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

March 4, 2021

California Department of Health Care Services

Agenda

10:00 – 10:05 Welcome and Introductions

Data and Evaluations

10:05 – 10:20 Review Existing Data Reporting and Evaluations for Cal MediConnect (CMC)
10:20 – 10:30 Review Centers for Medicare & Medicaid (CMS) Medicare Data Measures
10:30 – 10:55 Discussion

2022 D-SNP SMAC Updates

10:55 – 11:05 High-level Review of 2022 State Medicaid Agency Contracts (SMACs) for Dual Eligible Special Needs Plans (D-SNPs)
11:05 – 11:20 Stakeholder Suggestions for SMAC Updates
11:20 – 11:45 Discussion
11:45 – 12:00 Discuss Upcoming Meeting Topics and Next Steps

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for the CalAIM MLTSS and duals effort.
- Provide an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for the Department's transition plan for dual eligibles and the Coordinated Care Initiative (CCI) transition within the CalAIM initiative.
- Open to the public. Charter posted on the Department of Health Care Services (DHCS) website.

We value our partnership with plans, advocates, beneficiaries, providers, and CMS in developing and implementing this work.

Data and Evaluations

Data and Evaluations

- **Goals:**
  - Review existing DHCS and CMS data reporting and evaluation efforts.
    - Cal MediConnect Dashboard and Evaluations
    - Medicare Reporting Requirements, and potential D-SNP reporting measures
  - Understand what is useful about existing data reporting and evaluations to help set the table for future conversations about how to align data, reporting, and quality initiatives for D-SNPs in accordance with the CalAIM framework and grounded in what we have learned from CCI.
- **Requested Feedback:**
  - What is useful in existing data that can be built upon moving forward in developing data and evaluation for duals population under CalAIM.

Cal MediConnect (CMC) Dashboard

- DHCS CMC Dashboard provides data and measures on key aspects of the Cal MediConnect program.
  - Note: most measures are demonstration-specific and are compiled by NORC, and thus sunset in their current form with the CCI transition.
- CMC Dashboard is updated quarterly.
- Latest CMC Dashboard: https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDB-Q4-1120020.pdf

CMC Dashboard Data

- Enrollment*
  - Monthly enrollment over time and by county and plan
  - Race/ethnicity
  - Age
  - Threshold language spoken
  - Gender
- Quality withhold measures met by plan
- Health Risk Assessments
  - Quarterly Rolling Statewide Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment, over time
  - The Percentage of Members Willing to Participate and who the Plan was able to Locate with an Assessment Completed Within 90 Days of Enrollment for most recent quarter

*Measure collected and analyzed by DHCS.

CMC Dashboard Data

- Care Coordination
  - Individualized Care Plan
    - Quarterly Rolling Statewide Percentage of Members with an Individual Care Plan (ICP) Completed Within 90 Days of Enrollment
    - Percentage of Members with an ICP Completed Within 90 Days of Enrollment for most recent quarter
  - Care Coordinator
    - Annual Percentage of Members who have a Care Coordinator and have at least One Care team Contact During the Reporting Period
    - Annual Number of Members to Care Coordinator Ratio
  - Annual Percentage of Members with Documented Discussions of Care Goals
  - Annual Percentage of Members with First Follow-Up Visit within 30 Days after Hospital Discharge

CMC Dashboard Data

- Grievances and Appeals
  - Annual Count of Grievances Broken Down by Type, besides "Other"
  - Annual Count of "Other" Grievances
  - Annual Count of Appeals Broken Down by Outcome
  - Annual Total of all Appeals Related to the Denial or Limited Authorization of Mental Health services
- Behavioral Health
  - Quarterly Rolling Statewide Average Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months
  - Annual Count of Emergency Room Behavioral Health Services Utilization per 10,000 Member Months

CMC Dashboard Data

- Long-Term Services and Supports (LTSS)*
  - Quarterly Rolling Statewide Average of Members Receiving LTSS per 1,000 Members
  - Count of Members Receiving LTSS per 1,000 members for most recent quarter
  - In Home Supportive Services (IHSS)
    - Quarterly Rolling Statewide Average of Members Receiving IHSS per 1,000 Members
    - Count of Members Receiving IHSS per 1,000 members for most recent quarter
  - Community Based Adult Services (CBAS) / Multipurpose Senior Services Program (MSSP) / Nursing Facility (NF) / Care Plan Options (CPO)
    - Quarterly Rolling Statewide Average of Member Referrals per 1,000 Members
    - Count of Member Referrals per 1,000 members for most recent quarter
    - Quarterly Rolling Statewide Average of Members Receiving service per 1,000 Members
    - Count of Members Receiving service per 1,000 members for most recent quarter

*Measure collected and analyzed by DHCS.

Other CMC Reports

- CMS contract with Research Triangle Institute (RTI) International:
  - To monitor the implementation of CMC and to evaluate the impact on beneficiary experience, quality, utilization, and cost. First report published November 2018.
- The SCAN Foundation funded CMC Rapid Cycle Polling Project:
  - To compare CMC enrollees' experiences by county, race, language, and disability. Most recent report in May 2019.
- DHCS Evaluation Outcome Report
  - Published annually, includes summary of all CMC reports.
- DHCS Health Plan Quality and Compliance Report
  - Published annually, reviews plan reporting requirements, quality monitoring, and quality improvement efforts.

D-SNP Data Sharing

- Beginning in 2021, D-SNPs have new data sharing requirements for hospital and skilled nursing facility (SNF) admissions, for at least one group of high-risk full-benefit dual eligible individuals.
- DHCS will use the data collected and work with stakeholders to develop an updated data sharing policy for 2023 in alignment with other CalAIM integration policies.
- DHCS is also considering what data can be made public at the aggregate level before 2023, as well as matching plan data to existing DHCS demographic data to enhance understanding of population.

D-SNP Reporting Requirements

Medicare-Medicaid Coordination Office

Centers for Medicare & Medicaid Services

Anna Williams

March 4, 2021

Overview

- Dual Eligible Special Needs Plans (D-SNPs) must comply with reporting requirements for Medicare health/drug plans, including:
  - **Healthcare Effectiveness Data and Information Set (HEDIS)**
  - **Health Outcomes Survey (HOS)**
  - **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**
  - **Part C and Part D Reporting Requirements**

HEDIS

- A set of measures developed by NCQA to measure performance on important dimensions of care and service. HEDIS measures are used extensively in the healthcare industry.
- Includes both contract-level reporting and Medicare HEDIS for special needs plans (SNPs), PBP-level reporting for a subset of measures
- Timing: NCQA-audited HEDIS summary-level and patient-level detail data for Measurement Year (MY) data are due June 15 of the subsequent year
  - E.g., Summary-level data for measurement year (MY) 2021 are due June 15, 2022

HEDIS (continued)

- Examples of contract-level measures:
  - Breast Cancer Screening
  - Adults' Access to Preventive/Ambulatory Health Services
  - Plan All-Cause Readmission
  - Language Diversity of Membership
- Examples of PBP-level measures reported by SNPs:
  - Care for Older Adults
  - Colorectal Cancer Screening
  - Controlling High Blood Pressure
  - Follow-Up After Hospitalization for Mental Illness

HOS

- Administered annually to a sample of beneficiaries from each Medicare contract. Two years later, the same respondents are surveyed again to track physical and mental health outcomes.
- Reported at the contract level
- Timing: Surveys are fielded August through November
- The survey is administered in English, Chinese, Russian, and Spanish

HOS (continued)

- Examples of HOS questions:
  - In the past 7 days, how much did pain interfere with your day to day activities? [Not at all/A little bit/Somewhat/Quite a bit/Very much]
  - Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or grocery shopping? [Yes/No]
  - Have you ever had a bone density test to check for osteoporosis, sometimes thought of as "brittle bones"? This test would have been done on your back or hip. [Yes/No]

CAHPS

- This annual survey asks a sample of beneficiaries in each plan about their experiences with, and ratings of, their health care plan and providers.
- Reported at the contract level
- Timing: Surveys are fielded from approximately March through June
- Administered in English and Spanish

CAHPS (continued)

- Examples of CAHPS survey questions:
  - In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? [Never/Sometimes/Usually/Always]
  - Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
  - Have you had a flu shot since July 1, 2020 [Yes/No/Don't know]

Part C Reporting Requirements

- A set of administrative measures that capture information about appeals/grievances, rewards and incentives programs, and payments to providers among others
- Reported at the contract level, except for the section on Special Needs Plans Care Management, which is reported at the PBP level
- Timing: Varies by measure, typically reported to CMS annually, for either quarterly or annual reporting periods

Part C Reporting Requirements (continued)

- Part C reporting requirements consist of five sections:
  - Grievances
  - Organizational Determinations & Reconsiderations
  - Payment to Providers
  - Rewards and Incentives Programs
  - Special Needs Plan (SNP) Care Management

Part D Reporting Requirements

- A set of administrative measures that capture information about appeals/grievances, pharmacy access, and medication therapy management (MTM) programs, among others
- May be reported at the PBP level or the contract level, depending on the section
- Timing: Reported annually, for either annual, biannual, or quarterly reporting periods, depending on the section

Part D Reporting Requirements (continued)

- Part D reporting requirements consist of five sections:
  - Coverage Determinations, Redeterminations, and Reopenings
  - Enrollment and Disenrollment
  - Grievances
  - Improving Drug Utilization Review Controls
  - Medication Therapy Management Programs

Resources

- HEDIS: https://www.ncqa.org/hedis/
- HOS: https://www.hosonline.org/
- CAHPS: https://www.ma-pdpcahps.org/
- Part C Reporting Requirements: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements
- Part D Reporting Requirements: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight

Discussion: Data and Evaluations

- What are the most useful existing data measures reported by DHCS?
- What Medicare data elements might be most useful for DHCS to consider?

2022 State Medicaid Agency Contract (SMAC) for D-SNPs

State Medicaid Agency Contract (SMAC)

- Understanding D-SNP contracts
- Review existing 2021 SMAC
- Review and discuss potential updates to 2022 SMAC

D-SNP Contract Requirements

- While Dual Eligible Special Needs Plans' (D-SNPs) primary contract is with Medicare, they also must have a contract with the state Medicaid agency (DHCS in California) to operate.
  - D-SNP's contract with Medicare may be at the plan sponsor level and include both D-SNP and other Medicare product lines as well as products in multiple states.
  - D-SNP's SMAC with DHCS covers just their lines of business in California.

2021 SMAC Changes

- For the 2021 plan year, DHCS updated some of the standard contract language with template language provided by CMS, mostly rephrasing but did not change D-SNP responsibilities.
- Information Sharing Policy Requirements
  - New CMS requirement - the main substantive change to the 2021 SMAC.
  - D-SNPs are required to periodically share hospital and SNF admission data for all full-dual eligible enrollees with DHCS.

Potential Updates for 2022 SMAC

- Updated SMAC for 2022 must be final by late March 2021, limiting our time to make changes.
- Some areas under consideration:
  - Clarifying care coordination requirements, including LTSS program contact information to facilitate coordination.
  - Clarifying balance billing protections for members and plan delegates.
  - Help providers understand and access member Medi-Cal eligibility verification.
  - Update nondiscrimination provisions.

Potential Updates for 2023 SMAC

- Longer timeline to finalize contract will allow for more extensive updates for SMACs, to reflect CalAIM provisions.
- Future workgroup meetings will address these items in detail, including:
  - Aligning coordination standards with CalAIM/NCQA model of care
  - Strengthening member billing protections.
  - Update provider directory and network standards.
  - Align plan data reporting and evaluation requirements with CalAIM.

Stakeholder Suggestions for SMAC Updates

- Focus on reducing health disparities
- Additional language about the role of the D-SNP in supporting members with Medi-Cal eligibility issues (e.g., deeming)
- Improved language re: care coordination, building upon language from Cal MediConnect
- Additional mechanisms for enforcement, other than termination

Discussion: 2022 SMAC

- Which potential 2022 SMAC updates should DHCS prioritize?

Topics for Upcoming Meetings

Meeting	Date/Time
Meeting #3	Wednesday, April 7, Noon - 2 p.m. • Lead Plan for Aligned Enrollment • Deeming
Meeting #4	Thursday, May 6, 11:30 a.m. - 1:30 p.m. • Noticing and Integrated Member Materials

Future topics may include, but not limited to:

- Care coordination standards and model of care;
- Data and reporting;
- Behavioral health;
- Health equity and disparities; and
- Dementia care.