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

May 6, 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

Zoom: Chat vs. Q/A

- We will be utilizing both the Chat and Q/A features for this meeting.
  - Chat: For participants to talk with one another, introduce themselves, etc.
  - Q/A: For submitting questions to presenters/panelists. If you have a question that you would like to have addressed, please submit it using this feature.

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.
- 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

11:30 – 11:35 Welcome and Introductions

Dementia Care

11:35 – 11:40 Dementia Care and CalAIM (DHCS)
11:40 – 12:00 Dementia Care Coordination (Alzheimer's Los Angeles)
12:00 – 12:10 Health Plan Perspective on Dementia Care Coordination (Molina Healthcare)
12:10 – 12:55 Discussion

Cal MediConnect Enrollment Policy

12:55 – 1:00 Cal MediConnect (CMC) Enrollment Moratorium (DHCS)
1:00 – 1:10 Discussion
1:10 – 1:15 Current Matching Plan Policy (DHCS)
1:15 – 1:25 Discussion
1:25 – 1:30 Upcoming Meeting Topics and Next Steps (DHCS)
1:30 Close Meeting

Dementia Care & CalAIM

Dementia Care and CalAIM

- DHCS will leverage lessons learned from successful Medi-Cal programs for beneficiaries experiencing cognitive impairment, traumatic brain injury, Alzheimer's disease, and related dementias through CalAIM.
- For duals eligible beneficiaries, DHCS will require that D-SNPs use a model of care that includes dementia specialists in their care coordination efforts.
- DHCS is reviewing other elements of CalAIM and how they relate to supporting beneficiaries with dementia, such as Enhanced Care Management (ECM), performance measures, and Population Health Management.
- DHCS values stakeholder feedback on these issues.

Alzheimer's Los Angeles

Alzheimer's
LOS ANGELES

Dementia-Capable Care: An Inflection Point for the State of California

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Funding

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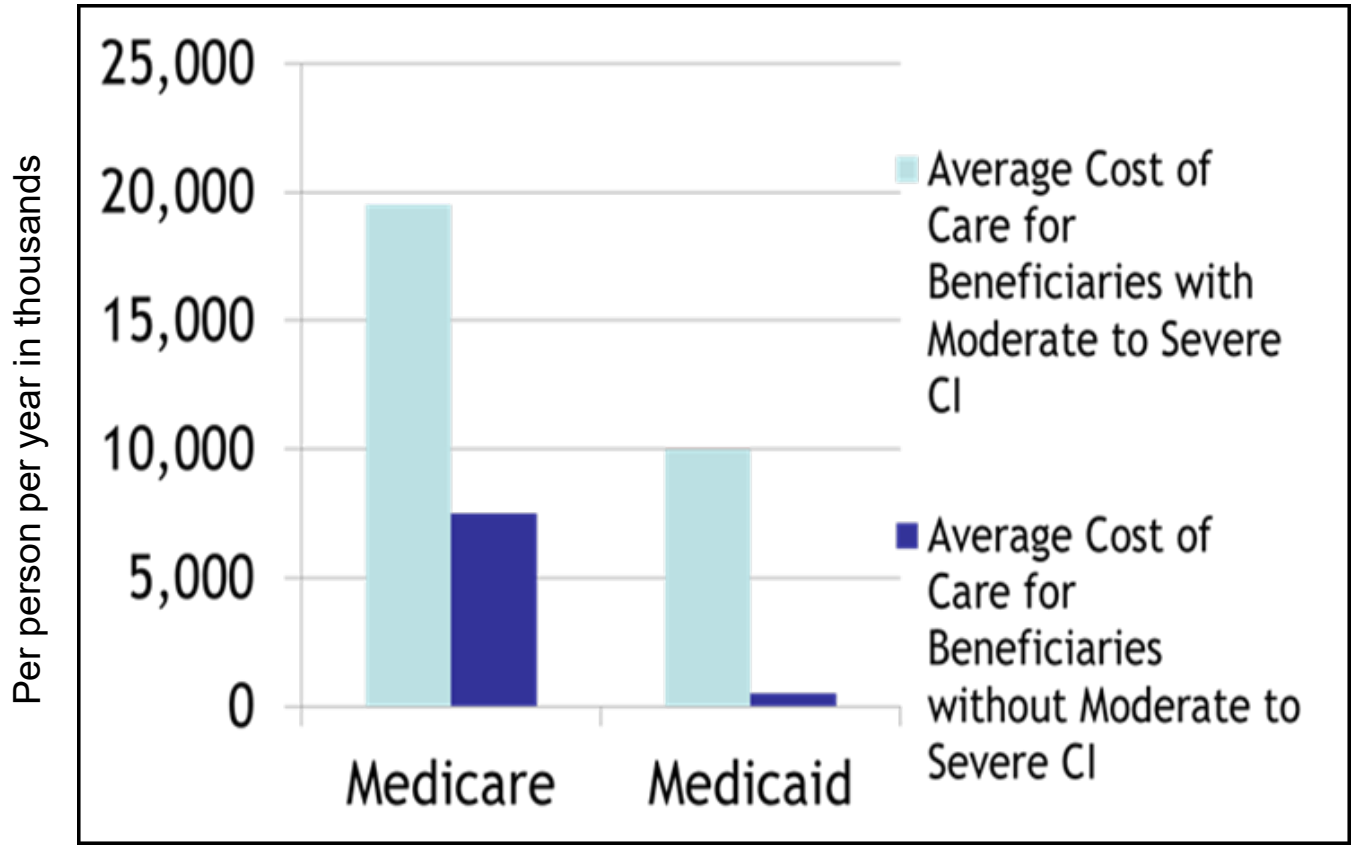
- The Case for Improving Dementia Healthcare
- Dementia Care in the United States: Current State & Inequities
- What We've Done in Cal MediConnect
- Where We Need to Go: Making California a Leader in Dementia Care

The Case for Improving Dementia Healthcare

- Increasing prevalence
- High cost of care in U.S.
- Multiple quality challenges
- Equity



Alzheimer's Association. 2015 Alzheimer's Disease Facts and Figures. Bynum ,J. (2011) Unpublished data from the Medicare Current Beneficiary Survey for 2008.

Tools for Making the Case: www.alzheimersla.org/professionals

Inequities

African American/ Blacks are:

- 2X more likely than older Whites to have Alzheimer's/dementia
- More likely to be diagnosed later in disease
- Higher caregiver strain & depression

Hispanic/Latinos are:

- 1.5X more likely than older Whites to have Alzheimer's/dementia
- More likely to be diagnosed later in disease
- Less caregiver support
- Greater care demands
- Higher rates of depression

Alzheimer's Association. 2021 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2021;17(3).

Dementia Care in the United States

- **Nearly ½ of all CA nursing home residents have Alzheimer's or dementia[1]**
- **Rates of nursing home placement have increased dramatically for people from communities of color[2]**

[1]Alzheimer's Association. 2021 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2021;17(3).

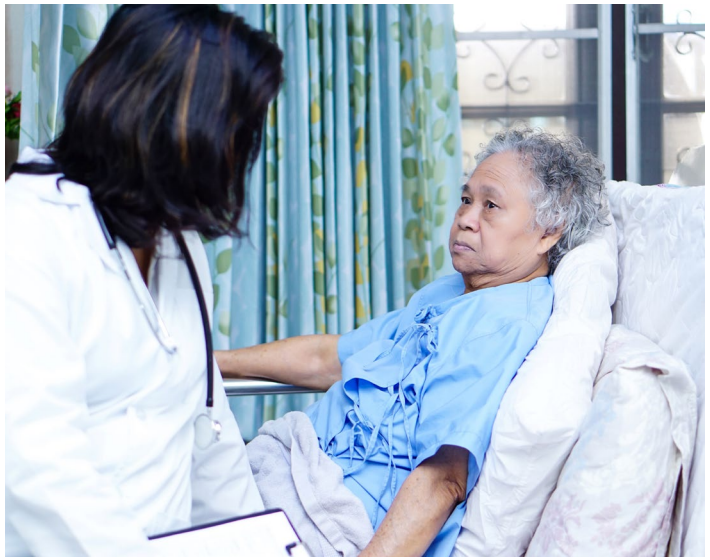
[2]Zhanlian Feng, Mary L. Fennell, Denisa A. Tyler, Melissa Clark and Vincent Mor."Growth of Racial and Ethnic Minorities in US Nursing Homes Driven by Demographics and Possible Disparities in Options", *Health Affairs*, Vol. 30 No. 7.

Adjusting Healthcare Systems to Make Them More Family-Centered

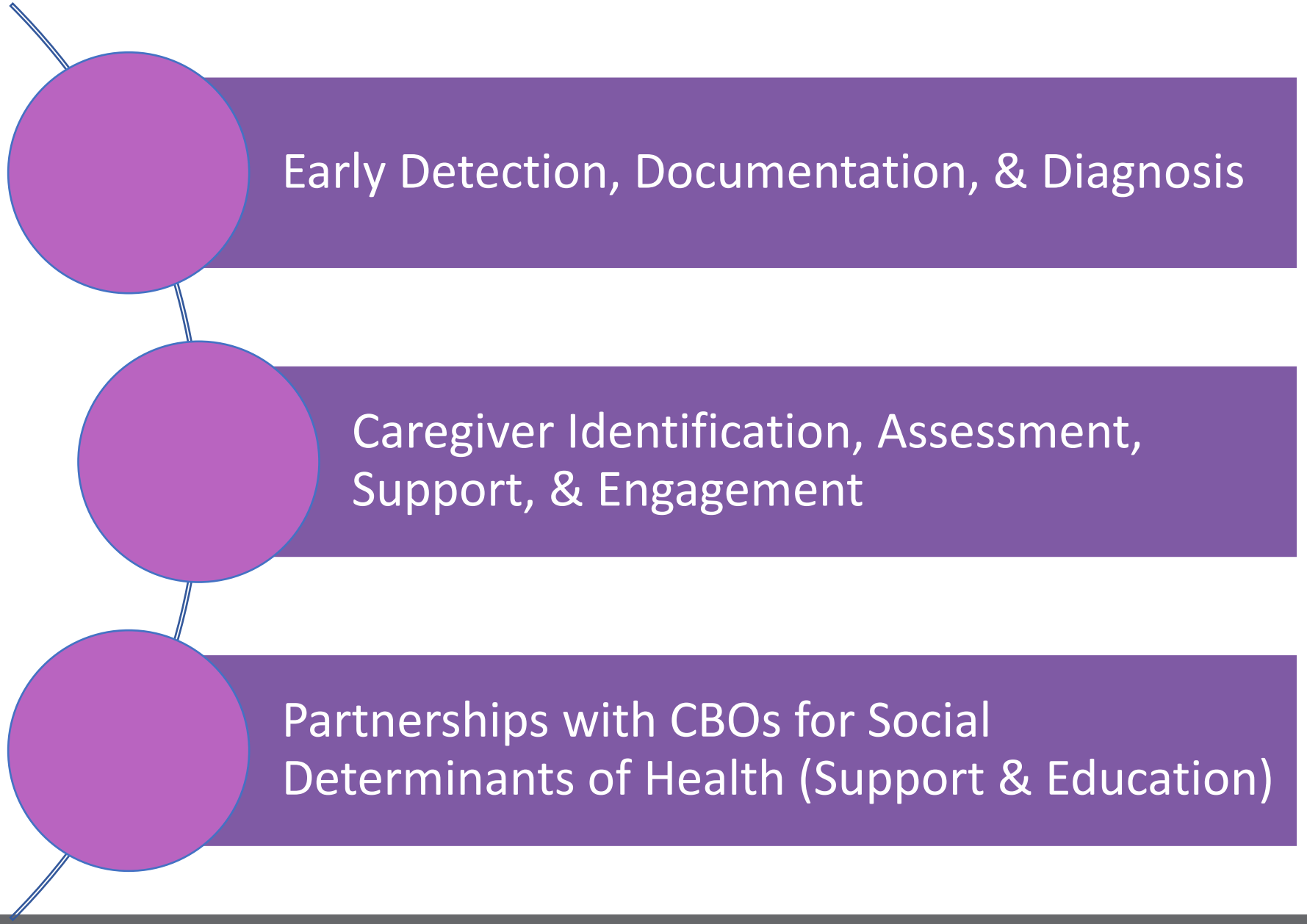
- Minimal caregiver focus
- Assessment of caregivers' needs is not formalized
- Lack of non-medical/social support focus
- Insufficient coordination between healthcare system and community-based organizations

Rationale: Why is a Dementia-Capable System of Care Needed?

- Equity
- Quality of life
- Quality care
- Cost of care



Components of a Dementia-Capable System of Care



The Dementia Cal MediConnect Project

Advocacy

Technical Assistance to Change Systems of Care

Dementia Care Management Training Program

Caregiver Education and Support

Much Has Been Done, Yet…

- How will promising practices be embedded into CalAIM?
  - ✓ SMAC language
  - ✓ CalAIM assessments
  - ✓ Health plan processes
- How will systems changes be operationalized?
  - ✓ How will diagnostic and care pathways be implemented?

What is the Vision? Roadmap for Making California a Leader in Dementia Care

Master Plan on Aging

- **Goal 2- Health Reimagined**
  - Be a leader in improving the lives of Californians living with dementia
  - Develop standard of care for dementia
- **Goal 4- Caregiving that Works**
  - Improving training and support for family caregivers

Population Health Management: Risk Stratification

Beneficiary is diagnosed with dementia or a cognitive impairment

AND

- 2+ co-morbid chronic conditions

OR

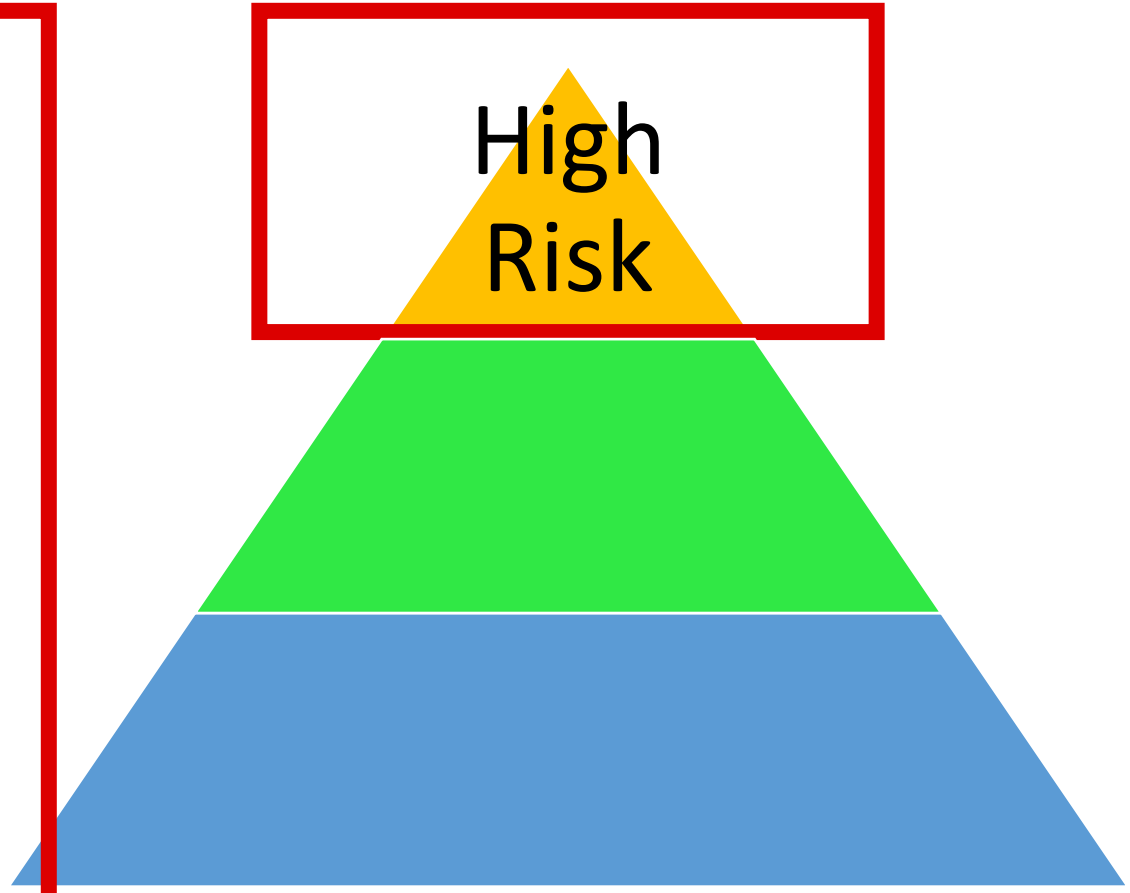
- 2+ unplanned hospitalizations or visits to ED w/in past 12 months

OR

- A psychiatric hospitalization w/in past 12 months

AND

- Insufficient caregiver resources (caregiver unable or unwilling to provide care)



Adapted from: UCLA Alzheimer's & Dementia Care Program. D. Reuben & the Alzheimer's Association

Population Health Management: Initial Health Assessment

At least 2 necessary questions:

- **Cognitive trigger question**
- **Caregiver availability *and* willingness to provide care/support**

Population Health Management: Plan Screening & Service Delivery

DIAGNOSTIC PATHWAY

- Cognitive trigger question
- Validated cognitive screening tool & documentation
- Diagnostic workup & documentation

CARE PATHWAY

- Family caregiver identification & documentation
  - Caregiver availability & willingness to provide care/support
- Validated caregiver assessment (unmet need & stress)
- Provision of support

www.alzheimersla.org/professionals

Enhanced Care Management

- **Dementia Care Specialists**

✓ *High risk members with enhanced care management should be assigned to a Dementia Care Specialist*

✓ *Clearly defined roles/responsibilities for Dementia Care Specialists*

✓ *Specialized training*

Enhanced Care Management

- **Caregiver Assessment & Support**

✓ *Family caregiver(s) identified & documented*

✓ *Validated caregiver assessment tools*

✓ *Support to caregivers*

Enhanced Care Management

- **Collaboration with Alzheimer's Organizations & Other CBOs**

✓ *Dementia Education*
✓ *Caregiver Education*
✓ *Caregiver Support*

In Lieu of Services

- **Ensuring Access**

✓ *Personal care services*
✓ *Respite*
✓ *Caregiver education & support should be on the list of ILOS*

There need to be workflows and processes to get to these services

Summary

- From promise to practice
  - Build on existing requirements using best practices in dementia care
  - Ensure current dementia-focused requirements are properly, equitably, and systematically implemented

Publications

Cherry, D.L., Yeh, J., Ross, L., Schlesinger, J., & Hollister, B.A. Building an advocacy model: Improving the dementia-capability of health plans in California. *Journal of the American Geriatrics Society*. [In submission].

Cherry, D.L., Hollister, B.A., Schlesinger, J., Ross, L., & Yeh, J. The California Dementia Cal MediConnect Project: Improving dementia care in the duals demonstration. *Generations*. Spring 2019.

Flatt, JD, Hollister, BA and Chapman, SA (2017). Dementia Care Specialist workforce in California: Role, practice, training, and demand. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care. 2018.

Cherry, D.L., Hollister, B., Schlesinger, J., & Wilson, N. Dementia Cal MediConnect: Creating partnerships between health plans and Alzheimer's organizations to improve care in the dual eligibles pilot. *Public Policy & Aging Report*. 2017; 27(S1): S12-17.

Cherry, D.L., Schlesinger, J. & Hollister, B. Dementia Cal MediConnect: Project evolution and results. *Generations*. Fall 2017: 62-67.

Reinhard, S. C., Fox-Grage, W., & Feinberg, L. F. Family caregivers and managed long-term services and supports (Rep.). Washington, DC: AARP Public Policy Institute. 2016.

Lindberg, Brian W. Formula for success. *Gerontology News*. March 2016: 4-5.

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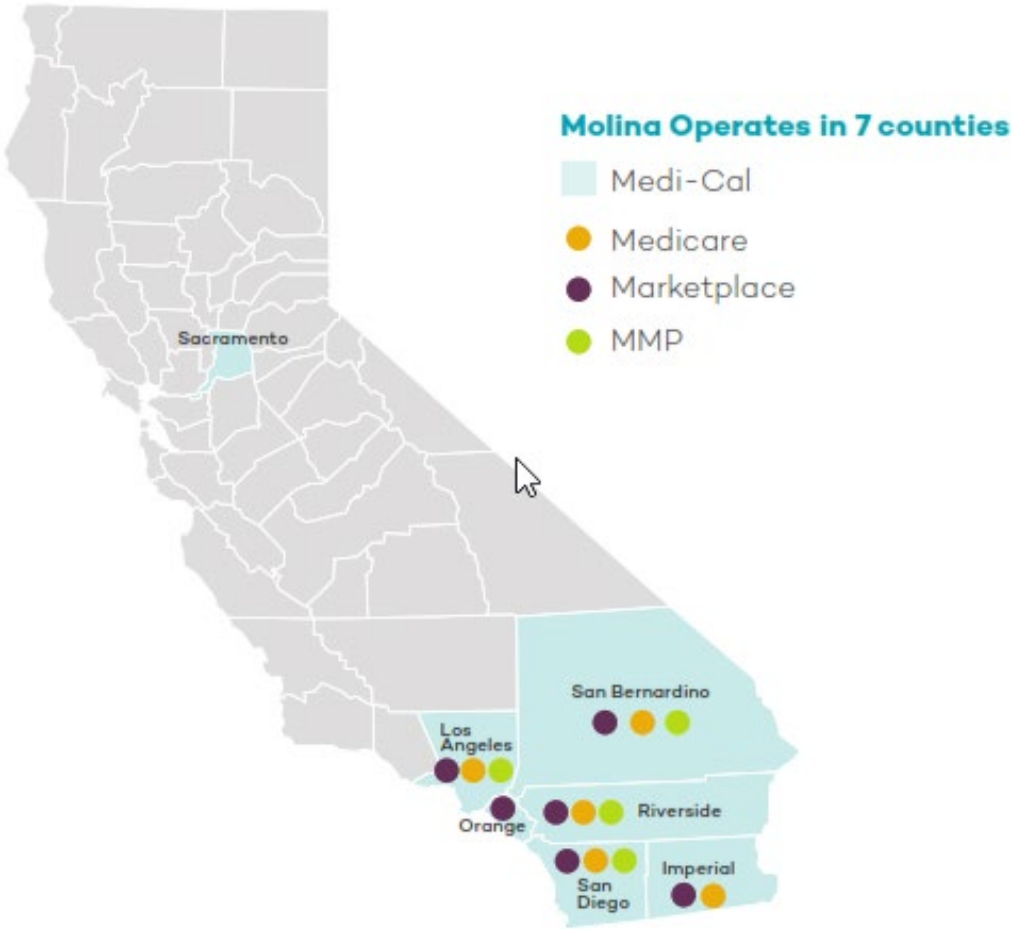
Molina Healthcare

Molina Healthcare of California

Dementia Model of Care

Molina Healthcare of California



Molina's Dementia Model of Care

- Case Manager Trainings
- Member Cognitive Screenings
- Caregiver Screenings
- Referrals to Community Resources

Case Manager Trainings

- **Case Manager Training**
  - Fundamentals of Cognitive Impairment, Alzheimer's Disease, and Related Dementias
  - Practical Dementia Care Management (role of CM, Mandatory Reporting/Elder Abuse, Elder Driving, Medication Management, Co-Existing Conditions, Safety, Managing Behavioral Symptoms)
  - Cognitive screening tool administration
  - Caring for the Caregiver
  - Recommended care plan interventions
  - Resources/Tools/ Support Services in the Community

- **Dementia Care Specialist Training**
  - More in-depth coverage of topics covered in full day training
  - Caregiver assessment

Case Manager Trainings

- **Alzheimer's and Dementia Training Bundles**
  - Online Modules included in the bundle are:
    - Fundamentals of Alzheimer's Disease
    - Effective Strategies for Managing Behavior Symptoms of Persons with Dementia
    - Caring for the Caregivers
    - Effective Communication Strategies for Caring for People with Dementia

Member Cognitive Screenings

- Health Risk Assessment (HRA) identifies member's memory concerns and recent changes in cognition

- Molina added a validated tool (AD-8) into the clinical software to screen members for dementia
  - Case Managers utilize screening based on responses in the HRA

- Creation of PCP Notification of AD-8 score
  - Letter to PCP shares score
  - Recommends that the PCP complete dementia diagnostic evaluation

Caregiver Screenings

- Health Risk Assessment (HRA) and other methods identify caregivers of individuals with dementia

- AMA Caregiver Self-Report Questionnaire was added to the clinical system as a method to assess the stress levels of family caregivers
  - Case Managers utilize tool when interacting with caregivers

- Caregivers are identified in the clinical system and engaged in the care planning process
  - Identification of goals, interventions and preferences

MOLINA HEALTHCARE

Referrals to Community Resources

- Case Managers link members and their caregivers to appropriate resources based on identified needs
  - Alzheimer's organizations
  - Long Term Service and Supports (LTSS)

- Alz Direct Connect Referral Form streamlines referrals and communication with Alzheimer's Los Angeles

- Molina has implemented various pilots to assist in increasing the identification of members in need of assistance and/or referrals related to dementia

Best Practices

- Dementia Model of Care interventions were incorporated for all Molina members and not just Cal MediConnect
- Screening tools were incorporated into Case Management trainings, workflows, and case audit tools
- Willingness to attempt different pilots to increase identification of members / caregivers in need of education and support
- The partnership with Alzheimer's Los Angeles has been extremely beneficial
  - Molina leadership / Case Managers have direct access to their expertise to discuss resources, tools, and workflows
  - Case Management staff have benefited from the ongoing training from experts in dementia care


thank you

Discussion and Input

DHCS CalAIM MLTSS and Duals Integration Workgroup

May 6, 2021

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alzheimer's association®

California by the Numbers

- 1.8 million Californians are living with or caring for a loved one with Alzheimer's or dementia
- $4.2 billion annual **Medi-Cal** spending -- projected to grow 25% by 2025
- Annual per capita **Medicare** spending on California beneficiaries with dementia = $35,364
- Californians with dementia average 1.5 annual ER visits = 1 million+ annually
- Nearly 1:4 are readmitted to the hospital within 30 days
- 27% with subjective cognitive decline live alone

DISCRIMINATION

is a barrier to Alzheimer's and dementia care. These populations reported discrimination when seeking health care:

of Black Americans

of Native Americans

of Asian Americans

of Hispanic Americans

CONTINUUM OF COGNITIVE IMPAIRMENT

Impairment does not interfere with activities of daily living

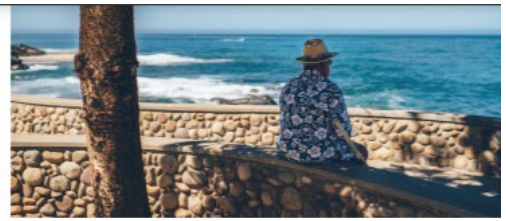
Impairment in two or more cognitive functions that interfere with activities of daily living

MCI is a known risk factor for dementia

Everyone who experiences dementia passes through MCI

Alzheimer's is the most common form of dementia (60-80%)

California at the Forefront



Assessment of Cognitive Complaints Toolkit

for Alzheimer's Disease

PRODUCED BY THE CALIFORNIA ALZHEIMER'S DISEASE CENTERS AND FUNDED BY THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, ALZHEIMER'S DISEASE PROGRAM

DISCUSSING THE DIAGNOSIS OF DEMENTIA

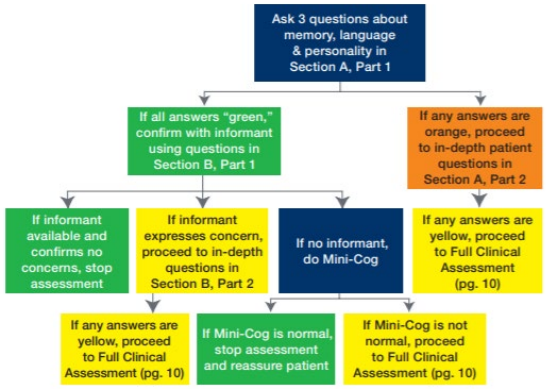
First, it's useful to start with an introduction and to assess the patient and family's goals and expectations. The bullet points below identify key components of the discussion.

- Ask patient and family their impression of the cause of problem and goals of appointment
- Explain dementia syndrome
- Explain components of work up/ruling out non-neurodegenerative causes
- Describe and discuss clinical diagnosis and syndrome of Alzheimer's disease

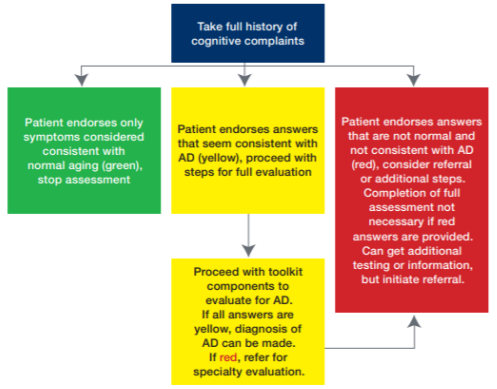
Thanks so much for your patience as we have collected all the information we need to assess your complaint. Now that we have gotten a full description of the problem, and we have gotten results on the blood tests and brain imaging results [can refer to MRI or CT scan, as appropriate]*, this is a good time to review what we've found and discuss what is causing these problems.*

Before I give you my impression, I think it would be good for you to tell me what you are hoping for in this discussion. Do you have own theories about what's causing the problem that you would like me to address? Are there specific diseases that you are worried about? Are there other specific questions that you would like me to answer if I can?

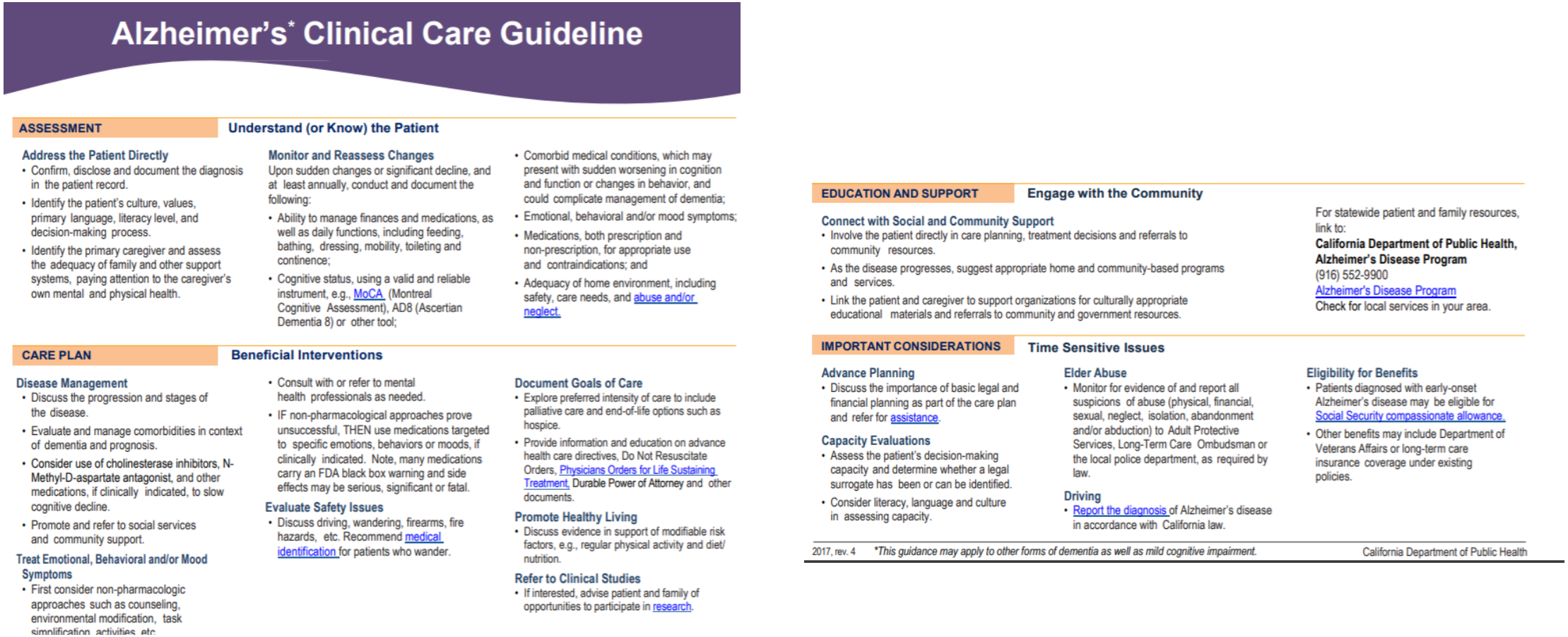
WELLNESS VISIT INTERVIEW



FULL CLINICAL ASSESSMENT



California at the Forefront



Alzheimer's* Clinical Care Guideline

ASSESSMENT — Understand (or Know) the Patient

Address the Patient Directly
- Confirm, disclose and document the diagnosis in the patient record.
- Identify the patient's culture, values, primary language, literacy level, and decision-making process.
- Identify the primary caregiver and assess the adequacy of family and other support systems, paying attention to the caregiver's own mental and physical health.

Monitor and Reassess Changes
Upon sudden changes or significant decline, and at least annually, conduct and document the following:
- Ability to manage finances and medications, as well as daily functions, including feeding, bathing, dressing, mobility, toileting and continence;
- Cognitive status, using a valid and reliable instrument, e.g., MoCA (Montreal Cognitive Assessment), AD8 (Ascertian Dementia 8) or other tool;
- Comorbid medical conditions, which may present with sudden worsening in cognition and function or changes in behavior, and could complicate management of dementia;
- Emotional, behavioral and/or mood symptoms;
- Medications, both prescription and non-prescription, for appropriate use and contraindications; and
- Adequacy of home environment, including safety, care needs, and abuse and/or neglect.

CARE PLAN — Beneficial Interventions

Disease Management
- Discuss the progression and stages of the disease.
- Evaluate and manage comorbidities in context of dementia and prognosis.
- Consider use of cholinesterase inhibitors, N-Methyl-D-aspartate antagonist, and other medications, if clinically indicated, to slow cognitive decline.
- Promote and refer to social services and community support.

Treat Emotional, Behavioral and/or Mood Symptoms
- First consider non-pharmacologic approaches such as counseling, environmental modification, task simplification, activities, etc.
- Consult with or refer to mental health professionals as needed.
- IF non-pharmacological approaches prove unsuccessful, THEN use medications targeted to specific emotions, behaviors or moods, if clinically indicated. Note, many medications carry an FDA black box warning and side effects may be serious, significant or fatal.

Evaluate Safety Issues
- Discuss driving, wandering, firearms, fire hazards, etc. Recommend medical identification for patients who wander.

Document Goals of Care
- Explore preferred intensity of care to include palliative care and end-of-life options such as hospice.
- Provide information and education on advance health care directives, Do Not Resuscitate Orders, Physicians Orders for Life Sustaining Treatment, Durable Power of Attorney and other documents.

Promote Healthy Living
- Discuss evidence in support of modifiable risk factors, e.g., regular physical activity and diet/nutrition.

Refer to Clinical Studies
- If interested, advise patient and family of opportunities to participate in research.

EDUCATION AND SUPPORT — Engage with the Community

Connect with Social and Community Support
- Involve the patient directly in care planning, treatment decisions and referrals to community resources.
- As the disease progresses, suggest appropriate home and community-based programs and services.
- Link the patient and caregiver to support organizations for culturally appropriate educational materials and referrals to community and government resources.

For statewide patient and family resources, link to:
California Department of Public Health, Alzheimer's Disease Program
(916) 552-9900
Alzheimer's Disease Program
Check for local services in your area.

IMPORTANT CONSIDERATIONS — Time Sensitive Issues

Advance Planning
- Discuss the importance of basic legal and financial planning as part of the care plan and refer for assistance.

Capacity Evaluations
- Assess the patient's decision-making capacity and determine whether a legal surrogate has been or can be identified.
- Consider literacy, language and culture in assessing capacity.

Elder Abuse
- Monitor for evidence of and report all suspicions of abuse (physical, financial, sexual, neglect, isolation, abandonment and/or abduction) to Adult Protective Services, Long-Term Care Ombudsman or the local police department, as required by law.

Driving
- Report the diagnosis of Alzheimer's disease in accordance with California law.

Eligibility for Benefits
- Patients diagnosed with early-onset Alzheimer's disease may be eligible for Social Security compassionate allowance.
- Other benefits may include Department of Veterans Affairs or long-term care insurance coverage under existing policies.

2017, rev. 4 **This guidance may apply to other forms of dementia as well as mild cognitive impairment.* California Department of Public Health

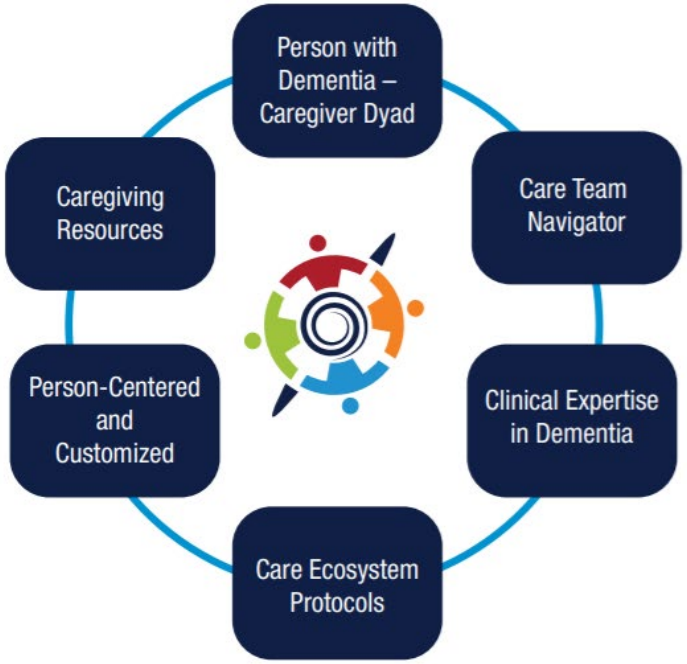
Model Dementia Standard of Care to the Nation

UCLA Alzheimer's and Dementia Care Program for Comprehensive, Coordinated, Patient-centered Care

1. Patient recruitment and a dementia registry
2. Structured needs assessments of patients in the registry and their caregivers
3. Creation and implementation of individualized dementia care plans based on needs assessments and input from the primary care physicians
4. Monitoring and revising care plans, as needed
5. Access 24/7, 365 days a year for assistance and advice. The program uses a co-management model with a nurse practitioner Dementia Care Manager working with primary care physicians and CBOs.

Model Dementia Standard of Care to the Nation

Figure 1. The Care Ecosystem Core Elements



1. The Dyad: A PWD and a Caregiver. Caregiver can be a family member or friend, paid staff, or other combination of people who support the PWD.
2. Care Team Navigator: actively supports the Dyad, empowers the CG to be the advocate for the PWD and leverages the protocols, resources, and clinical resources available. The Care Team Navigator receives training, has access to resources, and receives ongoing consultative support from licensed clinical experts.
3. The Care Ecosystem model is built around clinical expertise in dementia.
4. The Care Ecosystem has evidence-based protocols designed to support a PWD and the needs of the CG. The protocols address: medications, safety, behaviors, caregiver support, and advance care planning.
5. The Care Ecosystem model is person-centered and customized. Its resources are provided on an as-needed basis that is proactive and responsive, rather than in a prescribed order.
6. A distinctive part of the Care Ecosystem model is its focus on both the PWD and the Caregiver. The Care Team Navigator provides curated resources to alleviate caregiver burden in addition to addressing the needs of the PWD.

UCSF Dementia Care Ecosystem

Promising Models of Care

aces aware
SCREEN. TREAT. HEAL.

Screen Treat Heal About GET TRAINED

Medi-Cal providers have conducted 155,000 ACE screenings.

Learn more in our March 2021 Data Update

- Focuses on early intervention
- Relies on provider incentives
- Builds primary care capacity

- Hub & Spoke model
- Builds primary care capacity & competency
- Leverages telehealth – allowable cost

What Is Project ECHO?

Project ECHO (Extension for Community Healthcare Outcomes), launched in 2003, by Dr. Sanjeev Arora at the University of New Mexico Health Sciences Center, was originally developed to address the need for better Hepatitis C care.[1] Now, more than 130 academic organizations lead ECHO projects in 30-plus states and 23 countries to address more than 65 complex medical conditions. The ECHO model is designed to enhance the health care workforce in underserved areas by providing community-based primary care providers with knowledge and support to manage

Project ECHO®

Case Study: EHR Integration

- ✓ Direct referral to Alzheimer's Association at point of care
- ✓ High patient and family satisfaction

Access to suite of services:

- Care consultations by licensed professionals
- Peer support groups
- Caregiver education
- Patient education
- 24/7 access to licensed professionals *in language*
- Referrals for local, long-term services and supports

Community Resource Finder
alzheimer's association
AARP Family Caregiving
powered by Carelike

Debbie Toth

President & CEO, Choice in Aging

Dr. Zia Agha

Chief Medical Officer & Executive VP,
West Health

Discussion and Input

- What are best practices and lessons learned from the Coordinated Care Initiative (CCI)/ Cal MediConnect and other work on supporting beneficiaries with Alzheimer's and related dementias?

- What are key considerations in developing requirements for specialized dementia care coordinators in the D-SNP model of care?

CMC Enrollment Moratorium Policy Options

Background on Enrollment Moratorium

- Cal MediConnect (CMC) will sunset on December 31, 2022, and plans will transition members from CMC plans into D-SNPs with aligned MCPs on January 1, 2023.
- According to the CMC Memorandum of Understanding (MOU), the last effective date for new enrollment into a CMC plan is July 1, 2022 (known as the enrollment moratorium).
- With certain exceptions, dual eligible beneficiaries are not eligible for new enrollment into a D-SNP until 2023 in CCI counties.

Policy Considerations

- DHCS and CMS are considering shortening the six-month enrollment moratorium, subject to enrollment transition decisions and timeline.
- Shortening the enrollment moratorium would minimize the length of time in 2022 that beneficiaries would not have access to an integrated Medicare enrollment option, helping avoid more enrollment in non-integrated Medicare plans.

CMC Moratorium Options

- Option 1 – Last new enrollment effective date into CMC is July 1, 2022 (per the current 3-way contract/MOU)

- Option 2 – Last new enrollment effective date into CMC is August or September 1, 2022

Discussion and Input

- Should DHCS reduce the CMC enrollment moratorium by 1 to 2 months?

DHCS Current Matching Plan Policy

Existing "Matching Plan" Policy

- DHCS currently operates under a "matching plan policy" that requires dual eligible beneficiaries enrolling in a Medicare product to enroll in the matching Medi-Cal plan if one is available and if they are mandatory in Medi-Cal managed care.
  - The current matching plan policy was established prior to 2014 CCI implementation and applies.
  - This enrollment process applies to the Prime Plan operating in the county. DHCS does not enroll beneficiaries into delegate plans.
  - Health Care Options supports an opt-in choice process to help beneficiaries select the Medi-Cal managed care plan that matches their Medicare plan choice.
  - In County Organized Health System (COHS) counties, all Medi-Cal beneficiaries in managed care are enrolled in the COHS plan.

Questions?

Topics for Upcoming Meetings

Future topics may include, but not limited to:

- Care coordination, including:
  - Building on the lessons learned from CMC
  - 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

Next Steps

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