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

DHCS

February 24, 2022

How to Add Your Organization to Your Zoom Name

- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window and click “More.”
- Select “Rename” from the drop-down menu.
- Enter your name and add your organization as you would like it to appear.
  - For example: Hilary Haycock – Aurrera Health Group

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for CalAIM MLTSS and integrated care for dual eligible beneficiaries. Provide an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for upcoming changes for Medicare and Medi-Cal.
- The goal of the workgroup is to collaborate with stakeholders on statewide MLTSS and Exclusively Aligned Enrollment Dual Special Needs Plan (D-SNP) enrollment, including the transition of the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC), the D-SNP look-alike transition, and new enrollment in exclusively aligned enrollment D-SNPs.
- Open to the public. Charter posted on the Department of Health Care Services (DHCS) website.
- ***We value our partnership with plans, providers, advocates, beneficiaries, caregivers, and the Centers for Medicare & Medicaid Services (CMS) in developing and implementing this work.***

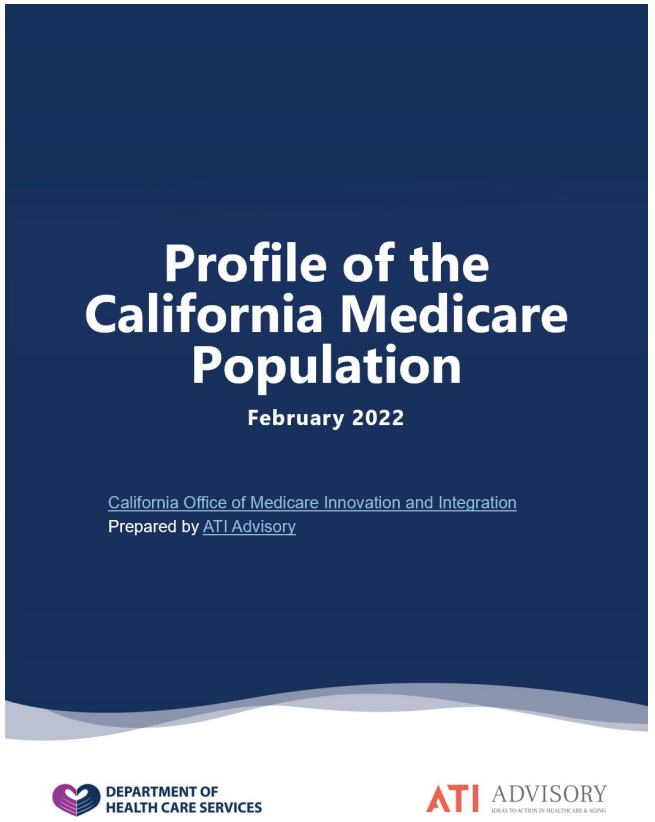
Agenda

9:00 – 9:05	Welcome and Introductions
9:05 – 10:05	Overview of DHCS Medicare Chartbook “Profile of the California Medicare Population” and Stakeholder Discussion
10:05 – 10:15	10-Minute Break
10:15 – 10:25	Update on Long-Term Care (LTC) Carve-In Benefit Workgroup
10:25 – 10:30	Update on Dementia Aware Program
10:30 – 10:50	Proposed 2023 State-Specific Reporting Requirements for Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs)
10:50 – 11:25	Breakout Room Sessions and Report Outs
11:25 – 11:30	Next Steps and Upcoming Meeting Topics
11:30	Closing

Overview of DHCS Medicare Chartbook "Profile of the California Medicare Population"

A New Chartbook on the Medicare Population in California

- **The chartbook provides** data on the California Medicare population to inform stakeholders about this growing cohort of beneficiaries.
  - It is the first in a series from the DHCS Office of Medicare Innovation and Integration (OMII).
- Analyzes demographic and enrollment data for Medicare beneficiaries as of March 2021 (unless otherwise noted).
- Supported by a grant from The SCAN Foundation: www.TheSCANFoundation.org



Definitions and Data

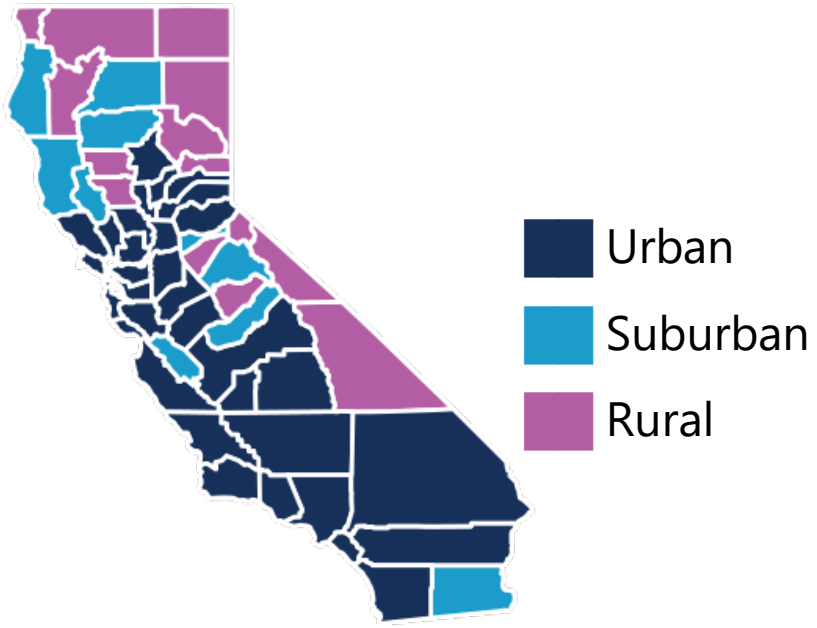
- Source unless otherwise specified: ATI Advisory analysis of the Medicare Beneficiary Summary File, as of March 2021.
- Other sources: ATI Advisory analysis of the Medicare Monthly Enrollment file, as of October 2021, for the Growing California Medicare Population… slide.
- Medicare Advantage includes regular Medicare Advantage, Special Needs Plans, Cal MediConnect, and PACE.
- Race/Ethnicity and Sex are based on federal definitions. Ethnicity is inferred by an algorithm.

Definitions and Data

» Rurality is categorized based on the Medicare Advantage Program rule: Network Adequacy, County type designations, 42 CFR 422.116(c).

Urban, Suburban, and Rural Definitions

Definition	Rule Designation	Map Color
Urban	Large Metro	
	Metro	
Suburban	Micro	
Rural	Rural	
	Counties with Extreme Access Considerations	



Profile of the California Medicare Population: Demographics and Program Enrollment

Overview of Key Findings

1 in 10
Californians with Medicare were under age 65

2 in 3
Californians with Medicare were White

1 in 20
Californians with Medicare lived in Suburban or Rural counties

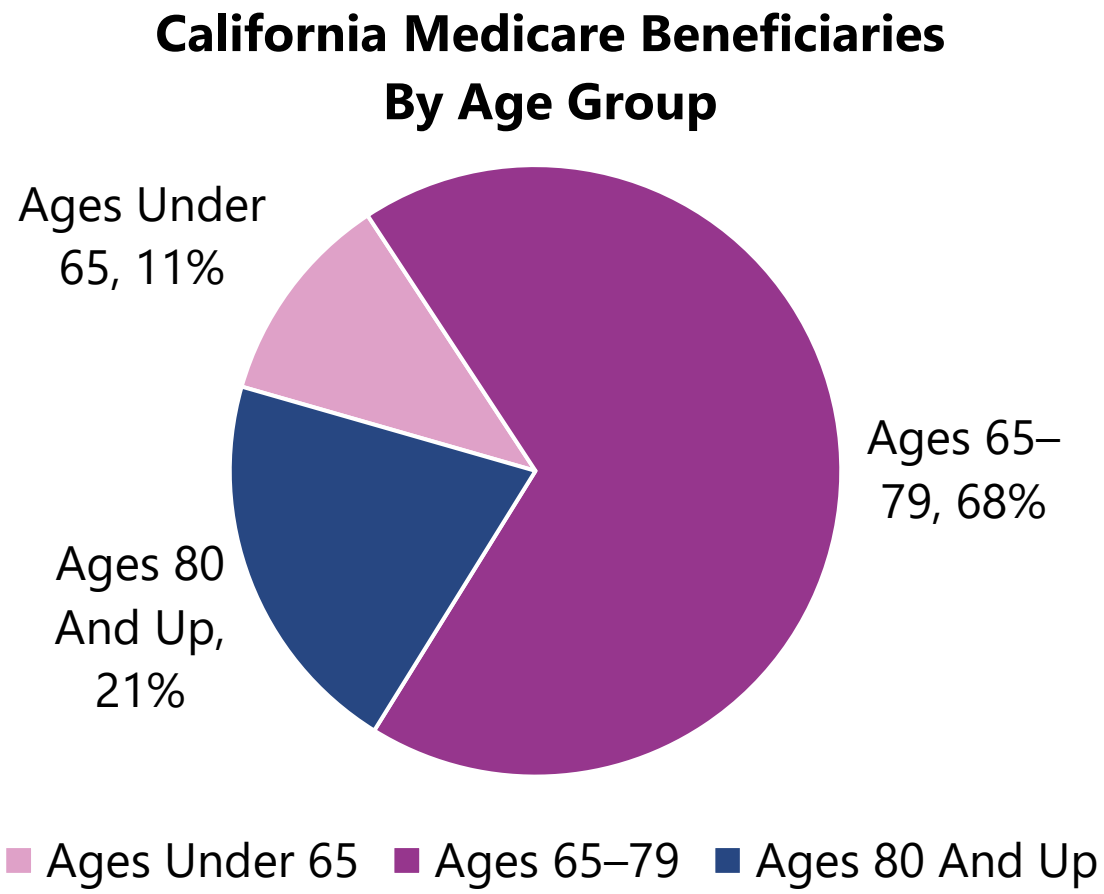
1 in 2
Californians with Medicare were enrolled in Medicare Advantage

1 in 5
Californians with Medicare had full Medi-Cal coverage

1 in 10
Californians with Medicare had both Medicare Advantage and Medi-Cal

As of March 2021

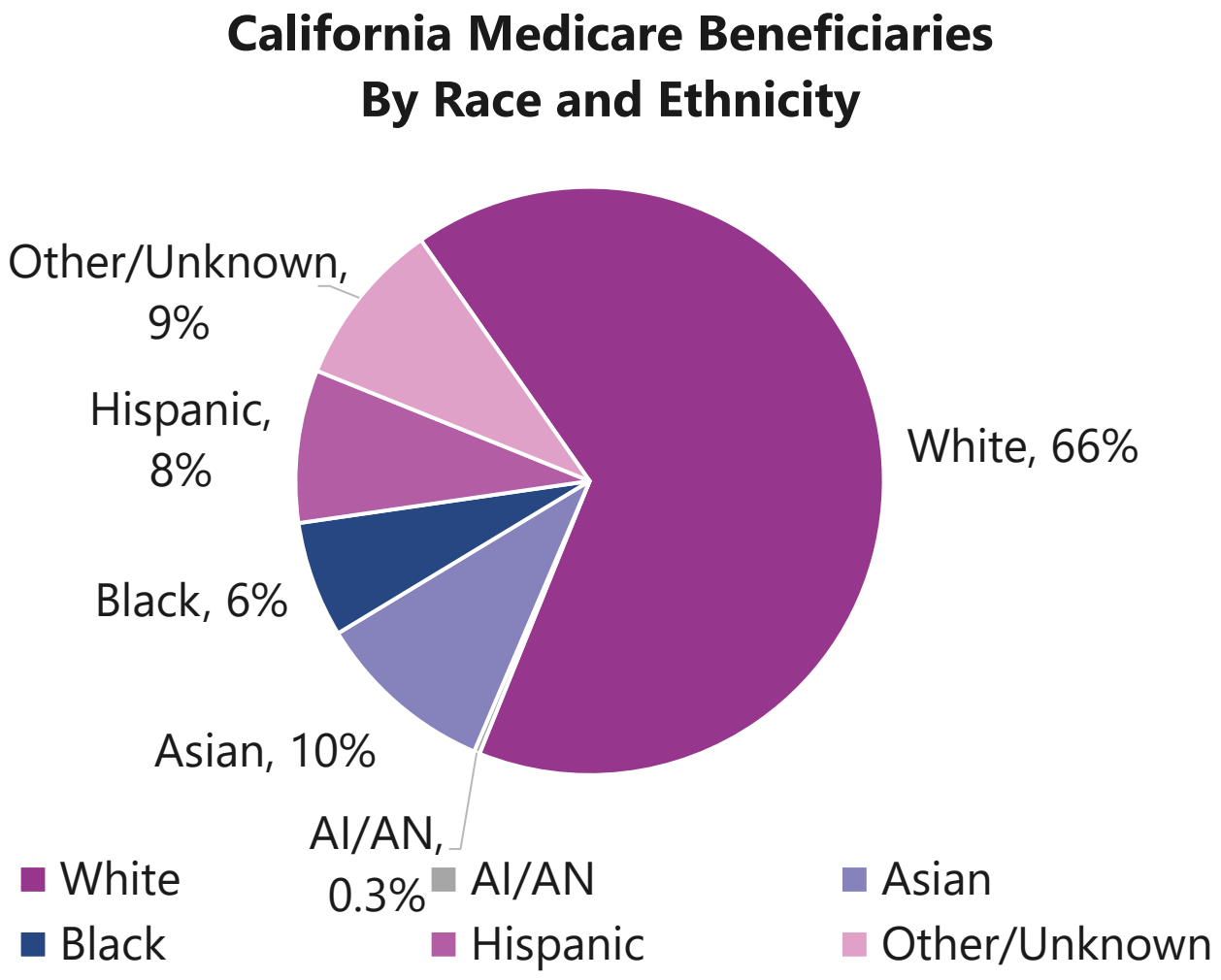
Composition of California's Medicare Population



Age Group

- 7 in 10 state Medicare beneficiaries are ages 65 through 79
  - 1 in 10 is under age 65
  - 2 in 10 are age 80 or older

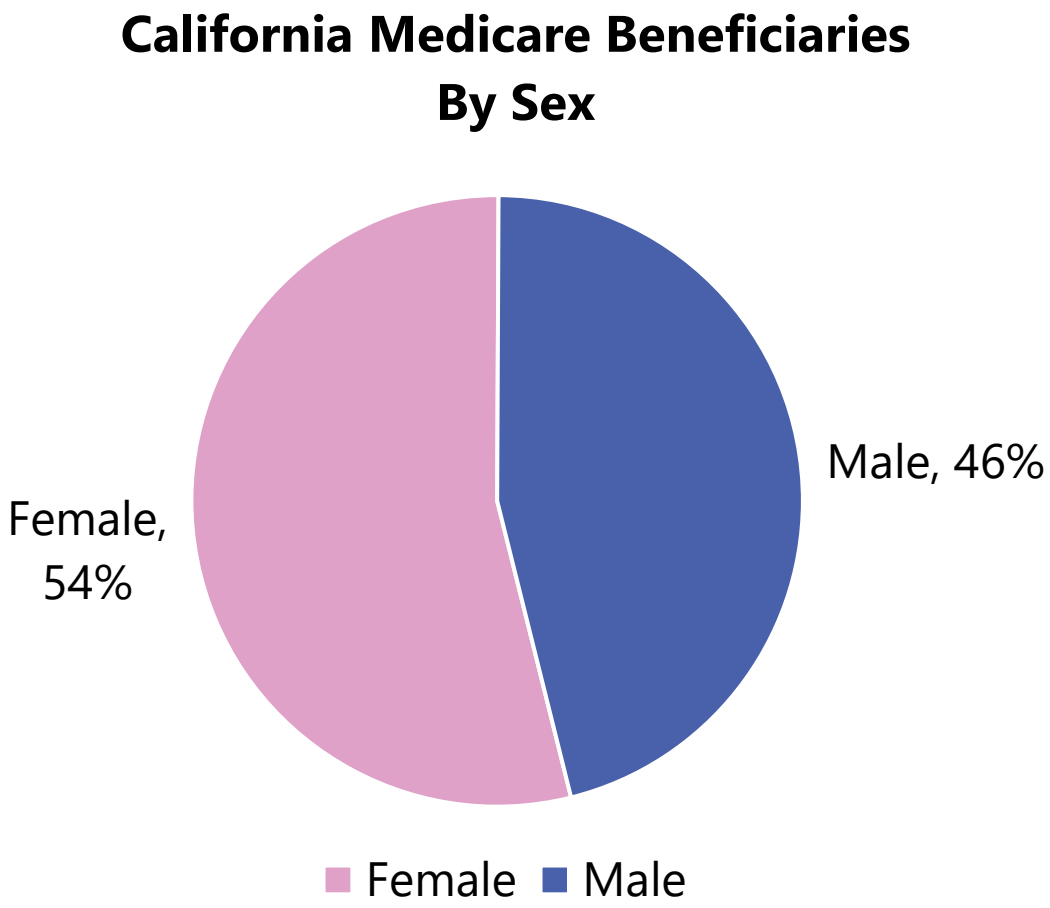
Composition of California's Medicare Population



Race/Ethnicity

- Most Medicare beneficiaries in the state are White
  - This majority is a smaller share than White beneficiaries in Medicare nationwide

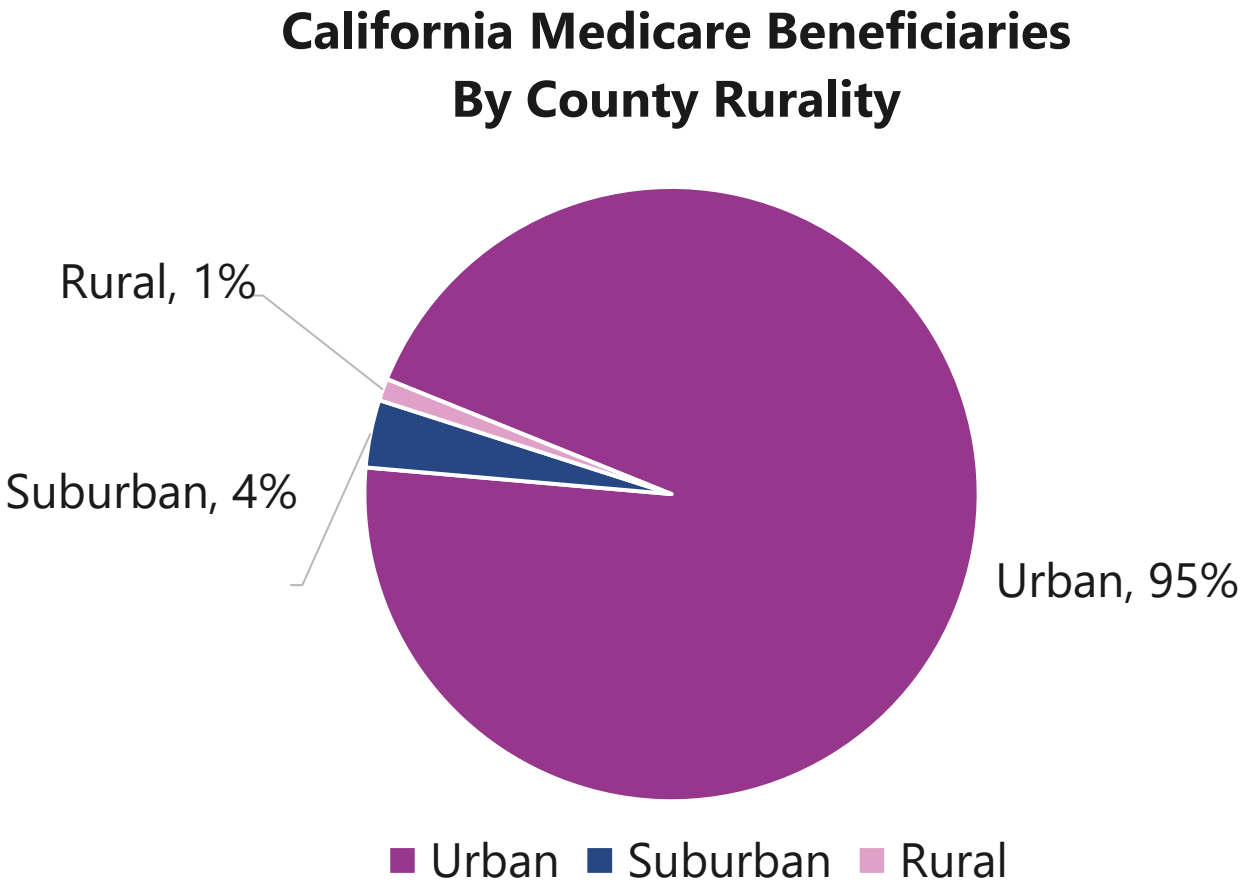
Composition of California's Medicare Population



Sex

- There are 17% more female Medicare beneficiaries in the state than male

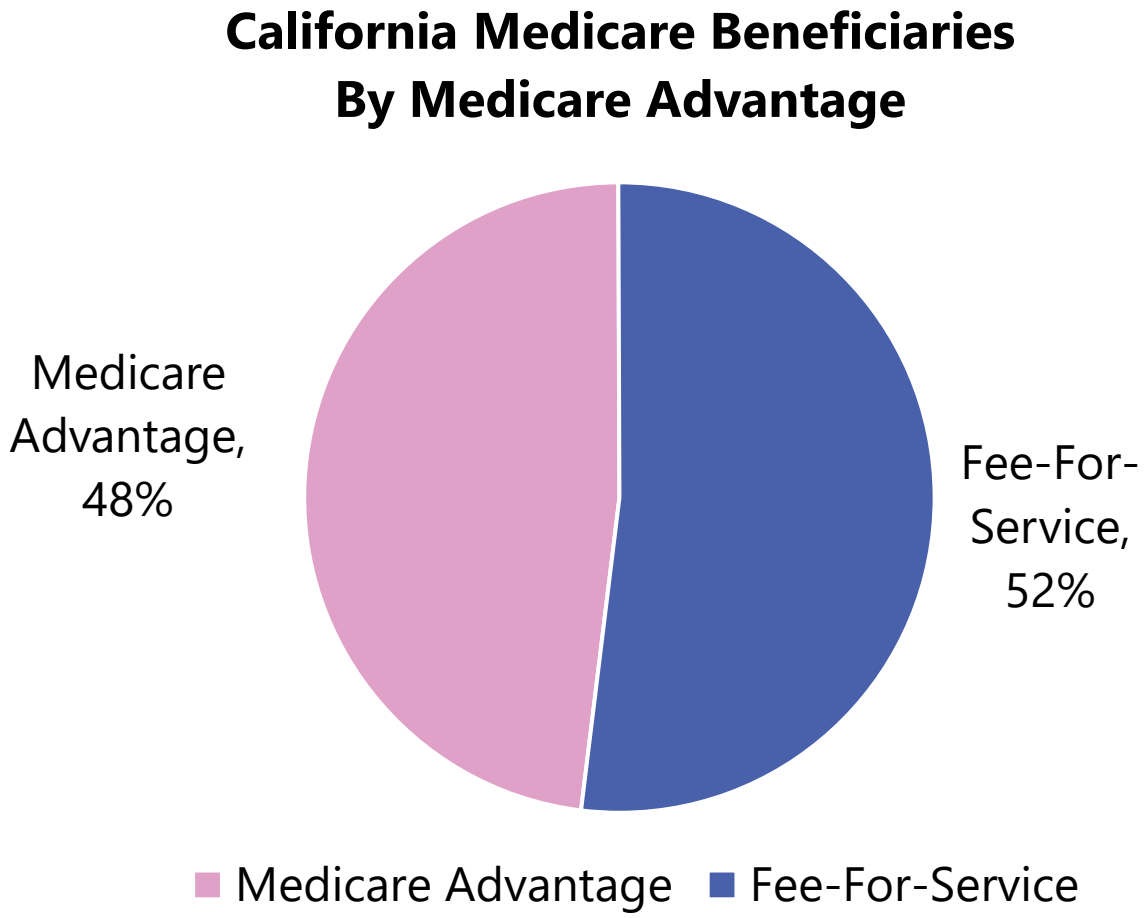
Composition of California's Medicare Population



County Rurality

- Just 1% of Californians with Medicare live in 14 Rural counties
- Just 4% live in 10 Suburban counties

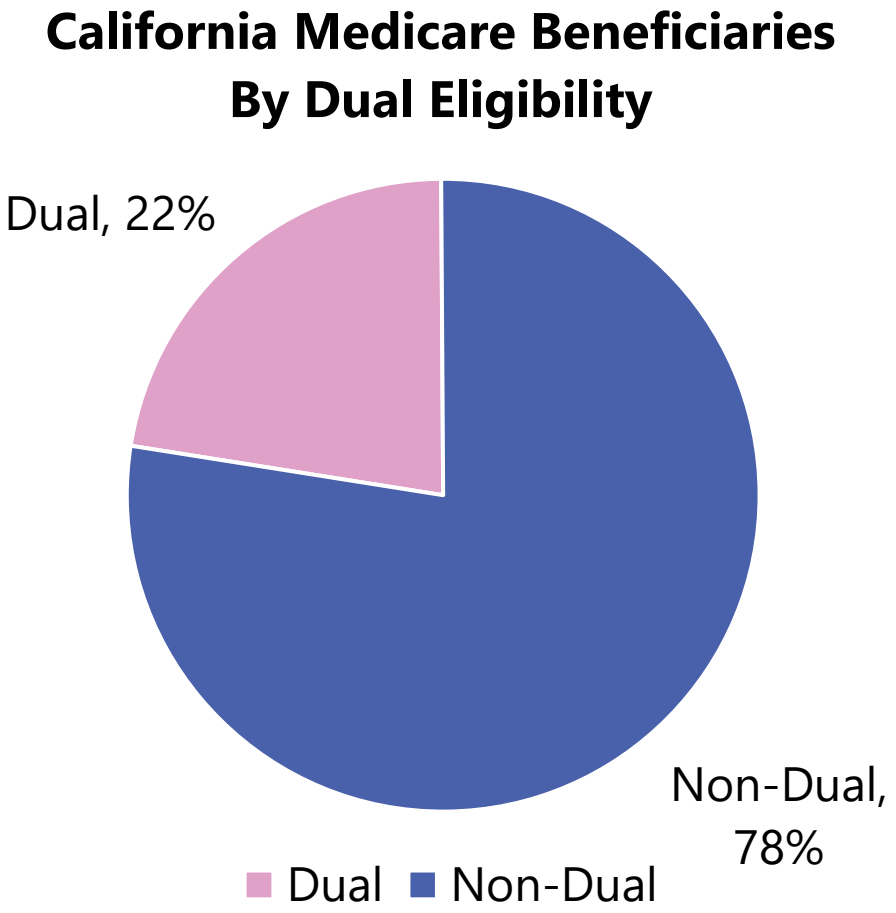
Composition of California's Medicare Population (Program Enrollment)



Medicare Program

- About one-half of Californian Medicare beneficiaries had Medicare Advantage
- For this chartbook, Medicare Advantage includes regular Medicare Advantage, Special Needs Plans, Cal MediConnect, and PACE

Composition of California's Medicare Population (Program Enrollment)



Dual Medi-Cal Eligibility

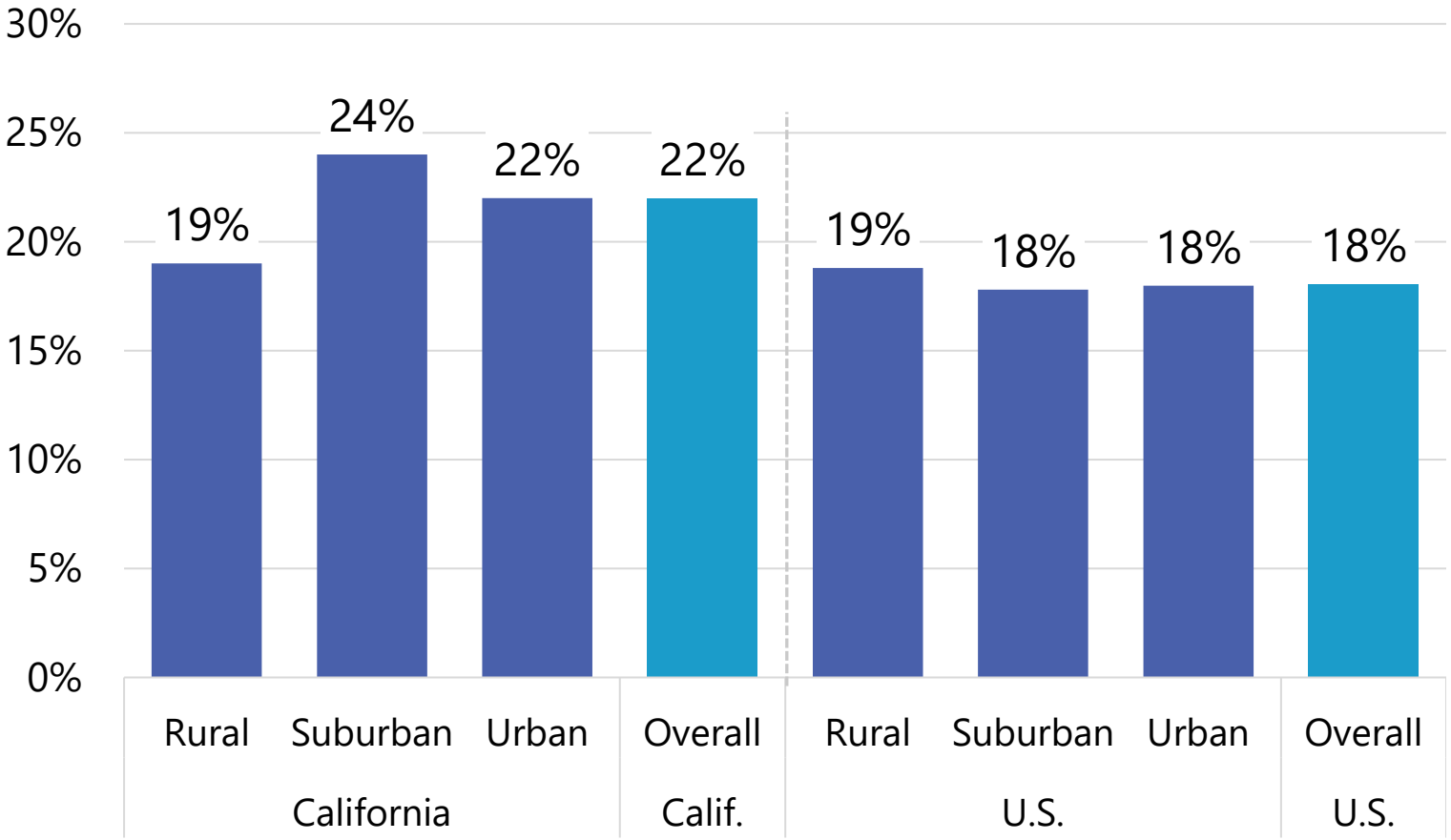
» More than one in five Medicare beneficiaries in the state have Medi-Cal

Profile of the California Medicare Population:

Share of Medicare Beneficiaries Enrolled in Medi-Cal (or Medicaid)

Share of Medicare Beneficiaries Enrolled in Medi-Cal

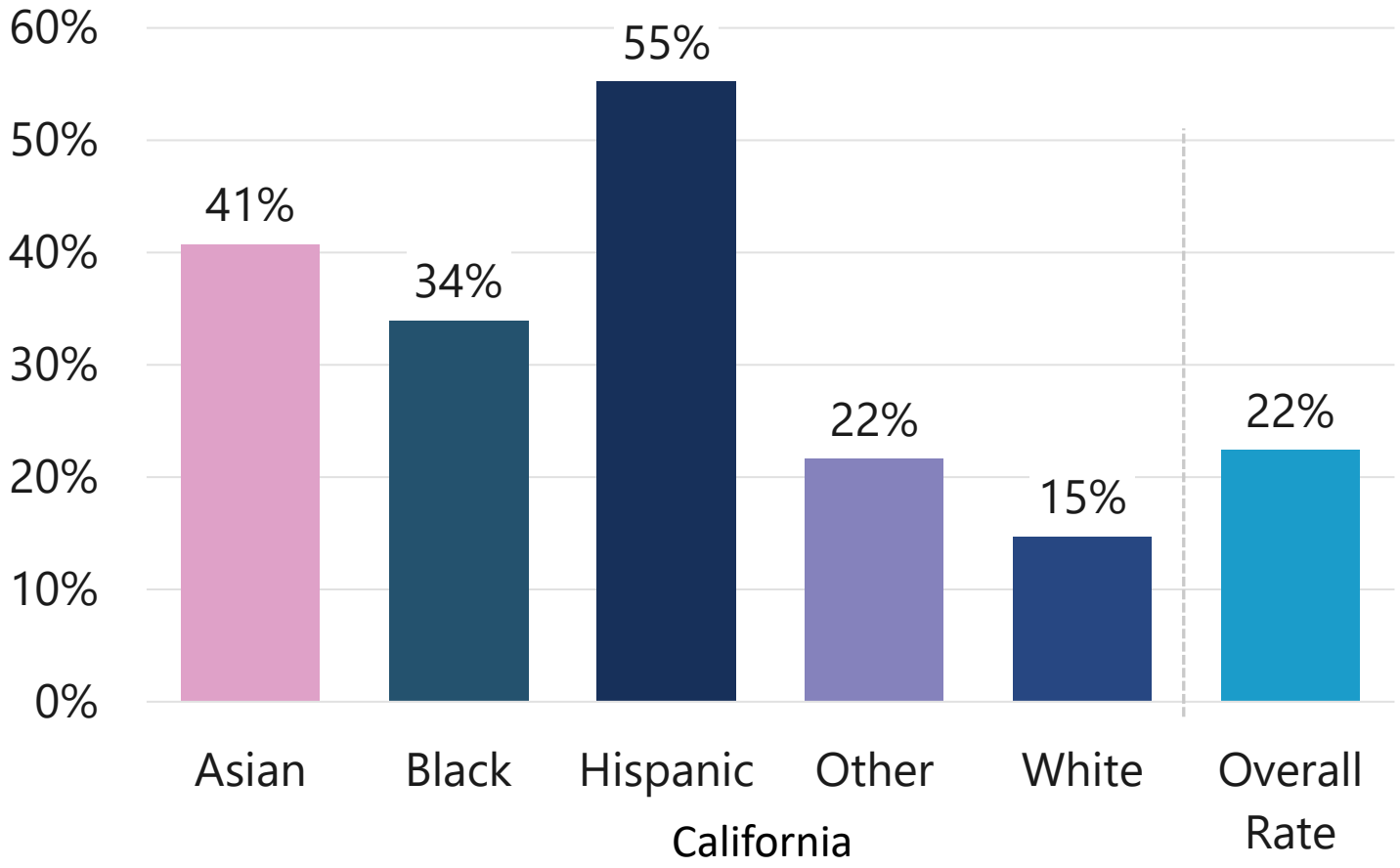
Medicare Beneficiaries, Share Enrolled in Medi-Cal



» Across geographies, Californians with Medicare are more likely to be dually eligible for Medi-Cal than Medicare beneficiaries nationwide

California Medicare Population: Share Enrolled in Medi-Cal

Medicare Beneficiaries, Share Enrolled in Medi-Cal

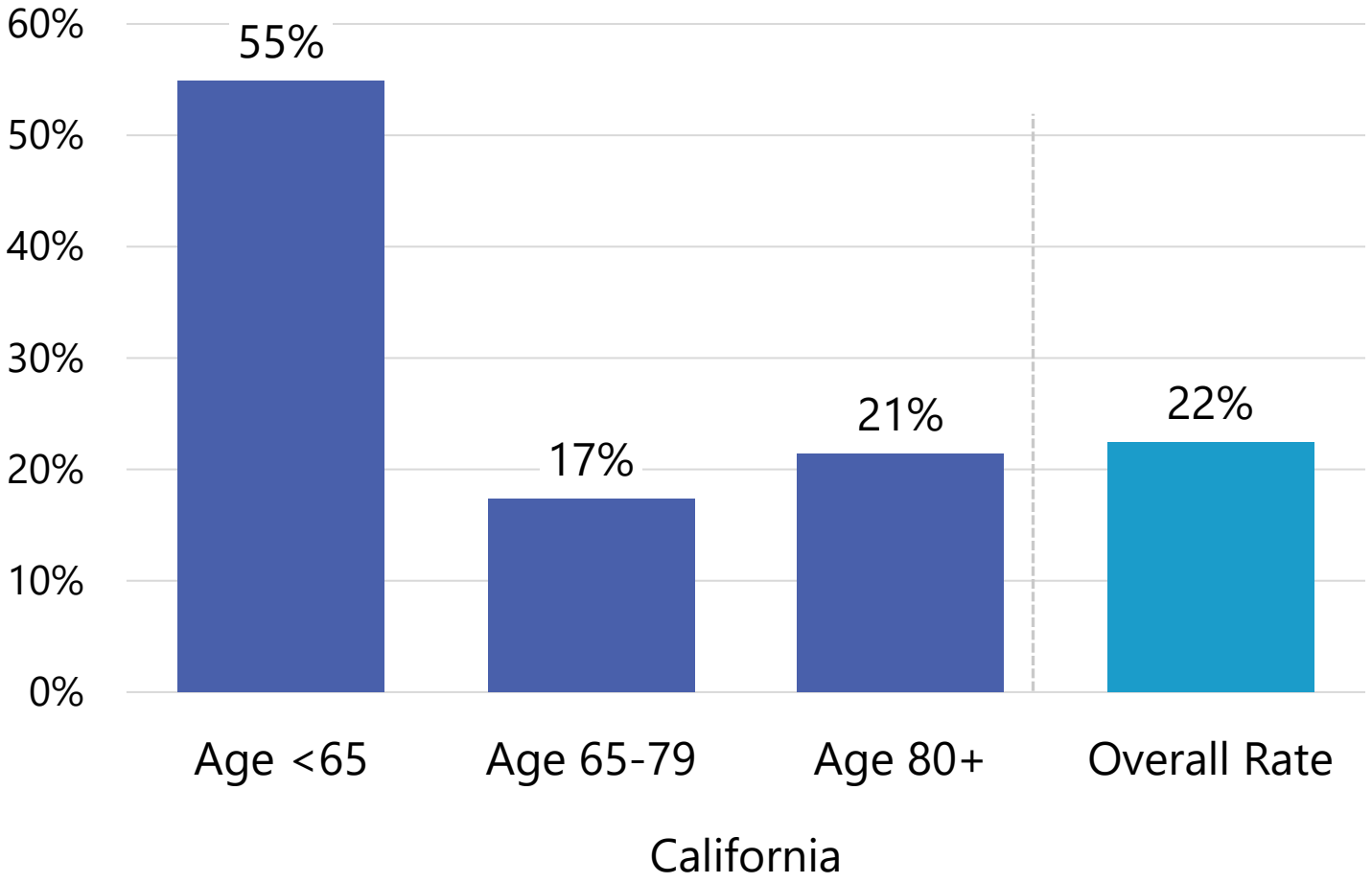


By Race and Ethnicity

» Wide variation seen by race/ethnicity, with dual eligibility more than twice as common among Hispanic Medicare beneficiaries

California Medicare Population: Share Enrolled in Medi-Cal

Medicare Beneficiaries, Share Enrolled in Medi-Cal

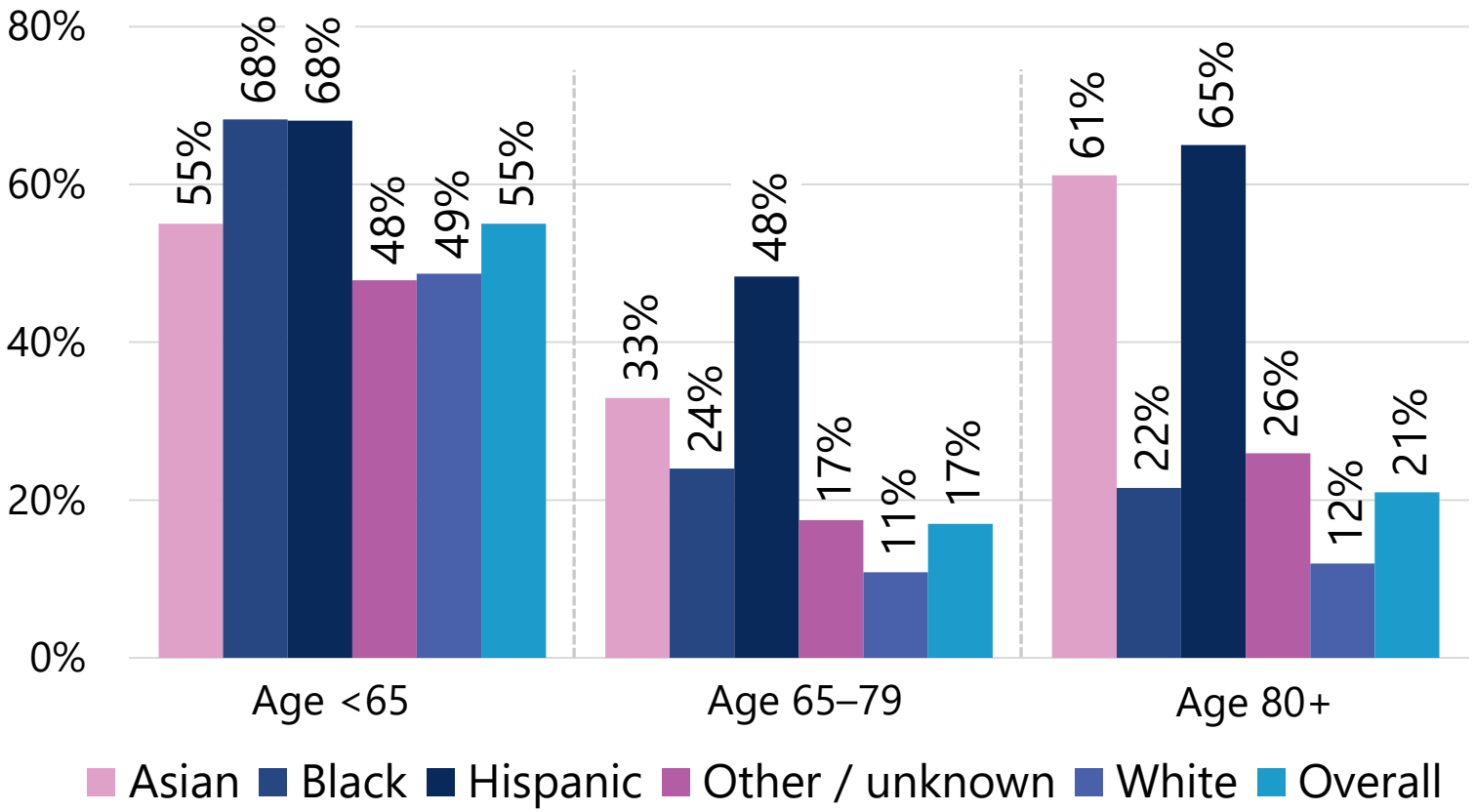


By Age Group

» Wide variation seen by age group, with dual eligibility more than twice as common among under-age-65 Medicare beneficiaries

California Medicare Population: Share Enrolled in Medi-Cal

Medicare Beneficiaries, Share Enrolled in Medi-Cal



By Age Group and Race/Ethnicity

- Some racial/ethnic differences lessen in the under-65 group
- Some widen in the over-80 group

Profile of the California Medicare Population:

Share of Medicare Beneficiaries Enrolled in Medicare Advantage and Related Programs

Share of Medicare Beneficiaries Enrolled in Medicare Advantage

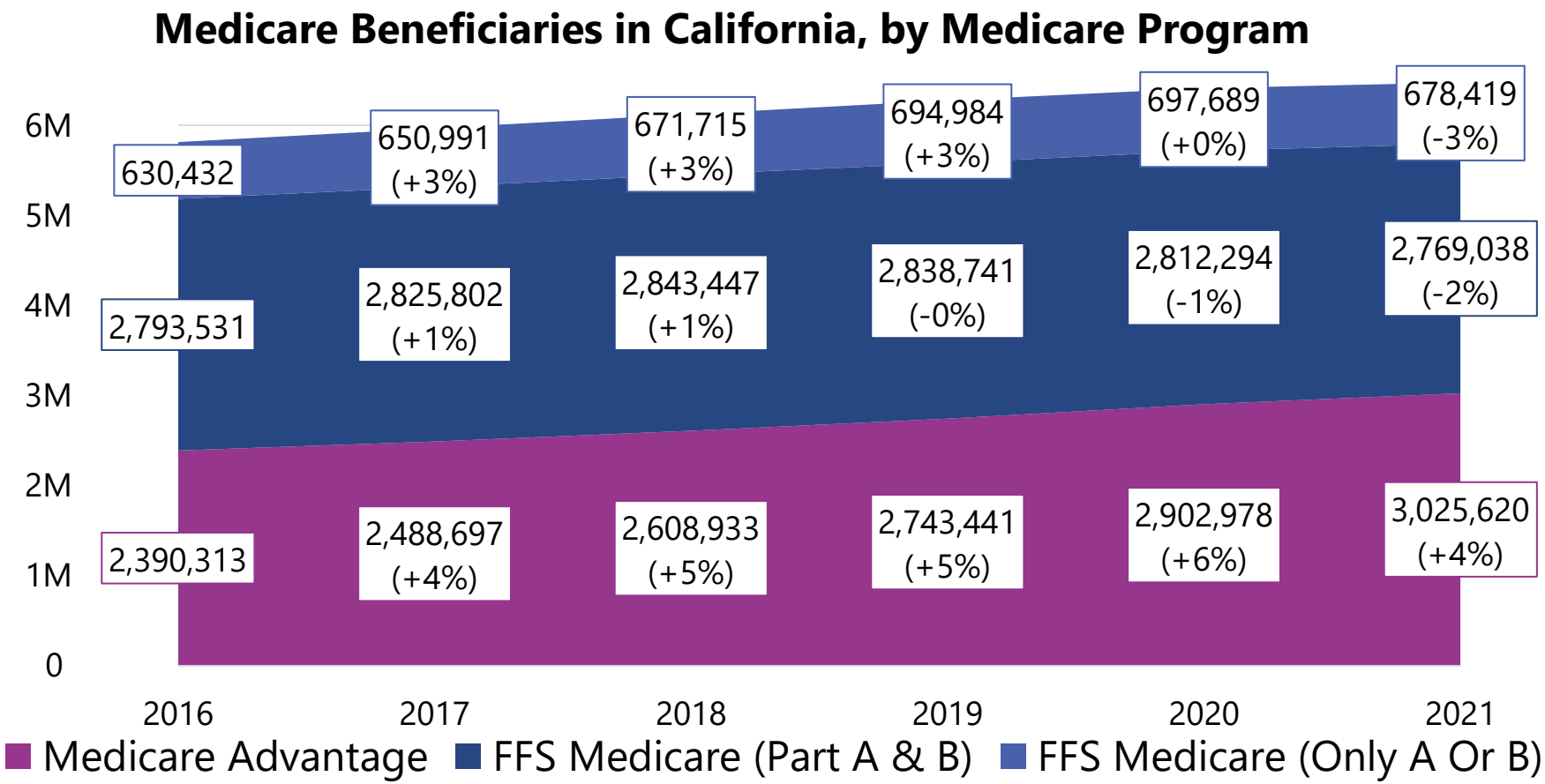
- California's Medicare Advantage penetration is higher than the US average

48%
of Californian Medicare beneficiaries have Medicare Advantage

43%
of overall U.S. Medicare beneficiaries have Medicare Advantage

- This high statewide rate hides low uptake in rural areas and among some demographic groups

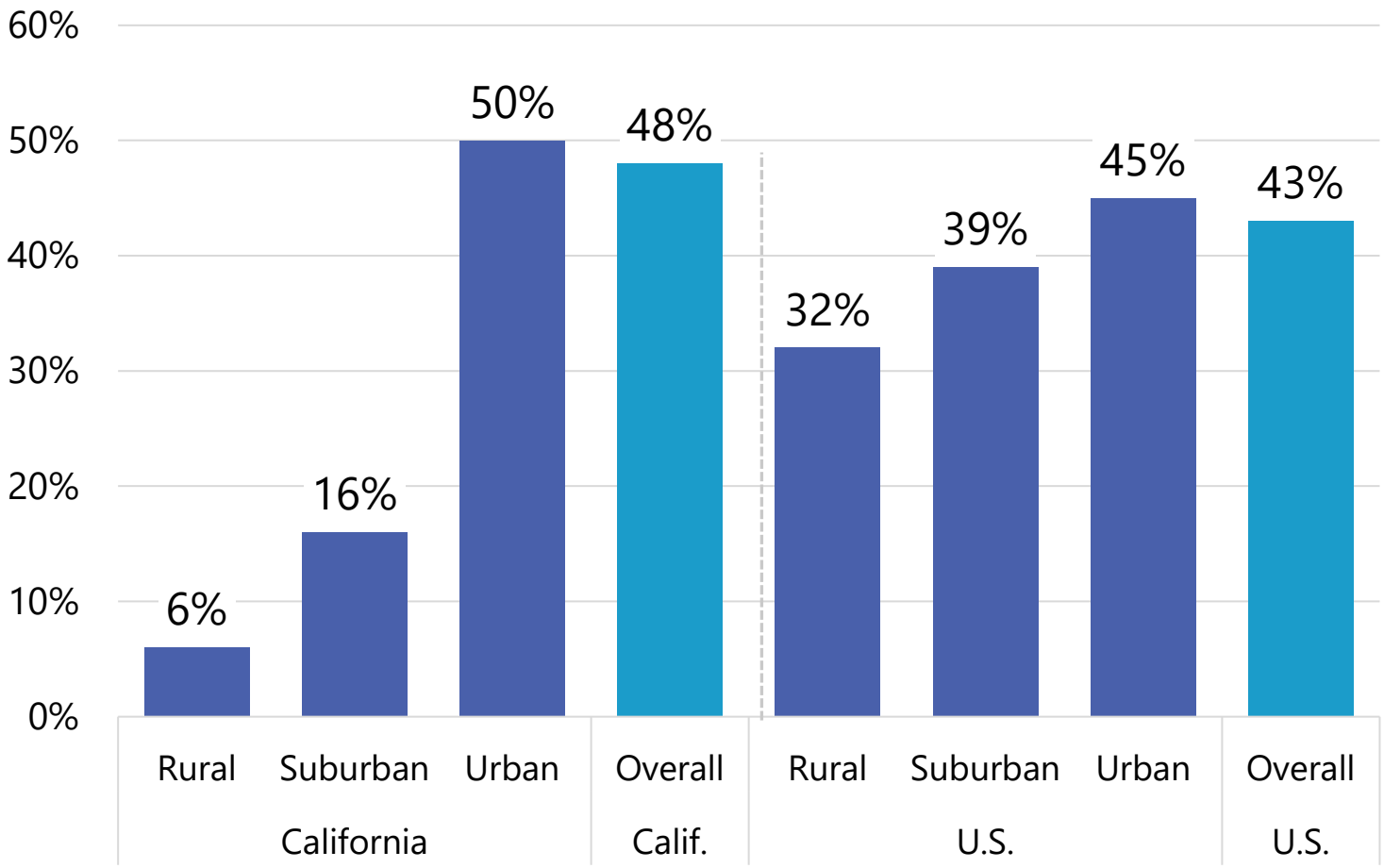
Growing California Medicare Population is Opting for Medicare Advantage



- California's Medicare population grew 11% from 2016 to 2021
  - Faster growth than the state's overall population
- Medicare Advantage has been capturing recent growth

California Medicare Population: Share Enrolled in Medicare Advantage

Medicare Beneficiaries, Share Enrolled in Medicare Advantage

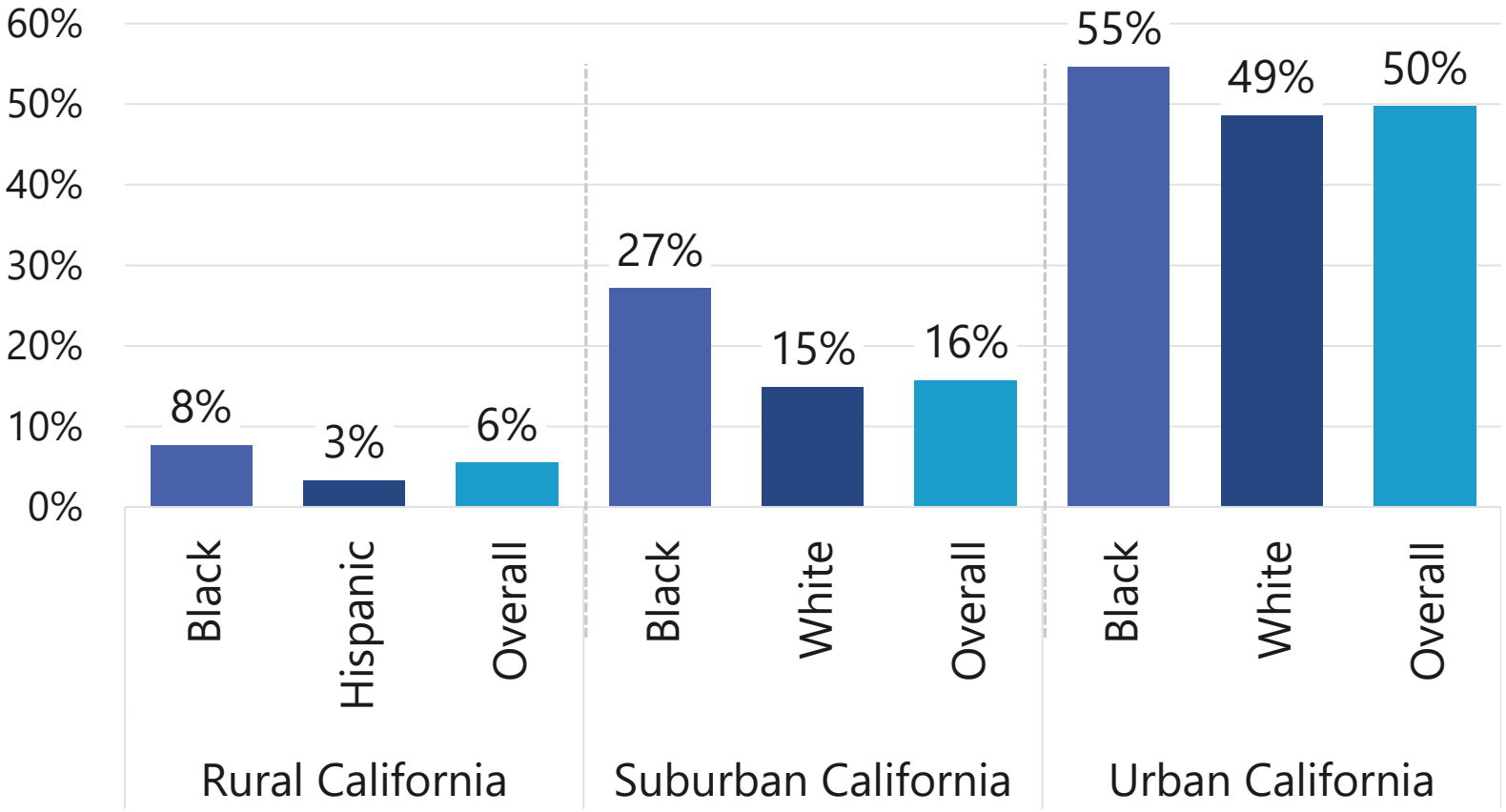


By County Rurality

- Medicare Advantage enrollment is highest in Urban counties
- Medicare Advantage enrolls one-half of California's Urban beneficiaries but just 1 in 17 Rural beneficiaries

California Medicare Population: Share Enrolled in Medicare Advantage

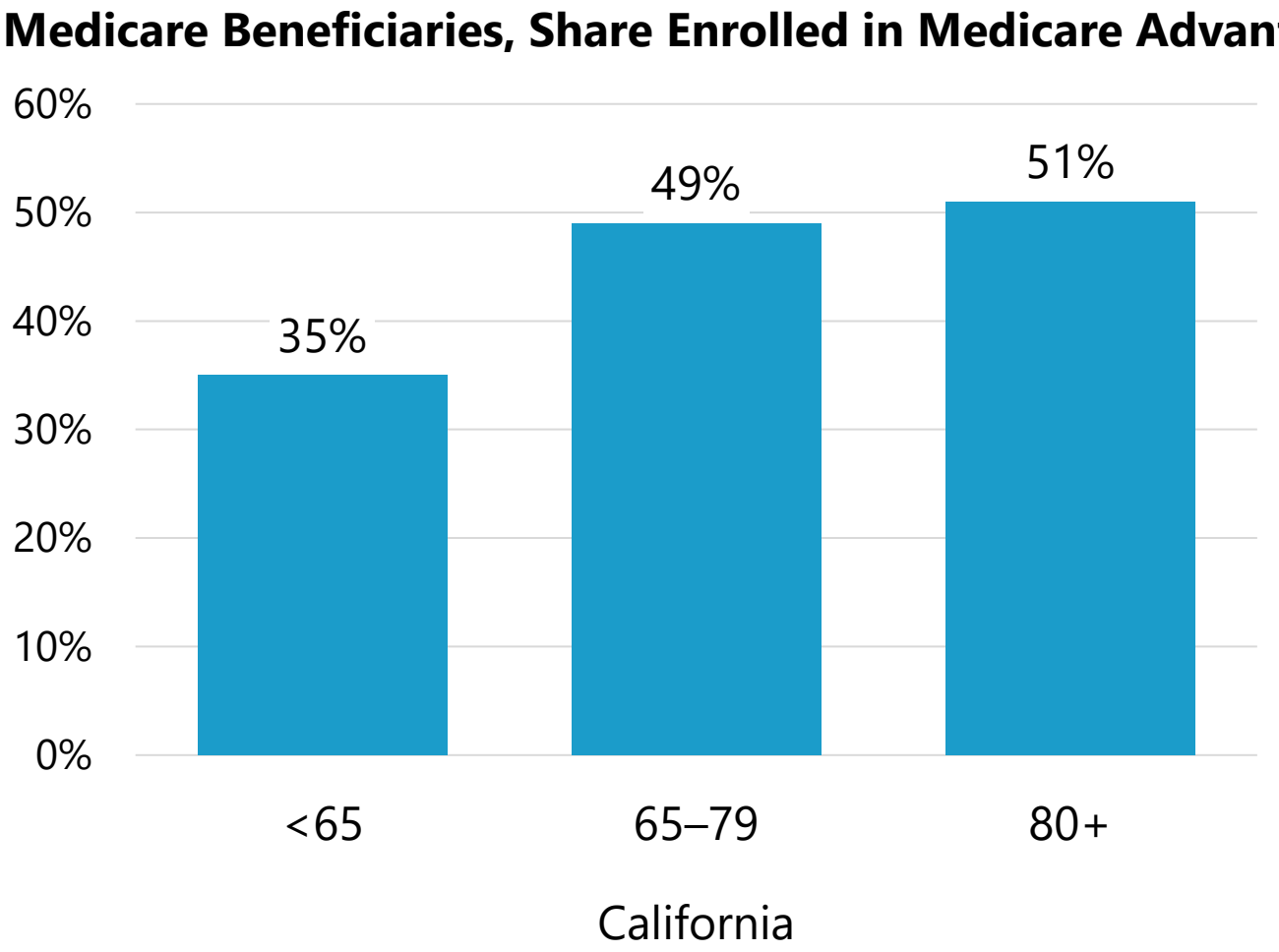
Medicare Beneficiaries, Share Enrolled in Medicare Advantage



By Race and Ethnicity

» Medicare Advantage enrollment is highest among Black beneficiaries, across geographies

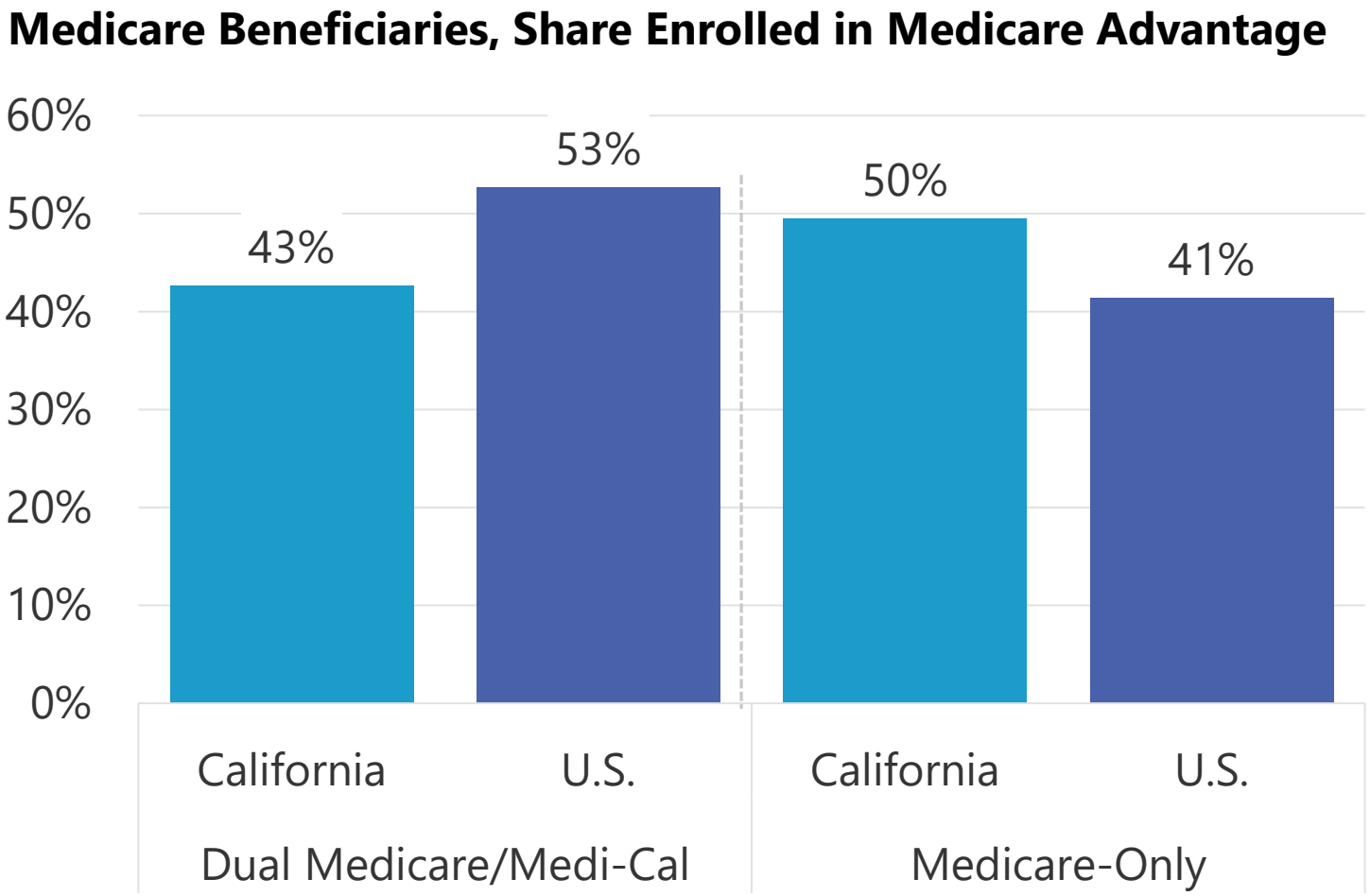
California Medicare Population: Share Enrolled in Medicare Advantage



By Age Group

- Medicare Advantage enrollment is far less common among under-65 Medicare beneficiaries, in California

Share of Medicare Beneficiaries Enrolled in Medicare Advantage



By Dual Medi-Cal Eligibility

- Californian dual Medicare/Medi-Cal beneficiaries enroll in Medicare Advantage less often than Medicare-only beneficiaries

Profile of the California Medicare Population: Closing Summary and Next Steps

Recap of Findings Presented Today

11% growth in state Medicare population, 2016-21

View the analyses and Chartbook here:
https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-2022.pdf

Among Californian Medicare beneficiaries:

21% were ages 80+
11% were under 65

54% were female

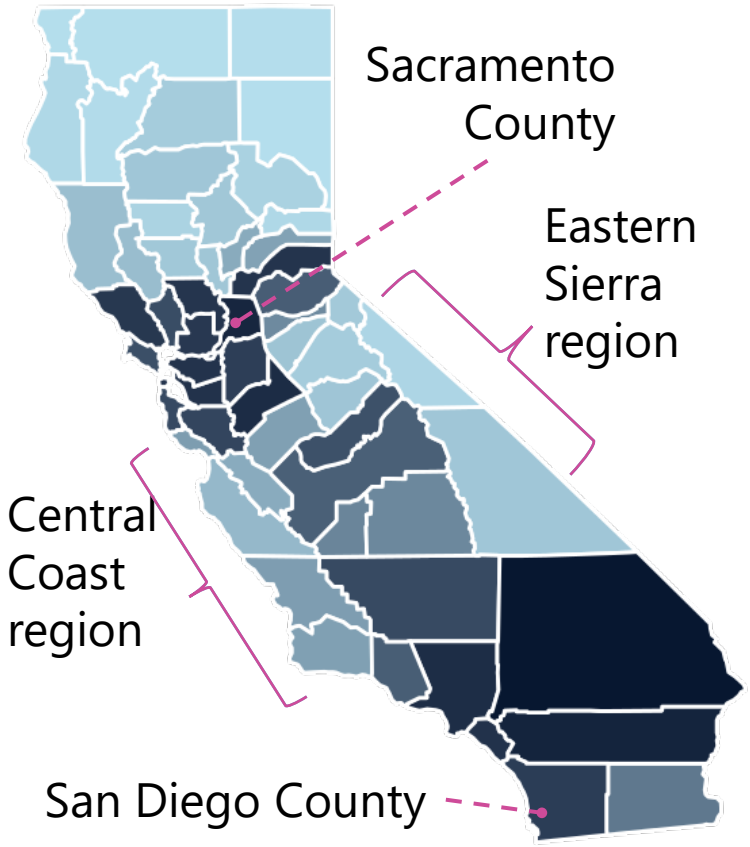
95% lived in urban counties

48% had Medicare Advantage

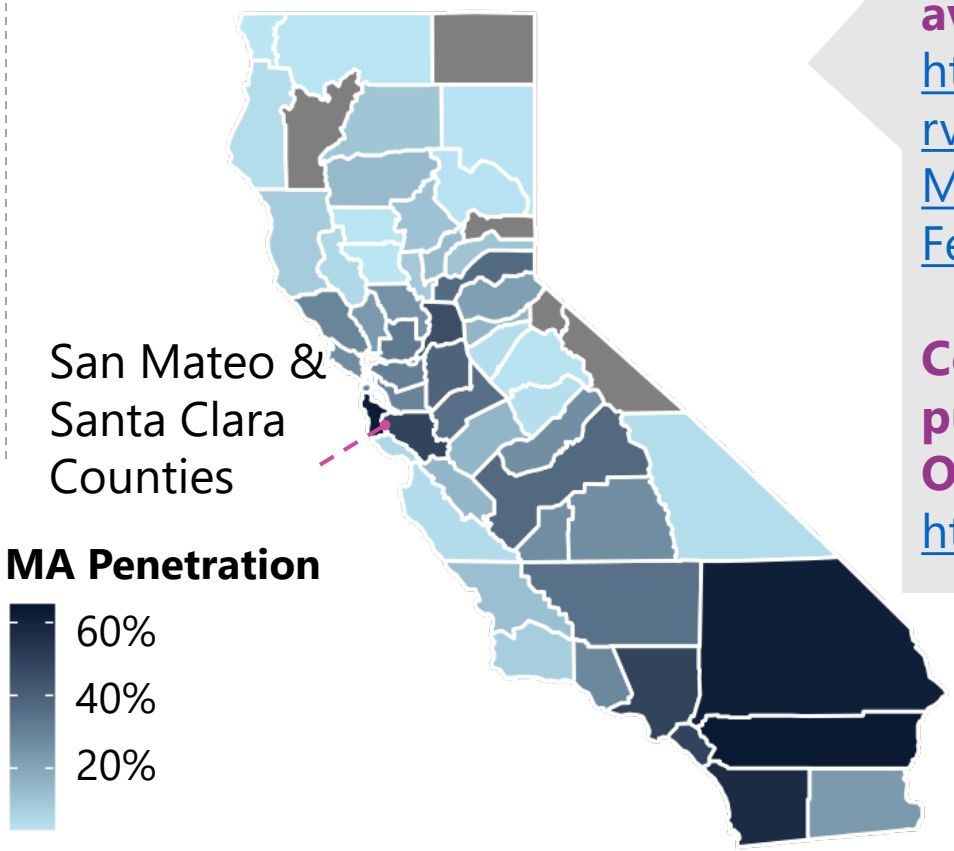
22% had Medi-Cal

How to Access the Chartbook for More Detail on the Medicare Population

County MA Penetration Rate, Medicare-Only Beneficiaries



County MA Penetration Rate, Dual Beneficiaries



View further analyses in the Chartbook, available here:
https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-2022.pdf

County-level data will be published at the CalHHS Open Data Portal:
https://data.chhs.ca.gov/

10-Minute Break

The workgroup will resume around 10:15 AM

Update on Long-Term Care (LTC) Carve-In Benefit Workgroup

Summary of January 25, 2022 Workgroup Meeting

Outline

- Managed Care Plan (MCP) Readiness
- LTC Continuity of Care
- LTC Data Sharing

MCP Readiness Process

- The LTC Carve-In will include a robust readiness process that will take place over the next year with MCPs. Activities will include but are not limited to:
  - **Network readiness** – reviewing network submission by plan
  - **Updating member-facing materials** – plan materials (e.g., member handbook, welcome packet, etc.) as well as DHCS materials (e.g., notices, FAQs, website)
  - **Data sharing** – DHCS shares data with MCPs for planning and transition
  - **Other**:
  - Creating and updating policies and procedures
    - Financial submissions

Workgroup Feedback: MCP Readiness Process

- **Network Readiness**
  - Network adequacy is more complicated than counting beds, although there is often a shortage of beds.
  - If possible, network adequacy should also address the time it takes to transition members from the hospital into a facility/home.
  - Care coordination is very important during this process to ensure that where appropriate, members are being connected to Home and Community-Based Services (HCBS) and have care plans designed to help transition them home.
- **Member Materials**
  - In addition to clearly communicating with beneficiaries and family members, providers (including LTC facilities but also physicians, care managers, etc.) and plan staff (including member services and provider relations) need direct communication about the transition.

Continuity of Care (CoC) During LTC Transition

- For LTC, CoC applies to the facility/home, provider, and covered services.
  - At a high-level, MCPs must provide CoC for all medically necessary LTC services at non-contracting LTC facilities for members residing in an LTC facility at the time of enrollment.
  - MCPs must provide up to 12 months of CoC with an out-of-network Medi-Cal provider, if certain conditions are met.
- CoC can apply to both providers and services.
  - For example, if a member's primary care provider is out of network, they might utilize CoC to continue accessing their physician.
  - CoC for services such as Durable Medical Equipment (DME) means continued access to the services themselves, even if a beneficiary switches to an in-network provider.

Workgroup Feedback: Continuity of Care

- Plans need to have very detailed data on **all** services that members are receiving to ensure continuity during the transition.
  - For LTC, this includes understanding what services are covered by LTC facility rate and what are outside that rate.

Proposed Data Sharing with Plans for LTC Transition

Type of Data	Specific Data	Timeline for providing data to MCPs
Planning Data	Estimate of population transitioning based on the number of beneficiaries residing in a LTC facility and in fee-for-service (FFS) today	2022 – Quarter 1
Planning Data	Population utilization data	2022 – Quarter 2
Transition Data	Beneficiary-level demographic and claim level data for each MCP's specific transitioning population	Dec 2022 / Jan 2023
Standard Ongoing Data Feeds	Beneficiaries new to Medi-Cal, or transitioning between plans	Post- implementation Jan 2023

Workgroup Feedback: Data Sharing

- MCPs would like to receive data as early as possible to help with planning (including network development) as well as to support CoC.
  - If possible, MCPs would like to receive data ahead of member effective date in the plan, as was done in the Coordinated Care Initiative (CCI) transition.
- Facilities/homes would like to have clear communication from MCPs regarding member transitions.

Dementia Aware and Senate Bill (SB) 48 Update

Dr. Sohrab Sidhu, MD, MPH
Medical Quality Officer
Office of the Medical Director (OMD)
Quality and Population Health Management (QPHM)
DHCS

HCBS Spending Plan: **Dementia Aware and Geriatric/Dementia Continuing Education**

- Funding: $25M enhanced federal funding, one-time
- Lead Department(s): DHCS, with California Department of Health Care Access and Information (HCAI) and California Department of Public Health (CDPH).
- Investments to improve rates of dementia screening to ensure early detection and timely diagnosis, while also connecting individuals and families to community resources.

HCBS Spending Plan: **Dementia Aware and Geriatric/Dementia Continuing Education**

- Provider training in culturally competent dementia care
- Referral protocol on cognitive health and dementia
- Promote use of validated tools, training, and referral protocol
- Make continuing education in geriatrics/dementia available to all licensed health/primary care providers
- Aligns with SB 48: Medi-Cal: Annual cognitive health assessment

Medicare Annual Wellness Visit (AWV)

- Medicare covers yearly "Wellness" visits to develop or update a personalized prevention plan to help prevent disease and disability, based on the individual's current health and risk factors.
- Detecting cognitive impairment is a required element of Medicare's AWV.
- The existing Alzheimer's Association Cognitive Assessment Toolkit is intended for physicians to use during the Medicare AWV. These cognitive assessment tools are used to identify individuals who may need additional evaluation.
- If a physician detects cognitive impairment at an AWV or other routine visit, they may perform a more detailed cognitive assessment and develop a care plan during a separate visit.
- For more information and background: Cognitive Assessment & Care Plan Services | CMS and Cognitive Assessment Tools | Alzheimer's Association

SB 48: Medi-Cal: Annual cognitive health assessment

- SB 48 establishes an annual cognitive health assessment as a Medi-Cal benefit, for beneficiaries age 65 and older, if they are otherwise ineligible for a similar assessment as part of the Medicare AWV.
- Medi-Cal providers eligible to receive payment for this Medi-Cal benefit, for Medi-Cal-only beneficiaries (not duals), if they:
  - Complete cognitive health assessment training, as approved DHCS
  - Use one of the validated tools recommended by DHCS

Dementia Aware/SB 48 Update: Billing Code Determination for SB 48

- No appropriate Category I CPT code identified
  - 99483 (Category I code) used in Medicare for 50-minute cognitive health assessment & care plan services
  - SB 48 aims to reimburse for a *brief* cognitive health assessment

- 1494F identified as code for new SB 48 Medi-Cal benefit
  - Category II CPT code, for performance measurement
  - SB 48 incentive payment tied to utilizing this code
  - Medi-Cal-only beneficiaries (not duals)

Dementia Aware: Contract

- DHCS is contracting with University of California, San Francisco
  - UCSF subcontracting with several other UCs (UCI, UCD, Harbor UCLA, UCLA Division of Geriatrics, UCSD)
- Leverages necessary expertise in both dementia care and screening implementation in primary care practices
- Training available for Medi-Cal providers by July 1, 2022*

*Goal date for implementing cognitive health assessment Medi-Cal benefit in SB 48

Dementia Aware:
UCSF Contract Scope of Work

Phase 1 (Mar 1, 2022 – Aug 31, 2022)

- Section 1: Project Management and Technical Assistance
- Section 2: Screening Tool Development
- Section 3: Training Development
- Section 4: Continuing Medical Education (CME) Accreditation and Maintenance

Phase 2 (Sep 1, 2022 – Mar 31, 2024)

- Section 1: Project Management and Technical Assistance
- Section 5: Practice-level Implementation Support
- Section 6: Training Evaluation and Updating
- Section 7: Training Outreach and Engagement Strategy

Proposed 2023 State-Specific Reporting Requirements for Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs)

Dr. Sohrab Sidhu, MD, MPH
Medical Quality Officer
Office of the Medical Director (OMD)
Quality and Population Health Management (QPHM)
DHCS

DHCS' Commitment to Quality

- State-specific reporting requirements for EAE D-SNPs are part of a larger quality strategy within DHCS, including an addendum to the Comprehensive Quality Strategy focused on dual eligible individuals, Long-Term Services and Supports (LTSS) dashboard, and the Master Plan for Aging.
- DHCS is examining existing D-SNP contract requirements and federal quality standards, and has been working with stakeholders, plans, and the Centers for Medicare and Medicaid Services (CMS) to identify the range of quality and reporting results that D-SNPs will report to DHCS on an annual basis.
- DHCS is committed to incorporating promising practices and quality reporting metrics from Cal MediConnect (CMC) plans.

Review of CMC vs. D-SNP Reporting Requirements

- D-SNPs have robust reporting requirements for Medicare (Part C and Part D).
- CMC Plans have Medicare-Medicaid Plan reporting requirements that include Part C and Part D reporting requirements as well as those specific to the demonstration (both federal and state-specific reporting requirements).

Cal MediConnect (CMC) vs. Medicare Advantage Dual Eligible Special Needs Plans (D-SNP) Federal Reporting Requirements

Reporting Requirement	CMC	D-SNP
Healthcare Effectiveness Data and Information Set (HEDIS)	■	■
Medicare Health Outcomes Survey (HOS)	■	■
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	■	■
Federal Core Reporting Requirements for CMC	■	□
State-Specific Reporting Requirements for CMC	■	□
Part C Reporting Requirements	◘	■
Part D Reporting Requirements	◘	■

■ = Required to report □ = Not required to report ◘ = Required to report a smaller subset

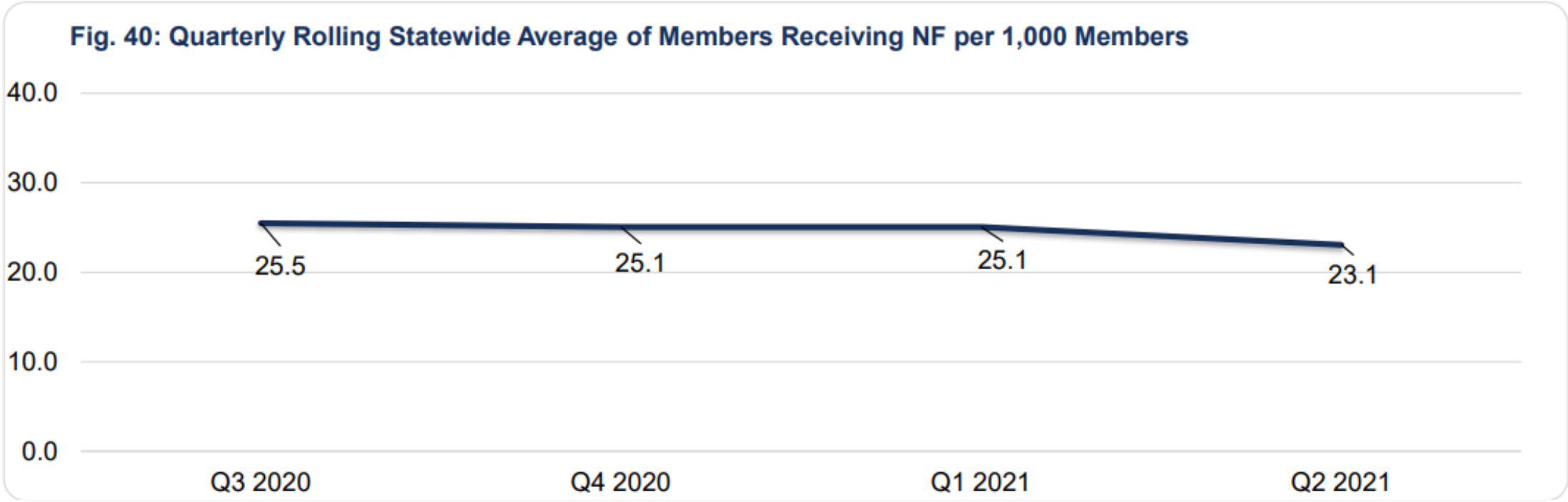
Cal MediConnect Dashboard

- Provides key data and measures on key aspects of the CMC Program using a combination of quarterly and annual measures, including:
  - Enrollment and Demographics
  - Quality Withhold
  - Care Coordination
  - Grievances and Appeals
  - Behavioral Health Services
  - LTSS, including In-Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), Nursing Facility (NF) and Care Plan Options (CPO).

Cal MediConnect Members Receiving Nursing Facility Care per 1,000 Members

Cal MediConnect Performance Dashboard - Released December 2021

Long Term Services & Supports (LTSS) Figure 40 & 41: Count of NF per 1,000 Members (07/2020-06/2021)
See metric summary for additional information



Importance of CMC Dashboard

- DHCS, plans, advocates, and other stakeholders have used the CMC dashboard to track progress on a number of different measures, including care coordination (e.g., health risk assessments, individualized care plans, individualized care teams) and LTSS referrals.
- Statewide and plan-specific performance has been a helpful benchmark to evaluate members' experiences in CMC plans.

D-SNP Reporting: Federal Medicare Part C and Part D Requirements

- **Healthcare Effectiveness Data and Information Set (HEDIS)**
  - Access/availability of care (e.g., access to preventative/ambulatory care)
  - Care for older adults (e.g., advance care planning)
  - Effectiveness of care (e.g., medication management, follow-up after emergency department visit)
  - Utilization (e.g., hospital readmissions)
- **Medicare Health Outcomes Survey (HOS)**
  - E.g., Falls risk management, transitions of care
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**
  - E.g., interaction with personal doctor, ability to receive care from specialists, receiving information from health plan

D-SNP Reporting: Federal Medicare Part C and Part D Requirements (cont.)

- **Part C Reporting Requirements**
  - Grievances
  - Organization Determinations & Reconsiderations
  - Special Needs Plans Care Management
  - Enrollment and Disenrollment
  - Rewards and Incentives Programs
  - Payments to Providers

- **Part D Reporting Requirements**
  - Enrollment and Disenrollment
  - Medication Therapy Management Programs
  - Grievances

Note: MCPs also have robust reporting requirements and performance measures.

D-SNP Reporting: State-Specific Medicare Reporting

- All CMC plan reporting is at the plan/county level (like Medi-Cal). D-SNPs report at the CMS contract level, which usually includes the D-SNP as well as other Medicare products in the state and/or region.
- DHCS is reviewing options for D-SNP specific quality measures. Options include 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 (in addition to CMS).

D-SNP Reporting: State-Specific Quality and Reporting Requirement Considerations

DHCS identified the following considerations in developing a proposal for additional state-specific quality and reporting requirements for D-SNPs:

1) Overall quality and integrated care goals for D-SNPs.
2) Clinical value, and alignment with Medicare and Medi-Cal goals and measures.
3) Existing data sent to CMS that DHCS can receive.
4) Existing DHCS data that can be analyzed.
5) CMC measures to maintain for initial enrollment transition monitoring.

D-SNP Reporting: Proposed HEDIS Measures

Data Collection	Abbreviation	Measure Definition
Access/ Availability of Care	AAP- Total	Adults' Access to Preventative/Ambulatory Health Services - Total
Effectiveness of Care	AMB-ED	Ambulatory Care-Emergency Department (ED) Visits-Total
	CBP	Controlling High Blood Pressure
	CDC-Poor Cont	Comprehensive Diabetes Care - Poor HbA1c Control
	FUM-7 days	Follow-Up After Emergency Department Visit for Mental Illness - 7 Days
	FUM-30 days	Follow-Up After Emergency Department Visit for Mental Illness - 30 Days
	FU- SUD	Follow-Up After Emergency Department Visit for Substance Abuse
Utilization and Risk Adjusted Utilization	PCR	Plan All-Cause Readmissions

D-SNP Reporting: CMC Measures To Continue

Data Collection	Abbreviation	Measure Definition
Assessment	Core 2.1	Members with an assessment completed
	Core 2.12	Members with an assessment completed within 90 days of enrollment
	Core 2.3	Members with an annual reassessment
Care Coordination	Core 3.2	Members with a care plan completed within 90 days of enrollment
	CA 1.5	Members with an Individualized Care Plan (ICP) completed
	CA 1.6	Members with documented discussions of care goals
Organizational Structure and Staffing	Core 5.1	Care coordinator to member ratio
	CA 3.2	Care coordinator training for supporting self-direction under the demonstration

D-SNP Reporting:
CMC LTSS Measures To Continue

Data Collection	Abbreviation	Measure Definition
Long Term Services and Supports (LTSS) Measures	CBAS	Total number of members currently receiving services during the reporting quarter
	CBAS	Total number of referrals made for Community-Based Adult Services (CBAS) services for the reporting quarter
	CBAS	Number of assessments/reassessments/denials
	IHSS	Number of ICTs with county social worker/trained social worker
	IHSS	Members referred to county for In-Home Services and Supports (IHSS)
	IHSS	Number of members receiving IHSS

D-SNP Reporting: CMC LTSS Measures To Continue

Data Collection	Abbreviation	Measure Definition
Long Term Services and Supports (LTSS) Measures	MSSP	Number of ICTs with Multipurpose Senior Services Program (MSSP) care manager
	MSSP	Number of members receiving MSSP
	MSSP	Number of referrals made for MSSP
	LTC	Number of members residing in Long-Term Care (LTC)
	LTC	Member referrals received for LTC stay
	LTC	Number of assessments/approvals/denials for LTC

D-SNP Reporting: Proposed Alzheimer's/ Dementia Quality of Care

Data Collection	Abbreviation	Measure Definition
Alzheimer's/Dementia Quality of Care		Percent of older adults (or patients) aged 65 and older who had cognition assessed

Breakout Room Discussions

- Breakout room sessions will be 20-minutes long.
- Participants will be automatically placed in breakout rooms.
- Each breakout room will be staffed with a note taker who will help to pose questions and take notes on the discussion.
- Each breakout room will need to choose one participant who will report out to the larger group when the breakout session concludes.
- We will have as many groups report out verbally as time allows, which is why written feedback is so important!

Discussion Questions

- The state-specific reporting requirements includes a mix of health outcomes as well as how plans are operationalizing care coordination. Is it helpful to have both types of measures?
- What are the most helpful pieces of public quality reporting information presented on the CMC Dashboard?
- Are the proposed HEDIS, CMC, and Alzheimer's/dementia metrics the most helpful in measuring quality and beneficiary experiences for duals in EAE D-SNPs, recognizing that there are many other required Medicare Part C and Part D reporting requirements? What additional measures should be considered and why?

***Choose one person who will write feedback in the chat and share with the broader group.**

Breakout Rooms and Report-Outs

Upcoming Meeting Topics

Future topics may include, but not limited to:

- Beneficiary communications and integrated member materials
- Quality reporting
- Information sharing
- Updates to 2023 State Medicaid Agency Contract (SMAC)
- Cal MediConnect transition process and status
- Crossover claims and balanced billing

Closing

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, March 24 at 10 a.m.**
- Next CCI Stakeholder Webinar: **Thursday, March 17 at 11 a.m.**

California Advancing and Innovating Medi-Cal (CalAIM) Background

CalAIM: Overview

- California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by DHCS to improve the quality of life and health outcomes by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

CalAIM: Goals for Managed Long-Term Services and Supports

- Improved Care Integration
- Person-Centered Care
- Leverage California's Robust Array of Home and Community-Based Services (HCBS)
- Build on Lessons and Success of Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI)
- Support Governor's Master Plan for Aging
- Build a Multi-Year Roadmap to integrate CalAIM Managed Long-Term Services and Supports (MLTSS), Dual Eligible Special Needs Plan (D-SNP), and Community Supports policy, the Master Plan for Aging, and all HCBS, to expand and link HCBS to Medi-Cal managed care and D-SNP plans

Current State of LTC Services Coverage for Beneficiaries

In COHS and CCI Counties

- MCPs are contractually responsible for all medically necessary LTC services (for most facilities) regardless of the length of stay in a facility.
- Medicare-Medicaid Plan (MMP) and MCP members requiring long-term stays at nursing facilities continue to stay enrolled in their Plan and do not transition to Fee-For-Service (FFS).
- MMPs, MCPs, LTC facilities, and other support services are required to coordinate care and transitions of care for beneficiaries.

MCP	Counties (* are CCI counties)
CalOptima	Orange*
CenCal Health	Santa Barbara, San Luis Obispo
Central California Alliance for Health	Santa Cruz, Monterey, Merced
Gold Coast Health Plan	Ventura
Health Plan of San Mateo	San Mateo*
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
LA Care Health Plan, Health Net	Los Angeles*
Inland Empire Health Plan, Molina Healthcare	Riverside*, San Bernardino*
Anthem Blue Cross Partnership Plan, Santa Clara Family Health Plan	Santa Clara*
Aetna Better Health, Blue Shield, Community Health Group Partnership Plan, Health Net, Kaiser Permanente, Molina Healthcare, United Healthcare	San Diego*

All Other Counties

- MCPs are contractually responsible for medically necessary LTC services provided from the time of admission into a LTC facility and up to one month after the month of admission for LTC.
- MCPs are required to submit a disenrollment request to DHCS for beneficiaries who require LTC in a facility for longer than the month of admission plus one month.
- Until the disenrollment is approved by DHCS, MCPs must provide all medically necessary covered services to the beneficiary.
- MCPs are also required to coordinate the beneficiary's transfer to the Medi-Cal FFS program upon the effective date of disenrollment.

MCP Contracting and Payment Requirements for SNFs Today

- MCPs are responsible for contracting with SNFs as licensed by the California Department of Public Health and other credentialing standards, as applicable.
- MCPs must pay SNFs rates that are not less than Medi-Cal FFS rates (Assembly Bill 133 – Chapter 143, Statutes of 2021).

LTC for Managed Care Members Today

- Medi-Cal Managed Care Plans (MCPs) in COHS and CCI counties cover LTC services for enrolled members (for most facilities.)
- MCPs in non-COHS and non-CCI counties cover LTC services for enrolled members for their month of admission and the following month.
  - Subsequently, the member is disenrolled from the MCP into the FFS delivery system and LTC services are covered under FFS.
- MCPs pay LTC providers according to the terms of their negotiated contracts.

LTC Services in FFS Today

- FFS LTC per diem rates are developed based on their respective facility specific methodology as outlined in the California State Plan.
- The Fiscal Intermediary (FI) processes FFS claims via a weekly check write process.
- FFS providers submit electronic or manual claims to the FI and providers are paid directly through a weekly check write process.
- Program provides the FI any rate changes, such as an annual rate update, so they can install the changes into the payment system.
  - Once updated rates are installed, the FI will pay FFS providers at the updated rates on a prospective basis. The process typically takes 60-90 days before provider's will see the updated rates in their weekly check write.
  - There is typically a lag between the beginning of the Rate Year and when the system is updated with the updated rates. During this time providers will continue to be paid at their prior rate.
  - Approximately 90-days following the prospective rate update, the FI retroactively reprocesses claims paid at the prior rate through an Erroneous Payment Correction process (EPC).
  - The EPC process retroactively adjusts payments so providers receive the difference up to the updated rate and will be included in their weekly check write.

Long-Term Care Carve-In

LTC Carve-In

- Effective January 1, 2023, MCPs will become responsible for the full LTC benefit in all California counties. Institutional LTC services will be carved into all plans, including those provided by ICF/DD homes.
- Some of the carved-in LTC services are currently within the scope of Medi-Cal managed care plans in COHS and CCI counties, but many services will be new to Medi-Cal managed care plans in other counties.

LTC Carve-In Requirements

- Beneficiaries who enter an LTC facility and would otherwise have been disenrolled from the MCP will remain enrolled in managed care ongoing.
- All Medi-Cal-only and dual eligible beneficiaries in Medi-Cal FFS residing in a LTC facility on January 1, 2023 will be enrolled in an MCP effective January 1, 2023. Beneficiaries will be defaulted into an MCP if they do not make an MCP choice.

LTC Carve-In Policy

- Welfare & Institutions Code, section 14182.201(b) states, in part:
  - "For contract periods from January 1, 2023, to December 31, 2025, inclusive, … each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services shall accept the payment amount the network provider of institutional long-term care services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102…"