CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS

February 15, 2019

Mari Cantwell
State Medicaid Director
1501 Capitol Ave
Sacramento, CA 95814

RE: Cal MediConnect (CMC) Stakeholder Comments

Dear Director Cantwell:

The California Collaborative for Long Term Services and Supports (CCLTSS) is comprised of 37 statewide aging and disability organizations that promote dignity, health and independence in community living. Our members include advocates, providers, labor, and health insurers, and collectively we represent millions of California seniors and people with disabilities, their caregivers, and those who provide health, human services, and housing.

The following policy proposals and recommendations for program improvements are in response to the request from the Department of Health Care Services (the Department) for stakeholder input on the Cal MediConnect (CMC) program in anticipation of a 3-year financial alignment demonstration renewal. The CCLTSS has worked with the Department and other stakeholders over the past several years to provide input as CMC was developed. Now that we are several years into the demonstration, the program has evolved over time and we can reflect on what is working and what could be improved. The CCLTSS understands that the landscape of choices for members is changing, and that we are at a nexus in the program implementation, which makes this comment period a very important part of the stakeholder process.

Please describe your policy proposal for Cal MediConnect

LTSS Referrals and Utilization

The CCLTSS continues to have concerns over the lack of data available on how plans are identifying/assessing members and making sure they are getting the LTSS services they need. Improving referral rates to LTSS was one of the stated goals for creating a set of standardized Health Risk Assessment questions for use by all plans. We request that DHCS include additional information on LTSS assessments and referrals in its CMC dashboard. Using the data that the plans currently provide to the Department will allow stakeholders to work with the Department on specific policy recommendations and best practices that could be implemented to ensure members are being provided appropriate access and referrals to LTSS. We suggest that DHCS convene a workgroup that includes its staff, plans, and other key stakeholders to review the currently collected data and develop an action plan for how to analyze this data and use it to properly inform future program and policy design.

Cal MediConnect Eligibility and HCBS Waiver Enrollment

The CCLTSS supports a change in policy to allow members to be enrolled in both CMC and HCBS waivers simultaneously. This allows for the coordination and continuation of access to HCBS and LTSS services regardless of the funding stream, which is core to the goals of CMC. It is currently our understanding that members enrolled in certain waiver programs, such as the Assisted Living Waiver (ALW), NF/AH, and IHO waivers, are not permitted to remain enrolled in CMC, which prevents true integration of services for these beneficiaries.

Increased/Improved Integration of In-Home Supportive Services (IHSS)

For members receiving IHSS it is important that those benefits are coordinated with the rest of their care. Unfortunately, since the full carve-out of the IHSS benefit, there has been a notable reduction in the coordination and communication between many of the county IHSS programs and the CMC plans, including the elimination of the ability for the health plan to approve additional IHSS hours. This movement back to a more siloed system of care is counter to the goals of CCI and CMC.

The CCLTSS suggests that the Department examine the role of IHSS in the CCI and work with stakeholders to identify policies and explore potential pilots that could

better integrate care for IHSS recipients, who are often receiving other services such as CBAS or MSSP due to the complexity of their conditions and living situation. Independent Living Centers (ILCs) and other Community Based-Organizations are a great resource for helping provide IHSS coordination and integration, and this is a natural partnership that should be further developed.

Building Care Coordination Protocols

Care coordination is at the center of better integrated care and the goals of CMC. The CMC evaluation data indicates very low levels of reported care coordination and interactions with care managers, which highlights the need for standardized data that can be evaluated for program interventions. The CCLTSS suggests that the Department work with stakeholders to develop a structure within CMC that would better standardize person-centered care coordination protocols and training for consistency and to allow for better measurement and evaluation of its effectiveness in CMC.

The Department could consider creating system-wide evidence-based care coordination protocols and evaluate outcomes. Additionally, it is imperative that all care coordination activities are person centered and include self-direction. Standardized protocols and reporting can help verify that there is a care coordination process in place that includes member engagement. The Department could also incorporate the growing need for home modifications, Durable Medical Equipment (DME), and assistive technology into care coordination responsibilities, recognizing what a significant impact access to these services has on quality of life and the ability of members to receive LTSS. Protocols could be developed to provide clarity to service providers on how they can connect beneficiaries with needed equipment and services to help maintain their living arrangement and promote greater use of LTSS.

There are several other programs that have deep and long experience with care coordination for complex populations, including the Program of All-Inclusive Care for the Elderly (PACE), the Multipurpose Senior Services Program (MSSP) Waiver, Community Based Adult Services (CBAS), and the state's Health Homes Program (HHP). DHCS should leverage best practices and lessons learned that may apply to CMC.

Standardization of Quality Metrics

CMC should have standard quality metrics in order to assess quality over time and across plans. The CCLTSS is supportive of using the current quality withhold metrics as a starting point for what should be tracked and measured over time to monitor quality improvement. However, there may be additional metrics that should be included, and the CCLTSS would appreciate the opportunity to provide input as the Department considers how it can further standardize and report on quality metrics in the CMC. One area that is not currently measured as part of the core measure set for CMC relates to evaluating cognitive impairment, and we request that DHCS work with plans and other stakeholders to identify how it can measure this and any other areas identified by stakeholders that are not currently reflected in the data.

The current CMC Dashboard does not reflect current or comprehensive data about the program. The lag in the data is a problem. For example, the current quality withhold data is from 2015, which does not allow stakeholders or DHCS to verify if plan performance is improving or to proactively address any concerns. All CMC data should be publicly available and used to help stakeholders and DHCS drive policy changes in a timely manner. Furthermore, health is significantly impacted by Social Determinants of Health (SDOH) and the data is clear that tracking and measuring SDOH leads to better interventions and improved health outcomes. There are many ways to measure SDOH and create a continuous feedback loop that plans and providers can use to act, and DHCS must work with plans and other stakeholders to implement quality metrics that ensure SDOH are being addressed.

Increased Access to Language Interpretation Services

CMC evaluation data indicates that over half of CMC Limited English Proficient (LEP) enrollees have a hard time accessing language interpretation services. This is very concerning, and we would appreciate a discussion with the Department on how it intends to ensure that members enrolled in CMC have access to the language interpretation services required under both federal and state law.

Uniform Services Assessment

The Department has a responsibility to ensure that services are made available to members consistently across the CMC program. Having a uniform services assessment tool that would help plans and providers consistently apply eligibility for access to services would go a long way in helping achieve this goal. The tool should

not just be about standardizing if someone is eligible, but also connecting them to the necessary services once the need is verified, preferably with a "warm hand-off."

As a starting point, the tool should ensure the member's interests, goals, and needs are expressed and identified in the Individual Care Plan (ICP), and that the member can review and sign the ICP. The CCLTSS recommends that the Department use the extension period to place some renewed attention to requirements of ICP. One initial step that DHCS could take is to provide information on what is happening with the standard LTSS HRA questions that were implemented last year. All stakeholders, especially those that took time to work on the development of those questions, would benefit from learning how these questions have impacted referrals to and utilization of LTSS and what other ways DHCS is using the data. This data could be used to determine best practices that should be replicated and/or identify ways to further improve this process.

Updates to the Rate Structure

On November 17, 2017 the CCLTSS submitted a letter to the Department of Health Care Services (the Department) in support of rate proposals that we understand were under discussion with DHCS at the time. The CCLTSS supports the goal of restructuring the rates paid under the Coordinated Care Initiative (CCI) in ways that incentivize plans to develop programs for institutional delay and diversion, promotes independent community-based living, and moves long-term SNF patients to a lower level of care. The CCLTSS supports the use of In Lieu of Services or Care Plan Options in the rate development process in order to align the financial incentives and promote the use of Long-Term Services and Supports (LTSS) in the CCI. While we recognize this is not something that DHCS is considering as part of the formal stakeholder comments on CMC, CCLTSS urges the Department to continue to implement fiscally responsible and actuarially sound measures that will provide proper financial alignment and appropriate reimbursement for a broad array of cost-effective home and community-based services, which will help California achieve better care at lower costs and improve quality and access for dual eligible enrolled in CMC as well as those enrolled in plans only for their Medi-Cal LTSS benefits.

How will this proposal improve Cal MediConnect in a cost neutral way?

The proposals outlined in this comment letter are all intended to create accountability, increase person-centered care, further develop the ability to achieve care coordination across systems, improve LTSS integration, and increase quality. These goals are all designed to achieve the goals of the CCI and CMC, which include better care at lower costs. While there is some nominal cost and resources that will be necessary to develop and implement policy changes, the CCLTSS does not believe that these recommendations provide an ongoing increased cost to the state or federal government and in fact believe that over time it will result in a more efficient and effective program that results in cost savings. Following are several examples of programs using similar approaches, interventions, and data to drive better care at lower costs that support the assertion that over the long-term these proposed policy recommendations will result in cost savings to the system while improving care. We believe they are important examples for the Department to consider during this process.

- Centers for Health Care Strategies – Social Determinants of Health
- CDC – Health Related Quality of Life

In conclusion, we would like to thank you for the opportunity to share these program recommendations, and we look forward to working with DHCS, the health plans, and other stakeholders to drive positive program changes for dual eligibles in CMC.

Sincerely

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cc:
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