July MLTSS and Duals Integration Workgroup Meeting

Summary and Key Takeaways - DRAFT

The following is a summary of key takeaways from the July 15, 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 a discussion of care management models and best practices for care coordination for dual eligible individuals.

Review of Past Meeting Discussions

The first part of the workgroup meeting reviewed key takeaways from the May 6 and June 10 MLTSS and Duals Integration Stakeholder Workgroup meetings. The Department of Health Care Services (DHCS) released Key Takeaways documents from these two meetings on the MLTSS and Duals Integration Stakeholder Workgroup website.[1]

Sarah Steenhausen (SCAN Foundation) – May and June MLTSS & Duals Integration Workgroup Overview and Key Takeaways

Sarah Steenhausen, Director of Policy and Advocacy at The SCAN Foundation, opened the meeting by discussing the May 6 MLTSS and Duals Workgroup meeting. The May workgroup provided a deep dive into dementia care and California Advancing and Innovating Medi-Cal (CalAIM), and the importance of early interventions within the disease progression, particularly as the incidence of Alzheimer's and dementia is increasing and the population is aging.

Sarah provided an overview of promising practices and opportunities to develop requirements for specialized dementia care that were discussed during the meeting, including: early detection and diagnosis for dementia care; a focus on person-centered care; the importance of assessment (to ensure a health risk assessment includes cognitive screening and follow up with a primary care physician); assessing for caregiver needs; training for care managers; and a focus on building infrastructure

---

[1] Please contact info@calduals.org with any questions, comments, feedback, or clarifications on this document, particularly if you feel you have been inadvertently mischaracterized.

(including resources like Alzheimer’s Day Care Resource Centers and Geriatric Emergency Departments).

Sarah then gave a brief overview of the June 10 MLTSS and Duals Workgroup meeting, which focused on the central role that care coordination plays in streamlining access to services, as well as lessons learned from Cal MediConnect (CMC) and how these can be transitioned into the new mandatory Managed Care Plan (MCP) and Dual Eligible Special Needs Plan (D-SNP) statewide model. DHCS provided an overview of their vision on coordinating and integrating care for dual eligible individuals, followed by brief presentations from expert panelists on lessons learned from CMC related to care coordination.

Sarah highlighted key takeaways from breakout room discussions, including both lessons learned from CMC for care coordination and opportunities for improvement. Many of the lessons learned were focused on the care coordinators and included: ensuring beneficiaries were aware that they had a care coordinator, who their care coordinator is, and what their responsibilities are; a discussion on workforce issues including cultural responsiveness and linguistic needs of enrollees; and identifying a single point of contact, and the idea that “more care coordination does not mean better care coordination.” Several stakeholders also shared the importance of providing patient-centered care and improving data sharing between providers, plans, counties and more. The opportunities that were discussed in the breakout rooms covered several different topic areas, including: improving communication channels; better education for members, their families, and care coordinators; the opportunities for virtual care (including telehealth) however continuing to emphasize a patient-centered holistic approach; and increasing partnership and coordination at all levels including between health plans, Skilled Nursing Facilities (SNFs), Long-Term Care (LTC) facilities, and mental health facilities.

Care Management Models

During the next portion of the workgroup meeting DHCS reviewed the D-SNP and Medi-Cal care management models, including some of the differences between care coordination in D-SNPs and in Medi-Cal Enhanced Care Management (ECM).

DHCS – D-SNP and Medi-Cal Care Management Models

Michel Huizar, from the Managed Care Quality and Monitoring Division at DHCS presented on the D-SNP and Medi-Cal care management models, their approaches to care coordination, and some of the key differences between them. For example, in D-SNPs, care coordination is available to all members. In Medi-Cal MCPs members may receive basic case management, but ECM is only available to members with the most complex health and social needs that are defined as “Populations of Focus.” D-SNPs must coordinate with Medi-Cal benefits, including managed care and carved-out services such as Specialty Mental Health Services, Substance Use Disorder Services, and In-Home Supportive Services (IHSS). Michel added that the development of the 2023 State Medicaid Agency Contract (SMAC) for D-SNPs over the next six months will be the venue for setting requirements for D-SNPs around care management. For Medi-Cal MCPs, ECM core services are defined in the MCP contract. MCPs are expected to coordinate with all carved out services for patients with ECM.

Finally, Michel discussed key considerations for care coordination for duals including: coordinating and aligning all Medicare and Medi-Cal benefits, providers, and more, as well as data sharing between entities in and out of managed care; ensuring clarity on the contractual lead of the care coordination as well as the beneficiary level care coordination lead; scaling care coordination dependent on beneficiary need (baseline needs to higher level needs, that may have ECM); and requirements to include in the D-SNP SMAC or the MCP contract.

Alexandra Kruse (Center for Health Care Strategies) – D-SNP Care Management Models in Other States

Alexandra (Alex) Kruse, Associate Director of Integrated Care State Programs at the Center for Health Care Strategies, presented on D-SNP care management models from a national perspective. Alex began by presenting background information on the D-SNP Model of Care (MOC), including how in states with aligned D-SNP/MLTSS programs, D-SNP care management models can reflect both Centers for Medicare and Medicaid Services (CMS) and SMAC requirements. Care coordination goals can be advanced by states by using their SMAC to specify care coordination requirements for D-SNPs, and by identifying the care coordination requirements D-SNPs must address in their Model of Care to CMS.

Alex provided a deeper dive into some of the key findings on care management standards across different states and explained that there is typically a greater specificity that states require for D-SNPs on some particular elements of care coordination such as: managing care transitions; data requirements and reporting; health risk assessment (HRA) integration and sharing; family and other caregiver involvement and assessment; and addressing social determinants of health.

Next, Alex presented on key findings around assessments and explained that D-SNPs are required to administer an initial HRA within 90 days of enrollment and annually after that. Although states typically don't specify the HRA tool D-SNPs need to use, states do require different things for HRAs such as: capturing certain types of information; being administered within a certain period of time around enrollment; being administered face-to-face for certain enrollees; and integrating administration of Medicaid assessment tools and data. Finally, Alex discussed the different D-SNP requirements for Individualized Care Plans (ICP) and Interdisciplinary Care Teams (ICTs).

Report Outs and Discussion after Breakout Rooms

After the speakers presented, the workgroup split into small breakout rooms where attendees discussed the most important elements of care coordination for dual eligible individuals and the role that the SMAC could play in defining these elements. Attendees also discussed special considerations for certain populations and/or programs that they work with (for example, beneficiaries with dementia, individuals with disabilities, and more). Appendix A includes notes from all breakout rooms.

Breakout rooms were asked to list the three most important elements of care coordination and top three special considerations for certain populations and/or programs and to select a member of the group to report out to the larger group. Below are key takeaways from this portion of the meeting.

Group Report Outs

Participants reported out themes from discussion in their breakout rooms, both verbally and in the chat:

- **Hilary Haycock (Aurrera Health Group)** reported out from the room that they were in and brought up that care coordinators should meet the unique needs of members (linguistically, culturally, etc.), and act as a single point of contact. HRAs should focus on the member experience and the state should focus on outcomes for the member experience and monitoring.
- **Anastasia Dodson (DHCS)** reported out for the room that they were in and brought up that assessments should collect information about all systems (even outside of D-SNPs and aligned enrollment) and that there needs to be additional explanation about acronyms for different systems and what they mean. The group discussed the number of phone calls that dual eligible individuals receive, and that providers and health plans should be more strategic about what phone

calls go out to beneficiaries. Anastasia raised having more diversity in the workforce (particularly by language). Finally, Anastasia highlighted churn rate of how many dual eligible individuals are losing Medi-Cal eligibility each year and how to reduce churn specifically for dual eligible individuals.

- **Sarah Steenhausen (SCAN Foundation)** said their group discussed beneficiary outreach, individuals not knowing what care coordination is, and developing common language for plans to use to reach out to beneficiaries. Sarah brought up workforce issues and ensuring care coordinators speak languages that reflect the population they serve and that they are culturally responsive. Regarding the SMAC, the group discussed specifying what a comprehensive care plan should look like, and the expectation that it should identify behavioral health, functional needs, and access to services that may not be provided by the health plan but must ensure there is coordination and a closed loop referral process.
- **Aaron Starfire (Aetna)** reported that there should be better coordination across different programs. The group discussed what DHCS could do to coordinate care coordinators and highlighted the potential use of technology to provide a cleaner front end for dual eligible individuals consistent with a “No Wrong Door” approach. Finally, Aaron mentioned that one of the populations of focus their group discussed was people with a behavioral health diagnosis, and how the services overlap with regional centers and other county programs.
- **Kristin Smith (County of San Diego)** brought up the importance of clear standards for the role of care coordinators. The group discussed how the Community Information Exchange is beyond a referral platform but is a legal framework for Home and Community Based Services (HCBS) to data share and that it would be good to involve health providers. However, a potential downside to this could result in double entry into Electronic Health Records. Kristin brought up the importance of standardized templates for HRAs, and for storage aspects of the data, particularly for delegated providers.
- **Jan Spencley (San Diegans for Healthcare Coverage)** shared that their group discussed the importance of taking the wants, needs, and preferences of dual eligible individuals into consideration during the implementation of the new statewide D-SNP and MCP structure. Jan also mentioned that the roles of care coordinators should be clarified, families should be included in the process of care coordination, and someone should help beneficiaries with diminished capacity if they do not have family or caregivers available. Finally, the group discussed that care managers should not only help facilitate referrals to care and services, but also ensure that services are actually scheduled and delivered.

- **Maya Altman (Health Plan of San Mateo)** brought up how important it is that care coordinators understand both Medicaid and Medicare benefits, and that they're able to communicate that information to the beneficiary. There is a need for a strong state role with In Home Supportive Services (IHSS) to ensure care coordination with plans, similar to individuals with behavioral health needs.

DHCS – Policy Updates

Anastasia Dodson highlighted aspects of the Health Omnibus Trailer Bill, which includes CalAIM provisions related to the statewide D-SNP/MLTSS policy. Anastasia discussed that in 2022, MCPs or subcontracted plans in CCI counties can transition beneficiaries in D-SNP lookalike plans into their affiliated D-SNPs, if those D-SNPs were approved prior to January 1, 2013.

There are additional notable pieces of the trailer bill for 2023, including: the statewide mandatory enrollment of dual eligible individuals into MCPs; the sunsetting of Cal MediConnect on December 31, 2022, and transition of members into D-SNPs with aligned MCPs on January 1, 2023; and that Medicare choice will drive the Medi-Cal plan enrollment under aligned enrollment. Anastasia also mentioned that the Trailer Bill includes language for an Ombudsman program, and that DHCS will look into this further. There are additional requirements around network adequacy, and continuity of care in the trailer bill language that DHCS will be soliciting stakeholder input on in the future.

Finally, Anastasia mentioned that in the non-CCI counties, the trailer bill language pushes out the requirements for MCPs to start up a D-SNP by one year (to 2026), and DHCS will conduct a feasibility study of D-SNPs in certain non-CCI counties. DHCS is keeping a close eye on comments for additions to the 2023 D-SNP SMAC and will continue to work in partnership with stakeholders.

Appendix A: Key Takeaways from Breakout Rooms

Key Takeaways from Question 1: What are the most important elements of care coordination for dual eligible beneficiaries? What role could the State Medicaid Agency Contract (SMAC) play in defining these elements?

Room One:

1. Assigning care coordinators that meet the unique needs of a member (culture, language, gender, lived experience) and who can serve as the single point of contact.
2. Establishing a floor of standards for health risk assessments (HRAs) that focus on the member experience and are standardized more broadly while allowing flexibility for plans.
3. Focusing on outcomes for any plan reporting or monitoring.

Room Two:

1. Including caregivers (as appropriate) in family-centered care planning and assessing the needs of caregivers.
2. Clarification of acronyms. This is a point of confusion among providers and beneficiaries - people do not know what acronyms mean unless they are working on the programs every day.
3. Assessments should collect information about all programs (e.g., IHSS).
4. There are often too many phone calls from too many different providers/programs. Phone calls and outreach to beneficiaries should be strategic, especially with older folks.

Room Three:

1. Closed loop referrals are important to ensure that beneficiaries are getting the services they need.
2. Beneficiaries need to be given more information about what the care coordinator’s role is, what a care coordinator can offer, and what care coordination is.
3. Data sharing and interoperability are important aspects of care coordination. There should be an effort to decrease excess data collection and duplication.

Room Four:

1. There is a need for better coordination across multiple benefit streams, carved out elements, and county run programs.

2. Improved training for care managers.
3. Providing technology supports to streamline care coordination.

Room Five:

1. Patient needs and preferences should be included in the development of their care coordination.
2. Clear communication about roles and coordination among coordinators. This includes ensuring beneficiaries understand who their primary, secondary, etc., contact is.
3. More follow through on outcomes is needed. This should go beyond just referring without follow up.

Room Six

1. Bi-directional data sharing for care coordinators.
2. Completing HRAs and developing an appropriate care plan with time-bound goals.
3. Working to build trust with the patient (for example: there is a model in Vermont where care is provided by a nurse and community health worker at a shared housing facility).

Room Seven

1. There should be a focus on language requirements for specific populations, both linguistic needs and common language/literacy levels.
2. Comprehensive care plans that are shared with PCPs, including identification of medical and social supports, behavioral health, and social determinants of health.
3. Way for counties to organize data sharing with health plans.

Room Eight

1. Care coordination works best when it is tailored to the needs of the beneficiary receiving the care and services.
2. The focus should be on outcome requirements, not the process requirements.
3. Care coordinators need to have a seamless understanding of what is available under Medicare and Medicaid programs to avoid overlap and ensure the beneficiary is getting full benefits.

Key Takeaways from Question 2: Are there any special considerations for your population or program (e.g., beneficiaries with dementia, individuals with disabilities, etc.)?

Room One:

1. Consideration of training care coordinators for sub populations (dementia, behavioral health, etc.)
2. Setting an expectation around the amount of time care coordinators will spend with beneficiaries face-to-face.

Room Two:

1. There is a need for more diversity in the workforce, particularly in language.
2. The inclusion of cognitive status questions in HRAs.
3. Churn rate: How many dual eligible individuals are losing eligibility each year because of asset tests and how might that change? In the meantime, what can we do to avoid people being disenrolled and potentially causing disruptions for patient and care teams?

Room Three:

1. Beneficiaries with diminished decision-making capacity and no family or caregivers, such as those in SNF care or those suffering from dementia, need person-centered programs and policies designed to support this unique need.
2. Beneficiaries experiencing homelessness need low threshold services such as street medicine and other considerations since it is difficult for them to access care.
3. A large service gap exists between IHSS and SNF care. Beneficiaries with needs in this area should have new services to support them and ensure they have coverage for the services they need.

Room Four:

1. Dual eligible individuals with a behavioral health diagnosis.
2. Partnerships with regional center clients, providing consistent point of contact, and establishing a consistent care plan.
3. Dual eligible individuals experiencing homelessness.

Room Five:

1. Ensuring a family member or caretaker is included in the day-to-day care management. This is particularly important for individuals with dementia.

Room Six:

1. Individuals experiencing homelessness have unique considerations (e.g., income instability, SUD, post-traumatic stress disorder).
2. Dual eligible individuals whose first or preferred language is not English.

Room Seven:

1. Access to mental health services for people with dementia and the intersection with county behavioral health issues. Not just dementia but broader neuro-cognitive disorders. How can people with co-occurring mental health needs access county behavioral health services?
2. Individuals experiencing homelessness' ability to access to care and developing outreach and care coordination strategies.
3. Assisting individuals that have spent extended time in SNFs transition back to community.

Room Eight:

1. More robust identification of older adults that would benefit from services.
2. Better state coordination with IHSS.