



Long Term Services and Supports (LTSS) Convening

California Advancing and Innovating Medi-Cal
(CalAIM)

February 24, 2020



Agenda

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|-------------|--|
| 1:00 – 1:15 | Welcome, Introductions, and Agenda Overview |
| 1:15 – 2:30 | Expanding Access to Integrated Care for Dual Eligible Californians |
| 2:30 – 2:45 | Break |
| 2:45 – 3:45 | 2021 D-SNP Information Sharing Presentation and Panel |
| 3:45 – 4:45 | Consumer Messaging and Protections |
| 4:45 – 5:00 | Public Comment |
| 5:00 | Closing |



Expanding Access to Integrated Care for Dual Eligible Californians

February 24, 2020



CalAIM Overview

- Comprehensive framework for the upcoming waiver renewals that encompasses a broader delivery system, and program and payment reform across the Medi-Cal program. Includes initiatives and reforms for:
 - Medi-Cal Managed Care
 - Behavioral Health
 - Dual Eligibles and Managed Long-Term Services and Supports (MLTSS)
 - Dental
 - Other County Programs and Services



CalAIM Goals

- Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.



Long Term Services and Supports Goals

- Improved Care Integration;
- Person-Centered Care;
- Leverage California's Robust Array of Home- and Community-Based Services;
- Build on Lessons and Success of Cal MediConnect (CMC) and Coordinated Care Initiative (CCI); and
- Support Governor's Master Plan for Aging.



Roadmap

- Dual Eligible Special Needs Plans (D-SNPs)
 - Cal MediConnect Transition to Aligned Enrollment
 - D-SNP Integration Requirements
 - Transitions and Enrollment Policies
- Medi-Cal
 - Mandatory Medi-Cal Managed Care
 - Long-Term Care Carve-In
 - In Lieu of Services (ILOS)
- Timeline



Aligned Enrollment

- Vision: Dual eligible beneficiaries to receive more integrated and coordinated care through aligned D-SNP and Medi-Cal Managed Care Plans (MCPs)
 - D-SNPs are Medicare Advantage health care plans that provide specialized care to duals and offer wrap-around services but must also maintain a State Medicaid Agency Contract (SMAC) with DHCS
- Beginning in 2023 in CCI counties
- Phased-in approach for non-CCI county MCPs
- Technical MCP workgroup starting in Spring 2020



D-SNP Integration Requirements

- Starting with 2021 federal D-SNP information sharing policy, building toward alignment with CalAIM model of care requirements
- Other requirements to phase-in starting in 2023:
 - Integrated member materials
 - Include dementia specialists for care coordination
 - Coordination with carved-out LTSS benefits
 - Consumer involvement in existing D-SNP governance structure
 - DHCS/CMS contract management teams and audit coordination



Transitions & Enrollment Policies

- Aligned Enrollment
- Voluntary Enrollment
- Default Enrollment
- Crosswalk Enrollment
- “Look-Alike” Plans
- D-SNPs without Medi-Cal Contracts in Service Area
- Delegated MCPs
- Marketing/Brokers
- Limiting Churn



Transitions & Enrollment Policies

- Aligned Enrollment:
 - Goal: Dual eligibles are enrolled in “aligned” D-SNP and MCP operated by same organization
 - D-SNPs only allowed to enroll new members who are in aligned MCP
 - Begins in CCI counties on January 1, 2023; phases into other counties by 2026
 - Beneficiaries already in a non-aligned D-SNP when aligned enrollment is effective may stay; no new enrollment into non-aligned D-SNPs
- Voluntary Enrollment:
 - Medicare managed care is OPTIONAL and voluntary
 - Individuals in Medicare FFS will not be passively enrolled into Medicare managed care, they will remain in Medicare FFS
 - Individuals in a Medicare managed care product will remain enrolled in that MA or D-SNP plan



Transitions & Enrollment Policies

- Default Enrollment
 - Aligned D-SNPs may automatically enroll existing MCP members into the plan when they become Medicare eligible (through age or disability)
- Crosswalk Enrollment
 - Transition duals from CMC into aligned D-SNP and MCP operated by the same parent company
 - Transition duals from a D-SNP that is no longer available into another comparable D-SNP, for example if Medi-Cal reprocurement changes which D-SNPs provide aligned enrollment
 - Existing, recent HRAs and care plans will transition with crosswalk members
- “Look-Alike” Plans
 - DHCS will request CMS approval to crosswalk enrolled in MA “look-alike” plans into aligned D-SNPs



Transitions & Enrollment Policies

- D-SNPs without Medi-Cal Contracts in Service Area
 - Duals enrolled in a non-aligned D-SNP (without a matching MCP) will be able to stay in that D-SNP
 - The D-SNP will not be allowed to enroll new members after aligned enrollment takes effect in the county
- Delegated MCPs
 - DHCS will work with CMS to find a path for MCPs without a direct contract with DHCS to participate in aligned enrollment
- Marketing/Brokers
 - Require D-SNPs to target marketing to MCP enrollees
 - Enhance training for brokers on integrated care, health plan navigation, and cultural competency
- Limiting Churn
 - Allow 6 month deeming period in D-SNPs



Medi-Cal Managed Care and Managed Long-Term Services and Supports (MLTSS)



Mandatory Medi-Cal Managed Care & MLTSS

- 2021: MLTSS Expansion
 - Mandatory Medi-Cal managed care for non-duals
 - Long-term care carve-in for non-duals and duals already in managed care
 - In Lieu of Services added to Medi-Cal managed care
- 2023: Full- and partial- benefit duals mandatory in Medi-Cal managed care
 - Including LTC residents previously in FFS Medi-Cal



Mandatory Medi-Cal Managed Care & MLTSS

- DHCS is leveraging lessons learned to support transitions to Medi-Cal managed care and MLTSS:
 - Developing long-term care carve-in best practices tip sheet based on CCI transition.
 - MLTSS evaluation efforts are underway to look at how the expansion of mandatory Medi-Cal managed care and MLTSS impact utilization and health outcomes.



Medi-Cal Managed Care & Long-Term Care

The LTC carve-in includes:

- Skilled nursing facilities
- Subacute facilities
- Pediatric subacute facilities
- Intermediate care facilities
 - ICF/DD (Developmentally Disabled)
 - ICF/DDH (Habilitative)
 - ICF/DDN (Nursing)
 - Specialized rehabilitative services in skilled nursing facilities and ICFs

DHCS will provide technical assistance to plans on long-term care carve-in.



DHCS Guidance and Oversight for LTC Carve-In

- MCPs will contract with providers to build their networks
- DHCS released information about LTC carve-in in September 2019, to allow adequate time for plans and providers to prepare and establish contracts.
- DHCS is working on minimum requirements for MCPs to demonstrate readiness.
- There are existing MCP timely access standards for SNFs that DHCS monitors and includes in Annual Network Certification. In 2021, DHCS will include this validation in the EQRO timely access study.



Medi-Cal Managed Care In Lieu of Services

- Housing Transition Navigation Services; Housing Deposits; Housing Tenancy and Sustaining Services
- Short-term Post-hospitalization Housing
- Recuperative Care (Medical Respite); Sobering Centers
- **Respite Services**
- **Day Habilitation Services**
- **Nursing Facility Transition/Diversion to Assisted Living Facilities**
- **Community Transition Services/Nursing Facility Transition to Home**
- **Personal Care and Homemaker Services**
- **Home Modifications**
- **Meals/Medically Tailored Meals**

Year	Policy Change
2021	<ul style="list-style-type: none"> • Statewide integration of long-term care (LTC) into Medi-Cal managed care • Statewide mandatory enrollment of non-dual eligible Medi-Cal populations into Medi-Cal managed care • Voluntary in lieu of services (ILOS) in all Medi-Cal Managed Care Plans (MCPs) • Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties • All existing D-SNPs must meet new regulatory integration standards effective 2021
2022	<ul style="list-style-type: none"> • December 31: Discontinue CMC and CCI
2023	<ul style="list-style-type: none"> • Statewide mandatory enrollment of full- and partial- dual eligible beneficiaries into MCPs for Medi-Cal benefit, including LTC residents • Aligned enrollment begins in CCI counties and MCPs in those counties must stand up D-SNPs; All CMC members cross walked to matching D-SNP and MCPs, subject to CMS and state requirements
2025	<ul style="list-style-type: none"> • Aligned enrollment implemented in all non-CCI counties; All MCPs required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit)



Questions?



D-SNP Information Sharing Presentation and Panel



Speakers

- Paul Precht, Senior Policy Advisor, Medicare-Medicaid Coordination Office, CMS
- Kerry Branick, Deputy Group Director, Medicare-Medicaid Coordination Office, CMS



California's Information Sharing Policy Proposal

- All non-FIDE and HIDE D-SNPs must notify a member's MCP of hospital and Skilled Nursing Facility (SNF) admissions for high-risk enrollees to improve coordination of care during transitions of care.
- Target population is likely to be members receiving Community-Based Adult Services.
- Technical workgroup developing recommendations around notification time frame, mechanism, and data package.

Implementing New D-SNP Information-Sharing Requirements

February 24, 2020

Background on D-SNP Information Sharing Requirements

Bipartisan Budget Act of 2018

- The Act includes several provisions that impact D-SNPs and Medicare-Medicaid alignment
 - Permanently authorizes MA SNPs, including D-SNPs, Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs)
 - Requires increased integration of D-SNP benefits and appeals and grievance processes
 - Requires that CMS establish new minimum integration standards
 - Designates MMCO as the dedicated state point of contact to address D-SNP integration misalignments

New Integration Criteria for D-SNPs

- D-SNPs must meet at least one of the following criteria effective CY 2021
 - 1) Cover Medicaid behavioral health services and/or LTSS to qualify as either:
 - A Fully Integrated Dual Eligible (FIDE) SNP, or
 - A Highly Integrated Dual Eligible (HIDE) SNP
 - 2) Notify state and/or its designee(s) of Medicare hospital and skilled nursing facility (SNF) admissions for group of high-risk enrollees to improve coordination during transitions of care
- States will need to work with D-SNPs on new contract provisions ahead of the July 1, 2020 state contract submission deadline

Source: CMS. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." *Federal Register*, April 16, 2019, pp.15710-15718 and 42 CFR 422.107(d)) p. 15828. Available at: <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

Hospital and SNF Admission Notification Requirement

- **Goal:** Improve coordination of Medicare and Medicaid services between settings of care for at least one group of high-risk full-benefit dual eligible individuals
 - D-SNPs (or a designated entity) must notify the state (and/or individuals/entities designated by the state)
 - State determines:
 - Who is “high risk”
 - Who will be notified
 - The timeframe for the notification
 - The notification method
- Requirement does not apply if D-SNP is a HIDE or FIDE SNP

Source: 42 CFR §422.107(d), as amended by the Final Rule entitled “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” published at 84 FR 15828.

Review of State Approaches for D-SNP Information Sharing

Approaches to Information Sharing

- **Potential populations.** States have broad flexibility to define a target population, including all D-SNP enrollees or a targeted subset, such as:
 - Home- and community-based services waiver participants
 - Medicaid health home program participants
 - Another group defined by the state Medicaid agency
- **Potential mechanisms.** States determine the notification method, entities to be notified, and process that will be used, including use of existing systems and/or Health Information Exchanges (HIEs), such as:
 - D-SNP-to-state designee (i.e., via reports to Medicaid MCO or FFS care manager)
 - D-SNP receives alerts from an event notification system or gathers admission data from an HIE platform and can share it with state designated entities
- In identifying a high-risk population and entities to be notified states should consider whether care management infrastructure is available to respond

Information Sharing Directly Between D-SNPs and Medicaid MCOs

Parameter	Pennsylvania
Target Population	D-SNP FBDE enrollees, in both affiliated and unaffiliated D-SNPs
Entity Notified	Community Health Choices (CHC) MCO service coordination staff
Timeframe for Notification	Within 48 hours of specified events
Notification Method	D-SNP to Medicaid MCOs/MLTSS plans
Linkage to LTSS Goals or HCBS Waiver Operations	Linked to MLTSS requirements for timely post-discharge re-assessment/care plan updates and NF transitions
Early Lessons	<ul style="list-style-type: none"> • Information sharing to support care transitions can be linked broader MLTSS goals (i.e., performance improvement projects) • D-SNPs need a relatively easy way to identify the state designated target population to ensure timely sharing of data • Setting up business agreements between D-SNPs and Medicaid MCOs takes considerable time – a standard agreement may help

Additional details on state approaches can be found in, “Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations.” ICRC, August 2019.

Information Sharing Between D-SNPs and Medicaid MCOs via State Portal

Parameter	Tennessee
Target Population	D-SNP FBDE enrollees, in both affiliated and unaffiliated D-SNPs
Entity Notified	State and TennCare MCO
Timeframe for Notification	Within 2 business day of the “anchor date” ¹
Notification Method	Daily census reports via state-developed, secure portal
Linkage to LTSS Goals or HCBS Waiver Operations	MCOs work with D-SNP to facilitate timely HCBS, and ensure services are provided in the preferred and least restrictive setting
Lessons	<ul style="list-style-type: none"> • State and plans found value in working together to determine how data would be collected, shared, and used to improve care • Ongoing implementation meetings across plans fostered relationships that carried forward into coordination of care

Additional details on state approaches can be found in, “Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations.” ICRC, August 2019.

¹ TennCare defines the anchor date as, “The date of receipt of notification by the Contractor of upcoming (i.e., planned) or current inpatient admissions and current or recently completed observation days or emergency department visits. The anchor date is not included in the calculation of days within which the Contractor is required to take action.”

Information Sharing via Established Health Information Exchange Platform

Parameter	Oregon
Target Population	D-SNP FBDE enrollees, in both affiliated and unaffiliated D-SNPs
Entity Notified	Medicaid MCO or state care management (CM) staff and providers
Timeframe for Notification	Timely
Notification Method	Event notification system (ENS) and web portal
Linkage to LTSS Goals or HCBS Waiver Operations	State pays subscription for HCBS waiver care management agencies alerts and populates web portal with HCBS contacts
Impacts to Date	<ul style="list-style-type: none"> • Oregon has seen a decrease in hospital visits by patients with high utilization patterns and an increase in care coordination • A behavioral health provider with past difficulty getting admission notifications leveraged alerts to ensure 99 percent of patients were receiving timely follow-up

Additional details on state approaches can be found in, “Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations.” ICRC, August 2019.

Key Design and Implementation Questions

Parameter	Key Questions
D-SNP Landscape	<ul style="list-style-type: none"> Which D-SNPs are operating in the state and will they all be required to share admissions data with the state effective January 2021?
High-Risk Population and Receiving Entities	<ul style="list-style-type: none"> Which group(s) of high-risk FBDE beneficiaries would benefit? What entity(ies) will receive the admission notifications to support care coordination? Can Medicaid care management (CM) resources (i.e., HCBS waiver care managers, local CM agencies, or MCOs) act on data received for this group? What mechanism will be used by D-SNPs to identify target enrollees in the high risk group?
Timeframe for Notification	<ul style="list-style-type: none"> What are reasonable timeliness standards, given the selected notification method(s) and information technology capacities of sending and receiving entities?
Notification Method	<ul style="list-style-type: none"> What mechanisms are available in the state for notification? Are there notification systems, portals, or file exchange processes already in place that can be leveraged?
Contracting and Oversight	<ul style="list-style-type: none"> What contract language needs to be added to the state D-SNP contracts? How will the state work with D-SNPs and receiving entities to establish new processes? How can the state monitor any impacts of admission data sharing on Medicaid and D-SNP care transition efforts?

For details see: “Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation.”



Questions?



Consumer Messaging and Protections



Cal MediConnect Ombudsman – Lessons Learned

JACK DAILEY, HCA COORDINATOR

Cal MediConnect Ombudsman



- Independent and local ombudsman services for Cal MediConnect members
- Local and Trusted partners - Legal Aid Society of San Diego, BayLegal, Legal Aid Society of San Mateo, Neighborhood Legal Services of Los Angeles, and Inland Counties Legal Services
- Serving 7 CMC demonstration counties since 2014
- One statewide toll-free number - (855) 501-3077

Lessons Learned from CMC



Enrollment and engagement phase

- Consumer, provider, and stakeholder engagement is vital, especially among LEP communities
- Consistent and coordinated messaging, education, and notices
- Limit or avoid passive and default enrollment
- Maintain Special Enrollment Periods (SEPs)
- Strong continuity of care protections
- Maintain independent consumer assistance programs/ombuds

Lessons Learned from CMC



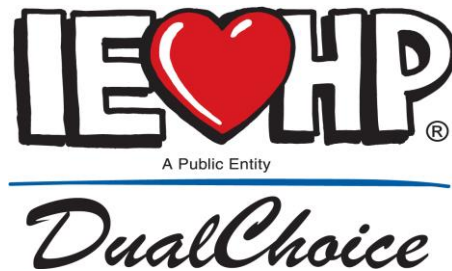
Ongoing, D-SNPs should –

- Demonstrate network readiness at the plan and group level
- Exert accountable oversight over provider networks, delegated plans/groups, and supplemental plans
- Ensure accountable care coordination, engaged IDTs, and integrated utilization management
- Use and report meaningful data metrics, especially around LTSS utilization
- Maintain robust stakeholder engagement and input opportunities to mitigate problems

Thanks and Wrap-up

- Thank you for the opportunity to discuss our lessons learned
- Contact information:
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DSNP TO CCI TRANSITION



Arif Shaikh, Director of Compliance and Regulatory Affairs

Overview

- IEHP serves both Riverside and San Bernardino Counties

Line of Business	Membership
Medi-Cal	1,200,618
Cal MediConnect	28,605
Total Membership	1,229,223

DSNP/CMC Timeline

Event	Date
DSNP begins	January 1, 2007
Cal MediConnect begins	June 1, 2014
Voluntary enrollment by birthdate begins	June 1, 2014
Passive enrollment of remaining eligible DSNP Members	January 1, 2015
DSNP Sunset	December 31, 2015

Successes

- Communication
 - Outbound calls from the Plan
 - Reminded members of enrollment deadlines
 - Provided contact information for questions/concerns
- Enrollment
 - IEHP is the largest Medicare-Medicaid Plan nationwide
 - Streamline Enrollment
 - Beginning October 2016, DHCS allowed Plans to enroll beneficiaries who were enrolled with the Plan for Medi-Cal Managed Care
 - CCI Stakeholder Community
 - Partnered with Molina to reach out to and engage advocates and Members within the Riverside/San Bernardino area

Challenges

- **Communication**
 - Initial notifications (90/60/30 days) were sent directly from DHCS
 - Members either disregarded or didn't understand notifications

March 2015 CMC Enrollment			
	Enrolled	Opt-Out	Disenrolled
IEHP	50%	37%	13%
California	37%	49%	14%

Transition

- Seamless crosswalk of members
 - Communication on transition should come from the Health Plan
- Enrollment process handled by Plan
 - Does not require a hand-off of the member to another entity to process enrollment
- DSNP has been permanently authorized – Plan is sustainable compared with a Demo
- Crosswalk of HRAs from CMC to DSNP

Lessons Learned and Promising Practices from CCI Implementation

Ryan MacDonald, MHA
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At the intersection of health care policy, politics and communications.

Today's Topics

- Lessons Learned from CCI Implementation
- Promising Practices from CCI Implementation
- Key Takeaways for the DSNP Transition

Lessons Learned: Enrollment

- Beneficiaries and those who advise beneficiaries found passive enrollment:
 - Confusing
 - Frustrating
- This caused:
 - Nervousness
 - Beneficiaries to opt out of the program
- Multiple plan options, choices between Cal MediConnect and MLTSS, coverage differences, and enrollment deadlines furthered complications

Lessons Learned: Enrollment

- Some beneficiaries were wary of managed care and opted out without fully considering coordinated care
- Coordinated care was a new concept for many beneficiaries and they did not fully understand how it could help maximize their care
- Many beneficiaries opted out because their current providers were not part of the Cal MediConnect plan networks

Lessons Learned: Beneficiary Noticing

- Series of three notices wasn't enough to inform beneficiaries
- Beneficiaries:
 - Lost notices
 - Never received them/threw them away
 - Were confused by/could not understand notices
- Packet of information and notices were overwhelming to beneficiaries

Lessons Learned: Engagement

- Reaching beneficiaries was difficult
 - Diverse population – different needs
 - Some physicians and other beneficiary advisors did not understand and/or like the program
 - Some advisors steered beneficiaries away from the program and engagement activities
- Other providers and organizations felt left out of the process. Some of these groups felt ill-equipped to help beneficiaries make decisions.

Lessons Learned: Engagement

- Reaching physicians/office staff was difficult
 - Numerous providers to engage
 - Many physicians (key beneficiary advisors) resisted the program
 - Some physicians actively told beneficiaries to opt out
- Physicians/office staff are busy providing care
 - Even if interested, this made it hard to reach them
 - They had little time to focus on learning the program and how it could help their patients

Promising Practices: Enrollment

- Engage stakeholders, including beneficiaries, in focus groups prior to enrollment
- Make enrollment as clear and simple as possible
- Engage providers and other beneficiary advisors ahead of enrollment so they understand the program and can help

Promising Practices: Enrollment

- Train providers, CBOs, and other advisors on enrollment processes and supports with the consistent and clear messaging. This ensures:
 - Consistent messaging for beneficiaries
 - A clear referral path
- Coordinate the various advisors to minimize duplication and different messaging
- Be creative in engaging beneficiaries who are enrolling – telephone townhalls are a great tool

Promising Practices: Beneficiary Noticing

- Gather stakeholder feedback on noticing materials when possible
- Ensure no erroneous notices are sent
- Ensure notices are in the correct language and have a quick and easy process for beneficiaries to obtain materials in their preferred language
- Have helpful phone numbers and possibly in-person locations where beneficiaries can get help

Promising Practices: Engagement

- Engage and train providers and other advisors early and keep them apprised of programmatic and/or policy changes
 - Providers/other groups can make or break outreach
- Do not exclude stakeholders who have resources and a willingness to help
- Have dedicated outreach staff when possible
 - Outreach is difficult and time consuming
 - Outreach staff require a specific set of skills

Promising Practices: Engagement

- Training for outreach staff should include:
 - Talking about the program in a clear, simple way
 - Strategies for building relationships with beneficiaries, providers, and CBOs
 - Using scripts so that messaging is consistent
 - Roleplaying
- Meet beneficiaries where they live, congregate, or receive services
- Use multiple approaches to communicate with beneficiaries

Promising Practices: Engagement

- Create outreach materials:
 - With consistent, simple, and clear messaging
 - In all beneficiary languages
 - That are accessible
- Partner with CBOs who have regular contact with beneficiaries
 - Trusted sources of information
 - Can help engage beneficiaries

Key Takeaways

- Beneficiaries often have low health literacy
 - Enrollment, noticing, and outreach materials must be simple, in preferred languages, accessible, and have clear, consistent messaging
- Trusted advisors are important
 - Use focus groups before enrollment
 - Outreach and training for these groups should happen early and as often as necessary
 - Partner with these entities to help with outreach and to gather feedback on materials

Key Takeaways

- Use dedicated outreach staff who are culturally competent know the area of outreach
- Use existing channels of information to reach beneficiaries
- Meet beneficiaries where they are
- Be proactive – beneficiaries are not always likely and/or able to seek out programs
- Expansive provider networks are important



Questions?