February MLTSS and Duals Integration Workgroup Meeting Summary

On February 24, 2022, California Department of Health Care Services (DHCS) Deputy Director of the Office of Medicare Innovation and Integration (OMII), Anastasia Dodson was joined by Allison Rizer and Nils Franco from ATI Advisory in presenting an overview of the DHCS Medicare Chartbook, "Profile of the California Medicare Population." Anastasia also provided a summary of the Long-Term Care (LTC) Carve-In Benefit Workgroup meeting which DHCS held on January 25, 2022. The LTC Carve-In Workgroup Meetings are closed to the general public, however DHCS will be providing a summary of the discussion during the Managed Long Term Services and Supports (MTLSS) & Duals Integration Workgroups and other DHCS public stakeholder meetings.

The next section of the workgroup featured a presentation by Dr. Sohrab Sidhu, Medical Quality Officer for the Office of the Medical Director in the Quality and Population Health Management Division at DHCS. Dr. Sidhu provided an overview of the Dementia Aware Initiative before transitioning to the final workgroup topic of the day, the Proposed 2023 State-Specific Reporting Requirements for Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs).

Following each topic section, stakeholders were given the opportunity to ask questions and provide comments. The recording and transcript of the MLTSS and Duals Integration Workgroup meeting contain additional information about the presentation and discussion.

During the breakout room portion of the workgroup, participants broke off into rooms to discuss the proposed 2023 EAE D-SNP reporting requirements and were asked which reporting measures should be carried forward to EAE D-SNPs. Upon rejoining the larger group, one representative from each breakout room was asked to provide a summary of their discussion. An overview of the key takeaways from each breakout room is in Appendix A.

The next MLTSS and Duals Integration Workgroup will take place on Thursday, March 24, 2022, at 10 AM.

Appendix A: Takeaways from Breakout Discussion Rooms

Discussion Questions:

1. The state-specific reporting requirements include a mix of health outcomes as well as how plans are operationalizing care coordination. Is it helpful to have both types of measures?

2. What are the most helpful pieces of public quality reporting information presented on the CMC Dashboard?

3. 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?

Key Takeaways

Summary of Key Takeaways

- Need for improved network capacity assessment.
- Reporting should include how CMC Dashboard data currently being use to operationalize the improvement of health outcomes.
- Need for Health Risk Assessments to be written in plain language for increased understanding.

Room 1

- Reporting should include information on member satisfaction and be person-centered.
- Cognitive questions should be included in health risk assessments to help reduce the number of assessments members are required to fill out.
- There should be a better way to assess the size of the network and the availability of and access to providers and specialists.

Room 2

- Quality reporting should include information on how the data being collected is operationalized and health outcomes.
- Assessments should be written in plain language and include qualitative member satisfaction questions and access to care questions.

Room 3

- Quality reporting should focus on process measures like care coordination to ensure members are receiving the services they need.
- It would be nice to have a better understanding of how the plans use the data to make changes and improve.

Room 4

- It is helpful when reporting requirements include both health outcomes and how plans are operationalizing care coordination, as both increase accountability and transparency, leading to a better quality of care for the beneficiary.
- In addition to grievances and appeals, public quality reporting measures should include consumer satisfaction, source of grievances, and the response rate for authorizations.
- Additional measures should be considered, such as communications about patient needs between MCPs and county IHSS programs.

Room 5

- Important to have both the health outcomes and how plans are operationalizing care coordination measures as we move forward.
- Would like to see dementia assessments having a more systematic sequence of care, and ensure the right members are being identified.
- Should ensure there is a broad enough network to serve the patients in need.