Cal MediConnect Stakeholder Input Survey Summary

In January and February 2019, the Department of Health Care Services (DHCS) invited stakeholders to provide recommendations for cost neutral initiatives and activities that could help improve the Cal MediConnect (CMC) program without requiring a change to plan rates. DHCS received 23 comment letters representing input from 43 organizations and individuals.

Improve CMC Care Coordination

- *Health Risk Assessment (HRA) & Individualized Care Plan (ICP) Processes*
    - Provide guidance to the plans on how to use the LTSS referral question data to improve care planning and care coordination, including:
        - When identified, what unmet needs are the plans accountable for?
        - What is the timeline for addressing unmet needs?
        - How will the state oversee health plans' development of person-centered care?
    - Require plans to use a validated cognitive screening tool and enter results into an electronic health record (EHR); Require positive screenings to trigger referral to primary care provider for diagnostic; document dementia diagnosis in EHR
    - More closely monitor ICP processes and content, and work with plans and stakeholders to develop strategies that ensure ICPs are person-centered, meaningful, and useful to the member – as well as reviewed and signed by the member
    - Loosen outreach for HRA/ICP completion to just two phone calls and one mailing in 45 days, and five combined outreach attempts for six months of eligibility
    - Create a uniform services assessment for all plans, including "warm-hand-off" guidelines
    - Create a standard HRA for all plans, so members do not have to take a new HRA when switching plans
- *Care Coordination*
    - Establish protocols to help people access the right level of care coordination to meet their needs and provide more intensive care coordination to highest risk individuals including comprehensive assessments, frequent contacts, and direct referrals to supportive services
    - Standardize person-centered care coordination protocols and training, and improve data collection and public reporting, leveraging best practices from Programs of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and the Health Homes Program (HHP)

- Improve metrics and oversight of plan care coordination, including access to LTSS and access to specialized case management services for complex patients and patients with behavioral health needs
- Require plans to identify and record caregivers in the EHR; adopt a caregiver stress tool and integrate results in EHR and notify PCP; engage caregiver in care coordination; provide caregiver respite
- Require plans to stratify as high risk all beneficiaries with cognitive impairment and two or more chronic/co-existing health conditions (or cognitive impairment and live alone) and connect them with dementia care specialists
- Require care coordination staff training to include screening and diagnosis of dementia

Connecting Members to Benefits

- *Care Plan Options (CPOs)*
  - Conduct utilization reviews and publicly report types and rates of CPOs
  - Incentivize provision of CPOs
- *Long-Term Services & Supports (LTSS)*
  - Form an LTSS and Care Coordination Workgroup to review data on LTSS, CPOs, and care coordination and develop best practices for new policy guidance
  - Encourage plans to connect members with dementia to local Alzheimer's organizations; train plans about available community resources, reduce privacy/data barriers to these partnerships
  - Convene a workgroup to review LTSS referral data and develop action plan
  - Support carve-in of MSSP
- *Durable Medical Equipment (DME)*
  - CMS, DHCS, health plans, and stakeholders should work together to identify barriers and pilot innovative solutions to improve DME access
  - Develop protocols on how service providers should connect beneficiaries with needed DME, home modification, and assistive technology to stay in their homes
- *In-Home Supportive Services (IHSS)*
  - Explore pilots to improve coordination for members with IHSS, particularly those also receiving services through CBAS or Independent Living Centers (ILCs)
  - Explore pilots, including the use of contract mode, to increase integration of IHSS
  - Incentivize or require IHSS coordination with CMC plans, potentially piloting use of withheld quality withhold dollars as quality incentives for counties

- *Interpretation*
    - Conduct periodic beneficiary surveys and work with health plans to ensure access to interpreters/culturally appropriate services are provided to beneficiaries
    - Talk to stakeholders about how DHCS will ensure access to required language interpretation services
    - Investigate availability of interpreter services and penalize CMC plans who do not meet this requirement, maybe add metrics to dashboard
- *Other*
    - Improve metrics and oversight of member access to community-based primary care, post-hospital care (including delays in transitions) and discharge rates from skilled nursing facilities
    - Review existing policies and issue new guidance to better coordinate behavioral health, including improved dashboard metrics
    - Coordinate supplemental dental benefits with Denti-Cal and enforce Denti-Cal rules, for example require supplemental dental providers to contract with Denti-Cal
    - Extend palliative care All Plan Letter (APL) to duals
    - Issue revised transportation DPL requiring plans to inform beneficiaries of NMT benefit in addition to changes in member handbook; prohibit prior authorization for NMT or disallow exhaustion of public transportation options before NMT
    - Encourage CMC plans to formalize agreements with service providers to address social determinants of health

Data Sharing / Reporting

- *Improve Data Sharing Across CMC Partners*
    - Create a workgroup process to identify ways to improve/streamline sharing of IHSS and behavioral health data between plans and counties, much like the process used for the plan-to-plan data sharing workgroup
    - Work with plans and shareholders to identify barriers to data-sharing and craft solutions to share member information
    - Increase funding for new software and data systems for providers and counties to share records, like Santa Clara County's CareAccess
- *Improve CMC Dashboard/Data Reporting*
    - Expand dashboard to include all CMC data (especially LTSS assessments and referrals), more timely data reporting, and measure and report data on social determinants of health

- Maintain current quality withhold measures; include plans in a process to identify new or revised measures
- Compile list of all required reporting, particularly CMS Core Medicare-Medicaid Plan (MMP) reports and California State Specific MMP reports, and analyze how the reports can be consolidated, streamlined, and/or reduced
- Streamline LTSS referrals/utilization reporting requirements
- Include dental metrics on the CMC performance dashboard
- Adopt a measure tracking whether duals have been offered and participated in an annual Medicare wellness exam with the attendant cognitive assessment

Enrollment

- Find ways to allow plans to outreach and enroll new-to-Medicare duals into CMC
- Allow default enrollment of new-to-Medicare duals or new all new duals
- Allow plans to directly enroll duals
- Allow brokers to enroll duals in all plans, including PACE
- Continue to include PACE in any enrollment efforts going forward
- Allow members to enroll in CMC and Home and Community-Based Services (HCBS) waivers (especially the Assisted Living Waiver) simultaneously
- Extend the deeming period
- Encourage CMC plans to work more closely with members to resolve Medi-Cal redetermination issues
- Adopt the three-month MA special enrollment periods (SEPs) policy
- Keep the continuous SEPs policy
- Expand CMC to include end-stage renal disease population or expand CMC to include Chronic Conditions Special Needs Plans (C-SNPs)
- Limit availability of Dual Eligible Special Needs Plans (D-SNPs)
- Fix enrollment issues due to erroneous aid codes and inadequate HCO CSR training
- DHCS should explore Opportunity #9, related to improving Medicare Part A buy-in. California should permit direct enrollment of eligible individuals into Medicare Part A at any time of the year. The State should also consider Opportunity #8, concerning improvements in State buy-in file data exchanges and Opportunity #10, to simplify eligibility and enrollment processes that align Low Income Subsidy (LIS) and Medicare Savings Program (MSP) income and/or asset criteria.

Other Issues

- *Rates*
  - Consider CPO and in-lieu of services (ILOS) in rates

    - Look to the New York model for using ILOS authority
- *Billing/Claims Issues*
    - Require CMC plans to automate cross-over billing and reconcile cross-over billing on an annual basis with hospitals
    - Periodic beneficiary surveys to monitor balance billing practices
    - Adopt reconciliation processes like those used by CMS to report and resolve discrepancies
- *CMS/DHCS Coordination Issues*
    - Cal MediConnect Audits
        - The CMC pharmacy benefit is audited under the stand-alone CDAG audit protocol, rather than the hybrid plan Service Authorization Requests, Appeals and Grievances (SARAG) audit protocol
        - CMS/DHCS should use an integrated denial notice of action for the pharmacy benefit
        - DHCS and CMS should audit CMC products together
    - Extension Request
        - Exclude member transitions to PACE or other integrated products from the disenrollment penalty
        - Delay disenrollment penalty
    - Align CMS and DHCS eligibility status data
    - Improve coordination between DHCS and CMS on appeals and grievance processes, renewing the demonstration, and developing updated contract language
- Develop robust stakeholder process to further duals integration in California and Cal MediConnect, like the Medicare Advantage (MA) One Care Implementation Council in Massachusetts
- Require plans to help people develop and maintain personal emergency plans
- Allow CalPACE and/or members to educate Health Care Options (HCO) on the PACE program
- Create standardized state CMC training for providers
- Publish provider manuals on CalDuals.org
- Require risk stratification and tiered provision of care management to Medi-Cal beneficiaries