AMERICA'S PHYSICIAN GROUPS
Taking Responsibility for America's Health

State Government Programs Committee Meeting
Tuesday, October 7, 2021
12:00 – 2:30 pm Pacific

Zoom

AGENDA

- Welcome from the Chair: Sean Atha, River City Medical Group
- Presentation by Magellan staff re: CalRX Implementation on January 1, 2022
- Discussion of CalAIM ECM/ILOS provider participation, models of care
- Adjourn

Upcoming Events

Annual Conference 2021: December 9 - 11, San Diego, CA

AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

Susan Philip
Deputy Director, Health Care Delivery Systems
Dept. of Health Care Services

Re: Follow-up to October 1 Introductory Call

Dear Susan:

Thank you for the opportunity to discuss the role of the delegated model physician organizations in Medi-Cal managed care today with myself, Sean Atha and Mike Myers. We certainly look forward to working with you and hope to act as a resource in the future.

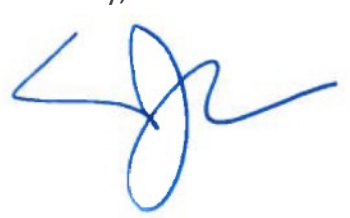
As we mentioned, APG holds quarterly meetings with its Medi-Cal membership and has in the past hosted Department staff to facilitate two-way communications between it and the providers delivering Medi-Cal services. This can be a forum to help the Department communicate changes to the program that affect providers, solicit input on developing policy, and provide education to DHCS staff on care delivery to beneficiaries. We will provide you with a schedule of upcoming meetings for 2022. We are also happy to schedule ad hoc meetings as necessary and to use our weekly email updates to our members a conduit for the Department's communications strategy.

In follow-up to our call today, these are the open issues that we discussed:

- Seeking Department leadership in convening sit-downs between MCPs and network providers on impacts to risk-bearing contracting in the CalAIM process (letter of July 29th, attached)
- Seeking dialogue with the Department on initiatives and suggestions on administrative simplification for CalAIM and other Department programs, including:
    - The ICE automated DOFR project (We will provide further information to you on this project)
    - Standardized/Regionalized reporting formats between MCPs and delegated providers
    - Audit process standardization
- APG endorses the attached issue lists of June 29 and September 2 provided by MPM
- ICE has requested follow-up and further direction from the Department on a long-standing issue concerning notification to beneficiaries of their loss of eligibility. ICE will follow-up with Deputy Director Rene' Mollow, per your suggestion during our call today
- ICE has also requested further dialogue concerning the EDGE initiative and will follow-up with Dr. Linette Scott, per your suggestion today

Thank you again for reaching out in response to our letter of July 29th. We look forward to a productive relationship with you and your team.

Sincerely,



William Barcellona, Esq, MHA
Executive Vice President for Government Affairs

wbarcellona@apg.org
(916) 606-6763

CC: Sean Atha, Chair, APG State Programs Committee
Mike Myers, CEO, ICE

Attach's:

APG letter of July 29, 2021
ICE Issue Sheet
MPM CalAIM Issue List

AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

July 29, 2021

Will Lightbourne, Director
Dept. of Health Care Services

Via email

Supplemental comments on today's SAC meeting of July 29, 2021

Dear Director Lightbourne:

During today's DHCS SAC meeting the Department outlined a contracting strategy for the reprocurement of managed care plans, that included the adoption of CalAIM model contracts. In either, or both, of these initiatives, there are critical issues concerning the role of risk-bearing providers in the contracting process that we feel need to be addressed soon.

Our Ask: We urge you to consider the importance of recognizing the role of risk-bearing physician organizations in the Medi-Cal system and to convene stakeholder processes that bring all the parties involved in the risk-shifting process to the table to discuss the changes to plan-provider contracting that are coming in the implementation of CalRX, CalAIM, and the reprocurement.

More Value-Based Contracting Increases the Urgency of Our Ask: In your slide at page 10, the Department cited that "the procurement proactively encourages, promotes and requires…using value-based arrangements with providers to better align payment with quality of care and performance." We appreciate that the DHCS is recognizing the advantages of shifting from a purely fee-for-service provider reimbursement methodology as a cornerstone of an improved Medi-Cal system in California.

Our Concern: Stable and predictable contracting is critical to the continued financial solvency and thus the ability to provide access to California's Medicaid population. During today's meeting we heard that reprocurement contracting may be subject to intensive further development through All-Plan Letter processes. Repeated changes to the level of both financial and clinical risk during the pendency of a two- or three-year capitated agreement can wreak havoc with the stability of a physician organization. The relative uncertainty of the contracting process in the CalAIM initiative has also been a concern.

Risk-Based Contracting Requires a Stable Process: The Knox Keene model for risk-based contracting between health plans and providers anticipates that health plans will outline the level of financial and clinical risk involved in the risk-shifting agreement and then provide an estimate up-front, so that a provider can make an informed decision and later demonstrate its capability to assume that risk (Health & Safety Code Section 1374.4).

Moreover, the provider bill of rights process does not appear to apply to Medi-Cal managed care contracting – which would go a long way toward stabilizing mid-contract material changes to the level of risk being assumed by providers. Even when a health plan complies with the Knox Keene process, changes that are introduced to the risk-shifting agreement after it has commenced can often reach material levels and destabilize the provider. A very recent example has been the risk-shifting by health plans of COVID-related testing costs, the unilateral waiver of copay revenue, and other pandemic-related costs.

Contract Amendment through All Plan Letters: The discussion today implied that much of the final contracting rules for CalAIM and the reprocurement could be handled through the APL process. The Department's issuance of All Plan Letters is often used by MCPs as a rationale for imposing further material risk-shifting within their capitated agreements with providers. We simply ask that the Department (DHCS) consider the ramifications of changes that are implemented through the APL process that eventually flow-down to risk-bearing providers.

What Happens in an Uncertain Environment: The Department of Managed Health Care can confirm that over the past decade the majority of risk-bearing physician groups that struggle with financial solvency compliance are those that contract with Medi-Cal MCP plans to provide services to over 4 million Californians in the Medi-Cal system. The difficulty these physician groups face is not just due to the contracted rates but to the instability of frequent changes to the risk profile that they have assumed, which is far more volatile than what they experience in Medicare.

Other Potential Conflicting Policy Efforts: California is also embarked on a historic effort to develop strategic oversight of its health care system through the Office of Health Care Affordability. OHCA will focus on the results of provider consolidation within regions. Once of the principal causes of consolidation over the past decade has been the unrelenting onslaught of more and more administrative compliance burdens on providers. They simply cannot keep up with the pace of change and are forced to merge into larger and larger organizations to reach compliance. It is also common practice for the DMHC to encourage the sale of financially troubled organizations to larger receiving entities to ensure financial stability and continuity of access.

APG is ready, willing, and able to bring a representative group of our members to the table at any time. We feel strongly that the DHCS should convene a stakeholder process to work out the onboarding of risk-bearing contracting in both CalAIM and the reprocurement. The Department, DMHC, MCPs, and risk-bearing providers all need to be involved. We need your assistance and leadership to make that happen.

Thank you for your consideration.

Sincerely,

William Barcellona, Esq, MHA
Executive Vice President for Government Affairs

wbarcellona@apg.org
(916) 606-6763

CC: DMHC Director Mary Watanabe

Industry Collaboration Effort

REQUEST TEMPLATE FOR CLARIFICATION OF A REGULATORY ISSUE

ICE CLARIFICATION REQUEST LOG (CRL) - RESUBMISSION OF ICE CRL #228

INFORMATION FOR ICE TO PROVIDE ON ISSUE REQUIRING CLARIFICATION	INFORMATION / RESPONSES
Issue Requiring Clarification	Claims Denials for Medi-Cal - the genesis of this issue is relative to eligibility.
Background Information on Issue	Medi-Cal beneficiaries cannot be held financially responsible for anything other than share of cost, thus, there are no industry standard templates for claim denial letters to the beneficiary.
Resources that ICE Team has Referenced in Doing Research (e.g., Part C Manual, Appeals and Grievances Chapter - Sec. XXX; HPMS memo X/2016, DMHC Technical Assistance Guides, DHCS All Plan Letters, etc.).	The regulation is clear that a Medi-Cal beneficiary cannot be billed; however, the ICE team is requesting clarification specifically when it is strictly eligibility-based, which the team is unable to find in a regulation and therefore, requesting direction. In prior queries to the DHCS, ICE was told that this issue would be directed to the A & I Auditors at the Department.
ICE's Interpretation of the Resources (if guidance is unclear, specify what is unclear)	When a beneficiary is no longer eligible with Medi-Cal, is there a regulation that requires a notification to beneficiary and provider for the beneficiary's financial responsibility as they are no longer covered under Medi-Cal? And if so, what are the required elements and language needed to present in the beneficiary communication?
Time Sensitivity of this Request	URGENT as Plans are handling differently and Providers feel stuck in the middle.
Proposed Next Steps	Please advise if plans will be able to send letters to patients when no longer Medi-Cal eligible, and if so, will the format of that communication be the same as that identified by DMHC for commercial plans or something else defined by DHCS? This would not be an NOA letter template. There are old member liability letters that were archived unless there is now a standard letter that DHCS has similar to the Medicare Integrated Denial Notice (IDN).

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

September 2, 2021

Roadblocks to Data Exchange:

As both a generator and consumer of health information on behalf of 1.5 million Medi-Cal managed care members under the delegated model, MedPOINT Management (MPM) has significant experience with data exchange among numerous entities in the managed care delivery system. Over decades, MPM has developed industry-leading software, hardware, and human resources infrastructure to successfully collect, store, analyze, and transfer health information. Still, delegated model entities often face major challenges and roadblocks to data exchange that we are hopeful will be addressed in the forthcoming development and eventual implementation of the Health and Human Services Data Exchange Framework under AB 133.

The following information outlines roadblocks to data exchange from MPM's perspective. As we have stressed, MPM applauds Dr. Ghaly's leadership and the efforts of the California Health and Human Services Agency staff on this important effort. Moreover, MPM continues to pledge to do everything it can do to assist the Newsom Administration, working in coordination with our fellow stakeholders, to successfully achieve the important goals outlined in this initiative. We remain hopeful and thankful for your consideration of Dr. Rahul Dhawan, MPM's highly qualified leader on these issues, for appointment to one of the Data Exchange Framework Stakeholder Advisory Group's subcommittees.

1. Actionability and accuracy
    a. Data is often provided in formats, types, or scales that are not clinically or operationally actionable. For time-sensitive care coordination activities like inpatient discharge planning and urgent authorizations, receiving too much raw or unindexed data causes delays to patient care.
    b. Data does not always uniquely or accurately identify members, including outdated identification numbers or misspelled identifying information, creating confusion.
2. Timeliness
    a. Data is often provided months or years after the fact, at which point patients may have suffered worsening health outcomes or death that make data no longer actionable.
    b. Real-time data exchange, where possible, has been either a costly endeavor in which private companies provide and control the application programming interface (API) or a manual endeavor in which websites or portals must be checked for each individual inquiry received. A lack of regulation of Health Information Exchanges (HIEs) exacerbates these challenges.
3. Unpredictable Requirements
    a. MCPs frequently reject implementing specifications of data exchange in common formats (e.g. Electronic Data File layouts, CMS universe requirements) and instead expand, modify and adapt specifications to their own needs, hindering standardization and increasing the burden on delegated entities to meet the various MCP requirements.

   b. MCP and regulatory auditors often request new or modified reports on short notice, which require significant time to develop or validate. In most cases, at least 14 working days are necessary to restructure databases to meet new expectations.

4. Privacy and security
   a. Data exchange partners often cite HIPPA and other privacy regulations as reasons data cannot be exchanged, even when these regulations have already been satisfied in a particular context. Fear of high fines and lack of clarity between overlapping regulatory entities exacerbate this issue.
   b. Understanding of encryption technology and expectations for data protection vary across data exchange partners.
   c. Behavioral health, immunizations, and other sensitive or discretionarily reported data are often subject to higher-level protections that create barriers to integration with data at other levels of protection.

5. Transparency and open communication
   a. Technical experts are not always involved in the development of standards or agreements between data exchange partners, leading to ambiguity and confusion in expectations for data exchange.
   b. Knowing how data will be used impacts how it should be collected, stored, and exchanged. Without this information and continuous communication among partners, data exchange can be delayed as extraneous data may be provided.

6. Common definitions
   a. Definitions of measures, formats, terms, and diagnosis and procedure code mappings are not standard across MCPs' and regulators' reporting requirements, even where industry or national standards exist, which causes issues for interoperability of data.
   b. Plain English terms are often not included with technical specifications, or vice versa, leading to gaps in understanding among data exchange partners and delays to data exchange and ultimately to patient care.

7. Dispute resolution processes
   a. While ongoing and open communication outlined above will resolve most issues, there will still be cases in which data exchange partners disagree on the structure or interpretation of health information.
   b. Health information in particular is often still subject to individual interpretations by clinical professionals who may disagree. Similarly, technical experts may disagree on the most effective methods for data processing, storage, and exchange.
   c. In these cases, there must be a dispute resolution process in which partners can continuously improve data exchange practices to meet evolving needs.

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

June 29, 2021

Health Homes Program Responsibilities and Lessons Learned:

MedPOINT Management (MPM) strongly supports the CalAIM initiative and is committed to bringing forth solutions that benefit Medi-Cal members and downstream risk providers to ensure CalAIM's success. Under Health Homes Programs (HHP) administered by Medi-Cal managed care plans (MCPs), delegated entities such as Independent Physician Associations (IPAs) and Participating Provider Groups (PPGs) have taken on additional responsibilities in care coordination and have faced challenges caused by unintended consequences of program implementation. Some similar challenges arose in Whole Person Care (WPC) pilots. Since CalAIM is expected to transition services offered under WPC to an MCP-based model, HHP is addressed here as a structurally similar comparison that directly relates to the transition to Enhanced Care Management (ECM).

1. Data-sharing to support coordination of care
    a. Consistent communication to support coordination of care was a key goal of HHP. Unfortunately, breakdowns in data-sharing between community-based care management entities (CB-CMEs), MCPs, Community Providers, and IPAs hindered communication and created duplicative processes.
    b. **Downstream provider impact:** CB-CMEs, many of whom are primary care providers (PCPs), are unable to identify and notify a member's PPG at the time of enrollment in HHP, since the member's PPG affiliation is not listed on eligibility rosters provided by MCPs. This has limited the possibility for collaboration between the CB-CMEs and IPAs.
    c. **Member impact:** Members receive potentially confusing outreach from HHP providers as well as IPA care coordinators, especially in cases of hospital discharges and other care transitions.
    d. **CalAIM Solution:** With consistent sharing of enrollment and quality data generated through ECM, IPAs and ECM providers can more effectively collaborate to manage member care.
2. Direct referrals to CB-CMEs
    a. IPAs identify high-risk members who would benefit from HHP services but cannot refer members directly to CB-CMEs. Instead, IPAs must notify MCPs for outreach and enrollment.
    b. **Downstream provider impact:** PCP guidance on a member's risk factors that necessitate increased care coordination communicated via specialty referrals and other network providers affiliated with the IPA may not be heeded by MCPs in determining HHP eligibility. PCPs lose the opportunity to leverage existing relationships with members to promote enrollment in the program.
    c. **Member impact:** Members face delays in receiving care coordination services, which can lead to decreased trust in the health care delivery system and poorer health outcomes.
    d. **CalAIM Solution:** IPAs should be able to refer members directly to ECM providers to leverage IPA core competencies in member outreach and care management to increase member participation.
3. Members assigned to non-PCP CB-CMEs
    a. Many high-risk members are assigned to community-based PCPs, PCPs in Federally Qualified Health Centers (FQHCs) and community health centers not contracted as CB-CMEs.
    b. **Downstream provider impact:** PCPs lose desired and essential opportunities to build trust and foster health education with patients. CB-CMEs cannot benefit from the historical medical and contact information data stored by PCPs that could increase engagement in the program.
    c. **Member impact:** Members are assigned to a CB-CME, often another FQHC, outside of their PCP setting, which creates a disconnect in care and increased transportation and access burden.
    d. **Solution:** MCPs should consider delegation of ECM to IPAs, particularly for high utilizers and other high-risk groups already identified by IPA data analysts and care coordinators. Through delegation, MCPs may be able to leverage existing primary care networks and incentivize providers to adopt ECM, thereby increasing access for the expanded populations of focus in CalAIM.

MEMO

TO: **Susan Philip, Deputy Director, Health Care Delivery Systems Department of Health Care Services (DHCS)**

FROM: **Michael Myers, Chief Executive Officer, ICE**

DATE: **October 1, 2021**

RE: **October 1 Teleconference – Follow-Up**

Thank you very much for your time today. Given the magnitude of the numerous initiatives currently underway at DHCS, we greatly appreciated the opportunity to introduce you to our organization to explain the criticality around collaboration. The opportunities for standardization and enhanced regulatory compliance are beneficial across our industry, and having that connectivity and a path for communication with the DHCS, as we do with CMS and the DMHC, is a crucial part of the equation.

Thank you also for allowing us to discuss the following issues:

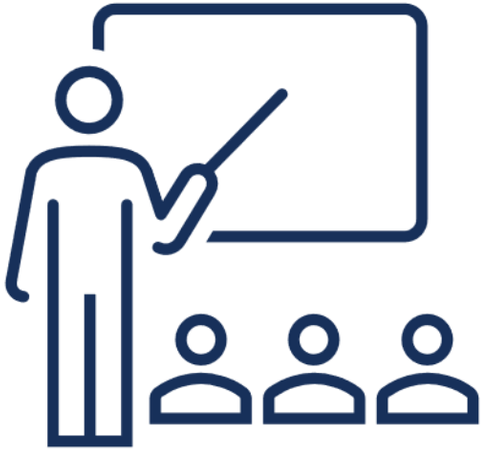
- Notification of Claims Denials for Medi-Cal Beneficiaries Relative to Eligibility (see attached document for additional information)
- IHA EDGE Initiative - ICE is working with IHA as an EDGE partner organization under the Data Standards workstream, and we are at a bit of an impasse in moving things forward without having participation from the data subject matter experts at the DHCS

We have copied and will be reaching out to Ms. Mollow for the first item, and Dr. Scott for the second item, as you recommended, to further discuss these matters.

If we can provide any additional information on our organization or on either of these issues as this time, please feel free to let me know. I can be reached at 661-839-2847. Thank you.

cc: Rene Mollow, Deputy Director, California Department of Health Care Services
Linette Scott, MD, MPH, Chief Medical Information Officer, Deputy Director, Information Management Division, California Department of Health Care Services
Bill Barcellona, Executive VP, Government Affairs, America's Physician Groups

Attachment: ICE Clarification Request Template – Claims Denials for Medi-Cal Beneficiaries



Medi-Cal Rx 101

What You Need to Know

America's Physician Groups

Agenda

- Introductions
- Medi-Cal Rx Transition Background
- Provider Portal Registration
- Prior Authorization (PA)
- Contract Drugs List (CDL) & Other Covered Products
- Beneficiary Details
- Contacts & Resources
- Q&A
- Webinar Evaluation

Medi-Cal Rx Background

Katie Trueworthy, Vice President External Affairs
Vanessa Chavez, Education and Outreach Supervisor

Medi-Cal Rx: Improving Pharmacy Processes

- Searchable Contract Drugs List (CDL)
- All Medi-Cal pharmacies are in the network
- 24-hour, 365-day Customer Service Center available
- Compatible with CoverMyMeds® for ePA
- Compatible with EHR under CoverMyMeds and Surescripts

Objectives

- Awareness of Medi-Cal Rx
- Smooth transition
- Ongoing partnership and education
- Resources and contact information

What is Medi-Cal Rx?

Medi-Cal Rx

Medi-Cal Rx is the administration of Medi-Cal pharmacy benefits through the Fee-for-Service (FFS) delivery system.

Medi-Cal Rx implements on January 1, 2022.

Outpatient Drugs

Pharmacy Reimbursable Physician-Administered Drugs (PADs) *

Specific Medical Supplies *

Enteral Nutrition Products

*** For more detailed information about covered products please refer to the Medi-Cal Rx Contract Drugs List (CDL) and Provider Manual**

Medi-Cal Rx Pharmacy Benefits

Includes

- Medi-Cal Managed Care
- Medi-Cal FFS
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Family Planning, Access, Care, and Treatment (FPACT)

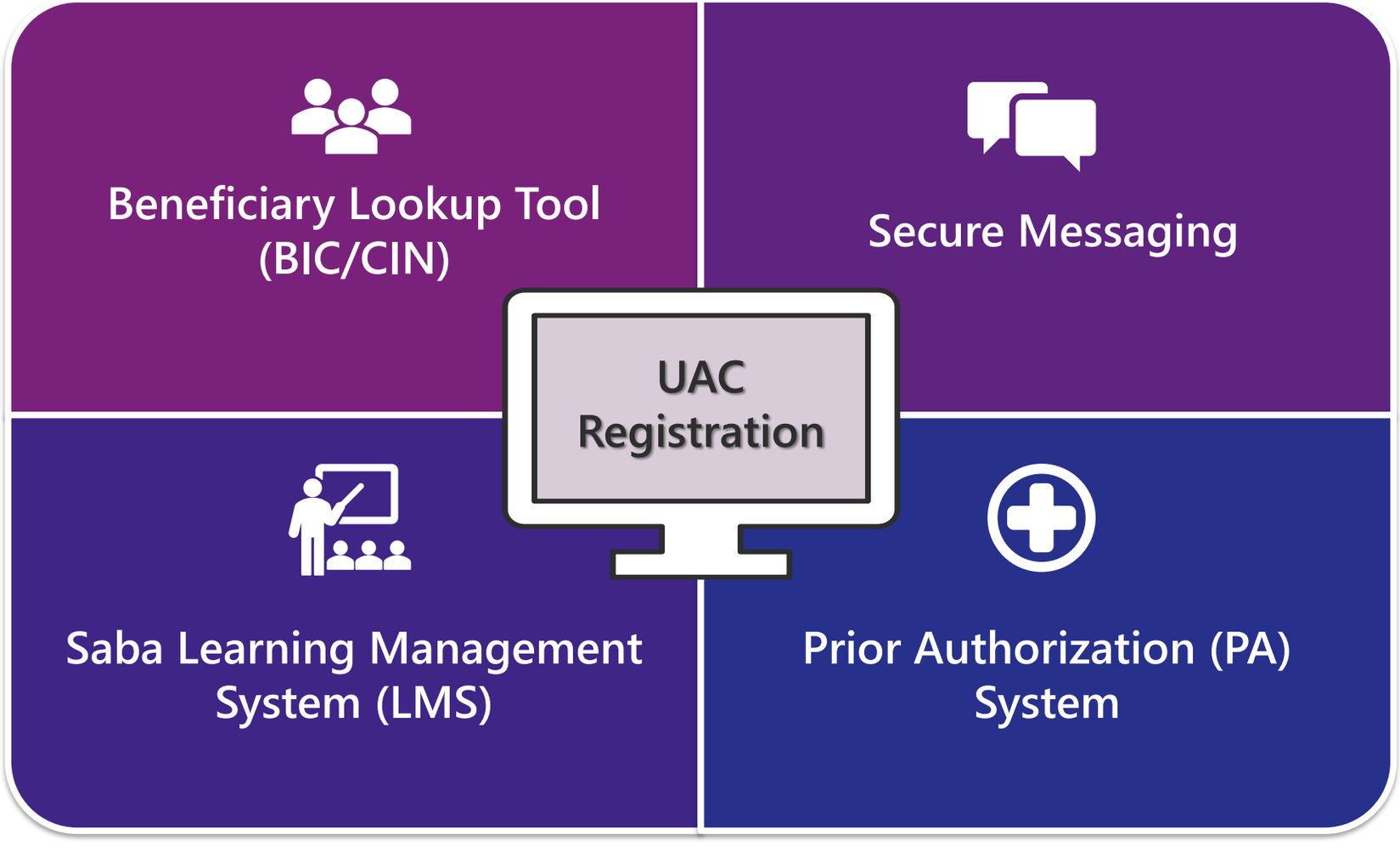
Excludes

- Senior Care Action Network (SCAN)
- Cal MediConnect
- Major Risk Medical Insurance Program (MRMIP)
- Programs of All-Inclusive Care for the Elderly (PACE)

Medi-Cal Rx Provider Portal

Shaylene Gilkison, Sr. Pharmacy Services Representative

Benefits of the Secured Provider Portal



Provider Portal: https://medi-calrx.dhcs.ca.gov/provider/

Provider Portal – Registration Overview

Step 1. Request PIN in the UAC Administration Console (UAC)

If needed, request Pin to be sent to an Alternat Address

Step 2. Receive PIN

Sent by United States Postal Service

Step 3. Register with PIN

Return to UAC to complete registration

Step 4. Validate your account

Validate via email activation link

Step 5. Add Roles and Standards Users

Add staff as Standard User and assign their roles

Assign UAC User Roles Under Your NPI

1. After logging on, click on the "**Orgs and Roles**" tab
2. Select the correct organization from the organizations list
3. Click the "**role assignments**" application and select what is appropriate
4. Click "**Save**" to save your changes

UAC Applications/Roles/Descriptions

Application	Role: User Privileges	Description
MRx Provider Portal	California Provider Portal	Able to access the Secured Provider Portal, which features the following: Beneficiary Eligibility Lookup, Prior Authorization Submission and Inquiry, Secure Message Center and Chat
Web Claims Submission	Web Claims Submission Access	Able to submit claims (includes reversals and resubmissions)
Financial Portal	Financial Portal Access	Able to have full access to financial information and medical insurance payment explanation
	835 File Access	Able to have access to and download the 835 File
	EFT Access	Able to add and remove financial information only
	ERA Access	Able to request data of medical insurance payment explanation
Saba	Saba Training	Able to view and register for trainings, class schedules and courses, calendar of education and outreach events

Registration Support

Office Hours

- Pharmacy Service Representatives (PSRs) are available for walkthrough registration.
- Set up a meeting by sending a request to: medicalrxeducationoutreach@magellanhealth.com

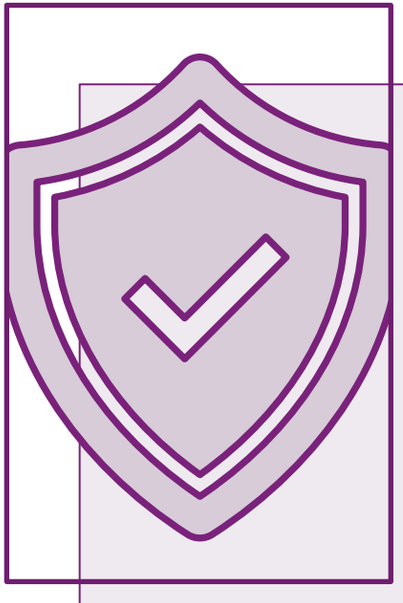
YouTube Tutorials

- Found on the Education & Outreach Website
- Provides easy-to-follow guides to help you with registration

Prior Authorization (PA)

Samantha Fink, RN, Medi-Cal Rx Clinician

Prior Authorizations (PAs)



PAs will replace SARs and TARs as of January 1, 2022.

Prior Authorization 180 Day-Transition Period

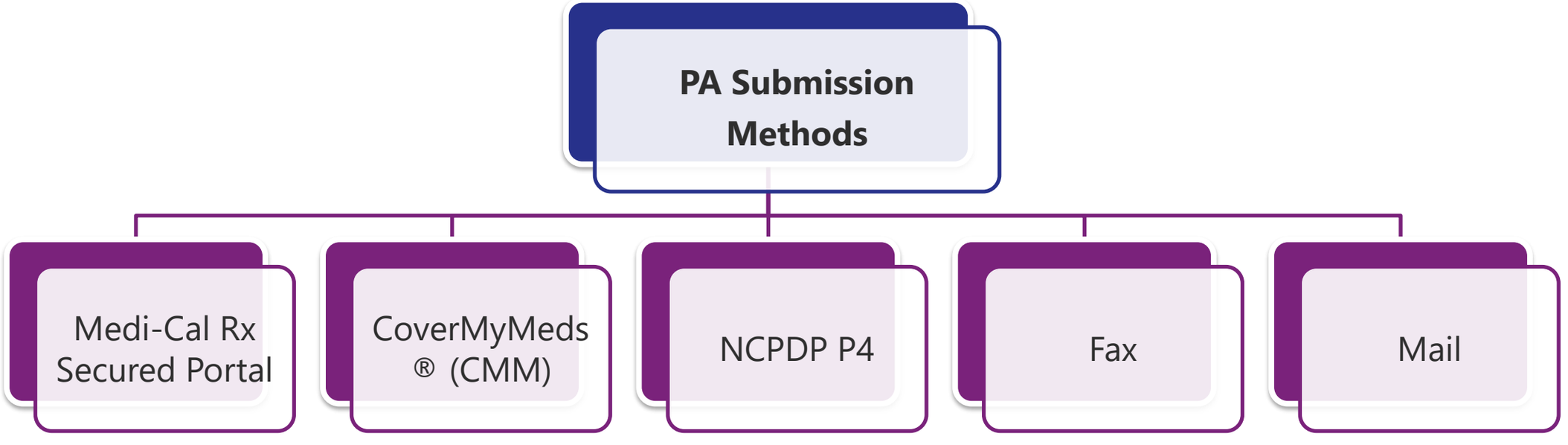
Pharmacy Transition Policy

Existing prescriptions without previously approved PAs

- Uses historical encounters/paid claims data to validate prior prescription
- Includes drugs not on the Medi-Cal CDL
- Includes drugs that otherwise have PA requirements under Medi-Cal Rx
- Excludes medication used for off-label diagnosis

Prescriptions with previously approved PA

- Uses PA and encounter/claims history data to "grandfather" those prescriptions
- Allows continuation of the PA through its stated duration
- Not to exceed one full year


PA Submission Methods
Medi-Cal Rx Secured Portal
CoverMyMeds ® (CMM)
NCPDP P4
Fax
Mail

PA Submission via the Secured Provider Portal

- Submit
- Check status
- Cancel
- Add additional information

PA Submission via CoverMyMeds® (CMM)

- Submit
- Receive Real-Time Approval
- View Covered Alternatives
- Add additional information

Prior Authorization Submission Methods

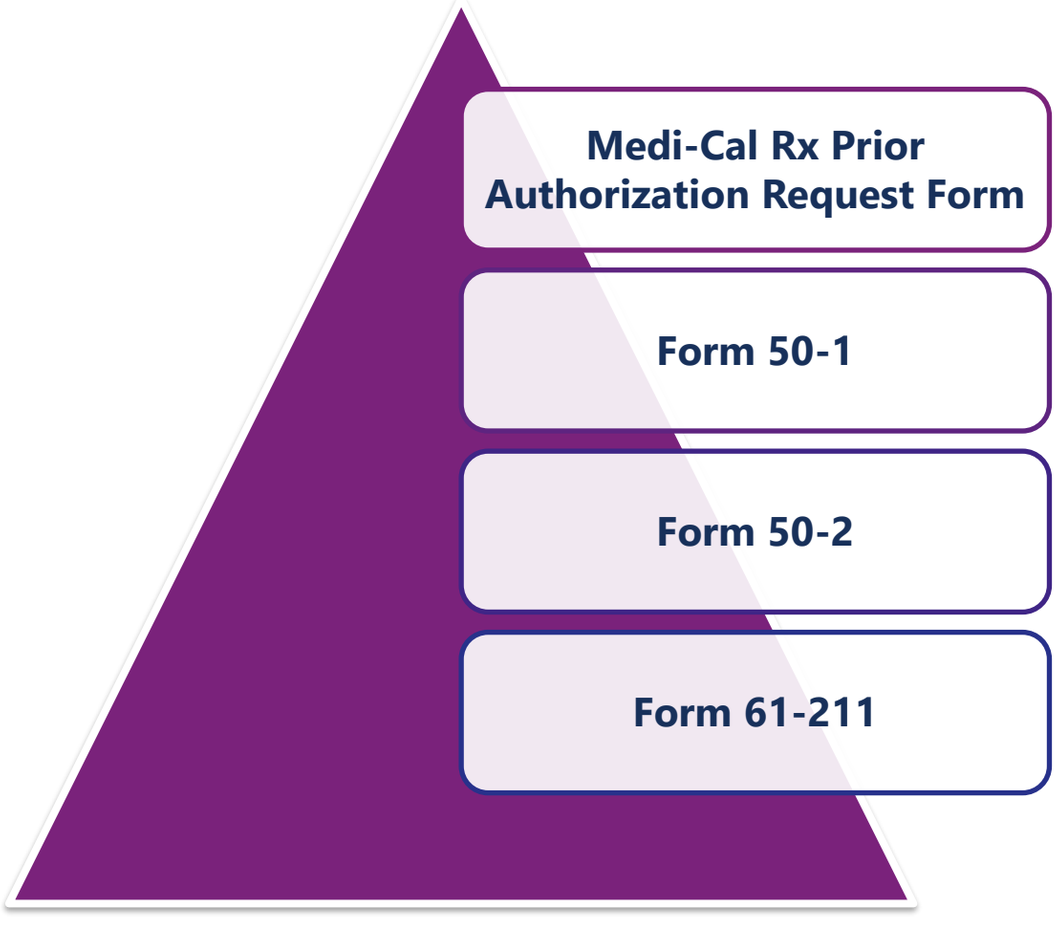
Fax

- Fax number:
  800-869-4325

Mail

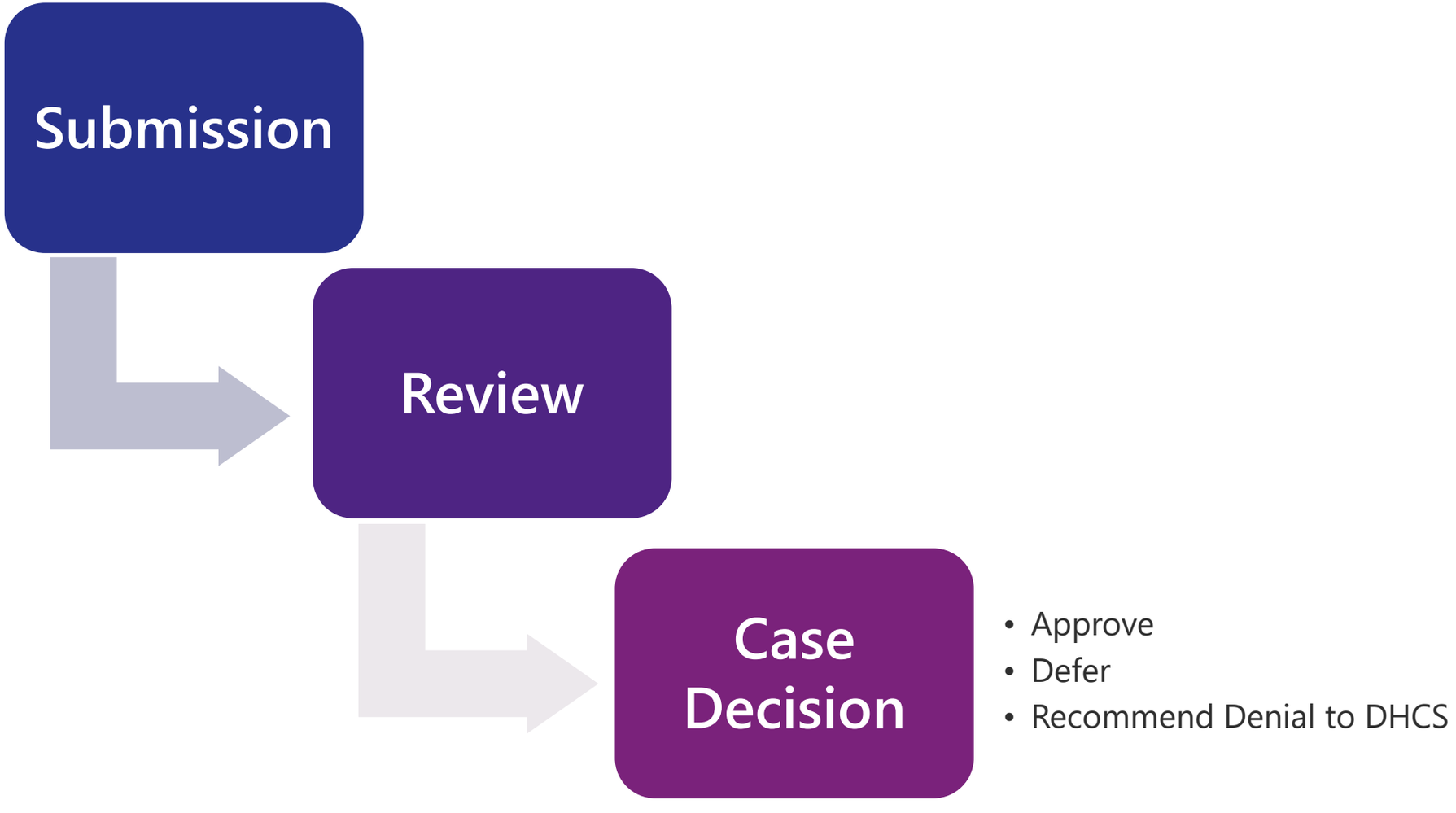
- Medi-Cal Rx Customer Service Center
  Attn: PA Request
  P.O. Box Number 730
  Rancho Cordova, CA 95741-0730

Approved PA Forms



Unapproved Forms
Forms not listed above will not be accepted.

What is the PA Process?



PA Appeal Intake Channels

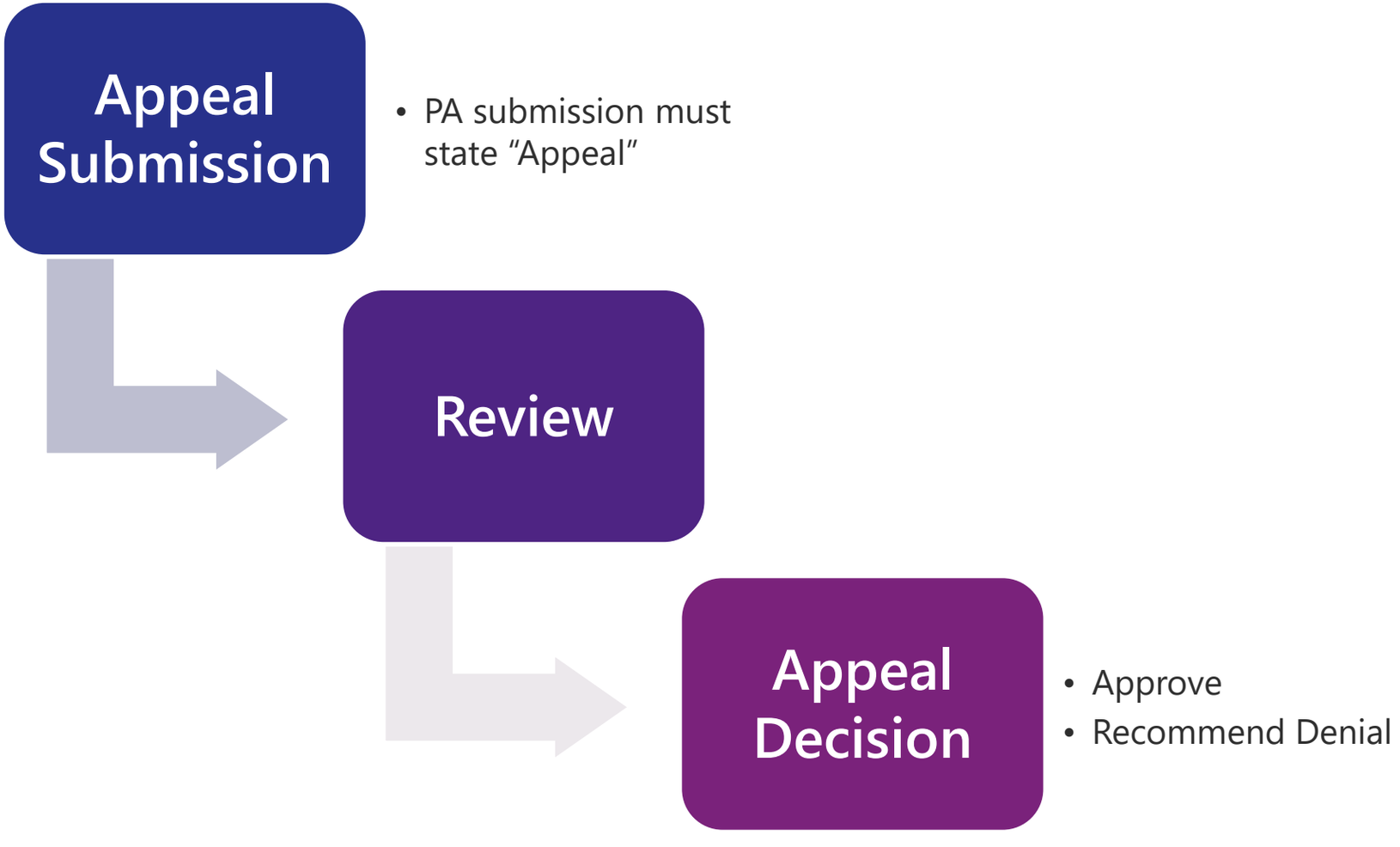
Secured Provider Portal

Fax

Mail

Appeal Submissions may be sent within 180 days from the date of the initial denial

What is the PA Appeal Process?



Contract Drugs List (CDL) and Other Covered Products

Contract Drugs List

- Searchable by generic name
- Alphabetized by Therapeutic Class
- Medications not on CDL, require a PA
- Code 1 Restrictions: AL, QL, LR, and diagnosis

Code	Description
Age Limit (AL)	Claim will reject if age parameters are not met.
Labeler Restriction (LR)	Claim must reflect indicated labeler code for claim to pay.
Quantity Limit (QL)	Claim will reject if defined quantity limits are exceeded.
Diagnosis	Claim will reject if diagnosis is not met. Note: This rejection may be resolved by the pharmacy inputting an ICD-10 code as provided on a prescription.

CDL Navigation

Drug Name	Dosage	Strength/ Package Size	Billing Unit	UM Type	Code 1
Diazepam *	Injection *	5 mg/ml	ml	AL	* Use in beneficiaries less than 2 years of age requires prior authorization approval for all dosage forms except the nasal spray.
	Nasal Spray *	5 mg 10 mg 15 mg 20 mg	ea ea ea ea	AL, LR, QL	* Restricted to use in Cerebral Palsy, Athetoid States, or Spinal Cord Degeneration for the injection only.
	Tablets + *	2 mg 5 mg 10 mg	ea ea ea ea	QL	* Restricted to use in the treatment of acute epilepsy in patients 6 years of age and older. Also restricted to a maximum quantity of 20 blister packs (10 cartons) in any 12-month period; and to NDC labeler code 72252 for the nasal spray only.
	Rectal Gel *	2.5 mg twin pack 10 mg delivery system twin pack 20 mg delivery system twin pack	ea ea ea	AL, LR, QL	**Note:** The billing unit for the nasal spray is a blister pack. Each carton contains 2 blister packs.

Medi-Cal Rx: Forms & Information Page

- **Contract Drug Lists**
  - Blood Factors
  - Over the Counter Drugs
  - Over the Counter Cold/Cough Preparations

- **Other Lists of Covered Products**
  - Covered Enteral Nutrition Products*
  - Covered Diabetic Test Strips and Lancets*
  - Covered Pen Needles*
  - Family PACT Pharmacy Formulary
  - Pharmacy Reimbursable Physician Administered Drugs

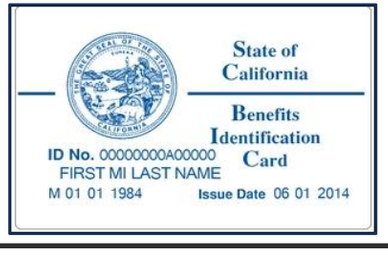
Beneficiary BIC/CIN

Paola Barajas Sr. Pharmacy Services Representative

Beneficiaries must provide one of the options below:

Examples of Benefits Identification Card (BIC)*

OR



*Either of these versions are acceptable

Examples of Client Index Number (CIN)

90000000A

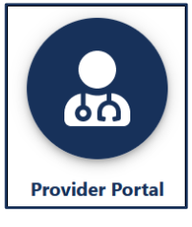
OR

01234567A

Beneficiary Eligibility

Validate eligibility through methods listed below:

- ✓The Secured Provider Portal
- ✓Contacting the Customer Service Center (CSC)



Contacts & Resources

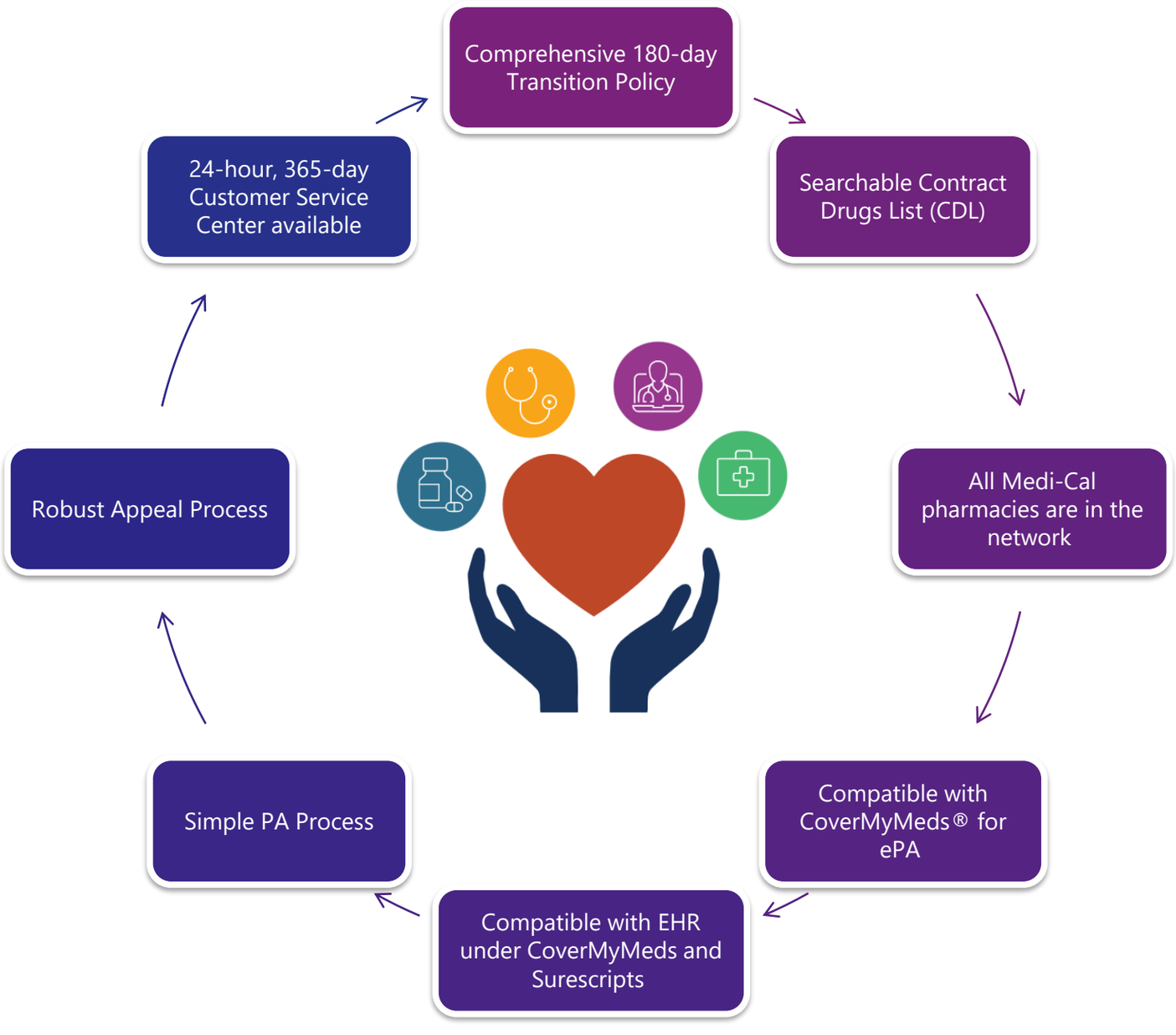
Need Additional Help or Want to Learn More?

Pharmacy Service Reps	MediCalRxEducationOutreach@MagellanHealth.com
Customer Service Center	1-800-977-2273
Medi-Cal Enrollment: PAVE	1-866-252-1949
Live Chat & Messaging	For assistance, visit the Contact Us page
Readiness Survey	Take the Medi-Cal Rx Readiness Survey
Medi-Cal Rx Subscription Service (MCRxSS)	Sign up for MCRxSS for the latest Bulletins & News

Resource Links

Medi-Cal Website	https://medi-calrx.dhcs.ca.gov/home/
Medi-Cal Rx Education & Outreach	https://medi-calrx.dhcs.ca.gov/home/education
Provider Manual	https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf
FAQs	https://medi-calrx.dhcs.ca.gov/home/faq
Medi-Cal Rx Communications	https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/

Medi-Cal Rx Summary: Improving Pharmacy Processes



Questions?

Thank you for attending the Medi-Cal Rx 101 Webinar

Appendix

BIN, PCN and RX Group Information

Effective Date
January 1, 2022
Beneficiary ID
14- digit beneficiary identification number located on the front of the BIC or 9-digit Client Index Number (first nine digits of the beneficiary identification number)

BIN	PCN	Group
022659	6334225	Medi-Cal Rx

Medi-Cal Rx Team Introductions

- **Katie Trueworthy-** *VP, MCO Liaison and External Affairs*
- **Bassant Khalil -** *VP, Clinical Management*
- **Jason Manviller-** *Education & Outreach Senior Manager*
- **Vanessa Chavez-** *Education and Outreach Supervisor*
- **Shaylene Gilkison-** *Sr. Pharmacy Services Representative*
- **Paola Barajas-** *Sr. Pharmacy Services Representative*
- **Samantha Fink RN, BSN-** *Medi-Cal Rx Clinician*
- **Karen Mikhael, PharmD -** *Medi-Cal Rx Clinician*

Expanding Access to Integrated Care for Dual Eligible Californians

Initial release February 24, 2020, Revised March 1, 2021

Under the California Advancing and Innovating Medi-Cal initiative (CalAIM), the California Department of Health Care Services (DHCS) is proposing to transition Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI) to a statewide Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plan (D-SNP) structure. DHCS will work with health plans, stakeholders, and CMS to transition and expand integrated care statewide. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both the CalAIM and the California Master Plan for Aging.

Table 1: Timeline of Proposed Program Changes

Year	Program Change
2021	• All existing D-SNPs must meet new regulatory integration standards effective 2021
2022	• January 1: Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties • CMS will not enter into contracts with D-SNP "look-alike" Medicare Advantage (MA) plans • Certain MA plans with D-SNP look-alike enrollees may transition those beneficiaries to aligned D-SNPs • December 31: Discontinue CMC and CCI
2023	• January 1: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into MCPs for Medi-Cal benefits, and statewide carve-in of long-term care (LTC) into Medi-Cal managed care • January 1: CMC enrollees transition to aligned D-SNP/MCPs. Aligned enrollment begins in CCI counties and MCPs in those counties must stand up D-SNPs; All CMC members crosswalk to matching D-SNP and MCPs, subject to CMS and state requirements • CMS will not renew contracts with D-SNP look-alike MA plans, in most cases[1]

[1] See Contract Year 2021 Medicare Advantage and Part D Final Rule 42 CFR 422.514 for more details, available at https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program.

Year	Program Change
2025	• Aligned enrollment required in non-CCI counties; All MCPs required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit)
2027	• Implement MLTSS statewide in Medi-Cal managed care

Promoting Integrated Care through D-SNP and MLTSS

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties.[2] As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into MCPs for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their Medi-Cal managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies in this document will rely on California's robust and diverse array of home and community-based services (HCBS) across the state who serve older Californians and people with disabilities.

DHCS' intent is that the policies outlined in this paper, and the related enhanced care management (ECM) benefit and in lieu of services (ILOS) policy[3] in CalAIM, will expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

Note: D-SNPs are Medicare Advantage (MA) health care plans that provide specialized care to duals and offer wrap-around services but must also maintain a State Medicaid Agency Contract (SMAC) with DHCS. The Bipartisan Budget Act (BBA) of 2018 permanently authorized D-SNPs, modified integration requirements, and established unified grievances and appeals procedures.[4]

Selective Contracting with D-SNPs

DHCS maintains the authority to contract or not to contract with D-SNPs. DHCS will use selective contracting to move toward aligned enrollment in D-SNPs: having beneficiaries enroll in an MCP and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

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[2] Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara counties.
[3] Find information on the Department of Health Care Services' Enhanced Care Management and In Lieu of Care Services policy on their website, https://www.dhcs.ca.gov/provgovpart/Pages/ecm_ilos.aspx.
[4] Bipartisan Budget Act of 2018 (P.L. 115-123) (https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf)

- In CCI counties, aligned enrollment will become effective in 2023. Cal MediConnect (CMC) members will transition to aligned D-SNPs and MCPs operated by the same organization as their Cal MediConnect product. New D-SNPs in these counties will be restricted to those operated by the MCPs in the county. Beneficiaries not already enrolled in a D-SNP will only be able to enroll in a D-SNP operated by the same organization as their MCP (although they retain the choice of any other Medicare options, including Medicare fee-for-service, non-D-SNP MA plans, or a Program of All-Inclusive Care for the Elderly (PACE) plan).

- Aligned enrollment will phase-in in non-CCI counties as all plans in the county are ready. DHCS will require MCPs to apply for aligned D-SNPs to be effective no later than contract year 2025. Until 1 year before aligned enrollment is effective in a county, DHCS will continue to contract with new D-SNPs in these counties (including non- aligned D-SNPs not operated by the county MCPs). After that point, DHCS will only newly contract with D-SNPs operated by an MCP in that county. Existing enrollees in non-aligned D-SNPs will be able to keep their plan, but non-aligned D-SNPs will not be allowed to accept new enrollment.

- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their MCP) when aligned enrollment takes effect in their county (both CCI and non-CCI counties) will be allowed to remain in that D-SNP. New enrollment in those non-aligned D-SNPs will be closed.

DHCS launched an aligned enrollment technical workgroup with managed care plans in February of 2020 to begin working through additional policy and operational details around implementation. DHCS will share the workgroup recommendations for stakeholder feedback.

DHCS will also pursue several avenues with CMS to limit enrollment into MA plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost-sharing to duals as D-SNPs, but which do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population such as risk assessments or care plans. Per the Contract Year 2021 Medicare Advantage and Part D Final Rule[5]:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- Will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals) starting in 2023.

[5] 42 CFR 422.514 available at https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program.

DHCS will allow plans in CCI counties with Medi-Cal managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA D-SNP look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in CMC plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs must use a model of care addressing both Medicare and Medi-Cal services in order to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

DHCS will not contract with new D-SNPs to operate as fully-integrated (FIDE) or highly-integrated (HIDE) D-SNP, based on our interpretation of CMS guidelines[6] that the current LTSS and behavioral health carve-outs in Medi-Cal would not permit plans to meet HIDE and FIDE requirements.

D-SNP Integration Standards for 2021

D-SNPs that will be operating in plan year 2021 and beyond were required to submit an updated SMAC by July 6, 2020 to meet the higher standards of coordinated care by January 1, 2021. DHCS began working on SMAC updates in 2019.[7] These new integrated care requirements include hospital and SNF admission notification requirements. DHCS' contracts with D-SNPs now require all non-FIDE and HIDE D-SNPs to notify, or to arrange for another entity/entities to notify, the state or its designee(s) of hospital and Skilled Nursing Facility (SNF) admissions for at least one state-identified population of high-risk enrollees to improve coordination of care during transitions of care.

In 2020, DHCS developed an information sharing policy that requires D-SNPs to share hospital and SNF admission data for all full-dual eligible enrollees with DHCS on a monthly basis. This new policy applies to all existing non-FIDE D-SNPs n 2021, and all new non-FIDE D-SNPs as they stand up operations.

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[6] Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs) (https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf)

[7] A recent memo further detailing the new D-SNP requirements (https://www.integratedcareresourcecenter.com/sites/default/files/CY%202021%20Me dicare-Medicaid%20Integration%20and%20Unified%20Appeals%20and%20Grievances.._.pdf) and a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (https://www.medicaid.gov/sites/default/files/Federal-Policy- Guidance/Downloads/cib111419-2.pdf) can be found online.

D-SNP Integration Standards for Aligned Enrollment

As DHCS implements aligned enrollment, other integration requirements for D-SNPs will include:

- DHCS will require D-SNPs to develop and use integrated member materials.
- DHCS will require D-SNPS to include consumers in their existing advisory boards.
- DHCS will work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and MCPs.
- DHCS will require D-SNPs to include dementia specialists in their care coordination efforts, incorporating existing Cal MediConnect contract requirements and best practices in serving this population.
- DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/MCP being audited by both agencies at the same time.
- DHCS will require D-SNPs to coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Medi-Cal Managed Long-Term Services and Supports

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of long-term care (LTC) into managed care plans for Medi-Cal populations in 2023.[8] This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care in 2023. Based on lessons learned from CCI, DHCS will work to ensure continuity of care through a smooth transition of existing treatment authorization requests to the managed care format and facilitate communication between the MCP provider relations team and nursing facilities. DHCS will develop a promising practices tip sheet for the plans in the transition and alignment with delegated plans. DHCS will also consider new requirements for MCPs working with the long-term care facilities, align quality metrics, and potentially require SNFs to coordinate with D-SNPs to align with D-SNP requirements to coordinate around hospital and other facility discharge planning. The integration of LTC into Medi-Cal managed care, along with the existing HCBS programs and new ILOS available to MCPs, will promote more integrated care for beneficiaries, and greater opportunities and incentives for MCPs to promote home and community-based choices.

Reporting Requirements, Oversight, and Quality

DHCS will be examining existing CMS D-SNP contract requirements and federal quality- based standards. DHCS may potentially require D-SNPs to provide the state annual Medicare Part C and D reporting and any compliance actions taken including areas of quality or access by CMS. DHCS will require separate contract numbers for

[8] Dual eligible individuals are defined as Medi-Cal members with any Medicare Coverage. Partial-duals are Medi-Cal members with only Medicare Part A or only Medicare Part B. Full- duals are Medi-Cal members with Medicare Part A and B or Medicare Parts A, B, and D.

new D-SNPs, subject to CMS approval, to allow DHCS to receive quality reporting for only California duals. DHCS will work with stakeholders, plans, and CMS to identify the range of quality and reporting results that D-SNPs will report to DHCS on an annual basis. To the extent DHCS requests D-SNPs to provide Medicare reporting materials, DHCS will align those requirements with new CalAIM and MCP requirements, to the extent possible.

D-SNP Transitions and Enrollment Policies

DHCS will implement the following policies to support aligned enrollment. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

- **Aligned Enrollment:** As aligned enrollment implements in a county, DHCS will require beneficiaries to be in an MCP product aligned with their D-SNP (if they choose to enroll in a D-SNP) to promote coordination and integrated care. Aligned enrollment will take effect in CCI counties in January 2023 and will phase-in in all other counties as all plans in the county are ready, no later than 2025. DHCS is considering other flexibilities for MCPs operating in rural areas should they be unable to meet Medicare network adequacy or other requirements.

- **Voluntary Enrollment:**

    - *Medicare Fee-For-Service:* Dual eligible beneficiaries who are in Medicare FFS will remain in Medicare FFS, unless they voluntarily choose to enroll in a Medicare managed care product. DHCS will not passively enroll dual eligible beneficiaries from Medicare fee-for-service into a managed care product for their Medicare benefits.

    - *D-SNPs:* Dual eligible beneficiaries already enrolled in a D-SNP product that is continuing operations will remain in those Medicare products. They will not be passively enrolled into a D-SNP that aligns with their MCP. They would have the option to voluntarily enroll into an aligned D-SNP or PACE plan and receive their care from an integrated product.

- **Default Enrollment:** DHCS will allow D-SNPs to pursue approval from CMS and DHCS to enroll, unless the member chooses otherwise, existing MCP members into the D-SNP when they become newly eligible for Medicare due to age or disability.

- **Crosswalk Enrollment:**

    - DHCS will request that CMS use existing authority to allow a crosswalk transition for full-benefit, dually eligible individuals from an

integrated D- SNP that is no longer available to the individual into another comparable D-SNP in instances where integrated care coverage would otherwise be disrupted. For example, if during Medi-Cal reprocurement (see below), a parent organization will no longer offer an MCP and/or D-SNP in a county, CMS could enroll the member in a comparable, integrated plan.

- DHCS will request that CMS allow a crosswalk transition for beneficiaries from a CMC plan to a D-SNP and MCP operated by the same parent organization to minimize disruptions in care coordination and benefits for Cal MediConnect enrollees. The D-SNPs must offer a substantially similar provider network, cover the same or more benefits as the CMC product, and may not impose additional cost-sharing requirements, and may be subject to additional CMS requirements such as financial criteria and CMC performance metrics. DHCS will request CMS provide these criteria in sufficient time for CMC plans to plan their transition.

- These crosswalk transitions will be managed by the CMC and D-SNP plans in accordance with CMS rules and guidelines. DHCS has convened an aligned enrollment technical workgroup composed of managed care plans to develop recommendations on how plans should support beneficiaries in the transition. DHCS will share the proposed recommendations for stakeholder feedback. In addition to CMS required notices, DHCS will require D-SNP plans educate beneficiaries about all their enrollment options, including PACE plans.

- **D-SNPs without Medi-Cal Contracts in Service Area:** DHCS will allow existing eligible members of D-SNPs that do not have a matching MCP product in the service area to remain enrolled. This will protect beneficiary choice, even though these beneficiaries will not receive the same level of integrated care as beneficiaries in aligned plans. After aligned enrollment is effective in a county, beneficiaries would not be able to join a D-SNP if they are not also in the plan's MCP product.

- **Delegated MCPs:** Current D-SNP regulations may not allow crosswalk or default enrollment for plans that do not have a direct contract with the state Medicaid agency. DHCS will request CMS determine how to allow CMC plans that do not have a direct Medi-Cal contract to participate in aligned enrollment, with the intent of allowing beneficiaries to remain with the plan of their choice.

Cal MediConnect Transition

DHCS will work with CMS to ensure that Cal MediConnect plans continue to provide high quality care to members during the transition.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around MCP requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into an MCP or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

- Provide technical assistance around new MCP requirements for duals. MCPs will have new responsibilities and tools to better serve beneficiaries. DHCS will determine what requirements apply to MCPs serving dual eligible beneficiaries and how those requirements will align with D-SNP requirements, such as in lieu of services.

Enrollment Considerations

- **D-SNP Crosswalk Transition:** Given the large volume of beneficiaries that would crosswalk from CMC plans to D-SNPs, DHCS will request continued demonstration authority from CMS during the transition to allow CMC member health risk assessments (HRAs) and care plans to qualify under the D-SNP, rather than requiring plans to conduct new assessments for all members. Existing care plans would remain in effect during the transition. Plans would be required to outreach, attempt an HRA, and develop care plans for members that previously declined an HRA, were unreachable, or do not have an existing plan.

- **Prescription Drug Benefits**: California is carving out prescription drug benefits in Medi-Cal. Upon implementation, Medi-Cal prescription drugs will be fee-for-service (FFS) (except for CMC plans, which keep their pharmacy benefit until the transition to D-SNPs). D-SNPs still must meet CMS requirements to maintain a Medicare Part D Prescription Drug plan.

Enrollment Consumer Protections

- **Limiting Churn:** Medicare allows D-SNPs to voluntarily allow members to remain enrolled in the plan for a deeming period of up to six-months. DHCS will encourage D-SNPs to maximize the deeming period to resolve any Medi-Cal eligibility issues.

- **Marketing and Brokers:** DHCS will ensure consumer protections are standardized across the state. DHCS will explore how to require D-SNPs to only target marketing materials to enrollees in their affiliated MCPs. Insurance brokers will be required to explain the value of enrolling in an integrated product, as well as how to navigate a health plan network (including the delegated model) and receive training on how to work with limited English proficiency beneficiaries, and the important of using beneficiary-facing materials that are culturally appropriate and in Medi-Cal threshold languages.

- **Notices to MLTSS Duals:** Notices will be sent to MLTSS dual eligible members informing them of their new option to enroll in a matching D-SNP, as well as their other options for their Medicare and Medi-Cal benefits, such as PACE. DMHC and DHCS will review marketing rules to ensure D-SNPs are able to educate members in their matching MCP plan about their integrated care options.