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

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

DATE: Thursday, July 15, 2021, 10:00 AM to 12:00 PM

NUMBER OF SPEAKERS: 5

FILE DURATION: 1 hour 14 minutes

SPEAKERS

Hilary Haycock
Anastasia Dodson
Sarah Steenhausen
Michel Huizar
Alexandra Kruse

Hilary Haycock:

Good morning and welcome to our fifth, Managed Long Term Services and Supports and Duals Integration CalAIM workgroup. We are excited to have everybody with us today, and we've got a great discussion, so we're looking forward to it. We have some wonderful guest speakers with us today from DHCS, we'll be hearing from Anastasia Dodson, the Associate Director for Policy in the Director's Office. Michael Huizar, from the Managed Care Quality and Management Division. Sarah Steenhausen, Director of Policy and Advocacy at The SCAN Foundation. And Alex Kruse, the Associate Director of Integrated Care State Programs at the Center for Health Care Strategies.

Hilary Haycock:

A few meeting management items to note before we begin, all participants will be on mute during the presentation. Please feel free to submit any questions you have for the speakers via the chat box. We will be monitoring that as we go along, so please feel free to put any comments or questions in there. During the discussion periods, if you would like to ask a question or provide comments and feedback, please use the raise hand function, and we will be calling on folks and unmuting their lines as we go along. The PowerPoint materials, the PowerPoint slides, and all other materials, will be available shortly after the workgroup concludes on the CalAIM website. We will be posting the link to that in the Zoom chat periodically, so go ahead and look for it there.

Hilary Haycock:

We are asking folks, because it's a Zoom meeting and we can all see each other, and we've got a participant list, to go ahead and rename yourself so that you add your organization names, so we know who's here and that'll help us as we're tracking different comments and putting together takeaways from the day's meeting. So, click on the participants icon at the bottom of the window, hover over your name, find your name and that participants list on the right side of the Zoom window, select rename, and then enter your full name and your organization as you would like it to appear in our records. So those are our meeting notes for the day, and with that, I am delighted to hand it over to Anastasia Dodson from DHCS, to kick us off this morning. Thank you so much.

Anastasia Dodson:

Good morning and thank you Hillary and welcome everyone. We're very pleased to be talking with you all today and we're pleased to have a continued collaborative format as we've been using in previous meetings. So, thank you for being such great participants in the last few meetings using this format. So, the purpose of this work group, as you know, is to serve as a stakeholder hub for the CalAIM MLTSS and integrated care efforts for dual eligibles, including the transition of CCI and Cal MediConnect. We're trying to provide an opportunity for stakeholders to give feedback and share information about policy and operations for upcoming changes. And it's open to the public, we have a charter posted on the DHCS website, and again, we really value our partnership with all of you and with CMS, and across the next few months, we'll continue to work together.

Anastasia Dodson:

And today's meeting is, I would say, not completely, well, the last meeting that we had, we had entirely breakout room focused, this time we're saving some time at the end to provide some updates on policy. So, we'll continue that format in the coming months. Sometimes we'll have a little bit more of presentation, but we always want to make sure that we're including stakeholders in the presentation and in the process, and you'll see that today.

Anastasia Dodson:

Next slide. So, Sarah Steenhausen has graciously agreed to help us go through the discussions and takeaways from the past meetings. We're going to talk a little bit about care management models and how are Medi-Cal and the D-SNPs models will work together. We'll have a breakout group discussion and then we'll have report outs. And then as I said, at the end, we'll have some policy updates and those will focus on what we have so far in the budget trailer bill. But to my knowledge, it's not been signed just yet, so we'll have to dive into those details at a future meeting.

Anastasia Dodson:

All right, next slide. Great. So, I'm going to hand it over to Sarah Steenhausen from The SCAN Foundation, and she'll be presenting on the key takeaways from the May and June work groups. And just flagging that we have drafted summaries of those work group meetings on our website. And we've done our best to summarize what was said and who said it, but if there's anything that you see on our website, on that summary that's been misrepresented, please let us know and we'll correct it. All right. I'll hand it over to Sarah. Thank you, Sarah.

Sarah Steenhausen:

Great. Well, thank you so much, Anastasia. It's my pleasure to be here and to provide a brief summary and the takeaways from the last two meetings in May and June. Next slide please. So, I want to talk a bit about the May work group meeting. There was an opportunity to provide a deep dive into the needs of people living with Alzheimer's and dementia, and the importance of developing models of care that ensure the appropriate screening, early detection, and diagnosis, so that we can have the early interventions within the disease process.

Sarah Steenhausen:

We all know that the incidence of Alzheimer's in the population is increasing and it's going to become even more challenging as the population ages. So, it's a particularly important conversation, as we think about models of care and development. We heard from Jennifer Schlesinger of Alzheimer's Los Angeles, she highlighted several promising practices in supporting individuals with dementia and their caregivers as well. We also heard from Megan Dankmeyer of the Molina Health Plan, who discussed Molina's dementia model of care and some of the practices that they've developed through the Cal MediConnect program. Then this followed with a stakeholder discussion

panel, including Susan DeMarois of the Alzheimer's Association, Debbie Toth of Choice in Aging and Zia Agha of West Health. Next slide please.

Sarah Steenhausen:

So just focusing on some of the key takeaways, the first is opportunities. There was a lot of discussion on the important opportunity with CalAIM to address dementia related disparities and develop a Population Health Management strategy that would ensure the screening, early detection, and diagnosis, so that again, these interventions could be done early on in the disease process. There was discussion about the importance of leveraging tools, such as Enhanced Care Management, In Lieu of Services, to provide the intensive case management and non-medical services that would help people with dementia remain in the community, and in the settings of their choice.

Sarah Steenhausen:

There was a lot of discussion on person centered care and the importance of creating an approach to care that had pathways to coordinate care across healthcare and community-based organizations. Something that was talked about was creating a closed feedback loop that can ensure the individuals connect with and receive the services that are outside of the plan. There was also an emphasis on the importance of the family caregiver, or the individuals designated caregiver, as they really are part of the care pathway. So, health plans have been focusing on how they might assess for their needs and support them in their role in that capacity.

Sarah Steenhausen:

There was discussion on the importance of assessment and ensuring that the health risk assessment includes cognitive screening, with a process to ensure follow-up with the primary care physician, and as well as how you assess for the caregiver needs as well, since they are part of the care process. I talked about training and ensuring that case managers are trained on dementia related issues, as well as having dementia care specialists within health plans, that can screen for dementia and work with the consumer and the caregiver to develop specialized care plans that respond to their needs.

Sarah Steenhausen:

And finally, looking at infrastructure and capacity. We heard about the critical role that home and community-based services play, programs like the Alzheimer's Day Care Resource Centers that provide support and interventions for people who are maybe in their mid to late stages of Alzheimer's. And this is important because it not only improves the care process and the care delivery for the individual, but it also provides important respite for the caregiver. We also heard about the model of Geriatric Emergency Departments and how they can serve an important role in identifying risk factors for Alzheimer's and dementia, as well as screening and referring to resources in the community. Next slide please.

Sarah Steenhausen:

So, the June meeting really focused on, just one moment here, the June meeting focused on the central role that care coordination plays in streamlining access to services. And there was a focus on what the lessons were learned from Cal MediConnect, and where are the opportunities for the next phase as the state transitions to a D-SNP platform. We heard from Anastasia in outlining DHCS's vision for care coordination, as a person-centered approach that recognizes the range of services people need across the continuum of care. Anastasia indicated that the state intends to leverage both the Medi-Cal Managed Care Plan contracts, as well as the D-SNP care coordination requirements in the D-SNP State Medicaid contracts, or the SMAC, to operationalize this vision.

Sarah Steenhausen:

We heard from Carrie Graham, the director of LTSS, at the Center for Health Care Strategies. And she presented the findings of the care coordination aspects from the Cal MediConnect evaluation, with additional insights on lessons learned from Jack Dailey of the Cal MediConnect Ombudsman Program, and Maya Altman of Health Plan of San Mateo. And as was indicated, the meeting then transitioned to a breakout session, with opportunities for everyone to engage in lessons learned in care coordination, and opportunities in the transition to a D-SNP platform. I know this is something that we'll have the opportunity to continue the discussion in today. Next slide, please.

Sarah Steenhausen:

So finally, the key takeaways from this meeting in June, first focusing on lessons learned. One of the significant findings that Carrie reported on from the Cal MediConnect evaluation, it was the finding that only 30% of those individuals who were surveyed actually received care coordination services in the Cal MediConnect program. This is important because it shows that care coordination is a real central tenet to any integrated system of care. So, there were some lessons learned about how can we ensure that in integrated delivery systems, people are actually receiving the care coordination that they need, and that is a benefit in the system. We did learn from what Carrie said, that of those who did receive care coordination, there was a very high level of satisfaction in how the care coordination helped people streamline their access to services, how they access durable medical equipment and prescription drugs, getting their appointments made more efficiently. So, it's a very beneficial service, but again, how can we ensure that people get it, who need it?

Sarah Steenhausen:

The second lesson learned really focused on beneficiary education and awareness. How can we ensure that beneficiaries are aware of and understand the care management benefit? And also, how can we ensure that managed care plans are assessing the beneficiary and identifying the need for care coordination, to target services to those who really need it most. An important discussion on lessons learned in workforce issues, with care coordination, we all know that our aging population is very diverse and has a lot of needs in terms of cultural competency in the workforce, as well as linguistic access beyond the English language. So, building a workforce that can

meet these cultural and linguistic needs of enrollees, is really critical because as we know, a one size fit all approach doesn't always work.

Sarah Steenhausen:

Another important opportunity is looking at who is the point of contact? Does the beneficiary have one person that they know to contact, who can help them address their issues? Ideally, this would be the care coordinator in the health plan, maybe it would, maybe it would be a care coordinator that they have in another service outside of the health plan, but it was discussed that it was important for beneficiaries to have one person to go to that can help them. This raised the issue of who's coordinating the care coordinators and that multiple programs have coordinators, but the beneficiary often gets lost in a maze of who is doing what for which service, and it can complicate the care delivery process.

Sarah Steenhausen:

Something that stuck out to me is Maya Altman's comment that more care coordination does not equal better care coordination. Another really important theme in care coordination that was mentioned, is the issue of transition, challenges in transitioning individuals from hospital to home, or from nursing home to home. And the really critical role that care coordination plays in helping ensure that the beneficiary can get their needs met across a continuum. And central to all of this is the role of partnerships and how you can ensure that there's collaboration across medical, social service delivery systems, home and community-based services, so that that sort of transition is seamless. Partnerships, another important theme along the whole care coordination continuum.

Sarah Steenhausen:

Data sharing was also identified as a really important opportunity. The importance of robust shared data, helping plans know how to identify the needs and target services for the beneficiary. So, this is data from all parts of the continuum, medical providers, functional health needs, behavioral health needs, social determinants. The challenge with this is that we don't have a unified platform that connects all the data system. So, it's important for the state to get the data to the plan, the plans to get the data to the providers, and the providers to share data amongst themselves. So, it's complicated, but one of the most critical elements of a coordinated delivery system. And finally, as was discussed, some opportunities around building partnerships and better coordinating service delivery across both the medical and social service delivery system. So next slide, please.

Sarah Steenhausen:

Finally, was opportunities. Looking at how we can educate beneficiaries to ensure that they are aware of their right to care coordination and how they might access it. Opportunities to build capacity and train care coordinators and ensure that the cultural and linguistic competency needs are met of those who are receiving this from us. And then again, partnership, it's not just a nice thing, it's a really critical element. We've

learned about some efforts to develop regional home and community-based services hubs, that convene partners and help develop standardized ways to connect home and community-based service providers with the health plans. Looking at how we can develop a shared data platform.

Sarah Steenhausen:

And what are the incentives to coordinate care across the providers? We know that we used to require IHSS care coordination with the health plans, that changed once IHSS was carved out from the coordinated care initiative, but there's been a lot of discussion of how important that was in identifying needs and coordinating care across the continuum. And then finally, opportunities to leverage technology. How can we consider new modalities and service delivery and care coordination through virtual care, which includes telehealth as well. So that's a summary of the key takeaways and look forward to the discussion ahead.

Anastasia Dodson:

Thank you so much, Sarah. We have Michel Huizar from our Managed Care Division, who's going to be talking about the D-SNP and care management models. And so again, Sarah's very clearly articulating all the things that we are trying to do, we're holding ourselves to this challenging, but very, very important goals that we've elicited from all of you. So how do we operationalize the feedback that we've gotten from you? Let's talk a little bit about that and you'll see some slides, one or two repeats from the last meeting, but we do want to bring those lofty and important goals into what do we do in our contracts, how do we operationalize this? And we're not going to solve it today, but we want to keep both sides of that discussion going.

Michel Huizar:

Thanks, Anastasia. Okay, good morning everyone. My name is Michel. Can everyone hear me? Anastasia, can you hear me? Did folks hear me?

Anastasia Dodson:

Yep. We can hear you.

Michel Huizar:

Okay, good. Excellent. Good morning again, everyone. My name is Michel Huizar, and I'll be covering the next few slides regarding the D-SNP and Medi-Cal Managed Care models. So, the next slide, please. All right. For care coordination and integration for the dual eligible beneficiaries beginning in 2023, DHCS will ensure that D-SNPs and the Medi-Cal managed care plans have clear requirements for integrated coordinated care, particularly in the aligned plans. In addition, as part of the integration, there will be improved sharing among plans and providers, as well as opportunities to create more robust connections between managed care and carved out delivery systems, particularly for the home and community-based services, programs, and providers. Next slide please.

Michel Huizar:

Okay. So, care coordination opportunities. While the care coordination elements of Cal MediConnect and D-SNPs are similar, as you'll note in the table here, the baseline D-SNP model of care requirements are less prescriptive. So, in addition, California can establish requirements for a D-SNPs to include in their Model of Care for 2023. So again, you'll just note in this table, some of the elements of care coordination that are similar requirements for both Cal MediConnect and D-SNPs. Next slide please.

Michel Huizar:

Okay. So, looking at the D-SNP and Medi-Cal approaches to care coordination, we see here in the two graphics, some of the differences between the D-SNP and Medi-Cal managed care plan approaches to care coordination. The Dual Special Needs Plans model line for care coordination for all members, in addition, the D-SNP approach to care coordination must include assessing member needs, developing individualized care plans, establishing integrated care teams, and coordinating care, overall. The D-SNP model also addresses model of care requirements for D-SNP provider networks, so for example, within the clinical practice guidelines, care transition protocols, and so forth.

Michel Huizar:

So also, important to note here that Dual Special Needs Plans must coordinate with Medi-Cal benefits, including those in managed care and those carved out. So, i.e., the behavioral health and substance use disorder and long-term services and supports. We do want to call out here for the development of the 2023 State Medicaid Agency Contract for D-SNPs, over the next six months will be the appropriate opportunity for setting requirements for D-SNPs around care management and supplemental benefits.

Michel Huizar:

So, on the other side of the slide for the managed care plan approach to care coordination with Enhanced Care Management, being at the top of the pyramid as shown in the graphic, with providing the highest level of care to members, followed by a basic and complex case management, excuse me, and finally, the lower risk population care coordination needs as identified by plans through risk stratification, through population health management. As they said, and you'll note in the slide, the ECM will be available to members with the most complex health and social needs, as defined by the population of focus definitions. In addition, all core service components of ECM, so those being outreach and engagement, comprehensive assessment and care management, enhanced coordination of care, health promotion and comprehensive transitional care, will be defined in the managed care plan contracts. And finally, under Enhanced Care Management, the plans are expected to coordinate all carved out services. So those being, for example, the specialty mental health services and drug Medi-Cal organized delivery system services. Next slide please.

Michel Huizar:

Okay. Rounding out my final piece of the presentation around the care coordination for duals key considerations. So, we'll be paying special attention to the coordinating and aligning of the two models for the D-SNP and managed care plan contracts, making sure to, of course, to connect all Medicare and Medi-Cal benefits providers and other key elements. In addition, focusing on the data sharing between entities in and out of managed care, also through leading the care coordination, there'll be clarity and non-contractual leading clarity on beneficiary level care coordination lead. And as for scaling care coordination to fit beneficiary need, we're considering the baseline care coordination for all members, versus a higher-level service for higher level need. So, for example, an ECM enhanced management. Finally, just especially wanting to call out, we are considering the specific requirements to be included in the D-SNP State Medicaid Agency Contract or managed care planning contract. So, I think that rounds it out for me. Thank you. Hillary, I will hand it back to you for the next transition.

Hilary Haycock:

Wonderful. Thanks so much for that presentation, Michel. We are now going to transition to Alex Kruse, the Associate Director for Integrated Care State Programs, at the Center for Health Care Strategies, to talk about D-SNP care management models in other states.

Alexandra Kruse:

Great. Thank you so much. Good afternoon, thanks so much for the introduction. And just a couple things to start, CHCS, for folks who may not be familiar, focuses on advancing innovation and healthcare delivery for low-income Americans, but more specifically in introducing myself to this group, I, as an Associate Director for Integrated Care, work predominantly on projects that aimed to improve care delivery and system integration for duly eligible individuals. So, I'm particularly excited to be a part of the conversation today and be paying attention to all the work and the consideration to these issues in California. I'll present from a national lens, on D-SNP care management models, to compliment some of what you heard from Michel and help inform hopefully some of the breakout discussions that are happening today. So next slide, please. Actually, you can shift to the agenda slide.

Alexandra Kruse:

So, we'll do a quick background on the D-SNP Model of Care, understanding there may be folks here more or less grounded in that and what that looks like, as compared to maybe experience with the MMP model. And then I'll spend some time sharing some findings and examples of approaches that states have taken to influence the D-SNP care management model, and in many cases, align that, as Michel was describing, with Medicaid managed care program goals and parameters. And the findings draw from review of State Medicaid Agency Contracts around the country, where D-SNPs and Medicaid or MLTSS programs are aligned, as well as just general familiarity with those models. So, it's not an exhaustive example of all of the things states do, given the variation in Medicaid programs across the country, but hopefully a good illustrative example for you all. So, you can move to the next slide.

Alexandra Kruse:

So just a little baseline on the D-SNP model of care. This does, as I think is discussed in some of the earlier work groups, provide the basic framework under which the Medicare special needs plan, in this case, the D-SNP is required to demonstrate how it will meet the unique needs of duals. And while these requirements and required elements that you see on the slide here are comprehensive, including requiring assessment of needs, and developing care plans, and using interdisciplinary teams, considering the federal requirements alone, D-SNPs have significant flexibility to determine how they'll structure that care management model. They determine how and when care plans are developed and updated, the frequency and methods for things like ICT meetings and what that will look like.

Alexandra Kruse:

And that's, again, all considering just what's required on the federal side, there are also beyond what feels like I would say the more typical care planning care coordination requirements, there are model of care requirements and standard elements that address things that build on, on that, and look at that. Which include the D-SNPs approach to quality measurement, performance improvement, and really monitoring health and beneficiary outcomes, how do they propose to do those things? So, while these are really comprehensive, they're not prescriptive at the start. So next slide.

Alexandra Kruse:

So again, as noted in some of the earlier work group meetings, D-SNP requirements for care coordination, reflect both those CMS expectations, but also any State Medicaid Agency requirements. And states really have considerable opportunity to influence the care management model to advance specific care coordination standards. And they do that in two ways, which is using the State Medicaid Agency Contract with the D-SNP to further Medicaid program goals, and then also can specify requirements for D-SNPs to actually address in their Model of Care submissions to CMS. And I think the last piece of background here that may be the most helpful, is that the quote from Minnesota here, which really attempts to explain the relationship between these two vehicles, the state's contract with the D-SNP, and then this Model of Care, and the Minnesota officials who've been working with this for quite a while, sum it up as the contract is really describing what the plans have to do, and then the model of care describes how they will do that. Next slide, please.

Alexandra Kruse:

So, thinking about some key findings related to care management standards nationally, states typically do not require greater specificity in requirements for all of the various things that D-SNPs may do related to care coordination, but tend to focus on particular elements that are again, important to the state or important to duals when you're thinking about the relationship with Medicaid. And so those are listed here to some degree, some examples, including of course, managing care transitions for folks who will experience benefits and services that they need to support those transitions, covered both by Medicare and Medicaid very often. Expectations often for states to be a

little bit more particular around data requirements and reporting related to care coordination and the work that SNPs are doing. Health risk assessment integration and data sharing is something I'll talk about in a moment.

Alexandra Kruse:

And then there's other really just state specific parameters around things like family and other caregiver involvement, in the care coordination model, as well as in assessment, and then addressing things like social determinants of health, as well as more recently states looking at the D-SNP care management models in programs where they've aligned it with Medicaid, to think about also addressing health disparities and health equity, and other high priority issues for Medicaid programs. So, we can go ahead and shift to the next slide.

Alexandra Kruse:

So, thinking about assessments as the start of the process of coordinating care delivery across Medicare and Medicaid, there can be a variety of assessments administered at different points in time. And in considering how those tools and those requirements could be integrated, it's helpful to understand what the baseline CMS requirements are for health risk assessments. And so that's on the top part of this slide you see here, in terms of D-SNPs being required to administer an initial health risk assessment within 90 days of enrollment, and as a baseline annually thereafter. And there are particular elements that CMS requires that the health risk assessment that the D-SNP develops tackle, including medical needs, functional needs, and the things you see here. And then there's a use of that HRA that's also specified in terms of using it to identify risk and help stratify the D-SNP population in terms of the care coordination support that they'll receive. And I think the main thing to note here is that there's a lot of, again, flexibility on the part of the D-SNP on building that tool, and then thinking about using that to best serve their population.

Alexandra Kruse:

So, if we look nationally at state experience with models that are similar to what's envisioned in California, states, while they typically haven't specified the HRA tool that D-SNPs use, there are several trends in terms of the kinds of things that they have done to promote alignment. These include expanding beyond the required CMS, HRA elements, and really specifying how, and when assessment should, maybe not for all, but a subset of D-SNP enrollees. And so, an example there is in Virginia, where they require that the HRA plan identify, their specific about unmet needs they want to have identified, including things like social determinants of health, behavioral health needs, cognitive supports, LTSS needs, and also focus on, at that initial health risk assessment, looking at strengths and goals in other state specified elements.

Alexandra Kruse:

Additionally, states with the line D-SNP and MLTSS programs often require that the HRAs be administered more quickly than federal guidance require. So, Virginia, in their case, they asked for HRAs to be done within 60 days of enrollment, while Minnesota

and Tennessee have had an expectation of 30 days. But it is important to note that in both of those cases, the shorter timeframe pertains to individuals or a subset of duals that qualify for MLTSS in these states, and therefore you can see why someone who may meet nursing facility level of care, that that would correlate to a need for an earlier assessment. And then I think the other pieces here is sometimes states have looked at requiring for a subset of the population that the assessments be administered face-to-face, which are not always done that way without state requirements. And then there's downstream implications for integrating just the administration of the tools to reduce beneficiary burden and thinking about how the assessment data is integrated across Medicare and Medicaid, that states are pretty focused on. Next slide.

Alexandra Kruse:

So similar to considering integration and alignment of assessment processes, it's helpful to know what the baseline individualized care plan and care team requirements look like on the Medicare side. And I'm not going to go through all of these today, but just want it as a reference, to note that you can see for the individualized care plan, that there are expectations around the care plan touching on things that may correlate to Medicaid program priorities like personal healthcare preferences, identifying goals. And then there is flexibility on the part of the D-SNP to think about the roles and the credentials of various staff that are involved in that, whereas state Medicaid programs are often a little bit more prescriptive. And on the ICT side of things, again, you can see there's some baseline expectations that when the D-SNP is developing a care management model, they're thinking about how these ICTs will work and who may be included in those, but states can drill down.

Alexandra Kruse:

And if we move to the next slide, you will see examples in the care planning and interdisciplinary care team space, the kinds of things that for beneficiaries that are aligned in a D-SNP and a Medicaid plan that states often require. And that includes having one comprehensive care plan, that the exact content and format for those care plans may vary by state, it might vary by the risk level of the enrollees, without any specific state expectation of requirements, it can vary a bit by plan. But a lot of work done around how to make that more comprehensive in nature, and then sharing of care plans, which is something that Michael may have noted in some of the slides he was sharing earlier and has come up in some of the takeaways from prior conversations. That the benefit carve-outs that exist in a state, can sometimes require, or create an opportunity really, to think about who that care planning information should be shared with.

Alexandra Kruse:

States often specify requirements for ICT composition, participation, and also think about things that aren't really as specified by CMS for D-SNPs, but things like the frequency of care manager and enrollee contacts, and then again, person centered care planning. Which is a priority for all duals, but particularly for the subset of duals that are needing long-term services and supports. So, I think just in conclusion for this information, I'm just pointing out that it's naturally more complex to operationalize some

of this, when benefits are delivered inside versus outside of an integrated health plan, but hopefully these findings in other states, give folks with less familiarity, a sense of the kinds of things that have been done to help inform some of the California specific conversations. And it may be helpful to know, and I'm sure folks have observed, that several of the state approaches that have been used nationally in aligned D-SNP and MLTSS models, are pretty similar to requirements that exist today for Medicare Medicaid plans operating the Cal MediConnect model. So that is the conclusion of my slides, thanks so much.

Hilary Haycock:

Great. Thank you so much, Alex. That was a lot of really rich information, so I hope folks enjoyed their presentation. There's certainly a lot to think about. So, we're really excited that now we're going to go into breakout discussions. We're going to have 25 minutes in our breakouts. We're going to be automatically assigning folks, every breakout room, we'll have a note taker to help pose the questions we want to discuss and take notes, and then we'll do report outs. So, this is similar to what we did last time. And so, it'll be helpful to have both some written feedback that folks can put in the chat, as well as the verbal feedback, just so we can continue to be collecting and integrating the takeaways from these meetings as we're moving forward in this process.

Hilary Haycock:

So here are the discussion questions. Having thought about the best practices and lessons learned from CCI so far, as summarized by Sarah Steenhausen, and then all of the interesting ideas about what other states are doing and the different elements of care management in the D-SNP, that Alex walked through for us. We want to discuss what do we think, what do you think as stakeholders, are the most important elements of care coordination for dual eligible beneficiaries? And what role could the SMAC, the State Medicaid Agency Contract that DHCS is going to develop for our D-SNPs, play in defining those elements.

Hilary Haycock:

And then we also want to drill into, are there any special considerations for different populations or programs? We know that the dual eligible beneficiary population is not how much ... I'm just going to move past that. There's lots of different folks that have different needs, and we want to make sure that we're thinking through populations with different needs, for example, beneficiaries with dementia, taking into account all of the great lessons learned from our previous work group or individuals with disabilities, individuals with chronic conditions, individuals experiencing homelessness. So those are our key discussion questions, and now, we will break out. Thanks so much.

Hilary Haycock:

Welcome back folks. If you were like our team, our breakout room, man, we had a great discussion, so I hope that that was true across all the breakouts. There certainly was more to dig into then there was time, but I'm looking forward to hearing from the different groups. So why don't you, if folks now wouldn't mind, put their top three

takeaways from your group into the chat, every group should have designated one person to do that. So just say what your breakout room was and then your top three things. So, we'll give folks a chance to do that, and then we'll start calling on volunteers. Is there a breakout room that would like to go first? You can raise your hand if that is you. All right, I'll start and then I'll hand to Anastasia.

Hilary Haycock:

Our group, our three things were one, care coordinators should meet the unique needs of the members. So, whether that's culturally, language, gender, or lived experience, and be that single point of contact. There should be a floor of standards for HRAs, sort of like maybe the NCQA standards, that they all should have questions that meet those different areas, but that they should focus on the member experience and there should be flexibility for plans to add to and tailor. And that the state should focus on outcomes and the member experience for any plan reporting or monitoring. So, I put that in the chat and then Anastasia, I think you volunteered to report out for your breakout group.

Anastasia Dodson:

Yes. And I'm sorry to be tardy putting it into the chat, we had a lot of really good feedback and discussion, talking about HRAs and needing to include cognitive status there, and then including caregivers as appropriate, in family centered care planning as appropriate, and needs of the caregiver being assessed as well. Acronym confusion, we talked about that a little bit because it's not just maybe confusion amongst providers, but even could spill over to beneficiaries. But the point was that people don't know what the acronyms mean unless they're working on it every day. And speaking of acronyms, that the assessment should collect information about all systems, there are some, of course, outside of D-SNP or aligned enrollment.

Anastasia Dodson:

Perhaps too many phone calls from too many different providers or programs, wanting to be a little more strategic about what phone calls go to folks, especially as people are older and they get overwhelmed with some of that. And then needing more diversity in the workforce, particularly by language. And then thinking about also the churn rate, we had a really interesting discussion about how many duals are losing eligibility each year because of the asset test and how might that change, but in the meantime, what can we do to reduce that? Because being disenrolled from Medi-Cal can cause interruptions in the care and the care team. So, thank you, we had a lot of really great discussions.

Hilary Haycock:

That's great. All right.

Sarah Steenhausen:

I'll go if you want me to Hilary, for our group.

Hilary Haycock:

Yeah, I was just going to call on you. Thanks Sarah.

Sarah Steenhausen:

Very similar things that were highlighted by both you and Anastasia. A lot of discussion on this notion of the beneficiary outreach, we've heard a lot about people not understanding what care coordination is and developing common language to use in outreach to beneficiaries, but also ensuring, of course, that the linguistic needs are met as well, when you do the translation into other materials. Second is similarly workforce issues and ensuring that the care coordinators have cultural competency to serve the population, but also that there are this spoken languages that reflect the population served. And then finally, the third, what we would like to see as a requirement that's detailed and specified in the SMAC, is really specifying what a comprehensive care plan should look like, and the expectation that it should identify behavioral health, functional needs, as well as access to services that may not be provided by the health plan, but how to ensure that there's coordination and a closed group loop referral process to meet the comprehensive care plan requirements.

Hilary Haycock:

Great. Who would like to go next? Feel free to raise your hand. Here we go. Aaron Starfire.

Aaron Starfire:

Hey, good afternoon. Yeah, so we had a nice conversation in our group, similar themes to what's been expressed. Essentially better coordination across, I think what Terry in our group called slivers of programs, especially for dual eligibles. Like how do you coordinate the coordination if you will? So, I think there was a general feeling a question like, what can the department do to coordinate the coordinators, especially with technology in this day and age. So that there's something like a clean front end for dual eligible folks, consistent with the No Wrong Door theme, and then something that assists the care managers in delivering and connecting folks to the right services across payers, across carved in, carved out, potentially across health plans. So maybe just for consideration, what is the best way to do that?

Aaron Starfire:

As far as populations of focus, there was comments about focusing on people with behavioral health diagnosis, also the overlap with regional centers, and other county programs, just as an example, of coordinating the coordinators. And then finally, the themes of homelessness, of substance use disorder, how did those overlay, that is where a lot of the need is being seen the most. So that's what our group had. Thank you.

Hilary Haycock:

Wonderful. All right, Kristin Smith. Thank you so much, Aaron.

Kristin Smith:

Hi, thank you. So, in group three, a lot of what we talked about were important elements of care coordination, could probably be put under the rubric of clear standards for the

role of the care coordinator. We said giving referrals is not enough to call yourself a care coordinator. We want to have closed loop referrals, making sure that there was actually follow up and that the member got the service. We talked about how the community information exchange, it's beyond a referral platform, it's a legal framework for the social, for the home and community-based services to data share, and that it would be great if the health providers were also involved with that. But there might be some downsides that would need to be mitigated, as far as like double entry into EHRs and CIE tools.

Kristin Smith:

And we talked about the importance of standardized templates for health risk assessment information and for storage aspects of the data. One person talked a lot about the delegated providers, that if they're working with different health plans, they need to have a way to have more standardized data storage. And so, you've got that clear standard for the care coordinator, with those elements, and then of course you want to have the awareness of care coordination by the members and also provider expectations, so providers need to be educated.

Kristin Smith:

And then we also talked about, we had a question and it was interesting because we really had a lot of knowledge in the group, but we were thinking about D-SNPs, and we weren't actually sure and we wanted clarification on if a member is enrolled in one Medicare plan, but a different Medi-Cal plan, does the Medicare plan, actually will they be required or can we, to do coordination of home and community-based services, where does that happen? Is it only within the Medi-Cal side or can it also be on the Medicare side? And if my group wants to add anything, I'm hoping I reflected all that we talked about. We did a lot on that question.

Hilary Haycock:

I think that's a question we're trying to solve for thank you. I think we're going to go next to Jan Spencley.

Jan Spencley:

Hi there. This is Jan Spencley from San Diegans for Healthcare Coverage. I was in room five, which used to be right next to my comment in the chat. We had a great recommendation that came in, it's in the chat further up, from The SCAN Foundation, but essentially that summarized down to taking the wants, needs and preferences of the beneficiary into consideration when establishing goals, and then valuing that input, capturing it, and valuing it and including it in implementation. Much better stated in the chat, that's my summary. I think others had said the same thing, clarify roles of different care coordinators, who's primary, who is population versus episodic, that kind of thing, and clarifying those roles. And there was a point about who's getting paid to do it, I think it was who can charge time for it, which I think may be something I'm not aware of, but it did come up.

Jan Spencley:

The other was inclusion of family and the process for care coordination, especially for dementia patients. Added to that was if no one is available, facilitate securing someone to help the consumer with diminished capacity. That's not everybody, but as people get older, there are more and more people with diminished capacity who may not have a family member that can help them. Care managers should facilitate fulfillment of care plan through to appointments, not just approved, but that goes back to some points made, I think, by other groups, is not just approved, but ensure that care is scheduled and delivered. Because a lot of times we run into, the poor beneficiaries knows that they've got something approved, a care manager said they could have it, but they can't seem to get it scheduled and delivered in the appointment.

Jan Spencley:

And then the question about the state includes all of this stuff that we're all talking about in contracts, in metrics and oversight and reporting. If it's not measured, if it's not reported or standardized, it's hard to say it's being performed, the standards are being met and how well they're being met. And I think I want to just throw in that the whole issue of access to care was put into the comments, and I think that's extremely important to bring up that it's a problem, no matter how much it's authorized, finding a doctor to take care of somebody is a problem.

Hilary Haycock:

Thank you. Very helpful. Great comments. All right, Maya Altman, you're next.

Maya Altman:

Hi. I'll just make a couple of comments from our group, of things that haven't been said before, and Trish or others from the group, if I forget something, please join in. But I think we talked about also that it's really important that the care coordinator fully understand Medicare and Medicaid benefits and be able to communicate that to the beneficiary, and to jump in when necessary, and make sure that if Medicare doesn't pay for something, they know that Medi-Cal well and not leave that beneficiary stuck. Also, we talked about the importance, since IHSS was carved out of CCI, some of us felt that was a loss and that the SMAC, we know it's directed at plans, but there really is a need for a strong state role with IHSS, to make sure that the coordination with the plans around people who need IHSS services is there, and that that information is shared.

Maya Altman:

Similarly for people with serious mental illness, because the carve out presents a lot of challenges, that there be a strong state role, encouraging coordination and sharing of information with behavioral health entities and plans around dual eligibles. I think that the other things that I think that we talked about have been mentioned already, but if I'm forgetting anything, please jump in someone from my group.

Hilary Haycock:

Great, great. I think we've got a couple of groups that haven't reported out verbally yet, and we've still got a couple of minutes. Anybody wants to do another verbal report out? Great. Well, we really appreciated all the feedback we got in the breakout. So please know, we took notes on those breakouts, we're copying all the information in the chat. We know that the chat, that participants cannot copy out of the chat, so we apologize for that, we will turn that on for next time, that was not intentional on our part. So, if there's anything from the meeting that you would like in the short term, please feel free to contact us info@calduals.org and we will be happy to share any of the public report outs in the chat with folks. So, I apologize for that, we'll get that fixed for next time. But super helpful, and so all of that will be wrapped up and we will be compiling a key takeaways document from this meeting, all of the things in the chat will be included in that document verbatim as an appendix, as well as the overall summary.

Hilary Haycock:

So really great conversation, so thanks so much folks, we really appreciate that, and look forward to continuing the conversation on this topic as informed by all of your feedback moving forward. With that, I would like to transition to Anastasia Dodson from DHCS, to give some policy updates.

Anastasia Dodson:

Thanks so much Hillary and agree, thank you again, everyone, I'm just so happy to have all of the feedback documented. So, as we move forward in the next few months to design the 2023 SMAC and other related documents, because we recognize there's a lot going on on the Medi-Cal side as well. And so, keeping both of those pieces in mind and looking for ways that we can make things better in 2023, and I'm sure we'll continue to iterate in future years as well. So next slide.

Anastasia Dodson:

I wanted to just briefly highlight some components of the trailer bill. So, the trailer bill is a piece of legislation that is a companion to the state budget, and there's usually an Omnibus Bill on the health side, an Omnibus Bill on the human services side and that's the case this year as well. And although the budget, there have been several pieces that have been approved by the legislature and signed by the governor, some pieces are still outstanding. This year was really an unprecedented year, as far as the dramatic increase in revenue, and then as may know, we submitted an HCBS spending plan because we got additional federal funds through that enhanced FMAPs. So, there's a lot of moving parts in the budget this year, and so it's not all final and wrapped up as it might normally be this time of year, but the outline is there.

Anastasia Dodson:

And for AB and SB 133, those are the bills that are the trailer bills for CalAIM, and in that are the statutory provisions for D-SNPs going forward. And again, I'm going to try not to be super technical, those of you who want to know all the details, certainly please take a look at the language in the bills, but at a high level we're just where we thought we would be as far as 2022, where managed care plans, Medi-Cal plans or

subcontracted plans, they can transition beneficiaries that are in basically lookalike, D-SNP lookalike plans, which we talked about in previous meetings. They can transition beneficiaries in lookalike plans, into an affiliated D-SNP, and if those D-SNPs were approved prior to 2013.

Anastasia Dodson:

So, as you may recall, when we launched Cal MediConnect, we wanted to highlight and direct as much as possible, beneficiaries to enroll in Cal MediConnect and D-SNPs were frankly a competition and added more confusion in the CCI counties to the existing array of choices for duals. So, there was a statutory prohibition on new D-SNP enrollment in the CCI counties. So, this language allows beneficiaries who are already enrolled in a D-SNP lookalike, which is not the same as a D-SNP, to be transitioned into D-SNPs in 2022. And the reason I'm spending time on this is because it's actually a large number of beneficiaries that are in D-SNP lookalikes in CCI counties, over a hundred thousand beneficiaries.

Anastasia Dodson:

So, in 2022, there will be the transition of those beneficiaries, some of them, and then there'll be a transition of many of the remaining D-SNP lookalike members into a D-SNP that's affiliated with a Medi-Cal plan. So that will really help minimize the different permutations of plans combinations in CCI counties, and that will give a good start as far as an even greater membership in aligned D-SNPs and Medi-Cal plans. So anyway, sorry, a lot of technical stuff after a wonderful conversation about care coordination and person-centered care.

Anastasia Dodson:

The other piece, so there's pieces in the trailer bill language around 2023. So, as you know, one of the key components that we've been talking about is D-SNP aligned enrollment and the trailer bill includes the provisions to sunset Cal MediConnect and then require a Cal MediConnect plans to establish D-SNPs with aligned enrollment as of 2023. This language will enact that into law. One piece that was added is that the Medicare choice will drive the Medi-Cal plan enrollment. So that was made more explicit in the statute, and so wanted to call that out. Also in 2023, as we transition out of Cal MediConnect, the statute requires us to continue to have some kind of an Ombuds program. So, we will be looking at that in the coming year, as far as how to crack that. We have an existing Cal MediConnect Ombuds program, and we'll be taking a look to see how that might continue, change, grow, modify as needed in 2023.

Anastasia Dodson:

The statute also requires us to convene a work group, which we have with all of you. And then there are also requirements in the statute around network adequacy, aligned networks and continuity of care in the SMAC. So that's a new provision that's been added, and so we will add that in our work in the coming months, as to how to put that language appropriately into the SMAC. Continuity of care has been a longstanding topic that we have discussed with stakeholders for all of our transitions over the last 10 years

or so, and so we'll add that continuity of care to the stakeholder discussion here with all of you, as well as network adequacy and provider networks. And it's an interesting conversation, in the past it's been a little more straight forward, it's been from maybe one type of plan to another plan, but now this is combining it both on the Medicare and the Medi-Cal side, so very good topic and we're looking forward to those discussions.

Anastasia Dodson:

Also, as we'll see on the next slide about future topics, we're going to be talking about informing notices in this work group, and that's in the statute as well. And then the last piece that I want to talk about in the trailer bill language is that so for the non-CCI counties, the statute is pushing out the implementation date for the requirement for Medi-Cal plans to establish a D-SNP by one year. And that will be also dependent on the outcome of the feasibility study of D-SNPs in the non-CCI counties. So, we've heard that there could be some financial and other implications for a Medi-Cal plan to stand up a D-SNP if they have not in the past. And so, we'll be looking at that over the coming year, and we certainly hope, and we know that the managed care plans are very much committed to the aligned enrollment model, but we do need to also consider the fiscal implications, so we'll be looking at that in the coming years.

Anastasia Dodson:

So I guess for the work group here though, we're keeping our eyes very, very closely on the comments that you have all made as to regarding what should go into the SMAC, and then the additional requirements that we'll need to consider based on the trailer bill language, and then next month and the following month, et cetera, we'll continue our work in collaboration with you on the SMAC, and then go ahead to the next slide, but we also will need to talk a little bit more about the enrollment policies and the beneficiary notices. So, we'll have, I would say two threads, two major threads, the enrollment issues and the beneficiary communication and the SMAC. And those topics are very complex, and we could have even more meetings if we need to on those topics, but we have some specific deadlines, particularly on the enrollment policies that we need to address so that the IT systems are set to go January of 2023.

Anastasia Dodson:

So, for our next agenda, you may find that we are focused a little more on the enrollment policy, and we will be consulting with some of you in advance so that we have as much put together that we can present and discuss here at this meeting. But we will also be working simultaneously on the care coordination issues and communication issues. Data sharing, quality recording, those are also really important topics, and so we have those on our radar, and we have actually a population health management platform that we're working on, that will relate to the data sharing. So, more work behind the scenes at this point on a DHCS side, around data sharing, but we're aware and same with quality reporting. All right. So, I know we're a little bit ahead, but I don't know if we want to do any questions on any of these topics or any last comments from anyone?

Hilary Haycock:

There were a couple of comments in the chat. So, I know since things aren't final, I'm not sure if you want to take those questions or if we want to take them back? What if someone does not choose a Medicare plan, if someone wants to be in Medicare fee for service?

Anastasia Dodson:

Right, right. So, this has been our policy from the beginning, is that enrolling in for dual eligible for any Medicare beneficiary, it's their choice as to whether or not they want to enroll in any type of Medicare Advantage plan or stay in fee for service, go back and forth, that's their choice. There are certain windows and timelines that CMS has established for making that choice, and they're slightly different for dual, there's more flexibility there. But that will remain that if a beneficiary is already in Medicare fee for service, there's no requirement that they transition to Medicare Advantage.

Anastasia Dodson:

However, as we talked about in previous meetings, on the Medi-Cal side, we have talked about what will happen in 2023 in the non CCI counties, and that in that dual eligibles in the non-CCI counties, will be transitioned to Medi-Cal managed care, but as you know, duals in the CCI counties are already enrolled in Medi-Cal managed care. And that those requirements on the Medi-Cal side are totally separate from the choices and options that folks have on the Medicare side. So, there will be no requirement to enroll in Medicare Advantage on the Medicare side. However, we really think that there's wonderful opportunities, and particularly for just as we've been talking about, how can we improve care coordination because in fee for service the beneficiary has to navigate across the two systems on their own or with their caregivers.

Hilary Haycock:

Great. Comment from Janine Angel, and just for the need to figure out some of the technical enrollment processes, which I think Anastasia, you covered and talk about that in previous and upcoming meetings. A comment from Jared Giarruso from the Alzheimer's Association, that he'd love to see more on data sharing with respect to dementia diagnosis, and the Cal MediConnect transition to ensure a smooth care transition. So that's a, I think, helpful comment. Otherwise, I've not seeing any other questions or hands raised. There's a question about dual eligibles being able to enroll in Cal MediConnect plan by calling HCO Healthcare Options or using their online form. And a question about how Medicare Advantage enrollment and Medi-Cal plan enrollment will work moving forward. I'm not sure if that's level of detail we're able to get into at this point, Anastasia, if you want to hold that question.

Anastasia Dodson:

Yeah. I wouldn't want to give an incorrect answer, but it's a very important question. And so, I'll also say that we are looking at FAQs and other types of information to post on a website about the enrollment issues, because again, some of those are ... we want to make sure we say them exactly the right way, the correct way, to avoid any confusion. So, we will add that to our upcoming information, and FAQs.

Hilary Haycock:

All right. There's a question about In Lieu of Services, I don't think we've got our friends from MCQMD with us any longer, so I'm not sure if we'll be able to answer that question either. But maybe the team could put in the chat, there is an inbox for CalAIM and ECM ILOS issues, you could also just go to the DHCS website and find it there. Comment asking us to make sure that we're noting differences for CCI counties that are COHS versus non-COHS. That's an excellent point and something we definitely want to be mindful of as we're thinking through enrollments, as enrollment processes work differently. Great. All right, well, thank you everyone for truly a great meeting today, so much wonderful feedback that we deeply appreciate. Our next meeting will be Thursday, August 19th at 10:00 AM. The agenda meeting materials will be forthcoming for that meeting, so please stay tuned, as well as the meeting materials for today will be posted shortly. So, thank you everyone for your participation in this work group. We appreciate it and have a wonderful rest of the day.