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MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Department of Health Care Services
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SPEAKERS

Hilary Haycock
Anastasia Dodson
Nils Franco
Allison Rizer
Dr. Sohrab Sidhu

Hilary Haycock:

Good morning and welcome to today's CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup. We're going to go ahead and get started, just a little bit of meeting management. We have some wonderful presenters with us today. As always, we're joined by Anastasia Dodson, Deputy Director of the Office of Medicare Innovation and Integration at DHCS. ATI advisory is going to be joining us to share a Data Chartbook, that's very exciting, so we've got Allison Rizer and Nils Franco from ATI. And then we'll be also joined as well by Dr. Sohrab Sidhu, the Medical Quality Officer with the Office of Medical Director and Quality and Population Health Management at DHCS to share some updates as well.

Hilary Haycock:

So just as a reminder, participants will be on mute during the presentations. So please feel free to use the chat feature to submit any questions or comments you might have during the presentations. And then when we reach the discussion portion of the morning, you can use the raise hand function and we'll be happy to unmute you, or you can continue to use the chat, and we'll be monitoring and responding to that throughout the day. All of the PowerPoint slides and meeting materials are available on the CalAIM website, and you can find a link to those materials in the zoom chat.

Hilary Haycock:

So, we'll be posting that periodically. All right, we are asking folks if they can add their organization name to their zoom name so that it appears when you chat or raise your hand, so we kind of have a sense of where people are commenting from. So, click on the participant's icon at the bottom of the window, hover over your name, click more, and then rename from the dropdown menu and you can update your name and organization.

Hilary Haycock:

So, today's agenda. As I mentioned, we're going to start with the DHCS Medicare Chartbook presentation. We've got a long meeting today, so we'll take a little break. And then when we come back, we're going to have an update on the DHCS Long-Term Care Carve-In Benefit Workgroup. We're going to hear an update on the Dementia Aware Program, and we're going to have a presentation on the proposed 2023 State-Specific Reporting Requirements for Exclusively Aligned Enrollment, Dual Eligible Special Needs Plans (D-SNPs). And we'll have some Breakout Sessions and Report Outs as a part of that last segment, so please stick with us for that. We're excited to have a conversation with you about that. All right, so then that is our morning. And with that, I'm going to transition over to Anastasia to start us off. Thanks so much.

Anastasia Dodson:

Thank you so much Hilary, and welcome everyone. Really glad to have you all here. As you know, this is our regular monthly group meeting, and we're going to have a special presentation in the beginning. But just a reminder, our workgroup purpose and structure

here is around the CalAIM Initiatives and for Managed Long-Term Services and Supports and Integrated Care for Dual Eligible beneficiaries. We use this forum as a way to collaborate with all of you on the elements of CalAIM around the D-SNP transition and the transition of Cal MediConnect as well as other related initiatives in CalAIM. And you'll see, we've added a couple of things on the agenda here that updates on some other areas that are not just about D-SNPs.

Anastasia Dodson:

We've got a charter and we really appreciate our partnership with all of you plans, providers, advocates, beneficiaries, caregivers, CMS, of course, we're always glad to have as well. And so next slide. Okay, so the first thing we're going to dive into is an overview of the Medicare Chartbook that was recently published on the DHCS website. It's called "Profile of the California Medicare Population". And we're so pleased to have our partners ATI here. They're going to be presenting the chartbook, but it is available on the DHCS website. There's a page on the DHCS website for the office of Medicare innovation and integration. Go ahead to the next slide.

Anastasia Dodson:

And this chartbook you'll see has wonderful information. We know that all of you, there's sort of a variety of familiarity that you may have with how does Medicare work, Medicare Advantage, et cetera. So, we're going to proceed, present this. But we encourage you to look at the website for the Office of Medicare Innovation and Integration. If you have questions that are sort of key questions about how Medicare Advantage is different from Original Medicare, et cetera, we've got links there on that DHCS webpage. And then a special thanks to the SCAN Foundation, which is supporting this work with a grant and has been also a very important partner with us on this. And we're going to have questions and opportunity for dialogue, but we're going to start with the presentation. So, with that, I will turn it over to the ATI team. I believe Allison is going to be presenting and look forward to hearing your questions.

Allison Rizer:

Thank you, Anastasia. I will just very briefly kick us off before handing it over to Nils Franco. Allison Rizer with ATI Advisory, we are incredibly appreciative and excited to be a part of this partnership with the SCAN Foundation and DHCS and OMII to build out some really important data analytics. This is the first of many, and we're looking forward to the conversation today. So, Nils, I will actually turn it over to you to walk us through the data analytics. Nils was the lead Data Analyst on this project.

Nils Franco:

Thank you, Allison. Thank you all for joining us today. We designed this Chartbook to be informative to stakeholders like yourselves about the Medicare population in California, and to look at intersections between common Medicare program elements and Medi-Cal program within California. So just to kick us off, I want to do a couple of key definitions and describe some of our data sources. Largely in this Chartbook we were looking at and analyzing the Medicare Beneficiary Summary File and using March 2021

as our reporting period. So, when we describe the prevalence of a certain characteristic, it tends to describe that characteristic as of March 2021 in 100% of Medicare beneficiaries in California. So, this is a 100% extract of an administrative record set from the Centers for Medicare and Medicaid services that ATI advisory licenses. Another source, and it's used in just one slide, and I'll call it out, is the Medicare Monthly Enrollment file, which ATI advisory analyzed through October 2021.

Nils Franco:

And I'll again, point that out and that is the public use file. Now, as far as definitions go, when we talk about Medicare Advantage in this data book, and also in these slides, we're referring not only to the regular Medicare Advantage plans, those private insurance options within Medicare, but also other programs that fall under the Medicare Advantage umbrella, such as Special Needs Plans, Cal MediConnect and the PACE organizations within California. Now, one data note here that we should make is about the demographic characteristics that we describe and specifically race and ethnicity, and the variable for sex that are available in the centers for Medicare and Medicaid services data, are based on federal definitions that may vary from DHCS's own definitions. And indeed ethnicity, specifically Hispanic ethnicity is actually inferred by an algorithm.

Nils Franco:

Next slide, we'll be discussing just in one of the crucial data definitions here, which we'll use again and again, we describe Rurality. So, three different categories of Rurality, and that is at the county level within the state. And we used a definition based on the Medicare Advantage program rule, and specifically the section about network adequacy, designating county types, according to the likely availability of health services and healthcare providers in the area. And this is defined by the county's population and population density. And essentially here, we have a map and a table that describes how we're defining urban, suburban, and rural in this report and also in these slides, according to that rule. And so, the rule has five definitions, Large Metro, Metro, Micro, and Rural, as well as counties with extreme access considerations. And we break these down so that urban in this report, describes the 34 counties in California that were designated Large Metro or Metro, and Suburban in this report describes the 10 counties that were deemed Micro or Micropolitan.

Nils Franco:

And then the Rural designation in this report and in these slides, lastly just describes the remaining 14 counties that were either deemed rural, or to be Counties with Extreme Access Considerations. So, the rural areas here on this slide are those counties in a purplish pink, the light blue is Suburban, and the darker blue is Urban. So, when we describe Urban, Suburban, and Rural, these are the counties of residents that we're talking about in those contexts. And so, on the next slide, we'll move into the data and start describing in a couple of succinct ways, the demographics, the geographic breakdowns, and the program enrollment breakdowns for this larger California Medicare population. And so, we'll start with this next slide about the key findings. And so, up top we have the key findings regarding demography and geography. So, using these

administrative data about 100% of Medicare beneficiaries in the state, we found that 1 in 10 Californians with Medicare were under age 65 and 2 in 3 were white beneficiaries.

Nils Franco:

1 in 2 lived in suburban or rural areas as we just described. With regard to program enrollment, 1 in 2 Californians with Medicare were specifically enrolled in Medicare Advantage as we described earlier. And 1 in 5 had full Medi-Cal coverage in addition to their Medicare benefits. And so, they were dual beneficiaries of both Medicare and Medi-Cal and had some coverage interactions that are able to be particularly influenced by state governance and state policies. Lastly, the intersection between Medicare Advantage and Medi-Cal, 1 in 10 Californians with Medicare had both of these programs, both Medicare Advantage and Medi-Cal benefits. So dual beneficiaries with Medicare Advantage make up 1 in 10 of all Medicare beneficiaries in the state. On the next slide, we'll start diving into a sequence of pie charts that describe the overall Medicare beneficiaries in the state, by these demographics and other characteristics.

Nils Franco:

So, to begin with, we just mentioned that 1 in 10 Medicare beneficiaries in California were under age 65, here we see specifically that's 11%. Then the next oldest group ages 65 to 79 made up 68% or about 7 in 10 state Medicare beneficiaries. And then the oldest group ages 80 and up make up 21% or about 2 in 10 Medicare beneficiaries in California, and this is as of March 2021, as we discussed. On the next slide, we break it down by race and ethnicity. And so again, we mentioned that there are some nuances to how these categories are defined in DHCS as a category would be defined. But what we see is that 2 in 3 are 66% of California's Medicare beneficiaries are white, and 10% of those Medicare beneficiaries are Asian beneficiaries. 8% are Hispanic beneficiaries, 6% are black beneficiaries, 0.3%, 0.3% were American Indian, Alaska native, and a remaining 9% were other or unknown, so not specified by the CMS data available.

Nils Franco:

Now you note that most Medicare beneficiaries in the state are white, but it's worth noting that this majority is in fact, a smaller portion of Medicare beneficiaries within the state. Then you see white beneficiaries making up among the Medicare population nationwide. And so, I think that's an important point that it's 66% of California's Medicare beneficiaries who are white, and nationwide it's something like 75% of all Medicare beneficiaries who are white. On the next slide we'll break it down by…And very briefly I'll mention that 54% of all Medicare beneficiaries in California are female, which means that 17% more female Medicare beneficiaries live in the state than do males. And so, what I mean by this is that essentially for every five male Medicare beneficiaries in California, there would be about six female Medicare beneficiaries in the state.

Nils Franco:

This has some interaction with life expectancy differences between the two genders and so forth. And so next I'll describe the same composition, but by County Rurality. So, the Medicare beneficiaries in the state are overwhelmingly in those 34 out of the 58

California counties that were deemed urban, so Large Metro or metropolitan areas, according to the Medicare Advantage program rule. And just 4% live in the 10 suburban counties and merely 1 in 100, 1% of Californians with Medicare live in those 14 rural counties, which have particular access considerations regarding health services and healthcare professionals. On the next slide, we'll describe the program enrollment, and then up next will be Medi-Cal, but this one is Medicare Advantage. So, a Medicare beneficiary is going to either be in traditional fee for service Medicare or be in Medicare Advantage. And what we see is that it's a pretty even split, about one half of California's Medicare beneficiaries had Medicare Advantage, 48%. While the other half had fee for service Medicare.

Nils Franco:

For this chart book again, Medicare Advantage includes not only the regular Medicare Advantage plans, but also Special Needs plans, Cal MediConnect, and PACE organizations. On the next slide we'll describe Medi-Cal enrollment or dual eligibility. And so, among California's Medicare population, about 22% of the Medicare beneficiaries also have full Medi-Cal benefits that's between one and five and one and four. And then the compliment of that, the converse 78% were Medicare only. And so again, this is a pie describing Medicare beneficiaries, and then whether they had Medi-Cal or not, and here non-Dual means Medicare only non-Duals. Moving on to the next slide. We're going to switch sections now to describe the share of Medicare beneficiaries who are enrolled in Medi-Cal, or in the national context, enrolled in Medicaid, Medi-Cal being the state's Medicaid program. And another term for this is dual eligibility, so the dual eligibility rate in the state. The next slide, and we view this just a moment ago, breakdown of different geographies within the state and within the U.S. overall, and the dual eligibility rate for each of those areas.

Nils Franco:

And so, we just discussed that about 22% of overall Medicare beneficiaries in California have Medi-Cal, as well as Medicare benefits. You see that here in the fourth bar from the left, the overall California bar, and then each of the different subsidiary areas, Rural, Suburban, and Urban in California are the other three bars to the left of that one. And then we have the same for the U.S. on the right side of the overall table here. This figure, there's a couple things, and I'll just briefly describe them. One is that in California, rural areas have a markedly lower Medi-Cal eligibility rate among Medicare beneficiaries than the overall rate. And so, this is interesting in particular, when we compare this to the U.S. dynamic, where rural areas tend to have higher rates of Medi-Cal eligibility and enrollment than the suburban and urban areas. The highest dual eligibility rate is seen in those suburban counties, those 10 suburban counties.

Nils Franco:

But what we see overall is that across geographies, whether it's Rural, Suburban, or Urban, Californians with Medicare are more likely to be dually eligible for Medi-Cal than Medicare beneficiaries nationwide in those same areas are likely to be dually eligible for Medicaid. This interacts with both the state's own criteria for eligibility with Medi-Cal, but there are also factors like the actual underlying populations income or assets, right? So,

states may vary in both the population's income and assets, and then also vary in terms of how they define medical eligibility based on each income and asset variable.

Nils Franco:

On the next slide, we'll describe the Medi-Cal eligibility rate among Medicare beneficiaries by race and ethnic group. And so, what we see immediately is that there's wide variation that the overall rate of Medi-Cal eligibility sort of doesn't tell us this story. That for example, there's more than twice as high dual eligibility rate in the Hispanic Medicare population in California, than in the overall Medicare population in California. And you can see a wide variation between these five different categories, which again are defined by CMS's own administrative data.

Nils Franco:

On the next slide we'll describe the Medi-Cal eligibility rate among Medicare beneficiaries by age group. And so here you see that there's again, a large variation seen by age group, and in particular dual eligibility in California is more than twice as common among under age 65 Medicare beneficiaries than among Medicare beneficiaries overall. The lowest rate is for the middle age group of age 65 to 79.

Nils Franco:

On the next slide, we're going to describe now a more complicated scenario where we've got grouped bars and each group is going to be a different age group. And you can recognize maybe the number from the prior slide is seen here in the right most bar of that age group. So, 55% of age under 65 beneficiaries overall had Medi-Cal in March of 2021, 17% for age 65 to 79 and 21% for age 80 plus.

Nils Franco:

Now, what we see is that some racial and ethnic differences really lessened for that under age 65 group, and then widen for the over age 80 group of Medicare beneficiaries. And so, for example, just to take one example point here, the overall Medicare population under age 65, has almost an identical dual eligibility rate as the Asian Medicare beneficiaries under age 65 in California, both of those are 55%. And then it's almost twice as high a dual eligibility rate for the middle-aged group, age 65 to 79, for the Asian beneficiaries versus overall. And then it's almost three times as high for Asian beneficiaries versus overall a dual eligibility rate among Medicare beneficiaries. And so, this example goes to show a larger dynamic here that it's true more generally, that racial and ethnic differences are much lessened in the under 65 group in terms of the propensity to be in Medi-Cal, if you're in Medicare, and then widen for that age 80 plus group.

Nils Franco:

On the next slide we'll move on to Medicare Advantage. And here we're going to talk about the Medicare Advantage penetration rate, which is to say the share of Medicare beneficiaries who are enrolled in Medicare Advantage, and as we discussed, related programs such as Special Needs Plans, Cal MediConnect, and the PACE organizations

around California. So, we'll dive right in on the next slide. So very briefly, I think that it's worth noting that when you look at just the overall state of affairs, California's Medicare Advantage penetration rate is higher than the U.S. average as of March 2021. 48% of California's Medicare beneficiaries had Medicare Advantage. Whereas 43%, a lower rate of overall U.S. Medicare beneficiaries had Medicare Advantage. Now that high statewide rate seen in California actually hides some differences in uptake, and in particular lower uptake of Medicare Advantage in rural areas and amongst certain demographic groups. And we'll dive right in here with the next slide to just sort of key everything off.

Nils Franco:

I want to highlight something, and this is the slide that I mentioned earlier, is based on multiple years of a public use file called the Medicare Monthly Enrollment file. And what it shows us is the enrollment of Californians in the Medicare program overall, and then by specific subsidiary programs. So, in particular, the bottom section here that you see growing over time from 2016 through 2021 is Medicare Advantage beneficiaries in California. And then the top two sections which are colored blue, are the Fee-for-Service Medicare beneficiaries. And I'll just bring your attention to one item here, which is that while this population, the Medicare population overall, the total size of the colored area in this chart has been growing consistently over time. The Medicare Advantage population really is the component that's driving that change. And even in recent years, the fee for service Medicare population in California has been receding in size, has been shrinking. And the Medicare Advantage population has been growing during that same time.

Nils Franco:

Now, this suggests that the Medicare Advantage program is capturing recent growth in California's Medicare population. And now looking from the start of this time period to the end, 2016 to 2021, California's Medicare population has grown 11%. That's faster growth than the state's overall population.

Nils Franco:

On the next slide, we'll start breaking down Medicare Advantage penetration rates by different geographic areas within California and in comparison, to the U.S. With the California side being the left side of four bars in this chart describing rural California counties, suburban Californian counties, urban California counties, and then in a different color, the lighter blue, overall California Medicare Advantage penetration rate. And what you see very distinctly is that the MA penetration rate, the Medicare Advantage penetration rate, falls off very quickly when outside of urban counties which have about almost exactly 1 in 2 Medicare beneficiaries being enrolled in a Medicare Advantage plan. There's just 1 in 17 rural beneficiaries in California, who are enrolled in a Medicare Advantage plan. And so, what's particularly interesting is then we said, "Okay, well how does this compare to the United States at large?" And the answer was it's very starkly different.

Nils Franco:

The rural counties in California are defined in the same way that rural counties are in the U.S. overall. But the Medicare Advantage penetration rate and rural counties overall in the U.S. is five times as high as the Medicare Advantage penetration rate in rural counties in California. And you can see that there's not that precipitous decline in Medicare advantage between Urban and Suburban and Rural in the U.S. overall, that you see in California specifically. So just to go back to the top line figure here, while there's 48% Medicare Advantage penetration rate in California being higher than the U.S. average, this varies a lot by whether you reside in a rural county or a suburban county or an urban county.

Nils Franco:

And now I'll move to the next slide where we look at Medicare Advantage penetration rates between different racial and ethnic groups. And in particular here, we look at the overall rate of Medicare Advantage penetration for Rural, Suburban and Urban counties. And then we look at the highest and lowest MA penetration rate for biracial and ethnic category as defined by CMS. And so, in rural areas, for example, on the left-hand side, you see that the highest racial and ethnic groups, Medicare Advantage penetration rate was 8% for Black beneficiaries in rural areas. The lowest was 3% for Hispanic beneficiaries in rural areas. And then the overall was 6%. And what you can see is that consistently across Rural, Suburban, and Urban, the highest Medicare Advantage enrollment rates were seen among Black beneficiaries across all of these geographies. And I think that that's just worth noting. And then we have more complete data about this I will just note in the chartbook, if you're curious to dig in deeper and see other racial and ethnic groups that we weren't able to fit into this presentation slide. Now, I'll move on to the next slide. But here very simply we look at age groups differences in the Medicare Advantage penetration rate in California. And so, for those who were ages under 65 and enrolled in Medicare in California, 35% were enrolled in Medicare Advantage specifically, leaving about two in three under age 65 Medicare beneficiaries enrolled in fee-for service Medicare.

Nils Franco:

And then very briefly, about one half of both the 65 to 79 group, and the 80 plus group in terms of age, were Medicare Advantage and released among the Medicare beneficiaries. So, Medicare Advantage enrollment in summary, is far less common among the under 65 age group of Medicare beneficiaries in California, than among the 65 and up age group in California. Next slide, please. Here we have the Medicare Advantage penetration rate, but for those who are dually in Medicare and Medi-Cal, and those who are Medicare only beneficiaries in California, none in the United States.

Nils Franco:

Obviously in the United States it's dually Medicare and Medicaid, because Medi-Cal is California specific. So top-line takeaway here is that California's dual Medicare, Medi-Cal beneficiaries, enroll in Medicare advantage much less often than Medicare only beneficiaries. This is quite contrary to the dynamic that you see in the United States overall. In the United States overall, dual Medicare, Medicaid beneficiaries are

substantially more likely to be enrolled in Medicare Advantage than those Medicare beneficiaries who are not Medicaid enrolled or eligible.

Nils Franco:

And so, this is just to say that targeting programs that look at Medi-Cal, Medicare intersections through Medicare Advantage, will reach about two in five, 43% of California's dual Medicare Medi-Cal beneficiaries. And would not reach about three in five, about 57% of California's dual Medicare, Medi-Cal beneficiaries in California who are in fee-for-service Medicare. I apologize for a little bit of a tongue twister there. And on the next slide I'll just move forward. We're going to know just close out with the summary and some next steps, and I'll pass it back to Allison and then to Anastasia.

Nils Franco:

But this next slide has some of our top line items here. So, you'll recall that we saw an 11% growth in the state's Medicare population, in California's Medicare population, from 2016 to 2021. And that this was captured by Medicare Advantage in particular with recent years seeing an actual decline in the number of fee-for-service Medicare beneficiaries in the state, while Medicare Advantage increased. Among California's Medicare beneficiaries, 2 in 10 were ages 80 plus, 21%. 1 in 10 were ages under 65, 11%, and 54% were female, 95% lived in urban counties as defined by access to providers using the Medicare Advantage program rules, federal classification of counties.

Nils Franco:

48% of California's Medicare beneficiaries had Medicare Advantage, which was higher than the national average. And 22% had Medi-Cal, full Medi-Cal benefits, or in another way of saying it, were dual beneficiaries. That's again, higher than the national average. But as we pointed out, these top line figures for Medicare Advantage penetration and for dual Medi-Cal enrollment, varied greatly between geography, between demographics. When you interact the two programs of Medicare Advantage and Medi-Cal, there's large differences in uptake between important characteristics of Medicare beneficiaries in the state.

Nils Franco:

So, closing out really quickly, and then I'll hand it back to Allison. We have a full set of analyses available in a chart book that was recently published by the California Office of Medicare Innovation and Integration. It's available here and at the Office of Medicare Innovation and Integration website. And we definitely encourage that if this piqued your curiosity, that you take a look at those more detailed offerings of drafts and data, including some summary tables in the appendices. And if you're curious about some of the definitions or data sources, we have additional information there. So, with that, I'll close out. Thank you all for listening and for your time. And I'll hand it over to Allison.

Allison Rizer:

Thank you, Nils. And thank you, to everyone for some of the questions that are coming through. I think I'm just going to make a few initial comments and respond to some of these questions that are coming through, and then Anastasia, turn it back to you. But I think a few points here that this is the first of a number of analytics that are going to be coming out of this effort and this office. This really sets the groundwork to some of the questions that are coming in are really important questions about kind of the next level of analytics. So, really love seeing them.

Allison Rizer:

I think I want to address counties; I saw that come through in a lot of questions while Nils was presenting. This particular set of analytics occurred at the county level and is not pointed out. And you see the hyperlink here, the chartbook provides a little bit more granularity at that county level. There are other analytic opportunities that can go more granular than county. This particular data source only goes to the county level. Eve had a question about the homeless population and data around sources of coverage. For example, beyond just Medi-Cal in the under 65 population.

Allison Rizer:

Again, this particular data set is a CMS specific data set. And so, what we have accessed through this data set is, are you dually eligible for Medi-Cal? And what type of dual eligible status do you have? This particular data set does not have other source of an insurance coverage moving in. However, there are survey data sets that we're also going to be working with that will allow for some more of that sort of richness around what are some of the other sources of coverage that individuals might have access to.

Allison Rizer:

And then, one other question that I think was partially answered in the response already, but there was a question about D-SNP, versus Dual-Eligible Special Needs Plans, versus Medicare Advantage. So, if you think about Medicare Advantage as sort of this umbrella program, there are different types of Medicare Advantage plans, one of which are in a bucket called Special Needs Plans. Special Needs Plans are limited to specific individuals who qualify based on condition. If it's a chronic condition special needs plan, in this case, Dual-Eligible Special Needs plan, or D-SNP, individuals qualify based on being dually eligible for Medi-Cal and it's instant.

Allison Rizer:

So, I think that was a lot of the questions that came through. I'm going to pause and Anastasia, I think turn it back to you, or Hilary to see if there are other questions or comments on this section.

Anastasia Dodson:

Yeah, just one other thing framing this, because again, we've been meeting monthly with all of you and talking primarily about D-SNPs and Cal MediConnect and the transition there. And that this is a broader population in California. The 6.5 million ballpark Medicare beneficiaries. And then of those, it's the 1.6 or so million, that are

duals that we have been talking about in this work group. So again, this is a much broader population, but really important to look at and to consider, because the policies are interrelated for duals and Medicare only folks.

Anastasia Dodson:

And the charge, the assignment for the DHCS Office of Medicare Innovation and Integration, is to look more broadly not just at dual eligibles, but at Medicare only beneficiaries as well. So, we're very excited to have this initial document published and this presentation. And in addition to what we have on the DHCS website, the chartbook, and these slides, our California Health and Human Services, open data portal. Also, we're going to be uploading data files there so that if you all want to dive even deeper into the data, you'll be able to manipulate it and kind of go down to particular areas.

Anastasia Dodson:

So, with that, Hilary, could you help us with maybe questions verbally or any other online questions we may not have gotten to yet?

Hilary Haycock:

Yeah, absolutely. So as a reminder, if folks want to ask a question, you are welcome to raise your hand at this point and we will recognize you. We've seen a couple of questions in the chat pop up. One is about the time period of this analysis includes COVID-19 pandemic? And sort of wondering if one of the increases in the growth rate of persons with disability might be related to long COVID.

Allison Rizer:

I can take that and certainly welcome Anastasia if you want to add into this. I think there is potentially a COVID impact in terms of increasing dual eligibility nationwide. And that just is a consequence of Medicaid eligibility recertification kind of being paused during the public health emergency. Specific to disability though, it should increase Medicare eligibility because there is a 24 to 25 month waiting period that we're not necessarily going to be picking up here. So, I think it's a really good question generally about the COVID impact, and Medicaid eligibility and Medi-Cal eligibility, but I don't think it's going to have a direct impact on Medicare beneficiaries.

Hilary Haycock:

That's helpful. Great. Rick.

Automated Voice:

Zoom meeting.

Rick Hodgkins:

Yes. Well, two things real quick. One, so the D-SNPs are different from the Medicare Advantage plans, correct? And also, is it true that if I choose a D-SNP, will it be only

restricted to my county? And also, will it only work... Is it true that I can only receive care in my county? Because keep in mind, I see specialists all over.

Anastasia Dodson:

Yeah. D-SNP is a type of Medicare Advantage plan and in California, for dual eligible beneficiaries it's voluntary. So, dual eligibles can choose whether or not they want to enroll into a D-SNP, and that's true in Sacramento County and every other county in California. In Sacramento County, that is not one of our CCI counties. So, Cal MediConnect is only in the seven CCI counties. And in this transition from Cal MediConnect to D-SNP Aligned Enrollment that we've been talking about, that's only in those CCI counties for 2023.

Anastasia Dodson:

So, Medicare has rules about the enrollment timelines as to when people can enroll into a Medicare Advantage plans. They set those rules, and in Sacramento and every other county, it's the same rules of there's a certain quarterly time period and annual sort of election process. Again, those are the Medicare rules. And Rick, does that answer your questions or anything else that you had a question about?

Rick Hodgkins:

I was also wondering that if I choose a D-SNP plan, are there only certain plans available in certain counties?

Anastasia Dodson:

Right. Yeah, that's correct. So, each county and sometimes even different areas within a county, will have certain Medicare Advantage and D-SNP plans available either for duals or for Medicare only beneficiaries. And then Tatiana, has reminded us very helpful the HICAP programs in each county. They can help individuals decide and get information about what plans are available both for Medicare Advantage, D-SNPs, as well as Part D plans.

Rick Hodgkins:

If that's the case though, would I still be able to access the specialist I currently have elsewhere of like cross claiming?

Anastasia Dodson:

Yeah. So, we're not able to provide information for individuals on this work group, but the HICAP program can meet with any individual that is either already eligible for Medicare or potentially eligible and give them information about the enrollment options that they have in their particular zip code and county. And then, they can help look at the provider networks across the different Medicare plans.

Rick Hodgkins:

All right. Because I thought being in a D-SNP would help alleviate the issues I have, I guess not.

Anastasia Dodson:

I think it's an individual decision and so would definitely encourage you to, if you're considering enrolling in a D-SNP, then you can talk to HICAP, and they can advise you as to how to look at the providers there. But again, it's all voluntary in California for duals as to whether or not to enroll in a D-SNP.

Rick Hodgkins:

All right. Thanks.

Anastasia Dodson:

Thank you.

Hilary Haycock:

Yeah. And Tatiana helpfully dropped the HICAP phone number in the chat. We're now looking at the steps and plan networks. And there's a link as well. I think the only other question that's come up... Oh, we've got Octavio Cortez. I see your hand. Here we go.

Octavio Cortez:

Yeah. Thank you. So, I'm barely kind of getting my feet wet with all this new information, but I'm not in one of those six or seven counties that you mentioned that are going to transition over to the D-SNPs. Once they are transitioned over, do they have the option to disenroll and just stick with original Medicare as they are now?

Anastasia Dodson:

Yes, that's an option now and will continue to be an option. And that's across the state. It's a voluntary enrollment process for Medicare only folks and for dual eligibles, whether or not they want to enroll in any type up of Medicare Advantage plan. And really for that matter, PACE, Cal MediConnect, SCAN FIDE SNP, all of it is all voluntary. And there's certain windows again, that CMS Medicare sets for enrollment based on the time of year. And then, a certain effective date based on that time of year.

Anastasia Dodson:

But again, it's all voluntary. And Cal MediConnect is actually more frequent opportunities to enroll and disenroll. But in general, the CMS Medicare roles drive the time periods that you can enroll.

Octavio Cortez:

Thank you.

Hilary Haycock:

Tatiana.

Tatiana Fassieux:

Hi. Thank you, for letting me ask a question. These charts are just fantastic. Is there a plan to incorporate or project the impact of the increased asset limits that will be effective July 1 and subsequent into 2024?

Anastasia Dodson:

Thanks, Tatiana. That's a great point. We don't have a sort of integrated chart at this point in time to connect with these charts. And in our budget, in our Medi-Cal estimate, which I know is a very technical document, but it posted on the DHCS website. And it does have certain assumptions about the dollars, et cetera, there, but in caseload. And in case just to remind everyone, in case you're not tracking this, we have a change in Medi-Cal policy. That will be upcoming in the middle of this calendar year in 2022, where the Medi-Cal asset test is going to change. And the amount of assets that an individual is allowed to have and be eligible for Medi-Cal will increase.

Anastasia Dodson:

And then in future years, the asset limit will be going away entirely. But in 2022, it will be substantially increased. And that will change the number of people who are eligible for Medi-Cal, and specifically the number of people who are dually eligible for Medicare and Medi-Cal. But sorry, short answer, we don't have a sort of integrated estimate between these charts, it's just what we have in our Medi-Cal estimate.

Hilary Haycock:

Great. Thank you. All right, Susan LaPadula.

Susan LaPadula:

Good morning. Thank you for this wonderful presentation. I have a question. Will this data be utilized to help us move forward in automation of the Medicare coinsurance claims for the health plans and the exclusively aligned enrolled D-SNPs?

Anastasia Dodson:

That's a policy that we're tracking and thinking about very actively and looking at all the options. This data is helpful, but a lot of times the data that we need more kind of real time, or if not real time, more sort of ongoing data flows on an operational basis, to make those kinds of policy changes. This data is just a snapshot point in time. And I think Allison, maybe you can comment on what is the sort of lag time or timeline between when a claim or an encounter is processed, versus how does it get into the data sources that you have? And there's probably a cleanup process on the data as well. So, I don't know, Allison.

Allison Rizer:

Yeah, I mean, just a quick reaction to that. We, right now I believe, are expecting Q3 of 2021 to be made available by a CMS. So, to give you all an understanding, what is that that ends up being at least a six-month lag, typically more of like a nine-month lag.

Between when we can pull at least some of these data and present them. And that's the beneficiary demographic detail and all of the enrollment information that Nils was presenting on claims data and a fee for service environment encounters. Anastasia mentioned encounters. There's even more of a data lag on encounters.

Allison Rizer:

Those are the data points that Medicare Advantage plans themselves essentially are getting to CMS. So, we do have to account for that lag. That said, there are some things that are immediately available, like CMS is really fantastic at publishing money enrollment in Medicare Advantage and D-SNPs. So, there are certainly some things that we can be real time on. But in the context of that broader policy question that was asked, there really is typically this sort of nine-month timeline.

Hilary Haycock:

Great, thanks. That's helpful. There was a question in the chat from Judy Mackey, about D-SNPs offering separate medication lists. And I got an answer from someone else in the chat, but just wanted to highlight that here that, D-SNPs, and in addition to having their own provider networks, also have their own formularies. But those of course, must comply with Medicare Part D requirements. Yeah. I think that covers the questions that have been raised in the chat.

Anastasia Dodson:

Yeah. Thank you. Thank you again, Hilary, Allison, Nils. Again, as we are thinking about all of these populations, this information, et cetera. We're trying to build the knowledge frankly, with all of you as well. As we think about policies, we at DHCS and really, we don't have all the sort of perfect ideally answers. Of course, we partner very closely with CMS on all of this, but there are different things being done in certain states, and then there's new Medicare policy that comes out.

Anastasia Dodson:

And we try to think about what is in the best interest of Medicare beneficiaries in California, and what fits our landscape? Because as pointed out in these slides, California is not identical to the rest of the country and really probably no state is. But if we think about what policies will have what effect in California? It's really important for us to think both for Medicare only, and for duals, what are the characteristics? What is the delivery system landscape in California? Urban, rural, suburban what's going on there?

Anastasia Dodson:

So anyway, just want to really emphasize why we need to start with this type of data set. And then as we work with ATI and thanks again to the SCAN foundation and our other partners as well at CHCS, and Aurrera, thinking about then, what policy changes might there be? We're going to look at future data sets and we appreciate any feedback that you all want to send. You can send it to the CalDuals inbox of course or type it in the chat. Of how we might want to look at future data sets. And know what do we want

to encourage, or more than encourage our Medicare Advantage plans to do as far as supplemental benefits?

Anastasia Dodson:

What do we see there now? There's a lot of other interesting questions that we will be tackling and thinking about again, in sort of partnership with all of our partners and with all of you. So, your ideas and thoughts are very welcome in this area. Yeah. So, Hilary, anything else, any last call for comments or questions on the chart book?

Hilary Haycock:

It's like you might have a follow up question from Susan.

Susan LaPadula:

Yes. I just wanted to show on the healthcare delivery landscape. Our county organized health systems, our COHS, have accomplished automation of the crossover claims, and they're following the DHS rules. So, it can be done I believe.

Anastasia Dodson:

Thank you. Yes, and great. We know that that's been an issue that's come up quite a bit on these calls. And you're right. And thank you, yes.

Susan LaPadula:

Thank you.

Hilary Haycock:

All right. Tatiana has also flagged in the chat that, for folks looking for more information on Medicare, HICAPs, that you can go to CAHealthAdvocates.org for other opportunities to learn more about Medicare. Great. So, I think we are at a 10-minute break portion, and we sort of an extra-long meeting today with lots of great information. So strongly encourage folks to come back. We'll be at 10:10.

Anastasia Dodson:

Hilary, before we go, can we I think just go to that last slide. Sorry. I forgot about that one. Yeah. So that gives the links to the chart book and then the open data portal. And with this again, very interesting graphic here on Medicare Advantage enrollment and what it looks like for Medicare only beneficiaries on the left, and then duals on the right. So, maybe we'll just keep that slide up another 15 seconds or so and then go to our break. Thank you, so much.

Hilary Haycock:

Absolutely. And the slides are posted along with the chart book on the CalAIM webpage. So, we've got those links have been in the chat a couple times. So definitely want to welcome folks to go download. It's a lot of data and a lot of great slides to dig into. All right, well, we are going to take a brief break. But please come back, we've got

some very exciting policy updates that we're going to be making and providing to this group. Around the long-term care carve-in, around dementia aware, and reporting and quality measure requirements for our EAE D-SNPs. So, we will see you back here around 10:15. Thanks so much.

Hilary Haycock:

We are excited to move on to the next portion of our meeting, which is an update on the long-term care carve-in benefit workgroup. And we will be transitioning to Anastasia, to give us an update from this work group. Thanks so much.

Anastasia Dodson:

Great. Thank you, Hilary. So, as you all probably know, we have in our CalAIM proposal, we included an expansion of our current policy around the carve-in of long-term care into Medi-Cal managed care. Long-term care is usually considered skilled nursing facility care. And so, for dual eligibles, Medicare may cover some of the initial time period that someone is in a skilled nursing facility. But any kind of sort of ongoing custodial care is covered by Medi-Cal for dual eligibles. And so, and in Medi-Cal only individuals again, their stays at nursing facilities are covered by Medi-Cal.

Anastasia Dodson:

So, we have a policy in California for the county organized health systems and the CCI counties, they include as a Medi-Cal benefit carved-in all of a nursing facility stay. And the policy here in for 2023 with CalAIM, is to expand the Medi-Cal managed care long-term care carve-in policy to include all of the rest of the counties in California. So, about a majority of the population in California, but about half the counties have long-term care carved-in as a Medi-Cal benefit now. And then January 1st, 2023, long-term care will be carved-in as a medical managed care benefit statewide. So that's the background on this. And then as we have been thinking about the best way to plan and implement this policy change, we have been convening a group of health plans, providers, nursing home providers, and advocates to work out and dialogue with the different pieces that need to be discussed. The policy is also to carve into Medi-Cal managed care, other types of long-term care facilities that serve individuals with developmental disabilities. That is kind of a new policy. That's more of a statewide change. So that's part of our discussion as well. Although we also have kind of a separate working group on that program for those particular types of facilities and those individuals. So, with all that in context, we wanted to give an update on that sort of intensive work group discussion, kind of a report out of where we're at.

Anastasia Dodson:

So, this outline here... And again, this is just meant to be sort of a brief update and we'll continue to provide these brief updates at this stakeholder venue as things progress throughout the next few months. But we have been talking with this group about Medi-Cal managed care plan readiness. So again, similar to what we thought about when long-term care was carved-in to the CCI counties back in 2014. So, the readiness of plans, how are we measuring that, what the data that the health plans will get. We'll kind

of go to that in just a sec. Also, the continuity of care, how can an individual be... With this transition, there'll be choices that beneficiaries can make about which plan to enroll in, and how to make sure that on all directions everybody is clear what the continuity of care provisions are, and then data sharing as well. So those are the key topics we're going to talk about very briefly today. Next slide.

Anastasia Dodson:

So, with regard to the readiness process, the long-term care carve-in is going to include a robust process over the next year with Medi-Cal plans, we're going to be looking at network readiness, reviewing the network submissions, updating member-facing materials. So, plan materials and DHCS materials and data sharing DHCS shares data with Medi-Cal plans for planning and for this transition. We're also creating and updating policies and procedures, particularly around financial submissions to make sure that everybody sort of has the same shared understanding of the policy and that any new... I mean, again, we have an existing policy already in a number of counties but making sure if there's any updates that need to be made for the remaining counties and for all counties, making sure that we have consensus and shared understanding on all of those policies. Next slide. We've also talked about in the network that network readiness, network adequacy is more complicated than just counting beds, but also an acknowledgement there can be a shortage of beds.

Anastasia Dodson:

Network adequacy is also intended to address the time it takes to transition members from the hospital into a facility and to home. And that care coordination is very important during this process to make sure that, where appropriate, members are being connected to home and community-based services, and they have care plans designed to help them transition home. For member materials, in addition to clearly communicating with beneficiaries and family members, providers, long-term care facilities, physicians, etc. and plan staff, they all need to have direct communication about this transition. Not only should it be sort of certainly not a surprise, but expected, but also not just at a broad level, but also at a detailed level so that everybody knows what to expect. And it is all looped in the planning process. Next slide.

Anastasia Dodson:

Continuity of care. So, there are existing continuity of care requirements that we will continue to have. So, at a high level Medi-Cal plans must provide continuity care for all medically necessary long-term care services at non-contracting long term care facilities for members that are residing in a long-term care facility at the time of enrollment. So, I know that's a lot of words strung together, but the gist of it is that we certainly don't want this policy implementation to result in any kind of a concern or crisis for individuals needing to change facilities. It's really more about having behind the scenes... No impact to beneficiaries, but having behind the scenes, the health plans and the facilities work together, and again, should be planned well in advance what these policies are and making sure that the contracting and payment provisions are all set up in advance.

Anastasia Dodson:

There'll be probably a number of people where a certain circumstance will be in the plan and that facility is contracted with that plan, and it should all go smoothly. And if not, then there are these continuity of care provisions. The Medi-Cal plans must provide up to 12 months of continuity of care with an out-of-network provider if certain conditions are met again. Again, our intent is not to have any disruption of care here. Continuity of care can apply to both providers and services. So, if a member's primary care provider is out-of-network, they might utilize continuity of care to continue accessing their physician. Services such as DME means continued access to the services themselves, even if the beneficiary switches to an in-network provider. All right, next slide.

Anastasia Dodson:

All right. A little bit more about continuity of care. So, plans certainly need to have detailed data on all the services that members are receiving to ensure continuity during the transition, because, of course, individuals in nursing facilities, it's not just necessarily the nursing home care that they're accessing, but other services as well. So, we need to understand what services are covered by the facility rate and what are outside that rate. Next slide. So, we have data sharing information. We think about planning data, transition data, and then the ongoing data feeds. And so, we are working again with plans and providers about what type of data would be provided to them in advance of the transition in 2022, and then beneficiary level information for the specific transitioning populations at the end of the year and in early January, and then standard ongoing data feeds in 2023. So, we have a lot of wheels in motion here around data, and it's really important. All right, next slide.

Anastasia Dodson:

So, the feedback that we've gotten from Medi-Cal plans is that they, of course, want to receive data as early as possible to help with planning and to support continuity of care. Thinking about what worked in the transition for the coordinated care initiative. So, building on lessons learned there, and facilities homes would like to have clear communication from Medi-Cal plans regarding member transitions. So all of that is as we're having these discussions and we're trying to really create an environment where we can have everybody being honest and clear about what they need for a successful transition and trying to basically put all of the concerns on the table and then think about the benefits and how can we make those types of benefits and the sort of having one health plan to manage all of the Medi-Cal benefits, how can that be as seamless as possible for as many beneficiaries, because we know how that has worked in CCI and COHS counties.

Anastasia Dodson:

And again, as part of the overall CalAIM effort here, we want to have a more seamless transition as people need nursing home care. We want that care to be as integrated as possible with their overall care plan. And to make sure that if someone is discharged from the hospital, they need to go to a nursing home, the managed care plan is partnering with the hospital, partnering with the facility and the beneficiary and their caregivers, of course. It's a really fundamental component of CalAIM and of the efforts

that we've had underway for a long time in the coordinated care initiative. So, with that, Hilary, do we have any key questions that we want to look at from the chat?

Hilary Haycock:

There's a comment, a couple comments from Beth Garver about sort of how valuable it is for providers to be able to see how many enrollees with each health plan they have. So that's helpful feedback that we can definitely take back, and then a request for providers to have the opportunity to provide feedback to the state on their experience in Cal MediConnect as we're planning for the CalAIM transition. And I do think we will be releasing some materials for public comment. So, I think there will be opportunities for that. But otherwise, we are continuing with... This workgroup is not open to the public, but we will be continuing to provide updates at these and other public stakeholder meetings. So, we can have that dialogue with stakeholders.

Anastasia Dodson:

Yeah. And certainly, we have made sure that we have representatives from plans, facilities, advocates, and then just trying to make sure that we can be as thorough as possible with these discussions. Great.

Hilary Haycock:

Great. All right. Wonderful. Well, now I think we can transition to Dr. Sidhu and an update on Dementia Aware. Thanks so much, Anastasia.

Sohrab Sidhu:

Great. Thank you so much, Hilary. And hello everybody. My name is Sohrab Sidhu. I'm a Medical Quality Officer here out of the Quality and Population Health Management Division at DHCS, and I'm going to be providing a couple of different updates today, starting with Dementia Aware and Senate Bill 48. Next slide. So, Dementia Aware is part of the HCBS spending plan, which is a group of initiatives and programs that are working to address the needs of people with functional limitations who need assistance with activities of daily living such as bathing, dressing, toilet, and eating as well as individuals with disabilities and older adults. So, the HCBS spending plan, which was provided for through the Rescue Plan Act provides qualifying states with a 10-percentage point increase in the FMAP for certain Medicaid expenditures. And so, one of those initiatives is Dementia Aware. DHCS along with some sister department, CDPH and HCAI are working to stand up in an initiative to improve rates of dementia screening, to ensure early detection, and timely diagnosis while also having a referral protocol and connecting individuals and families to community resources. Next slide.

Sohrab Sidhu:

So, the aims of Dementia Aware are to provide training in culturally competent dementia care to providers, establish a referral protocol on cognitive health and dementia, promote the use of validated tools, training, and that referral protocol, and make continuing education available to providers. And then this initiative aligns with SB 48, which is an annual cognitive health assessment for Medi-Cal only beneficiaries. And I'll

get into a little bit more about the details of that. But first, next slide, just some background here about the Medicare annual wellness visit. So, Medicare covers a yearly wellness visit to develop or update a personalized prevention plan for beneficiaries and detecting cognitive impairment is a required element of that annual wellness visit. And there is an Alzheimer's Association cognitive assessment toolkit, which is intended for physicians to use during the annual wellness visit. And so, if the physician detects cognitive impairment at the wellness visit or at another routine visit, they can then perform a more detailed cognitive assessment and develop a care plan during a separate visit.

Sohrab Sidhu:

And there's some helpful resources there to the toolkits as well as more information about the cognitive assessment in Medicare. So, this transitions us to the next slide, SB 48. So, kind of taking from that model, SB 48 establishes an annual cognitive health assessment as a Medi-Cal benefit specifically for beneficiaries aged 65 and older, who are otherwise ineligible for a similar assessment as part of the Medicare annual wellness visit. So Medi-Cal providers are eligible to receive reimbursement for this cognitive health assessment if they're doing so for Medi-Cal only beneficiaries and if they've completed that cognitive health assessment training that will be provided for through Dementia Aware, and then they have to use one of validated tools that DHCS recommends in consultation with specified entities in SB 48. So that's how the two initiatives are kind of connected. Next slide.

Sohrab Sidhu:

So currently we are in the process of implementing both Dementia Aware and SB 48 here at DHCS. And one of the things we've been determining is exactly what coding information we would be using for the cognitive health assessment. So ultimately what our benefits division determined is that there's no appropriate Category I CPT code that could be identified. There is this 99483 code that's used in Medicare, but this is again for that 50-minute cognitive health assessment kind of follow up after the initial brief assessment is conducted and SB 48 aims to reimburse for that initial brief cognitive health assessment. So, 99483 was deemed to not be an appropriate code for these purposes. Ultimately, we've landed on 1494F as a potential code for SB 48 for this new benefit. This is a Category II CPT code, which is used for performance measurement. So, SB 48 incentive payment will be tied to providers utilizing this code. And again, it would be for Medi-Cal only beneficiaries and not duals. Next slide.

Sohrab Sidhu:

So currently we are in the process of contracting with UCSF who will be subcontracting with several other UC entities. We're excited about this partnership. We feel like it leverages the necessary expertise in both dementia care, as well as screening implementation and primary care practices, both of which will be essential to a robust Dementia Aware program. And the goal here is to have training available for Medi-Cal providers by July 1st of this year, as that is the goal date for implementing the cognitive health assessment benefit in SB 48. Next slide.

Sohrab Sidhu:

This is just an overarching view of the scope and rough timeline of when these things would be conducted with the UCSF contracts. So, step one is phase one, which will go from right about now, March 1st, through the end of August would involve project management, developing and coming to conclusions about which screening tools could be used, developing the training and setting up that training by July 1st, and then establishing CME credit and MOC credit. And then phase two would again, continue that project management and get more into practice-level implementation support, and then get into evaluating the training, updating it accordingly, and conducting robust outreach engagement strategy. And with that, I'll transition it back to Hilary to see if there's any questions we can address before we get onto the next topic.

Hilary Haycock:

Great. Thank you so much. A question from Janet van Zoeren with the Coalition for Dementia Care Services. There's no cognitive health assessment being used for those who have cognitive deficits before developing dementia. Guess it's more of a comment. And the need to rectify that. I know identifying is a challenge. And then a question from Lydia Missaelides, the Alliance for Leadership and Education about why someone would be age 65 plus and not a dual.

Anastasia Dodson:

Yeah. I'll chime in on that. Due to someone's immigration status, there may be... They may not be eligible for Medicare. Also, we think about... And frankly, I'm not the eligibility expert here, so I don't want to go too far afield, but essentially, we'll just say it's most likely due to immigration status. There could be other reasons why, I don't know. Tatiana may want to weigh in on the chat.

Hilary Haycock:

Yeah. Tatiana has dropped in a... She's dropped in a link about some Medicare coverage for cognitive assessments.

Anastasia Dodson:

All right.

Hilary Haycock:

Yep. HICAPs would-

Sohrab Sidhu:

I can just add that while the SB 48 benefit is strictly for Medi-Cal only beneficiaries, the Dementia Aware training will be available to providers more broadly. And so certainly those providers who are serving duals could definitely take advantage of the training that will be available to them and even providers outside of California.

Hilary Haycock:

Tatiana weighing in saying that someone might not have sufficient work history to be eligible for Medicare. That's a part of eligibility as well. Wonderful. Well, thank you so much for that great presentation on that important initiative. And now we'll move on to our next topic. Thanks so much, Sohrab.

Sohrab Sidhu:

Great. So, we're going to transition now to talking about proposed 2023 state-specific reporting requirements for our exclusively aligned enrollment D-SNP plans or D-SNPs. So next slide. This is just recapping. This was all born from our department's commitment to quality. And that obviously applies to our EAE D-SNPs as well. So, we're aiming to have state-specific reporting requirements for these D-SNPs, which are part of our larger quality strategy within DHCS. And much of that information can be found in an addendum to our comprehensive quality strategy, as well as in other initiatives like our long-term services and supports dashboard, which we're standing up in the Master Plan for Aging. So, we are examining existing D-SNP contract requirements and federal quality standards and working with stakeholders, plans, CMS essentially to identify the range of measures in reporting results that D-SNPs will report to DHCS on an annual basis. And we're obviously committed to incorporating promising practices and quality reporting measures from Cal MediConnect plans. Next slide.

Sohrab Sidhu:

So, there are robust reporting requirements already in place for D-SNPs today. And the intent of these requirements for 2023 is to pull from these priority Cal MediConnect metrics and combine them with Medicare D-SNP measures to capture the most accurate understanding of a California D-SNP member's experience and outcomes. Next slide. This is just a table that essentially shows the reporting requirements, comparing Cal MediConnect plans to Medicare Advantage dual eligible or D-SNP plans at the federal level. And so, you see there's a good amount of overlap between the two. And so, next slide, also wanted to bring folks attention to the Cal MediConnect dashboard, which provides key data and measures on aspects of the Cal MediConnect program.

Sohrab Sidhu:

It includes measures that involve enrollment, demographics, quality withholds, care coordination, grievances and appeals, behavioral health services, and long-term services and supports. Next slide. This is an example of one such measure that can be found in those dashboard reports. This is just nursing facility care per 1000 members, tracked quarterly. And so many measures like this one can be found on the dashboard in its reports. Next slide. So, the importance of the Cal MediConnect dashboard is that it allows DHCS plans, advocates, and other stakeholders to track progress on a number of different measures, including care coordination and LTSS referrals. And then it's also helpful in establishing benchmarks to evaluate members' experiences in Cal MediConnect plans. Next slide. So, these next two slides are about D-SNP federal Medicare Part C and Part D reporting requirements. So, at the top of the list here, we see that they report on HEDIS measures as it relates to access and availability of care, care for older adults such as advanced care planning, effectiveness of care and

utilization. They also report on the Medicare Health Outcome Survey, and then CAHPS questions as well.

Sohrab Sidhu:

Next slide. And then these are the Part C and Part D reporting requirements that were also displayed in that table, comparing them to the Cal MediConnect plans. Next slide. So, all Cal MediConnect plans reporting at... They report at the plan/county level, similar to Medi-Cal. However, the D-SNPs report at the CMS contract level, and this can include the D-SNP, but also other Medicare products in the state and/or region. So currently DHCS is reviewing options for D-SNP-specific quality measures. And these include either a separate contract numbers for D-SNPs in 2024 and/or state-specific requirements for D-SNPs to provide annual Medicare quality data to the state like they do to CMS. Next slide.

Sohrab Sidhu:

So, we identified the following criteria in developing these proposed measures for additional state-specific quality and reporting requirements for D-SNPs. We looked at the overall quality and integrated care goals for D-SNPs. We looked at clinical value and alignment with Medicare and Medi-Cal goals and measures. We looked at existing data that was already sent to CMS that DHCS could leverage, and as well as existing DHCS data that could be analyzed. And then finally, CMC measures, Cal MediConnect measures to maintain for initial enrollment transition and monitoring. And so, at the end of this, we'll have some discussion questions essentially asking you all to respond to these measures considering what Cal MediConnect measures should be carried over to the EAE D-SNPs for 2023. And what measures for Cal MediConnect are important and non-duplicative to require the D-SNPs to report on. Next slide. So, this begins the list of the proposed measures, and we'll start with HEDIS measures. Under the category of access and availability of care, we have the adult access to preventive/ambulatory health services, and then we have measures for effectiveness of care, the ambulatory care ED visits, controlling high blood pressure, controlling diabetes poor control, follow up after the ED for mental illness, and then follow up after the ED for substance abuse. And then finally for utilization and risk adjusted utilization, the plan all-cause readmissions. Next slide.

Sohrab Sidhu:

This is the list of measures from Cal MediConnect that we would continue in the categories of assessment, care coordination, and organizational structure and staffing. So, starting with assessment, we would have members who have had an assessment completed, who had an assessment completed within 90 days of enrollment, and then those who had an annual reassessment. For care coordination, it would be members with the care plan completed within 90 days of enrollment, members with an individualized care plan completed, and members with documented discussion of care goals. And then finally, organizational structure and staffing, the care coordinator to member ratio, as well as care coordinator training for supporting self-direction under the demonstration. Next slide.

Sohrab Sidhu:

These are Cal MediConnect LTSS measures that we would continue, and they involve essentially CBAS and IHSS measures, the total number of members receiving those services in CBAS during a particular quarter, the total number of referrals that were made to CBAS for the quarter, and then the number of assessments, reassessments, and denials for CBAS. And then for IHSS, it's the number of ICTs with county social worker and trained social workers, members who were referred to IHSS, and then the number of members receiving IHSS. Next. Continuing with these LTSS measures with the MSSP it would be similar again, the number of ICTs with an MSSP care manager, the number of members receiving MSSP, and the number of referrals made. And then for long-term care, the number of members residing in long-term care, the number of referrals received for long-term care, and then the assessments, approvals, denials for long-term care.

Sohrab Sidhu:

Next slide. And then finally with stakeholder feedback, and because it aligns with the Dementia Aware and SB 48 initiatives and benefit that we are establishing, we're also proposing including this Alzheimer's dementia quality of care measure, which is essentially is from the American Academy of Neurology measuring the percent of older adults or patients aged 65 and older who have had their cognition assessed. Next slide. And with that, I'll turn it back over to Hilary. Thank you.

Hilary Haycock:

Thank you so much for that great presentation. And we are excited now to go into our breakout room discussions. Our breakout room sessions will be 15 minutes long. We're going to automatically assign folks out into groups. Every group will have a note taker to help pose the questions and take notes on the discussion, but we'll need you to assign someone to do a report out and we'll bring folks back once we're there. All right. I think we're having slides going a little funky. Great. So here are our discussion questions and we will be putting these in the chats for the breaker groups. Cause I know they're long. So one is, so the proposed measures, including mix of health outcomes, as well as how plans are operational care coordination. We want to hear if that feels like a helpful mix of measures, we would like to hear about folks' experience with the Cal MediConnect dashboard and what was the most helpful part of the publicly reported data from the dashboard, as we're thinking through next steps.

Hilary Haycock:

And then wanted a specific question on specific feedback on whether are these the specific measures that we've suggested, the right mix for understanding how things are going in the EAE D-SNPs. Understand there's a lot of other measures out there that we could have chosen from. So wanted to get some feedback on the specific measures. So, with that, we're going to join breakout rooms. Thanks so much. All right. Well, I hope everybody had a great just discussion in their breakout session. We're going to move now to report outs. So, if we have any, happy to have folks drop the report outs in the chat and/or raise your hand, if you would like to share.

Hilary Haycock:

I would say some of the top line feedback we got from our, in my workout group was the need to make sure that we're looking at measures from the patient perspective and member satisfaction. The importance of looking at access to providers in terms of timeliness for, and timeliness and proximity for referrals to specialists. And just thinking through the real importance of making sure that we are screening folks for dementia, particularly among the duals population. Are there other folks who would like to report out? Great, Jessica. There we go.

Jessica Nunez de Ybarra:

Sorry. Thanks everyone. I'm trying to learn all these details. We had a fabulous group that we heard from the health plans. Want to give a shout out to Janine at Health Net, who for these questions in brief was able to state to us that there may be some concern, they formally submitted their input, but of about duplication of some of the metrics in terms of NCQA. But one of the things that she emphasized was two things that she doesn't have a MOU in place for all the carved-out service providers and that it would be nice to have reliable data feeds. In other words, could there be standards developed?

Jessica Nunez de Ybarra:

She gave an example of her group working on internal measures because they need to know if a patient has a new information, a new care plan that requires new services and they, as the health plan, want to make sure that those new services, especially by the carve-out providers, have they been delivered and where are they going to get that information, claims encounter, IHSS data, she needs actionable data. So, she wants to make sure that she has guarantees on transition of care. And so anyway, it was really nice to see that she's trying to emphasize a proactive data feed again for services that standardize across all these different provider groups, as well as different health plans.

Jessica Nunez de Ybarra:

The next thing she mentioned also, or we heard from the scan foundation was making sure we apply the lessons learned from Cal MediConnect, are people getting services. And again, that's mainly access to the home and community-based services and the long-term services and support, which again, Janine at Health Net spoke to in regard to the data questions. She also discussed in terms of the dashboard. Something that I thought was really nice that the dashboard provides a great high level picture of change, but that what she'd like to see is that when there's a change, either improvement or maybe some challenges for those measures, that somehow there's a reach out to the plans when the change happens and that information's gathered about what made the difference if they improved, for instance, and then sharing out best practices, details that other plans can view about what really brought them back to a best practice or to better outcomes.

Jessica Nunez de Ybarra:

And similarly, if there were challenges, what was done and what are they doing to improve upon it, because she's really trying to create a standard for all health plans to

meet. And then finally, in regard to other measures, she didn't have a note regarding that. But again, back to when the measures are decided that the health plans need the specific technical requirement detail, so that they're already to report, and that there's a uniformity so that when different health plans are assessed across, that they have comparable comparison so that, people can know how the health plans are doing. That's it. Thank you.

Hilary Haycock:

Definitely sounds like a robust discussion. Is there another group that would like to report out? Tatiana? Maybe?

Tatiana Fassieux:

Yes. Hi. So, we were in group four. We basically all agreed that there should be, it would be very helpful to have the two measures combined or at least be related. We didn't have much discussion about the Cal MediConnect dashboard because some people were not involved, neither am I. So, but the key takeaways would've been that those health outcomes that are measured and that are operationalized have a direct impact on future contracts, on the quality of care and on the end user satisfaction.

Tatiana Fassieux:

And that is sort of relates to the second question is that the dashboard does not have a lot of information regarding individual experiences. In particular, there were comments about the problems that some individuals experience with the delay in authorizations for specific care or specific referrals. So, it now gets into the level of how well a beneficiary’s health is being coordinated, if there is going to be a delay in authorizations for care. So, it was a mixed bag, but definitely those two are key elements. Those two measures are key elements to have a robust plan that can provide the adequate services that an individual needs.

Hilary Haycock:

Yeah. That's helpful. That echoes a lot of what I think we heard.

Tatiana Fassieux:

Yes, exactly.

Hilary Haycock:

Our group as Well. That's great. Any other breakout rooms want to provide some feedback?

Anastasia Dodson:

Hilary, I wonder if we could have Sohrab on again, just, I think, maybe just a couple minutes to discuss what we've heard. Cause I think it's relevant. I don't know. I’m having trouble to find him.

Hilary Haycock:

I think he had to run to another meeting, unfortunately.

Anastasia Dodson:

Okay. One thing then I'll just say that. So, in the big picture, as we thought about these measures and really just for 2023, at least, we've kind of feel like there's a little bit of, there's a tradeoff. We can't administratively and even just functionally for all of you to review, we can't measure and report on every single thing. So, we sort of were thinking of it as a tradeoff between operational type measures where, grievance and appeals is probably a good example of that or anyway, adverse sort of overall quality of care and even health outcomes. Like sort of, reduced readmissions or other types of acts, true outcomes of care, maybe even sort of reduced prevalence of certain diseases or, there's very big picture outcomes that, of course we could look at. Sometimes harder to attribute all of that to specific interventions that a provider or plan could make because health is sort of a complex thing to measure and we at DHCS over all with our quality strategy, want to think about that big picture, how are we improving health outcomes?

Anastasia Dodson:

Because at the end of the day, of course that's really what is going to make a positive impact in someone's life. But what you all are saying, not all of you, but what many of you've heard you say is about back to grievance and appeals, time getting to providers, sort of network impacts and all of that delay in authorizations. It's very helpful you're reminding us that, of course it's not either or, but that some of those operational measures for now may really be particularly valuable to you all. And particularly because many of you are direct service providers working with beneficiaries one on one and that maybe those measures are kind of a proxy for what you're seeing day to day. And that can provide maybe a more sort of immediate feedback to health plans about what's working and what needs to be improved. But again, I don't want to let go of hospital readmissions or other types of measures that are more about outcomes. So anyway, I welcome anybody else's thoughts on this with this tradeoff between the different types of measures

Anastasia Dodson:

And maybe you all just said what you needed to say. And I just want you to know that we heard you and again, we're kind of getting to... We've had this meeting, we need to kind of land the plane, so to speak on what measures are we going to require and publish. And so really helpful again and can think about also the HEDIS and other types of measures that you are looking at patient satisfaction, et cetera. And let's make sure there isn't duplication. So, we know that there's already measures reported to CMS. So anyway, thank you. And I see there's more in the chat. So, we'll look at that as well.

Hilary Haycock:

Question about what, which agencies require, which measures. And we, I think we do have sort of a chart up earlier in the slide deck where D-SNPs really do just report to Medicare. And so, it is trying to think about what do we want them to report to the state

and what can be kind of available at the plan level that we're interested in to see. A question, if there's a plan for qualitative beneficiary interviews too, as it was done with Cal MediConnect.

Anastasia Dodson:

Yeah. We don't have a research project queued up yet. So far as I know on D-SNPs, like we did for Cal MediConnect, but would welcome and love to have that.

Hilary Haycock:

Yeah. We, there won't be an evaluation component to this because it's not a demonstration. The way that Cal MediConnect was. A language access metric. I'm not sure If we know if there is a specific Medicare language. Existing measure, but we can certainly look into that. Janine is reminding us, there are some reporting requirements that D-SNPs have, but they aren't quite the same quality, quality measures as we're talking about. Yeah, there'll be a number of reporting requirements where, going to be requesting of the D-SNPs that will include some network pieces. Janine is saying that there is a question on language in the CAHP surveys. So again, the Medicare reporting requirements are pretty extensive. There's the CAHP members, satisfaction survey and a whole long list of HEDIS and health outcomes measures that plans are required to report as well. Great. There was a comment in, from Sarah Gonzaga in the chat about being interested on the additional measures about tracking if the IHSS provider is on the ICT, if the provider, another information about, IHSS provider training, sort of if referrals to IHSS result in enrollment.

Hilary Haycock:

So, I think that's helpful feedback. I'm interested in more information on the IHSS program and interest in the HEDIS care for older adults' measures.

Anastasia Dodson:

One last piece. I know it looks like there were some questions earlier about the proposal that was announced around Kaiser. I know this is not related to quality measures, but just wanted to address that, did not have that on the agenda today, where it's a proposal that is still to be weighed in on by the legislature. But we have for frankly, right now, this work group, this discussion is focused on 2023, which is when the Cal MediConnect plans will transition to exclusively align D-SNPs in the CCI counties. And that is, and as well as we've talked about long term care carbon and dual eligible carbon to Medi-Cal managed care in 2023.

Anastasia Dodson:

So those are the specific main focuses that we have for this work group, which is, these are all things that have been enacted in statute approved by CMS, and that we want to get your feedback on anything that's proposed in the governor's budget type of thing. There's a legislative process that they would review those proposals. So basically, probably premature for us to get too much in the details on all of that, but we just want

to acknowledge seeing those comments. And then I think there was another…looks there's another couple of comments on the chat.

Hilary Haycock:

Yeah. Some comments from Janine on just that the challenges that health plans don't get information on IHSS providers. So just some of the challenges around trying to engage with IHS providers include them care plans and ICTs. And I know that's something the Department's thinking about, and there's definitely something the department's been thinking about in terms of future requirements for MOU and coordination. And then comment from Tatiana at CHA, the HICAP around sort of the HICAP concerns around the number of calls that they might receive around the Cal MediConnect transition. I'm looking for a resource at DHCS to help with any sort of...

Anastasia Dodson:

Yes. Well, okay. So, Tatiana great. Thank you. That was perfect cue for me. So yes, there's a meeting, I believe next week that the DHCS will be presenting to the HICAP folks and then Janine, exactly, just going to say that the, we have our Cal MediConnect Ombudsman exactly for this purpose. And in fact, last year in the budget trailer builder was approved, directed DHCS to have to continue the Ombudsman. So, we don't have a fancy name, Cal MediConnect Ombudsman, but basically DHCS is working on basically establishing a new contract, but for the same type of services as Cal MediConnect Ombudsman. So, we certainly intend to have full support at the local level in CCI counties for high, for HICAP, for Cal MediConnect Ombudsman. And of course, the plans themselves, for any questions about the transition, the Cal MediConnect transition.

Anastasia Dodson:

And I'll just say, CMS of course are important partners. And our Health Care Options team will also have information and scripts about that. So, I just really want to triple reassure you that it is an extremely high priority for us at DHCS and CMS to have a very smooth transition. And in January/late December 2022/ early 2023. So, sometimes that's all we do all day is making sure that we have all the tech technical information lined up. Information for the plans, et cetera. We have a, it's just extremely high priority for the department to make sure that transition goes well. But we also want to make sure that we're, as we talked about collecting the right information for quality measures, and as we talked about here, so that we can tell, maybe the immediate transition went well, but if there's some things that happen afterwards in January, February, March, making sure that we're, capturing the right measures to see what's going on,

Anastasia Dodson:

Yes, Health Consumer Alliance. I don't want to speak prematurely, but we're looking to, leverage the existing resources that people, people who are extremely familiar with these issues and have been working with consumers from the get, go on this. So again, very extremely high priority for the department to have a smooth transition.

Hilary Haycock:

Great. There was a comment around data being collected for LGBTQ+ beneficiaries, sort of their access to care. And I'm not familiar with the Medicare demographic data collection, but we can certainly take that back and look at it. Understand that is a population that can be at higher risk. Those were questions directed at data. Rick looks you have your hand raised. I think we'll open it up to you. And then I will probably close, close out the meeting for this morning.

Rick Hodgkins:

I have a concern about not necessarily network adequacy, but plan adequacy. In my county when it comes to Medi-Cal managed care plans, we will only have two plans. And my concern is that whether or not either plan will...either Medi-Cal managed care plan will meet my needs with regards to whether any of them will be accepted at any of my providers. I know Medicare will not be an issue, but my concern will be about the Medi-Cal managed care plans, because it has been said that Sacramento County will only have two plans. And two plans only.

Anastasia Dodson:

Thanks so much, Rick. So, the procurement and sorry, I should say the re-procurement process and the process of deciding how many plans in which counties that is, discussion and process underway. And we will need to see how that all lands in the coming months, but we have existing continuity of care provisions on the Medi-Cal side. There are. And again, you, I know you talked about, yeah, so I…

Rick Hodgkins:

I know I just to know that as of right now, there are only two plans and I'm afraid it'll probably stay that way for the foreseeable future. And I'm afraid that if I choose, one plan's not going to be better than the other plan.

Anastasia Dodson:

We want to make sure that all of the medical plans meet the requirements the state has set out for Medi-Cal plans. And in fact, through this RFP process that we've launched on the Medi-Cal side, we are strengthening the requirements for Medi-Cal plans across a variety of areas. So we're raising the bar on Medi-Cal plans, and we want to do quality reporting and a variety of other areas, we want to have high standards for our medical plans and then incentives and follow up either way, if things go well and things, things don't go well, we want to make sure that we're holding plans accountable, highlighting the good things and holding them accountable for the things that need to be improved. So, stay tuned for more on the Medi-Cal plan changes that may be coming up. But again, for dual eligible, most of your services are through Medicare and it's voluntary whether to involve in a D-SNPs or a Medicare Advantage plan.

Hilary Haycock:

Thanks. All right. Well, we are at time. So, lots of upcoming topics that we'll be bringing back to folks and future and future meetings. And our next meeting will be March 24th at

10:00 AM. So please join us. Join us then. We're looking forward to talking to you then, and we'll be doing an update on the coordinated care initiative Thursday, March 17th. So, save the date and thank you so much, everyone for your participation today. So, appreciate it very much. Thank you.