Department of Health Care Services
California Advancing and Innovating Medi-Cal (CalAIM)

TITLE: Managed Long-Term Services & Supports & Duals Integration Workgroup

DATE: Thursday, March 4, 2021, 10:00 AM to 12:00 PM

NUMBER OF SPEAKERS: 5

FILE DURATION: 1 hour 44 minutes

SPEAKERS

Hilary Haycock
Anastasia Dodson
Jacqulene Lang
Anna Williams
Denny Chan

Hilary Haycock:

Just going to let some more folks jump on the line and then we will kick today off.

Hilary Haycock:

All right. We are going to go ahead and get started. So welcome everyone. Thank you for joining us at our second CalAIM Managed Long-Term Services and Supports (MLTSS) and Duals Integration Workgroup. We are so pleased to have so many folks with us today, and really looking forward to some great conversations. We've got a number of panelists today, and so I'm excited. I'll just run through them pretty quickly. We are joined by from DHCS Anastasia Dodson, who is the Associate Director for Policy in the Director's Office. From the Managed Care Operations Divisions, we have Michelle Retke, and Stephanie Conde. And from the Managed Care Quality Division, we've got Jacqulene Lang. From ourcolleagues at CMS in the Medicare Medicaid Coordination Office, we have Kerry Branick and Anna Williams. And we're also going to be highlighting some input from stakeholders today. So we've got Denny Chan from Justice in Aging, as well as Maria Lackner from Blue Shield Promise Health Plan.

Hilary Haycock:

So we will just start with some housekeeping. All participants will be on mute during the presentation. Please feel free to submit any questions you might have using the chat box. We will be collecting thoseboth during the work group to be highlighting and answering some of those questions. We'll also be reviewing those questions at the end to help inform our work going forward. So very useful for folks tobe using the chat function when we do open up for discussion. And if you have a question or a comment, please raise your hand and we will be unmuting people through that discussion section. ThePowerPoint presentation, all of the slide decks, our meeting materials are available on the CalAIM website. So if you go to the DHCS County website you can find that, there should be a link to those materials and the zoom chat.

Hilary Haycock:

I will say that sometimes hyperlinks get funky getting pasted into the zoom chat. So if it doesn't work, letus know we'll fix it. But just to highlight that it's occasionally a challenge. So for today's agenda, we're going to be tackling two very important topics. The first is on, maybe we can go to the agenda slide. The first is on data and evaluations, and we're going to be sort of reviewing what existing data reports and evaluations have been done for the Cal MediConnect demonstration. And we're going to be asking our colleagues at CMS to review the sort of standard Medicare data measures that D-SNPs are collecting andreporting to the federal government. And then we're going to have a discussion to think about what out of the existing universe is most useful. As we look ahead to future conversations about what we would like data and reporting to look like under CalAIM for duals.

Hilary Haycock:

The second part of our conversation today will be on the 2022 D-SNPs SMAC updates. The SMAC is theState Medicaid Agency Contract and so D-SNPs, while they're Medicare products, must have a state contract to operate in the state. And so we're going to be walking through some updates that the stateis thinking through for 2022. We'll be getting some input and updates perspectives from some stakeholders and we'll be having a robust discussion about that. So looking forward to the conversationtoday, and with that, I will hand it over to Anastasia Dodson, Associate Director for Policy at the DHCS Director's office and take it away, Anastasia.

Anastasia Dodson:

Okay, good morning everyone. Can you hear me okay?

Hilary Haycock:

Yup. Loud and clear.

Anastasia Dodson:

Okay. Super. Okay. So we'll first start with just a reminder of the structure of this work group and the purpose as part of CalAIM, DHCS is certainly committed to robust stakeholder engagement. There's a number of policies in CalAIM that are related to dual eligibles and the transition of Cal MediConnect to adecent aligned enrollment model. So the purpose of this work group is to have a hub for those discussions, as well as the MLTSS components. We're inviting various presenters to each of the meetings on certain topics. At our last meeting, we went over sort of the scope of what's in CalAIM around these issues. And then we have gathered some topics from that feedback at the last meeting. And we've set out today, as Hilary mentioned to cover two topics and then future meetings we'll cover other topics.

Anastasia Dodson:

We don't have specific members of this workgroup. Rather, we invite everyone to comment as Hilary mentioned. And also if there are particular topics that anyone would like to present on, in the future, wewelcome those suggestions and we'll have a little bit of discussion at the end about future meeting topics. But I also want to note that we received a lot of great feedback and we are developing a list of allthe potential future topics. So please know that your comments have been well received and we're taking note of them. All right, next slide.

Anastasia Dodson:

So this topic around Data and Evaluations is important. We think to start the discussion, we'll certainly have future discussions on this in the coming years. Next slide. So the goals here are to review what is already in place for Cal MediConnect and both on the DHCS side and on the CMS side, and then considerwhat's useful about those pieces and what might be considered going forward.

Anastasia Dodson:

We may not necessarily have exactly the same structure in the D-SNP and aligned enrollment

as we have in Cal MediConnect, as far as data and reporting. There's opportunities to look at new reporting. What do we like about the existing reporting and also thinking about what's feasible now or in the near term versus longer term. So none of this is, has been decided yet, but we do want to start at least by thinking about what's currently being done. So that we're all starting from the same place as far as information and consideration of some of the flexibilities or constraints that we may have at the federal or state level on some of this reporting. So again, thinking about in this conversation, what's useful and what can we build on. Next slide.

Anastasia Dodson:

Okay. So here, I'm going to turn it over to Jacqulene from our Managed Care Team to talk about the CalMediConnect dashboard.

Jacqulene Lang:

Hi there. Good morning. Can everyone hear me?

Hilary Haycock:

Yes.

Jacqulene Lang:

Okay. Great. Great. Good morning everyone. Again, my name is Jacqulene Lang. I'm a Data Reporting and Chief in the Data Analysis branch of the Managed Care Quality and Monitoring Division. My team is currently working closely with our Program Analysis Unit. That unit is led by Eugene Stevenson. So we'retraining on all of the moving pieces that are involved in the development of this dashboard. And so Eugene's team works pretty diligently on the production of this dashboard. And so as my team transitions with this dashboard, we're going to do our best to maintain the high standard that they set for this dashboard. So I'm here today to talk about the data that DHCS makes available on a quarterly basis for the Cal MediConnect program through this performance dashboard. And this dashboard includes more than 40 different measures from demographic data on enrollees to measures of care coordination, access to care, grievances and appeals, and long-term services and supports access in utilization. And most of these measures are specific to the duals demonstration and they're compiled at the central level by NORC. And that is the National Opinion Research Center at the University of Chicago.

Jacqulene Lang:

A couple of things to note concerning these measures, they aren't common Medicare measures and they will sunset with the demonstration in 2023. Also, note that these measures are reported by plan, aswell as aggregated over time. And you can find the most recent dashboard at the DHCS web address listed in the PowerPoint here on the screen. And so we are on track to post the March release of this dashboard, hopefully next week. Next slide, please.

Jacqulene Lang:

Thank you. So this dashboard tracks enrollment and CMC plans over time and includes a variety of demographic data on enrollees, including race, ethnicity, age, threshold language

spoken, and gender. The dashboard also reports out on the quality withhold measures for each CMC plan. And these are themeasures CMS and DHCS uses to monitor plan, and they include both core and California specific measures. There are also financial incentives tied to these measures and they include plan all-cause readmission, annual flu vaccine, follow-up after hospitalization from mental illness, encounter data, behavioral health shared accountability outcomes, documentation of care goals and interaction with their care team.

Jacqulene Lang:

There are a number of care coordination measures on the dashboard, starting with measures on healthrisk assessments and these health risk assessment measures report on health risk assessment completion within 90 days. Next slide, please.

Jacqulene Lang:

Thank you. This slide summarizes the remaining care coordination measures, and some of these are careplan completion, members who have a care coordinator and at least one care coordinator contact, including care coordinator ratios, members with documented care goals, and these most include a member's goals, preferences, choices, and abilities. And lastly members with follow-up visits after a discharge from a hospital. Next slide, please.

Jacqulene Lang:

Thank you. The dashboard also includes counts of grievances and appeals, and these are broken down by grievance type and appeal outcome. Grievances are complaints or disputes that members filed with plans that express dissatisfaction with their plans operations, activities, or behaviors. And an example ofthese could be wait times or inability to schedule appointments. Social plan denies, reduces, or terminates benefits or services for a member, that member can appeal. And these appeals can be determined as adverse, which is denying the members appeal or partially or fully favorable to the number's appeal. The dashboard also has one measure on behavioral health related emergency room visit. Next slide, please?

Jacqulene Lang:

Thanks. This last set of measures on the dashboard are on the topic of long-term services and supports. So these measures were developed by California DHCS and unlike the previous measures, they're not compiled by NORC. These measures look at counts of members receiving LTSS both overall and by type of service. And it also includes In-Home Supportive Services utilization (IHSS). We also report on plan referrals to Community-Based Adult Services (CBAS), the Multipurpose Senior Services Program (MSSP), nursing facilities and care plan options. Okay. That concludes my portion of the presentation on the CMCdashboard. Thanks for your time and Anastasia, I'll hand it over to you now. Thank you.

Anastasia Dodson:

Great. Thanks so much, Jacqulene. Yeah. And again, this is a data effort that has been ongoing for a number of years since we've launched Cal MediConnect and we have a dedicated team. But as you cansee, there's a lot of measures and it takes a certain level of effort in the department to present these measures.

Anastasia Dodson:

So as we proceed, we'll need to get your input on which of these folks are most interested in continuingand then consider any technical issues that may need to grapple with as far as what's the source of a data, how readily will that data be available with the transition to a D-SNP aligned enrollment, and howall of that will work together. So before we get to the discussion about that, I want to just also flag that there's several other ways that we measure and monitor at DHCS for Cal MediConnect, CMS contracts with the Research Triangle Institute (RTI) international, for an evaluation. The SCAN foundation has wonderfully funded the Cal MediConnect Rapid Cycle Polling Project and their results on both the evaluation and the rapid cycle polling available on the DHCS website. We also have an evaluation outcome report that we publish annually that summarizes all the pieces here, as well as the health planquality and compliance reports specifically for Cal MediConnect, that reviews plan, reporting requirements, quality monitoring, and quality improvement efforts. Next slide.

Anastasia Dodson:

Okay. So we're going to shift gears a little bit just on this particular slide around decent data sharing, because it does relate to the overall data landscape. So as we talked about in the last webinar a month ago, there are new federal requirements around D-SNP data sharing that actually have gone into effect in 2021. And as we look forward to 2022-2023, we want to just consider how these data sharing efforts can merge in with data reporting and to improve care, to improve coordination among partners, as wellas perhaps improve our data recording or give new openings for data reporting.

Anastasia Dodson:

So, as you know, in 2021 D-SNPs have a new data sharing requirement for hospital and skilled nursing facility admissions, and we're getting that data right now at DHCS. And as we're receiving it, which onlybeen just a couple months. We're looking at how that data can be made public at the aggregate level before 2023, as well as looking at whether we can match that data to our existing demographic data toenhance everyone's understanding of the population that accessing hospital and skilled nursing facilitythese days. So more to come on that, but just want to make sure it's part of the landscape that we're talking about today.

Anastasia Dodson:

All right. So with that, I'm going to on the next slide, transition over to CMS and ask Anna Williams topresent. Thank you.

Anna Williams:

Thanks, Anastasia. So I'm going to go over the Medicare quality reporting requirements of D-SNPs whileCal MediConnect plans have some demonstration specific reporting requirements, but D-SNPs reportingrequirements are standardized across all D-SNPs nationwide. Next slide, please.

Anna Williams:

So there are four main quality reporting requirements in which D-SNPs and other Medicare

advantage plans must participate. And they include the Health Effectiveness Data and Information set known as HEDIS, Health Outcome Survey or HOS, the Consumer Assessment of Healthcare Providers and Systems Survey, or the CAHPS survey, and Part C and Part D Reporting Requirements. Cal MediConnect plans alsoreport these measures with some Part C modifications. This set of requirements provides Medicare beneficiaries and the general public with information to help make more informed choices among Medicare plans. Typically, through the star rating system. They also help health plans identify problems, and improve the quality of care and services by providing them with information about their performance at the contract level, relative to the other contracts in the region and nationally.

Anna Williams:

These requirements also enhance CMS's ability to monitor the quality in care and performance of healthplans. The specifications of many reporting requirements are at the contract level, not at the plan level. So a health plan organization generally has one contract with CMS for a geographic area, and may have multiple plans and plan types within that contract. For example, a D-SNP is maybe just one plan within a broader contract, because many reporting requirements are available only at the contract level. Results are often not broken down into that individual California D-SNP level. And this is different than reportingfor Cal MediConnect plans is only Cal MediConnect beneficiaries are included in the plan reporting. And so only results for the Cal MediConnect beneficiaries are reported and are reflected in the results.

Anna Williams:

Star ratings, which provide information on a number of plans quality measures, include select HEDIS, HOS and composite measures for CAHPS at the contract level, but not at the plan level. There is also onePart C and one Part D measure that's included in the star ratings calculation. In addition to the availability through star ratings, HEDIS measures, and Part C and D measures are also made available online through public use files. So the subsequent slides will have a bit more detailed than what I'll speak to, but like the slides can be a useful reference to look back to. Next slide, please.

Anna Williams:

So HEDIS is a set of measures developed by the National Committee for Quality Assurance to measure performance on important dimensions of care and service and are used extensively in the health care industry. CMS requires that all contracts collect and submit HEDIS summary level data. And HEDIS measures include both contract-level reporting and for Medicare contracts plan or plan benefit package,PBP-level reporting for a subset of measures. There is some variation between Medicare HEDIS measures and its other versions of HEDIS such as the Medicaid Managed Care HEDIS. And as mentioned,these data are made publicly available through CMS in a public use file. Next slide, please.

Anna Williams:

And so there are 50 contract-level of measures. A couple examples are breast cancer screening and planall-cause readmissions. There are also 13 measures that are reported at the plan level in addition to the contract level, examples include colorectal cancer screening and follow-up after hospitalization for mental illness. There's one exception and that's care for older adults

measure and this measure is only reported for special needs plans and MMPs. And it's reported at the plan level rather than the contract level. Next slide, please.

Anna Williams:

The Health Outcome Survey or HOS is administered annually to a sample of beneficiaries from each Medicare contract. After the survey, there's a follow up survey two years later and it tracks the same respondents, and it's a way to track both physical and mental health outcomes. The surveys made available to beneficiaries in English, Chinese, Russian, and Spanish, and these results are also reported atthe contract level and not at the plan level. Next slide.

Anna Williams:

The HOS survey includes a variety of questions. Some examples include, "In the past seven days, how much did pain interfere with your day-to-day activities?", "And have you ever had a bone density test tocheck for osteoporosis?". Next slide, please.

Anna Williams:

CAHPS is an annual survey that asks a sample of beneficiaries in each contract about their experiences with, and ratings of, their health care plan and providers. This survey is available in English and Spanish,and it is reported at the contract level. There are three versions of the Medicare CAHPS survey. There'sthe Medicare advantage only, the version for Medicare advantage with prescription drug plans, and then a stand-alone prescription drug plan survey. There's also the Medi-Cal Managed Care Plan survey, but this is a different version of CAHPS than what's available for Medicare. So through CAHPS, some responses are combined to make up six different composite measures and these are then used in the star ratings. Examples include a composite measure for getting needed care or getting appointmentsand care quickly. Next slide, please.

Anna Williams:

So some of the examples of CAHPS survey questions for beneficiaries include "In the past six months when you needed care right away, how often did you get care as soon as you needed?", and "Have youhad a flu shot since July 1st of the previous calendar year?". Next slide.

Anna Williams:

The Part C reporting requirements are a set of administrative measures that capture information aboutappeals and grievances. A set of administrative measures that capture information about appeals and grievances rewards and incentive programs and others. They're reported at the contract level. And the one exception for this is the section for special needs plans care, or care management, which is specificto special needs plans, and is reported at the plan level. Next slide, please.

Anna Williams:

There are five part C the reporting requirements sections for D-SNPs. It's grievances, organizational determinations and redeterminations, payment to providers rewards and incentives programs, and thespecial needs plans care management. Special needs plans care

management is, as I mentioned, that's specific to special needs plans and it measures health risk assessments and reassessment rates at the plan level. Next slide please.

Anna Williams:

So similar to part C, part D reporting requirements are also a set of administrative measures. They capture information about appeals and grievances, pharmacy access, among others. And depending onthe section, these are either reporting at the contract level or they may be at the plan level. Next slide please.

Anna Williams:

So there are five part D reporting sections that D-SNPs must report. These include coverage determinations, redeterminations and openings, enrollment and disenrollment, grievances improvingdrug utilization review controls, and medication therapy management programs. Next slide, please.

Anna Williams:

Additional information for each of these reporting requirements is available online. You can find links toeach requirement on this slide for your reference. Thank you. And with that, I think I'll hand it back to DHCS.

Hilary Haycock:

Great.

Anastasia Dodson:

Thank you. I don't know. Can you all hear me?

Hilary Haycock:

Yep.

Anastasia Dodson:

Super. Okay. So Hilary, I think next, are we going to have discussion about all of this and think through?

Hilary Haycock:

Absolutely.

Anastasia Dodson:

Okay. Super.

Hilary Haycock:

Great. All right.

Anastasia Dodson:

Yeah.

Hilary Haycock:

Thanks so much folks for those great presentations. I know that was a lot of really dense information.Again, the slides have been posted online and so they are available, as Anna said, as a good referenceabout what data is happening. So I think there were a couple of questions that came into the chat. Although we would also like to say, please raise your hand if you would like to ask a question or makecomment. We certainly would encourage folks to do that.

Hilary Haycock:

But there were a couple questions that came in about the source of the data. The data is primarily sourced from the plan, plan reporting on what's happening. There was a specific question about grievances and appeals, and that is data that comes from the plans. There was a question maybe Annamight know the answer to, about whether there are any federal incentives at the contract level for D- SNPs. I think this might be a question about if there are quality withholds at the federal level, these quality measures for standard D-SNPs.

Anna Williams:

Yeah. So they're not quality withhold measures at the federal level or the contract level for D-SNPs. However, these are incorporated into the star ratings and that's a really helpful tool for beneficiaries and others to assess the quality of different D-SNPs and different Medicare advantage plans.

Hilary Haycock:

Great. Thanks Anna. There's another question about the D-SNP information sharing and if that's happening in all counties. It is, and the D-SNP information sharing requirement applies to all these stepsoperating in California. Every state has their own information sharing policy. So it is not specific to the CCI demonstration, it's any D-SNP.

Hilary Haycock:

There is a comment that these measures are all centered around the administrative needs of the funding entities and the plans. And it would be fantastic to see measures that center populations ofinterest, for example, all older or dual eligible adults experiencing homelessness or mental health challenges, regardless of plan or contract or global race, gender age analysis.

Anastasia Dodson:

I think that's, yeah, this is Anastasia. I want to flag that, that's an important and doing noted comment. And as we think about what we're doing now, because we do have some information available now posted for Cal MediConnect about demographics. We do want to move toward being able to have someof those similar demographics available under the D-SNP aligned enrollment model. And then of course,in the last few years, we've grown a lot across the health and human services agency, and our use of ouropen data portal. So you will see that

in addition to the dashboard, there's data there around enrollment in various plans and other demographics for groups, whether it's tools or others. So all of those things are definitely on the table going forward, and we expect it will be an incremental approach that as we, and for some of the populations, as you're identifying individuals who are homeless or have mental health needs, there may be some type of one time reporting that we're able to do based on a partnership with other programs as well, other pieces in CalAIM. So just want to appreciate that comment.

Hilary Haycock:

Great. All right. We have, Tatiana has raised her hand. So well, go ahead. And your line has been unmuted on our side. So go ahead, and there we go. Great to hear from you Tatiana. If you're talkingTatianna, we can't hear you. Okay. I'm not sure what's happening there. We'll give that another shot.Pat Blaisdell, your line has been unmuted on our side.

Pat Blaisdell:

Okay, good afternoon. Or good morning. Thank you for this. Can you hear me?

Hilary Haycock:

We can.

Pat Blaisdell:

Oh, great. Yeah. I was looking at the discussion questions here, I think, and I spent some time on the dashboards that you provide the links to. I think, one thing that strikes me is that many of the – even thevery useful data elements are more based on utilization and process items. And I would like to just throw out there the idea of including some outcome measures. In particular, you ask what Medicare data elements might be most useful. I know within Medicare, some of the medical settings are required to report a discharge to community and changes in functional status or attention to functional status. SoI think, considering some measures that would be more outcome based and or addressed specifically looking at independence, would be worthy of consideration.

Hilary Haycock:

Great. Thank

you.

Anastasia Dodson:

Thank you. That's a great, yeah, that's a point. And it does go along with, I think some of the other chat about what is done now in Cal MediConnect, what will change in D-SNPs. And one factor I want to also raise is that the state can require certain reporting by D-SNPs, even if it's not necessarily a standard CMSreporting requirements, back to the point of that special data reporting that D-SNPs have now. So, thankyou Pat. And that's a great point about outcome measures.

Hilary Haycock:

Yeah. There was a question from Denny Chan about which data metrics are, how many connect specificnot currently captured otherwise and maybe lost in the transition to the aligned enrollment model. I think there's two levels to the answer to that question. I know one of them is this shift from receiving Medicare metrics at the plan level to the contract level, that we're thinking through. But I believe manyof the Cal MediConnect demonstration measures are specific to the demonstration. Some are specific even to California. I'm not sure if there's a panelist who would be able to speak with a little bit more specifics to that.

Anastasia Dodson:

Right. Hilary, one thing I'll just flag is that, back to that other point though, we do know that there'll be some pieces that are specific. I believe it's the NORC areas that may not continue to be captured. So we will look at ways to, and frankly, that's why we're having this conversation with all of you. It's to think about specifically, which of these measures that are on the dashboard, which of them would you prioritize? Because of course, in some ways we all like more data, because then we know we have a bigger picture of what's going on, but then thinking about the resources needed to compile the data andback to Pat's point of what is most valuable. So again, we'd really appreciate your feedback on which of these measures is most interesting, and perhaps some of them are more annual instead of quarterly. Allof those things are up for consideration.

Hilary Haycock:

Great. All right. Tatiana, we're going to try again.

Tatiana Fassieux:

Okay. Can you hear me now?

Hilary Haycock:

We can.

Tatiana Fassieux:

Oh, great. Thank you. High technology. I am concerned as it happened also with CMC and now the D- SNP of marketing abuses. Because those definitely have an impact on data. And so we have agents thatare incented by the plans and consequently, the plans are getting this money to market their programs.Will there be any data collection or oversight of financial incentives? Because sometimes these enrollments are inappropriate.

Anastasia Dodson:

Thank you for flagging that. I wonder if anyone from our CMS colleagues might want to weigh in on that.

Anna Williams:

Hi, it's Anna. So any time there's poor marketing, this can be reported to CMS. I think there's a CMSmailbox. And we could also share that with you after this meeting. Yes, thanks.

Anastasia Dodson:

Great.

Hilary Haycock:

Great. So there's a question about the LTSS utilization measures, and that they seem to be missing fromthe federal D-SNP reporting requirements. Does DHCS plan on keeping those CMC data reporting requirements for D-SNPs? And so these are the LTSS utilization measures the department developed specifically for Cal MediConnect plans, to track referrals and utilization of different LTSS measures.

Anastasia Dodson:

Right. And that's a great question. So, and I'll actually put it back to you all as a group. What are your thoughts on that? And when we, maybe we can actually go back to the Cal MediConnect Dashboard. Make the slides further up on the dashboard and just to look at those measures, because I think that's areally important question.

Anastasia Dodson:

Well, while we're doing that, just, yeah, I don't know if we're able to go back to this, but the idea thoughis since we're doing it quarterly now, is it value added to do that type of reporting on a quarterly basis, perhaps only with the initial transition, but if the numbers are staying the same and I'm, in my mind looking at the dashboard that I reviewed earlier this week, that, and you all can see if you go online to that website, there's not a huge increase or decrease from quarter to quarter for many of those measures. And so, again, thinking about the... Let's see, okay, we're going to, there it is.

Anastasia Dodson:

So you can see this slide shows the actual types of measures for LTSS utilization. Again, we know that people are interested in this, but if it's not changing much from quarter to quarter, is this something that we look at annually? Is this something that we look at more frequently during the initial transition,and then thinking about what are the mechanisms for that, is there, do we incorporate that into our D-SNP contract requirements? Do we just use DHCS behind the scenes data poll with member matching? That type of thing. We will need to look at all that, but mostly we want to hear from you right now of what seems most important and going forward to, as we proceed with this work group in the coming months.

Hilary Haycock:

Great. We definitely got to comment on interest in seeing more data on members social determinants of health, that's certainly a really important area and definitely central to the work of CalAIM. There's aquestion about the pending carve out of MSSP and LTSS, how the department would propose the plansfulfill some of the LTSS reporting requirements. And I think this goes to a comment you just made Anastasia about, is it plan reporting, or is it DHCS looking at internal data and thinking through what could be made available?

Anastasia Dodson:

Right. And again, thinking about that, even back to Pat's comment, is it, are we looking at outcomes? Are we looking at utilization? Are we looking at demographics? Probably some of each, but what is the best use of the data team here, the CMS information, how can we bundle it in a way that's useful and feasible, frankly, for the department considering there's always so much more that we could be lookingat, but what's adding the most value?

Hilary Haycock:

So you've got a comment in the chat from Marty Lynch about, we need a measure for D-SNPs about howmany members have care coordination, or care management provided to them, and some measure of integration of care to the beneficiary. So, that seems like helpful input.

Anastasia Dodson:

So, thank you.

Hilary Haycock:

Great. All right. Another comment that data that would help understand different levels of care and transfers between them whether they're stepping up or stepping down, would be useful. I'd also say, so our team behind the scenes has put up a poll on whether DHCS should consider continuing LTSS utilization data collection reporting. So folks want to participate in that poll that will help give us a little piece of information. There are folks agreeing in the chat with wanting to know how care coordination isbeing provided, which is great. Maybe we can move to the slide that looks at some of the existing care coordination measures.

Hilary Haycock:

Under the demonstration, we're looking at completion of the health risk assessment, which is the entry to care coordination, but there's also measures looking at care coordinator ratios, care team contacts, documented discussions of care goals, care plan utilization. So, would love to hear from folks on, are these the types of measures that are interesting and helpful and understanding how care coordination isworking in the plan?

Anastasia Dodson:

- all the comments here are, just so you know, even if you're just typing in the chat, not speaking, we have a record of all those. And so what we will be doing in the coming months is looking over all of thatand then thinking about what we do to move forward.

Hilary Haycock:

Yeah. So there's a question in the chat about why only MSSP and CBAS, when there are so many other LTSS options. And so, because the Cal MediConnect demonstration is an MLTSS about managed long term services and supports. We are looking at the LTSS services that the plans are responsible for, and that the plans are making referrals to. And so CBAS is carved into managed care across the state and inCCI counties, we also have MSSP. So that's why we're looking at those specific LTSS.

Hilary Haycock:

So interest in IHSS caregivers participating on care teams and other IHSS metrics. And I guess thereagain, under CalAIM, IHSS is intended to remain out of an LTSS. Definitely appreciate the interest in understanding that program, but it might not be best identified through an MLTSS dashboard.

Anastasia Dodson:

Well Hilary, we'll certainly take a look at that.

Hilary Haycock:

Yeah.

Anastasia Dodson:

We know that there's a strong connection between IHSS and the broader delivery system. And so as wethink about care coordination, and we think about how an integrated care can really benefit individualswith complex care needs. And IHSS is a key component of that array of services. Looking at how well managed care plans are coordinating with their County counterparts for IHSS, is something that we willcertainly look at.

Hilary Haycock:

Yep. Great point. So there's a question on, because enrollment in MA plans will remain an option to Medicare beneficiaries, will the data collection also collect data on Medicare covered care coordination in original Medicare?

Anastasia Dodson:

Thanks for that question. Yeah. We know that there'll be further discussions needed with CMS around some of these data reporting options. As Anna was saying, some of these data measures are collected atthe contract level, which means the plan may have multiple products for the same contract. And so it may be hard to distinguish in some of the ways that we have done in the past, but we'll certainly keep working with CMS and with all of you on ways that we can get some of that data. And maybe it's alreadyavailable in some format on the CMS website. And if there's ways that we can point to that on the DHCSwebsite or pull some of that on a routine basis, we will. That's an option that's on the table.

Hilary Haycock:

Great. Scrolling back through. It seems like the chat has slowed down. Again, if folks want to raise their hand, I'm happy to open your line. One of the chat comments is, the question coming to mind looking atthe data elements is, what action will this data inspire? Which I think is a great question, and really the heart of the conversation today. Right Anastasia? We want to be trying to identify the data measures that are meaningful to help promote improvement.

Anastasia Dodson:

Absolutely. Yeah. And that ties in with the broader CalAIM initiatives there, in many ways.

Hilary Haycock:

Great.

Anastasia Dodson:

So seems like we should probably proceed to the next part of the agenda, unless there's any otherquestions.

Hilary Haycock:

That sounds great. All right. Very helpful feedback. So thank you everyone. And now we will move on toour next topic. The 2022 State Medicaid Agency Contract for D-SNPs. And, go ahead Anastasia.

Anastasia Dodson:

Okay, great. Hopefully everyone remembers this terminology from last time. This is the contract between the state and the D-SNP. Go to the next slide. So we're going to try to tackle a few things in thissection. Again, reminding everyone what the D-SNP contract is and does, the existing 2021 provisions and then potential updates in 2022. Next slide.

Anastasia Dodson:

Okay. And as we talked about in the last meeting, that D-SNPs primary contract is with Medicare, for Medicare benefits, but they must also have a contract with the state Medicaid agency, of course, DHCS in California. That D-SNPs contract with Medicare could be at the plan sponsor level, and include other product lines, D-SNPs and Medicare advantage. And again, that goes back to the point that Anna was making earlier about the type of reporting they get and how granular they're able to receive that data atthat level, multiple States as well. So, but a D-SNPs SMAC with each state agency, it just covers their lines of business in that state. So in California, our contracts are with each individual D-SNP, although that may cover multiple counties in California. Next slide.

Anastasia Dodson:

So, in 2021, we updated the language with some template language provided by CMS, mostly rephrasing, but didn't change template language provided by CMS, mostly rephrasing but didn't change major D-SNP responsibilities. And reminder that we have these contracts, the model contracts posted on the website for this workgroup. And we've also created a new landing page on the DHCS website, justfor D-SNPs or information about D-SNPs, so that it's available to the public. And intending to provide more information there with perhaps data about enrollment in particular plans or data about just overall enrollment in the state and how that's changed, we do have some data that again, we're looking at what's the best way to display it and most useful for all of you. And as I mentioned, we're also receiving the individual's specific data about nursing facility and hospital admissions. And so thinking about how we might be able to compile and present that data back.

Anastasia Dodson:

The information-sharing policy requirements were before the pandemic it was intended to look

at specific vulnerable groups. But because of the upheaval in our delivery system, we've shifted that, but in the future, we can ask D-SNPs to focus on specific groups. The intent is not just reporting to the state, but really information sharing among partners, HIPAA, covered partners so that there is better integration and coordination among all of the services.

Anastasia Dodson:

We know that there could be misalignment between which D-SNP plan and individuals enrolled in versus their Medi-Cal plan, or maybe they're not enrolled in a Medi-Cal managed care plan right now. But there are elements that are covered by Medicaid that the D-SNPs needs to know about and partners that they should be working with. For example, nursing facilities, hospitals, et cetera, even County HSS programs.

Anastasia Dodson:

So we want to make sure that going forward, we will continue to increase the requirements for D-SNPson information sharing to make it more relevant to the care coordination requirements. All right. Next slide.

Anastasia Dodson:

So the updates for 2022 contract year for the SMAC must be made final by the end of this month, March, which does limit our time to make changes. This is based on the process at the federal level to update and get those contracts in place in time for certain other Medicare schedule items. So again, andat the state level as well, we need to have this language reviewed by various teams internally. So we would like, and we asked at the prior meeting, any feedback on the SMAC contract, and we got some great feedback from a team of advocates, and we're going to have Denny present shortly on that. But based on that feedback that we got, we're looking at clarifying the care coordination requirements, including LTSS program contact information, to facilitate better coordination.

Anastasia Dodson:

Some of these requests and suggestions we think can be made even without necessarily changing the SMAC contract language. In the summer, we undertook an effort in Central Valley counties to enhance the information that all of the different care partners and teams might have in those counties. And we can do something similar where, and you can see the information posted on our website, where we listed all of the different home and community-based service providers and organizations with their contact information. So we can look at doing something similar for D-SNP plans. Because we want to make sure that as we're making these requirements for the D-SNPs, that we're giving them informationthat they may need in order to implement those requirements around care coordination.

Anastasia Dodson:

Other items that were flagged for us is clarifying balance billing protections, helping providers understand and access Medi-Cal eligibility verification, and updating non-discrimination provisions. Sowe're looking at all of those, and we're kind of on a fast track to try to get that done and welcome thisconversation today so that we can complete those contract updates by the end of this month. Next slide.

Anastasia Dodson:

So we have a longer timeline for the 2023 changes in the SMAC. And at the same time, we have alreadyquite an ambitious list of changes that we're looking at for 2023. So we're looking at aligning the coordination standards with the work that will be undertaken in CalAIM, sorting out whether it's in the SMAC contract or otherwise how Enhanced Care Management and In Lieu of Services connect in with Medi-Cal managed care plan, contract requirements, strengthening member billing protections, lookingat provider directory and network standards and aligning the plan data and evaluation requirements with the efforts that are already underway in CalAIM.

Anastasia Dodson:

So that's, in a nutshell, the topics that there's much more detail behind each one of these for the 2023 SMAC. And that will be discussed with this workgroup in the coming months. Next slide.

Anastasia Dodson:

Great. So with this, I believe it's time for me to hand the mic over to Denny from Justice in Aging, andcongratulations, Danny, on your new assignment as well.

Denny Chan:

Thank you, Anastasia. Hi everyone. Can you hear me okay?

Anastasia Dodson:

Yep. Go right ahead.

Denny Chan:

Right. Thank you, Anastasia. Denny Chan from Justice in Aging. First, I want to start off by thanking DHCSfor organizing today's presentation and allowing me the opportunity to present on behalf of some otherstakeholders. I'll start off by saying these suggestions for the State Medicaid Agency Contract, I don't intend to represent all stakeholders because I know that there are probably a couple of lots of different suggestions that people have, but these are really initial suggestions from Justice in Aging and the Cal MediConnect system home-based program. And the word-initial reactions is really worth stressing. This is not an exhaustive list of feedback. We did provide the state and more detailed feedback through a redline form.

Denny Chan:

So to sort of pullback 10,000 foot and look at a larger picture, what are updates? What are the things that we as advocates think is valuable and including in an updated State Medicaid Agency Contract, whether it's for 2022 or 2023, realizing that the timeline that Anastasia has laid out, the 2022 contractshave to be finalized by the end of the month, essentially make it harder to tackle some bigger ticket items. But, regardless if we're thinking about 2022 or 2023, what are the high ticket items for us?

Denny Chan:

First, we think that focusing on reducing health disparities is absolutely critical in this moment and moving forward for older adults and people with disabilities who will be best served in the aligned enrollment model. This has to be a priority because if it's not called out specifically, disparities will continue to linger, will continue to be masked, or are actually exacerbated by racially neutral policies.

Denny Chan:

We know that the COVID disparities among dual eligibles and in particular dual eligibles of color there's national Medicare data on this, the disparities are staggering. And concurrently, we know that as we were attempting to roll out vaccination for older adults and people with disabilities shortly that we are lagging behind as well with respect to vaccination. But it's also important to remember that these are issues, of course, that were, you know, these are part of systems that long existed before COVID-19. If we look at research even from 2019 research uncommonly connected, really some of the research thatwas mentioned earlier in the presentation, we know that disparities are showing up even with current enrollees in the MMPs.

Denny Chan:

So, for example, we know that 25% of Latinos, only 25% of Latinos are reporting to be very satisfied withthe choice of doctors and hospitals while enrolled in comedy conducts the lowest of all racial groups.

Denny Chan:

We also know that Asian-American enrollees are least likely to know who to call if they have questions about their healthcare and most likely to report problems with interpretation, transportation, and unmet care needs. So these are all points that we need to be thinking about as we're updating the StateMedicaid Agency Contract and moving into a transition with an alignment enrollment model.

Denny Chan:

This is a goal that the state has identified in the commercial Medi-Cal plan re-procurement process in terms of reducing disparities. So we think it needs to be explicitly addressed in the SMAC for the department to remain consistent. There's a lot of ideas here. I look forward to continuing to talk to and work with you all on figuring out what the right sort of mechanisms are, what their incentive, new payments, stronger reporting requirements. There were a number of comments in the chat about moredis-aggregated data that looks at metrics by race and other demographics.

Denny Chan:

I'll also flag for everyone that our partners at the California Pan-Ethnic Health Network did put togethera really great and comprehensive paper on contracting and health equity, specifically in the Medi-Cal space. So I referred you all to that as a resource. The next two suggestions, one about additional language, about the role of the D-SNP and supporting members who

experienced Medi-Cal eligibility issues and also improve language from care coordination or regarding care coordination, building uponCal MediConnect is really the same kind of spirit. It's really about leveraging the learnings from Cal MediConnect to improve the aligned enrollment model with an eye towards the 2023 transition.

Denny Chan:

One principle that we adjusted staging have continued to try and maintain through building this processis that no dual should be worse off in the new model than they currently have experienced in Cal MediConnect.

Denny Chan:

So to that end, the deeming protection offers dual eligibles are critical protection as they are in bold andhave experienced enrollment issues or eligibility issues with their Medi-Cal. Cal MediConnect includes a deeming period, as we know, and not only should one be included in the State Medicaid Agency Contract, but consumers would benefit immensely from additional language requiring the D-SNPs to support members, actively, proactively support members during that time period.

Denny Chan:

I think that if we look at some of the other States that have, how they handle deeming. And New York,my understanding is, they have some pretty robust proactive requirements on put on their plans. Similarly, under Cal MediConnect, if we go to the third bullet, there was significant work done andintentional work done in building out a meaningful care coordination benefit for enrollees.

Denny Chan:

There's kind of two specific examples I want to offer around that. One is specific requirements around care coordination for individuals with dementia, as well as inclusion of an independent consumer Ombudsman Program. These are both elements that currently exist in the three-way contract between DHCS, CMS, and the health plans. The dementia care training requirement was really intended to be a building block and the start of a foundation to build a more friendly care system for this population, andrecent COVID-19 data show how at-risk that population is. So there's even more on top of including thatrequirement in the SMAC to go further.

Denny Chan:

In addition, at the risk of sounding like a broken record, protections like the independent consumer Ombudsman program are critical for consumers. This is a trusted community resource for individuals toget help on anything related to their health care Medi-Cal eligibility, plan denials, helping, getting help filing a complaint.

Denny Chan:

I know these are more complicated requirements. These are things that might not make it into the 2022contract, but given the timeline of everything, I think it's really important for us to be thinking about what type/what kind of language we want to include with an eye toward 2023.

To Anastasia's earlier point, what are things that we can do outside of the State Medicaid Agency Contract that would still effectuate some of these consumer protections? But I think it's really important as we're thinking aboutthe State Medicaid as a contract to really be thinking about what has worked in Cal MediConnect and what needs to go in this updated contract.

Denny Chan:

That really, it kind of brings me to my last point, which is that improving, which is a suggestion to improve the existing language around state enforcement. Short of termination of the contract, there'scurrently no other mechanism for the state to enforce different provisions of the state contract.
Termination, of course, is a viable option, but we would really encourage the state to include otherenforcement mechanisms, short of termination, that would allow the state to better enforce and monitor compliance with the contractual requirements.

Denny Chan:

There are, of course, a number of actions that can happen on the Medicare side. But a lot of the things that we're talking about today in terms of care coordination, data sharing requirement, if we're buildingthat into the State Medicaid Agency Contract, that's a contract between the state and the plan. CMS willno longer be - we don't all have the three-way contractors as we currently do. So that's why it's really important that when thinking about the State Medicaid Agency Contract, that we build out a more robust enforcement process so that the contract will actually have some teeth.

Denny Chan:

So, I know that was a lot of information, more to come and really welcome again, the opportunity ofworking with all of you to improve the State Medicaid Agency Contract with an eye toward 2022 andalso 2023. So with that, I'm going to turn it back to Hilary.

Hilary Haycock:

Great. Thank you so much, Denny. Lots of helpful stuff to think about there in terms of moving forwardand contract updates. We are now going to hear from Maria Lackner with Blue Shield Promise Health Plan. Maria, are you… Your line should be open. Great.

Maria Lackner:

There you go. Hi, good morning, Hilary. Thank you for the opportunity to share a perspective from a current both Cal MediConnect and D-SNP plan. So we had the opportunity to review the State MedicaidAgency Contract, as well as some of the proposed edits that are being shared with this stakeholder group. And really, from this plan's perspective, again, our plan's perspective only. So I don't mean to speak on behalf of every D-SNP plan that is currently operating in the State of California.

Maria Lackner:

We do think that the opportunity for edits to the 2022 State Medicaid Agency Contract really lies with creating clarity to and providing additional detail for areas related to program

eligibility and eligibility verification.

Maria Lackner:

In addition, augmenting some of the care coordination requirements, as well as the timeframe that those requirements are to be monitored around for the medical services and state-specific reporting requirements, is an area that, although are included today in the State Medicaid Agency Contract, we believe in agree with our stakeholder and community advocacy partners that could benefit from someadditional clarity in the contract this year.

Maria Lackner:

With that being said, as we do prepare for 2023, we also think that with the eye of aligned enrollment inthe future, D-SNP plans both current and any new that would be entering in operation in the State of California would most benefit from continued conversations with CMS and DHCS that will lead to potential edits and or modifications to the State Medicaid Agency Contract around contracting and MOUrelationships in support of additional integration requirements that may come about as a result of our CalAIM initiatives in the State of California, as well as network requirements. And more importantly, look at language specific to division of responsibility between the Medicaid and the Medicare plans within each organization. Specifically around care coordination and reporting requirements as D-SNPs today, we will need to continue to adhere to CMS part C and part D reporting requirements, as Anna Williams shared earlier on this call. And we anticipate that many of the existing Cal MediConnect lessonslearned and, or reporting requirements that we've learned so much from, with likely fall under the State Medicaid Contracts with the managed care plans.

Maria Lackner:

So there's definitely significant work to be done with an eye towards 2023. And we think that as part ofthese stakeholder calls, as well as individual conversations with the plans that will be impacted both D-SNPs and medic health plans, we can come to a place where we feel that we are ensuring that we are integrating all of the great benefits that the CMC plan has offered and building upon those to ensure a better service to our dual eligibles.

Hilary Haycock:

Great, thank you so much, Maria Lackner, for sharing that perspective. We will now go ahead and open the discussion. We want to hear from folks in our broader stakeholder community about what potentialupdates should DHCS prioritize for this next year's extra update. I think we'll go to Debra Cherry, who has been very patiently had her hand raised. Your line is open. And could you please let us know what organization you're with?

Debra Cherry:

I'm with Alzheimer's Los Angeles. And I apologize. In the meantime, while I waited, I put everything I meant to say into the chat. But let me take a moment to just reinforce something that my colleague Denny Chan has said, which is that along with people from diverse ethnic communities, people with dementia have been disproportionately impacted by the COVID virus and dying at disproportionately high rates. And I would encourage you to consider a quality measure that takes a look at something like staff turnover in contracted nursing homes. Because I think that can be a stand-in measure for quality inthose nursing homes and may well,

according to Cal research, lead to a decrease in risk for death as well as improvement in quality, but everything else I said is in the chat. So I'm going to sign off.

Anastasia Dodson:

Thank you. Thank you so much, Debra. And we do recognize the helpful and hard work that folks made under Cal MediConnect or Dementia Care standards. And we absolutely are looking at whether it's in our business contracts for 2023 or in our Medi-Cal managed care contract. That's where we need to sortthings out, but we do absolutely want to make sure that we've got those provisions and that we recognize. And as you and Denny have noticed that there has been a disproportionate impact due to COVID on certain populations that it's really very discouraging, but at the same time, we need to learn from that and, going forward, find ways to put a spotlight on what's causing those issues and look for solutions together amongst all of us, because it's something that can be addressed at every level of the health care delivery system, all the way up to the state.

Hilary Haycock:

Great. Yeah, very important issues. We have again, I would encourage folks if you want to participate inthe conversation, please raise your hand, and we will be happy to unmute your mic. We did get one comment in the chat about considering adding language to the 2022 SMAC to automate crossover claims from the health plan to the providers. And so this is, of course, the issue of ensuring that providers receive both the Medicare and Medicaid payment. So that's definitely something worth the chat.

Anastasia Dodson:

Right. We want to acknowledge that we've received that comment in writing as well. And we're lookingat the feasibility of that either for 2022 or 2023.

Hilary Haycock:

Great. Thanks to support in the chat for looking at that staff turnover measure nursing homes. And wehave another comment from Tatiana. So we'll unmute your line and ask you to just-
Tatiana

Fassieux:Thank

you.

Hilary Haycock:

... let us know your organization.

Tatiana Fassieux:

Yes, Tatiana Fassieux with California Health Advocates that supports the local HICAP in California, the Medicare Counseling Programs. It is extremely important that we recognize that there is going to be animpact on the local HICAPs. Dual eligibles have consistently, and we're gratified about that relied on theHICAP for accurate information. Knowing that there will be that impact is additional funding to support at least their involvement at the initial rollout stage

or on an ongoing basis. Thank you.

Anastasia Dodson:

Thanks for that question. We have that as an item that we're tracking, don't have a solution yet on that,but we certainly recognize that as a question and an issue that we'll need to sort out.

Tatiana Fassieux:

Thank you.

Anastasia Dodson:

And we absolutely value and recognize the important role that HICAP plays and those specialized expertise that those teams have, and very important part of making sure that people know how toenroll, what programs to enroll in, and make sure that their choices match what they need.

Tatiana Fassieux:

Thank you. Because we have seen a lot of changes lately, for example, with the Magellan change on the prescription drugs and those notices that went out to beneficiaries, totally confused, dual eligibles, because they thought that their part D plan was going to be replaced, so we want to make sure that notonly our organization but the Department of Aging HICAP section get fully informed and involved. Thankyou.

Anastasia Dodson:

Thank you.

Hilary Haycock:

All right. We've got a new comment in the chat on Medi-Cal Managed care delegation. So D-SNPs thatdelegate care or member management to medical groups should be required to assist members no matter where the ultimate responsibility lies. Too often, members are told to direct their inquiries to their medical group, which does not meet their needs. And so for counties such as LA, in which plans delegate to groups at high rates, contracts should make this a seamless experience for members.

Anastasia Dodson:

Thank you. Yes, we agree, it should be seamless and also recognize, I'm sure there are opportunities forimprovement there. One thing that we are looking at, but again, in the context of the overall efforts here is, are there consistent delegation standards as far as what benefits are delegated and would it improve care to make those standards consistent? As far as what is, whether long-term care or other types of benefits are or are not delegated.

Anastasia Dodson:

There may be some benefits to having it locally decided between the plan and their delegate, or there could be some benefits to having it more standardized, we're open to hearing people's

thoughts on that.But agree that we do not want delegation to lead to any member confusion.

Hilary Haycock:

Great. There's a question about, how will palliative care and hospice care be affected in the D-SNP?

Anastasia Dodson:

Great. That's a wonderful question and thank you for bringing that up. So Medi-Cal has a palliative care type of benefit right now through SB 1004. We focus that on non dual eligibles because all of the components of palliative care are already covered through Medicare. They may not necessarily be bundled together in the same way that SB 1004 does for Medi-Cal, but Medicare does cover all types ofpalliative care components such as home health, social worker visits, a variety of physician codes that can be used for consults, nurse codes. All of those elements of palliative care are available in Medicare and there's obviously been a movement here in California and across the nation to increase the use andaccessibility of palliative care but some of that also relies on training of providers and having, whether it's in hospitals or outpatient settings, having that care team fully trained and versed in palliative care, and then able to offer that to patients.

Anastasia Dodson:

So I guess the bottom line for dual eligibles and for hospice, hospice is a benefit in Medicare as well. So on the D-SNP side, certainly for hospice, the Medicare rules apply there, but for palliative care it may besomewhat dependent on the particular delivery system, whether it's the hospital, or the clinic, or the physician offices as to whether they're well-versed and able to provide palliative care, but both from the Medicare and the Medi-Cal side, those services are available, the benefits are available.

Hilary Haycock:

Great. All right, so there's a comment going back to the delegation question just saying that if health plans, delegate care management, medical groups will also need to have dementia care specialists ontheir teams. So wanting to make sure that there's dementia care requirements that we're considering for the D-SNP proposals carry through.

Anastasia Dodson:

Great point. Thank you.

Hilary Haycock:

Yes. There's another comment on whether contracts could require plans to set up a unified grievance and appeal procedures before 2023, so that it's ready to go in CCI counties, Cal MediConnect plans didnot fully set up those procedures before launch and the absence of unified procedures remains a challenge for members when coverage is spread across multiple benefits, Medicare and Medi-Cal benefits.

Anastasia Dodson:

Yes, that's an interesting comment and very helpful. So as we think about what the timeline

looks like in 2022, leading up to that January 1st, 2023, transition, that's a great point and we will think about that also in context of the 2022 contract. Any anyone else want to raise your hand and speak to that, either from the stakeholder group or from DHCS or Centers for Medicare & Medicaid Services?

Hilary Haycock:

I know that there've been some pretty significant challenges unifying appeals and grievances in the Cal MediConnect program and I know that's something that we've looked at internally are trying to think through. It's a challenge in an integrated product like Cal MediConnect and could be challenge in the D-SNP model. Right.

Anastasia Dodson:

Yes. I see Marty's comment, what a great comment Marty, it's important that case management is available at primary care site to assure real day to day integration. That speaks to the issue of either delegating it or placing case managers at delegated primary care sites. Thank you so much Marty, thatyou hit it right on the head there. Yes.

Hilary Haycock:

All right. Another comment related to delegation, just wanting to make sure that managed care contracts make clear the responsibility to communicate clearly to their provider groups about how to implement changes and the challenges of moving information and changes at the plan contract level,pushing that down to the provider contract level.

Anastasia Dodson:

Thank you. Great point.

Hilary Haycock:

All right. It seems like the comments are slowing down and no one has their hands raised. So, folks, onelast chance for additional comments on the –

Anastasia Dodson:

If Denny is still available, Denny, do you have any thoughts on any of these comments here, anythingstrike you in particular or something that we should talk about at future stakeholder meetings?

Denny Chan:

Can you hear me okay? Thanks. Yes, I would say the point about the unified appeals and grievances stands out and if there's ways that we can work on putting something together prior to the transition,that makes total sense. We've routinely, in working with the Ombuds program across the state, comeacross lots of cases where the lack of a unified system results in lots of confusion and problems for consumers. So, if it would be helpful, we can identify some specific cases that maybe we can work through and with an eye toward that language. So I think that's a really insightful comment and definitely an action item for us to take back.

Hilary Haycock:

All right. Well, so maybe we will move to wrapping up a little early.

Anastasia Dodson:

Yes, Hilary, let's just see if anyone has any feedback on the upcoming meeting topics perhaps.

Hilary Haycock:

That sounds great. So our next meeting will be on April 7th. We're going to be covering two topics. One is Lead Plan for Aligned Enrollment, which is a very weedy topic, let's see if I can explain it in just a minute. The idea is that when you have aligned enrollment, of course you want to be encouraging folks to be in a D-SNP and an MCP plan that are covered by the same parent organization. And so part of thatis limiting enrollment for folks that are in both a D-SNP and a Medi-Cal plan, two plans with the same parent enrollment and which plan has the priority under that. And so the current way that it works in California is the Medicare plan is the laid plan. So we want to further discuss that and how that would work, ways of improving that under aligned enrollment.

Hilary Haycock:

So we'll be very excited to get stakeholder feedback, particularly trying to help understand the beneficiaries perspective. So if folks are interested in that topic, please reach out to us and let us know and we'll be also doing a scan out for folks to try to make sure that we're hearing really robustly from folks on how to think through that process.

Hilary Haycock:

We will also be looking at Medicare Deeming for D-SNPs. So I know there's Medi-Cal Deeming, there's lots of different types of deeming we could be talking about but for next time it will be specifically on the D-SNP Deeming process. And so that came up a little bit today, and so we'll be looking forward to talking about how we can help encourage D-SNPs to support members as they're going through deeming.

Hilary Haycock:

And then in May, we will be turning to Noticing and Integrated Member Materials. And those are our current plans meeting topics. There are a lot of other topics that we want to cover as we continue moving forward. We have some suggestions listed here on the slide, including digging in on those care coordination standards and the model of care, particularly, how can we be aligning the work of the D- SNPs to match all of the exciting work happening under CalAIM? Digging back in onto data and reportingas we continue to move those conversations forward and thinking about what data and reporting we want to have under the statewide D-SNP and MLTSS model, looking at behavioral health issues, looking at health equity and disparities issues and dementia care. And we know these are topics many of which that came up today, so we'd love to open up now to folks for weighing in on what should we be prioritizing in this list? What else should we be adding to this list as we keep moving forward?

Anastasia Dodson:

Yes, I see a comment about the Centers for Medicare & Medicaid Services geographic direct contracting model. I think we will just wait and see how different federal issues may come up in the coming months around that, but certainly looking at other types of Medicare models would be a good topic that at DHCSwe think would be helpful.

Hilary Haycock:

We had a couple of folks raise their hands, so we'll go ahead and open Christina Mills, your line is open, please let us know what organization you're with.

Lisa Hayes:

Hi Hilary, this is Lisa Hayes with Rolling Start. I don't know – if –

Hilary Haycock:

I think you're registered as Christina.

Lisa Hayes:

I know. I'm sorry.

Hilary Haycock:

Go ahead, Lisa, with Rolling Start. Great to hear from you.

Lisa Hayes:

Thanks, I appreciate that. And I'm not really, really sure where this fits in, but there's so many great statewide efforts to create a no wrong door system for people that need services. And we're doing thatthrough the aging and disability resource connection models, the ADRCs. And this is some great work being done, there needs to be some way to fit in the ADRCs, or the ILCs, AAAs into this mix of providingsupports for long-term supports and services.

Lisa Hayes:

We do a tremendous work in transitions and these are, I think in some way, we could really benefit if there was some inclusion of data and reporting so that we can really expand and really maximize the work that's being done on the no wrong door side, as well as CalAIM. And I'm not really sure where thatfits in here, but I think the conversation needs to be had just because I think, I don't want to miss an opportunity so that we can really provide all of those wraparound services for the members that the health plans are serving and the consumers we serve.

Anastasia Dodson:

Thank you for that. The first thing that comes to mind is the Money Follows the Person Grant applicationwhere we're asking for funding from the federal government to develop a HCBS roadmap and gap analysis. Then at least that's one way where we will intend to look at the whole picture and plan out what future efforts we can make and plan for to include, not just the Medicaid programs, but other allied programs that are serving the same populations. So

great point there.

Anastasia Dodson:

And then we can look at, in future topics, if there's a good way to incorporate you or others as presenters, again, trying to make sure we address the core issues that this work group needs to focus on, but then as you have ideas or ADRCs, for example, can be a part of that picture then, yes please, wewant to include that and highlight that.

Lisa Hayes:

Awesome. Appreciate that.

Anastasia Dodson:

And I see other comments in the chat box. I think actually you are all right that all of these issues withinCalAIM and then outside of CalAIM are related such as ILOS, ECM, all of the other pieces that are not necessarily things that are even just for dual eligibles but MLTSS broadly. And we know that it's important to look holistically at this. So you've probably all seen materials posted on the DHCS website for comments on ILOS and ECM, and we're working closely internally across all the teams to make sure that the comments that are received there and the work that we're doing here, we sync those up and it's possible that we could have future presentations on those topics and how they interrelate. Right now we're really gathering information, gathering feedback, and then in the future we can look at whether it's this form or another and how to present all of those things together.

Hilary Haycock:

Great. Susan LaPadula, you've raised your hand, you have opened your line.

Susan LaPadula:

Hi Hilary. Hello Anastasia.

Anastasia Dodson:

Hello there.

Susan LaPadula:

How are you today? Thank you so much for this wonderful presentation. I would just like to ask regarding the department of insurance having a new meeting next week for the California long-termcare of insurance task force and how will their decisions affect CalAIM?

Anastasia Dodson:

Great question. Yes, so there was a state law that was passed two years ago that requires the department of insurance to convene a task force, and there's specific provisions in that law that outlinea new potential benefit for long-term services and supports that is separate from Medi-Cal, separate from Medicaid. And there was a report that DHCS contracted with Milliman and the report was published in 2020 around LTSS public benefit. Again, that would be separate from Medicaid, but would need to work hand in hand with Medi-Cal and just as in

other related programs.

Anastasia Dodson:

So we don't know yet what the outcome of the taskforce will be, but they do have a particular set of instructions from that legislation as to what types of programs they should be looking at. And so we will see next week how that meeting goes, and that is certainly a large undertaking as far as any type of newbenefits, but we know that, that's something that a lot of stakeholders have been talking about for quitesome time, so we're pleased at DHCS to be part of that meeting next week.

Susan LaPadula:

Thank you so much. And then just to expand on the Centers for Medicare & Medicaid Services geo model, there's some real concern in Southern California because of the three counties, Los Angeles, Riverside, and San Diego, tremendous population in those three counties.

Anastasia Dodson:

Right. We're looking at that as well and we believe that there may be more information coming soon from Centers for Medicare & Medicaid Services about that and we don't want to say anything prematurely, but we think that there'll be more information coming soon from Centers for Medicare &Medicaid Services on that.

Susan LaPadula:

Thank you for watching that. I did read an article that it's been paused by the Biden administration, butperhaps it's still on your radar even if it is in a pause mode.

Anastasia Dodson:

Right. No, we're watching and we want to make sure that the federal government and the state are working hand in hand, and we have frequent collaboration calls with our federal partners so we try our best, and hopefully we are making sure that all of these efforts that have similar goals are complimentary and not contradictory. So we're working very hard on that. But some efforts that Centersfor Medicare & Medicaid Services may be making on the Medicare side, it may be that as they explore options there, I would expect that there's opportunities for feedback and they'll be looking at different ways to communicate with folks about those as well.

Susan Lapadula:

Thank you so much. And once again, thank you for considering the automatic crossover and explainingthe palliative care and Hospice benefit. Appreciate it and appreciate all the hard work on your team. Thank you so much.

Anastasia Dodson:

Thank you.

Hilary Haycock:

Great. All right. Well, I think we are, it looks like the comments have slowed down. Anyone else hasraised their hand? I think we might-

Anastasia Dodson:

Hilary can we ... I think there's a really good comment in the chat about the three-way contracts on medical, behavioral health and LTSS, and I just want to recognize that, that was a topic that, behavioralhealth in particular was brought up last time and if any of you have suggestions around improving integration and coordination of specialty mental health, behavioral health in the D-SNP contracts we'reall ears. This is work that was done many years ago on Cal MediConnect and CCI recognized this set of services and certain populations have great needs there and great opportunities for better care coordination. So we welcome your feedback and recognize that it's an important issue.

Hilary Haycock:

Yes. There were a number of comments about being interested in talking about care coordination from a number of different angles, cross walking ECM iOS with D-SNP and MLTSS, and how do those pieces fittogether? Thinking about how do you do care coordination for duals with primary and secondary insurance, Medicare and Medi-Cal, was another one listed. Thinking about how care coordination could include dementia care. So a lot of, I think, interest in a need to really break down expectations on care coordination and think through all of the different pieces for duals, from behavioral health, to LTSS, tolinking across Medicare and Medi-Cal and the new CalAIM initiatives. So I think there's a lot of rich content there that we can dive into as a work group.

Anastasia Dodson:

Yes. And as we think about behavioral health or other topics, some of these options that we're looking at, as far as policy, there may be other things that can be complimentary either highlighting best practices, technical assistance, or even just information sharing about contacts, et cetera. So any and allof that is really fair game and we welcome the feedback and suggestions.

Hilary Haycock:

Great. Anything else you would like to highlight or cover Anastasia?

Anastasia Dodson:

I think that's it. Thank you.

Hilary Haycock:

All right. Well we will wrap up today then. Thanks everyone for a great conversation. So much wonderfulfeedback that we received, so we will be going through both, everything's submitted in the chat as well as verbally and bringing that back. And again, we are really looking forward to our next conversation on April 7th, from noon to 2:00 PM, so save the date and we will be speaking with you all again then. We'vesent out links to all of the background materials and

other materials discussed today in the chat, so please go ahead and grab that if that is something of interest. And have a wonderful rest of your day.

Anastasia Dodson:

Thank you

everyone.