures based on figure 20. One goal for plans is to improve the coordination of behavioral health services for the members that includes mental health and substance use disorder treatments covered by the plans and specialty mental health services, excuse me, provided by county behavioral health departments.

Jacqulene Lang:

Figure 20, it shows the overall trend of Cal MediConnect members seeking care in the emergency room for behavioral health services. It's decreased

from 18.1 visits per 10,000 member months in Q1 of 2020 to 14.1 visits per 10,000 member months in Q4 of 2020. And the last thing I'll point out for this measure is in mid 2017, plans did begin to receive additional and more accurate behavioral health data that may have affected how plans are reporting. And so with that said, DHCS and CMS are monitoring any potential effects of this change. That is it for the CMC dashboard updates. And I will hand it back over to you, Hilary. Thank you so much.

Hilary Haycock:

Wonderful. Thank you so much, Jacqulene. Now I'm going to invite Autumn Boylan, assistant deputy director for integrated systems at DHCS to provide an update on the Multipurpose Senior Services Program carve-out.

Autumn Boylan:

Thank you, Hilary. Good afternoon, everybody. I'm glad to provide an update to you all this afternoon regarding the MSSP carve-out. As you all know, it's part of our CalAIM initiative, we are carving MSSP out of the managed care program where it exists today and managed care. It'll continue to live in the 1915(c) waiver world, but it is being carved out of managed care as part of our CalAIM initiative. You're probably all aware of this. But just wanted to share some updates with you about kind of action sets that we are implementing in order to make sure that we can achieve our goal to carve MSSP out of managed care. And we are having regular meetings with the MSSP sites, as well as managed care plans in order to kind of talk through all of the moving pieces related to the carve out, which we're going to share some of those with you today. So if you can move to the next slide, that'd be great.

Autumn Boylan:

Part of this effort, the department is developing beneficiary notices that will be mailed out to beneficiaries, informing them of the change in the program from being in as part of the managed care benefit to being not a part of the managed care benefit being carved out. We are planning to send the notices out for stakeholder review in early July before we actually send them out to beneficiaries. And so we'll be sharing the beneficiary notices with the MSSP sites, managed care plans and CCI counties, CMS, the managed care advisory group to make sure that the notices are relaying the appropriate information. And we'll be taking input on those before we mail them out. As you can see on the slide, we have kind of the schedule

here on the 90, 60, 30-day noticing timeline in terms of when all of those various notices will be mailed out to beneficiaries in October, November and December. And like I said, before we're developing the notices including the notice plan and frequently asked questions. And all of that will be shared with stakeholders in early July. Next slide.

Autumn Boylan:

We're also working with the MSSP sites in the plans on several other deliverables to make sure that members are appropriately informed about what's happening. We're working on readiness deliverables, including deliverables list, which we plan to share in July, the final deliverables list. We're working on contract updates and some guidance to accompany the contract updates to make sure that the MSSP sites and managed care plans are appropriately prepared in advance for the changes that are going to be coming into play. And we'll be releasing the draft contract language in quarter three of this year. We're also working on updates to the member handbook to make sure that beneficiaries are appropriately informed of their continued availability of MSSP and what's happening in terms of the change from it being available as a managed care plan benefit.

Autumn Boylan:

The next slide. Some of the other things we're working on at a higher level are working on updates to the provider manual to make sure that those updates go into effect in time for the transition on January 1st as well as updating an all plan letter related to the CalAIM initiative that will be sent out also for stakeholder review in early July. And we plan to issue the all plan letter to the plans in August. And so there will definitely be a time for stakeholder input in July before it gets sent out in August. And then lastly we are working on a plan for post transition monitoring. Sorry, on the next slide. Plans will be required to complete post transition monitoring after implementation of the carve-outs to make sure that beneficiaries are appropriately transitioned. And we will be sharing more details about the post-transition monitoring requirements in the future. That's kind of the brief update I have for you this afternoon. And now I'm going to turn it back over to Hilary.

Hilary Haycock:

Thanks so much, Autumn. I appreciate that. Great. And we are collecting up questions that we can handle at the Q&A unless you ... All right. Great.

Thanks so much, Autumn. Looks like she's on mute there. Wonderful. We are going to now hand it over to Jim Elliot, staff services manager for DHCS benefits division to talk about durable medical equipment, prescription policy updates.

Jim Elliott:

Thank you very much. Next slide, please. Prior to the public health emergency of federal regulations limited those who could prescribe on our services, which would include durable medical equipment and medical supplies to only physicians, but during the public health emergency, that department submitted as part of CMS to allow all licensed practitioners within their scope of service to practice or to prescribe DME. And this flexibility will continue throughout the length of the public health emergency. Next. You guys are ahead of me. Also during the public health emergency CMS updated the federal regulations to allow several other provider types to prescribe durable medical equipment. In addition to physicians, those other providers. Next slide, please.

Jim Elliott:

Those other medical providers or the physician assistants, nurse practitioners and clinical nurse specialists. They can order home health services, durable medical equipment and medical supplies. In response to this federal regulation we submitted as about last year spot 2035, which authorized these other vendors to prescribe the home health services. These changes will be reflected in the provider manual in August, but until that time we're still operating under the flexibilities of the home health services of the public health emergency. And these changes would take effect after the public health emergency to allow those four different provider types to order services. That's pretty much the highlights.

Hilary Haycock:

Great. Thank you so much, Jim. All right, moving on to our next presenter.

Anastasia Dodson:

Sorry, Hilary, it's Anastasia. I don't know if you can take my video on for one second.

Hilary Haycock:

Sure.

Anastasia Dodson:

This is Anastasia and I just wanted to flag that this DME policy was something that there was actually a group of folks that worked on finding ways to clarify DME policy. And we have some fact sheets that we have been working on based on that great work group effort in 2019. And of course, because of the public health emergency, we had new policies that Jim just explained. But we recognize that there have been questions and a need for continuing consumer and provider information about DME. We're excited to be providing more information in writing soon and keeping you all engaged on this important issue. Thanks Hilary.

Hilary Haycock:

Thanks so much Anastasia for that clarification. All right. Great. And now we are going to move to our final presenter before we move to our Q&A section. Anna Edwards, care management clinical director from IEHP. I'll hand you the mic.

Anna Edwards:

Hi there. Could you hear me?

Hilary Haycock:

Yeah. Great.

Anna Edwards:

Wonderful. Well, thank you very much for the opportunity to present and also to participate. I'm particularly excited to hear the last presentation being a nurse practitioner myself. So I think that's very excellent. I was asked today to talk to you a little bit about what IEHP has been doing around the completion rate for ICP space. And so if we go to the next slide, we'll talk about some of the common challenges that we've definitely had amongst multiple health plans. And some of those have been unable to contact. We have difficulty at times to contact our members. Sometimes our members declined to participate and perhaps it's difficult to communicate that value of care coordination and participating in the care planning process.

Anna Edwards:

And there are also been resource constraints, particularly amongst the time during the pandemic. I know that many of the plans had a strained resources. Those are some common challenges that we've shared with CMS and also with DHCS and despite common challenges, we are all kind of a push to be creative and think outside of the box to address some of the challenges. We did just that. And if you can go to the next slide, please. We identified the problem and the problem basically was that we failed to meet the satisfactory rates of ICP completion for the initial ICP. And when we really took a look at the root cause analysis, and we did this through the lens of our lean thinking, which is throughout our whole organization we noticed that really it was the process that we put in place that impacted our opportunity.

Anna Edwards:

So next slide, please. Knowing that the process was part of the issue, what did we need to do to address process improvement? Number one, regarding that process improvement, we really took a look at the need to collaborate internally with several different departments, which I'll explain a little bit later. We definitely needed to take a look at the training, the development of training and the implementation of that training. Of course, improving our monitoring and oversight plan for the ICP completion process. And then once we had the monitoring oversight plan, really sharing those results throughout the organization, because when you're really taking a look at your rates to improve, and you're kind of you know under a microscope, if you will, it's really important to kind of share the improvements and the wins so everybody in the organization is updated. Those were four key components that I believe that are really important in our process improvement initiatives. Next slide please.

Anna Edwards:

You may ask what did we actually do differently? I wanted to kind of highlight on the left side the before and the after our process improvements. Before the process was we have a wonderful member services Health Risk Assessment team that reaches out to our members within the timelines that we are all aware of and they completed the HRA. But then it was kind of passed along to our care management team. So we were notified, okay, the HRA is completed. Oftentimes it was the next day. We had that missed opportunity of connecting with the member right then and there when they completed it. The next step in the process was we had

our coordinator that's our nonclinical team who attempted to outreach to that member to talk to them about the initial care planning process that they could have the opportunity to do with the clinical care manager.

Anna Edwards:

And that was a really area of focus because you're adding another person into that team mix, even though it may help in some ways so that the care managers can be looking at the ongoing care management in this particular process that was a bit of a hindrance. And then finally, if the coordinator was able to connect with the member we would transfer that member to the clinical care manager. So I think you could actually see if you actually had hands in the process, how many hands were in that process? On the right side, we have the after when we really took a look at all of our opportunities. We partnered that collaboration with that member services health risk assessment team. What we essentially do is have that warm transfer right then and there when the health risk assessment is completed.

Anna Edwards:

We actually began the initial care planning process in that timeframe. We're talking about the HRA that was just completed. We actually begin the care plan that's for both our direct recall and also for our delegates. That also helps the delegates to begin that ICP completion process. Right then and there is an opportunity to essentially decrease the number of kind of handoffs and increased the kind of satisfaction for the members as well. Another thing I think is very important to highlight that we do actually have a dedicated clinical team that is called our HRA ICP team within care management. When we were taking a look at process, we had to take a look at people as well. Did we have enough people?

Anna Edwards:

We piloted this process, it was successful. We were able to demonstrate the success, which I'll share towards the end. And we actually have a robust team dedicated to this. And another final thing that I think is important even before this look at the process improvement. We had that collaboration with our Medicare sales team and that's for the streamlined enrollment process. When these members are saying that they want to be part of Cal MediConnect, there's that warm transfer right then and there to our clinical team, who's waiting to start the health risk assessment with a member and start planning for that future when they're going to be a new

CMC member. The next slide, please, I think hopefully you got a good view of kind of our before and after.

Anna Edwards:

I think it's important to point out because many of the health plans in California have a delegate. And so addressing the delegate process is also part of our improvement initiatives. We really focused the training around the ICP completion for all of our delegates and this included actually taking a look at the process that we had in place. We looked at the report that we asked them to submit with their data. We wanted to make sure they really understood, what we're needing from the data and where they should probably be looking in their systems to pull accurate data. We started monthly live review system review files for each one of our IPAs. And during each one of those monthly reviews, we reinforced all of the reporting requirements, the importance of accurate data submission, the importance of data validation even before submitting to the plan. It's two processes that we've improved both when we're interacting with the members and when we're interacting with our delegates. Next slide, please.

Anna Edwards:

What are our results? Well, it has a historical results and which is why we had the problem in the first place that we had a completion rate of about 30%, all of those handoffs and those process issues it didn't yield a satisfactory result. And currently we still monitor this on a monthly basis. And we're consistently greater than 90%. Again, we just take advantage of every possible opportunity to stay connected with the member, because it's so difficult sometimes when we hang up the ... Are you able to hear me with the computer?

Hilary Haycock:

Yeah, we can hear you again.

Anna Edwards:

Wonderful, for some reason I just got kicked out of my phone. I think one of the really important things to take a look at aside from, okay, we have these great rates now, is really focus on the member, that timely identification of those new issues for the members, by reducing the number of handoffs so important. For issues like continuity of care, just connecting to that clinical care manager is so important and really kind of delighter, if you will. We

reduce those handout- offs and really improve our delicate relationships through this process. I hope that I shared some good points with you and we're always open also to hearing [inaudible] access. I believe that is the end. Thank you, Hilary.

Hilary Haycock:

Great, thank you so much for a very informative presentation. We've now moved to the question and answer portion of today. We did get some questions in the chat so we'll go through those, feel free to continue to put questions into the chat. But also happy to have you raise your hand and we will unmute you for discussion. The first question which may be Anastasia, would mind helping answer, is a question the timeline for the long-term care changes under CalAIM and whether that timeline has shifted.

Anastasia Dodson:

We are still targeting January 1st, 2023 to carve in the long-term care benefit and to also include all dually eligible beneficiaries throughout the state in mandatory Medi-Cal Managed Care. There are some exceptions for dual eligibles in 2022 related to share of cost. Those folks will not be mandatorily enrolled in Medi-Cal Managed Care, except if they are in long-term care. I know that's more weedy answer, but the gist of it is that we're still January 1st, 2023 long-term care carve in throughout the state. And of course it's already carved in in CCI and COHS counties.

Hilary Haycock:

Great. Thank you so much for that clarification Anastasia. I'm going to now go to Janine Angel. She's submitted a couple of questions in the chat. We'll just unmute your line.

Janine Angel:

There you go. Awesome. Thank you. And thanks for the opportunity. Again, really, really love these conversations and feel they're so helpful to all of us. I had one question on the MSSP carve-out in that will the MSSP sites in the post implementation of the carve-out, will they be required to share utilization data with the health plans?

Autumn Boylan:

Hi, Janine, this is Autumn Boylan. So we're still working out some of the details of the transition and we'll be putting that into the contract language

that we're working on, as well as the APLs. I think that's a good question and it's something that we are talking to the plans and the MSSP sites about. But I don't have a specific answer to share back with you today. We're still working out the details of how all of that will work.

Janine Angel:

Okay, great. If I could have a vote I would vote for yes. The next question I had on the DME policy, which I think is great is, Cal MediConnect we always hear that DPLs apply to us but APLs may not. I just wanted to call out that if we're only going to get an APL on that, we just want to make sure that it does indicate that it would be applicable to CMC as well. And lastly on the IEHP presentation for Anna, congratulations on your great numbers. I know we've been trying to manage ours and get ours up there as well. I did have kind of twofold question. Number one, what is the method that you guys use to share the HRA and ICP that you guys share with your delegates? Do you use SFTP exchange, do you have provider website. I'm just kind of wondering we're looking to refine our process as well and look at some of these things that you guys have done already. I want to just see, do you have any best practices in terms of sharing that information with your delegates?

Anna Edwards:

Can you hear me Janine?

Janine Angel:

Yes, I can.

Anna Edwards:

Excellent. Thank you for your question. I don't know if it's at such a best practice per se, but we do share all of the data in a file. If our IPAs have the systems, they can envelop the data into their own system, we post that to an SFTP site, but we also have a portal, so they're able to take documents or pull documents down. That's available really on two methods, some IPs have systems that may be a more savvy and then being able to envelop that data in that way.

Janine Angel:

Okay. That helps. And I'd love to bother you offline if possible on that. The other question I had was when you looked at your data and what was your

completion rate, was it that you guys had a higher number of refusals or was it that just we have a similar situation where it's just members are hard to reach. The outreach happens at the same time the HRA and the ICP. And so was there any kind of one thing that you saw that kind of contributed to the lower completion rate other than just that the process was not, I call them married together for both of the assessment and the care plan.

Anna Edwards:

I would definitely say that just having our in-house health risk assessment team improve the unable to contact rate. And then once which was a big contributor, actually, even more than refusals, because they're pretty good at convincing of our members of the importance of this. I think that using the number of handoffs improve the unable to contact. Because you don't have to then try to engage the member again and phone numbers change. I think it's all related, but I would definitely say we had improvements in both.

Janine Angel:

Awesome. I would love to pick your brain a little bit more and if you don't mind, we can maybe connect offline and have a quick chat.

Anna Edwards:

Absolutely. I'd love that. Thank you.

Janine Angel:

Thank you. I don't think I have any more Hilary, thank you so much for the opportunity.

Hilary Haycock:

Wonderful. Thanks so much. We'll have to see plan collaboration and that stuff. Great. There's a question that maybe Anna could help us with on the need or challenges with the creation of an ICP between the managed care plan, care manager and the delegated or IPA care manager. And how do you figure out who's the lead.

Anna Edwards:

Are you able to hear me now?

Hilary Haycock:

Yeah. It's great.

Anna Edwards:

Maybe someday I'll get a hang of this and be really quick. I think that's a really good question because in the beginning we really had to take a look at both processes. Our direct and our delegates were kind of suffering in the process that we had, so it actually is not so much of IEHP is necessarily the lead because that's really not our responsibility.

Anna Edwards:

Our delegates are responsible for the whole care management process, but what we do is essentially focus are the members' top concerns. In fact, one of the questions basically towards the end is what are the three things that you really want to work on? So we can kind of build that trust from the get go. We kind of start with those and then present the data to our delegates, and then it is up to them to contact the member further, explore the rest of the health risk assessment with the member and then work on the rest of the ICP. I hope that helps.

Hilary Haycock:

Great. Thank you so much. A question in the chat that will go to Autumn about the MSSP carve-out. There's a question about how MSSP differs from the assisted living waiver and if the assisted living waiver program is changing.

Autumn Boylan:

Hi. This is Autumn Boylan again. There are two separate waiver programs under the 1915(c) authority, the MSSP program and the assisted living waiver. Neither of programs are going away. Both will continue to exist. The only difference that's happening that we're sharing with you today is the MSSP program being carved out of managed care in the CCI counties, where it had been previously carved in. But the MSSP program will continue to operate under the 1915(c) authority. And there are no changes resulting from this carve out to the LW program is that is completely separate.

Hilary Haycock:

Great, thank you so much, Autumn. Question in the chat from Lydie Barnett. Maybe this one could go to Anastasia. She's worked with Cal MediConnect. She's worked with, I guess the duals demonstration probably in Texas and California. Great program. Is the current outreach going to continue with the transition or is that being lowered now that CalAIM is on the horizon.

Anastasia Dodson:

We are not making any changes as far as outreach and enrollment. The plans are doing a lot of that themselves, but we're still encouraging people to enroll in Cal MediConnect absolutely all the way through the cutoff date, which is going to be approximately late August for September enrollment in 2022. We want to continue to encourage people to enroll in Cal MediConnect as integrated care for dual eligible beneficiaries. And as I said in our other work group, we'll be talking more about the details of that transition, but still a great opportunity to have all of your benefits Medi-Cal and Medicare from one central plan that can coordinate with all of your providers.

Hilary Haycock:

Great. Thank you. All right. There's a question in the chat from Melissa Bojorquez who is asking if there are any special care management programs specific to members who have been identified with either dementia or ... And here's an acronym I don't know. And I thought I was pretty good with them, AD/ADRD. If there are any specific programs for those numbers if they're identified with their HRA. So I'm not sure if Melissa wants to raise her hand, we can have her educate us. Alzheimer's disease. There we go. We did a phenomenal presentation on things that we've learned about dementia care in our May MLTSS and duals work group. Those materials are posted. We're hoping to put up a summary of that meeting in the coming weeks. And so I would definitely invite you to take a look at that because we did do a pretty unique pilot as part of Cal MediConnect to support members with dementia. I'm not sure Anastasia, if you wanted to answer the question.

Anastasia Dodson:

Yeah. We have some great initiatives that have been partnerships through local Alzheimer's Associations and local plans, and we really encourage

that through all the plans and we're looking at how we can incorporate that into the 2023 so that those types of initiatives can continue.

Hilary Haycock:

Great. And we'll get the link to that presentation put out in the chat. I'm not sure if Melissa, you want. All of you raised your hand. Any other questions from folks, either through chat or if anyone who wants to raise their hand? There's a question of Cal MediConnect is the same as CalDuals. CalDuals is the name of the website that provides a lot of useful information. The program is called the coordinated care initiative and it encompasses a couple different parts. One is the expansion of managed long-term services and support and managed care for duals. The other is the community connect program, which is the financial demonstration creating the Cal MediConnect health plan that incorporate both Medicare and Medi-Cal benefits. Hopefully that answers that question from Irene Thomas.

Hilary Haycock:

All right. We are not seeing additional hands or questions coming through, so maybe let's go to the next slide for our wrap up today. We just mentioned more information is available on calduals.org, as well as on the DHCS website. You can always send any questions or comments you have to CalDuals and we are happy to respond to you as soon as possible. We did mention the MLTSS, Managed Long-Term Services & Supports & Duals and duals integration stakeholder work group. And this is the group working on that transition for duals under CalAIM. We are meeting again Thursday, July 15th at noon. You can find out more about that on the DHCS web website. I think Alyssa just sent around the link there. A question in the chat about, is there a summary of all the many initiatives occurring?

Hilary Haycock:

I'd strongly encourage you to check out the DHCS CalAIM page. It is a treasure trove of various resources on all the different pieces. And with that we will just thank everybody for your participation today. We really appreciate the ongoing interest and engagement on this program and many thanks to our many presenters for sharing such great information today, particularly Anna Edwards for my IEHP for joining us. Thank you very much and have a wonderful rest of your Wednesday.