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

July 15, 2021

California Department of Health Care Services

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- Click on the “Participants” icon at the bottom of the window.
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  - For example: Hilary Haycock – Aurrera Health Group

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for CalAIM MLTSS and integrated care for dual eligible beneficiaries, including the transition of the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC).
- 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 in developing and implementing this work.***

Agenda

10:00 – 10:05	Welcome and Introductions
10:05 – 10:20	Review of Past Meeting Discussions
10:20 – 10:45	Care Management Models
10:45 – 11:15	Breakout Group Discussion
11:15 – 11:35	Breakout Group Report Outs
11:35 – 11:55	DHCS Policy Updates
11:50 – 12:00	Close Meeting

Key Takeaways from May and June MLTSS and Duals Integration Stakeholder Workgroups

Sarah Steenhausen, Director of Policy and Advocacy, The SCAN Foundation

May Workgroup – Summary

- DHCS provided information about dementia care and CalAIM, particularly around leveraging lessons learned from successful Medi-Cal programs for individuals living with dementia.
- Alzheimer's Los Angeles and Molina Healthcare discussed lessons learned from Cal MediConnect, followed by a reaction panel consisting of Alzheimer's Association, Choice in Aging, and West Health.
- DHCS presented on several enrollment topics, followed by stakeholder discussion.

May Key Takeaways – Dementia Care

- Best Practices and Opportunities to Develop Requirements for Specialized Dementia Care:
  - Center care around patients, understand how to provide treatments and services to members with cognitive impairments.
  - Use policy levers, including CalAIM and ECM/ILOS, to support individuals with cognitive impairments and reduce dementia-related disparities in communities of color.
  - Promote early interventions to connect members with cognitive impairments, such as Alzheimer's Day Care Resource Centers.
  - Focus on supporting family/caregivers.

June Workgroup – Summary

- DHCS Vision:
  - Coordinate and Integrate Care for Dual Eligible Individuals; Leverage MCP and D-SNP Care Coordination Contract Requirements.
- Panelists: Lessons Learned from Cal MediConnect
  - Carrie Graham, Center for Health Care Strategies
  - Jack Dailey, CMC Ombuds Services Program
  - Maya Altman, Health Plan of San Mateo
- Breakout Rooms/Report Out/Panelist Reaction

June Key Takeaways – Lessons Learned

- Care Coordinators:
  - Awareness: Sharing Benefits available to members, who care coordinator is/what is their responsibility.
  - Workforce: Diverse backgrounds, language barriers, important to have interdisciplinary ICTs.
  - Point of Contact: Importance of single point of contact, but teams should follow a member (in case of staff turnover.)
- Importance of Being Patient Centered
- Data Sharing (Providers, Plans, County, etc.)

June Key Takeaways - Opportunities

- Improve Communication Channels
- Education (For members and their families, care coordinators, etc.)
- Virtual care, including telehealth (along with emphasizing a patient-centered holistic approach.)
- Increased coordination (between health plans, SNFs, LTC facilities, and mental health facilities.)

D-SNP and Medi-Cal Care Management Models

Michel Huizar, Staff Services Manager II, Managed Care Quality and Monitoring Division, DHCS

Care Coordination and Integration for Dual Eligible Beneficiaries in 2023

- Ensure that D-SNPs and Medi-Cal Managed Care Plans (MCPs) have clear requirements for integrated, coordinated care, particularly in aligned plans.
- Improve data sharing among plans and providers.
- Create more robust connections between managed care and carved out delivery systems, particularly HCBS programs and providers.

Care Coordination Opportunities

- While the care coordination elements of CMC and D-SNP are similar, the baseline D-SNP Model of Care (MOC) requirements are less prescriptive.
- California can establish requirements for D-SNPs to include in their MOC for 2023.

Element	CMC Requirement	D-SNP Requirement
Health Risk Assessment	✓	✓
Individualized Care Plan	✓	✓
Interdisciplinary Care Team	✓	✓
Coordination of covered Medicaid benefits/services	✓	✓
Quality Measurement and Performance Improvement	✓	✓

Comparing the D-SNP & Medi-Cal Approaches to Care Coordination

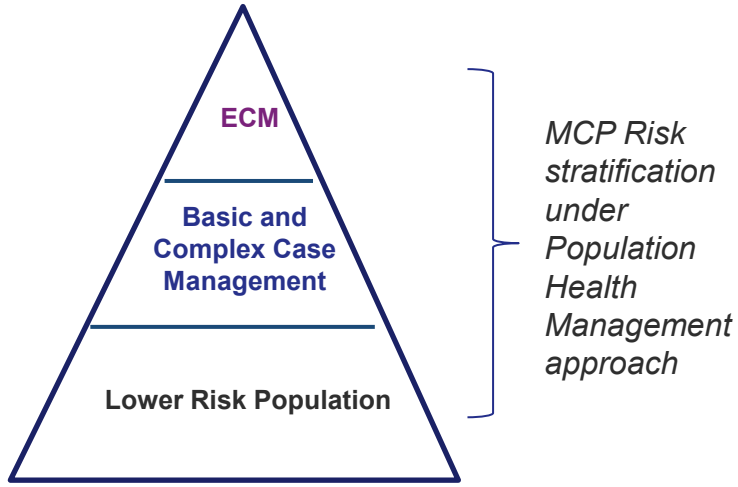
D-SNPs

- Care coordination available to **all members**
- Approach to care coordination must include a plan to:
  - Assess needs (health risk assessment)
  - Develop individualized care plans (ICPs)
  - Establish integrated care teams
  - Coordinate care
- Addresses Model of Care (MOC) requirements for D-SNP provider network (e.g., via clinical practice guidelines, care transition protocols, etc.)
- Must coordinate with Medi-Cal benefits, including those in managed care and those carved out (BH/SUD and LTSS).

The development of the 2023 SMAC for D-SNPs over the next six months will be the venue for setting requirements for D-SNPs around care management and supplemental benefits.

MCPs

- ECM available to **members with the most complex health and social needs** as defined by **Populations of Focus.**
- ECM Core Services are defined in the MCP Contract.
- Under ECM, MCPs are expected to coordinate with all carved out services (e.g., SMHS, DMC-ODS).



Care Coordination for Duals: Key Considerations

- Coordinating and aligning the two models –
  - Connect ALL Medicare and Medi-Cal benefits, providers, etc.
  - Data sharing between entities in and out of managed care.
- Leading the care coordination –
  - Clarity on contractual lead, and clarity on beneficiary-level care coordination lead.
- Scaling care coordination to beneficiary need –
  - Baseline care coordination for all members vs. higher level services for higher level need (e.g., ECM).
- **Specific requirements to be included in D-SNP State Medicaid Agency Contract (SMAC) or MCP contract.**

D-SNP Care Management Models in Other States

Alexandra Kruse, Associate Director Integrated Care State Programs, Center for Health Care Strategies

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

D-SNP Care Management Models: A National Lens

Managed Long-Term Services & Supports & Duals Integration Workgroup

July 15, 2021

Agenda

- **Quick Background**
  - D-SNPs and the Model of Care (MOC)
- **National Lens: Key Findings**
  - Care Management Standards
  - Assessments
  - Care Planning and Interdisciplinary Care Teams

D-SNP Model of Care Overview

What is a MOC?

- CMS framework for how SNPs will meet needs of target population (i.e., duals)

What does the MOC include?

- The D-SNPs plan to:
  - Assess needs
  - Develop individualized care plans (ICPs)
  - Establish interdisciplinary care teams (ICTs)
  - Coordinate care

Other MOC Requirements

- Quality measurement
- Performance improvement plans
- Health outcome and beneficiary experience monitoring

What are the standard MOC elements?

- Description of the D-SNP's population;
- Plan's approach to care coordination;
- How the MOC is implemented among the D-SNPs provider network (e.g., via the use of clinical practice guidelines or care transition protocols); and
- How quality measurement and performance improvement is conducted.

Source: SNP MOC elements and scoring criteria described in chapter 5 of the Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf

D-SNP/MLTSS Care Management Models

- In states with aligned D-SNP/MLTSS programs, the D-SNP care management model can reflect both CMS and State Medicaid Agency requirements.
- States advance their specific care coordination goals by:
  - Using the state Medicaid agency contract (SMAC) to specify D-SNP care coordination requirements, and
  - Identifying care coordination requirements that D-SNPs must specifically address in their MOC submissions to CMS.

> ***"The contract describes what the [D-SNPs] have to do, and the MOC describes how they do it."***
>
> ***– Minnesota State Official***

Source: Integrated Care Resource Center, Tip Sheet: Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care, June 2019. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC-MOC-Tip-Sheet-June-2019.pdf

Key Findings: Care Management Standards

- **States typically develop greater specificity in requirements for D-SNPs on *particular* care coordination elements, including:**
  - Managing care transitions;
  - Data requirements and reporting;
  - Health risk assessment integration and sharing;
  - Family and other caregiver involvement and assessment; and
  - Addressing social determinants of health (SDOH).
- **States often:**
  - Align D-SNP care coordination requirements with Medicaid managed care program goals.
  - Extend expectations around person-centered care planning to D-SNPs, particularly if any LTSS benefits are capitated.
  - Require integrated care planning processes across aligned D-SNP and Medicaid plans.

Key Findings: Assessments

- **D-SNPs are required to administer an initial health risk assessment (HRA) within 90 days of enrollment and annually thereafter, that:**
  - Assesses the medical, functional, cognitive, psychosocial and mental health needs of each enrollee.
  - Assigns an overall risk score and is used to stratify the D-SNP population by health status and develop care plans.
- **States typically do not specify the HRA tool that D-SNPs must use, but do require that HRAs:**
  - Capture certain types of information (VA);
  - Be administered within 60 (VA) days or 30 days of enrollment (MN, TN);
  - Be administered face-to-face for a subset of D-SNP enrollees (VA); and
  - Be integrated with administration of Medicaid assessment tools and Medicaid data, particularly in fully-integrated programs.

Source: SNP MOC elements and scoring criteria described in chapter 5 of the Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf

D-SNP Requirements for Individualized Care Plans and Interdisciplinary Care Teams

Individualized Care Plan (ICP)

- D-SNP must develop an ICP for each enrollee that includes at a minimum:
  - Self-management goals and objectives.
  - Personal healthcare preferences.
  - Description of services specifically tailored to the enrollee's needs.
  - Identification of goals (met or not met).
- D-SNPs must identify roles and credentials of responsible staff; involvement of enrollee or caregiver, /representative(s); and processes for sharing ICP updates.

Interdisciplinary Care Team (ICT)

- ICT must be developed for each enrollee. Critical ICT components to address in the MOC include:
  - How ICT composition is determined (using HRA and ICP) and how on-going communication occurs within the ICT.
  - Roles and responsibilities of each ICT member and how they contribute to improving enrollee health status.
  - How enrollees and/or their caregiver(s) are included in the process.

Key Findings: Care Planning and Interdisciplinary Care Teams

- **States with an aligned D-SNP/MLTSS model often require:**
  - Comprehensive care plans that include Medicare and Medicaid service planning information
    - Exact content and format varies by state, enrollee risk level, and often by plan
  - Sharing of care plan with an enrollee's primary care provider (PCP)
    - When benefit carve-outs exist, states require sharing with relevant Medicaid providers (e.g., fee-for-service LTSS providers in Oregon).
  - Specifying requirements for interdisciplinary care team (ICT) composition and participation
  - Specifying frequency of care manager and enrollee contacts
  - Inclusion of state-specific elements in care plans, including requirements for person-centered care planning

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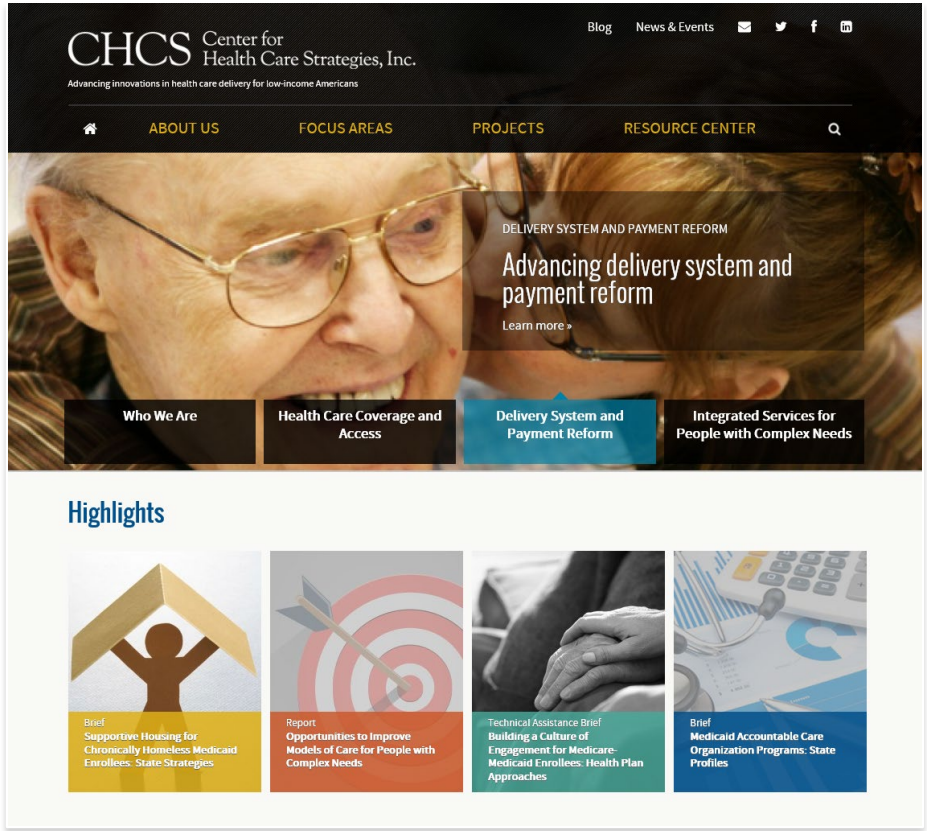

Contact Information

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Breakout Room Discussions

- Breakout room sessions will be 25-minutes long.
- Participants will be automatically placed in breakout rooms.
- Each breakout room will be staffed with a notetaker who will help to pose the questions and take notes on the discussion.
- Each breakout room will need to choose one participant who will report out to the larger group when the breakout session concludes.
- We will have as many groups report out verbally as time allows, which is why the written feedback is so important!

Discussion Questions

- What are the most important elements of care coordination for dual eligible beneficiaries?
  - What role could the State Medicaid Agency Contract (SMAC) play in defining these elements?

- Are there any special considerations for your population or program (e.g., beneficiaries with dementia, individuals with disabilities, etc.)?

Breakout Group Report Outs

DHCS Policy Updates

Anastasia Dodson, Associate Director for Policy

D-SNP Aligned Enrollment

- Health Omnibus bill includes CalAIM provisions and is in print as identical companion bills: Assembly Bill (AB) 133 and Senate Bill (SB) 133.
- 2022: MCPs or subcontracted plans may transition beneficiaries enrolled in affiliated non-D-SNP MA plans into their affiliated D-SNPs (if those D-SNPs were approved 1/1/2013).
- 2023:
  - Statewide mandatory enrollment of dual eligible individuals into MCPs.
  - CMC will sunset on 12/31/2022, and plans will transition members from CMC plans into D-SNPs with aligned MCPs on 1/1/2023. Under aligned enrollment, Medicare choice will drive Medi-Cal plan enrollment.
- 2026: Non-CCI Counties: MCPs must stand up a D-SNP, based on outcome of feasibility study.

Topics for Upcoming Meetings

Future topics may include, but not limited to:

- Enrollment policies
- Beneficiary communications and integrated member materials
- Care coordination, including:
  - Coordination with carved-out benefits and delivery systems, including behavioral health and long-term services and supports programs
- Data sharing
- Quality reporting
- Cal MediConnect Transition

Next Steps

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, August 19, at 10 a.m.**