**MSSP Transition Model of Care Workgroup**

***Recommendations Memo 1***

***August 2018***

**BACKGROUND**

The Coordinated Care Initiative (CCI) was developed to improve coordination and integration of care for dual eligible and Medi-Cal beneficiaries, and in particular to improve coordination with long-term services and supports benefits such as the Multipurpose Senior Services Program (MSSP). As a part of the CCI, MSSP will transition from a federal 1915(c) HCBS waiver to a fully integrated Medi-Cal managed care benefit in the CCI counties in 2020.

To support this transition, the Department of Health Care Services (DHCS) has convened a workgroup composed of MSSP sites, managed care plans, and the two sister agencies overseeing the MSSP program (DHCS and the California Department of Aging, CDA). This workgroup is tasked with developing recommendations for a model of care for the new Home and Community-Based Services Care Planning and Management (HCBS CPM) benefit that will take the place of the MSSP program.

This workgroup was convened in January 2018, and is working through a number of topics related to the model of care. The workgroup has regularly met bi-weekly for 16 meetings to date. The workgroup is releasing its first set of recommendations for public comment in this memo as it continues to work through outstanding issues.

* Recommendations Memo 1:
  1. Eligible Members
  2. Data Sharing
  3. Joint Care Planning
* Forthcoming Recommendations:
  + Screenings & Assessments
  + Waitlist Transition
  + Staffing Requirements
  + Telephonic and In-Home Visit Requirements
  + Purchased Services

**RECOMMENDATIONS**

1. **Eligible Members**

The Model of Care Workgroup spent two meetings discussing the age criteria for the HCBS CPM benefit post transition. The workgroup as a whole agreed conceptually that this program would be beneficial to frail beneficiaries younger than the current age criteria of 65 years and over. However, because no one knows for certain how many beneficiaries would meet the level of care criteria, and be willing to participate in the care planning process, the workgroup discussed taking a conservative approach to addressing the age criteria.

The workgroup recommends that:

* For the first year post transition (currently calendar year 2020), the age criteria for the HCBS CPM benefit should remain as is, at 65 years of age and over.
  + This will remain consistent with the first year protections of the grandfathered population and allow the health plans to continue serving their members who are existing MSSP participants, and time to identify and assess members who may be eligible for the benefit.
* In the second year post transition (currently calendar year 2021), the workgroup recommends the age criteria should be lowered to 62 years and over, with the same level of care criteria (e.g. nursing home certified as defined by California Code of Regulations, Title 22, Sections 51118, 51124, 51334 and 51335).
  + This will allow those members who are frail, but just under the 65 year age cutoff, to receive the high-touch care management services of this benefit to remain in the community, delay or prevent their placement in a nursing facility.

1. **Data Sharing**

The workgroup spent several months discussing both data sharing in the context of joint care planning. The workgroup concluded that plans and HCBS CPM providers should determine their data sharing process and protocols at the time of contracting and should choose the most integrated, highest level of data sharing possible.

This proposal outlines several options for plans and providers to choose from, based on their needs and operational capacity. For limited scope members (for example, duals who are in a plan’s MLTSS product), there may be some limits on the data available to be shared by the plan. All of these data sharing options should replace the current monthly formal reports provided by MSSP sites to the plans.

The workgroup recommends plans and providers choose one of the following options:

* *Bi-Directional Data Sharing:* 
  + The plan and provider regularly share member data.
  + Data packages and processes should be agreed upon and outlined in contracts and/or policies and procedures.
  + The plan’s HCBS CPM liaison could be leveraged for this process.
  + At a minimum, data should be shared on a quarterly basis, and include:
    - Updates to the care plan;
    - Changes to the member’s health status;
    - Claims/encounter data, as applicable;
    - Newly completed assessment or reassessment data;
    - Other?
  + The plan and provider should also share data if the member has a change (such as a change in member’s condition, hospital admission, etc.) or if the member need for plan-covered benefits changes.
* *Real Time Data Access:*
  + The plan could give the HCBS CPM provider access to an online provider portal or FTP site where they can access and view updated information for their members
  + The HCBS CPM provider may maintain a separate care plan/member data and provide data updates to the plan as outlined above. Alternatively, the provider could be allowed to upload their data into the plan’s portal or system, allowing the plan real time access to the provider data.
* *Integrated Care Plans and Member Data:* The HCBS CPM provider and plan could use an integrated care plan/electronic health record system using the format of their choice. The HCBS CPM provider would have the same access, etc., as any other contracted provider.

1. **Joint Care Planning**

Our proposal includes two approaches to joint care planning by the health plans and Home and Community-Based Services Care Planning and Management (HCBS CPM) providers. One approach is for members where the health plan has risk for their full scope of benefits, for example full duals in a Cal MediConnect product or Medi-Cal only SPDs. The other approach is for members where the health plan only has risk for a limited set of their benefits, for example duals who have an MLTSS plan and receive their Medicare benefits separately.

*NOTE: Each approach is under the assumption that the HCBS CPM provider is an external contractor with the plan. Care plans may differ in structure/content for HCBS CPM providers as they are providing direct services with the member and health plans must gather information from the HCBS CPM providers and other entities to incorporate into the care plan at the health plan. If the HCBS CPM provider is directly employed by the health plan, there would be one care plan with a designated role of the HCBS CPM provider versus a care coordinator role adding to one care plan.*

**Full Scope Member Care Planning Proposal (Cal MediConnect/Medi-Cal Only)**

* **Goal:** Members enrolled in the HCBS CPM benefit will have full access to specialized home-based care coordination and health plan benefits that ensure health, safety and welfare and delay or prevention of institutionalization. Care planning will be as integrated as possible.
* **Initial Care Planning:** Upon HCBS CPM enrollment, the plan and the HCBS CPM provider will convene an in-person or telephonic collaborative meeting to:
  + Develop a care plan with:
    - Risk-based problems.
    - Measurable (SMART) goals and interventions.
    - Identification of gaps in care or participant needs that are based on clinical/utilization review (for example, existing health record/care plan) to include information gained from in-home health and psychosocial assessments of member).
    - To the extent appropriate, this care plan will comply with the care plan requirements under DPL 15-001 and APL 17-012.
  + Determine which entity will take responsibility for which interventions on the care plan (plan, HCBS CPM provider, member, member representative, caregiver, other provider).
  + Determine the frequency of future joint care planning meetings between the plan and HCBS CPM provider, based on the needs of the member.
* **On-Going Care Planning:** 
  + *Annual Meetings:* Based on what the member wants and needs, the plan and HCBS CPM provider will hold, at a minimum, annual care planning meetings going forward.
  + *Need-Based Meetings:* If there is a change (such as a change in member’s condition, hospital admission, etc.) or if the member need for plan-covered benefits changes, the plan and HCBS CPM provider will meet to update the care plan, determine responsibility for interventions, and create a plan for ongoing communications.
  + *Ad Hoc Collaboration:* The plan and HCBS CPM provider will convene care plan discussion as needed beyond the initial or periodic care planning session.
* **Alignment with ICT***:* These care planning meetings can serve as meetings of the member’s ICT, provided that the functions and composition of the meetings aligns with the requirements of DPL 15-001.

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| **Health Plan Role** | **HCBS CPM Provider Role** |
| * Designate a liaison for HCBS CPM providers to facilitate client access to covered benefits.   + The liaison can be a designated individual/role or unit.   + Roles and responsibilities should be clearly delineated in policies and procedures, and includes facilitating member access to covered plan benefits as identified by the HCBS CPM provider.   + Plan liaison contact information should be available to the HCBS CPM provider, and any updates to contact information should be proactively shared with the HCBS CPM provider through an established process.   + If member in delegated model, the delegated entity must also have an HCBS CPM liaison (unless the plan wishes to serve in that capacity and facilitate all communication). * Share relevant member data with HCBS CPM provider, including:   + Changes/updates to member’s health status or plan care plan. | The lead care coordinator (as defined in DPL 15-001) but must seek to coordinate with CMC plan.   * To the extent that the plan delegates care coordination activities to the HCBS CPM provider, this must be specified in their contract.   + In place of existing reporting requirements, the provider share report any care plan updates on a monthly basis. The format of that data sharing should be determined in consultation between the plan and provider.   + The HCBS CPM provider would be responsible for convening care planning meetings and/or ICT meetings as appropriate.   + The HCBS CPM provider will work with the plan liaison to help clients access plan benefits. |

**Limited Scope Member Care Planning Proposal (Opt-Out Duals)**

* **GOAL:** Facilitate member access to needed plan benefits, improve plan-provider communications and reduce reporting burdens
* **Initial Care Plan Meeting***:* Upon HCBS CPM enrollment, the plan and the HCBS CPM provider will convene an in-person or telephonic collaborative meeting to:
  + Develop a care plan with:
    - Risk-based problems.
    - Measurable (SMART) goals and interventions.
    - Identification of gaps in care or participant needs that are based on clinical/utilization review (for example, existing health record/care plan) to include information gained from in-home health and psychosocial assessments of member).
  + Determine which entity will take responsibility for which interventions on the care plan (plan, HCBS CPM provider, member, member representative, caregiver, other provider).
  + Determine the frequency of future joint care planning meetings between the plan and HCBS CPM provider, based on the needs of the member.
* **On-Going Care Planning:** 
  + *Annual Meetings:* HCBS CPM provider and plan will meet annually to update the care plan, and this meeting will meet the DHCS APL 17-012 requirement for annual care planning for the plan.
  + *AD Hoc Collaboration:* If there is a change in the member’s status (such as a change in member’s condition, hospital admission, etc.) or if the member need for plan-covered benefits changes, the HCBS CPM provider or health plan can call an ad hoc care plan meeting or just request help from the HCBS CPM provider’s care manager or plan HCBS CPM liaison.

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| **Health Plan Role** | **HCBS CPM Provider Role** |
| * Designate a liaison for HCBS CPM providers and HCBS CPM care plan meetings to facilitate member access to Medi-Cal benefits covered through the plan.   + The liaison can be a designated individual/role or unit; there should be an established and stable process for contacting the liaison.   + Roles and responsibilities should be clearly delineated in policies and procedures, and includes facilitating member access to covered plan benefits as identified by the HCBS CPM provider.   + Contact information should be available to HCBS CPM provider, and any updates to contact information should be proactively shared with the HCBS CPM provider through an established process. * Participation in annual care planning meetings will count as meeting the assessment review/care planning requirement in DHCS APL 17-012. | * Primary care coordinator, manages and updates care plan (this role is to be specified in the contract with the plan). * Convenes care planning meetings with plan liaison. * Reports member care/service needs to MLTSS plan liaison through an established process for their assistance connecting member to that care or services. * Provides care plan updates to MLTSS plan on annual or quarterly basis, as needed. |