DHCS California Department of HealthCareServices

Aurrera HealthGroup

# Department of Health Care Services
# September 2021 MLTSS and Duals Workgroup Meeting
## Summary and Key Takeaways

The following is a summary of key takeaways from the September 16, 2021, Managed Long-Term Services and Supports (MLTSS) and Duals Integration Workgroup, including those that presenters and stakeholders shared during the meeting. The meeting focused on building connections to carved out services such as behavioral health and long-term services and supports, as well as policy updates from the Department of Health Care Services (DHCS).

### D-SNP Exclusively Aligned Enrollment Update

The first part of the workgroup meeting centered on a policy update from DHCS on Dual Eligible Special Needs Plan (D-SNP) exclusively aligned enrollment, followed by a discussion with stakeholders.

Anastasia Dodson, Deputy Director of the Office of Medicare Innovation and Integration (OMII) within DHCS, shared a summary of exclusively aligned enrollment for D-SNPs. This policy limits new D-SNPs' membership to only beneficiaries also enrolled in the Medi-Cal managed care plan (MCP) for Medi-Cal benefits owned and controlled by the same parent organization. Anastasia provided additional information about the DHCS approach to the policy, including timelines for both plans in Coordinated Care Initiative (CCI) counties and non-CCI counties, and the decision that the Medicare choice will drive the Medi-Cal plan enrollment at both the prime and delegate plan levels. The D-SNP exclusively aligned enrollment policy is consistent with the California Advancing and Innovating Medi-Cal Initiative (CalAIM) and the Health Omnibus Trailer Bill (AB 133, Chapter 143, Statutes of 2021).

Anastasia reminded stakeholders that enrollment in a D-SNP is voluntary, and in 2023 beneficiaries enrolled in Cal MediConnect (CMC) plans will automatically be enrolled into the Medicare D-SNP and Medi-Cal MCP affiliated with their CMC plan with no beneficiary action needed. Different examples of exclusively aligned enrollment for beneficiaries were also detailed in the presentation.

After the update on the D-SNP exclusively aligned enrollment policy, stakeholders were encouraged to ask DHCS questions. Many of the discussion questions that were asked are highlighted below.

> Julianne Holloway from Blue Shield California asked about beneficiaries who prior to 2023 were enrolled in an existing D-SNP and a MCP which were un-

aligned, and whether they would be forced to change their MCP or D-SNP plan. DHCS reminded stakeholders that the policy of matching a Medicare and Medi-Cal plan was already in place in California and that the Department will not be making changes to beneficiaries' Medicare plans.

Karli Holkko from WelbeHealth asked if the D-SNP choice will drive the MCP enrollment, and if the differences between exclusively aligned enrollment and aligned enrollment will be described clearly to beneficiaries. DHCS confirmed that the D-SNP choice would drive the MCP enrollment, and that the Department has been working with consumer advocates on the clearest messaging to beneficiaries.

Kendra Tully from the California Senate Office of Research asked DHCS to elaborate on how exclusively aligned enrollment will incentivize Community Supports (ILOS) for dual eligible beneficiaries. DHCS explained that plans covering both the Medicare and Medi-Cal benefits for a dual eligible beneficiary have a greater financial incentive to provide Community Supports to those beneficiaries.

Several stakeholders asked if there would be an integrated appeals process in for exclusively aligned D-SNPs similar to the process for CMC plans. DHCS shared that having an integrated appeals process is one of their goals, and that the Department is working with their partners at the Centers for Medicare and Medicaid Services (CMS) on this.

Wendy Soe-McKeeman from DSR Health Law asked if there is a timeline for the 2023 State Medicaid Agency Contract (SMAC) and when a draft may be available. DHCS responded that they are working on pieces of the SMAC and hope to have information available in November 2021.

Joyce Felix from Santa Clara Family Health Plan asked if there is a difference in benefits between Cal MediConnect and D-SNP exclusively aligned enrollment aside from the name change. DHCS shared that the contracts are different because technically Cal MediConnect has a single three-way contract between the state, the federal government, and the health plan whereas for D-SNP exclusively aligned enrollment there are two separate contracts with the federal government and state. The Department emphasized that they want the experience in D-SNP exclusively aligned enrollment plans to be at least as good as in Cal MediConnect plans.

## Coordination of Carved Out Benefits for Dually Eligible Beneficiaries

The second part of the meeting focused on the main topic – coordination with carved out benefits, including promising practices and opportunities from Cal MediConnect. DHCS gave an overview of Medi-Cal Behavioral Health Services and Long-Term Services and Supports (LTSS) to do some level setting. Then a panel of experts presented on best practices from the CMC demonstration.

### DHCS – Medi-Cal Covered Services and Carved Out Benefits for Dually Eligible Beneficiaries

Anastasia Dodson began the presentation by explaining that Medi-Cal includes some covered services delivered through and paid for by Medi-Cal plans, and that there are some “carved out” benefits that are covered by Medi-Cal but not delivered or paid for by MCPs. These carved-out benefits are often delivered through counties, waiver programs, and Medi-Cal Fee-for-service (FFS).

Anastasia gave an overview of the Medi-Cal mental health services, including that mild-to-moderate impairment of mental, emotional, or behavioral functioning was a covered service under Medi-Cal managed care, and that Medi-Cal members who receive treatment for Serious Mental Illness/Serious Emotional Disturbance get it as a carved-out benefit from County Mental Health Plans (MHPs). Medi-Cal Substance Use Disorder (SUD) services, such as the Drug Medi-Cal state plan benefit and the DMC Organized Delivery System (DMC-ODS), are both carved out benefits. In CCI counties, CMC plans are responsible for providing access to all medically necessary behavioral health services covered by both Medicare and Medi-Cal.

LTSS are a collection of programs which provide services to individuals covered by Medi-Cal who require assistance with activities of daily living. The LTSS carved in to CMC include Long-Term Care (such as Skilled Nursing Facilities) and Community Based Adult Services (CBAS). The Multipurpose Senior Services Program (MSSP) is currently carved in to CMC, but will be carved out starting in 2022. Most Home and Community Based Waiver Services, such as In Home Supportive Services (IHSS) are carved out of CMC.

### Panel – Overview of Best Practices from Cal MediConnect

The workgroup panel included the following experts:

- George Scolari, Behavioral Health and Community Services Administrator at Community Health Group

- Edward Mariscal, Director of Public Programs and Long-Term Services and Supports at Health Net
- Ryan Uhlenkott, Deputy Director of Public Social Services at Riverside County

George Scolari shared some background information on his work at Community Health Group and in San Diego on behavioral health services, particularly focused on the Healthy San Diego Collaborative which was developed in 1998 and the behavioral health subcommittee. He explained that the group has been meeting monthly since 1998 and has continued to help educate the community on carved-out behavioral health benefits and worked with partners to help coordinate care with County Mental Health and Medi-Cal managed care plans. George detailed how this work helped to inform the lead up to CMC beginning in 2014, and how the Healthy San Diego CCI/CMC Advisory Committee has since then helped to work on various areas of carved out benefits including long term services and supports. He then shared some of the resources that Healthy San Diego has created for CMC including the Behavioral Health Quick Guide and Behavioral Health Plan Coordination Contact Card, both of which were shared as supplemental materials for the workgroup on the DHCS MLTSS & Duals Integration Workgroup website. George concluded his presentation by sharing that he is hopeful the best practices that were done under CMC will continue into exclusively aligned enrollment D-SNPs, and that coordination requirements under CMC will be continued as much as possible.

Edward Mariscal shared some background information about Health Net's Empowered Living Program (H.E.L.P) which assists members with connecting to the member services and public program specialist teams regarding benefits and services within CMC and other community services that are not managed care benefits to assist them with living well in the community for as long as possible. He gave some examples of outreach to members, including a welcome call to CMC members which goes beyond introducing them to CMC benefits by also focusing on listening for needs they may not have met and connecting members to a benefit or a community-based service. The goal is to help get a Health Risk Assessment (HRA) completed along with understanding a member's needs during one phone call to help avoid multiple calls to a member. Health Net has also partnered with Community Based Adult Services (CBAS) centers, and non-benefits Community Based Organizations (CBOs) in order to understand their services offered and to be able to make appropriate referrals to them. Edward shared the H.E.L.P Referral form, which helps ensure that members are connected to additional services and informed the group that this form is shared with medical groups, LTSS providers, and case management teams to try to make connections for members.

Ryan Uhlenkott shared some of the work that Riverside County has been doing with In Home Supportive Services (IHSS) in partnership with health plans, such as Inland Empire Health Plan (IEHP) and Molina Healthcare. The county and the health plans communicate about clients regarding IHSS or other long-term services and support

needs to ensure that the clients are receiving all of the services they need, and the partnership between the counties and health plans extends to participating in one another's team meetings. Ryan shared that with their health plan partners, Riverside County has developed an online portal for anyone to apply for IHSS with an expedited enrollment process. Additionally, Riverside County developed a ticketing system where each inquiry for IHSS that calls into the 800 number is connected to an agent and given a ticket number, which helps the County be able to follow the request through and even coordinate with the health plan on an individual's care (if the appropriate releases are signed).

## Report Outs and Discussion after Breakout Rooms

Once the panel discussion concluded, the workgroup moved into eight breakout rooms to allow for a smaller discussion on how to improve coordination of behavioral health and LTSS benefits in CCI. Each breakout room was asked to select one member to report three promising practices or opportunities out to the larger group once the breakout rooms were closed. Appendix A includes notes from the breakout rooms.

The last thirty minutes of the meeting were spent sharing breakout room report-outs and reactions from the panelist. Below are the takeaways from the report out and panelist reaction.

### Group Report Outs

Hilary Haycock from Aurrera Health Group began the breakout room report-outs by welcoming participants back to the main room and asking for volunteers to share what their rooms discussed. The following participants shared their promising practices and/or opportunities to improve coordination of behavioral health and LTSS in the CCI.

> Pat Blaisdell from the California Hospital Association started the breakout room report-outs by sharing the common themes between behavioral health and LTSS coordination. The group agreed behavioral health providers should be educated about CMC beneficiaries and be knowledgeable about how to access services. The importance of relationships and clear communication during care delivery at all levels (regional, county, state) was also shared. The themes were similar for LTSS, and the participants agreed plans should have a mechanism to meet with providers directly. The group members shared appreciation for early dementia detection and ensuring the individuals that need care are connected to the right services. Finally, breakout rooms highlighted the importance of having a post-Skilled Nursing Facility (SNF) plan so health plans know where beneficiaries will be transitioned to, and SNFs know there is a plan for care transition, which is important to care coordination.

Brianna Crouch from Mom's Meals shared the need to provide timely services and process referrals as quickly as possible and that in order to operationalize this there should be adequate staffing to keep referrals and approvals moving. It is important for care management teams to be available to the members, and the care manager should aid the members in understanding the benefits and selecting the services they would like to receive.

Jan Spencley from San Diegans for Healthcare Coverage highlighted the need for clear communication when establishing care coordination. The group agreed regional health plans should work with agencies to remove barriers to care. This may be achieved by making sure there are Memorandum of Understanding (MOUs) across health plans and counties that require coordination and communication.

Jackie Dai from Neighborhood Legal Services of LA County said they enjoyed George Scolari's presentation and agreed there should be one sheet of contact information available to members, so they know who to contact. The group also agreed that MOUs should be available to members. Jackie stressed the importance of interdisciplinary care team meetings, which have allowed providers to coordinate and communicate care for members. The group suggested providing clarity around the medical necessity and communicating what is clinically best for the beneficiary by using a person-centered approach, similar to what was done under Whole Person Care.

**Panelist Reaction**

Finally, Tyler Sadwidth, Assistant Deputy Director of Behavioral Health at DHCS, and Leora Filosena within the Adult Program Division at the California Department of Social Services (CDSS) were asked to react to what they heard in the breakout rooms and what can be done to build connections and support coordination across the continuum of care to better serve dual eligible individuals and other beneficiaries.

Tyler Sadwidth from DHCS thanked the participants for the discussion and encouraged continued dialogue and communication to help support the processes and outcomes of how the MCPs and counties function. Tyler also expressed that while a carve-out system exists, it is important that everyone work together to ensure the responsible entities are collaborating and closed their comments by reminding participants that under CalAIM, there are also several behavioral health initiatives are meant to improve coordination.

Leona Filosena from CDSS provided comments from the IHSS perspective. Leona highlighted how using technology can help beneficiaries access care and improve coordination between plans and counties.

This concludes the key takeaways from the September 16th MLTSS and Duals Workgroup. The next meeting is scheduled for Wednesday, October 13, 2021.

## Appendix A: Key Takeaways from Breakout Rooms

*Key Takeaways from Question 1: What are promising practices from Cal MediConnect to improve coordination of behavioral health and LTSS benefits?*

**Room One:**

1. Ensuring resources, structure, and requirements for coordination are the same for the plans and the providers of carved-out services.
2. Providing the necessary information and resources to the agencies providing consumer information.

**Room Two:**

1. Providing contact information to beneficiaries who do not know who to contact or where to go.
2. Health plan referrals to IHSS improved client understanding of the program.
3. A County portal allowed beneficiaries to sign up for IHSS when they were ready and had phone numbers where people could reach someone to answer questions and help them sign up.

**Room Three:**

1. Building coordination between plans, providers, CBOs, and counties.
2. Coordinating with carved out services and providers to provide the best possible care coordination.

**Room Four:**

1. Building good relationships with the public authority.
2. Improved coordination across multiple entities.

**Room Five:**

1. Building relationships between providers and staff.
2. Forming joint committees to encourage communication between plans, providers, and staff.
3. Including early dementia detection under CMC to helped beneficiaries receive appropriate care.

**Room Six:**

1. Offering one-page behavioral health contact sheets for beneficiaries.
2. Sharing county mental health and Medi-Cal managed care plan MOUs with the people who are on the ground.
3. Ensuring that the downstream providers are aware of what to do when something goes wrong (e.g., the initial clinicians doing screenings).

**Room Seven:**

1. Including a specialized care coordinator or case managers, like a CHW or nurse.
2. Co-located care coordination teams.

**Room Eight:**

1. Forming acute hospital partnerships to identify behavioral health needs and referral services.
2. Conducting a full assessment to identify behavioral health needs.
3. Providing frequent education and training to groups and providers on LTSS and other benefits available to members.
4. Leveraging contractual enforcement for communication and data exchange among providers and health plans.

*Key Takeaways from Question 2: What are the opportunities from Cal MediConnect to improve coordination of behavioral health and LTSS benefits?*

**Room One:**

1. Coordinating to create standardized approaches in Counties with multiple plans so that there is not a duplication of effort. Standardization will also ensure that members get the same benefits no matter which plans they are enrolled in.

**Room Two:**

1. Removing barriers in smaller counties with fewer resources and staff to improve coordination between health plans.
2. Improving technology and removing barriers to sharing health information to help make collaboration between health plans and county IHSS programs easier.
3. Cross-training social service workers so they can suggest additional services when during IHSS assessments.

**Room Three:**

1. Processing referrals and getting member's services as quickly as possible by increasing staffing and workforce development.

2 Improving authorization processes and putting procedures in place to expedite issues with authorizations.
3. Aligning rates to incentivize providers and plans to provide proper care coordination and complete care.

**Room Four:**

1. Improving education around MOUs and business associate agreements (BAAs) to coordinate information being shared across counties and health plans.

**Room Five:**

1. Ensuring behavioral health providers are educated on CMC beneficiaries.
2. Creating a plan to move people out of a skilled nursing facility (SNF) when they no longer need the level of care.

**Room Six:**

1. Holding interdisciplinary care team meetings that focus on beneficiaries.
2. Holding clinical discussions that are focused on what the beneficiary needs, and how the stepwise approach to medication might present barriers.

**Room Seven:**

1. Creating a more streamlined system of communication and coordination between plans, networks, county mental health.
2. Training case managers and help the patient navigate the system.

**Room Eight:**

1. Statewide collaboration of resources.
2. Offering coordination of care at the point of service.