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

June 10, 2021

California Department of Health Care Services

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.
- Select “Rename.”
- Enter your name and add your organization as you would like it to appear.
  - 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

Care Coordination Overview

10:05 – 10:20 DHCS Vision for Care Coordination and Integration for Dual Eligible Beneficiaries

10:20 – 10:35 Overview of CMC Promising Practices and Lessons Learned - Panel

Care Coordination: Stakeholder Feedback on Promising Practices and Opportunities from Cal MediConnect

10:35 – 11:05 Breakout Group Discussion

11:05 – 11:50 Breakout Group Report Outs and Panel Reaction

11:50 – 12:00 Upcoming Meeting Topics and Next Steps (DHCS)

12:00 Close Meeting

DHCS Vision for Care Coordination and Integration for Dual Eligible Beneficiaries

CalAIM Goals

- Identify and manage member risk and need through whole person care approaches and addressing social determinants of health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

CalAIM Goals for Long Term Services and Supports

- Improved Care Integration
- Person-Centered Care
- Leverage California's Robust Array of Home and Community-Based Services (HCBS)
- Build on Lessons and Success of CMC and CCI
- Support Governor's Master Plan for Aging
- Expand and better link HCBS to Medi-Cal managed care and D-SNP plans

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 Standards

- Cal MediConnect 2013 standards based on Medi-Cal managed care requirements, California state statutes, and D-SNP Model of Care requirements.
- D-SNP requirements reflect Centers for Medicare & Medicaid Services (CMS) Model of Care (MOC) requirements and State Medicaid Agency Contract (SMAC) coordination requirements
  - MOC: The basic framework outlining care management and care coordination processes, as well as quality measures
  - SMAC: Requirements for coordination with Medi-Cal benefits
- MCP requirements will be updated in 2022 to reflect Enhanced Care Management and In Lieu of Services, and in future years to reflect Population Health Management and other updates.

Care Coordination Opportunities

- While the care coordination elements of CMC and D-SNP are similar, the baseline D-SNP 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	✓	✓

Overview of CMC Promising Practices and Lessons Learned

Carrie Graham

Director, Long-Term Services and Supports
Center for Health Care Strategies

Takeaways from Cal MediConnect Evaluation

New collaborations between CMC plans and:

- IHSS/MSSP
- HCBS Brokers or “hubs”
- Alzheimer’s Association/ LTC Ombs.

Transitions to lower levels of care was successful in some plans

Beneficiary knowledge and provider buy in were challenges.

Data Sharing and capacity for coordination were major barriers

https://generations.asaging.org/care-management-managed-care-world

Jack Dailey

Health Consumer Alliance
Coordinator/Director of Policy and Training
Cal MediConnect Ombuds Services Program

Lessons learned from CMC Care Coordination

A strong care coordination benefit must continue to be available to D-SNP members with appropriate accountability measures.

Care Coordination works…

- When Members
  - Have awareness of their care coordinator, as well as their role.
  - Know when and how to engage their care coordinators or to expect engagement.
  - Have meaningful assistance and collaboration to access both carved in and carved out service needs.
- When care coordinators
  - Engage members early and often with affirmative offers of support
  - Meaningfully and actively support LTSS care transitions, including hospital and LTC discharge planning, etc.

CalMediConnect
Your choice for complete care

HCA
Health Consumer Alliance

Maya Altman

Chief Executive Officer, Health Plan of San Mateo

Lessons from CMC: Care Coordination

HealthPlan OF SAN MATEO
Healthy is for everyone

- Importance of Close Partnerships
  - Wide range of providers, HCBS, CBOs, and local agencies
  - Who is the quarterback?
- Importance of an “Integrated” Approach
  - Nurses, social workers, behavior health specialists, nonclinical staff
- Importance of data/information
  - Risk stratification and targeting
  - Nonmedical data
  - Data sharing among partners
  - Shared care plans

Breakout Room Discussions

- Breakout room sessions will be 30-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 additional lessons learned on care coordination in CMC? Where are there opportunities to improve care coordination in CMC?

- List of three best practices and opportunities for improvement to share with the group. Choose one person who will put these in the chat and potentially share with the rest of the group.

Breakout Group Report Outs

Panel Reaction

- What are your reactions to the breakout group feedback?
- How did you address or work through any barriers discussed in CMC and/or in an aligned D-SNP?
- What additional lessons learned from CMC should be incorporated into an aligned D-SNP model?

Topics for Upcoming Meetings

Future topics may include, but not limited to:

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

Next Steps

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, July 15, at 10 a.m.**

- Quarterly CCI Stakeholder Webinar: **Wednesday, June 30 at noon**.