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

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

DATE: Thursday, September 16, 2021, 10:00 AM to 12:00 PM

NUMBER OF SPEAKERS: 5

FILE DURATION: 1 hour 34 minutes

SPEAKERS

Hilary Haycock
Anastasia Dodson
George Scolari
Edward Mariscal
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Hilary Haycock:

Good morning. Welcome to today's CalAIM Managed Long-Term Services and Supports and Duals Integration Workgroup, everyone. We are so pleased to have you with us this morning, and we're going to go ahead and get started. We have some great presenters with us today. So thrilled to introduce Anastasia Dodson joining as always, Deputy Director of the Office of Medicare Innovation and Integration. We have George Scolari from the Behavioral Health and Community Services Administrator at Community Health Group. We have Ed Mariscal, the Director of Public Programs and Long-Term Services and Supports at HealthNet, and Ryan Uhlenkott, the Deputy Director of Public Social Services at Riverside County. So, we're going to have some great presentations and then have some really dynamic breakout groups anticipating.

Hilary Haycock:

A few meeting management notes before we begin. Everyone will be on mute during the presentation, but please feel free to submit any questions or comments you might have for the speakers using the chat function. We'll be monitoring the chat throughout today's presentation and trying to address questions and comments as they come in. When we reach a formal discussion period, if you would like to ask a question or provide a comment, you can raise your hand and we'll unmute you and you can offer your question or comment that way, or you can continue to use the chat function. All of the PowerPoint slides and other materials will be available on the CalAIM website. You can find a link to those materials in the Zoom chat. We'll be posting that periodically.

Hilary Haycock:

So, all of those materials available on the website, as well as this recording after the event. So first we would like to ask you to take a minute and add your organization's name to your Zoom name, so that it appears when we're seeing chats and other things. And we can just help know where comments and questions are coming from. Click on the participant's icon at the bottom of the window, find your name and hover over that name. And you click more and select rename from the drop-down menu, and then you can enter your name and organization as you'd like it to appear. And with that, I am thrilled to hand it over to Anastasia to kick us off this morning. Thank you so much.

Anastasia Dodson:

Great. Thank you, Hilary. We have, as Hilary said, a great panel discussion and a great breakout group structure coming up. So, before we get to that, I'm going to spend a few minutes talking about the introduction on the workgroup and a couple other topics. But I am anxious to get to the breakout groups, because I think it's going to be a really great discussion today. So, a reminder, the workgroup purpose, that we've had this workgroup mostly monthly for about eight months now, nine months. And we're trying to make this group serve as a stakeholder collaboration hub for CalAIM and Managed Long-Term Services and Supports and integrated care for dual eligible beneficiaries. So, this is the transition of CCI and Cal MediConnect.

Anastasia Dodson:

We want to hear your feedback. We've been capturing the feedback notes and posting them on the website for these meetings. And we want to keep this meeting open to the public. Anyone can join. We really value the partnerships that we have and are continuing to strengthen with health plans, with providers, with advocates, beneficiaries, caregivers, and of course our strong partner CMS. And so just again, thank you all for joining these meetings and helping us learn how to adjust our priorities as needed based on what's happening for beneficiaries, for providers, for health plans, and how we can make policy better, based on the real needs of people and the care coordination efforts that have already been well underway under Cal MediConnect and CCI. Next slide.

Anastasia Dodson:

So today we're going to do a little bit on exclusively aligned enrollment, and it is, I'll say a little bit technical, but we want to make sure we're fully transparent about how the policy will work. And then we're going to talk about services that are carved out. So, that means they're not part of the payment that we make to the managed care plans. They're administered separately but it's all one beneficiary, one client, one patient that receives services from multiple delivery systems. So how can we work to increase partnerships, collaboration, coordination across those delivery systems? And in particular, what have we already learned from Cal MediConnect and what can we improve and then carry with us in the transition to D-SNP aligned enrollment. Next slide. Okay. So, this is the technical part of the meeting, and there will be time for questions. Next slide.

Anastasia Dodson:

So, we have been talking for actually since late 2019 about this aligned enrollment process for a Medicare plan and a Medi-Cal plan that are administered by the same organization. We're going to be introducing a new terminology to really specify exactly what we mean now, going forward. And it's called exclusively aligned enrollment. So aligned enrollment means there's a beneficiary that's enrolled in a D-SNP for their Medicare benefits, and a D-SNP is a type of a Medicare Advantage plan. And then they are enrolled in a Medicaid/Medi-Cal Managed Care plan for their Medi-Cal benefits. And that D-SNP and the Medi-Cal plan are both owned and controlled by the same parent organization. And we say on the slide the D-SNP parent organization because that's kind of a federal terminology.

Anastasia Dodson:

So, exclusively aligned enrollment means that we, in California, will limit that D-SNP's membership to only individuals with aligned enrollment. And there are non-aligned D-SNPs that will still exist or legacy plans, where the D-SNP has members enrolled in a Medi-Cal plan that's not affiliated with the D-SNP. So, we're making a distinction between exclusively aligned enrollment and non-aligned D-SNPs. And why does that matter? We'll get to that in the next couple of slides. So next slide. So just our broad policy that we had been talking about for a number of actually a couple years and which

was codified in the budget, the trailer bill language that gives the statutory, the legal backing for our CalAIM efforts, is that all of our Medi-Cal plans in the seven CCI counties must establish exclusively aligned enrollment D-SNPs in 2023.

Anastasia Dodson:

And again, this is not brand new. This is the same policy that we've been talking about, but just to put a more technical and precise terminology on it. So, we will not approve any new non-aligned D-SNPs in 2023 in those seven counties, even if the parent organization of the D-SNP is also a Medi-Cal plan. So, what that means is we're really saying very clearly to our Medi-Cal plans that we need you to stand up a D-SNP. We've been talking about that for some time. And that we are going to... On our side, on the DHCS side, the technical side, and with you all, we're going to really ensure that beneficiaries, when they choose a Medicare plan, they will automatically be enrolled in the Medi-Cal plan that matches their Medi-Cal, sorry, that matches their Medicare plan. So that there will be alignment between Medicare and Medi-Cal plans, and that's our official policy. So, the Medicare choice, which again, beneficiaries always have a choice around Medicare, whether or not they want to enroll in a Medicare Advantage plan and which particular plan and a D-SNP, if they want to enroll in a D-SNP.

Anastasia Dodson:

But once they make that choice on the Medicare side, then that will drive the Medi-Cal plan choice. So, if they choose a D-SNP or a Medicare Advantage plan, they must be enrolled in the aligned Medi-Cal plan. And if they want to change their Medi-Cal plan, which in some counties such as Orange and San Mateo, those are County Organized Health Systems. There's just one Medi-Cal plan. But if they want to change their plan in a two-plan model county, then they have to change their D-SNP or their Medicare Advantage plan and that will... Or they can disenroll to Medicare Fee-for-Service, and that will allow them to change their Medi-Cal plan. There are some exceptions as far as exceptions to this matching process, where if a Medicare plan that a beneficiary chooses is not affiliated with a full benefit Medi-Cal plan, there's still a few of those, then there may not be a match.

Anastasia Dodson:

But really for the most part, we want to have the Medicare plan and the Medi-Cal plan match, so that there's one organization coordinating care. Less confusion for beneficiaries. And some other benefits we're going to talk about in the next couple slides. Next slide. So, this policy aligns with our Budget Trailer Bill provisions. It aligns with the process that we already have been using for a number of years with our healthcare options, which is the program managed by DHCS that facilitates the beneficiary choice on the Medi-Cal plan. So, we have already been doing this matching process based on Medicare choice. It's just now we're being just very explicit and trying to lay it out in the slides and be very clear about the policy. And it's also consistent with all of our CalAIM policy documents. Next slide. So again, a reminder, beneficiary enrollment in a D-SNP or any other Medicare Advantage plan is voluntary. There's no passive enrollment. There's no required Medicare plan enrollment.

Anastasia Dodson:

Of course, we do encourage dually eligible beneficiaries to enroll right now in Cal MediConnect. And then in the future in these exclusively aligned enrollment Medicare plans, because we think that it really is a great opportunity for beneficiaries to be able to have a simplified way of coordinating benefits across both their primary, acute, and long-term services and supports. But at any rate, Medicare beneficiaries can remain in Medicare Fee-for-Service, otherwise known as original Medicare, and they don't need to take any action to remain in Medicare Fee-for-Service. For 2023, beneficiaries who are already enrolled in Cal MediConnect... So right now, beneficiaries, if you are already enrolled in Cal MediConnect, you do not need to do anything in order to continue to be enrolled with your same plan. So, if you're enrolled in plan such and such under Cal MediConnect, there's an automatic process in 2023 that will keep you in that same plan and then just transition you to the D-SNP and the Medi-Cal plan, the matching Medi-Cal plan, but they will be the same plan. And the process is automatic. No action is needed. Next slide.

Anastasia Dodson:

So here are some examples, and I hope this is helpful. I know this is a lot of technical information. So, example one, we have a beneficiary enrolled in Medicare Fee-for-Service. And then a Medi-Cal plan, we'll just call it Plan E. If a beneficiary chooses to enroll in a Medicare D-SNP, we'll call it Plan F, then Department of Health Care Services will automatically change the Medi-Cal plan to the matching Plan F to match that D-SNP Plan F. So that's an automatic process, and there will be notifications that go to a beneficiary in that situation to say, because you have chosen this such and such Medicare plan, your Medi-Cal plan will be adjusted to match. Example two, if a beneficiary is initially enrolled in Medicare Fee-for-Service and a Medi-Cal plan/Plan F, for example. If they choose to enroll in a D-SNP and the D-SNP is Plan F, F is the same for their Medicare and their Medi-Cal that they've already chosen, then we don't need to take any actions since those plans will match. They're both managed by the same parent organization.

Anastasia Dodson:

A third example is someone who's already enrolled in Cal MediConnect and then automatically transitions to the D-SNP and the Medi-Cal plan that is the same organization as that original Cal MediConnect plan. There's no action needed by the beneficiary. It will be an automatic transition. We're working hand in hand with our partner at CMS and with the health plans, so that this will be an automatic process. So, if you're enrolled in a Cal MediConnect plan in 2023, you'll automatically be transitioned to within that same plan organization to the D-SNP and the Medi-Cal plan. And we're working hard to make sure there's no network interruptions and it should be as seamless as possible. All right, next slide.

Anastasia Dodson:

So, this, again, I hope this is helpful, but any feedback is welcome. So dual eligible beneficiaries, they have the following choices. And again, it really depends on the

county, whether it's a County Organized Health System, whether it's a Two-Plan model or GMC, and also if there's delegate plans and what those plans are. But this is a general approach that for folks who are already enrolled in Cal MediConnect, they will automatically transition to the D-SNP and the Medi-Cal plan that are affiliated with their Cal MediConnect plan. There's also a choice. All dual eligible beneficiaries can select, newly select, or remain in original Fee-for-Service Medicare, and then choose any Medi-Cal plan based on the choices in that county. This is in 2023, they can choose an exclusively aligned D-SNP, which is what we've been talking about, and then they're automatically enrolled in the affiliated Medi-Cal plan. They can choose another type of Medicare advantage plan, not a D-SNP. And again, there's automatic enrollment in the affiliated Medi-Cal plan, if there is one.

Anastasia Dodson:

There's also Medicare Advantage plans that are not affiliated with a Medi-Cal plan, and those choices will still be available. And then there's flexibility on the Medi-Cal plan side. And then in certain counties and locations, of course, PACE is an option, Programs of All-Inclusive Care for the Elderly. And there's also in some counties SCAN, which is a fully integrated dual eligible SNP, another type of Medicare Advantage plan. So, both PACE and SCAN are for both Medicare and Medi-Cal benefits. Those are the range of options. And again, Fee-for-Service, always an option on the Medicare side, but we do have automatic matching plans for D-SNPs and most Medicare Advantage plans. All right, next slide.

Anastasia Dodson:

I can't see the questions, but I'm sure Hilary's going to read them out. And I'm glad for whatever you're putting in the chat. Well, again, we've been talking about this since 2019, but exclusively aligned enrollment. What are the opportunities and benefits here? First of all, it's similar to the Cal MediConnect approach. And we know that that has been refined and worked on with all of you over a number of years. And so, again, very similar where there's one organization responsible for both Medicare and Medi-Cal benefits, aligning, communicating, coordinating those both Medicare and Medi-Cal benefits. And there are financial incentives. So that one organization is responsible for both benefits, both sets of benefits. And it actually incentivizes the plans in some ways to provide those in lieu of services that we've been talking about with CalAIM to dual eligible beneficiaries. They have a greater financial incentive through this exclusively aligned enrollment.

Anastasia Dodson:

Integrated Member Materials are permitted by CMS if we have this exclusively aligned enrollment. Benefit coordination, their CMS, our federal partners allow Medicare plans to do a unified benefit package. Coordinated benefit administration, processes like Durable Medical Equipment, that's covered by both programs. There's a, can be a more unified process. And it also allows us to work on plan-level integrated appeals. Integrated Beneficiary and Provider Communications, so it's simpler for beneficiaries and providers as far as the notices and materials. And of course, Simplified Care

Coordination, so that there's one care coordinator for both Medicare and Medi-Cal benefits. Okay, next slide.

Anastasia Dodson:

So, next steps on Aligned Enrollment. So now that we have our Trailer Bill Language enacted, and we've got the policy down in a more detailed way, excuse me, we'll be developing even more detailed enrollment processes and beneficiary notices for 2023, in consultation with all of you. We're going to be developing integrated member materials, in consultation with stakeholders. Our State Medicaid Agency Contract we've been talking about, we're going to be working on that in partnership with all of you. We also know that we need to start working on more local outreach to support Cal MediConnect transition. We know that there are maybe some concern or confusion or just questions around, okay, if someone is in Cal MediConnect now, what does that mean for them in 2023?

Anastasia Dodson:

So, we want to reinvigorate that effort that we have had at the local level to make sure that the word is getting out around what it means for current Cal MediConnect beneficiaries and what that transition will mean. And again, it's automated, streamlined, should not be disruptive. And then, of course, we want to educate and promote enrollment in our exclusively aligned D-SNPs and the affiliated Medi-Cal plans. And so, we'll need all of your help to think about what's the best way to get that messaging out. There's a lot more detail that we could add in here, but we'll keep it high level for now. And I think next slide is probably about questions. Yes. Okay, great.

Hilary Haycock:

Yes, it is. And we've got some really good ones submitted in the chat. So, let's dive in. From Julianne Holloway, a question is what will happen to members who are enrolled in an existing D-SNP operated by Plan A and a Medi-Cal plan operated by Plan B? So, if there is a member in a non-aligned D-SNP and Medi-Cal plan, will they be forced to change their Medi-Cal plan and/or D-SNP?

Anastasia Dodson:

Our current policy is already to have a match between the Medicare and the Medi-Cal plan. So actually, right now, right now is 2021, if someone is enrolled in a D-SNP and there is a matching Medi-Cal plan for that D-SNP, then our health care options process will work on aligning that enrollment in the Medi-Cal plan into the Medi-Cal plan that matches the D-SNP. There could be certain scenarios, if the D-SNP does not have a matching Medi-Cal plan where that won't happen. And certain processes, if there's a delegate, DHCS does not... I warn myself not to talk about delegates on this call because it is a more complex issue there. And maybe we can have a future meeting where we talk through some of the delegate issues, but in general, for many people, there's an automatic process for matching.

Hilary Haycock:

Great. And if somebody is already in one of those unaligned D-SNPs that does not have a matching Medi-Cal plan, what happens to them?

Anastasia Dodson:

We're not making any changes on someone's Medicare. If they want to be in that D-SNP, they can. And if there is no matching Medi-Cal plan for that D-SNP, then we will not change the Medi-Cal enrollment.

Hilary Haycock:

From Karli Holkko, Welbehealth. One question, is it correct to say that the D-SNP choice will drive the MCP enrollment?

Anastasia Dodson:

That is the gist of it. Yes.

Hilary Haycock:

Great. And then, will the differences between exclusively aligned enrollment and aligned enrollment be clearly described to beneficiaries? And I would amend that question to say, does it need to be clearly defined/described to beneficiaries?

Anastasia Dodson:

Right. Right. We have been talking with consumer advocate partners, and we will continue those conversations and with all of you, about what type of information should we put out from the state or from the health plans, et cetera, to beneficiaries. And I don't think that the distinction between exclusively aligned and aligned, it may not make sense to get to that level of detail with beneficiaries. We'll have FAQ documents and information on our website at DHCS. You know, certainly don't want to hide anything. But I think when it comes to information for beneficiaries, we know there are already a lot of Medicare choices. And so, we want to find ways to provide information in a clear way that does not get overly technical, because I don't think that's in the best interest of most beneficiaries. But the technical information will be there for anybody that wants it.

Hilary Haycock:

Okay. From Kendra Tully at the California Senate Office of Research, can you elaborate on how exclusively aligned enrollment will incentivize In Lieu of Services for duals?

Anastasia Dodson:

Great question. So, probably, I can't give as complete an answer as you might like, but we could talk offline about that. But, in general, In Lieu of Services, if a Medi-Cal plan does not have, or if a plan does not have both the Medicare and the Medi-Cal benefits that they are covering, if they're only covering the Medi-Cal benefits for a dually eligible beneficiary, then they don't have the full financial incentive to provide In Lieu of Services to dual-eligible beneficiaries.

Anastasia Dodson:

However, I will say, and I'm sure some of the plans are typing in the chat. Oftentimes, our Medi-Cal plans, they have a global approach for all of their members, and they're not always looking at who's a duly eligible person, who is not. But in some cases, if they're determining, "Okay, how can I target such-and-such type of In Lieu of Services to such-and-such population?" If they see that they have dual-eligible beneficiaries and they have both Medicare and Medi-Cal, then they have a greater financial incentive to target that set of In Lieu of Services to dual-eligible beneficiaries when they have both parts of the benefit package.

Anastasia Dodson:

But, again, some plans may be determining their set of In Lieu of Services, irrespective of how many, what members are dual-eligible or not. But anyway, that's just a bit.

Hilary Haycock:

There are a couple of questions about, will there be integrated appeal processes for D-SNPs and Medi-Cal plans along the lines of what's in Cal MediConnect since Medicare and Medi-Cal appeals are very different?

Anastasia Dodson:

Right. Well, that's one of our goals for sure. And we have... I think in one of the slides talked about next steps, so we will work on that. And, again, we really appreciate the partnership we have with CMS, and they will help us navigate through what is the process that we need to follow in order to get that integrated appeal process.

Hilary Haycock:

From Wendy Soe-McKeeman, is there a timeline for the 2023 SMAC and when a draft might be available?

Anastasia Dodson:

Good question. So, we're working on pieces of the SMAC and some of the pieces are prioritized because of the timeline for when the Medicare plans need to submit certain things to CMS. So, the care coordination pieces, those are what we are prioritizing right now. And we hope to have information available perhaps in November about that.

Anastasia Dodson:

But I want to just tell you, our process right now, our goals are to build on what works and what has already been developed successfully in Cal MediConnect. And so, we're looking at how the model of care on the Medicare side for D-SNP's, how we can put information and structure from Cal MediConnect and how that fits into the model of care on the D-SNP side. And there's already a lot of alignment. So, anyway, more to come, hopefully in November.

Hilary Haycock:

So, here's a question that refers back to our examples. So, I don't know if maybe we could go back to that slide. Great. So, for example one, David Kane from Western Center... There. Go back. There we go.

Hilary Haycock:

Example one, will beneficiaries have continuity of care for any Medi-Cal services? For example, if they have a preferred vendor supplier from their prior Medi-Cal plan, while they wait for the new D-SNP MCP to authorize new vendors or suppliers?

Anastasia Dodson:

Great point. Yes, we have existing continuity of care provisions, and those will still apply. But sounds like this would be a good piece for us to add to FAQs for this particular example. And, again, it's a current practice already. But let's put that in our FAQ's.

Hilary Haycock:

Question from Joyce Felix at Santa Clara Family Health Plan, in terms of benefits, what is the difference between Cal MediConnect and exclusively aligned enrollment, D-SNPs, other than a name change?

Anastasia Dodson:

Fair question. Technically, Cal MediConnect is a single three-way contract between the state, the federal government, and the health plan. And D-SNP exclusively aligned enrollment is separate contracts. There's a separate contract between the state and the Medi-Cal side of a health plan. And then there's a separate contract between the federal government and the Medicare side of the health plan. And then there's this SMAC contract between the state and the Medicare side of the health plan. So, separate contracts, but we really want the experience to be at least as good, if not better, than Cal MediConnect.

Hilary Haycock:

There are a couple of questions, I think from various health plans, around if there are unaligned members in D-SNPs moving to an exclusively aligned enrollment D-SNP, how will they need to account for those unaligned members in an exclusively aligned plan? Will they need to launch a new D-SNP?

Anastasia Dodson:

Right. I think let's take that one offline. We're very glad to have questions from plans. Some of them are probably too technical for this audience, but we will answer that separately.

Hilary Haycock:

Great. There is a question from Peter Hansel at CalPACE. Anastasia, you said the state will be encouraging duals to enroll in aligned D-SNP's, what does that mean? And will

the state be promoting aligned D-SNP enrollment over other Medicare choices, such as fee-for-service Medicare or other integrated plan options, such as PACE or SCAN?

Anastasia Dodson:

Right. I know this is a loaded issue and we want beneficiaries to enroll in whatever works best for them. But we know that the D-SNP aligned enrollment model, just as the PACE model, has been tried and tested and found very favorable for beneficiaries in other states. And it fits with Cal MediConnect. So, we want to promote integrated options.

Anastasia Dodson:

And we can certainly have further discussions about what does that promotion, or what have you, look like? But there's not PACE or SCAN in all parts of California or in all parts of CCI counties. So, we want to promote integrated options, but particularly for folks who may not be able to enroll in PACE and SCAN, and just in general, we do want to promote a D-SNP aligned enrollment.

Hilary Haycock:

So, I think those were all of the questions that have come in so far that are connected to our exclusively aligned enrollment example. And we are right at time to transition to our next topic. So, I'll hand it back over to you, Anastasia. Thanks so much.

Anastasia Dodson:

Okay, great. So, shifting gears, we want to talk about benefits that are provided in separate delivery systems, particularly in behavioral health, specialty mental health, substance use disorder services, and certain LTSS programs, particularly IHSS, and how that has worked in Cal MediConnect, and then how it can work in the future. And these are called carved out services, but they're really different delivery systems.

Anastasia Dodson:

So, we'll go to the next slide. So, some Medi-Cal services are covered services that are delivered through and paid for by Medi-Cal plans. And some are carved out benefits that are covered by Medi-Cal but are not delivered or paid for by the Medi-Cal plans. So, and again, this is all in the realm of Medi-Cal benefits. So, carved out benefits are delivered through non-Managed Care Plan delivery system, including counties and waiver programs, 1915(c) waiver programs, and Medi-Cal fee-for-service. Next slide.

Anastasia Dodson:

So, for behavioral health... Next slide. There are covered services in behavioral health that are covered by Medi-Cal Managed Care Plans. And those are certain types of mental health services with... The phrase that's sometimes used is mild-to-moderate impairment of mental, emotional, or behavioral functioning. There are some examples there on the slide.

Anastasia Dodson:

And then there are carved out services that are provided by county mental health plans. And sometimes this is called specialty mental health or treatment for serious mental illness or serious emotional disturbance through outpatient day treatment or inpatient services. And those are provided through a county mental health plan. Next slide.

Anastasia Dodson:

There's also Medi-Cal Substance Use Disorder Services. And, again, both of those components here are carved out of Medi-Cal Managed Care Plans. So, there's the Drug Medi-Cal state plan benefit where Medi-Cal members can receive substance use disorder treatment services through a county-administered fee-for-service program. And then we also have our Drug Medi-Cal Organized Delivery System. In the 37 counties that have opted into Drug Medi-Cal Organized Delivery System, Medi-Cal members can receive those drug Medi-Cal state plan benefits plus additional treatment services, residential treatment services, withdrawal management, case management through a county Drug Medi-Cal Organized Delivery System health plan. So, again, these are services not delivered by the Medi-Cal Managed Care Plan, but through a county organization. Next slide.

Anastasia Dodson:

So, in Cal MediConnect, and there have been a number of discussions for the last eight or nine years, at least, about the Cal MediConnect Plan, because there are benefits on the Medicare side or on behavioral health, as well as the Medi-Cal side. And I will also point you to the website, the webpage that we have for this meeting. We have some materials provided by George Scolari that are used in San Diego County to help distinguish between the different types of benefits in Medicare and Medi-Cal.

Anastasia Dodson:

And the Cal MediConnect Plan is responsible for providing access to all necessary behavioral health services that are currently covered by Medicare and Medicaid, including all Medicare-covered behavioral health services. So, in a short version, Medicare covers some behavioral health services that are carved out from Medi-Cal Managed Care that are part of specialty mental health, primarily inpatient stays.

Anastasia Dodson:

Members can receive those services through the county behavioral health system, but they're actually paid for by the Cal MediConnect Plan. And then some members receive Specialty Mental Health Services paid for by the Cal MediConnect Plan. And some is paid by the County mental health plan. Next slide.

Anastasia Dodson:

So, going to the related topic of carved out services in long-term services and supports. All right, next slide. So, long-term services and supports. I'm assuming almost all of you are very familiar with these. They're programs that provide services to individuals that

are... These are covered by Medi-Cal. And so, beneficiaries that need assistance with activities of daily living, bathing, dressing, eating, et cetera.

Anastasia Dodson:

Some long-term services and supports are home and community-based services, and some are institutional long-term care. The nomenclature, again, I think many of you are very familiar with this. So, the long-term services and supports that are carved-in to Cal MediConnect include long-term care, skilled nursing facility services, CBAS, community-based adult services, and until the end of this year, Multipurpose Senior Services Programs. So, those are part of the payment that goes to Cal MediConnect Plans. And once the D-SNP transition occurs in 2023, long-term care and CBAS will continue to be carved-in services.

Anastasia Dodson:

And, in fact, they're carved-in for Cal MediConnect, as well as all Medi-Cal Managed Care Plans in 2023. The carved-out services that are not part of Cal MediConnect but need to be coordinated by the Cal MediConnect Plan include most home and community-based waiver services. And there's a variety of waiver programs for individuals with intellectual and developmental disabilities, the Home and Community-Based Alternatives Waiver, the Assisted Living Waiver, and then a very large program, In-Home Supportive Services, of course.

Anastasia Dodson:

That is also not part of the payment and the responsibility, necessarily, for Cal MediConnect Plans. But we do require that Cal MediConnect Plans coordinate with counties because IHSS is a county-administered program. Next slide.

Anastasia Dodson:

Great. So, enough for me. I'm really pleased to transition over to the panel that we have to talk about the best practices with these carved out services from Cal MediConnect, and then let's go to our breakout sessions.

Hilary Haycock:

Great. All right. Well, I introduced our three presenters at the top today, George Scolari, the Behavioral Health and Community Services Administrator for Community Health Group in San Diego, Ed Mariscal, the Director of Public Programs and Long-Term Services and Supports at Health Net, and Ryan Uhlenkott, the Deputy Director of Public Social Services at Riverside County. Now I'm going to hand it over to George to kick us off. Thanks, George.

George Scolari:

Thank you. And thank you for having me. Again, I'm George Scolari with Community Health Group, and I oversee behavioral health and community services, which has to do with a lot of stuff that Anastasia just spoke about which is more than behavioral health long-term supports and services.

George Scolari:

So, I'm going to talk a little bit of how we work in San Diego, acknowledging that all of my county partners, health plans, mental health systems and aging and independent services, who've done similar work and really good work over the years.

George Scolari:

Some background, I've been at Community Health Group since 1993. So, I've been around for a while. Back in those days, as far as behavioral health is concerned, and for Medi-Cal, this is before Cal MediConnect, Medi-Cal Managed Care Plans covered all behavioral health services. However, our membership back in those days were strictly voluntary. It wasn't until 1998, when certain aid codes, meaning certain types of Medi-Cal beneficiaries, where you get Medi-Cal for particular reasons like being on public assistance, had to start enrolling in Medi-Cal Managed Care.

George Scolari:

So, that was a big thing that happened in 1998. And due to that, our collaborative, called Healthy San Diego, was developed. And immediately, I put together a behavioral health subcommittee, which is now up to 180 members. So, all seven of our San Diego Medi-Cal Managed Care Plans at multiple levels participate. A lot of federally qualified health centers and our wonderful partners at San Diego Health Center Partners, which is a collaborative of almost all of the federally qualified health centers, hospitals. A lot of advocates at the table. We've been meeting monthly, if not every two weeks, ever since 1998.

George Scolari:

And we have a lot of different subgroups that work underneath that group. And one of the first things we did back in 1998 when specialty mental health was contractually carved out of Medi-Cal Managed Care, was start doing a lot of activities in the community to help people understand what a carve-out is, what it means to receive mental health benefits outside of the Medi-Cal Managed Care Plan and work together to be able to coordinate care because it's really hard to coordinate care for Medi-Cal Managed Care Plans when you're not paying for all the services.

George Scolari:

There is HIPAA rules and a lot of barriers and stuff that we need to be able to work through. And I think San Diego, from day one, has done a great job, and I've seen all of the other counties do very similar work. And it's been very impressive to watch. The Behavioral Health Subcommittee that I chaired for a long time has work groups that are within it. One of them is our operations teams.

George Scolari:

So, because the subcommittee is so large, you can't really develop policies and procedures and update MOUs that are required and meet all those requirements and assign the liaison to do all of that super-detailed work. So, we have an operations team

that's co-chaired or chaired by the County Mental Health Plan Representative, Nilanie Ramos, that reports up to our Behavioral Health. And within that group, what's really important is we have a case consultation team that meets monthly.

George Scolari:

So, if we wanted to discuss a case, the six health plans would be excused from the meeting and the one remaining health plan that had the case would work with the county leadership to go over the case and make sure that the member receives the best and most appropriate services and paid for by the right person. But that's normally not the issue. It's just making sure somebody is in the right place.

George Scolari:

So, we've done a really cool job with that. And, also within our behavioral subcommittee, we did all of our work leading up to 2014, April 2014, when Cal-MediConnect first started. So, most of the operations were our team really focused on Cal MediConnect in those early days, probably late in 2013, because there was a couple of postponements before Cal MediConnect got off the ground. So, it officially got off the ground, April 2014.

George Scolari:

We were ready in San Diego. We had trained all county behavioral health providers on how we're going to work together and coordinate care. We were required to contract with county behavioral health providers, which we do not do for Medi-Cal. So, we were contracted with all, and all the health plans, or all the counties did this for Cal MediConnect. We contracted with county mental health providers.

George Scolari:

In San Diego, there's a lot of county behavioral providers, but only nine of them that actually treat the dual-eligibles. So, all four of our health plans, which are Blue Shield of California Promise Health Plan, Community Health Group, Health Net, and Molina. We contracted with those county behavioral health providers to pay them, reimburse them for the Medicare covered services, but not the Medi-Cal covered services, because those are still contractually carved out of our health plans, which creates other barriers or problems that I'll get into, which we found ways to work around.

George Scolari:

I think one of the early things I was most proud of, and shows our collaboration in San Diego, is we did not want our county behavioral health providers to have to deal with being credentialed by four different health plans. So, we hired a single CVO, Credentialing Verification Organization, called Gemini Diversified Services. They are NCQA accredited. And they're basically... We all have our own credentialing departments, but we didn't want them to have to go through them.

George Scolari:

So, Gemini Diversified Services, they were the one-stop shop to get credentialed by all four health plans. And we did that for about the first two years. And then it was mostly just recredentialing. So, we didn't need to continue that. But it was a really good system, and I think really helped them out quite a bit.

George Scolari:

One of our committees that we also formed within the Healthy San Diego collaborative was our Healthy San Diego CCI Coordinated Care Initiative staff slash Cal MediConnect Advisory Committee. Within that committee, we have different work groups and teams. One of them that works really hard that Anastasia was just speaking about is long-term supports and services.

George Scolari:

So, we have a health plan and county agent and long-term services work group that focuses on in-home supportive services and MSSP and care transitions and coordinating care. And we're having lots of discussions at that group, too, about what happens when Cal MediConnect moves to D-SNPs because, under Cal MediConnect, for both behavioral health and long-term supports and services, we have a lot of quality measures and dollars that are withheld and requirements and things we have to do. And those same requirements might not be required down the road.

George Scolari:

And, for myself, I'm hoping that all the good stuff that's done will continue to be done. I'll give examples for that. If we can... I don't know if we want to share the Cal MediConnect Behavioral Health Quick Guide, but it is being posted. And I think it's on the next page from here if you want to flip. There we go. So, this is a one-pager that we put together from day one. It really started with working with Hilary's team and working on the Cal MediConnect behavioral health benefits.

George Scolari:

So, it's hard to read, but this will be available to you guys. And so, it first lists... On the right side is the front page of the form. And that's our four health plans in San Diego for Cal MediConnect. It lists our behavioral health members and how to reach us. It gives an explanation about Cal MediConnect and what it is. And it talks a little bit about the fact that the health plans will pay for certain things and the county will continue to pay for other things.

George Scolari:

And when we developed working with Harbage Consulting and Aurrera Health Group, when we developed the behavioral health benefits back throughout 2013, it really is, I think it's eight pages of benefits and stuff. So, I took those eight pages and really put it on just the left side of the card, which is the backside, in a simple version, not in as much detail. So, they're both really good if you've seen that eight-page document, but this is just for all of the trainings that we did.

George Scolari:

So, on the right side, really, is the managed care plan. So, it talks about how the Cal MediConnect Plan pays for anything that's a covered Medicare benefit, like seeing a psychiatrist, seeing a licensed mental health professional, other than a LMFT, and that's a whole different story, and inpatient psychiatric treatment, and intensive outpatient programs, and partial hospitalization programs. Things like that are covered by the Medi-Cal or the Medicare Health Plan, the Cal MediConnect Health Plan. And then on the left side, are those contractually carved out Medi-Cal only types of services. So, when you look at clubhouses, for example, at Club Health, we've got 13 in San Diego, it's where a seriously, mentally ill population would go and get some services throughout the day and stay active instead of just staying at home and not staying active. So, it's normally peer-run and stuff like that. It's covered on the Medi-Cal side of things, through other fundings, but covered by the mental health plan. So, the idea is that we coordinate care and work really, really well together. And so, we like this tool that also talks a little about who covers what for substance abuse.

George Scolari:

And then if we go to the next slide, we had developed early on, a contact card. We have 30 contact cards like this in San Diego for county mental health. For again, if somebody can help me get to the next slide, if possible, if not, it'll be posted. It's a contact card that lists all, here we go, that lists all of our health plans you're able to reach, when you need something. These are all real people that answer their phones and stuff. So, we use this to coordinate care. Where it says behavioral data contact, that's so that our county mental health plan can send us, every month, a list of all of our Cal MediConnect members who are receiving services within one of their providers, because they have all that information, because they bill the Medi-Cal component, to them. So, they send us that list, and we can look up on that list to see, do we have authorizations? Are we being claimed? Are we coordinating care? Because that's what this is all about.

George Scolari:

You know, part of the requirements for Cal MediConnect is that all of our county here with providers and others are invited to participate in an interdisciplinary care team. Every member has a care plan and county behavioral health has to see a copy of that care plan, and sign off on it, send it back to the health plan. We send that care plan to the primary care doc on the member. There's a whole process. So, we use this tool to help out with that. And then on the backside of this card if we can go to that side.

George Scolari:

Nope, never mind, sorry. There's no backside, but this will be available on the back –

Edward Mariscal:

George, you went on mute.

George Scolari:

I don't know how that happened. Can you hear me now?

Anastasia Dodson:
Yes.

George Scolari:
Thank you. So, on the back side of the card, which will be posted, gives a documentation that tells the county and us how they will send us information, what fields are in there, what information to send, who to send it to specifically, and gives us that tool so that we can go through all those steps to coordinate care.

George Scolari:
And then additionally, it says behavioral health claims contact address. I think some health plans might be wondering what that's about and others, that has to do with early on, with Cal MediConnect, when a county behavioral health provider would send us a claim for the Medicare covered services, they would also include on that claim, the Medi-Cal covered services. And the health plans, being the good guys that we all are in California, just would pay the entire claim, including the Medi-Cal side, that really was the responsibility of the mental health plan.

George Scolari:
And there were issues with that because the mental health side actually reimbursed more than the co-payment is for, on the health plan side. So, we fixed that by saying, just send all Cal MediConnect claims to a specific person at the plan, and then we can walk it through to make sure we pay appropriately. And so, the message here, before I move on to my partner, Ed, for LTSS conversation, is, this is really cool stuff, I think we do. And not just in behavioral health, but I know in San Diego, all the stuff we do with our aging and independent services with IHSS and MSSP and other stuff. It would be really sad to see it all go away, just because under D-SNP and separate Medi-Cal contracts, there might not be all the same requirements.

George Scolari:
So, I'm hoping that San Diego, and every other county that has Cal MediConnect, when it does move to a D-SNP update, that you start looking at that coordination stuff that we did, that we are required to do right now under Cal MediConnect. That even if those requirements aren’t exactly there that you continue to do so as much as possible.

George Scolari:
I'll give an example, which is early on, In Home Supportive Services, for about two years, became part of the Coordinated Care Initiative and was a covered Medi-Cal managed care benefit. And then a couple of years ago, it was removed and sent back to the counties directly through the state. So, suddenly we once again had that barrier of, we can't share information without a release, when it was a health plan benefit, we could. So, we're hoping that, as we move forward and into the D-SNP world, that we just take all these best practices we did under Cal MediConnect, because it's really good stuff, and that we continue this on under the D-SNP. And with that, I will end my piece of the conversation and turn it back to you guys.

Hilary Haycock:

Great. And now I will hand it over to Edward Mariscal at Health Net. Thanks.

Edward Mariscal:

Thanks Hilary. And thanks George for the handoff. And of course, thanks to everyone for joining and participating. I was going through the list of the 240 plus participants. I see a lot of great friends and colleagues, old and new, so it's my pleasure to present to you today.

Edward Mariscal:

As the slide there says, I'm the director of public programs and long-term services and supports for Health Net. Next slide, please.

Edward Mariscal:

Just generally, I've been asked to speak to you about our Empowered Living Program, or our HELP Program, everyone loves a great acronym, right? And what this program is, and what it does, and what it's intended to do is, is to not only supplement our member services and some of our other community teams within Health Net, to help our members access their benefits. But additionally, we've empowered the group and we've empowered the team to support our members through non-managed care benefits at the same time. So, listen in, talk to our members, engage with our members, engage with providers, and connect our members to additional community-based organizations or other community services that are not managed care benefits that will ultimately assist them in living well, living healthy in the community for as long as possible. Next slide please.

Edward Mariscal:

And I'll just go by this quickly, because I think it really speaks to what a lot of us do, focus on the individual. We're looking at better outcomes, and we want to ensure that treating the whole person and not just a physical body is what we focus on when we're really looking to improve our members' health. The idea of social determinants is really key, and it's been a focus for us, and a best practice for us over the last several years. And we're really looking forward to continuing that drive in the future through CalAIM initiatives, as well as this program here today. Next slide please.

Edward Mariscal:

So, what are we doing? And what does the program do? What we have done, is we've looked at the role of our member services teams, but also the role of our public program specialists teams. And we looked at their roles when we talk about our new Cal MediConnect member welcome calls, and also the completion of the HRAs, and what we're trying to do, is of course, not call our members 10 times. They don't like that very much, and that's understandable. So, we try to make sure that when we do call our members, that we do as much as we can within that call. So, the first outreach that the public programs team does to our new Cal MediConnect members is our welcome call.

We introduce them to the benefits within the Cal MediConnect program, but we're also listening for some of their needs that may not currently be met.

Edward Mariscal:

And we do that specifically to ensure that during that call, we connect them to the benefit, but if they really need something that is not a benefit, we use our resources to connect them to that non benefit as well, whether it's a community-based service or something that we'd just have to get really, really creative with. Sometimes it's short-term housing. Sometimes it's a home modification. Sometimes it's helping get some really unusual equipment into the home. And then other times it's what we're all trained to do, right? Like identify new providers, closer providers, get them an appointment. And the welcome call is really a great opportunity for us to do and connect our members to a lot of those items. Additionally, when we have our member on the phone, we look and see if there are any HRA questions that are not yet answered. And we work to complete that HRA at that time to prevent a second, third, or fourth phone call to our members.

Edward Mariscal:

Of course, we have a very, very close partnership with care management and our population health teams. What I don't have highlighted here, but it's certainly, certainly, super important to point out, is our partnerships with our ancillary contracting teams and my esteemed colleague, Eleanor, who's probably listening here today. It's super important that we work, and we leverage all of the relationships internally to assist with our members accessing and receiving services timely. Nowhere is this more important than with our LTSS providers. For example, we all know, and we all work very closely with our CBAS centers, our community-based adult service centers, but the closest CBAS center may not necessarily be the best one, or the most appropriate one.

Edward Mariscal:

And so, we've partnered with our CBAS centers, and we've partnered with other teams, to identify, what specific languages are spoken? Do they cater to dietary needs of the population that they serve? One of my favorite items in some CBAS centers, is their English as a second language classes, and more importantly, English classes designed to help participants train and test for the citizenship exam, which I think is a really, really great thing. And it's great to know that, because sometimes when we're talking to our members, that's a question they have around citizenship. So, it's great to be able to support them there. And then of course, we do a lot of work with non-benefits, CBOs, in the community. We visit them, we tour with them, we engage with them, so we can know what services they provide, who they cater to, so that we can make appropriate referrals to them.

Edward Mariscal:

And then finally, into a little bit more detail, our Empowered Living Program. And this is our attempt at warm handoffs to services and supports. We don't want to just give someone a phone number to call and say, "Here, this is who can help you moving forward". We want to, when we have them on the phone, or when we received the

request for help, we call the member, and we keep the member on the line until we connect them with the provider. And we assist with the appointment, with the assessment, with the review, whatever is necessary. And this is a program that was shared with medical groups. We share with internal care management teams. We share with our nursing facility providers. It's super important that before anyone leaves a nursing facility, they have the ability to connect with LTSS, doctor's offices, even discharge planners at the acute care hospital.

Edward Mariscal:

We provide them this form, so that before the patient leaves, before our member leaves their care, or as they're leaving their care, they connect with the potential for additional services that we can help them with.

Edward Mariscal:

Yes, Jackie Dai, your question just popped up. One of the biggest things that we do is connect to IHSS. And we have a lot of great partnerships in all of our counties, not just our CCI counties, to ensure that if our members need IHSS, or MSSP, or if they're on an MSSP wait list, we help them do all of those things. We help connect to all of those services to ensure they get the help that they need and the support that they need. Next slide, please.

Edward Mariscal:

So, super small print, I'm not going to go through it all. This is just a snapshot of what the form looks like. It's being revised, and it's going to be revised not only with the dual alignment in mind, but also with CalAIM in mind, and a lot of the in lieu of services that we will be offering in the 31 counties where we operate, but also of course, in Los Angeles and San Diego, which are our CCI counties. Like I said, we provided the form and the contact information, and the resources to the medical groups, to LTSS providers, to our case management teams. We, pre-pandemic, would go onsite and provide training. But we also do webinar trainings to our providers too, so that they have the ability to understand what it is we do, but what services we can connect our members to.

Edward Mariscal:

It still surprises me to this day, how many LTSS providers are on the same block as a medical group office, and they still have never worked together and they don't know of each other. And so, we try to make those connections as best we can. I talked about the warm handoff; the initiating of the care plan options that we provide for our Cal MediConnect members. But although we don't call it care plan options, we do something very similar to all of our members if they meet medical necessity. And if it's not a benefit, but it's something that they need, we will do our best to make sure that they get it. And of course, it allows opportunity to connect to community-based support. We want to know who they are, and we want to make sure that they know who we are so that we can work together to support our members.

Edward Mariscal:

One item that we have on this form that we provide, maybe not under the name, Connect the Needs, but really that's what we do. Connect the Needs was a great pilot we did with our esteemed friends at Partners in Care, who I hope are listening today. But it was a super important, very specific program, where we assist our members with unmet needs, and Partners, of course, did a great job in making sure that our members received the care that they needed. And it's something that we hope to continue on with them and with others in the community, through CalAIM, the dual alignment, through many other programs and pilots moving forward. I believe this is my last slide. I will certainly be available for questions. And let me go ahead and turn it over back to you, Hilary.

Hilary Haycock:

Great. Thank you so much for a wonderful presentation. We will go now to Ryan Uhlenkott.

Ryan Uhlenkott:

Thank you. Good morning, everybody. My name is Ryan Uhlenkott. I'm the Deputy Director for In-Home Supportive Services for Riverside County, which for those of you who don't know, is a pretty large county down in the south. We're just east of Orange County and we go all the way to the Arizona border. So, for our In-Home Supportive Services program, we serve about 40,000 IHSS clients and about another 35,000 providers. So, it's a fairly large system. I think we're number three or number four in the state. And we're growing year over year. By 2050, we're posed to be the second largest county, in terms of In-Home Supportive Services, in the state of California. So, part of my pleasure in speaking to you all today, also as Ed and George said, recognizing that I am one of 560 or so employees for DPSS adult services division.

Ryan Uhlenkott:

So, they all work hard every day to meet our clients' and providers' needs. I get to do things like this, like come on this teleconference and speak to you all. But I just want to recognize that there's a lot of work, and a lot of fine employee’s efforts behind the scenes that make all this possible, including the CCI and initiatives like this.

Ryan Uhlenkott:

Next slide, please. We were one of the original pilot CCI counties in California, many, many years ago, I think seven or eight years ago, when we started this. Our primary health plans that we work with in Riverside County are IEHP (Inland Empire Health Plan), and Molina Healthcare. IEHP represents about 75%, a little more, 80%, of our clients, and Molina, the other 20%. Of course, not all clients are Cal MediConnect, so there are several pockets, but those constitute the lion's share of our in-home supportive services clients.

Ryan Uhlenkott:

Starting with CCI, really, in earnest, but certainly over the years, we have really collaborated closely with our partners to be able to offer long-term services and support, it's like In Home Supportive Services, and make sure that our clients are getting all of their needs met. So, I just wrote down a few examples here, or, I have written down a few examples here. We have coordinated client care meetings, and I'm going to go over a slide that shows some of our data in a little bit. And those coordinated care team meetings can be initiated by IEHP and Molina, by our health plans, or by the social workers themselves.

Ryan Uhlenkott:

So, if they're working with a client in their health plan, and they know that client is connected to IHSS or should be connected to IHSS, they can reach out to us. Conversely, if we're out to the home, and we see that there really are needs, other long-term services and support needs that are not in place, not in the home, then we reach out to the health plans and coordinate the CCT meetings, coordinated client care meetings, with those health plans. They also, IEHP and Molina, participate in our multidisciplinary team meetings.

Ryan Uhlenkott:

We have several of them in Riverside County. We have what we call a Homeless Care Team meeting, that meets every month. And we also have an Elder Abuse Forensic Center team meeting that meets bi-monthly. When we're in a position where, let's say, that there is a senior who's living alone and is not doing so well, maybe the health plan has similar concerns. It's an opportunity for us to come together and really talk about holistically, as Ed was talking about, what are the things that we can do as agencies to provide better care and support to allow this individual to live safely in their own community.

Ryan Uhlenkott:

Years ago, again, one of the concerns that we heard from our health plans was, when they call our 800 number to submit an application for any unsupported services, they're waiting on hold for a long time. They're with their client, and maybe they don't have, their client needs to go, where they don't have time to sit there with them during that process. If they send the client home, a consumer home, with the 800 number, and they're not sure about the follow-up and they have a lot of the information to be able to help them with that application. So, with our health plans, we developed an online portal for IHSS missions, 24 hours a day, seven days a week. Anybody can apply for IHSS in Riverside County, and it's an expedited enrollment process.

Ryan Uhlenkott:

It's not a preferred enrollment process. So, everybody gets the same treatment, whether you apply individually or you apply through a health plan. But because health plans have that information, that Medi-Cal information, that shared-cost information, it is a lot easier, I think, to submit their applications when they're with their clients in the office. And when we received the application, we can expedite that referral, send that out to

the social worker in the region sooner, rather than later, so that we can make sure that we do the intake paperwork, and we make sure that they're eligible for in-home supportive services. And, you know, it's a service that they can take advantage of along with their provider. We have an intensive case management program through our IHSS. I think we're one of only a handful of counties in California that does.

Ryan Uhlenkott:

So, we have our regular in-home supportive services, social workers, that will meet with a client annually, go out to the home, and make a home visit. That's changed a little bit with COVID-19, although we're back on track in terms of home visits. But we do have an intensive case management unit that really recognizes that there are some clients that need more than that. It's a monthly contact either by phone or in person. It's a pretty thorough assessment of their needs. It's regular conversations with the health plans, regular coordinated client care meetings with the health plans. And so, it offers just an additional level of support for those clients and customers that need it. And again, those referrals can come internally from us, it can be a social worker recognizing that a client doesn't have, really, everything in place that they need, or it can be IEHP or Molina identifying one of their clients and referring them to us and saying, you know, I really think that this client would benefit from more intensive case management services.

Ryan Uhlenkott:

And finally, we developed a ticketing system in Riverside County. So, when you call our 800 number, you're connected to an agent. We answer those phones between eight and five, Monday through Friday, and there's a ticketing system involved there. So, every call, every inquiry for in-home supportive services, is given a ticket number. And that information can be shared by a client to their health plan, so that if their health plan is calling on their behalf, and if we have the appropriate releases signed, we can better coordinate their care. So, it can be a care plan calling on behalf of a client, or a client on behalf of themselves. But with that ticket number and identification, we can really follow the request all the way through, whether that's for a question about a form, or a question about enrollment in the electronic services portal that the state has set up, or more to the point, or more frequently for us, it's a change assessment.

Ryan Uhlenkott:

So, we do that annual assessment, but certainly conditions can change outside of that year, or inside of that year. So, we do an initial intake in July, and in December, there's a fall or a stroke, and we need to go back out to the home where we need to conduct the change assessment to reevaluate our in-home supportive services. So that can be done through our ticketing system, and it can be delivered to our social worker within the day. And we can contact that client and make sure that their needs are taken care of. Next slide, please.

Ryan Uhlenkott:

So, this is just, as I referred to in my previous slide, our coordinated care client data. This is for this fiscal year, so you'll see January, excuse me, July, and August, that are

filled out. We just got this September, or we're just starting on the September numbers. But this really shows you the coordinated client care team meetings that we have for ASD. That stands for the Adult Services Division, that's the division that IHSS is within. And then these interdisciplinary care team meetings that are set up, whether they're requested by the health plan, whether they're requested by our staff. The number of inquiries. So, we got 53 inquiries from the health plans, 75 inquiries from the health plans in the month of August. The number of forms that the health plans help us fill out or that we receive from the health plans. So again, when they're meeting with the client in their offices, they can fill out the SOC H73 or the 320.

Ryan Uhlenkott:

They can fill out the SOC 8-73 or the 321 that we really need that physician authorization, or we really need that medical diagnosis information. Those can come directly from the health plans to us, through our portal. And then, we received miscellaneous requests from the health plans too. So, it's proven to be a tremendous success for us. Again, that's not just due to us, that's due to our health plan partners, really with a commitment beyond CCI to make sure that we're able to offer all of our clients the services and support that they needed recognition that, you know, care and coordination doesn't end at the office visit, right, it extends to the home, and it extends to everyday life as well. So, I turn it back over to Hilary.

Hilary Haycock:

Great, thanks Ryan. You guys are really doing great work in Riverside. Thank you for presentation. So, we're thrilled that it is time to go to our breakout rooms for discussions. Our breakout room sessions will be 20 minutes long. We're going to automatically sort everyone out, so don't worry about that, just go ahead, and click accept when Zoom asks, if you want to move on over. Every breakout room, will have a note taker who'll help post questions, take notes on the discussion, and then every workout room needs to identify one person to report out to the larger group when that breakout sessions at the end. We'll have as many folks report out verbally as possible, but we really do want you to enter your report outs into the chat to make sure that we really got that captured for our notes and for the department in thinking about these policy decisions moving forward.

Hilary Haycock:

So, the discussion questions we are going to tackle today are going to be "What are those promising practices and opportunities to improve behavioral coordination and behavioral health benefits as we move from CCI into explicitly aligned D-SNPs and what are the promising practices and opportunities to improve the coordination of long-term services and supports as we are moving again from camera to connect into this exclusively aligned D-SNP MCP environment. So, we want to have top three for both for behavioral health and for long-term services and supports. And so, with that, we will go ahead and move everyone into their breakout rooms. Thank you.

Hilary Haycock:

Welcome back to the main room. I hope everyone had a good discussion in your breakout sessions. I would like to encourage folks to go ahead and copy and paste your top threes into the chat so that we've got them. And then I will ask if folks have assigned someone to do a report out, we would love to hear it, so go ahead and raise your hand and I will start calling on folks so we can start hearing from each other about the great discussions that hopefully everyone had.

Hilary Haycock:

All right, Pat Blaisdell. Unmute yourself.

Pat Blaisdell:

Okay. I think I'm good to go. Thank you. I had an excellent discussion in our breakout group, and I think Jessica did a great job of summarizing the things we came up with. Let me make sure I have that in front of me, so I do justice to the input folks provided. I will say that from my standpoint, there was a little bit of commonality between the practices. I think there's some implications, although our discussion was separate for behavioral health versus long-term services and supports. I think there are, there was some overlap between the policies and best practices. I think one of the things that came up in particular for behavioral health is that behavioral health providers need to be educated on Cal MediConnect beneficiaries and how to access services and what policies and relationships are available to them. One big theme was around building the relationships between the providers and the plan personnel.

Pat Blaisdell:

George Scolari had some excellent examples of places where they felt they were able to impact care delivery when they had direct and effective communication among and between the providers, the county manages medical, county behavioral health plans, as well as the plans, the broader Cal MediConnect plan. So, the Cal MediConnect plans, the behavioral, the county medical, mental, and behavioral health plans and the providers. And I very much appreciate that. I think what I've learned is that that needs to happen kind of on the broad level, in the context of these conversations, but also at very much the regional and operational level that providers, plans, both in terms of the Cal MediConnect plans and the county behavioral health plans need to be working together. And when those relations were established both formally and informally, it was to everybody's benefit.

Pat Blaisdell:

So additionally, in terms of long-term services and support some similar themes, I've heard of some great practices, and we discussed in the group of having a joint committee so that if the plans are working with particular providers, having some kind of mechanism to meet directly. I don't know if this was the best practice early in the Cal MediConnect implementation, I think it kind of evolved out of necessity when there were issues around provider and plan communication. But I think some of the best practices

I've heard about have really allowed those joint operating committees at a local level to address problematic issues.

Pat Blaisdell:

I think two of the other things we learned about that were identified as best practices were looking at some way to facilitate coordination across the continuum of care, not only in individual care transition, but looking at subsequent care transitions. So, for example, the example that Liz shared from Orange County with homelessness, where they worked when patients were leaving the hospital, they could go to a SNF, but have in place already a plan for that person to leave the SNF and go to recuperative care so that the individual patient got the care they needed, that might've been more than the recuperative care setting could provide. But also, the SNF knew that when they accepted that individual, that there was a plan for an appropriate care transition down the road. So, I think more of that kind of longitudinal care commission care, transition and care coordination is indicated.

Pat Blaisdell:

We also heard about some excellent examples with best practice models for identification of individuals with dementia, especially early dementia and making sure they get connected to the right services and educating plan personnel about the special needs of that population. So, I think I did justice to, I hope I did justice to the suggestions that came up in our conversation and thank you for the opportunity.

Hilary Haycock:

All right. We want to make sure we're hearing from a couple more groups, but we still do have reaction panel. So, we're going to ask folks to try to give one or two minutes, top, top highlights and add more into the chat. Cause we do want to capture the richness of the debate. Brianna Crouch.

Brianna:

Hello everyone. So, our group talked a little bit about timeliness being an issue like Pat said, I think many of the things we want to keep in mind are both very similar for behavioral health and LTSS, but timeliness, making sure that members are getting serviced as quickly and referrals are processing, and requests are being processed as well, as fast as possible. We know that these members need their services quickly. And so, trying to coordinate that and get those done as quickly as possible, as well as authorizations, what are best practices. We didn't really come up with an answer, but we know that there are a lot of issues with understaffed places right now. And so, what can we do to help kind of streamline that process as well, to help with the timeliness of the services, reaching the member, and then rates were another thing that came up.

Brianna:

And so, making sure that there are incentives for those providers to really help with getting those services out to the members as well, let's see anything for LTSS... Coordination, so making sure that the care management or case management teams

are aware of all of the providers available to the members and CBOs in the area and things like that, so that they have all of those services available, have their platter in front of them. So, they can kind of pick and choose really easily and quickly for the member, what would best help them to meet their needs? And I think the last thing, specific to LTSS was really keeping in mind, those carved out services. You know, this member still may need coordination and to kind of make it not necessarily so black and white, maybe there's another bridge there to help them cross.

Hilary Haycock:

Great. Thank you so much. All right, now we are going to go to Jan Spencley.

Jan Spencley:

I'll try to make this quick, I'm sorry.

Hilary Haycock:

Good, there's so much good conversation.

Jan Spencley:

It was a good conversation. The coordination across plans to establish clear communication, status, and care coordination across agencies, where we heard from George Scolari earlier. That was more than just mental health, I mean that addressed long-term services and supports and other services and I think it's extremely important that all the health plans in the region who work with all the agencies, we talked about that coordination, getting that coordination in place, and getting rid of the barriers to that coordination. Building relationships with the in-home support services, public authority, to assist with securing and addressing caregiver issues. This means a lot of them can't negotiate, can't manage their own caregivers, can't find their own caregivers, all of those things. So, it's reaching into that relationship as well as hearing about a barrier to working with the agency itself.

Jan Spencley:

So, we talked about making sure there were MOUs or BAAs across health plans, agencies and counties that are all supposed to be coordinating, which apparently was supposed to be in place. So having education, the model agreements would come from the state and feds to support coordination and communication. So, we saw that as another area that was intended with Cal MediConnect as people have turned over. Apparently, some of that has gone by the wayside, but so their communication without individual authorization with the exception of substance abuse can take place.

Hilary Haycock:

Excellent. All right. We're going to hear quickly from Jackie Dai and then we are going to go to our reaction panel.

Hilary Haycock:

You are still muted.

Jackie Dai:

All right. Hi everyone. So, I'm going to make it quick because I put it in the chat box as well. From our group, we had a number of suggestions related to behavioral health and care coordination. The first one is a one sheet contact. One just like George's presentation earlier, and a lot of people highlighted on that as a best practice. Number two is the MOUs between the county mental health and medical managed care plans. It's a living document, and it's useful for the people that are on the ground to be aware of what's contained in the MOUs. And to know all of the details about the MOU. Someone shared that in their county, they do an interdisciplinary care team meeting, and that's an integrated meeting which has, received a lot of positive feedback in terms of having different providers that are invited to participate.

Jackie Dai:

And a key part of that is that the beneficiary themselves are also participating in that care coordination meeting. And fourth best practice that our group shared was having a more open approach in terms of not following a step wise approach. I'm not a clinician, so I'm not familiar with the terms to receive medication, but maybe instead of following the steps, what it is and debating what it is between the medical plan and also, the health plan and the county mental health clinicians on what is needed for that individual person. A fifth suggestion was the medical necessity model, and it's kind of going in alliance with the MOU clarity to make sure that the clinicians that are doing the initial assessment or doing the screenings and are clear on what is detailed in the MOU.

Jackie Dai:

The sixth suggestion is what is clinically best for that individual, a person-centered approach and involving the family, if there is a family involvement and what is it that the person needs. So wraparound approach with regards to treating the human. Last but not least the person also shared that they have a recovery-oriented approach instead of the medical model and the particular county. All right. Hope I didn't repeat.

Hilary Haycock:

All right, great. So now I am going to try to hand it over to Autumn Boylan, Assistant Deputy Director of Integrated Systems of Care Division at the Department to introduce our reaction panel. Is your audio working Autumn? I cannot hear you.

Hilary Haycock:

All right. I know we've been trying to tech support that, okay. Well, to wrap us up since we don't have Autumn, so sorry, Autumn. We're so grateful that you are doing this today. We've got with us Tyler Sadwith with the Assistant Deputy Director of Behavioral Health at DHCS and Leora Filosena from the California Department of Social Services. So not sure if either of you want to just jump in and say a little bit of something about what you heard with all this great feedback we got today, about how can we build those connections? How can we support coordination across that continuum of care and build

connections between counties and health plans to better serve our dual eligible and other beneficiaries?

Tyler Sadwith:

Hi, thanks Hilary. This is Tyler Sadwith, I'm Assistant Deputy Director at DHCS. And I just want to thank everybody for participating in sharing their input. This has been an incredibly rich meeting. I don't know if I have any single silver bullet to highlight, but I think what I would simply say is that continued dialogue, coordination, communication, and even, gentle advocacy on an ongoing basis, being persistent can help from an operational perspective, the processes, and outcomes of how the managed care plans and how the counties are performing their respective functions. The reality is that there is a bit of a carve-out system, that is how the financing, and the administration of behavioral health services are designed in our state.

Tyler Sadwith:

So, with that, I think just building that connective tissue and ensuring that the plans, the counties, the providers, the CBOs, and most importantly, the consumers are being heard and are identifying the issues and ensuring that the responsible entities are collaborating is perhaps the most effective approach absent and the radical system transformation reforms. So, thank you, I think this has been really helpful and I would highlight under CalAIM, there are a number of behavioral health initiatives that are designed to improve the performance of the county mental health and substance use disorder system. So those would be applying to all consumers and all services delivered under those systems, not limited to dually eligible individuals.

Hilary Haycock:

Thanks so much, Tyler. There's a lot of system transformation underway. Leora, I'm not sure if you are on or want to have…

Leora Filosena:

Yes, I'm here. I want to echo Tyler's sentiments that it was really great hearing all of the conversations and the feedback from everybody, and really from an IHSS perspective and care coordination, really what we're trying to focus on is the barriers to that collaboration. And what we're trying to focus on is using technology, business process improvements and things that we can do to help counties with ongoing workload, to free up space for them to do some of these other activities, and also to really focus in on the recipients of the program. And so really that's we want to start really focusing on the care that people need versus the processes and the things that people have to do to get that. And so those are the things that we're really working on and looking forward as we go through this process of really making some improvements and hopefully doing some great work with you all.

Hilary Haycock:

Great. All right. Well, we are at time. I know I see someone with their hand raised…

Yvette Willock:
Am I unmuted?

Hilary Haycock:
You are, and then we're going to close out because we are at time.

Yvette Willock:
I'll be so swift, thank you for unmuting me. So just to echo something that Tyler shared about the reality of our bifurcated system that's our reality. And then now how do we engage with it? And as Tyler mentioned, some of the principles in CalAIM, I think of ECM, especially, and the fact that care coordination is so critical to ECM and the associated codes that have been provided to facilitate that ECM service that the care coordination service historically may have been a challenge for us to determine how do we document, and what's an appropriate code to connect that to, I think, lessons that we're going to initially learn in ECM for the specific populations of focus that we look to see how we can apply that broadly across the entire Medi-Cal population associated with the MCP system and our system.

Yvette Willock:
So, it's not just for those seven populations of focus, but for everybody meaning the care coordination approach, having some, just some basic codes for that, and the documentation reform that results in lack of burden in having to make this note demonstrate medical necessity criteria when we know care coordination is critical to the improvement and recovery of someone. So, I just wanted to, to share that.

Hilary Haycock:
Thanks, Yvette. And you're with LA county, is that correct?

Yvette Willock:
Yes, ma'am, LA County DMH.

Hilary Haycock:
Wonderful.

Hilary Haycock:
Great. Always wonderful to hear from our county partners. So, thank you so much for participating today and yep. So, excellent message to end, on looking forward to building that continued collaboration with everyone. Thanks everyone for such a wonderful, robust conversation today, we will see you Wednesday, October 13th at 10:00 AM, and we'll do it again. Thanks so much already. Have a great afternoon.