June MLTSS and Duals Integration Workgroup Meeting

Summary and Key Takeaways - DRAFT

The following is a summary of key takeaways from the June 10, 2021, Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup, including those that panelists and stakeholders shared during the meeting. The meeting focused on best practices for care coordination in the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC).

Care Coordination Overview

The first part of the workgroup meeting focused on the Department of Health Care Services' (DHCS) vision for care coordination and integration for dual eligible beneficiaries. This was followed by a panel of experts summarizing their thoughts on promising practices from care coordination in CMC and lessons learned. Below are the key takeaways.

DHCS

Anastasia Dodson, Associate Director of Policy at DHCS, opened the meeting by thanking workgroup members for sharing their feedback which will be used to shape the policy in the future. Anastasia provided an overview of DHCS' vision for care coordination and integration for dual eligible individuals, including the long-term goal of centering care around people and improving care integration across different programs (e.g., Home and Community-Based Services, D-SNPs, and Medi-Cal managed care plans). In addition, DHCS aims to leverage existing resources at the county, plan, and provider level.

Anastasia also discussed ways that DHCS intends to coordinate and integrate care for dual eligible individuals as well as the Medi-Cal managed care and D-SNP care coordination contract requirements. Anastasia noted that they recently posted a Duals Demonstration Care Coordination Principles Summary fact sheet on the MLTSS and Duals Integration Workgroup webpage and concluded her presentation by discussing how California can establish care coordination requirements in D-SNPs, based on lessons learned from CMC.

Panel Presentations

There were three experts that made up the workgroup panel:

- Carrie Graham, Director of Long-Term Services at Supports at the Center for Health Care Services (CHCS),
- Jack Dailey, Health Consumer Alliance Coordinator/Director of Policy and Training for the CMC Ombuds Services Program, and
- Maya Altman, CEO of Health Plan of San Mateo (HPSM).

- **Carrie Graham** – Carrie was the Principal Investigator of the Cal MediConnect evaluations funded by the SCAN Foundation and began by discussing the evaluation process (working with DHCS and stakeholders) and research methods (including focus groups, key interviews, and more). The evaluation research found that only 30% of patients in CMC were receiving care coordination services, however those who reported receiving it were very satisfied. One of the best practices from CMC that Carrie identified was new collaborations between CMC plans and In Home Services and Supports (IHSS)/Multipurpose Senior Services Program (MSSP), Home and Community-Based Services (HCBS) Brokers or “hubs”, and Alzheimer’s Association/Long-Term Care Ombuds. Some of the challenges Carrie identified were around beneficiary education and provider buy-in, and she highlighted that data sharing and capacity for coordination were major barriers.
- **Jack Dailey** – Jack began by sharing the importance of a meaningful and consistent care coordination benefit which engages members in a patient-centered manner. This includes meeting members where they are, ensuring care and engagement needs are being met, providing appropriate accommodations, and being sensitive to the different cultural and linguistic needs of members. Jack shared that care coordination works when members have awareness of the care coordination benefit, the care coordinator, and their role, and that the Ombuds has, in some cases, acted as a facilitator to connect a member to their care coordinator. Care coordination also works when members know when and how to engage their care coordinators, or how to expect engagement, as well as when members have meaningful assistance and collaboration to access both carved-in and carved-out services. One way to do this is for care coordinators to engage their members early and often with affirmative offers of support, and when they meaningfully and actively support LTSS care transitions, including hospital and Long-Term Care (LTC) discharge planning, etc.
- **Maya Altman** – Maya began by describing who Medi-Cal/Medicare users are, including how varied the population is and the different needs that each member has. Because of

the diversity within the duals population, any care coordination developed for these members is challenging to establish and implement. The first takeaway Maya highlighted from CMC care coordination is the importance of close partnerships and mentioned that plan staff have to work with a wide range of providers, HCBS, Community-Based Organizations (CBOs) and local agencies but need to decide who is the point person (the “quarterback”). The second takeaway was the importance of an integrated care coordination approach. At the beginning of CMC, HPSM had a “nurse heavy” staff, and over time added more social workers, behavioral health specialists, and non-clinical staff. The third takeaway that Maya highlighted was the importance of data/information for risk stratification and targeting, non-medical information (e.g., homelessness, if the person lives alone), data sharing among partners, and shared care plans.

Report Outs and Discussion after Breakout Rooms

After the panel shared their thoughts, the workgroup split into small breakout room where attendees discussed lessons learned and opportunities for care coordination in CMC. Breakout rooms were asked to list three lessons learned/opportunities for care coordination in CMC and select a member of the group to report out to the larger group. Appendix A includes detailed notes from all breakout rooms.

After the breakout rooms met, the second half of the workgroup meeting focused on report outs from the breakout rooms and reaction from the panelists to what was discussed. Below are key takeaways from this portion of the meeting.

Group Report Outs

Anastasia Dodson began the discussion by letting participants know that DHCS would be sharing the notes and feedback from participants in this meeting across the different DHCS divisions, including the teams working on Enhanced Care Management (ECM), In-Lieu of Services (ILOS), and Population Health Management. Participants began to report out and share their group discussions:

- **Cynthia Jackson (Heritage Clinic)** brought up member education to improve understanding of the care coordination benefit and how to access it as well as training care coordinators (e.g., using community groups to provide training). Cynthia commented that the care coordination benefits did not seem practical for the Serious

Mental Illness (SMI) population, and that housing navigation and support would be important.

- **Sarah Steenhausen (SCAN Foundation)** said their group discussed lessons learned in other states (such as New York) and experiences from a rural county in California. The group discussed the importance of data, and that New York had developed a common data platform statewide which enabled a more streamlined delivery system. Sarah mentioned that this platform that helped detangle the web of "who is coordinating the care coordinators." Finally, Sarah brought up New York's cross sector partnerships that built the workforce needed for a successful delivery system.
- **Hanh Truong (Beacon Health Options)** reported that the data sharing process should be more mainstreamed in order to be meaningful to the member and the services being provided. Understanding the culture of mental health services and agency policies helps break down communication barriers to focus on the member and their needs.
- **Lisa Hayes (Rolling Start)** brought up some of the challenges of delegating care management to providers, and providers who "don't get the big picture." For these reasons, Lisa recommended that care management not be delegated at all. Lisa brought up that there is great work going on with Independent Living Centers (ILCs) and suggested that delegating to the Aging Disability Resource Centers (ADRCs) would present good outcomes. Their group discussed that they don't always know who is driving the train with care coordination and trying to request Interdisciplinary Care Teams (ICTs) can be really challenging. Finally, Lisa brought up that there will be an increased number of seniors in the next 10 years and the focus should be on coordinating keeping members in the community.
- **Gretchen Alkema (SCAN Foundation)** shared their group discussion on ensuring opportunities to identify people with cognitive impairments as well as opportunities for people to self-identify for care coordination. They wanted to ensure that virtual care (telehealth and virtual technologies) is included as a pathway and modality for care for duals. Their group also discussed coordinating people's health benefits in a meaningful way, including helping people understand their eligibility for Medi-Cal and the connectivity between Medi-Cal and Medicare coverage.
- **Christina Dimas Kahn (Health Insurance Counseling & Advocacy Program, HICAP, at California Health Advocates, CHA – San Mateo County)** brought up that one of the primary accomplishments in San Mateo County was that the LTC population were brought to live at home, and there was seamless coordination between skilled nursing facilities (SNFs), mental health and community partners, and responding quickly during

the COVID-19 Public Health Emergency (PHE) to get members vaccinated, food, and supplies during shelter in place. Christina highlighted potentially changing the language and terms that professionals use to make it more relatable for clients (e.g., defining "discharge planner" for CMC members).

- **Ryan Caceres (Tulare County Mental Health Plan)** suggested having a lead entity or individual to help coordinate carved-out benefits with various stakeholders as a best practice. In addition, Ryan suggested that provider engagement will improve if reporting requirements are modified to what providers most care about. Ryan also mentioned that it would be a good idea to build a more uniform communication plan for CMCs to build off for the transition.
- **Grace Kotoyan (Health Net)** brought up establishing better public relations with contracted providers early on and focusing care coordination on all MLTSS services (e.g., carved-out services) rather than just CMC benefits.
- **Anna Edwards (Inland Empire Health Plan)** brought up serving families as a central goal, such as providing services for food insecurity. Additionally, Anna highlighted making sure a care coordinator's role is clearly defined and ensuring that members know they have a care coordinator. Finally, their group discussed that having a heavy focus on reporting requirements can distract from getting members the resources they need (giving the example of ICP requirements).

Panelists Reaction

Following the breakout group report outs, the panelists reacted to what they heard from stakeholders. The key takeaways from the panelist reactions are below:

- **Maya Altman (HPSM)** said that health plans have a role to play as conveners, but there at different times there are various entities who can take the lead. Groups of stakeholders can hold each other accountable to improve care coordination. Maya echoed stakeholders' focus on housing and the importance of CalAIM initiatives to address housing. Maya had questions about how to evaluate the success of encounters for non-traditional providers, like ILC and ADRCs, as people are preparing for CalAIM. Finally, Maya supports having a single point of contact for care coordination but suggested that teams can follow people because of job turnover and other concerns.
- **Carrie Graham (CHCS)** brought up one theme that had not yet been discussed - coordinating across Medicare, Medi-Cal, the Veterans Administration (VA), and that

veterans often fall through the cracks. Carrie also brought up that their group discussed the importance of an evaluation framework, collecting data at baseline, the medical model versus social model of disability, and importance of collecting information addressing social determinants of health.

- **Jack Dailey (CMC Ombuds)** brought up that it is important to center patients in care coordination. Jack agreed with previous comments that having a single point of contact is beneficial for CMC members, and also discussed the importance of workforce, and that these ideas need to work in tandem (e.g., patient to care coordinator ratios). Jack highlighted that the care coordinator cannot be the last person to learn about member's care transition for patient care transitions. Jack also mentioned that data sharing should also be patient-centered and should come back to what the patient is comfortable with sharing about their care. This ties into engaging a patient's family members since they are often the first to hear about an issue from the patient, not the health plan. Finally, Jack is supportive of virtual care as long as the patient has opted-in to telehealth, and the core principle of keeping the patient in charge of their health care is maintained.

Anastasia Dodson closed the meeting by thanking the panelists and participants for the feedback. DHCS will use the stakeholder feedback in future policies, including the D-SNP contracts, state requirements, local collaborations, and best practices.

Appendix A: Lessons Learned and Opportunities from Breakout Rooms

Room 1:

Lessons Learned

- With clients who were really aware of the program and benefits and were functional, they were able to access benefits. It wasn't as successful for those who didn't understand or those whose medical providers advised against.
- ICT meetings were helpful between the LTSS providers and the plans.

Opportunities

- Need to educate members about what care coordination is – as well as educating providers about care coordination and the benefits.
- Include all providers in ICTs, specifically LTSS providers.
- Bi-directional data flow with health plans and providers.

Room 2:

Lessons Learned

- For people with cognitive impairment, focus on identifying those members for care coordination and their caregivers.
- Having a person on the phone for people to ask questions and help connect people to social services and authorize benefits.
- Focus on client-centered outcomes to coordinate both physical and social services care by creating deeper connections between providers.

Opportunities

- Incorporating virtual care as a pathway/modality to provide care coordination for dual eligible beneficiaries.
- Ensuring that health benefits are coordinated between Medi-Cal and Medicare in a seamless way for beneficiaries.
- Quality measures around plans should focus on measuring what matters to people and that is inclusive of care coordination.

Room 3:

Lessons Learned

- The role of care coordinators should be to manage the complexity of care coordination because it is often too overwhelming and confusing for members. In order for this to work, members need to know who their care coordinator is, how they can help, and what the core coordinators responsibility is.
- Communications to members should be done in plain, easy to understand language.
- It is important for plans to understand the different modes of service delivery so that they can deliver optimal care coordination. Plans need to train care coordinators on how to understand the different service delivery methods.

Opportunities

- It is important for plans to have agreements and/or contracts in place with care coordination agencies so that they can try new approaches and different ways to ensure members receive all the services they need, e.g., how plans coordinate with county mental health and other mental health organizations.
- Good data sharing is key to the care team and care coordinators performing their duties. Less fragmented data allows the team and coordinator to really know the member and their needs.
- Member-centered care should be at the core of everything that health plans and care coordination entities do. This will ensure that barriers are broken down and that members receive the coordination they need.
- There can be better communication channels between plans, care coordinators, and partner agencies. An example of this is the need to have better communication with hospitals and discharge planners.

Room 4:

Lessons Learned

- For the SMI sub-population, benefits sometimes felt limited and they worked better for a clinic to manage whereas health plan coordination felt like another layer.
- Look to lessons learned from other programs, e.g., housing navigation and supports in Whole Person Care (WPC).

Opportunities

- Member education to improve understanding of what the benefit entails and how to access.

- Tailored training for care coordinators and re-education of care coordinators, providing training through community organizations, and using 211 to identify resources.

Room 5:
Lessons Learned

- Care coordination required regular check-ins (no less than monthly). Members are too often only checked in on every 4-6 months, and too many health issues can arise in that period of time.
- Understanding the community and utilizing Community Health Workers (CHWs)/Licensed Clinical Social Workers (LCSWs) improves care coordination. CHW's are able to reach members in communities and build relationships that plan representatives cannot replicate. To best serve a community, it is important to understand the members of a community.

Opportunities

- Expansion of services – some of the services are limited and not able to provide the level of care the members need. There is an opportunity to expand these services under CalAIM.
- Defining care coordination for patients (who is involved and what to expect). During the transition period, members can be very overwhelmed and confused about the amount of outreach they are receiving. Having the care coordination team collaborate on outreach and purpose can reduce confusion and allow members to understand what they need to do.
- Telehealth services and technology – COVID offered an opportunity to improve telehealth services for this population. Some members are not technology proficient and need family or caregivers help with technology and meetings.

Room 6:
Lessons Learned

- Single point of contact person, particularly around how to reach members as we transition. There is a need to have a point person that takes on the primary care coordination role and coordinate outside of the health plan with community.

Opportunities

- It is important to share care plans and health risk assessments (HRAs) when a member transitions between plans. .
- Data sharing, especially at the county level, can be improved. It is important for health plans to know when members are accessing services, so there should be requirements from county agencies to inform the health plan.
- Encourage members to opt-in to electronic communications.

Room 7:
Lessons Learned

- Communication with members during the transition period is key to success.
- Health plans should provide education to members about how to use their plan effectively.

Opportunities

- There is an opportunity to improve relationships between health plans and providers, ensuring members get the best possible services.
- Putt less of a focus on CMC, and more of a focus on MLTSS.
- Establish regular outreach with members to share resources and identify challenges.

Room 8:
Lessons Learned

- Care coordinators should have diverse backgrounds (nurses, behavioral health specialists, etc.). A diverse care coordinator staff, as well as an integrated approach, is necessary.
- Care coordinators should build rapport before the HRAs, and Integrated Care Plans (ICPs) are sent out.

Opportunities

- Need for more coordination between health plans and SNFs, LTC facilities, and mental health facilities. Having designated staff at health plans beneficial for coordinating with these facilities, especially during transition/discharge.
- HRA's are beneficial for health plans and consumers but find that members are experiencing assessment fatigue. There is a need to develop a universal tool among health plans, LTSS providers, etc.

Room 9:

Lessons Learned

- There should be more standard of care; care coordination definitions vary by plan which makes it harder for families.
- There should be more specific details in contracts and CMS and DHCS should have a strategy for continuous accountability and oversight.

Opportunities

- 2020 made everything harder, especially for those who need face-to-face interactions. There should be innovation to develop care that is closer touch.
- Emphasize a holistic approach. For example, ensure a member receives a diagnosis and then that the diagnosis is not just in a patient's chart but in the whole system (e.g., emergency care, dietician, etc.).
- There are clinical care guidelines that could be implemented and to make it easier for families. Focus on how to get to low-income seniors who need the support. Sometimes it takes years to get a diagnosis, especially for patients for whom English is not their primary language. The goal is to make it easier and care counselors are having a hard time helping families to get resources and classes when families are saying they are trying to secure housing and jobs.

Room 10:

Lessons Learned

- Care-management should not be delegated. This creates challenges with providers and their understanding the bigger picture issues.
- Care management should be standardized across plans. There is too much variation across the state.
- Care coordination should be person centered, and members should have one point of contact to avoid confusion about who should be contacted when. HRA's and ICPs are too complicated for most members to do on their own.

Opportunities

- Data sharing should be made more accessible and LTSS should be included.
- There is an opportunity to put an emphasis on community-based services.

Room 11:

Lessons Learned

- Increase member education around the program benefits in communities to address lack of awareness or hesitation/concerns about the program.
- Ensure bilingual care coordinator and printed materials are in a member's native language to encourage engagement and establish trust.

Opportunities

- Establish strong consumer advisory group to inform the work—this should include members and Ombudsman to identify issues as they arise.

Room 12:

Lessons Learned

- Provider engagement in reporting development, ensure that providers are not burdened with unnecessary measurements and that they are being asked to capture data that will be meaningful (e.g., not just HRA completion, but the success of various interventions).

Opportunities

- Improving data sharing by creating/requiring data sharing with carved-out entities and ensuring robust bidirectional data sharing between plans and providers.
- Improving coordination with the delegated model.
- Improving member communication and notification, ensuring members understand the benefits and implications of a new product.
  - It would be helpful for all MCPs to have clear talking points.
- Identifying clear accountable party for member outcomes.
- Improving reimbursement rates, especially for provider groups.

Room 13:

Lessons Learned

- Care coordination more seamless in SNF in-home support and adult daycare, this has previously been with separate agencies. The in-home support, case worker, and county should work as one entity.

Opportunities

- Improving prescription drug coordination.

- Developing a database for electronic health records that all could access.
- Bringing in a more diverse care coordination staff. Language can be a barrier for a lot of members.

Room 14:
Lessons Learned

- More consistent care coordination – make things easier on families when urgent medical issues come up. Having one person to coordinate with is easier than having a care team.

Opportunities

- There need to be stricter standards about how the plans interact with the counties, particularly around how they interact with IHSS.
- There is an opportunity to make the HRAs more socially focused, as opposed to medically focused. Making sure members are getting the necessities (food, companionship, personal care) is just as important.
- Providing specific information about what care coordination is. There should also be more guidance to ensure standardized services and experiences.
- Coordinating services with organizations like Veterans Affairs to ensure they are receiving the same level of care and services.

Room 15:
Lessons Learned

- Discharge planners do not always have the information care coordinators have, which can lead to a disconnect.
- Provider buy-in is important. When providers are invested, members understand the value and the care coordination transition is smoother. The messaging must show members this helps them meet those value-based goals.
- There was a high opt out rate and high enrollment rate in CMC and CCI which meant the transition was chaotic.

Opportunities

- Reach out to senior housing communities - housing is an integral part of healthcare.
- Must have buy-in from city planners to look at what available services in community and how to attract them.

- Have multi-disciplinary approach from enrollees but also from community.
- Expand how integration is being discussed in the Master Plan for Aging.

Room 16:

Lessons Learned

- Importance of data sharing and development of common platform for information sharing across providers.
- Single point of contact – one person that the enrollee can work with to help identify needs and develop person-centered plan.
- Workforce development – example in New York of communities focused on building partnerships across platforms.

Opportunities

- Statewide approach to grow and develop the workforce.