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

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

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SPEAKERS

Hilary Haycock
Anastasia Dodson
Dana Durham
Jennifer Schlesinger
Megan Dankmyer
Susan DeMarois
Debbie Toth
Dr. Zia Agha
Stephanie Conde

Hilary Haycock:

All right, we're going to go ahead and get started. So good morning, everyone. Thank you for joining us and welcome to our third Managed Long-Term Services and Supports MLTSS and Duals Integration Workgroup. We are very excited to have everyone with us. Today, we have an exciting lineup of speakers and presentations on our topics today. So we're excited to get started. All participants will be on mute during the presentations. Please feel free to submit any questions you may have into the Q&A box. We're using both the chat and Q&A features, so we'll go over that in a second. And then once we open it up for discussion, feel free to raise your hand and we'll be happy to unmute you and have you join the conversation.

Hilary Haycock:

We are asking folks on the next slide, make sure that your name and organization is correct on your Zoom name. You can hover over your name in the participant's list, select rename, and add your organization. This is possible having my team check. Next slide. So today we're going to be doing something a little new for our MLTSS workgroups. We're going to be using both the chat and the Q&A feature. So for the chat, we wanted to give participants a chance to talk to each other and introduce yourselves. So we would love it if folks could go ahead and enter your name into the chat function. So folks can have a sense of who all is on the call today and have an opportunity to interact with each other during today's work group meeting. We are also using the Q&A function. The Q&A function is for submitting questions to the presenters and the panelists.

Hilary Haycock:

If you have a question that you would like to have us address during the webinar, please use the Q&A function that's where we'll be going and looking for questions. So please use the Q&A and we'll be answering some of those questions live or using the Q&A box during today's webinar. All right. Great. So moving to the next slide, I will hand it over to Anastasia Dodson from the Department of Health Care Services to kick us off this morning.

Anastasia Dodson:

Great. Thank you, Hilary. And thank you everyone for joining. We're very excited to be adapting to a little bit of a new approach here with this stakeholder meeting using more Zoom functions. So we've heard you loud and clear over the past few weeks as you've given feedback to us on how we can improve the meeting format. So many things to Hilary and her team for helping us expand and grow in our use of Zoom and different ways for folks to interact on the meeting. We really have a wonderful panel here today on an important topic. But before we dive into that topic around Alzheimer and dementia care, I want to just remind everyone of the purpose of this stakeholder group. We are using this meeting as a stakeholder collaboration hub for CalAIM MLTSS. So sounds like folks can't hear.

Hilary Haycock:

I can hear you.

Anastasia Dodson:

Okay.

Hilary Haycock:

Some people are reporting they can hear you.

Anastasia Dodson:

Okay.

Hilary Haycock:

All right, folks, please. If you can't hear us we'll put in the chat, make sure folks check that their laptops aren't muted.

Anastasia Dodson:

Okay. I think folks are saying they can hear you Hilary, but not me. Interesting. Okay. Well, let's try one of the other panelists. And now people are saying they can hear both on the cell phone.

Hilary Haycock:

All right.

Anastasia Dodson:

It's interesting, you know what? This happened at another webinar earlier this week. Okay. Everyone says good now. All right.

Hilary Haycock:

All right. Take it again.

Anastasia Dodson:

Oh, good. Somebody is suggesting checking personal audio settings. And again, I think we had a similar issue at a webinar earlier this week. So there may be some settings. So I'll be brief and then let's get to the panel. But anyway, just so you know for folks who can hear me, we're continuing to evolve this meeting format structure, getting your feedback. And we know that the topics we have started out with those topics can grow. And so we know that there's other topics besides just CCI Cal MediConnect. And so we'll continue to grow the topics and we really want your feedback, and don't want to hear just me presenting. Let's go to the next slide. We'll go to the main event in this or group meeting today. Let's see the next slide should have the agenda.

Anastasia Dodson:

Good question about being recorded. We haven't been recording or posting the recordings, or maybe we have. Hilary, have we been posting the recordings?

Hilary Haycock:

We have, yes.

Anastasia Dodson:

Okay, good. So hopefully the recording will capture this, but let's get to Dan in just a sec, and then we'll try and see if maybe folks can hear her as well. And I see people saying join through the web browser, maybe that makes a difference, I'm not sure. But today we're the first part of the meeting is going to be focused on dementia care and CalAIM, and thinking about all the different ways that we can look at dementia care and incorporate that into our Medicare programs for duals even for non-duals, looking at what's been helpful in Cal MediConnect, looking toward the future of new efforts that we could undertake. But really we do want to recognize that significant efforts that were made under Cal MediConnect.

Anastasia Dodson:

And so we want to start with that so people were all on the same page, we're not starting from scratch, but building on the successful efforts that have been made already. And then we will look forward and have a good discussion on this topic. So with that, I'm going to turn it over to Dana Durham from the department of health care services. And hopefully folks can hear Dana.

Dana Durham:

Great. Can you go to the next slide? Thank you. And the slide after that, if you don't mind. So we're really excited about the work that has been done in the area of dementia care. It really is some of what we will use going forward with CalAIM, because a lot of amazing things have been done because we do have beneficiaries who are experiencing cognitive impairment, TBIs, Alzheimer's and other related dementia issues. And as we work through CalAIM, we're really feel like there is some great opportunities for the plans to really leverage that information moving forward specifically for dual eligible beneficiaries, DHCS will work required that D-SNPs to use a model of care that includes dementia specialist in their care coordination. And we're actually looking at other elements of CalAIM and seeing how they can support beneficiaries with dementia. Just to name a couple of places we're looking at and see a pretty good intersection, our enhanced care management, or you'll often hear it referred to as ECM.

Dana Durham:

And In Lieu of Services, you'll often hear that referred to as ILOS. We'll be looking at performance measures potentially tied to dementia. And then each plan will be submitting their population health management. And they'll be talking about how they care for each population, including those with dementia. There's going to be plenty of times to get your feedback and other feedback about CalAIM going forward. But we really want to use this time to focus on dementia care. And as we consider CalAIM, we want to make sure everyone understands the important work that's been done in that area, and we will come back and talk about CalAIM more going forward, but just want to spend this time focusing on that. And with that, I will go back to Hilary.

Hilary Haycock:

Thank you so much, Dana, for providing that overview, and hopefully that was helpful to folks. So I'm very excited to introduce our first external panelists today. We are being joined by Alzheimer's Los Angeles to talk about the project that they've been working on in Cal MediConnect. So I will hand it over to Jennifer Schlesinger. She has the associate vice president for health care services and community education with Alzheimer's greater Los Angeles.

Jennifer Schlesinger:

All right. I un-muted, but being told I cannot start my video. Here we go. Great. Thank you so much for the opportunity to speak today. My name is Jennifer Schlesinger and I work for the organization Alzheimer's Los Angeles. We are an independent community-based Alzheimer's organization that along with Alzheimer's Orange County and San Diego served the southern part of the state of California, so from Los Angeles county down to the border. And we really appreciate the commitment of the department and all of the health plans to that CalAIM truly meets the unique needs of families affected by dementia. We're at an inflection point for the state, as we roll out CalAIM. And we have the opportunity to be a leader in quality dementia care by taking the promising practices and lessons learned from Cal MediConnect and integrating them into CalAIM.

Jennifer Schlesinger:

Next slide. We're always appreciative of funders who allow us the opportunity to engage in this work including the administration for community living and the California Department of Aging. Next slide. So what I want to speak to you all today is the case for improving dementia health care, what dementia care in the United States looks like? What the current situation is and inequities that still exist? What we've done in Cal MediConnect and where we need to go in making California a leader in dementia care?

Jennifer Schlesinger:

Next slide. So the rates of dementia are increasing in the United States and around the world, and it's still not being well managed. Prevalence is about 6.2 million now, and is set to triple by mid-century. And there's extremely high cost of care. People with moderate to severe cognitive impairment cost Medicare an estimated three times more than other Medicare beneficiaries, and this is primarily driven by hospitalizations. And they cost Medicaid an estimated 23 times more than other Medicare beneficiaries, largely driven by nursing home use. And there's tremendous quality challenges, only about half of people with Alzheimer's disease get a formal diagnosis, and of those that do only half of them get the diagnosis documented in their medical record.

Jennifer Schlesinger:

There's stigma around the disease which further complicates this picture. Physicians and other health care providers often feel that they can't do enough for the person impacted by the disease and perhaps as a result, only about 45% of people with dementia are even told that they have a diagnosis. Complicating the picture even further is that the average person with dementia has somewhere between two and eight chronic conditions, meaning that care is incredibly complex and this population is vulnerable. And we've seen this past year with the disproportionately high death rate from COVID-19 virus. And there's tremendous inequities related to dementia care. And COVID also has put a magnifying glass on those health disparities, improving dementia. Healthcare is an equity issue.

Jennifer Schlesinger:

Next slide. And these are just some of the inequities that exist. African-Americans are two times more likely than older whites to have Alzheimer's or dementia. They're more likely to be diagnosed later in the disease process, and they have higher rates of caregiver strain and depression. And Hispanic Latinos are one and a half times more likely to have this disease, they're also more likely to get diagnosed later in the disease process. There's less caregiver support, greater care demands, and higher rates of depression. These are truly startling statistics that merit our attention and they merit our action.

Jennifer Schlesinger:

Next slide. 48% of all California nursing home residents have Alzheimer's disease or dementia. And we've seen trends showing that elderly, Hispanics, Asians, and blacks living in nursing homes are growing. This may indicate unequal access to home and community-based alternatives, which are generally preferred for long-term care. Next slide. Dementia care is largely social or non-medical given that we currently don't have a treatment or a cure for this disease. There continues to be minimal focus on caregivers yet they provide the majority of care for people living with dementia. In fact, caregivers, they're the backbone of our country's long-term services and support system. They keep people at home and out of hospitals and out of nursing homes, yet caregivers continue not to be identified, assessed for their needs or adequately supported.

Jennifer Schlesinger:

Our system of care is continuing to focus more and more on the social determinants of health, yet when it comes to dementia care, a critical social determinant is caregiver support, and there's minimal focus on this. Caregivers have not yet made the top of the list for social determinants of health when it comes to prioritizing them. And there's insufficient coordination between health care systems and community-based organizations. CBOs are deeply rooted in communities and have expertise in reaching families for social and educational needs, this is particularly important when we're talking about dementia care. Families need a tremendous amount of support and education. When referrals are made, there continues to be a lack of coordination between the healthcare system and the CBOs. The silos still exist, and we need to bridge the medical and nonmedical worlds.

Jennifer Schlesinger:

Next slide. So why is dementia care needed? Well, first as I said, it's an equity issue. You can't do quality dementia care unless you focus on health disparities. Quality dementia care impacts quality of life for those with dementia and their families. Quality and care, including care coordination, disease management and medical and non-medical support can help lower the cost of care. And dementia care drives hospitalizations and nursing home placement. Quality care can lower utilization.

Jennifer Schlesinger:

Next slide. So there three primary components of a dementia capable system of care, early detection of cognitive issues, the documentation, if there's a screening tool in place and ultimately a diagnosis. Caregiver identification, assessment, support, and engagement and partnerships with community based organizations for the social determinants of health, support and education of families in need.

Jennifer Schlesinger:

Next slide. The dementia Cal MediConnect project has been a collaborative project between Alzheimer's Los Angeles, the State of California, other local Alzheimer's organizations and our Cal MediConnect health plan colleagues. The goal has been to build a dementia capable system of care in the state of California to better serve lower income older adults with dementia and their family caregivers. The project began in 2013, 2014 with funding from the U.S. government and from the California Department of Aging. And there've been many lessons learned from this project that are best practices in most dementia healthcare models. These best practices should be built upon in CalAIM.

Jennifer Schlesinger:

Dementia MediConnect included technical assistance to the health plans regarding how to identify people with cognitive issues? The use of validated screening tools and assessment tools and workflow processes as well. We trained over 500 care managers in California and 150 dementia care specialists. And after the training, they reported being significantly more likely to screen members for dementia, identify caregivers, develop care plans and support caregivers through referrals to home and community-based organizations. There was also emphasis on caregiver education and support, care counseling disease, education, caregiver, education, support groups, respite, and array of programs and services to help caregivers on this very challenging journey.

Jennifer Schlesinger:

Next slide. A lot was accomplished in Cal MediConnect that needs to be now transferred to CalAIM. Cal MediConnect promising practices need to be embedded into CalAIM through the SMAC contract language in assessments and through health plan processes. The state mandated several things in Cal MediConnect, such as the HRA, including a cognitive screening trigger question, the plans having dementia care specialists and the mandate to identify caregivers. These systems changes were put in place by plans, and some either even further adopted other tools and processes to support beneficiaries with dementia. However, even when systems were put in place, the systems were not fully operationalized or activated to provide true quality care. For example, dementia care specialists were trained and embedded into the health plans, but they were not assigned to high-risk members with dementia. And in many cases, there are no longer any dementia care specialists at plans because of staff turnover.

Jennifer Schlesinger:

So I want to pivot and talk about the vision for how change can be implemented so that diagnostic and care pathways are operationalized systematically and consistently. In other words, how do we create a standard of care for dementia in California? Next slide. California has the opportunity through CalAIM to be a leader in dementia care. And I want to speak about this vision or what this ideal state may look like. Next slide. When you look at the master plan on aging, you see that priority is placed on how health care is delivered to older adults, including those with dementia and having systems to support caregivers. CalAIM not only brings this vision in the master plan on aging to reality, but it needs to bring this vision to fruition.

Jennifer Schlesinger:

Next slide. So there are various ways to conceptualize how to risk stratify members with dementia. The best available data suggests that people with dementia should be high-risk stratified based on coexisting conditions, utilization and availability of caregiver resources. The red box on the left outlines criteria for high risk stratification. A beneficiary is diagnosed with dementia or cognitive impairment and has two or more coexisting chronic conditions or two or more unplanned hospitalizations or visits to the emergency department within the past 12 months or a psychiatric hospitalization within the past 12 months, and insufficient caregiver resources, meaning that the caregiver is unable or perhaps unwilling to provide care. However, as you can see this way of risk stratification only works if someone already has a diagnosis. And as I mentioned, only half of people ever get a diagnosis for dementia.

Jennifer Schlesinger:

Next slide. So if there are no ICD 10 codes to pull and, or there's poor quality utilization or claims data to use, the net needs to be cast much wider to capture those who likely need to be classified as high risk and therefore given enhanced care management. The initial health assessment should include at least, at least one trigger question around cognition so that there's some way to catch early detection. This then activates a system for a diagnostic assessment and documentation of a diagnosis in a medical record. We don't want to wait for retrospective utilization data to prove a beneficiary has been placed in an institution or as a higher utilizer of services. The initial health assessment needs to also ensure that there's a caregiver who is both able and willing to provide care. The availability of caregivers significantly impacts hospitalizations, re-hospitalizations, and institutional placement.

Jennifer Schlesinger:

Next slide. So having a diagnostic pathway and a care pathway that are fully operationalized are the backbone of a standard of care for dementia, this is the master plan on aging. People need to be screened for cognitive impairment and then have a standardized way of getting to a documented diagnosis. This pathway is not conceptual, it must actually be activated. That means that processes must be in place and accountability insured. For those who screen positive, the caregiver is essential. A viable and capable caregiver is more likely to keep someone at home. So how to health systems address the needs of caregivers? Well, we first have identify who they are and put this information into the electronic health record. We need to assess the caregiver for their unmet needs and for stress and provide them with the support they need for those unmet needs and for the stress that they may be experiencing. This is the only way to set caregivers up for success. And again, this is in full alignment with the master plan on aging.

Jennifer Schlesinger:

We have an algorithm on the Alzheimer's Los Angeles website that outlines these processes. And the SMAC should outline these steps and include the integration of necessary tools and the processes that correspond with those tools to operationalize them. Next slide. Dementia care specialists. In the SMAC mandating the plans have dementia care specialists is not sufficient. It's a great start, but the SMAC needs to include how the dementia care specialists will be used. High-risk members with enhanced care management should be assigned to dementia care specialists, and there needs to be clearly defined roles and responsibilities for the dementia care specialists. Department of Healthcare Services has received some guidance on this. Dementia care specialists need to receive specialized training. And plans must ensure that they have an adequate workforce of dementia care specialists on their team to meet the needs of high-risk members with dementia, such turnover needs to be considered and planned for. Next slide. Enhanced care management that is specific for people with dementia needs to be defined in the SMAC. This means that not only are caregivers identified and documented, but as mentioned, they must be assessed for unmet needs stressed and provided with the necessary support to be successful caregivers. We demand so much of our caregivers. In fact, we have them do what people go to school and get trained to do. And yet, we don't provide them with the support that they need. Assessment tools and support pathways, those have to be operationalized.

Jennifer Schlesinger:

Next slide. Though most plans have some mechanisms in place to collaborate with local Alzheimer's organizations, including making warm handoff referrals, the SMAC needs to stipulate the processes are in place and implemented so that referrals can occur for disease education, caregiver education and support. And plans need to consider sustainability of partnerships with local Alzheimer's organizations so that they can be supported financially to carry out this essential work.

Jennifer Schlesinger:

Next slide. In lieu of services are important to caregivers, that there needs to be the workflows and processes in place so that people actually get to these services. We've learned this from Cal MediConnect, that care plan options can be available, but if they're not accessed, they're not used, they just look good on paper.

Jennifer Schlesinger:

The current list of in lieu of services is a good starting point, but when it comes to ensuring that people with dementia and their caregivers will have access to the services and supports, we need to consider what is available through this benefit and have the workflows to ensure access and utilization.

Jennifer Schlesinger:

Next slide. There is tremendous potential for CalAIM to improve the lives of people living with dementia and their caregivers. CalAIM gives California the opportunity to lead the nation and to fully support the master plan on aging. This is our chance to develop and implement a standard of care for dementia and make sure that we are not leaving caregivers behind. They need us and we need them, but it's not going to happen if the necessary contract requirements, guidance and processes for operationalization are not in place.

Jennifer Schlesinger:

I'll leave everyone with, next slide, a few publications about the work that we've done in California, specifically around Cal MediConnect, to improve care for lower income older adults with dementia. And I just want to thank everyone for the opportunity to speak to you. My colleagues, Dr. Debra Cherry and Barbra McLendon, and I look forward to continuing to engage with you, and we will be happy to take any questions that you may have when we participate in the Q&A and open dialogue.

Hilary Haycock:

Thank you so much, Jennifer, for that presentation. That was great. We're now moving on to Molina Healthcare. Megan Dankmyer is joining us to talk about their experience as a Cal MediConnect plan, implementing the dementia care specialists in Cal MediConnect.

Megan Dankmyer:

Thank you. I just want to make sure everyone can hear me before I get started. Okay, perfect. Thank you again. My name is Megan Dankmyer and I work with the case management team at Molina Healthcare of California, and we definitely appreciate the opportunity to speak today about Molina's Dementia Model of Care.

Megan Dankmyer:

Next slide. In case for anyone who's not familiar with Molina Healthcare of California, Molina Healthcare started about 40 years ago in Southern California, and our California plan is currently in seven counties total, four of those are Cal MediConnect counties, and then we also operate currently in five counties as a D-SNP.

Megan Dankmyer:

Next slide. Molina's Dementia Model of Care has really focused on the four core areas that are on the screen, that we'll talk about a bit today. And so, the first core areas on the next slide is the case manager trainings. And so, we had quite a few of our case managers attend the full day of training, the fundamentals of cognitive impairment, related dementias, really going over a ton of great information.

Megan Dankmyer:

And so, a lot of our case managers and other health care services staff have attended these trainings. And then, a subset of those case managers also did attend a dementia care specialist training, and that training was another day that really reinforced all of the topics in greater detail that were covered in the full day of training.

Megan Dankmyer:

Next slide, because ongoing is so important and we want to continue to remind the staff of the importance of this information, we did purchase a training bundle recently that was created by the Alzheimer's Los Angeles in partnership with the online learning company. And so, the online bundle that we purchased for some of our staff to enroll in, there's four different courses that they're able to take at their own pace.

Megan Dankmyer:

And so, it's really been great for staff to ... either new staff that never attended one of the trainings or staff that just need the reinforcement, it's been a while since they've had the training. It's been great for them to be able to continue to take these courses. And then, I also wanted to mention that Alzheimer's Los Angeles and their team have always been really great about keeping us updated on other training opportunities. For example, there was a training for staff on COVID-19 and how best to support those with dementia and their caregivers during this challenging time. We always really appreciate them for keeping us updated on these different opportunities.

Megan Dankmyer:

Next slide. The second core area of focus is member cognitive screenings. And so, the training that our staff received, definitely a piece of it is how to screen members for dementia. And so, one of the validation tools is called the AD-8, and we had that added into our clinical system for our staff to use as they're working with members to screen them for dementia.

Megan Dankmyer:

And then, we also really wanted to ensure that that information is being communicated to the member's primary care physician. And so, we created a letter to notify the members, primary care physician of the score on AD-8, and actually worked with Alzheimer's Los Angeles on some of the language that's included in the letter to educate the PCP and ensure that the member's receiving any dementia diagnostic evaluations, if needed.

Megan Dankmyer:

Next slide. The third area of focus has been caregiver screenings. And so, obviously, caregivers are so important, and like Jennifer said, we need them so much and they have such a hard job. And so, we wanted to make sure that, as our team is working with caregivers, that they're really screening them for their stress and burnout. We added a caregiver self report questionnaire into our clinical software that our case managers are able to utilize as they're interacting with caregivers. And we also make sure that the caregivers are identified in our clinical system and obviously engaged throughout the care planning process, like through the identification of goals, the members preferences and appropriate interventions.

Megan Dankmyer:

Next slide. The fourth key area of focus on our Dementia Model of Care is referrals to community resources. Obviously, it's so important that we're linking members and their caregivers to appropriate resources. They're linking them to Alzheimer's associations, Long-Term Services & Supports that the member may need, and also just different internal and external resources that may be appropriate for the member.

Megan Dankmyer:

And I did want to call out that Alzheimer's Los Angeles created a great tool for our team to make referrals. And then our case managers receive a feedback loop and they received the outcome of the referral. They really liked that, and it really helps in the communication and us working together to support our members and their caregivers.

Megan Dankmyer:

We've also implemented different pilots to help increase identification of members who are in need of assistance or possible referrals related to dementia. We've tried different pilots with vendors or different reports to really help and make sure we're identifying members that maybe haven't responded. Like Jennifer said, there's the screener question in the HRA, but sometimes if we're not able to complete the HRA with the member, we're using other data that we may have to identify members in need of outreach, just to make sure that we're connecting them to the appropriate community resources.

Megan Dankmyer:

Next slide. Just in conclusion, some of the areas that we've really recognized as a best practice for our Dementia Model of Care is that the training and the interventions, we really just implemented across the board. They weren't just for our Cal MediConnect members, but we really wanted all of our members to benefit from the best practice. Although it's great to have the different screening tools in our clinical system, we really wanted it embedded into our processes and our workflows.

Megan Dankmyer:

And so, we make sure that it's part of our trainings, our workflows, and even our case audit tools that we use to audit cases. And so, it's really just been incorporated as part of our processes. And then, again, the willingness to try different pilots or different reports just continually to make sure that we're identifying and outreaching to the members that are in need of support is really key. I definitely feel like our most important best practice has been our relationship and partnership with Alzheimer's Los Angeles. We first met the team back in 2014 when Cal MediConnect first went live, and for us as leadership and also our case managers, to have direct access to experts in the field of dementia has been really great and critical to our Dementia Model of Care. We appreciate all of their support over the years and look forward to continuing to work with them as things transition. Thank you. That's was what I had and I definitely appreciate you allowing me to share a bit about our model of care.

Hilary Haycock:

Thank you so much, Megan. Great to get that perspective on how it works from health plan. We are excited to open up our discussion section. We are going to start off with some formal discussers before we open it up to folks. Just a reminder, if you have questions or comments that you want to send to the panelists, please put them in the Q&A and then we'll be able to be tracking and answering them using the Q&A box. First, I am going to hand things over to Susan DeMarois with the Alzheimer's Association.

Susan DeMarois:

Thank you, Hilary, and good afternoon. A special thanks to the department for creating this forum for discussion today. I'm grateful for the opportunity to share the perspective of the Alzheimer's Association. We are a national nonprofit voluntary health organization with 21 local offices throughout California. Today in our time together, I want to focus on how CalAIM can further the goals of building health system capacity and developing dementia competence.

Susan DeMarois:

And I think I have slides. I don't know if they will be shared or not. There we go. With the next slide, let's start with where we are today. Alzheimer's and dementia are no longer niche issues that can be carved out or carved into Medi-Cal. CalAIM recognizes the value and benefit of integrating dual eligible beneficiaries in a very intentional way. Together, we can positively influence the statistics that you see here on this slide, staggering Medi-Cal and Medicare costs' high institutional utilization and poor health outcomes.

Susan DeMarois:

Next slide. Like all other chronic conditions, Alzheimer's disproportionately impacts people of color, with prevalence rates as much as double within some communities. A recent national report by the Alzheimer's Association surveyed people living with dementia and their caregivers and found widespread experience with discrimination and bias. We know that people of color, if they're diagnosed at all, are diagnosed much later in the disease process. The department shares these concerns and we commend the work underway to improve on diversity, equity and inclusion within the Medi-Cal program and its plans. And we look forward to the equity agenda to come.

Susan DeMarois:

Next slide. Over the next decade, as CalAIM plays out, California has the opportunity to deploy population health management strategies to intervene much earlier in the progression of the disease. This allows time, critical time, for the patient, the family, the provider, and the community to plan accordingly. We envision a huge shift from costly crisis care to a much more compassionate approach that empowers the person with dementia and their circle of support to direct their own path in ways that have never been done before.

Susan DeMarois:

This slide is important because next month an FDA panel will review, for the first time since 2003, a new drug treatment for Alzheimer's. If this treatment is approved, this will be the first disease-altering treatment targeted to individuals with mild cognitive impairment or early stage Alzheimer's, where maximum benefit can be achieved. We know, with less than half of all people being diagnosed, that many people will never benefit from this treatment if it is approved, unless we improve with screening detection and diagnosis.

Susan DeMarois:

In our remaining time, I want to quickly share ideas to build system capacity and develop dementia competency. California is well-resourced. We can move to the next slide here. In fact, we are a national leader. Just this week, the US Health and Human Services Agency heard from the National Alzheimer's Project Act, NAPA, about models originated by experts here in California. On the slide, you'll see a toolkit that was developed. The first two slides reflect decades of work by clinicians, for clinicians under the guidance of California's Department of Public Health, drawing on the expertise of our 10 California Alzheimer's disease centers.

Susan DeMarois:

Any plan or provider can access, at no cost, the tools to identify, diagnose, and plan for care, ideas on physician reimbursement, ICD and CPT codes, scripts for communicating with patients, and decision trees are included. In the next slide, you see that California was the first in the nation to develop a post-diagnostic Alzheimer's disease management guideline. That since has been updated four times, and the version you see on your slide is current as of 2017, again, developed by clinicians, for clinicians by California's Department of Public Health.

Susan DeMarois:

On the next slide, I share the first of two examples. CMS funded three CMMI initiatives after the Affordable Care Act, two of them originated in California. The one you see on the screen now, UCLA, and the next one, at UCSF with the dementia ecosystem, both build off of the concepts of enhanced care management, identifying individuals living with Alzheimer's and dementia through screening, detection, diagnosis, and care planning. Also, both of these models allow for a primary care workforce and physician extenders to help with the social needs of individuals and their caregivers.

Susan DeMarois:

Next side, please. This shares with you UCSF Dementia Care Ecosystem Model. What we've learned in COVID when so many tele-health visits, that both of these models also really leaned into remote monitoring and originated with these two models. And we've seen that done successfully during COVID. On the next slide, I wanted to share, by contrast, other promising models of care that we're closely examining.

Susan DeMarois:

One would be California's ACEs model, where the focus is on toxic stress and adverse childhood experiences, where Medi-Cal has focused on screening and provider training and provided provider incentives to conduct screening. And that's something we're examining right now with the legislature and the state budget. Also, the incredible work of Project ECHO sites throughout California and around the country with chronic disease management and developing primary care networks with specialized expertise to reduce costs and improve quality. There are a handful of Project ECHOs focused on dementia, and we're eager to bring that to California.

Susan DeMarois:

Finally, in the last slide, I wanted to close with one example from the Alzheimer's Association's work with a large health plan. If we could move to the next slide, initiatives like this, in partnership with the Alzheimer's Association in a large statewide health plan where we were embedded in the electronic health record, we were integrated there. So, there were direct referrals to the Alzheimer's Association at point of care and very, very high patient and family satisfaction.

Susan DeMarois:

Initiatives like this can fill the gaps in our statewide MLTSS infrastructure, and as we further define Enhanced Care Management and in lieu of services, we're eager to partner with providers and plans to extend Medi-Cal's reach deep into the community. Some of the services that we were able to offer were care consultations, peer support groups for individuals living with Alzheimer's and dementia, people in the early stages of the disease, younger onset Alzheimer's, caregiver support groups, caregiver education, patient education, health education, and the Alzheimer's Association is known for its 24/7 helpline that's available anywhere, anytime where a licensed clinicians, social workers, MFTs, are available 24/7 in language to support callers. We are sponsored by the Administration on Community Living to offer this nationwide.

Susan DeMarois:

And we also have a community resource finder that can help link individuals to local Long-Term Services & Supports. We do this in partnership with AARP, and this would help link beneficiaries to services like the Caregiver Resource Centers throughout the state, MSSP linkage sites, CBAS Centers, adult daycare, help with placements in long-term care, assisted living, skilled nursing and the like. Again, I just want to thank you very much for the opportunity to share today. I look forward to the conversation, questions and discussions to follow.

Hilary Haycock:

Thank you so much, Susan. Appreciate you being with us today. Next, I'm going to hand it over to Debbie Toth with Choice in Aging.

Debbie Toth:

And it will not let me start my videos. Oh, now it will. Yay, hi. And I do not have slides, everybody, so my apologies. You're going to have to stare at my face. There could be worse things in life, I suppose, but I am Debbie Toth. I'm honored to be here. I am so thrilled to bring into this conversation what I think is the greatest non-pharmacological intervention in the history of Alzheimer's disease for people with Alzheimer's or related dementia and their caregivers.

Debbie Toth:

It's called the Alzheimer's Day Care Resource Center. And sadly, our acronym ADCRC is very close to the Aging and Disability Resource Connection, so there's confusion. But let me be clear, the Alzheimer's Day Care Resource Center was a piloted program, and actually, I worked at an organization that was one of the original pilot sites. 19 years ago, I began working there and it forever changed my life. You cannot find, in my not so humble opinion, a more beautiful intervention for somebody in the mid to late stages of Alzheimer's and their family.

Debbie Toth:

What is an Alzheimer's Day Care Resource Center? You have an adult day healthcare program. That program is a daytime program, same staffing as in a skilled nursing facility, but in a day program model. It looks like a seniors center, feels like a seniors center, but it has the health staff. Now, if you have an Alzheimer's Day Care Resource Center, you have a specialized staff, a trained staff, your day is curated, choreographed based all around what we know about Alzheimer's and related dementia. So, we have, I would say, a prescription for joy.

Debbie Toth:

What happens with somebody when they have mid to late stage dementia and they start to lose their memory and lose their ability to do the things that they once did with their family? They're covering and they're trying to be on 24/7, to be what they were. When they walk into our program, we never knew them when they were a pilot or a lawyer or a teacher or whatever. We've only known them today. There is no expectation, there's no burden. They come into a place of love where we only know them who they are today, and we provide a place of dignity where we do not ask open-ended questions, where we do not have places where people are confused.

Debbie Toth:

Everything is we know what's going to happen, the activities are short in duration, we focus on joy. Why? Because the memory may be gone, but that emotional center is still intact. And if we can keep somebody in a place in space of joy, then the caregiver and the family member with Alzheimer's or dementia has less of what the hallmarks are that we see of fear, of agitation, of all the things that can be really, really hard for everyone.

Debbie Toth:

This place in space is specifically designed for that, created for success and dignity. Just something so little that you may not think about in a traditional healthcare system, that we take the time and have the opportunity and space for, is to say, "How much can Debbie really do on her own? I'm not going to sit down and do exercises with Debbie by starting and taking her hand and doing this. I'm going to say, 'Debbie, we're doing exercises, have a seat and join us.' And if Debbie doesn't understand what that means, then I might touch Debbie's hand. 'We're doing exercises,' and I'm showing Debbie. And if Debbie does it, then I'm going to take Debbie's hand."

Debbie Toth:

We take the time to make sure that everything we're doing is the lowest amount of intervention for the greatest amount of independence and success. Everything is thought about, cared for. That caregiver who's getting respite is not just getting respite, they're getting the right respite, that is knowing that their loved one is being engaged, is being cared for, is exercising and maintaining their strength and their ability to walk, that they're going to the restroom on a schedule so they're not having episodes of incontinence, and that they're in a room, in an environment and a place and a space where there's puppies and babies and music and interaction.

Debbie Toth:

There is no replacement for that. I can tell you at Choice in Aging, when the funding was removed, it was general fund money from California, it was removed, our board of directors made the difficult decision about whether or not to close that program. It's very expensive. It's a higher staffing ratio, we provide caregiver support groups, we provide caregiver training, we provide community education. There's a whole bunch of things that come with this. And we prevent hospitalizations, emergency department visits and skilled nursing placements, but it's expensive. And expensive to us in the Medi-Cal world is a little different than expensive, like the cost of a skilled nursing facility or an emergency department visit.

Debbie Toth:

But our board of directors, knowing that this is what caregivers need to keep their loved ones at home, and nobody ever wants to place somebody in an institution if they can avoid, said, "We are going to keep this program going." The need of the caregivers and knowing what the impact is on them was a no-brainer for our board. I want to tell you that one of our caregivers, back in the day, we have a video on our Choice in Aging website buried somewhere deep, it was from years ago.

Debbie Toth:

We did it in partnership with Justice in Aging, and we interviewed a caregiver and her name was Jan and her husband had Alzheimer's disease. And this is a quote from her from that video. "The center has been great for him. He does look forward to it every day when we come. He comes three days a week. I had no idea that I would get the support and the encouragement from this facility for myself and becoming a person again. I think this is the best thing that has ever happened to us at this point in our life." There's no reason that in lieu of services shouldn't, couldn't, and won't pay for Alzheimer's Day Care Resource Center for the person with dementia and for their family caregiver and for our community. Thank you.

Hilary Haycock:

Thank you, Debbie, for that really moving story. I appreciate you being with us today. Our last discussant is Dr. Zia Agha with West Health. Dr. Agha?

Dr. Zia Agha:

[inaudible 00:59:51]. And boy, Debbie, you [inaudible 00:59:57]. We're going to shift gears a little bit. I want to talk a little bit about point of care, and we talked in earlier presentations, how do we systemize care? How do we bring care to the system level? And I don't have slides either, so bear with me on that one too. But if you think about system wide change, there are a number of models that come to mind and we have had the good fortune at west health to work with our collaborators to develop the geriatric emergency department model. And I think there's some learnings from there and in particular, because the GEDs are designed to provide better emergency services to people with dementia and cognitive impairments. So what is a GED? It's a special place, just like Debbie said, it's a special place for seniors that is designed to provide them with a comfortable environment, to provide them with the screenings that go beyond just their acute presentation, to provide them with the connections with the community and resources for the caregivers.

Dr. Zia Agha:

And also from a medical point of view, to identify risk factors whether it comes to mobility issues and falls, a pharmacological issue, because we know that drugs have different effects on people with dementia or whether, it affects our transitions in care. We all know that when somebody has dementia, they're present to an ER and they've been waiting in the waiting room for six to eight hours. They haven't been fed, they have some hearing deficit or some sort of visual deficit on top of that. It's important that if you don't provide the right environment for them and don't take care of all of their needs, that they are on their way to being admitted. And that happens far too often today in all hospitals, even though we try to do our best. With a handful of sort of leading hospitals, starting in California and New York and Chicago, the GED movement sort of took steam, I would say over the last four to five years.

Dr. Zia Agha:

Today, there are more than 200 such specialized centers across the nation, and growing. We are partnering with our colleagues at the massive plan for aging to launch an initiative that will make California the first state to have wide penetration of GED in all markets. We also have some work that we just launched today with the veterans affairs, where all VA hospitals will have GEDs. And what's important from the learning from that perspective is, dementia care at the point of care in terms of hospital and ER, and the medical model is critically important. There are tailwinds such as value based care, such as the need to prevent hospitalizations and readmissions, the need to keep these seniors healthy and independent in their homes. And I think there's an opportunity now for all of us to address that gap. One way to think about it would be a public private type partnership.

Dr. Zia Agha:

We did that for our GED mark, but I can easily imagine based on what Susan was telling me, you guys already have developed good standards of care. There are screening protocols in place. There is obviously great evidence on how to improve care, both in the medical and the nonmedical setting. And there are opportunities such as CalAIM that provide those tailwinds that can allow us to dig this to the next level. Healthcare is a strong partner, but they cannot do it alone. I think having health plans, healthcare providers, community based organizations come together is critical. And I think that is something that groups like Alzheimer's and even our group are trying to do in different areas.

Dr. Zia Agha:

So my sort of key learning point here is that once you can identify those sort of beacons of success, we have to focus on how do we scale them and then how do we sustain them, if the unsustainable having data and evidence is critical. And it's so fortunate that there are amazing researchers in California who are engaged in this work. And even through the massive plan for aging, there's an opportunity to provide that level of evaluation that gives the robust evidence to policy makers that we need to improve care for dementia. So I'm going to stop there and open it up for Q and A.

Hilary Haycock:

Wonderful thank you so much. I know there's a lot of presenting, but a lot of really great information being shared today. So we're excited now to open up to discussion, question and answer if folks have questions for any of the panelists or comments that they want to make, feel free to raise your hand and excellent. All right, Marty Lynch, you can go ahead and unmute your line.

Marty Lynch:

Thank you. I think I'm un-muted, good. Thanks Hilary. Fantastic presentations all of you, by the way, I just wanted to say that what I wanted to add was this; in some ways it's ironic that we have so much progress and it's great on dementia care and thinking about it in the context of CalAIM, when an ECM, enhanced care management. When I, I don't think most of the plans have gone down the road of thinking about how they're going to deal with the older population in general.

Marty Lynch:

So maybe we can learn from the dementia care work, but I know that the counties and the plans seem to be more focused on making the transition for the whole person care and health home populations. And there's tremendous need, I think from our point of view on this call to start to see what are going to be the way that enhanced care management and iOS are going to roll out for the older population, the duals population of which the dementia population is one example. So fantastic work in that population. How can we use it to frame the broader older adult enhanced care management and iOS discussion?

Anastasia Dodson:

Thanks Marty. This is Anastasia. Can folks hear me?

Marty Lynch:

Yep.

Anastasia Dodson:

Okay, great. Great point. I'd be curious to hear thoughts from anyone else on the panel, but I'll just say that we know that for there is one population that's already enrolled in Cal MediConnect that enhanced care management does not apply to them. And then we want to build on those lessons learned as we've been talking about today. So when it comes to contract requirements, we will, we will do our best to look at how the language, and we did get a lot of feedback. We went out for stakeholder feedback on the ECM and in lieu of services, contracts, and other documents and got a lot of feedback. And I'll just say, if we don't get to the very best language right off the bat, we can continue to iterate and learn, particularly as we'll have more transitions coming up in 2023. But very good point. Thank you.

Marty Lynch:

Anastasia. Can I ask very briefly, are you going to have somebody summarize the feedback that you got or put out some kind of a paper that would summarize it, that'd be really helpful. I think for all of us too.

Anastasia Dodson:

That's a great suggestion. And I believe Dana Durham is still on and he had, so Dan is hearing that and we will talk with our team about doing that. Thank you.

Marty Lynch:

Thank you.

Dana Durham:

Just want to echo what Anastasia said that is a really good suggestion and we'll certainly see what we can do to make sure that we're as transparent as we can be.

Marty Lynch:

Thank you.

Hilary Haycock:

So again, if folks have comments or questions, feel free to click the raise hand icon, but we'll go to that. The questions that are in the Q&A. So the first one is whether DHCS is considering contracting with C-SNPs that specialize in dementia or, or will D-SNPs, seems to be the only option in terms of what Medicare beneficiaries will have the choice for in thinking through getting, a special needs plans.

Anastasia Dodson:

Thanks for raising that. We have been focused as you know, on D-SNPs and have not been considering C-SNPs. I believe that those are for both duals, duly eligible and Medicare only beneficiaries, but we can take a look at that. I don't want to say one way or the other at this point, we need to look further, but thank you. Great suggestion. And is there more that the commenter wants to say about C-SNPs?

Hilary Haycock:

The comment was from Tatiana. So with HICAPs. I'm not sure if you want to raise your hand and we would be happy to go ahead and you're welcome to unmute your line Tatiana.

Hilary Haycock:

Okay.

Hilary Haycock:

She's still on.

Anastasia Dodson:

And maybe in the meantime.

Tatiana Fassieux:

Yeah, I think I'm okay. Thank you. Yes. You know the problem is that in California, cause I do Medicare education and I analyze all the plans just before open enrollment. There are very few seats C-SNPs in California, but even though the screening for dementia is part of both the welcome to Medicare visit and the annual wellness visit, which was confirmed by one of the participants here from CMS, C-SNP would provide a lot more focus. And when I look at the CMS description on the Medicare website of C-SNPs. They currently do not have specifically dementia focus. So they have all sorts of other chronic conditions.

Tatiana Fassieux:

So that would be an idea, but definitely in the D-SNPs or any other Medicare advantage plan or also original Medicare, there is a screening for dementia care or dementia identification and consequently care coordination in original Medicare. That is a benefit that Medicare beneficiaries do not know because I can tell you from experience, they do not read the Medicare handbook that everybody gets every year. So there needs to be more education on that. And I know that HICAPs do that as part of their counseling, but there needs to be more, a broader education with respect to those benefits. Thank you.

Anastasia Dodson:

Thanks. I wonder if anybody else on the panel has any experience with C-SNPs or any thoughts about C-SNPs for dementia care?

Anastasia Dodson:

Okay. Well anyway. Great, great suggestion. We'll take a look.

Hilary Haycock:

There are a number of comments and questions sort of around also immersed daycare resource centers, questions about; one comment about sort of the need for significant and dedicated funding for social model Alzheimer's and other dementia daycare, and that we should make serious and thoughtful decisions about the lockout for mental health assistance services. And that symptom reduction can be helpful in at least delaying long-term care. One another question about how folks can locate Alzheimer's daycare resource centers. Are they just for Medi-Cal members or if Medicare members can participate as well? So I don't know, Debbie, if you.

Debbie Toth:

Yes. Hi.

Debbie Toth:

So I would echo the sentiments about there needing to be dedicated funding streams, but also in the absence of that, that certainly it would be a covered benefit through in lieu services. We also are providing care management and case management in these programs. So I don't know if that ties into enhanced case management or if it's listed in, in lieu of support services or how Anastasia you would categorize all that fun stuff. But certainly I'm sure that there's a way to go about that. So that it's covered in there. How do you find an Alzheimer's daycare resource center? Well, many have closed because the funding was eliminated in 2009.

Debbie Toth:

So along with linkages and a variety of other programs, which I think, I hope the intent with in lieu of services and enhanced case management can cover some of what we lost with linkages, but the Alzheimer's daycare resource centers. I believe the California department of aging had on their website. They serve anyone. It doesn't matter if there are people on Medi-Cal, if they're through Medi-Cal managed care can get those services, veterans if the site has a contract with the veterans' administration, we've served regional center clients, we have private pay clients.

Debbie Toth:

We write grants to get money through title three through the Older Americans Act funding to help provide scholarships for those in need. So there are a whole variety of folks that we serve in those programs. And I know there's another panelist who said she was one of the original six sites. And I know that in Chico, the Peg Taylor center has an Alzheimer's daycare resource center. I know the Yolo Adult Day Health Center has an Alzheimer's daycare resource center. I know Calabria Care in Napa does, and obviously Mount Diablo Center and the Bedford Center in Contra Costa are two programs of choice in aging. But again, the funding has been eliminated. So a lot of the original ones are no longer around, but there's a lot of industry institutional knowledge that we could probably bring them back on and do trainings and support other sites in that way, because it's magical.

Anastasia Dodson:

One other piece. Thanks Dana. That I want to emphasize going back to ECM is that there are assessments and there are processes already established for managed care plans. And then again, the processes established through Cal MediConnect for initial health assessments. And so just ECM is not the only way. It's not the only tool that we would hold health plans accountable for to assess, identify individuals with cognitive issues or dementia. So ECM is important, but there will be people who will need assessments and would benefit from the standard suite of care coordination tools that may not fit into the ECM bucket. So I would just want to flag that as well.

Dana Durham:

And I want to just, buttress up what Anastasia is saying, which is part of the population health management is coming up with a schema to treat populations within the managed care plan. And one of those populations for many managed care plans, if not all, will probably be a look at the dementia population. So just to point that out.

Anastasia Dodson:

Thank you Dana.

Hilary Haycock:

One question that came in through the chat was about what was learned in Cal MediConnect and how to get adequate personal care for IHSS recipients with dementia and sort of how that works with, with clients, with their dementia, with clients, with dementia, who may be incapable of supervising the care provider. And so, I don't know if either Megan or folks from Alzheimer's Los Angeles can talk a little bit about their experience in sort of helping with coordination or ensuring adequate IHSS and how that works for members with dementia.

Megan Dankmyer:

This is Megan, I can start, and then Jennifer can add on. Obviously when Cal MediConnect first went live, it was a lot easier to coordinate with IHSS. I think everyone knows the fact that we no longer have it [inaudible 01:17:52] it really does make it a lot harder to coordinate with IHSS. But definitely we've, there's processes in right now, we have to, in many of the counties, have the members sign a form, so allow us to communicate with IHSS. So it really does make a difficult. Now we dream of the days where we were able to coordinate so easily when Cal MediConnect first went live, I think it definitely makes it difficult to coordinate care and really make it as easy as possible on the member and their caregivers. And so unfortunately since we don't have the MOU with IHSS anymore definitely makes it a lot harder currently.

Megan Dankmyer:

We have, if there are situations where a member hasn't been able to find a caregiver, we can help them and reach out to the public authority, help with the list of caregivers. We've also utilized care plan options, if we really need to get a caregiver in and we're having difficulty through IHSS, that's something we've used our caregivers through care plan options through. So that's been a resource as well. And I see Deborah is on.

Debra Cherry:

Hi, I just wanted to have, can you hear me? Okay. I just wanted to add to us being said here, frequently people with dementia can direct their own care in the beginning of the disease, but I think more commonly in the Medi-Cal program, you're getting people with moderate to more severe dementia who have access the in-home supportive services program. And I think that surrogate direction is what becomes essential for this population. So this goes back to what Jennifer was saying earlier about when people have moderate to severe dementia, identifying a family caregiver and assessing their needs, be it for disease education or for training and other supports is essential because those are the individuals who will provide the consumer direction within in-home supportive services. I know I've gone on a different tangent than you were on Megan, but I think it's really critical that we recognize that you're serving a particular member or patient, but to do it adequately, you need a partnership with a caregiver once they are in the moderate to severe stages.

Debra Cherry:

And if I could speak back to Marty Lynch's comment a little bit earlier, I would hazard to say that if we create a system of care, that does good assessment of the functional capacity and the cognitive capacity of older adults and connects them with necessary supports, that kind of structure can be beneficial to many older adults within the Cal-M program. Cause this is one of the harder populations to serve. And if you create a structure that's supportive of them, it's going to likely be supportive of many people who are able to do self direction and speak up for their own needs.

Speaker 1:

Hey, I'll definitely echo what Debbie just said. In our work we have noticed it's more difficult in fact, for healthcare systems and providers to create sort of multiple different protocols for different segments of their population. I've often heard what's good care for dementia, what's good care for senior is essentially good care for everybody else, so that is definitely a trickle-down effect. And that is, that's a positive thing, in my opinion. On the caregiver needs, we did back in the days of work with CAPC the Center for Advanced Palliative Care to develop some dementia training tools.

Speaker 1:

And again, I call that what we recognize where there's tremendous medical burden, we ask our caregivers to literally do medical procedures that some of us would require training to do. And so the focus there was to really help these caregivers do things like wound care, bowel care, manage sort of changes in cognition. And that's a very sort of overlooked aspect of caregiving, but a real big challenge and anything that we think about within CalAIM or other areas, are really focusing on helping caregivers provide that medical care is critical.

Hilary Haycock:

Great. There were a pair of questions in the Q&A on case managers and how members are assigned case managers and trust building and making sure that they're served timely preventive interventions. The question was sort of specific, like could care managers sort of be based in member housing as an effective way to provide complex care coordination? So I don't know if maybe either Alzheimer's LA or, or Molina have anything to say about maybe at a broader level, how, how the process worked of making sure that for members of dementia, were assigned a case manager that was really able to build that trust and develop a relationship to be effective.

Megan Dankmyer:

This is Megan. So the way that we assign for our account MediConnect members, if they're higher risk or unknown risk, we may not have information on those members. They're automatically assigned to one of our Molina case managers who then outreaches to the member and conducts the HRA to identify all of the issues. And so if it is a member that does have dementia, and the particular case managers, not a dementia care specialist, they could transition the member to a dementia care specialist, but sometimes they've already developed a rapport with the member and the family really identified what all their needs are and kind of the roadmap to begin to help them, that isn't always the right process for the member or the caregiver. So we really take it really case by case. And then our dementia care specialists do participate in all of our different interdisciplinary care teams to offer that expertise for all of our staff. I don't know if Jennifer wanted to add anything

Anastasia Dodson:

This is Anastasia. I really want to acknowledge and appreciate the panelists and the presenters for calling out these important issues, caregivers, especially, and even just to add that we recognize that the department, what an important time this is as we are adjusting and things are evolving through the pandemic as we're transitioning to a new federal administration and recognition nationally and in the state of the importance of being thoughtful and looking at good strategies for addressing the needs of older Californians, older Americans, caregivers, home and community-based services, and thinking about what is ahead.

Anastasia Dodson:

So thinking about what is ahead head for our population in California, what's ahead for dementia care, what's ahead for treatments, clinical interventions, and then the services and supports that are needed for individuals and their families. So it's a great time to have this discussion, again at a state and a federal level and even a local level. So really appreciate the breadth and depth of the discussion today, and we are listening at the department and we're hopeful that through CalAIM or other actions in the coming months, that we can leverage this time. And then in 2023 for the SMAC, then we hear you on making those changes. And we want to work with all of you to get that language as good as we can, and then continue to iterate year by year.

Hilary Haycock:

Thank you Anastasia for wrapping us up. We will move on to our next topic now. So I will be handing it over to Stephanie Conde from the Department of Health Care Services to talk through the act enrollment moratorium policy options.

Stephanie Conde:

Good afternoon, everyone, Hilary and team. Can you hear me? Good afternoon, everyone. And we're going to transition a little bit here to a new topic as Hilary mentioned. I'm Stephanie Conde with Department of Health Care Services with the Managed Care Operations Division. And so let me go ahead and introduce the next topic, which is our Cal MediConnect enrollment moratorium policy and the options we have as we move forward. So walking through some of our bullets here, the Cal MediConnect demonstration will sunset on December 31st, 2022, as folks know. The Cal MediConnect plans will transition members from Medicare/Medicaid plans, MMPs into districts with Medi-Cal managed care plan aligned enrollment. Through these discussions with CMS, internally with the department, with all of you, we are working through quite a bit of operational issues and decisions associated with transitioning the current connect population, and this is one of them.

Stephanie Conde:

So the current MOU between CMS and DHCS states that no enrollments will be accepted within six months or less of the end of the demonstration. Meaning that the last effective date of enrollment into a Cal MediConnect plan will be July 1st, 2022. This is also known as the enrollment moratorium. Just as a reminder, which is our last bullet duals are not eligible to enroll in D-SNPs in CCI counties until 2023. CMS and DHCS have heard that the Cal MediConnect plans that are starting D-SNPs in 2023, want to minimize the length of time in 2022, that they will be unable to offer an integrated Medicare enrollment option for beneficiaries and DHCS wants to avoid more enrollment in non-integrated Medicare plans. We are working with our colleagues at CMS to potentially adjust that six month moratorium. And this is subject to enrollment, transition decisions and timelines. Next slide, please.

Stephanie Conde:

DHCS is considering two options here. The first option, which is bullet number one, no change. So enrollment into Cal MediConnect Plan would end July 1st 2022. This does not require a contract update. So we have a three-way contract with DHCS, Medicaid, CMC plans, and CMS. So no change to that contract. It's consistent with other demonstrations in New York and Virginia. However, it does create the longest time for duals to not enroll in an integrated product, and is also potentially confusing for prospective beneficiaries. So option number two allows enrollment into a Cal MediConnect plan until August or September of 2022. This option is also an early enough date that we can still transition members seamlessly into an aligned D-SNPs and Medicare plans in 2023. It minimizes overlapping or confusing notices to beneficiaries.

Stephanie Conde:

The transitioning beneficiaries do receive notices from CMS and DHCS. So if you're a new enrollee also receiving these transitioning notices, it may be very confusing. And as I said before, it keeps the integrated enrollment options available for longer. However, this does require a contract update and the current draft notices that will be going out to folks, we'll need to update those just to be a little bit clearer about the August or September last effective date.

Stephanie Conde:

Cal MediConnect plans, our clients expressed a strong preference for this option number two. And then just to know that anything later than September 1st of 2022 could potentially create an overlap with the transition to our D-SNP and MCP. So we have two options, and then I'm going to kick it back off to Hilary though, to open it up for discussion and or any questions that you may have for me for these two options.

Hilary Haycock:

Thank you so much, Stephanie, we have a question in the chat about when notices to members will go out?

Stephanie Conde:

A good question. We are developing our noticing and timeline plan, and we will be sharing that with this group soon. There are suggestions to do a 90, 60, and 30 day noticing plan to our transitioning beneficiaries.

Hilary Haycock:

Guys, a reminder folks can raise their hand and we'd be happy to unmute you.

Anastasia Dodson:

This is Anastasia. I know we are shifting gears pretty radically in going to this topic, and I want to acknowledge that, but also to say that both topics are important. And so we know that there'll be a lot of things going on in 2022, as far as dual-eligible beneficiaries, thinking about what plans they want to enroll in. If they're not in a plan versus if they are in a plan and our partners, either at HICAP programs or other community providers, other folks may be hearing about things or seeing things, seeing notices, caregivers, family members, beneficiaries. So we do want to make sure that, as we start to plan for 2022, that we're really consulting with you all and, being as clear as possible and doing the best we can to give as many choices as there are.

Hilary Haycock:

Janine Angel, you can unmute your line

Janine Angel:

Yeah. Hi, thank you. I wanted to see, normally we have the state enrollment broker who supports the enrollment process for these... for this- Oh hang on. I'm being told I am on mute. I'm not quite sure.

Hilary Haycock:

We can hear you.

Janine Angel:

Oh, you can hear me. Okay. So I'm not quite sure, or maybe you can let us know how Health Care Options, with either, if we go with option two, Health Care Options is a key partner in the enrollment process for the MMPs. And so how well Health Care Options... I think we could go along with option number two, if we understand that Health Care Options will be a partner and, and part of that education program for the members who if they're going into Cal MediConnect as with a 9/1 effective date, they're going to immediately, like you said, be receiving the notices that the plan is terming, and also be barraged with all this stuff that happens as a new Cal MediConnect member. So how will health care options participate in this?

Stephanie Conde:

Thank you good question. We will have robust call scripts. That will also be shared for feedback, because we do want all of our... Whether it's our managed care plans, whether it's Health Care Options, our ombudsman, to have the right information and to educate these folks on kind of what's going on and answer any questions because to your point, it could get a little bit confusing, but we will have call scripts that we've looked at, approved and just make sure that they're equipped with answering any questions or directing the beneficiary on kind of the next steps throughout this transition.

Hilary Haycock:

We'll take one more question, Jane Ogle. You can unmute, there you go.

Jane Ogle:

Hi Hilary. Thanks. My question is going forward, I have understood that the D-SNPs in the rest of the country have a six month period where somebody is enrolled but they stay in the plan. Will that happen in California and does that impact your decisions about this enrollment moratoriums?

Stephanie Conde:

And I'm going to pause just to make sure I understand. Is this the Dean Policy, Jane?

Jane Ogle:

Oh, no. I had understood that while in Cal MediConnect people can enroll or disenroll from Cal MediConnect at any time as a D-SNP. In other parts of the country, D-SNPs now require a person to enroll and stay enrolled for six months. And I'm wondering if that'll happen as we transition into a typical D-SNP in California, not Cal MediConnect.

Stephanie Conde:

It's a good question. And I'm jotting down your question and we can bring that back. I don't know about the policy in a future world. And so let me take that back and we will come back with you guys with an answer.

Jane Ogle:

Okay. Can I ask one more question?

Hilary Haycock:

Kerry, do you have... Kerry Branick? I think you have an answer on this, actually.

Kerry Branick:

Yes. Hi, everyone. You can hear me?

Hilary Haycock:

I can you hear you.

Kerry Branick:

Okay. I can write it in the chat as well after, but in Cal MediConnect we use demonstration authority to waive some of the requirements around special election periods. And so by waiving it, it allows beneficiaries to enroll in or move between or enroll out of Cal MediConnect plans every month. We won't have that demonstration authority for D-SNPs and for our dually eligible beneficiaries that want to enroll in other Medicare advantage plans, including D-SNPs. They have a special election period once per quarter for the first three quarters. And in the last quarter of the year, it's part of the annual open enrollment, and the enrollment takes effect January 1st. So that would be the policy in the future.

Hilary Haycock:

Great. So in brief, there's a quarterly special enrollment period for duals and D-SNPs. So it is not a six month period, but duals have the opportunity to select any plan on a quarterly basis. Folks could not hear Kerry, so maybe we'll have Kerry give a longer answer in the chat, but thank you.

Anastasia Dodson:

And Hilary, let's add this to our FAQ doc.

Hilary Haycock:

Absolutely. Great. All right. We have another hand raised, Amber Christ, if you want to go.

Amber Christ:

Can you hear me, Hilary?

Hilary Haycock:

We can. I can, at least.

Amber Christ:

I guess the consideration I have about the enrollment period moratorium is if we're thinking about a September date, that also means that then basically the next month, if we do 90 day notices to transition into the D-SNP and end Cal MediConnect, folks would only be in less than a month before they start getting notices about that transition, which would also coincide with getting notices about Cal MediConnect, which I think could be pretty confusing. So I think we should consider what that noticing looks like. And I'm also concerned about how close that is to the open and the annual election period. And so people will be bombarded with marketing materials during that time period as well.

Amber Christ:

So I just think that's a really big consideration to take into account when we're thinking about where that moratorium should end. And then on Kerry's point about the quarterly disenrollment for duals, I'm wondering in Cal MediConnect, we sought a waiver for continuous disenrollment for duals, and whether the department is thinking about seeking a waiver for that for the D-SNP proposal. I think the Cal MediConnect plans really appreciated the continuous enrollment period for duals. And just wondering, we've always been in favor of duals being able to make enrollment choices on a monthly basis, but I don't know where the department stands on that with regard to CalAIM. Thanks.

Anastasia Dodson:

Great question and great point. And sorry, if others want to chime in just to say – we will take a look.

Stephanie Conde:

Yeah, that's all I was going to say too. Oh, for the noticing though, it – they're all very good points about confusion to the beneficiary. And so thank you for making those. And we consider that as we're developing our outreach plan through this transition.

Kerry Branick:

Just to offer one other point to add to that, we're talking about an enrollment moratorium into the Medicare-Medicaid plans, the Cal MediConnect plans. Other Medicare options in the market will continue to be available for duals. And so beneficiaries could still enroll in a Medicare Advantage plan or a C-SNP that came up earlier during that period, that they wouldn't be permitted to enroll in an MMP. So just to consider it, consider that when you're thinking about your feedback on this too.

Hilary Haycock:

So just to repeat Kerry's point, because it sounds like some folks couldn't hear her, that the six-month enrollment moratorium is only for Cal MediConnect. So during that six-month period, members would not be allowed to enroll into the Cal MediConnect integrated product for Medicare and Medicaid, but they would be able to enroll into other Medicare products that are available to them. So that would include regular Medicare advantage plans and C-SNPs. So just for folks' understanding.

Hilary Haycock:

Great. I think there was one other question that I don't know if, Stephanie, you might be able to answer quickly, if not, we will take it back and add it to an FAQ, which is during the Cal MediConnect enrollment freeze, will there be exceptions for members that are disenrolled involuntarily and need to re-enroll in Cal MediConnect to continue accessing services? So sort of not new enrollments, but where there has been a challenge with their enrollment.

Stephanie Conde:

Yeah. And when we release our outreach plan, we'll address those members that are kind of going in [inaudible 01:43:34] eligibility. So more to come on that and very good question.

Hilary Haycock:

Great. Well, thank you all for sharing a lot of very important points that the department will take back in considering this. We're going to move on to our next topic. I'm going to hand it back over to Anastasia Dodson to discuss the DHCS matching plan policy.

Anastasia Dodson:

Thanks Hilary. And I certainly I'll phone a friend with Stephanie on this next slide. So I want to... We have discussed this I believe briefly in various meetings, but wanted to make sure we're being fully transparent about our current policy. And as we go forward and think about what is in, we've published our trailer bill language and thinking about how does a... When a beneficiary makes a choice on the Medicare side for Medicare advantage or a D-SNP plan, then how does that impact their Medi-Cal plan choice if they're in a county where there is more than one Medi-Cal plan, want to share what our current policy is, and then again our trailer bill language and our policy documents have outlined a proposed discussion point for the future matching plan and aligned enrollment policy. So right now, if a dual eligible beneficiary enrolled in a Medicare product, again, that's a Medicare Advantage plan, D-SNP in certain counties, they will be enrolled into the matching Medi-Cal plan.

Anastasia Dodson:

So if health plan XYZ, the beneficiary chooses to enroll with that health plan for their Medicare product, then our Health Care Options team will go through a notification process and give sort of this opt-in process to make sure that their Medi-Cal plan matches their Medicare plan. In County Organized Health System counties, all of the beneficiaries are enrolled in just one COHS plan on the Medi-Cal side, but in certain two plan counties, there is a behind the scenes communication with the beneficiaries to get them enrolled into the matching Medi-Cal plan that matches their Medicare plan choice. And this process only applies to the prime plan because in some counties, Los Angeles, for example, there are delegated plans. So the matching only applies at the prime plan level.

Anastasia Dodson:

That was very technical. Folks may or may not be aware of what all that terminology means, but we're glad to discuss it over the next few minutes. And then, you know, we can put more information out on our website if folks would like more information about it. Next slide. Okay, questions. And Stephanie, was there anything that I missed?

Stephanie Conde:

That was good. I'm available for any questions though, because as you know Anastasia said, it's very technical in nature.

Hilary Haycock:

Yes. We have one question on what is a prime plan and sort of where are the current prime plans?

Anastasia Dodson:

Right. At a high level, the department we contract with certain plans for Medi-Cal and those plans are called prime plans because we have direct contracts with them. Some of those prime plans may contract with other plans or organizations as their delegates. And we hold those prime plans accountable for the contract requirements that are in our contracts. And then those prime plans, they may delegate some of, or all or certain types of responsibilities to their delegates, but ultimately the prime plans are held accountable for meeting the contract requirements. And Stephanie, is there more you want to add about enrollment maybe for delegates?

Stephanie Conde:

Oh, sure. Yeah. For our delegates the normal process a little bit different, they do fill out the choice packet or call health care options and select the plan that they would like. And if it is a sub or a delegate, not the primary plan, that enrollment file will go to that primary plan to put them into to the delegate. So since we have our contracts with our primary plans, we require those primary plans to enroll them from a system standpoint. So again, very, very technical, but it's on the primary plan to ensure enrollment into our delicate plans. Right.

Anastasia Dodson:

So as we will see, again, proposed changes as far as the D-SNP requirement in our trailer bill language to require all health plans to stand up a D-SNP, one of the things that we'll need to work out is when someone... Because we've described our current process, but then in the future, when someone selects a particular plan for their D-SNP starting in 2023, then what will the state do so that we achieve our aligned enrollment goal? Which is to have the beneficiary enrolled in the same plan for their Medicare and their Medi-Cal benefits.

Anastasia Dodson:

And we have... I believe we talked briefly about this at a prior meeting, but again, when we look at other states, and it seems that the Medicare choice, because that is more of the sort of dominant delivery system for many beneficiaries, that's where we think the Medicare choice should drive the Medi-Cal choice. And that's reflected in our current policy. But in the coming months, we'll work with all of you to see is there any... Are there any exceptions? Are there any conditions? Are there any pieces to this that we need to consider further? And we do need to, just in order to make sure that we have everything properly set up for 2023, we need to land on that pretty soon, but we wanted to start the conversation today just by clarifying what our existing policy is.

Hilary Haycock:

So there's a question in the chat that if a member chooses a D-SNP of a subcontracted Medi-Cal plan, they wouldn't be matched to that sub contracted Medi-Cal plan? Can you cue from that, Stephanie?

Stephanie Conde:

Yeah, no one of what Anastasia just said for the futuristic policy, for our policy into the 23 world, that's one of the considerations. And so we're looking forward to... There would be matching, there would be an alignment, and we would have to ensure that alignment and with our sub plans, whether it be a Medicare or Medicaid sub, but we have to hear your thoughts on the policy before we can ensure that. So there would be alignment it's just kind of from, as Anastasia mentioned, the backend, how we ensure that with that primary plan.

Hilary Haycock:

So there's the question about if a member is enrolled in an MA plan and becomes a dual, but their MA plan does not participate in Medi-Cal, how does the matching plan policy apply to them if at all?

Anastasia Dodson:

Right, there's a gap there. So that's why it... And not to get too technical, but in our trailer bill language, we're proposing that we not allow new enrollment or new D-SNPs in a year prior to the year of aligned enrollment. And so that we... Because we do as a state policy, want to have that aligned enrollment. And if the Medicare plan is not affiliated with a Medi-Cal plan, then we can't get that aligned enrollment. So we want to give really good choices to dually eligible beneficiaries because we know that they very often have many chronic conditions are high utilizers of LTSS, many factors, social determinants of health that our Medi-Cal plans can address. And so we want to get that aligned enrollment so that both, all of the benefits are provided through the same organization and there's coordinated care. And so that is why our policy will be to stop new enrollment in D-SNPs that are not affiliated with a Medi-Cal plan.

Hilary Haycock:

So I think your answer kind of just answered this. So there's a question about if there's a limited number of Medi-Cal plans available in each county, so will that limit the Medicare choice for beneficiaries?

Anastasia Dodson:

So again, enrollment in a Medicare plan of any kind is always voluntary. We have always... There's Medicare advantage traces that are not D-SNPs that are available to beneficiaries, but as far as D-SNPs go, since the state has the authority to decide who to contract with for D-SNP contracts, that's where we're saying, we want to have a focused policy on aligned enrollment. There are other options as well. There's pace in some areas there's scan in other areas, but as far as D-SNPs, we want to have an aligned enrollment strategy that will provide integrated care that will allow data sharing between both the Medicare and the Medi-Cal sides, care coordination provides the right incentives for looking at the care that best meets the needs of the beneficiaries and leverages the wonderful opportunities through our home and community-based services network in California.

Anastasia Dodson:

And I see there's a comment in there about counties without D-SNPs. And so that is our work. In the work of our Medi-Cal managed care plans in the coming years is to stand up D-SNPs and for all of us to work together, to make sure that there are good options for aligned care so that we can... And make that clear to beneficiaries and their families and caregivers. So whether, and that's, of course, it's going to be intensive partnership with HICAP and with community organizations so that... All of us on this call, we're talking very technical terminology, but when it comes to beneficiaries and their family is spending, many of them are juggling a lot of concerns and needs, and we want to make it clear what the benefits are in each plan. If there are more than one Medi-Cal plan, what types of benefits are available? And on the Medicare side, what are the benefits that are available through the different options there so that people have a good choice.

Hilary Haycock:

Great. We are getting a lot of questions and comments coming in, and unfortunately we were not going to be able to answer them all since we are wrapping up here. But there is one comment just that we need new D-SNPs. This is an access issue for Medicare beneficiaries. So to Anastasia, comment on that. Yeah.

Anastasia Dodson:

So we'll look forward to further discussions about this, and I'm sorry to jam so much into one meeting, but we want to keep balancing the importance of talking about integrated care and, what does it actually mean for populations with dementia or Alzheimer's, screenings thinking about ways that the clinical guidelines can be incorporated. And then also on the other hand, looking at our enrollment issues, because those are important for us to get right, and talk with you all about as well.

Anastasia Dodson:

So for future meetings, you can see, we have enrollment policies, and the order of the bullets here on this slide doesn't necessarily mean that's the order of how that will take in the next meetings. Because I think we will need to kind of balance both types of topics, but we want to talk about care coordination, lessons learned from Cal MediConnect, beneficiary communications, data sharing, quality reporting, the actual transition for Cal MediConnect beneficiaries and continued discussion about enrollment policies.

Anastasia Dodson:

There's more than just these topics, but these are kind of the big categories. You know, behavioral health of course is another important topic we heard. There was some good chatter on the chat box today about IHSS and how we can strengthen those partnerships again between counties and health plans and how to communicate around the available benefits of IHSS. So we will keep working on having good discussions here and putting out FAQ's and other documents on the webpage.

Hilary Haycock:

No problem. Thank you so much Anastasia, and a huge thank you to all of our panelists, everyone for sticking through with us for a two hour webinar. But I think it was a wonderful conversation. We have saved all of the questions and chats that we were not able to get to you. So please know that we were taking that information back and the department will be using it and looking at it and your input is valued. And we look forward to seeing everybody at our next meeting in June. Thank you so much and have a great rest of your afternoon. Okay.