CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

April 19, 2023

How to Add Your Organization to Your Zoom Name

- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window and click “More.”
- Select “Rename” from the drop-down menu.
- Enter your name and add your organization as you would like it to appear.
  - For example: Mary Russell – Aurrera Health Group

Agenda

- Welcome and Introductions
- Update: Continuous Coverage Unwinding and Stakeholder Q&A
- Update: 2024 Medicare Medi-Cal Plan Expansion Counties and Stakeholder Q&A
- Medi-Cal Managed Care for Dual Eligibles: Crossover Claims & Balance Billing
- Stakeholder Feedback on the 2024 State Medicaid Agency Contract (SMAC) Templates and Stakeholder Q&A
- Palliative Care Overview and Stakeholder Q&A
- Overview: Enhanced Care Management (ECM) and Community Supports
- California Collaborative for Long-Term Services and Supports (CCLTSS) CalAIM Listening Session #1 Report Out

Workgroup Purpose and Structure

- Serve as stakeholder collaboration hub for CalAIM MLTSS, and integrated care for dual eligible beneficiaries. Provide an opportunity for stakeholders to give feedback and share information about policy, operations, and strategy for upcoming changes for Medicare and Medi-Cal.
- Open to the public. Charter posted on the Department of Health Care Services (DHCS) website.
- ***We value our partnership with plans, providers, advocates, beneficiaries, caregivers, and the Centers for Medicare & Medicaid Services (CMS) in developing and implementing this work.***

CalAIM MLTSS & Duals Workgroup: 2023 Topics

- Discuss implementation, data, results, opportunities and challenges of CalAIM initiatives for MLTSS, for all Medi-Cal members
- Discuss implementation, data, results, opportunities and challenges of CalAIM initiatives for integrated care for dual eligible beneficiaries (both Medicare Advantage and Original Medicare)
- Flag related DHCS efforts for Medi-Cal members who are older adults or people with disabilities

DHCS Medi-Cal Continuous Coverage Unwinding

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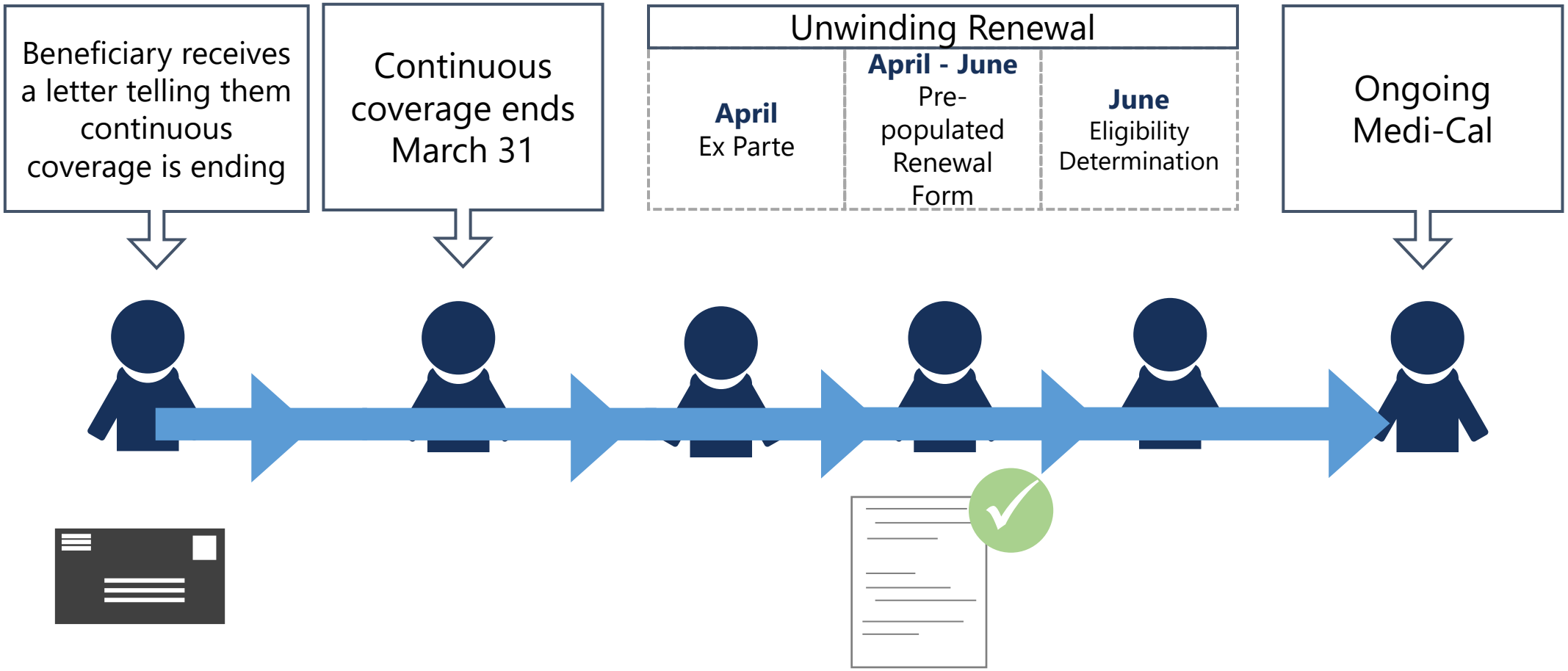
DHCS Medi-Cal COVID-19 PHE and Continuous Coverage Operational Unwinding Plan

- The Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan was originally released in May 2022 and last updated January 13, 2023 to incorporate policy changes as a result of the federal Consolidated Appropriations Act of 2023 and corresponding guidance released from CMS.
- **The plan includes two main components:**
  - **Part 1: Unwinding Medi-Cal Program Flexibilities**
    - Details PHE-related non-eligibility flexibilities obtained during the PHE that DHCS has already made permanent, seeks to make permanent, or will expire at the end of the PHE.
  - **Part 2: Resumption of Normal Medi-Cal Redetermination Operations**
    - Overviews the DHCS guiding principles and implementation approach for redeterminations, retention strategies, federal eligibility flexibilities, outreach, county/system readiness, and data reporting.

Beneficiary Journey

Continuous Coverage Unwinding Period Renewal



DHCS Outreach Campaign Goals & Objectives

Goals

- Drive Medi-Cal renewals once the continuous coverage requirement expires
- Drive Medi-Cal enrollment for newly eligible individuals

Objectives

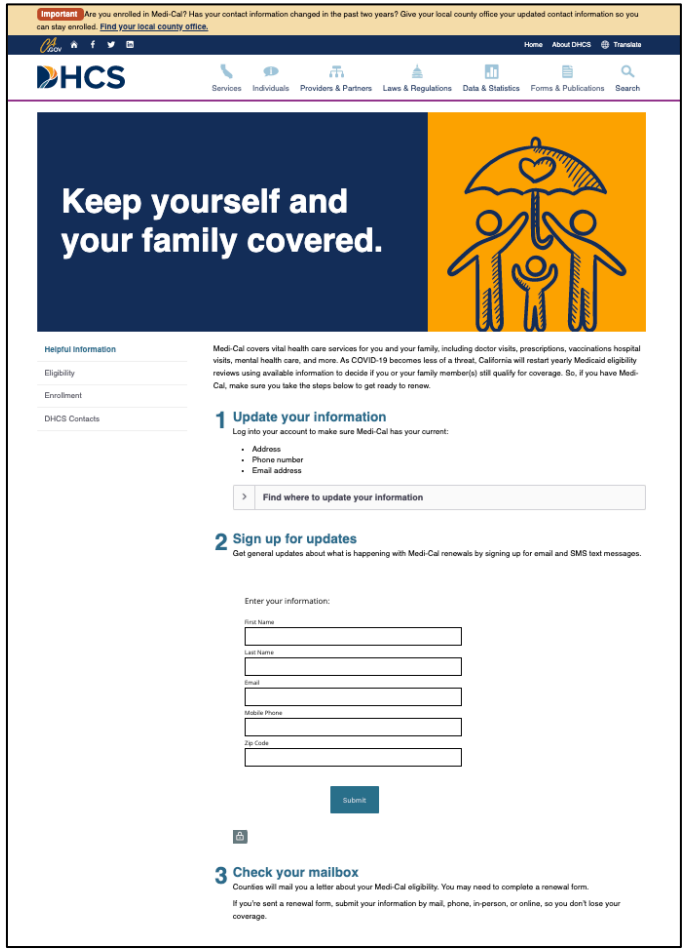
- Raise awareness about the need to renew Medi-Cal coverage and encourage enrollees to take the steps needed to do so
- Raise awareness about new Medi-Cal eligibility
- Engage the partner network to increase outreach and amplify messaging

Strategic Imperatives

- Deploy a data-driven integrated communications campaign to raise awareness and drive action among enrollees
- Equip partners with information and resources that leverage research-based messages
- Enlist trusted messengers to convey information authentically and credibly
- Recognize the diversity of the population and reach them in culturally and linguistically appropriate ways

Landing Pages

- Drive communications to landing pages
  - KeepMediCalCoverage.org and MantengaSuMediCal.org



How You Can Help

Partner Resources

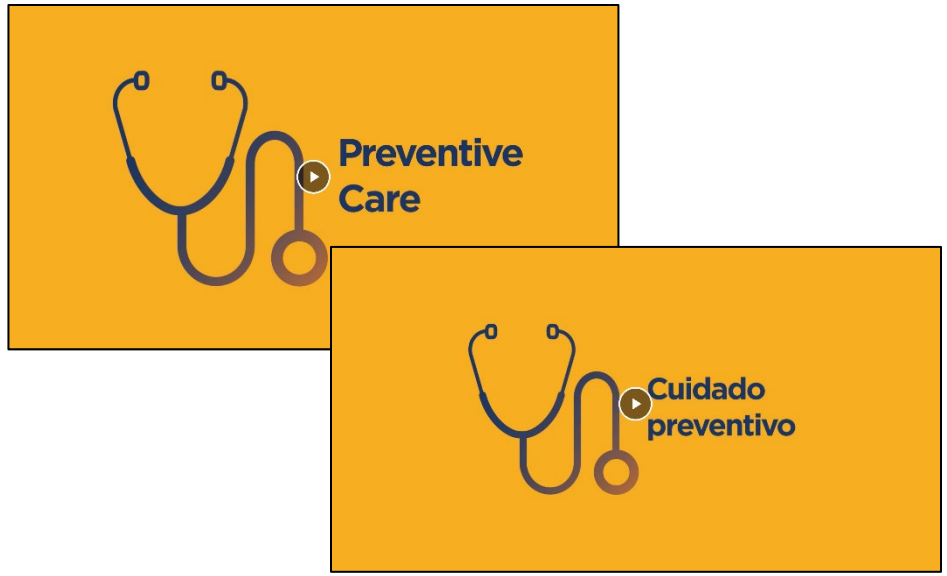
- **Available in 19 threshold languages**
  - English, Spanish, Arabic, Armenian, Cambodian, Mandarin, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese
  - www.dhcs.ca.gov/toolkits/Pages/Medi-Cal-Continuous-Coverage-Unwinding.aspx

Outreach Materials

- Script for call center staff
- Emails and Text messages
- Flyer/Insert snippets
- Interactive voice response--scripted messages
- Messaging and FAQs
- Social media posts
- Website text
- Coming Soon:
    - New tailored resources for groups including: In-Home Supportive Services recipients, tribal communities, providers, schools, senior centers

Videos

- "Take Care" and "Keep Covered" :30s, :15s, :06s videos
  - Available online in English and Spanish
  - Additional 17 threshold languages coming soon
- How-To informational video
  - Step-by-step explanation of the renewal process

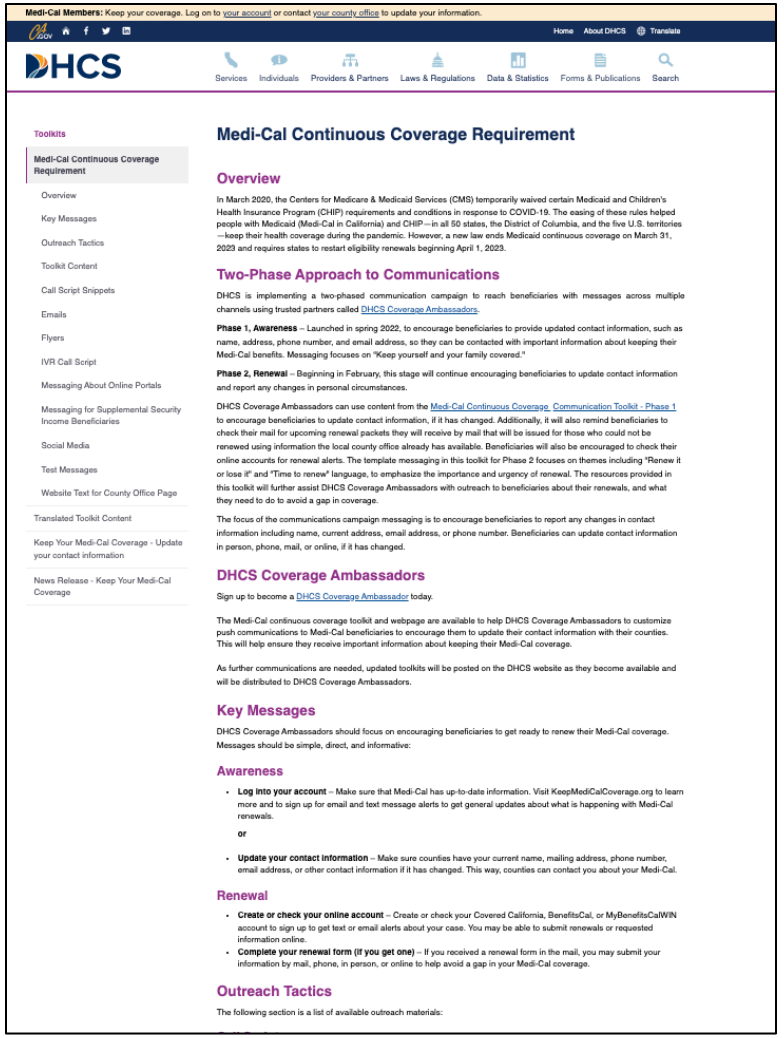


Downloadable Assets

- English and Spanish print materials have been shipped to all 58 counties and 200 ambassadors who completed a survey in February
- If you have not yet ordered print materials, fill out this survey: https://www.surveymonkey.com/r/BRTMBNQ

Become a Coverage Ambassador

- Check the stakeholder resource page for up-to-date content and resources
- Become a DHCS Coverage Ambassador (in English and Spanish)
  - Currently, we have 1700+ DHCS Coverage Ambassadors signed up to help DHCS spread the word on the Continuous Coverage Unwinding Efforts
  - DHCS developed FAQs for our Coverage Ambassadors to assist with outreach efforts
  - Sign up here



Medi-Cal Members: Keep your coverage. Log on to your account or contact your county office to update your information.

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DHCS

Services Individuals Providers & Partners Laws & Regulations Data & Statistics Forms & Publications Search

Toolkits

Medi-Cal Continuous Coverage Requirement

Overview
Key Messages
Outreach Tactics
Toolkit Content
Call Script Snippets
Emails
Flyers
IVR Call Script
Messaging About Online Portals
Messaging for Supplemental Security Income Beneficiaries
Social Media
Test Messages
Website Text for County Office Page

Translated Toolkit Content

Keep Your Medi-Cal Coverage - Update your contact information

News Release - Keep Your Medi-Cal Coverage

Medi-Cal Continuous Coverage Requirement

Overview

In March 2020, the Centers for Medicare & Medicaid Services (CMS) temporarily waived certain Medicaid and Children's Health Insurance Program (CHIP) requirements and conditions in response to COVID-19. The easing of these rules helped people with Medicaid (Medi-Cal in California) and CHIP—in all 50 states, the District of Columbia, and the five U.S. territories—keep their health coverage during the pandemic. However, a new law ends Medicaid continuous coverage on March 31, 2023 and requires states to restart eligibility renewals beginning April 1, 2023.

Two-Phase Approach to Communications

DHCS is implementing a two-phased communication campaign to reach beneficiaries with messages across multiple channels using trusted partners called DHCS Coverage Ambassadors.

Phase 1, Awareness – Launched in spring 2022, to encourage beneficiaries to provide updated contact information, such as name, address, phone number, and email address, so they can be contacted with important information about keeping their Medi-Cal benefits. Messaging focuses on "Keep yourself and your family covered."

Phase 2, Renewal – Beginning in February, this stage will continue encouraging beneficiaries to update contact information and report any changes in personal circumstances.

DHCS Coverage Ambassadors can use content from the Medi-Cal Continuous Coverage Communication Toolkit - Phase 1 to encourage beneficiaries to update contact information, if it has changed. Additionally, it will also remind beneficiaries to check their mail for upcoming renewal packets they will receive by mail that will be issued for those who could not be renewed using information the local county office already has available. Beneficiaries will also be encouraged to check their online accounts for renewal alerts. The template messaging in this toolkit for Phase 2 focuses on themes including "Renew it or lose it" and "Time to renew" language, to emphasize the importance and urgency of renewal. The resources provided in this toolkit will further assist DHCS Coverage Ambassadors with outreach to beneficiaries about their renewals, and what they need to do to avoid a gap in coverage.

The focus of the communications campaign messaging is to encourage beneficiaries to report any changes in contact information including name, current address, email address, or phone number. Beneficiaries can update contact information in person, phone, mail, or online, if it has changed.

DHCS Coverage Ambassadors

Sign up to become a DHCS Coverage Ambassador today.

The Medi-Cal continuous coverage toolkit and webpage are available to help DHCS Coverage Ambassadors to customize push communications to Medi-Cal beneficiaries to encourage them to update their contact information with their counties. This will help ensure they receive important information about keeping their Medi-Cal coverage.

As further communications are needed, updated toolkits will be posted on the DHCS website as they become available and will be distributed to DHCS Coverage Ambassadors.

Key Messages

DHCS Coverage Ambassadors should focus on encouraging beneficiaries to get ready to renew their Medi-Cal coverage. Messages should be simple, direct, and informative:

Awareness

- **Log into your account** – Make sure that Medi-Cal has up-to-date information. Visit KeepMediCalCoverage.org to learn more and to sign up for email and text message alerts to get general updates about what is happening with Medi-Cal renewals.

  or

- **Update your contact information** – Make sure counties have your current name, mailing address, phone number, email address, or other contact information if it has changed. This way, counties can contact you about your Medi-Cal.

Renewal

- **Create or check your online account** – Create or check your Covered California, BenefitsCal, or MyBenefitsCalWIN account to sign up to get text or email alerts about your case. You may be able to submit renewals or requested information online.
- **Complete your renewal form (if you get one)** – If you received a renewal form in the mail, you may submit your information by mail, phone, in person, or online to help avoid a gap in your Medi-Cal coverage.

Outreach Tactics

The following section is a list of available outreach materials:

Questions?

Update: Medicare Medi-Cal Plans and 2024 Expansion Counties

DHCS

Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans)

- Californians enrolled in both Medicare and Medi-Cal, known as dual eligible members, often have high rates of chronic conditions and functional impairments, and are three times more likely than Medicare only members to report being in poor health (13% vs. 4%).
- Medi-Medi plans offer an integrated approach to care and care coordination that is like Cal MediConnect.
- Medi-Medi plans deliver all covered benefits to their members, including medical and home- and community-based services, as well as medical supplies and medications.

Medi-Medi Plan Opportunities and Benefits

- Similar to Cal MediConnect (CMC) approach
- Financial Incentives
  - One entity financially responsible for both Medicare and Medi-Cal benefits
  - Incentivizes Community Supports for dually eligible beneficiaries
- Integrated Member Materials permitted by CMS
- Benefit Coordination permitted by CMS
  - Unified plan benefit package integrating covered Medi-Cal and Medicare benefits
  - Coordinated benefit administration
  - Unified process/policy for authorizing Durable Medical Equipment (DME)
  - Enable plan-level integrated appeals
- Integrated Beneficiary and Provider Communications permitted by CMS
- Simplified Care Coordination

Medi-Medi Plans in 2023 and Beyond

- On January 1, 2023, Medi-Cal plans in the seven CCI counties were required to establish Medi-Medi plans, and duals may choose to enroll in those plans, among other options: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties.
- Cal MediConnect beneficiaries were automatically transitioned to Medi-Medi Plans (D-SNPs) and matching Medi-Cal MCPs on January 1, 2023. The Cal MediConnect demonstration ended on December 31, 2022.
- Non-CCI counties will have Medi-Medi Plans (D-SNPs) and matching Medi-Cal MCPs available **no later than 2026.**

2024 Medi-Medi Plan Expansion Counties

- Starting January 1, 2024, Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans) will be newly available for voluntary enrollment by dual eligible beneficiaries in the following five counties:
  - Fresno, Kings, Madera, Sacramento, and Tulare
- All plans in the expansion counties have experience as Medi-Medi Plans in other counties.
- Dual eligible beneficiaries can select Medi-Medi Plans starting in the fall, during Medicare Open Enrollment (October 15 – December 7, 2023). To enroll, beneficiaries can contact their Medi-Cal plan or 1-800-MEDICARE.
- Lessons learned/technical knowledge from the Cal MediConnect transition will be applied in the expansion counties.
  - Local outreach for providers and members is a priority for DHCS and the health plans.

Total Medicare Advantage (MA) Enrollment Among Dual Eligible Beneficiaries in California (January 2023)

- Medi-Medi Plans: 218,000 (228,000 as of April 2023)
- Other D-SNPs: 153,000
- Other SNPs: 31,000
- SCAN FIDE-SNP: 22,000
- PACE: 16,000
- "Regular" MA: 287,000

- **Total MA Enrollment Among Dual Eligibles: 727,000**
- **Total Medicare Fee-for-Service Dual Eligibles: Over 800,000**
- **Total Dual Eligibles: ~1.6 million**

Questions?

Medi-Cal Managed Care for Dual Eligibles: Crossover Claims & Balance Billing

CalAIM Statewide Medi-Cal Managed Care

- The Medi-Cal program provides benefits through both a fee-for-service (FFS) and managed care delivery system. Most Medi-Cal beneficiaries (including dual eligibles) are now enrolled in Medi-Cal managed care plans.
- **CalAIM:** In January/February 2023, dual eligible beneficiaries in 31 counties transitioned into Medi-Cal managed care enrollment.
- **Enrollment into a Medi-Cal managed care plan does NOT impact Medicare provider access, or choice of Original Medicare or Medicare Advantage.**
- **Medicare providers do NOT need to be in Medi-Cal plans to continue billing Medicare as usual.**
- **Medicare Providers do NOT need to be enrolled in Medi-Cal plans to submit claims for crossover billing to the Medi-Cal plans.**
- Outreach Materials and Notices are available on DHCS webpage.

Crossover Billing Process

- **Original (Fee-for-Service) Medicare:** Provider bills Medicare Administrative Contractor (Noridian). Medicare (Noridian) processes the primary claim for Medicare payment, and then forwards the claim to the Medi-Cal plan (or DHCS) for secondary Medi-Cal payment.
  - Noridian receives Medi-Cal managed care enrollment information from the Medicare Benefits Coordination and Recovery Center.

- **Medicare Advantage (MA):** Provider bills MA plan for primary Medicare payment.
  - If patient's MA plan is the same as patient's Medi-Cal plan, same organization should process secondary claim.
  - If patient's MA plan is different than patient's Medi-Cal plan:
    - MA plan may send secondary claim to Medi-Cal plan, if known, OR
    - Provider will need to bill secondary to Medi-Cal plan (or DHCS).

Crossover Billing Toolkit for Medicare Providers

- Medicare providers (physicians, clinics, hospitals) may have questions about how to adjust their billing for duals enrolled in Medi-Cal managed care.
- DHCS prepared a Crossover Billing Toolkit, posted online, and has been providing technical assistance to providers.
- https://www.dhcs.ca.gov/services/Documents/Crossover-Billing-Provider-Toolkit-Jan-2023-1-13-23.pdf
- **Medi-Cal plans can help members and provide technical assistance to Medicare providers to help with the transition to Medi-Cal managed care.**

Balance Billing

- Dual eligible beneficiaries should **never** receive a bill for their Medicare services. This is called improper billing (or balance billing) and is illegal under state and federal law.
- Balance billing is prohibited in both Medicare Advantage and Original Medicare.
- Beneficiaries do not pay for doctor visits and other medical care when they receive services from a provider in their MA provider network. They may still have a copay for prescription drugs.

Stakeholder Feedback on the 2024 D-SNP State Medicaid Agency Contract (SMAC) Templates

DHCS

Overview: State Medicaid Agency Contract (SMAC)

- Medi-Medi Plans are technically known as Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs).
- D-SNPs without an aligned Medi-Cal plan are Non-EAE D-SNPs.
- For Contract Year 2024, DHCS will use the SMAC to require that all EAE D-SNPs:
  - (a) establish Medicare Advantage (MA) contracts (H contracts) that only include one or more D-SNPs within the state; and
  - (b) integrate certain materials and notices for members.
- A separate Medicare H contract provides greater transparency for quality measures for D-SNPs.

Overview: 2024 EAE and Non-EAE SMAC Templates

- As a reminder, D-SNPs must have a State Medicaid Agency Contract (SMAC) with DHCS, to outline care coordination and other D-SNP responsibilities.
- DHCS has separate SMAC templates for EAE and non-EAE D-SNPs.
- Key changes for 2024 D-SNP requirements are for Enhanced Care Management, Palliative care, and Dementia care requirements in the D-SNP Models of Care.
- DHCS shared drafts of the 2024 EAE and Non-EAE SMAC templates with plans, advocates, and other stakeholders for written review in March. The Department is currently reviewing all comments and will revise and edit the templates based on this input.
- The draft 2024 SMAC templates reflect feedback from stakeholders and advocates on 2023 contracts and align with CalAIM integration goals for 2024.

Overview: Feedback on 2024 EAE and Non-EAE SMAC Templates

- Some comments requested additional clarity on proposed requirements, including care coordination, integrated materials, and consumer governance boards.
- Some comments flagged discrepancies between the 2024 SMAC template language and 2023 D-SNP Policy Guide chapters. **Please note:** Updated 2024 D-SNP Policy Guide chapters will be released to align with 2024 policy guidance.

Overview: 2024 CalAIM D-SNP Policy Guide

- The CalAIM D-SNP Policy Guide is intended to serve as a resource for all D-SNPs in California, by providing additional details to supplement the SMAC.
- The Policy Guide provisions that apply to all D-SNPs, and those that apply only to EAE D-SNPs, are indicated at the beginning of each section.
- The provisions of the Policy Guide will be part of the DHCS SMAC requirements for 2024. Updates will be published as guidance is added.

2024 SMAC and D-SNP Policy Guide

- Similar to 2023, the 2024 EAE and Non-EAE SMACs will refer to the 2024 CalAIM D-SNP Policy Guide.
- The 2024 Policy Guide contains multiple chapters with detailed operational requirements and instructions for D-SNPs. D-SNPs will be held to the requirements referenced within the Policy Guide.
  - Chapter 1, Care Coordination, was released in January 2023
  - Other chapters will be released on a rolling basis from Spring to late Summer 2023
  - The Policy Guide is available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx

Questions?

Palliative Care Overview

DHCS

Overview: Palliative Care

- Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve the quality of life for both the patient and the family.
- Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and any stage in a serious illness, and it can be provided along with curative treatment.

D-SNP Policy Guide Requirements for Palliative Care

- Patients experiencing all the following circumstances may meet the referral criteria for Palliative Care:
  - The patient is likely to or has started to use the hospital or emergency department (ED) to manage their late-stage disease.
  - The patient is in a late stage of illness and is not eligible for or declines hospice enrollment.
  - The patient's death within a year would not be unexpected based on clinical status.
  - The patient has received appropriate patient-desired medical therapy, or for whom treatment is no longer effective.

D-SNP Policy Guide Requirements for Palliative Care (cont.)

- The patient and, if applicable, the family/patient's designated support person agree to both of the following:
  1. Willing to attempt in-home, residential-based or outpatient disease management as recommended by the MCP Palliative Care team instead of first going to the ED.
  2. Willing to participate in Advance Care Planning discussions.
- A patient must also meet the general and disease-specific criteria of one of four conditions.
  - Please see the 2024 CalAIM D-SNP Policy Guide for additional information: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-(D-SNP)-Contract-and-Program-Guide.aspx

Palliative Care Communications and Outreach Materials

- DHCS is developing a palliative care fact sheet to answer common questions.
- Once final, the palliative care fact sheet can be found on the **DHCS Medi-Medi Plan Webpage** under **Additional Resources**: https://www.dhcs.ca.gov/services/Pages/Medi-Medi-Outreach.aspx

Questions?

DHCS

Overview:
Enhanced Care Management (ECM) and Community Supports

DHCS

Enhanced Care Management (ECM)

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home
- ECM is part of broader CalAIM Population Health Management system design through which Medi-Cal MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

For more details, see ECM Policy Guide (December 2022).

Seven ECM Core Services

Outreach and Engagement

Member and Family Supports

Comprehensive Assessment and Care Management Plan

Health Promotion

Enhanced Coordination of Care

Comprehensive Transitional Care

Coordination of and Referral to Community and Social Support Services

Adults Living in the Community Who Are At Risk for Long Term Care Institutionalization

Population of Focus Definition

Definition
(1) Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;[1] **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;[2] **AND** (2) are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),[3] **AND** (3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

For more details, see ECM Policy Guide (May 2022).

Nursing Facility Residents Transitioning to the Community

Population of Focus Definition

Definition
Nursing facility residents who are: » Interested in moving out of the institution; » Are likely candidates to do so successfully; and » Able to reside continuously in the community.

Notes on the definition:

- **Able to Reside Continuously in the Community**: Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community.
- **Exclusions**: Individuals residing in Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

For more details, see ECM Policy Guide (May 2022).

Community Supports (CS)

What are Community Supports?

Community Supports are services that Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

- Community Supports are designed as cost-effective alternatives to traditional medical services or settings and to address social drivers of health (factors in people's lives that influence their health)
- Different Medi-Cal MCPs offer different combinations of Community Supports
- Medi-Cal MCPs must follow the DHCS standard Community Supports service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate
- Community Supports are not restricted to ECM Populations of Focus and should be made available to all Members who meet the eligibility criteria for a specific Community Support

For more details, see Community Supports Policy Guide (December 2022).

Pre-Approved DHCS Community Supports

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

For more details, see Community Supports Policy Guide (December 2022).

Community Supports for Members in Long-Term Care Populations of Focus

The entire menu of Community Supports may be applicable to Members in the Long-Term Care Population of Focus, but each Member will have different needs and functional limitations.

Community Supports that may benefit members in the Long-Term Care Populations of Focus include, but are not limited to:

- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Environmental Accessibility Adaptations (Home Modifications)
- Respite Services
- Personal Care and Homemaker Services

For more details, see Community Supports Policy Guide (December 2022).

California Collaborative for Long-Term Services and Supports (CCLTSS) CalAIM Listening Session #1 Report Out

Mariya Kalina

DHCS

CalAIM LTSS Provider Listening Session Overview

» The California Collaborative for Long-Term Services and Supports (CCLTSS), in partnership with Insure the Uninsured Project (ITUP) and Chapman Consulting, is launching monthly deep listening sessions aimed at:

- Creating a unique space for LTSS providers to share challenges and successes in CalAIM implementation.
- Identifying systemic challenges, gaps, and barriers – as well as best practices in service delivery to older and disabled adults.
- Offering peer-to-peer connection and collaboration across the state.
- Developing and pursuing resolution strategies to address systemic challenges identified through the listening sessions.

Questions Asked During the Session

- CalAIM Transition Challenges and Successes
  - What have been the biggest challenges thus far?
  - What are some best practices your organization has identified/ what successes can you share?
  - Where do you see disparities in LTSS service delivery?

Theme 1: Need for Clear, Transparent, Communication

- As CalAIM implementation continues throughout the state, ensuring clear and open communication among managed care partners will be critical to the success of CalAIM initiatives for older adults and dual-eligible populations. Lack of communication, information, and notification of changes in guidance from DHCS across various health entities and stakeholders has resulted in disruption to the continuity of care, for example in transferring an individual from a hospital to a skilled-nursing facility or other residential care alternative.
- Challenges faced by key health stakeholders vary by provider type, further contributing to the lack of transparency in communication channels. As Medi-Cal managed care plans (MCPs) extend their reach into a more diverse set of community providers, it will be vital to establish clear conduits of communication from both the managed care partners to providers and from DHCS to stakeholders to ensure there is access to updated guidance and information and consistent messaging on what the expectations are for plans and providers.

Theme 2: Difficulty Navigating Care Coordination Because of Inaccessible Information

- Many hospitals and other ECM and Community Supports providers experience significant difficulties identifying which individuals are associated with which MCP, whether they are accessing ECM services, who the ECM provider is, and what other services they are connected to.
- The lack of a centralized database and source of information has resulted in immense challenges in navigating Medi-Cal members to the correct resources.
- Clarity on what the criteria is/are for access to certain services, what areas of the criteria are standardized, and what areas of criteria for access are at the discretion of the MCP would be helpful in easing this transition and coordination amongst various entities.

Theme 3: One Size Does Not Fit All – Lack of Support for Non-Health CBOs

- Many non-traditional health care providers and community-based organizations (CBOs) are facing herculean obstacles in being included and integrated into CalAIM as part of the health care delivery system. The contracts, questions, agreements currently being used are designed for the medical health care community, leaving social service and other non-traditional health care CBOs challenged with exhaustive administrative work.
- Without being fully integrated into the system, these CBOs are unable to access funds and are left with minimal support and resources. Many have voiced concerns about the need for relationship-building as they require investment and time to curate overtime.

Resources

- Below are resources shared and mentioned during the listening session:
  - Transformation and Innovation: Advancing Health for California's Older Adults
  - Healthy Aging in California – ITUP Policy Toolkit
  - Engaging with CalAIM: Quick Links for Community-Based Organizations
  - DHCS PATH Collaborative Planning and Implementation

Questions?

DHCS

Next Steps

- Next MLTSS & Duals Integration Stakeholder Workgroup meeting: **Thursday, June 22nd at 10 AM**