Attachment A - Money Follows the Person (MFP) Supplemental Funding Proposal

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Gap Analysis and Multi-Year Roadmap

1. Population and provider composition

Enrollees: Conduct a robust analysis of the composition of enrollees in the various HCBS/(M)LTSS programs and service delivery systems across the state, to define at a granular level who is receiving which services and where, with the intention of identifying inequities in access to and use of services.

This analysis would examine the following:

- The geographic distribution of enrollees receiving services by county or sub-county;
- The demographics (race/ethnicity, age, language, sex, etc.) of enrollees in each type of HCBS/LTSS program, compared to demographic composition of the overall population and the Medi-Cal enrollee population in that county or sub-county region;
- The use of these services among those dually eligible for Medicare and Medi-Cal and the Medi-Cal-only population.

Providers: Conduct a statewide comprehensive provider assessment to identify service capacity, ensure providers' ability to provide culturally competent care, and highlight specific regions/locales that require additional access to services.

This analysis would examine the following:

- The geographic distribution of HCBS providers by county or sub-county;
- Review current Cultural Competency and Implicit Bias provider trainings and provide recommendations on effective ways to tailor services to meet clients' social, cultural, and linguistic needs;
- Identify providers who integrate HCBA medical and behavioral health services;
- Evaluate how providers and services have been impacted by the pandemic to determine if the State could provide any additional resources or assistance;
- Pinpoint which providers require additional technical assistance through provider or client surveys as well as low caseload numbers.

2. Unmet need

   - Assess unmet need for HCBS/(M)LTSS, comparing today's service mix and utilization by county or regional level with the desired core service mix and capacity/access.
   - Building on the Master Plan on Aging (MPA) LTSS subcommittee's recommendations on the minimum core service mix that should be available across the state, define access/capacity standards for these services.
   - Assessing and implementing changes to reimbursement rates and payment methodologies to expand HCBS provider capacity and improve service quality using standardized metrics to measure performance.
   - Collaborate with stakeholders that includes dual eligible beneficiaries, managed care health plans, providers, mental health representatives, county health and human services agencies, designated representatives of in-home supportive services personnel, and other interested stakeholders to determine prioritization of unmet needs.

3. Coordination of Care (include coordination across social determinants of health i.e. housing/food insecurity/etc.)
   - Identify gaps in the intersection between HCBS/LTSS providers and Managed Care plans and identify solutions on the path to the long term goal of program integration. Key areas to include/consider are:
     - Privacy/compliance - Support for infrastructure and training to promote a HIPAA compliant, data and information management system to facilitate collaboration between programs, providers, and systems of care
     - Data gaps - ID opportunities for multi-directional and standardized reporting to support care coordination, person-centered planning, and positive health outcomes
     - Contracting/MOUs - Develop boiler plate language to reduce the contracting burden and ensure a consistent set of expectations across health plans and providers
     - Providing technical guidance to community providers in model/infrastructure development to meet MCP requirements (including, but not limited to reporting, claims and encounters, credentialing, and provider certification)
     - Providing capacity support to providers to expand operations to serve the ECM/ILOS population
   - Evaluation of transition to MLTSS
     - Review CalAIM's plan to shift long-term care, out of Medi-Cal's fee-for-service delivery system and into managed care. CalAIM established an ILOS framework to help create HCBS networks throughout the State. The ILOS framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. The analysis could include the following:

1. Readiness of Medi-Cal managed care programs to incorporate the expanded responsibilities and how to best streamline the transition process.
2. Identify the complexities that could arise as providers meet CalAIM's new requirements. Such barriers may include, but are not limited to contractual processes, billing practices, and licensing/credentialing requirements.
3. Identify any risks or gaps in services clients may face during the transition.
4. Develop targeted technical assistance to providers during this shift.

- Identify gaps and opportunities for increased collaboration/partnership with providers of other social determinants of health (i.e. housing and food security).
    - Analyze current housing resources available for long-term Skilled Nursing Facility (SNF) residents. Identify housing barriers long-term SNF residents face transitioning to a community-based setting and provide actionable recommendations to alleviate the barriers without disrupting services.
- Assess pathways for increased coordination with and supports for unpaid caregivers.
- Identify long-term goals for program integration including the development of integrated payment models.

4. Quality measurement and monitoring

- Examine current capabilities and gaps in California's approach to quality measurement and monitoring of HCBS/(M)LTSS programs and services to identify opportunities for improvement.
- Review and analyze historical monitoring data identifying gaps in quality and provide recommendations to bridge evaluation gaps between programs; which may include identification of a common set of performance metrics across programs, providers, and systems of care.
- Assess current provider trainings to help focus future training and resources on continuous program quality improvement.
- Pinpoint areas to combine quality management and reporting processes to ensure program integrity and decrease administrative costs.

5. Single point entry system

    - Identify the gaps in the intake and enrollment process to help potentially create a streamlined procedure, so eligible clients can find what they need regardless of which provider, program, or system of care they contact first -- whether through the health care system, the public benefits system, the disability service system, including Regional Centers, or the community-based services system.
    - Evaluate the feasibility of a universal baseline assessment to assess base level of need (including nursing facility level of care) and to direct beneficiaries to appropriate programs.
    - Calculate costs to develop a basic statewide information and referral system for increased access and entry to supports and services options. This could support CDA's efforts to create a statewide No Wrong Door System to improve enrollment structure at the State level, create a streamlined intake process, and potentially help integrate information management systems.