

## DHCS Quarterly Stakeholder Webinar – September 30, 2021

Mary Russell:

...DHCS CCI's Stakeholder Update Webinar. This is Mary Russell with Aurrera Health. Very excited to have you all here. Today we're going to hear some great presentations from our speakers. That's going to include Anastasia Dodson, the deputy director of the office of Medicare Innovation and Integration at DHCS. We'll also hear from Jacqueline Lang, the CHCS data recording chief in the Managed Care, Quality and Monitoring division at DHCS. We also are joined by Jack Dailey, the Cal MediConnect Ombudsman and Dr. Kyle Allen, the health and aging policy fellow at the Administration for Community Living and CMS Medicare and Medicaid Coordination office. So, thank you all for joining and really excited to have these speakers today. Just a few meeting management items to note before we begin. For today, all participants will be on mute during the presentations. Please feel free to submit any questions via the chat feature on Zoom. And during the Q&A portion at the end of the webinar, if you would like to ask us a question or provide comments, please use the raise hand function. We will unmute you to open your line.

Mary Russell:

So, with that, we'll take a look at the agenda for today. DHCS will kick it off for us and share some policy updates. Then we'll walk through the September Cal MediConnect dashboard updates. We'll move into a review of the durable medical equipment work groups and fact sheets. Then we'll hear a presentation about the CMC COVID vaccination campaign for homebound members. And finally, we'll have some time for questions at the end. So, I'm excited to hand it over to Anastasia Dodson to begin our updates from DHCS. Anastasia.

Anastasia Dodson:

Thanks so much, Mary, and good to virtually see all of you today. So, this is our quarterly, as Mary said, it's our quarterly stakeholder webinar with updates about the existing Cal MediConnect program. And as you know, we've had a monthly stakeholder meeting on the transition of Cal MediConnect and the upcoming requirements around D-SNPs, so the slides that I'm going to go through right now are essentially the same as what we talked about earlier this month on our monthly MLTSS and Duals Integration Workgroup, but it's a reminder for those who weren't able to attend that meeting, or just if you had further questions. Next slide.

Anastasia Dodson:

So, again, this is the construct that we've been talking about for the last couple of years. Cal MediConnect is going to move to a D-SNP and Medi-Cal Managed Care structure, and we've started using the term exclusively aligned enrollment, because that is a term of our that says, in that D-SNP there are only beneficiaries who are dual eligible and they're in the same Medicare and Medi-Cal plan organization and they're enrolled in those same Medi-Cal Medicare plans together, so that there's integrated coordinated care. So, starting at the end of 2022, when the Cal MediConnect beneficiaries will be automatically transitioned to this D-SNP aligned enrollment model, that'll be effective January 1st, 2023, and then those D-SNPs that are exclusively aligned will be open for new enrollment as well, in addition to the folks from Cal MediConnect who will transition. And those aligned D-SNPs are going to have the same structure as far as integrated care, quality of care standards, other structures that Cal MediConnect had. It's just in a different framework from a contractual perspective, but the beneficiary impact and the level of coordination should remain the same.

Anastasia Dodson:

And then as we iterate on that D-SNP SMAC contract we've talked about, then we can make improvements there. So, we want to keep all of the stakeholders, beneficiaries, et cetera, engaged throughout this process. And we want to recognize that some beneficiaries or others may have heard, "Oh, Cal MediConnect is going away." It's transitioning. So, people will not be dropped. They're going to be automatically enrolled in the D-SNP and Medi-Cal plan that matches with their Cal MediConnect plan. So, this slide at the bottom has a little bit more about the different types of aligned enrollment. That's a technical definition. But the essence is, again, the Medi-Cal and the Medicare benefits are through the same organization. They're two separate plans, but it's the same organization that will coordinate those benefits. Next slide.

Anastasia Dodson:

So, again, we've talked about all Medi-Cal Managed Care plans in the seven CCI counties have to establish D-SNPs in 2023, and then the beneficiary's Medicare choice will drive their Medi-Cal plan enrollment. And that means if they choose... And this, again, we had some examples that we used at the monthly meeting, where if someone is already enrolled in a certain Medi-Cal plan and then they choose the Medicare plan that's the same organization, no problem. If they choose a Medicare plan that's different than their Medi-Cal plan, then their Medi-Cal plan will be adjusted to match their Medicare plan.

Anastasia Dodson:

Of course, beneficiaries at any time can change. Well, depending on the particular rules around Medicare plan changes. But basically there are a number of opportunities for beneficiaries to select a Medicare plan, stay in fee for service for Medicare, and of course, there's also PACE and other options as well. But it's up to the beneficiary to choose how they want to receive their Medicare services. And if they choose to enroll in a Medicare advantage plan, a D-SNP, then we will make sure that the Medi-Cal plan aligns to their Medicare plan. This is consistent also with the Budget Trailer bill that was enacted earlier this year. And again, it's even consistent with the current approach that we are using with our healthcare options, as far as how do we enroll someone in a Medi-Cal plan once they've chosen a Medicare plan? All right, next slide.

Anastasia Dodson:

So, again, beneficiary enrollment in a D-SNP or any other Medicare Advantage plan is voluntary. Medicare beneficiaries can stay in original Medicare fee for service. They don't need to take any action if they want to stay in Medicare fee for service. And for the beneficiaries that are already enrolled in Cal MediConnect in 2021, 2022, they will automatically be enrolled into the Medicare D-SNP and the Medi-Cal plan that are affiliated with their Cal MediConnect plan. No action is needed by the beneficiary. Next slide.

Anastasia Dodson:

And then this slide just highlights the choices in CCI counties. It does depend a little bit on the county. Some are county-organized health systems where there's just a single Medi-Cal plan. There may be delegates, and then PACE depends on the region sometimes within the county. But for those who are already enrolled in Cal MediConnect, there's an automatic transition at the end of 2022. And then of course, Medicare beneficiaries, duals, can always choose Medicare fee for service. They can choose the exclusively aligned D-SNP, which is what we are building here in the policy documents we've been talking to you about, and they can also choose a Medicare Advantage Plan that's not a D-SNP, and they

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can choose a Medicare plan or remain enrolled in a pre-2014 D-SNP that's not affiliated with a Medi-Cal plan. And that's a pretty small group legacy enrollment on the pre-2014 D-SNP, but there are some Medicare Advantage plans that are not affiliated with Medi-Cal plans. And anyway, that is an option. And then PACE or SCAN is also available depending on the location for dual eligibles. Next slide.

Anastasia Dodson:

So, as far as next steps on aligned enrollment, we're working on a detailed enrollment process and beneficiary notices for 2023, and we'll work with all of you in our next monthly meeting to talk further about those. Integrated member materials in consultation with stakeholders, that's a little further on the horizon. Developing the specific language for the 2023 SMAC. Local outreach. We know that we can't just keep talking about it at the state level. It needs to be also communication with providers and beneficiaries at the local level. So, we'll be bringing that up in future months and ramping that up. And then we want to educate and promote new enrollment in those exclusively aligned D-SNPs and affiliated Medi-Cal plans. And that's a topic that we'll want to talk more about in the future about how we do that, and we'll work with all of you on that as well. So, I think that's it. Next slide. Okay. Let's see. Mary, are we saving questions for the end?

Mary Russell:

I think we can take a quick pause here. I do see some questions coming in through the chat and a hand raise. I did just want to comment. So, Lorenzo, I thank you for your comment in the chat and I wanted to let that we are actively reviewing this request. We have received it, so thank you, and you can expect a response from the DHCS team shortly on that.

Anastasia Dodson:

Yeah. We have a meeting next week with all the health plans and we're preparing an FAQ document. So, a number of plans have written in with questions, and we have a monthly meeting series just for you, and we'll roll out answers to those questions as quickly as we can.

Mary Russell:

Great. There's also a question that just came in from Gisella Gomez, with the ETA on the FAQ.

Anastasia Dodson:

Yeah. We have a meeting next week and we will-

Mary Russell:

There you go.

Anastasia Dodson:

... have an FAQ for you then.

Mary Russell:

Perfect. Okay. And I see a hand raised from Rick Hodgkins. Can we unmute Rick with his question?

Mary Russell:

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(silence).

Mary Russell:

Rick, are you able to unmute?

Automated Voice:

Hold on. Zoom, [crosstalk 00:11:19].

Rick Hodgkins:

Can you hear me?

Mary Russell:

Yes, we can.

Rick Hodgkins:

Can you also see me?

Anastasia Dodson:

No.

Mary Russell:

We cannot see you, but we can hear you loud and clear.

Rick Hodgkins:

Okay. I just pressed Alt V to turn on my video.

Mary Russell:

Okay. Go ahead with your question.

Rick Hodgkins:

Okay. What are the advantages of being in a Medi-Cal Managed Care plan? I guess you might say that this is probably the first question I should have asked a long time ago. What are the advantages to being in a Medi-Cal Managed Care plan from a patient standpoint?

Anastasia Dodson:

Yeah. Good question. So, for people who are dually eligible for Medicare and Medi-Cal, most of their benefits are Medicare benefits. But in California, we have Medi-Cal Managed Care plans that serve most of our beneficiaries and for dually eligible folks, if you're in a CCI county or county-organized health system county-

Automated Voice:

[crosstalk 00:12:20].

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Anastasia Dodson:

... you're automatically enrolled in a Medi-Cal Managed Care plan. And the benefits that dually eligible folks use the most on the Medi-Cal side can be transportation. Of course, there's coverage of co-payments and premiums, but the benefits are most often transportation. And then of course, CBAS and other long term services and supports. So, I would say transportation, being able to get transportation to doctor's appointments and other type of medical appointments is a Medi-Cal benefit that Managed Care plans are supposed to coordinate and provide to you. But the policy is that most people, most duals are automatically enrolled in a Medi-Cal Managed Care plan anyway. And then in 2023, the remaining counties will transition so that all dual eligibles will be automatically enrolled in a Medi-Cal Managed Care plan.

Rick Hodgkins:

Now, that includes Bay Area counties as well, correct?

Anastasia Dodson:

Yes.

Rick Hodgkins:

Okay. Because I live in Sacramento County and hopefully I'll... I'm glad that Jack Dailey will be on the call today because he and I talked before. So, thank you for that. The good thing about transportation is if I need to get to a doctor in the Bay Area, I can get that transportation to that appointment.

Anastasia Dodson:

Good. I'm really glad it's working okay for you.

Rick Hodgkins:

Yeah. No, I haven't enrolled yet. I just need to find out which doctors will take what Medi-Cal Managed Care plans first, before I can pick a plan. And I know I have next year to decide.

Anastasia Dodson:

Yes. And I would assume most of your doctors are through Medicare?

Rick Hodgkins:

Yes.

Anastasia Dodson:

Yeah. So-

Rick Hodgkins:

All of them. All of them are.

Anastasia Dodson:

Right. So, the Medi-Cal plan that you choose will not change your access to your Medicare physicians. So, there's no restrictions on Medicare providers based on your Medi-Cal plan.

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Rick Hodgkins:

So, there will be no restrictions. But my follow up question would be, what if they look at the Medi-Cal things because they're going to want payment from the Medi-Cal as well?

Anastasia Dodson:

Good point. Fair point. Yes. So, that is, in fact, that's one of the benefits of choosing a Medicare plan is that they should coordinate and have a more seamless process to make sure that you're not stuck with any bills that you have to go through Medi-Cal to get the payment processed. So, sometimes providers-

Rick Hodgkins:

Choosing a Medi-Cal plan. You mean choosing a Medi-Cal plan?

Anastasia Dodson:

I'm sorry, I couldn't hear the first part of what you said.

Rick Hodgkins:

You're confusing me. You mean that's one of the benefits of choosing a Medi-Cal plan, not Medicare.

Anastasia Dodson:

For our exclusively aligned enrollment approach, if the same organization is responsible for your Medicare benefits and your Medi-Cal benefits, they can communicate more easily with your Medicare providers so that the providers get clear information that they don't bill you for anything. They just work with the Managed Care plan. And it's a single plan that works with both your Medicare and your Medi-Cal benefits.

Rick Hodgkins:

So, is it better to sign up with a D-SNP?

Anastasia Dodson:

I don't want to advise you personally. That's your choice. But I think as we move forward and we can also talk offline about what those choices mean, and it sounds like a good example of the type of clarification and outreach that we should be doing on this topic.

Automated Voice:

[crosstalk 00:16:47] LISSV/ica rod-

Mary Russell:

Thank you so much, Rick, for raising those questions. And I also see that Jack has put another comment in the chat about connecting, and we're also happy to help if you want to send some additional questions to the [info@calduals.inbox](mailto:info@calduals.inbox). So, thank you, Rick. It looks like we have two more questions and then we'll move on to the next section. So, the next question from Regan Matthew.

Regan Matthew:

Yeah. Hi. Could you guys hear me?

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Mary Russell:

Yes. Go ahead.

Regan Matthew:

Great. So, I was curious about the exclusive aligned enrollment. First off, does this mean that previous members will then be aligned? So, if currently we have a D-SNP member who is in another plan for Medi-Cal, does that mean when exclusive aligned enrollment goes into place, those members will be aligned or are those members grandfathered in?

Anastasia Dodson:

I think we would have to get more specific information about which plan you're calling from and which D-SNP you're talking about. If you're a Medi-Cal plan and you're launching a D-SNP and-

Regan Matthew:

No. So, say you're a D-SNP who's been established pre-2014 so that would apply and you have various cohorts of members, right? So, if a member is a D-SNP member and they've been with us and they have previous members and did get aligned, right? Versus that. So, I guess that's the difference that I'm trying to get clarity on.

Anastasia Dodson:

Yeah. I didn't quite follow the question, but it sounds like a question that should be, if you're calling from a health plan, let's talk about it next week at our health plan call because we'll be able to go into more technical detail there.

Regan Matthew:

Okay. And then the, I guess, the other question is, so exclusive aligned enrollment then will also apply to non-D-SNP MA plans. So, a member joining just a standard senior advantage plan will also be expected to be aligned.

Anastasia Dodson:

There will be alignment there. Exclusively aligned enrollment is a special term that refers to D-SNPs that are under the same organization as the Medi-Cal or Medicaid plan. And that's exclusively aligned enrollment. An MA plan that's not a D-SNP, they don't have exclusively aligned enrollment. But we have a matching policy so that when they choose the MA plan on the Medicare side, then their Medi-Cal plan will match their Medicare plan if there is a match. But I think-

Regan Matthew:

Okay. Got it.

Anastasia Dodson:

Yeah.

Regan Matthew:

And then if there's- Sorry. I cut you off. What were you going to say?

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Anastasia Dodson:

Well, just that I think we have other topics on this webinar. So, we have a call for health plans next week. We're happy to go through all the health plan questions then if you don't mind.

Regan Matthew:

Okay. Yep.

Anastasia Dodson:

Great.

Mary Russell:

Great. Oops. Sorry. Thank you, everyone. Let's transition. Next step is going to be Jacqueline Lang with the CHCS Data Reporting Chief to walk us through the CMC dashboard. So, Jacqueline, go ahead.

Jacqueline Lang:

Thank you. Thank you, Mary. Good morning, everyone. Yeah. I'm Jacqueline Lang, the data reporting chief in Managed Care, Quality and Monitoring division. And I'm just going to share some high level findings based on the September 2021 release of the Cal MediConnect dashboard. And so as you see here on the next slide, the dashboard has been posted at the link shown for your reference. Next slide, please. So, the first slide that I'm going to talk about is regarding enrollment and demographics. So, for statewide enrollment in Cal MediConnect, it did increase from about 107,000 members in April of 2020 to over 112,000 members in March of 2021. So, in the first quarter of 2021, 51% of enrollees spoke English and 33% spoke Spanish as their primary language, with 38% of enrollees identifying as Hispanic. Males and females aged 65 and older represent 30% and 45% of total CMC population respectively. Next slide, please.

Jacqueline Lang:

Thank you. And so this next slide depicts the care coordination trends in figure eight, and it shows that the percentage of members with a health risk assessment completed within 90 days of enrollment. It did increase from 94% in the fourth quarter of 2020 to 95% in the first quarter of 2021. Next slide. Thank you. And so figure 10 for this slide shows individualized care plan metrics. So, we see that the percentage of members with an individualized care plan completed within 90 days enrollment did decrease from 86% in the fourth quarter of 2020 to 85% in the first quarter of 2021. Next slide, please. Thank you.

Jacqueline Lang:

So, the last slide that I'll share out is regarding behavioral health emergency room utilization, figure 20 of the dashboard. And so one goal for health plans is to improve the coordination of behavioral health services for members, including between mental health and substance use disorder treatment covered by the CNC plan and the specialty mental health services provided by county behavioral health departments. So, this graph shows the rate of CNC members seeking care in the emergency room for behavioral health services. And that utilization has decreased from 18.1 visits per 10,000 member months in the first quarter of 2020 to 14.1 visits in the fourth quarter of 2020. So, that's it for the high level findings for this release of the dashboard, and I'll hand it back to Mary to introduce our next panelist. Thank you.



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Mary Russell:

Great. Thank you. And next I'll hand it over to Jack Dailey to you update us on the DME fact sheets. Jack.

Jack Dailey:

Great. Thanks a lot, Mary. Happy to join the conversation today and to talk about some of the work that we did with DHCS and other partners. So, back in September 2019, if we can remember back before the pandemic, Aurrera and CMS issued a survey to CMC plans to learn about their DME-related policies, their procedures, and their relative experiences administering DME. And following that, a work group was then launched in October of that year to bring together various stakeholders, DHCS folks, CMS, CMC plan representatives, DME providers, advocates, which included myself and Denny Chan from Justice in Aging, and some other folks, all to review those survey results, to discuss the challenges identified around access to DME, and then to develop some possible solutions. And again, we were super happy to be a part of that conversation and contribute our experiences in working with consumers. Next slide, please.

Jack Dailey:

One of the findings of this work groups was that members and caregivers, providers, and others involved in the members care may not understand the nuances of Cal MediConnect's plans coverage of DME. And so one of the thoughts was that the work group could put together two separate DME fact sheets targeting those two populations, providers and consumers, so that we would have a better understanding among members and providers about how this works, and hopefully clarify some of the misinformation that was out there or misunderstanding about, in particular, how CMC DME works. So, that first fact sheet was a provider fact sheet. It was targeted at clinicians and clinical team members who worked with dual eligible individuals in CMC plans.

Jack Dailey:

And then the second was a beneficiary fact sheet targeted at dual eligible individuals enrolled in Cal MediConnect plans. And we really felt this was important in our work. We'd be working with both consumers and providers that may have had a misunderstanding about limitations about when certain DME may be covered. And then that would be an unnecessary barrier in the process to ensuring folks access to the DME services or equipment that they needed. So, I thought this was a good way to help spread some clarity amongst the different stakeholders. Next slide.

Jack Dailey:

By the way, both of these sets of fact sheets are being finalized right now. I think the content is there. DHCS is working out some of the formatting on it, and it'll be released, I think, in October. But that provider fact sheet includes background on CMC plans, provides an overview of DME coverage requirements, a reference chart of Medicare and Medi-Cal benefits coverage for different DME and some additional DME and CMC resources. And I think there's some really important points in these fact sheets that identify or hopefully resolve some of the misunderstanding that we've seen present from providers out there serving duals. Next slide, please.

Jack Dailey:

Similarly, the member fact sheet is really focused on helping CMC members to better understand what those DME benefits are. And it's certainly focused on clarity in the language, so that folks aren't lost in

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any of the typical mumbo jumbo jargon that comes out of providers like us. And so hopefully it's well understood by members and it includes information about their CMC plan and what qualifies as DME and what's covered by their CMC plan, and then their rights and in the appeal process, if they're not able to access a piece of DME that they think they really should be entitled to. And then it also identifies additional resources so that that consumer can pursue their appeal rights and/or get more information about that process that they just went through. So, really excited to see these fact sheets come out. Hopefully it'll be a help to the various stakeholders working with CMC plans. And with that, I want to think DHCS and Aurrera for having me today to come talk about the work we did in that work group. Thanks, all. Back to you, Mary.

Mary Russell:

Great. Thank you so much, Jack. Really appreciate that update. Next we're going to transition to Dr. Kyle Allen, who is the health and aging policy fellow at the Administration for Community Living and Medicare and Medicaid Coordination office, to walk through the challenges and solutions to COVID-19 vaccination of homebound, dual eligible beneficiaries. So, really excited about this presentation. Go ahead, Dr. Allen.

Dr. Kyle Allen:

Thank you. And I want to thank you for inviting me today to present this work. If you can go to the next slide. I have been working as a health and aging policy fellow for the past year. I had a dual placement at ACL as well as with the MMCO office. And my background is as a geriatrician and lots of work between health systems and community-based organizations. So, I was able to work on that during my fellowship. My presentation today and disclosure is no formal opinion or viewpoint of the office of CMS or MMCO or ACL. Next slide. What I'm going to share with you today is some work that we did and some outcomes from a questionnaire that we did amongst the health plans that were involved in the duals demonstration across 39 different plans. And I'll go through that in a minute, but I wanted to provide some background. Because COVID-19 presented lots of challenges to us as a country and as a world, but in particularly as it related to very vulnerable populations.

Dr. Kyle Allen:

And as a geriatrician who did house calls, I knew how vulnerable the homebound were, including also those, just not age-related folks, but there's also children and other younger adults with disabilities. And so one of the things we did is we started to design this survey. We wanted to expand the definition of homebound to be a little bit broader than what was the norm, if you will, that people were using a Medicare definition of homebound. And as everyone knows, these subpopulations are at very increased risk of adverse health and safety concerns during, not only a pandemic, but also other natural emergencies or disasters like fire, water safety.

Dr. Kyle Allen:

We had a major power outage in Texas during this past year and things like that. And so the health plans are in a position, right? The responsibility and looking at their membership of, how do I serve these folks as well as a lot of the community-based organizations? And the family caregivers also need to be seen in this too, because they're a part of the team and often that's silent. So, we wanted to dig a little bit, too, to understand how the caregivers were being addressed during the COVID-19 pandemic. And particularly as it meant to, as the vaccines were approved, how are we going to get vaccines to homebound or home-restricted individuals? Next slide, please.

Dr. Kyle Allen:

I think I wanted to give a little bit of background. ASPE did some work on this, and they actually dug back through one of the surveys, the National Health Trends in Health and Aging. And they had a definition in that survey and they went back and tried to quantify because there really wasn't a solid number about how many folks would meet this definition of homebound, and what is the definition of homebound or home-restricted. And I have some more recent data to show you here in a minute, but they have this report, which I have the link at the bottom, about 1.6 million older adults living in the United States may have trouble accessing the COVID-19 vaccine because they are homebound. And 51% of these older adults face at least one additional barrier, such as living alone or lacking technology, or even folks that live in a rural area with transportation.

Dr. Kyle Allen:

Nearly 15% of Hispanic older adults are considered homebound compared to 70% of black older adults, 5% of American Indian, Asian or Pacific Islanders, and 3% are white. And just under half of the homebound adults are connected to assistance programs and services such as food stamps, Meals on Wheels and home rehabilitative care. Vaccinating homebound older adults could be facilitated through partnerships with these programs if it could be, maybe, better coordinated. And most all the adults from that survey actually had seen their primary care physicians, which would be a logical place, also, to help address vaccine hesitancy and vaccine access. Next slide.

Dr. Kyle Allen:

So, this is a more recent study that was just published in JAMA. The earlier data that I gave you was 2015 to 2016, but they reanalyzed the data. And particularly during COVID, during this period of time from 2019 to 2020, we went from 1.6 million people being considered homebound by these broader definitions to 4.2 million. And you can see on the right side there, the race and ethnicity breakdown and some other characteristics, folks that didn't have a phone, no computer and no email use. But I'll refer you to that article for a deeper dive. Next slide, please.

Dr. Kyle Allen:

And as we were working in the MMCO office, of course, there was a high priority through all of CMS, but also the MMCO office, of looking at the dual eligible beneficiaries. And if you drill down a little bit further with that category of dual eligible, they have a much higher risk of hospitalization and death, as we saw through the pandemic. White non-Hispanic individuals are more likely to reside alone, which made you question about caregiver adequacy, but on the flip side of it, black non-Hispanic and Latinos had people living in the home, but then you had the issue of spread, and particularly amongst vaccination of caregivers and things like that. So, it put that group also at risk. Even though they had adequacy, maybe, of caregiver support, but did they have adequacy of coverage for vaccination support? Next slide, please.

Dr. Kyle Allen:

I did a little bit of work as I was working along and wanted to do a shout out to the Trust for America's Health, who's been working on this with the Age Friendly Public Health System, and this is a slide that I adapted from them about these various challenges. So, you have to think about operations. You have to think about supply, hesitancy, scheduling, transportation, distribution issues, expanded post-vaccinations, reimbursement, and particularly the caregiver issues were significant. Can I go to the next slide, please? So, one of the things is they started to work on this, the Trust for America's Health and

Age Friendly Public Health System, is early on it was really this confusion around definitions and people were all over the place. And that's what we found, also, in the survey that we did. People didn't quite know what definition to use. And so CMS definition determining homebound as it is more defined for skilled home health services is written there. But we wanted to go a little bit broader than that.

Dr. Kyle Allen:

So, in the survey, we asked people to address this in addition to other barriers, such as that we talked about, which was transportation, social drivers of health and dependency. What other things were making people relatively homebound? So, the next slide, please. So, some people made the definitions a little bit more simple. So, in this National Health and Aging Trends survey, which is where some of that data I showed you from ASPE, as well as the JAMA article was, this is the definition that they used in those surveys is, do you require help going outside? And how much difficulty do you have when leaving the house by yourself? The other one, which was written also, there's very few articles on this, but homebound older adults were defined as leaving home only once a week or less. And I know that's probably a little bit too broad. And so I think that was some of the challenges about having these definitions and having more of a standardized approach. And we heard that clearly from some of the health plans. Next slide, please.

Dr. Kyle Allen:

The states also may have their own definitions for homebound status for long-term service and supports or home and community-based services. And the data system seems to be lacking to estimate younger adults and children that meet a homebound status definition. Next slide, please. The adverse consequences of this is just 45% need assistance with activities of daily living. This is specifically for the duals. And 50% of people needed assistance with one or more mobility tasks. And these rates of the dual eligible population specifically, which is where we had a focus, is two times the Medicare population. Next slide please.

Dr. Kyle Allen:

So, as I said, what we did is, I worked with the team at MMCO. We designed a 16 question survey. It had some sub-questions to it. And we interviewed and surveyed and got responses from 39 of the 39 MMPs, which we are grateful for their response. And we have tallied that information. We're working on collating that information and putting that back out through a brief, through the resources for integrated care, which we're in the final stages of that draft. But I'm going to share some highlights with you here of what we learned from that survey, and highlighting California particularly is because it was one of those early adopters and leading states of some best practices. And the survey was really aimed at, what are your challenges? What are your barriers? What are your innovations? What are your best practices?

Dr. Kyle Allen:

And that's what we got. We got a lot of information back, a lot of solid, good information that, like I said, we are coalescing into a report. But in general, these are general comments from what we learned from surveying all the plans, is that it really caused many of the plans to reevaluate their approaches to screening, targeting, and particularly predictive analytics in their care management operations. Many replied, and it seemed like their care management and health risk assessment approaches were not quite adequate enough and particularly not enough in real time, that during an emergency like this or a disaster, that they could pivot fast enough to be able to do it. They did heroic jobs and they moved

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very fast on pulling together the work groups and the work teams. And one of my roles prior to the fellowship is I was a CMO for a health plan that also was in part of the demonstration.

Dr. Kyle Allen:

And that's what I found is I had to work on creating work groups to be able to address this need very, very quickly. And we had to put it together and we had to do broad, cross-enterprise teams, and then we also work with our states. In general, the MMPs were challenged to begin to see the need for a homebound registry and are in the process to develop. So, they pivoted to that and many started working on that. They started working on analytics. And California as a state and the MMPs operating in California already had built into an operating registry to readily identify members and roles in a disaster, and I'll highlight some of that in the end. Many MMPs stated that the challenge, as I mentioned before, was this homebound definition required standardization. But those that had organized and had collaborative partnerships with the state or community-based organizations, that's one of the things they worked on, was to come up with a more standardization of who's homebound, who's eligible, who would meet that criteria, who do we need to focus on?

Dr. Kyle Allen:

And so that was the lemonade out of the pandemic, is people working to have a better idea of how to identify this homebound subpopulation. And many, but not all, of the plans began to modify their analytics, work with predictive analytics, started to bring in some other code sets and prior authorization. I'll share some of that with you at the end. Next slide. Data integration was a universal challenge of trying to be able to find who's been vaccinated, who hasn't been vaccinated and how to coordinate that between Medicare and Medicaid, the public health organizations and the community-based organizations, to be able to have an adequate accounting and not doing re-work and inefficient work was very difficult for folks. And it caused a lot of undue burden. There was high variability across the states and the MMPs, but not having in place a pre-COVID strong community partnerships with community organizations, such as the Area Agency on Aging or public health.

Dr. Kyle Allen:

That seemed to be one of the strong things that came out, is that those who had done investment in that ahead of time, or were already on that track... And that's a place where California had more evidence of that than some of the other states. Some states do have this and it was reported how valuable it was by the health plans, about being able to find trusted resources in the community that could help reach their members for vaccination. Vaccine access, once it was approved, availability was a challenge because most of the vaccine distribution went to the health systems and they had trouble accessing a vaccine for their membership. There were variabilities in vendors for home vaccination and challenges with getting people certified, if you will, for homebound vaccination. And prolonged timelines by the states for getting the health plan certified, as I mentioned, for homebound certification, like nurse practitioners, was a common challenge. Next slide.

Dr. Kyle Allen:

And some of the key innovations we learned in best practices was regarding this collaboration between the plans, managed care organizations, MLTSS, Area Agencies on Aging, public health, and the state. Those are things that came out pretty strong across all the various states and places where the demo was taking place. And they just leveraged off of the prior investment in those strategies, and people found it invaluable. And as I mentioned, they're considered more trusted. It was a better way to try to address

vaccine hesitancy. And there was other strategies that many of the plans used, including using their chief medical officer to hold Zoom meetings and town hall meetings, which allowed open dialogue and discussion to address a lot of the various opinions and news and different positions to address questions about vaccine and who should get it and what are the risks, et cetera. Next slide, please.

Dr. Kyle Allen:

One of the plans worked on developing a new CPT code. They went through the process and they authorized a new CPT code for prevention and counseling, moving back towards getting the members back to their primary care physicians and trusted physician discussions. New data systems and dashboards were developed that we learned from the different plans. Many started to digest, if you will, or include social vulnerability indexes. They started to add, from what was reported, that they were making COVID-19 dashboards, but also being able to stratify by age, gender, language, race, and the social vulnerability index scores.

Dr. Kyle Allen:

Some plans used IVR technology. So, they used the wait time, if people called in, to be able to use the CDC guidelines. And that was pretty universal, that most people followed CDC guidelines and recommendations for how they trained their member-facing staff and across the organization and out into the community. And there were specific person-centered approaches for some of the plans that were involved in subpopulations like the IDD populations. And some of the best practices that we heard about was the use of the EMTs and ambulance services to do homebound vaccinations, both from a logistics perspective, also a trust perspective, that there seemed to be a better trust if they could have an ambulance service delivering that vaccine at home. Next slide. So, just real briefly, and I want to thank LA Care for giving us permission to use their slides, it was much easier to use their slides than to me recreate them. Next slide, please.

Dr. Kyle Allen:

So, these were some of the things that they focused on. They brought those partners together around the table. They met weekly and started soon after the vaccine guidelines came out and they started to share efforts with the health plans including DHCS, a medical directors meeting that they would attend. And the department worked with community-based organizations and the Department of Aging. So, they collaboratively brought everybody to the table. Next slide. And they started to modify some of their analytics and identification, particularly focusing on not being redundant or removing, if you will, people who would be homebound could have other venues for homebound vaccination, like dialysis folks. So, they started to look at their data about, "Well, who do we really need to meet? How do we need to get to them?" and that type of thing. And then they started looking at their codes and logic and how to be able to better use analytics to identify who likely is on that registry that needs to be focused on homebound vaccination. Next slide.

Dr. Kyle Allen:

These were just some of the screening, targeting and care coordination. Some of the challenges that they had with transportation and pharmacies and had to work on care coordination. And next slide, please. And some of the successes was this leadership and passion that they said that was very helpful. Collaboration, helping to find clear roles and responsibilities, who's going to be the involved home health vendor or EMT vendor. Strong analytics and agreement on criteria, agreed upon work plan and meet regularly. Some of the challenges, as I mentioned before, was outreach challenges to contacting

members, unable to reach. The vaccine hesitancy was a major problem. That was universal across many of the plans, the 39-some plans that we interviewed. And some of the new processes for homebound member referrals, because there was things constantly changing in the state that they had to keep up with, particularly using MyTurn in public health, to be able to also use those resources to reach homebound members. Next slide.

Dr. Kyle Allen:

So, SCAN was also a highlighted plan. They early went very early at trying to focus on identifying the homebound. They achieved some remarkable successes of closing disparities, as you can read there. And they wanted to get to a goal of the 70% vaccination rate, which I think they achieved. And they had high satisfaction. And SCAN was one of the folks that used an EMT to be able to reach their members, and they also were focused on getting the caregivers vaccinated. Next slide. This is a list of some of the other California specific plans, a task force in San Diego. Again, you can see the theme of community organization and coordination, communication, working together to try to address those in the community that had needs and where the community resources are. Cal MediConnect, multi-pronged communications. They did a great job between their call center, all their community reach, their members. And Molina did a lot as far as...

Dr. Kyle Allen:

And Molina, of course, is in multiple states. But they were using a nurse practitioner program, but where they had the barrier with that was just trying to get the nurse practitioner certified and also the logistics and access of vaccine for homebound distribution. Next slide. So, I gave you some other slides. That was a lot of information in a very short period of time and I'm going to stop there. And I built the slides. You can read them at your leisure and also the supplemental information as well.

Mary Russell:

Thank you so much, Dr. Allen. That was really interesting, and thank you for sharing those lessons learned and best practices. There was one quick question in the chat for you on one of your previous slides. Did you mean registries or more precise stratification triage process?

Dr. Kyle Allen:

The way the question was posed in the questionnaire was we asked if people had registries. And people had registries, but they weren't quite defined as where you could hit a button in real time and say, "Where are my vulnerable members?" It was like, "Well, we get that information back through health risk assessment care coordination." But nobody was specifically keeping a registry where they could actually dial up a report. But what we saw through the interviews and through the questionnaire is folks were starting to move towards that. And again, I would reach out and talk about San Mateo health plan is that they had already worked on that, and that's what LA Care absorbed up into their work group. Because San Mateo had operationally already defined that, created a registry, how to find folks and how to put that together from an operations perspective.

Mary Russell:

Great. Thank you for sharing a bit more about that. We'll move now into our Q&A session, and it looks like we have one hand up from Greg Thompson. If we can unmute Greg. Or maybe not. Okay. And feel free to drop any other questions in the chat or raise a hand and we will unmute you.

## DHCS Quarterly Stakeholder Webinar – September 30, 2021

Mary Russell:

All right. It looks like we may not have any additional questions. So, thank you everyone. I do just want to remind everyone that for more information on the CCI, including enrollment, quality data and toolkits, you can always visit [calduals.org](http://calduals.org). You're always welcome to send any questions or comments to [info@calduals.org](mailto:info@calduals.org) and we will do our best to work with DHCS to get you an appropriate response. The next MLTSS and Duals Integration Stakeholder Workgroup meeting will be on Wednesday, October 13th at 11:00 AM, and that is open to the public. And then the next CCI Stakeholder Update Webinar will be in December on the ninth at 11:00 AM. And I just want to thank everyone for joining. Appreciate all of our speakers and presenters and hope y'all have a great rest of your day. Take care.