CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup

DHCS

January 19, 2023

How to Add Your Organization to Your Zoom Name

- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window and click “More.”
- Select “Rename” from the drop-down menu.
- Enter your name and add your organization as you would like it to appear.
  - For example: Mary Russell – Aurrera Health Group

Agenda

- Welcome and Introductions
- Update: Skilled Nursing Facility Long-Term Care Carve-In Transition and Stakeholder Q&A
- Updates: January 2023 Transitions and DHCS Monitoring and Stakeholder Q&A
- Update: Enhanced Care Management (ECM) 2023 Populations of Focus
- 2023 CalAIM D-SNP Policy Guide: Recently Released Chapters
- 2024 D-SNP Care Coordination Guidance
- Next Steps and Future Meeting Topics
- Appendix A: Public Health Emergency Unwinding

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for CalAIM MLTSS, and integrated care for dual eligible beneficiaries. Provide an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for upcoming changes for Medicare and Medi-Cal.
- Open to the public. Charter posted on the Department of Health Care Services (DHCS) website.
- ***We value our partnership with plans, providers, advocates, beneficiaries, caregivers, and the Centers for Medicare & Medicaid Services (CMS) in developing and implementing this work.***

CalAIM MLTSS & Duals Workgroup: 2023 Topics

- Discuss implementation, data, results, opportunities and challenges of CalAIM initiatives for MLTSS, for all Medi-Cal members
- Discuss implementation, data, results, opportunities and challenges of CalAIM initiatives for integrated care for dual eligible beneficiaries (both Medicare Advantage and Original Medicare)
- Flag related DHCS efforts for Medi-Cal members who are older adults or people with disabilities

California Advancing and Innovating Medi-Cal (CalAIM): Long-Term Care (LTC) Carve-In

CalAIM Long-Term Care Skilled Nursing Facility Carve-In Overview

- Effective January 1, 2023, Medi-Cal managed care plans (MCPs) in all counties now cover the LTC benefit for Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital.
- Enrollment in Medi-Cal managed care is mandatory for all Medi-Cal beneficiaries residing in a SNF.

SNF Carve-In Goals

- Standardize SNF services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal beneficiaries in SNFs.

SNF Carve-In: APL 22-018 Updates

- **Preadmission Screening and Resident Review (PASRR)**
  - To prevent an individual's inappropriate nursing facility admission and retention of individuals, federal law requires proper screening and evaluation before such placement.
- **Population Health Management: Transitional Care Services (TCS)**
  - As part of their PHM Program, MCPs must provide strengthened TCS that will be implemented in a phased approach. Effective January 1, 2023, MCPs are required to provide TCS for all high-risk members (this includes SNF residents).

SNF Carve-In: APL 22-018 Updates (cont.)

- **MCP Quality Monitoring**
  - MCPs are responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for long term care services provided.
  - MCPs must have a system in place to collect quality assurance and improvement findings from CDPH to including survey deficiency results, site visit findings, and complaint findings. APL 22-018 outlines additional requirements for the MCP QAPI program.
- **Monitoring and Reporting**
  - MCPs are required to report on LTC measures within the Managed Care Accountability Set (MCAS) of performance measures.
  - MCPs are required to calculate rates for each MCAS LTC measure for each SNF within their network for each reporting unit.

Post-Transition Monitoring Overview

- **Post-Transitional Monitoring (PTM)**
  - Components include Continuity of Care, Grievances and Appeals, system issues, provider issues, member concerns
  - Daily for first two weeks; weekly through the end of January; monthly beginning in February
  - Assessment of TARs/Prior Authorizations
- **Ongoing Network/Contract Arrangements**
- **Ongoing Monitoring**
  - Access
  - Quality
  - Encounter Data
  - Grievances and Appeals
  - Continuity of Care

- MCPs have provided daily PTM reports and there are no significant issues or concerns at this time. These PTM reports have included the number of:
  - CoC requests, bed hold authorizations and status, LTC calls from providers
- DHCS continues to regularly monitor call center reports from DHCS Medi-Cal Ombudsman and Health Care Options.

SNF Carve-In Monitoring: Ongoing Monitoring

- Starting in April 2023, MCPs must submit the completed Transitional Monitoring Template on a **quarterly** basis moving forward.
- Providers will need to contact the MCP's LTSS liaisons, or MCP representative, to escalate issues with the MCP, including any payment issues.
- DHCS will consider the overlap with Population Health Management and Quality of Care including:
  - How Complex Care Management (CCM), Enhanced Care Management (ECM), and Community Supports will work for SNF populations
  - Transitional Care Services (TCS)
- Provider/MCP dispute assistance if the issue cannot be resolved through direct engagement.
- DHCS assistance with the identification of a direct and appropriate MCP contact and provision of MCP contact/contact list.

Resources and Contact Information

Questions? Please contact info@calduals.org

- Upcoming SNF Carve-In webinar on January 30, 2023 at 2pm.
- SNF LTC Carve-In Frequently Asked Questions (FAQs) and Resources for Managed Care Plans available under Key Documents here: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx
- APL 22-018 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of members to Managed Care

Thank you!

Questions?

» Questions on the CalAIM SNF LTC Carve-In?

Updates: January 2023 Transitions and DHCS Monitoring

Cal MediConnect to Medi-Medi Plans Transition

Overview: Cal MediConnect Transition

- On **January 1, 2023,** beneficiaries in Cal MediConnect (CMC) plans were **automatically** transitioned into Medi-Medi plans operated by the same parent company as the CMC plan.
  - There will be **no gap in coverage**.
  - Provider networks should be **substantially similar.**
  - Continuity of care provisions.
- Medicare Medi-Cal Plans, or Medi-Medi Plans (MMPs), combine Medicare and Medi-Cal benefits into one plan. Available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties.

Cal MediConnect (CMC) to Medi-Medi Plans (MMP) Transition

DHCS CMC lift and shift to MMP Update:

- 112,232 out of 112,661 (99.62%) of CMC beneficiaries were shifted to an MMP or MCP aligned to their current Medicare Advantage Plan (Medi-Cal Matching Plan Policy)
- 429 (0.38%) of CMC beneficiaries were not shifted for valid plan exclusion reasons

Cal MediConnect Transition and Monitoring

- Plans are to report Post Transition Monitoring (PTM) regarding member and provider phone calls on access to care issues, technical issues, and grievances and appeals via SurveyMonkey (SM) utilizing the DHCS PTM template that was released to plans on December 15, 2022 using the following schedule:
- **Daily reporting has concluded.**
- **Weekly reporting is due:**
  - Week 3: January 20, 2023
  - Week 4: January 27, 2023
- **Monthly reporting is due:**
  - February 28, 2023
  - March 31, 2023
  - May 1, 2023

Cal MediConnect Transition and Monitoring (cont.)

- As of 1/13/2023, plans have not reported any major access to care issues.
- Plans have flagged the following:
  - Technical issue- members enrolled in Medicare have not been received on the 834 files
  - Complaints/grievances- member complaints indicating members did not make a plan choice

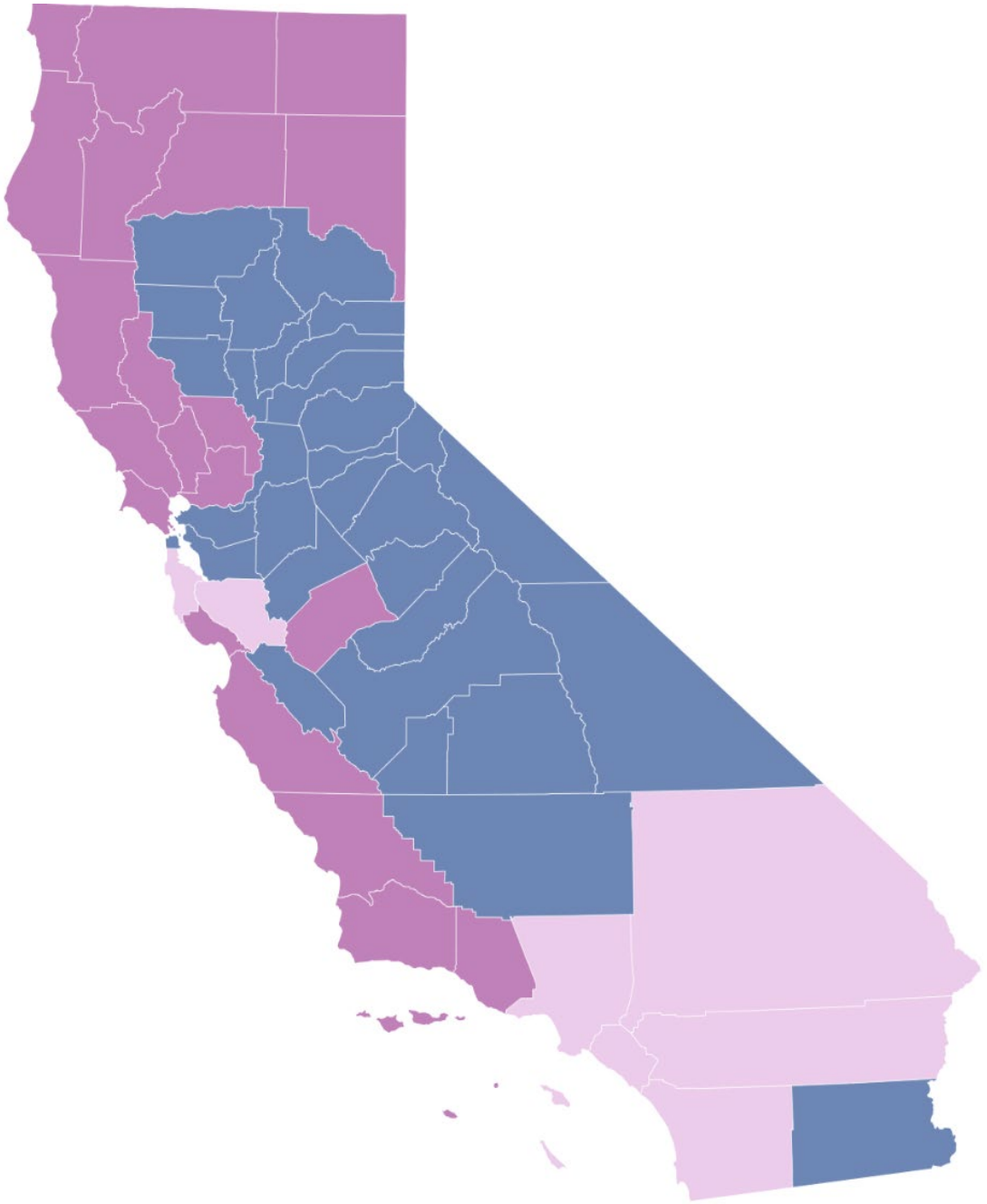
Medi-Cal Managed Care Enrollment for Dual Eligibles

Statewide Medi-Cal Managed Care/ Long-Term Care

COHS Counties with SNF Services and Duals already in Medi-Cal Managed Care

CCI Counties with SNF Services and Most Duals already in Medi-Cal Managed Care

Counties where SNF Services and Duals will be transitioned to Medi-Cal Managed Care starting January 1, 2023



CalAIM: Medi-Cal Managed Care for Dual Eligible Beneficiaries

- Currently over 70 percent, more than 1.1 million, dual eligible beneficiaries are enrolled in Medi-Cal managed care.
- **Starting January/February 2023, about 325,000 dual eligible beneficiaries will be newly enrolled in Medi-Cal managed care.**
- Key Impacted Counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, and Yuba.
- Beneficiaries can choose a Medi-Cal plan using materials they will receive in fall 2022. In 12 counties, Medi-Cal matching plan policy applies.

Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries

Mandatory Managed Care Enrollment (MMCE) and Long Term Care (LTC) Skilled Nursing Facility (SNF) Carve-In Transition Update:

- Dual members not part of the Matching Plan Policy:
  - 24,647 dual eligible beneficiaries enrolled by choice into a Managed Care Plan for an effective date of January 1, 2023. The remainder of the transitioning beneficiaries will default into a Managed Care Plan on February 1, 2023.
- Dual members part of the Medi-Cal Matching Plan Policy:
  - 33,427 dual eligible beneficiaries were enrolled into a Managed Care Plan that matched their Medicare Advantage Plan for an effective date of January 1, 2023.

Medicare Providers for Dual Eligible Beneficiaries

- CalAIM: January 2023, dual eligible beneficiaries in 31 counties will transition into Medi-Cal managed care enrollment.
- **Medicare providers serving dual eligible patients do NOT need to enroll in Medi-Cal plans in order to continue to receive reimbursement as usual.**
- **For patients, Medi-Cal managed care plan enrollment does NOT impact Medicare provider access, or choice of Original Medicare or Medicare Advantage.**
- Fact sheets and Notices in many languages are available on DHCS webpage.

Medicare Provider Billing Process for Dual Eligible Patients

- **Original (Fee-for-Service) Medicare:** Provider bills Medicare Administrative Contractor (Noridian). Medicare (Noridian) processes the primary claim for Medicare payment, and then forwards the claim to the Medi-Cal plan (or DHCS) for secondary Medi-Cal payment.
  - Noridian receives Medi-Cal managed care enrollment information from the Medicare Benefits Coordination and Recovery Center.

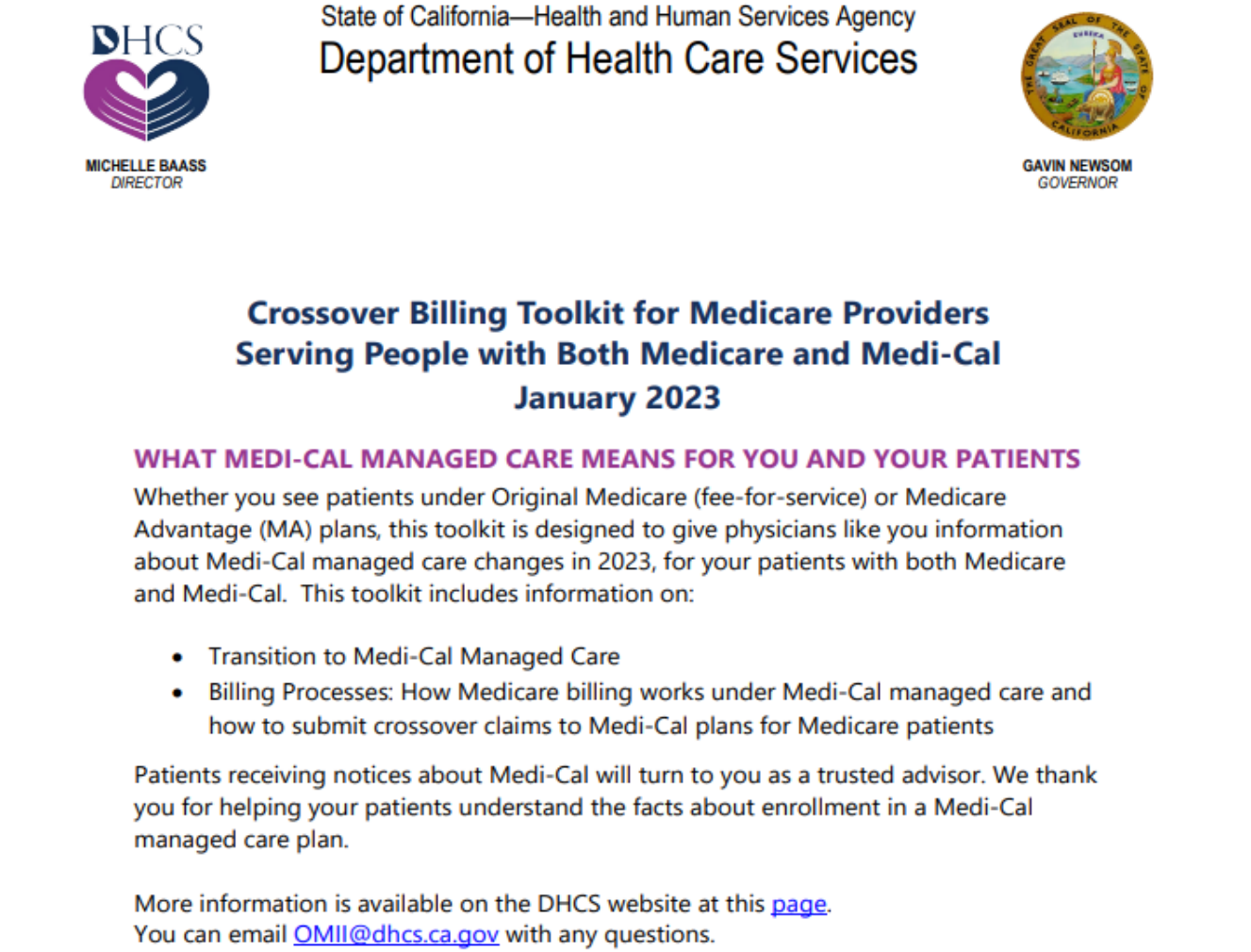
- **Medicare Advantage (MA):** Provider bills MA plan for primary Medicare payment.
  - If patient's MA plan is the same as patient's Medi-Cal plan, same organization should process secondary claim.
  - If patient's MA plan is different than patient's Medi-Cal plan:
    - MA plan may send secondary claim to Medi-Cal plan, if known, OR
    - Provider will need to bill secondary to Medi-Cal plan (or DHCS).

Medicare Provider Billing Information

- DHCS is currently updating APL 13-001, provider bulletins and other guidance to remind/clarify the crossover billing process for Medicare providers not within a Medi-Cal MCP network.
  - Provider Fact Sheet
    - https://www.dhcs.ca.gov/services/Documents/Medi-Cal-Managed-Care-Provider-Fact-Sheet-Dec-2022.pdf
  - Crossover Claims MCP Contact List: Plan contact list has descriptions for crossover billing processes specific to each plan including direct contact information for escalation of billing issues if needed.
  - For more information, please visit:
    - https://www.dhcs.ca.gov/services/Pages/Statewide-Medi-Cal-Managed-Care-Enrollment-for-Dual-Eligible-Beneficiaries.aspx

NEW: Crossover Billing Toolkit for Medicare Providers Serving People with Both Medicare and Medi-Cal

- DHCS has released a Crossover Billing Toolkit for Medicare Providers serving people with both Medicare and Medi-Cal. Available on the DHCS website: https://www.dhcs.ca.gov/services/Documents/Crossover-Billing-Provider-Toolkit-Jan-2023-1-13-23.pdf



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GOVERNOR

Crossover Billing Toolkit for Medicare Providers Serving People with Both Medicare and Medi-Cal
January 2023

WHAT MEDI-CAL MANAGED CARE MEANS FOR YOU AND YOUR PATIENTS

Whether you see patients under Original Medicare (fee-for-service) or Medicare Advantage (MA) plans, this toolkit is designed to give physicians like you information about Medi-Cal managed care changes in 2023, for your patients with both Medicare and Medi-Cal. This toolkit includes information on:

- Transition to Medi-Cal Managed Care
- Billing Processes: How Medicare billing works under Medi-Cal managed care and how to submit crossover claims to Medi-Cal plans for Medicare patients

Patients receiving notices about Medi-Cal will turn to you as a trusted advisor. We thank you for helping your patients understand the facts about enrollment in a Medi-Cal managed care plan.

More information is available on the DHCS website at this page.
You can email OMII@dhcs.ca.gov with any questions.

Crossover Billing Toolkit (cont.)

BILLING FOR MEDICARE PHYSICIAN SERVICES

For patients enrolled in a Medi-Cal plan, the physician should bill for Medicare services – which include physician and hospital services – exactly as in the past. There is no change in what Medicare will pay for billed charges, which is generally 80% of the Medicare fee schedule.

- **For patients in Original Medicare**, or Medicare Fee-for-Service (FFS), physicians should continue to bill the Medicare Administrative Contractor (Noridian). Medicare (Noridian) processes the primary claim for Medicare payment and then forwards the claim to the Medi-Cal plan (or DHCS) for the secondary Medi-Cal payment.

- **For patients in Medicare Advantage (MA) plans**, physicians should bill the MA plan for primary Medicare payment.

- If the patient's MA plan is the same as the patient's Medi-Cal plan, the same organization may process the secondary Medi-Cal claim (see Table 2 for more details about plans that automatically cross). If automatic crossover is not set up for the patient's Medi-Cal plan, the physician will need to bill the Medi-Cal plan for the secondary payment.

- If the patient's MA plan is different than the patient's Medi-Cal plan,

Crossover Billing Toolkit (cont.)

TABLE 1: DUAL ELIGIBLE PATIENT INSURANCE STATUS AND WHERE PHYSICIANS BILL FOR SERVICES

	Physician Contracted with Medicare Health Plan		Physician Not Contracted with Medicare Health Plan		
Patient Medicare & Medi-Cal Status	**Medicare Physician Service Claim**	**Medi-Cal Wrap/Copayment Crossover Claim**	**Medicare Physician Service Claim**	**Medi-Cal Wrap/Copayment Crossover Claim**	**Amount Payable**
Original Medicare Fee-For-Service (FFS) & FFS Medi-Cal	Not Applicable		Bill Medicare directly	State Medi-Cal will utomatically receive and process claims	Medicare: 80% of Medicare fee schedule. Medi-Cal: Amount allowable under state law.
Original Medicare (FFS) & Medi-Cal Managed Care Plan	Not Applicable		Bill Medicare directly	Medi-Cal managed care plan will automatically receive and process claims	Medicare: 80% of Medicare fee schedule. Medi-Cal: Amount allowable under state law.
Medicare Advantage (MA) plan & FFS Medi-Cal	Bill Medicare Advantage plan	Bill State Medi-Cal directly	Bill MA plan (only for continuity of care or emergency services)	Bill State Medi-Cal directly	Medicare: Refer to MA plan contract terms. Medi-Cal: Amount allowable under state law.
Medicare Advantage (MA) plan & Medi-Cal Managed Care Plan	Bill Medicare Advantage plan	Bill Medi-Cal Managed care plan (no contract required). See Table 2 for Medi-Cal claims with same parent plans that automatically process.	Bill MA plan (only for continuity of care or emergency services)	Bill Medi-Cal Managed Care Plan (no contract required). See Table 2 for Medi-Cal claims with same parent plans that automatically process.	Medicare: Refer to MA plan contract terms. Medi-Cal: Amount allowable under state law.

Crossover Billing Toolkit (cont.)

TABLE 2: MEDI-CAL MANAGED CARE PLAN CROSSOVER BILLING CONTACT INFORMATION

MEDI-CAL HEALTH PLAN & CONTACT INFORMATION	COUNTIES	IF A PROVIDER NEEDS TO SUBMIT A MEDI-CAL CROSSOVER CLAIM, HOW SHOULD THEY DO THAT?
AETNA BETTER HEALTH OF CA Provider Services: (855) 772-9076 (TTY: 711)	Sacramento, San Diego	Submit paper claims with Medicare EOB to: Aetna Better Health of California Claims and Resubmissions P.O. Box 66125 Phoenix, AZ 85082-6125 Other Crossover Claims Procedures: If a crossover claim is submitted where the member has Aetna coverage for Medicare and for Medi-Cal, the claim is routed internally for processing.
AIDS HEALTHCARE FOUNDATION dba Positive Health Care California Claims Department: (888) 235-9274	Los Angeles	Submit paper claims with Medicare EOB to: PHC California Attn: Claims P.O. Box 472377 Aurora, CO 80047 Electronic claims: Providers can electronically submit their claims as HIPAA-compliant X12 837 to our clearinghouse, Change Healthcare, submitting ID 95422. Providers must attach the Medicare EOB or RA to allow MCP to coordinate benefits under Medi-Cal.
ALAMEDA ALLIANCE FOR HEALTH AAH Provider Services: (510) 747-4510	Alameda	Submit paper claims with EOB to: P.O. Box 2460 Alameda, CA 94501

Balance Billing

- Dual eligible beneficiaries should **never** receive a bill for their medical services. This is called improper billing (or balance billing) and is illegal under state and federal law.
- Balance billing is prohibited in both MA and Original Medicare.
- Beneficiaries do not pay for doctor visits and other medical care when they receive services from a provider in their MA provider network. They may still have a copay for prescription drugs.

Questions

- Questions on CMC to MMP or the Medi-Cal Managed Care Enrollment Transitions?

Enhanced Care Management (ECM) 2023 Populations of Focus

CalAIM Care Management Continuum

Managed Care Plans (MCPs) are required to have a broad range of programs and services to meet the needs of all their members, including:

Enhanced Care Management (ECM) is for the **highest-need MCP Members** and provides intensive coordination of health and health-related services.

Complex Care Management (CCM) is for Members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** MCP Members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services are also available for all MCP Members transferring from one setting or level of care to another.

What is Enhanced Care Management (ECM?)

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home
- ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on MCP Member need, with ECM as the highest intensity level

Seven ECM Core Services

Outreach and Engagement

Member and Family Supports

Comprehensive Assessment and Care Management Plan

Health Promotion

Enhanced Coordination of Care

Comprehensive Transitional Care

Coordination of and Referral to Community and Social Support Services

Who is Eligible for ECM & How Does it Work?

ECM is available to Medi-Cal Managed Care Plan enrollees who meet "Population of Focus" criteria.

Eligible Enrollees…

- Can be identified through their managed care plan (MCP), provider, family/caregiver, community-based organizations (CBOs), or via a self-referral.
- Are assigned an "ECM Provider" who best meets their needs. The ECM Provider makes sure the enrollee has a single "Lead Care Manager" who coordinates their care and services across Medi-Cal delivery systems and beyond.

Enhanced Care Management and Dual Eligible Beneficiaries

- Dual Eligible Beneficiaries have high health care and Long-Term Services and Supports (LTSS) needs due to chronic conditions, and benefit from care management across Medicare and Medi-Cal benefits. Over 75% of In-Home Supportive Services (IHSS) recipients and 80% of long-term Medi-Cal Skilled Nursing Facility (SNF) residents are dually eligible.
- More than half of dual eligible beneficiaries are in Original Medicare (FFS). Those in some type of Medicare Advantage (MA) plan are in regular MA, D-SNPs, or integrated plans (CMC, PACE, SCAN).

Populations of Focus for ECM

ECM Populations of Focus	Go-Live Timing
• Adults and their Families Experiencing Homelessness • Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization • Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs • Individuals with Intellectual or Developmental Disabilities (I/DD)* • Adult Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes* • Individuals Transitioning from Incarceration (some WPC counties only)	January 2022 (WPC / HHP counties) July 2022 (all other counties)
• **Adults Living in the Community and At Risk for Institutionalization and Eligible for Long Term Care (LTC) Institutionalization** • **Adults who are Nursing Facility Residents Transitioning to the Community**	**January 2023**
• Children / Youth Populations of Focus	July 2023
• Birth Equity Population of Focus • Individuals Transitioning from Incarceration (statewide, excluding some WPC counties that went live in January 2022)	January 2024

** Members of these POFs are eligible from the start of ECM if they meet criteria for any other POF*

2023 ECM Populations of Focus

- On January 1, 2023, At Risk for Institutionalization and Eligible for Long Term Care and Nursing Facility Residents Transitioning to the Community were launched.
- Dual eligible beneficiaries are highly represented both populations. Since many of these beneficiaries are in Medicare FFS, the Medi-Cal Managed Care Plans (MCPs) would coordinate with Medicare FFS providers.
- More intensive patient-centered case management (ECM) and resources (Community Supports) can support at-risk elders and help them maintain in the community.

ECM 2023 Populations of Focus

- July 2023
  - **Adults (without family living w them) experiencing homelessness**
  - Children and Youth
- January 2024
  - Birth Equity
  - **Individuals transitioning from incarceration**

Populations in bold will have duals

Key Performance Indicators for ECM

- Members served
- Requests for Services
- Outreach
- Provider capacity

Further detail:

Quarterly-Implementation-Monitoring-Report-Guidance (ca.gov)

Questions/Bright Spots

» Questions on ECM 2023 Populations of Focus?

2023 CalAIM D-SNP Policy Guide: Recently Released Chapters

Recently Released 2023 D-SNP Policy Guide Chapters

- DHCS released the final chapters of the 2023 D-SNP Policy Guide which are available here: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx
  - Revised: Integrated Appeals and Grievances (EAE D-SNPs)
  - Revised: Quality Metrics and Reporting Requirements (EAE and Non-EAE D-SNPs)

2023 D-SNP Policy Guide: Integrated Appeals and Grievances for EAE D-SNPs

Integrated Appeals and Grievances

- As EAE D-SNPs in 2023 qualify as applicable integrated plans (AIP), the intent of this state-specific guidance is to ensure integrated processes for grievances, organization determinations, and reconsiderations for Enrollees.
- The process for 2023 EAE D-SNPs is detailed within the Policy Guide chapter and the comparison table, which has previously been reviewed with stakeholders and posted to the DHCS website.
- Revisions to the Policy Guide chapter released in early December include clarifications on integrated appeals and grievances noticing and definitions.

2023 D-SNP Policy Guide: Quality Metrics and Reporting Requirements for EAE and Non-EAE D-SNPs

2023 Quality Metrics and Reporting Requirements

- DHCS released an updated 2023 D-SNP Reporting Requirements Policy Guide Chapter.
- The new quality metrics and reporting requirements went into effect on January 1, 2023.
- State-specific reporting requirements are part of a larger quality strategy with DHCS, including the Comprehensive Quality Strategy, Long-Term Services and Supports (LTSS) dashboard, and the Master Plan for Aging.
- Measures have been reviewed at the Plan Workgroup Meetings, during the February and September 2022 MLTSS & Duals Integration Stakeholder meeting, and by advocates.

Quality Metrics and Reporting Requirements: Updates

- Updates include:
  - Added Core 2.1 (Members with an assessment completed within 90 days of enrollment) and Core 2.3 (Members with an annual reassessment) as requirement for all D-SNPs to report.
  - Requirements to report race/ethnicity stratifications according to the Office of Management and Budget standards.
  - Clarified language regarding state-specific data, Long Term Services and Supports (LTSS) measures, and the different reporting requirements for MMPs and non-EAE D-SNPs.

NEW: D-SNP Quality and Data Reporting Resources

- **Webpage:** DHCS posted a D-SNP Quality and Data Reporting webpage, which serves as a hub for EAE and non-EAE D-SNP quality reporting requirements and key resources. The webpage is available here: https://www.dhcs.ca.gov/Pages/D-SNP-Quality-and-Data-Reporting.aspx
- **Technical Specifications:** DHCS created the D-SNP Reporting Requirements Technical Specifications document, which applies definitions provided by CMS for 2022 Cal MediConnect reporting requirements.

NEW: D-SNP Quality and Data Reporting Resources (cont.)

- **Templates:** DHCS released three 2023 D-SNP Reporting Requirements Templates for plans to submit to DHCS via SFTP:
  - DSNP Annual Measures Reporting Template
  - DSNP Quarterly Reporting Template
  - DSNP MCI Annual Reporting Template

Questions

- Any questions on the Integrated Appeals and Grievances or Quality Metrics and Reporting Requirements D-SNP Policy Guide chapters?
- Additional questions regarding the 2023 D-SNP Reporting Requirements should be sent to QualityandHealthEquityDiv@dhcs.ca.gov

2024 D-SNP Care Coordination Guidance

2024 D-SNP Policy Guide: Care Coordination

- The Care Coordination chapter provides state-specific care coordination requirements to health plans operating EAE (MMP) and non-EAE D-SNPs. The chapter is now available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx
- Similar to 2023, topics in this chapter cover Risk Stratification, Health Risk Assessment (HRA), Individualized Care Plans (ICPs) and Interdisciplinary Care Teams (ICTs), and Care Transitions.
- **New for 2024**, additional information is provided on: Palliative Care, D-SNPs providing ECM-like services, and Dementia Care.

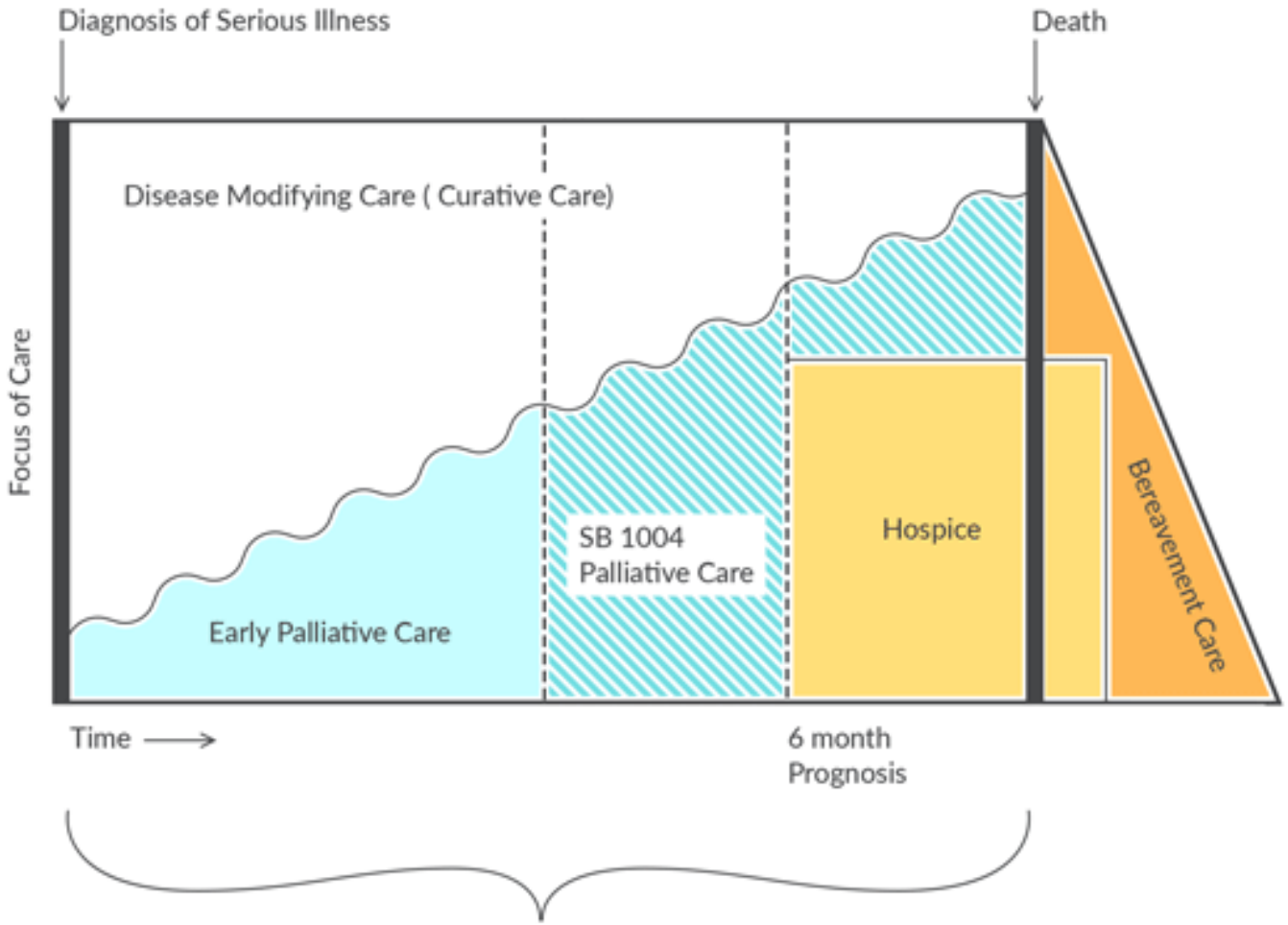
2024 Care Coordination Guidance: Palliative Care

What is Palliative Care?

- Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.
- Numerous studies show that palliative care significantly improves patient quality of life and lowers symptom burden. Apart from being the right thing to do for patients, this improved quality of life also means that an encounter with the health care system is less stressful and traumatic for families.

What is Medi-Cal Palliative Care?

Care Model for SB 1004 Medi-Cal Palliative Care



Advance Care Planning can occur at any time, including the POLST* form for those with serious illness.

To view the complete descriptions of this care model, please view the detailed version of graphic on the DHCS website.

Current Medi-Cal Palliative Care Requirements

- Medi-Cal plans currently follow palliative care criteria as outlined in APL 18-020 and per SB 1004 which requires DHCS to establish standards and provide technical assistance to MCPs for the delivery of palliative care.
- D-SNPs that have implemented APL 18-020 requirements through their MCP should consider how this can be leveraged for dual eligible members.
- DHCS has include further guidance in the 2024 D-SNP Policy Guide.

SB 1004 Eligible Conditions

- SB 1004 Palliative Care: As patient's illness progresses, those with serious illness who meet specific clinical criteria can enroll in SB 1004 palliative care programs.
- Four eligible conditions, and patient must meet both General and Disease-Specific Criteria for any of these conditions:
  - Cancer
  - Congestive Heart Failure (CHF)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Liver Disease
- These four conditions are the minimum; Medi-Cal MCPs may authorize palliative care for patients with other conditions.

General Eligibility Criteria – SB 1004

1. Patient is likely to or has started to use the hospital or ED as a means to manage their late stage disease. This refers to “unanticipated decompensation” and does not include elective procedures.
2. Patient is in late stage of illness (disease-specific) with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. Patient’s death within a year would not be expected based on clinical status.
4. Patient has received appropriate patient-desired medical therapy, or for whom treatment is no longer effective. Patient is not in reversible acute decompensation.
5. Patient and, if applicable, family/patient designated support person agree to both of the following:
    1. Willing to attempt in-home, residential-based or outpatient disease management as recommended by the MCP Palliative Care team instead of first going to the ED.
    2. Willing to participate in Advance Care Planning discussions.

2024 Care Coordination: D-SNPs Providing ECM-like Services

2024 D-SNP Care Coordination Requirements: ECM

- In 2024, EAE and Non-EAE D-SNPs will provide ECM-like services for D-SNP members.
  - DHCS included guidance on this in the 2024 D-SNP Policy Guide.
- The 2023 policy for ECM and D-SNPs is outlined in both the 2023 D-SNP Policy Guide and the ECM Policy Guide which are available on the DHCS website.
  - 2023 D-SNP Policy Guide: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx
  - ECM Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-Updated-May-2022-v2.pdf

Enhanced Care Management Populations of Focus and Go Live

2022	1. Individuals and Families Experiencing Homelessness 2. Adult High Utilizers 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD) 4. Transitioning from Incarceration (some WPC Counties)
January 2023	**5. At Risk for Institutionalization and Eligible for Long Term Care** **6. Nursing Facility Residents Transitioning to the Community**
July 2023	7. Children / Youth Populations of Focus 4. Transitioning from Incarceration (Statewide)

Dual eligible beneficiaries are highly represented in ECM Populations of Focus #5 and #6, for at risk and utilizing Long-Term Care (LTC). Since many of these beneficiaries are in Medicare FFS, the Medi-Cal Managed Care Plans (MCPs) would coordinate with Medicare FFS providers.

Enhanced Care Management and D-SNP Model of Care

- Significant overlap across D-SNP model of care and ECM requirements; potential for duplication/confusion for members and care teams, particularly for members in D-SNPs with LTSS needs.
- Over time, DHCS state-specific D-SNP model of care requirements will be more closely aligned with ECM requirements.
  - **2023 EAE D-SNP Model of Care Requirement**: Minor updates reflecting intent for D-SNPs to provide sufficient care management so that members that would otherwise qualify for ECM are not adversely impacted, and also for continuity of care.
  - **2024 Model of Care Requirements for All D-SNPs**: Additional state-specific requirements for integrating elements of ECM into D-SNP model of care were developed collaboratively with stakeholders.

Access to Enhanced Care Management for Dual Eligible Beneficiaries in 2023 and 2024

- MCP members in Medicare FFS and MA (non-D-SNP)
  - ECM provided by their MCP; Member must meet Population of Focus (POF) requirements
- Non-EAE D-SNP Members
  - 2023: ECM provided by their MCP, in coordination with D-SNP; Member must meet POF requirements
  - 2024: ECM-like care management provided by the D-SNP; Individuals enrolled in ECM will stay until they meet graduation requirements (continuity of care); MCP exempt from providing ECM
- EAE D-SNP Members
  - ECM-like care management provided by the D-SNP in 2023, with specific requirements to phase in for 2024 (with continuity of care); MCP exempt from providing ECM
- PACE/FIDE-SNP Members
  - ECM-like care management already provided in Model of Care

Timeline: ECM and Dual Eligible Beneficiaries

	2022	2023	2024
Most Dual Eligible MCP Enrollees In MA or Medicare FFS	• ECM provided by their MCP • Member must meet Population of Focus (POF) requirements		
Non-EAE D-SNP Enrollees	• Same as above	• Same as above	• ECM-like care management provided through D-SNP • Requirements to be outlined in D-SNP Policy Guide
EAE D-SNP Enrollees	• ECM-like care management provided by Cal MediConnect Plan	• ECM-like care management provided by EAE D-SNP	

Questions

» Questions on 2024 Care Coordination Guidance?

Next Steps

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, February 23rd at 10:00 A.M.**

Appendix A: Public Health Emergency (PHE) Unwinding

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a ***DHCS Coverage Ambassador!***
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.