INTRODUCTIONS AND HOUSEKEEPING

Carol Mitchell,
Deputy Director, Adult Services
Social Services Agency, Orange County

IMPROVING MEDI-CAL OUTCOMES: COORDINATED CARE INITIATIVE AND IHSS

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Ellen Schmeding, Assistant Deputy Director Aging & Independence Services
Health & Human Services, San Diego County
Candice Gomez, Interim Executive Director, Seniors and Persons with Disabilities, CalOptima
Wendy Aquin, Division Director, Adult Services and Assistance Programs
Social Services Agency, Orange County

CalDuals

Background – Dual Eligibles

- Eligible for both full scope Medicare (A, B & D) and Medi-Cal
- 1.2 million duals in California
  - Elderly and poor
  - Many with chronic health conditions
  - 70-80% of IHSS recipients are dual eligibles
- 71% over 65
- Less than 20% in managed care

Difficulty in Serving Dual Eligibles

- Programs cover different services:
  - Medicare covers physician, hospital and limited skilled nursing, rehab.
  - Medi-Cal covers home health, personal care/IHSS, skilled nursing, other services not covered by Medicare.
- Different payment rules
- Uncoordinated care for the most vulnerable

Goals of the Project

- Coordinate state & federal benefits
- Maximize ability for individuals to remain at home and avoid institutional care and unnecessary hospital visits
- Increase access to home & community based care
- Preserve ability to self-direct care (IHSS)
- Optimize the use of Medicare, Medi-Cal and other State/County resources

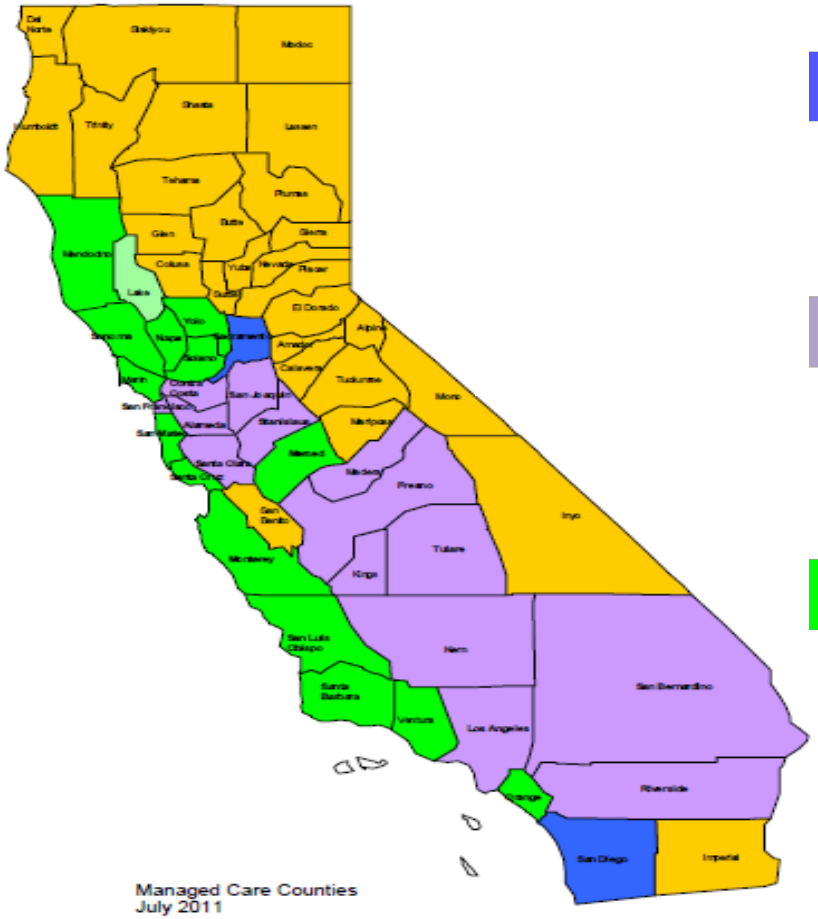
Original Enabling State Legislation

- SB 208 (2010) – Directs State Department of Health Care Services (DHCS) to seek federal waiver/demo approval for pilot projects
- Pilot projects in up to 4 counties

Integrated Services- Duals

- Medical Services
  - All Medicare and Medi-Cal services currently covered
- Long-term care services and supports (LTSS)
  - Institutional Long-Term Care (SNF)
  - Personal care services/IHSS
  - Community Based Adult Services (CBAS) (formerly ADHC)
  - Multi-purpose Senior Services Program (MSSP)

Medi-Cal Managed Care Models



Geographic Managed Care (GMC)

- State contracts with various commercial plans in county (2 Counties)

Two Plan:

- State contracts with one local public plan and one commercial plan (14 Counties)

County Organized Health System:

- State contracts with a local public plan (14 Counties plus one proposed County)

Of the 7.6 million Medi-Cal beneficiaries, 4.3 million are enrolled in a Medi-Cal Managed Care Plan

Federal – State MOU

- $1 million planning grant from the feds (CMS) to establish demonstration sites
- California one of 15 States moving towards integration

<u>Financing of demonstration:</u>

Capitated rate, three way contract

- Health plans, CMS and DHCS
- Blended capitated rate

Update on New Legislation – Coordinated Care Initiative

- Legislature/Governor completed 2 budget bills (AB 1496 & 1468)
- Dual eligible sites move from 4 to 8 (includes Alameda, LA, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara)
- Impacts 685,000 people
  - Begins March 2013 – June 2013
- Anticipated savings = $611.5 M FY 12-13, $881 M FY 13-14 (State funds)

Legislation Update

- Governor's plan to roll out managed care throughout California did not pass (only 8)
- Significant consumer protections added
- Poison pills:
  - Cost sharing arrangement not approved by feds
  - Feds do not approve six month Medicare lock-in
  - Not cost effective
  - Does not benefit consumers

Coordinated Care Initiative

- Two distinct parts to the legislation:
  - Duals Demonstration: Health plans administer a voluntary three year demonstration – medical, behavioral health, skilled nursing and home & community-based care (HCBC)
  - Managed Medi-Cal Long Term Care Services & Supports: All Medi-Cal recipients must join a health plan to receive Medi-Cal benefits and HCBC

Carve Outs in Both Programs

- Children
- Veterans Home residents
- PACE enrollees
- AIDS Healthcare Foundation enrollees
- Other health coverage

County – Public Authority Role

- Health plans to establish MOU for services including:
  - In-Home Supportive Services – client continues to hire, fire & supervise care provider
    - County social worker performs assessments
  - Public Authority provides registry, training, provider enrollment, payroll
  - Multipurpose Senior Services Program: Case Management services provided by County
    - January 2015, MSSP becomes managed care benefit

IHSS – Managed Care Benefit

- In order to receive IHSS in the future, recipients must be a part of managed care.
- Plans can request and pay for additional IHSS above what the county has authorized.
- Managed Care entity to contract with State for management of payroll, employer-related functions, quality assurance.

Universal Assessment Tool

- Need for assessment tool for home & community based services
- Stakeholder design process to begin June 2013
- Implementation no earlier than January 2015 in 2-4 counties
  - Will be used for day care, MSSP, IHSS
  - Will not be used in skilled nursing facilities
  - Will not replace plans' risk assessment

HCBC Plan Benefits

- The following benefits may be required – TBD by stakeholders and the Department of Health Care Services:
  - In-Home & out-of-home respite
  - Nutritional Assessment, counseling & supplements
  - Minor home repair
- Ability to offer value added services determined during rate-setting

Person Centered Care Coordination

- Health plans to identify individuals through risk assessment process
- Individual has primary decision-making role in identifying care needs, preferences and strengths
- Interdisciplinary teams, including the care recipient, to identify needs
- Plans to provide care management/care coordination to include Long Term Care Services & Supports
- Will include MSSP-like services

Communication with Consumers

- 90 days before enrollment, recipients to receive informing notice
- Enrollment materials to be shared 60 days prior to enrollment
- Reminder notice 30 days prior to start date
- Communications must be offered in a variety of languages and formats
- CBOs will need to assist with the educational process
- Federal funds may be available for enrollment assistance (HICAP)

Timeline

April 2012	DHCS announces sites – San Diego chosen
April 2012	DHCS releases Dual Eligible Demonstration Proposal/Coordinated Care Initiative
May 2012	DHCS submits proposal to feds (30-day public comment period begins)
October 2012	CMS (feds) approve proposal MOU between State/feds completed
October/November 2012	Health plans readiness reviews
December 2012	Contracts completed between plans, State & feds
June 2013	Coordinated Care Initiative begins in CA

Time of Significant Change

- Integrated care has been a focus for San Diego for 13 years
- California model preserves and integrates core safety net programs
- Partnerships between plans, health care providers and home and community based providers will be key to success
- For more information:
  - www.CalDuals.org

A Public Agency

CalOptima

Better. Together.

CWDA Conference

Candice Gomez

Interim Executive Director,
Seniors and Persons with Disabilities

CalOptima

Authority

- County Organized Health System for Orange County
- Public agency pursuant to federal, state and local action
- Governed by locally appointed Board of Directors

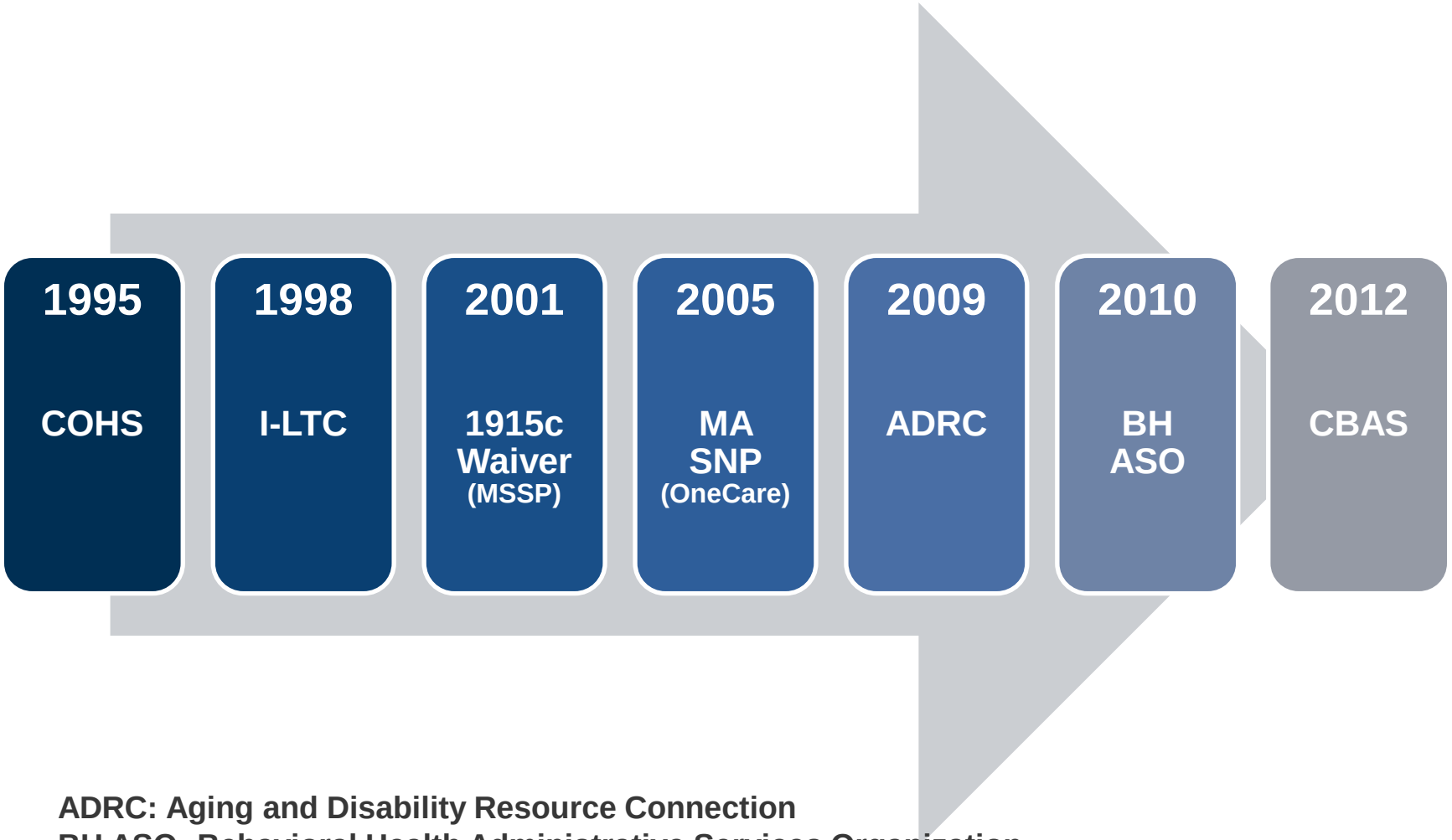
Model

- Exclusive Medicaid managed care plan for county
- Mandatory enrollment
- At risk for nearly all acute care services

Members

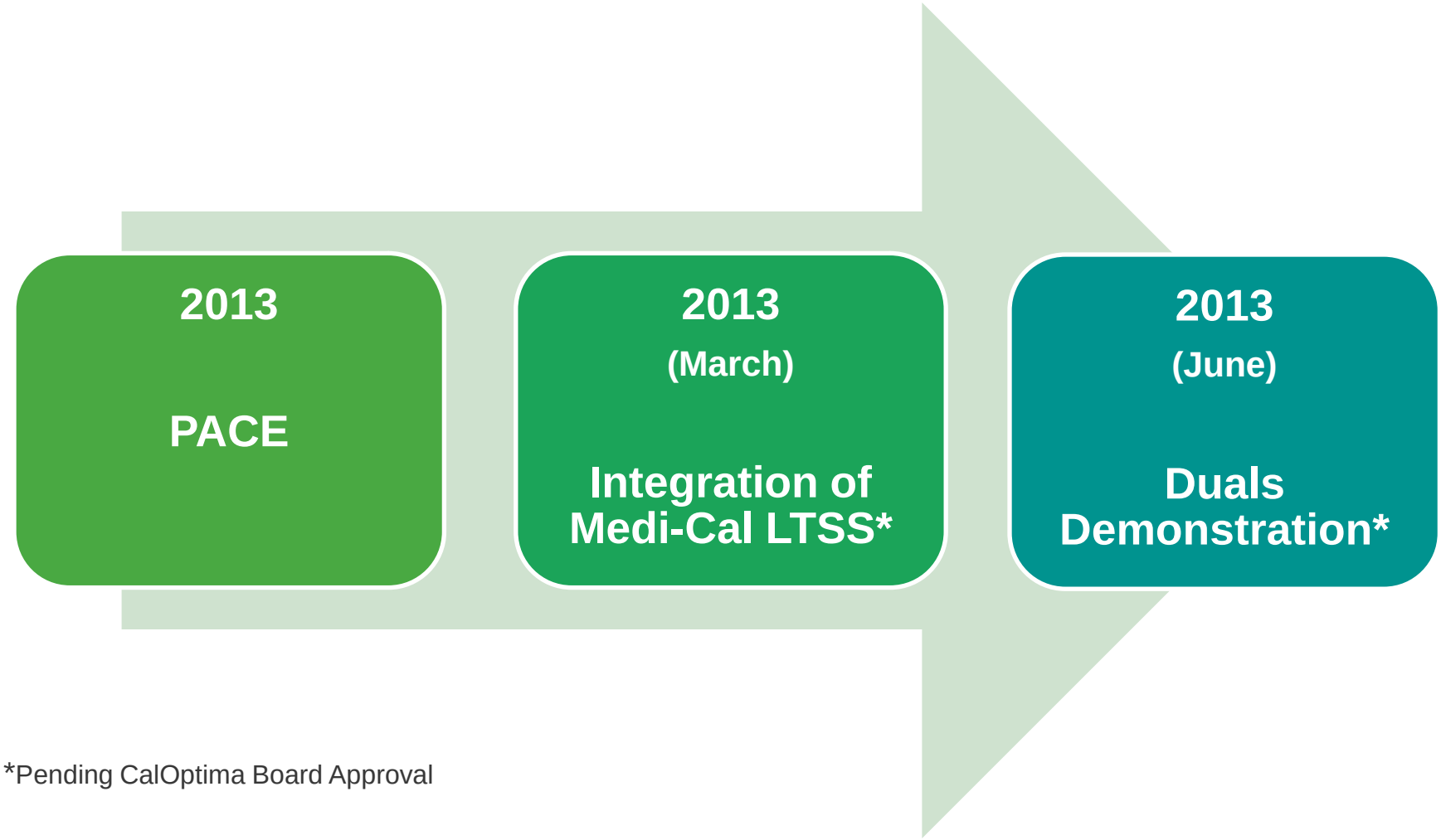
- More than 400,000 members
- Larger Medicaid enrollment than 18 state programs
- Larger SNP enrollment than 28 states

CalOptima's Integration Activities



ADRC: Aging and Disability Resource Connection
BH ASO: Behavioral Health Administrative Services Organization

Next Steps



*Pending CalOptima Board Approval

Coordinated Care Initiative (CCI)

Goal: Promote integrated delivery of medical, behavioral and long-term care Medi-Cal services and, for dual eligibles, Medicare services

- **Phase One:** Mandatory enrollment of all Medi-Cal beneficiaries into managed care for **all** Medi-Cal benefits, including long-term services and supports

- **Phase Two:** Optional enrollment into integrated managed care (Medi-Cal and Medicare) for dual eligible beneficiaries

Phase One: March 2013

- **All LTSS, including IHSS, will be provided through managed care (CalOptima in Orange County)**
- **No programmatic changes**
  - Same assessment process for hours and services
  - Consumer retains right to hire, fire and supervise workers
  - Maintain current grievance and appeals process
- **Key financing changes**
  - IHSS costs will be incorporated into managed care plans' capitation rates
  - In lieu of paying non-federal share of IHSS costs, counties will have an IHSS Maintenance of Effort (MOE)

Health Plan Requirements: Overview

- Ensure access to, provision of and payment for IHSS
- Create a care coordination team and maintain current role of IHSS providers
- Assume financial liability for payment of IHSS services
- Contract with existing agencies (DSS and county agencies) to continue administering and providing IHSS

Service Delivery Model

- **Per MOU with health plan, county agency (SSA) will:**
  - Assess, approve and authorize hours for recipients
  - Enroll providers, conduct orientation, etc.
  - Conduct criminal background checks and screen providers
  - Assist IHSS recipients in finding eligible providers
  - Perform quality assurance activities
  - Continue to perform other necessary functions
- **Per an MOU with the health plans, DSS will:**
  - Retain all program administration functions (e.g., pay wages to IHSS providers)
  - Perform obligations on behalf of the IHSS recipient as provider's employer (e.g., unemployment compensation)
  - Share recipient and provider data with plans to support care coordination
  - Retain responsibilities related to the hearing process for appeals

Readiness Assessment Requirements

- **Organization and administration of plan**
  - MOUs with relevant agencies to continue providing services
  - Necessary agreements to assume financial liability
- **Management Information Systems**
  - Data sharing agreements and ability to transmit data
- **Quality Improvement System**
  - Policies and procedures defining how plan will adhere to quality assurance provisions and other standards
- **Provider Network**
  - Policies to ensure access to and quality of providers
  - Policies permitting participation of IHSS providers on care coordination team

Note: Full list of requirements available at www.calduals.org

Readiness Assessment Requirements

- **Access and Availability**
  - Evidence of policies for access and referrals
- **Care Management and Coordination of Care***
  - Framework for structure, composition and role of care coordination teams (subject to consumer consent)
  - Policies for communication with county agency
  - Criteria for authorization of additional, optional service hours
- **DSS/County Agencies/Public Authority Coordination**
  - Policies for referrals and program administration
  - Evidence of temporary MOU with local PA
- **Member Services**
  - Policies in place to ensure beneficiaries are informed

State has indicated that it will release additional requirement related to care coordination

Preparations to Date

- Responded to state's Request for Solutions in February
- Selected for the demonstration in April
- Granted authority in May by the Board of Directors to begin preparing for demo
- Launched a series of collaborative meetings with provider and member stakeholder groups in June
- Preparing for readiness reviews by federal and state regulators
- Details are still in development and subject to approval

Recent Experience

- **On July 1, 2012, CalOptima began providing CBAS to eligible beneficiaries**

- **Lessons Learned:**
  - Importance of open communication with providers; sharing what we do know and being transparent about what we don't
  - Proactive approach to addressing concerns, e.g., site visits, responding quickly and thoroughly
  - Defined policies and procedures
  - Provider training before program changes — and after!
  - Evaluation of process after implementation

IMPACT ON IHSS PROGRAM

What changes:

- IHSS will participate on care teams
- IHSS may administer additional personal care services authorized or developed by managed care plans

What doesn't change:

- County IHSS social workers will continue to be responsible for eligibility and assessments
- Existing program rules do not change
- County/PA responsibility for provider enrollment remains the same
- Provider payments continue through CMIPS/CMIPSII

IMPACT ON OTHER LTSS

Multi-Purpose Senior Services (MSSP)

- Plans will contract with counties/providers
- Same amount of funding initially available
- Plans may wish to purchase additional MSSP-like services from providers
  - Unknown how this will work
- January 2015 – MSSP becomes managed care benefit
- Unknown whether plans will wish to continue contracting with current MSSP providers

Community Based Adult Services (CBAS)

- Health plans now operate this program
- ~80% of those formerly part of Adult Day Health Care were found eligible for CBAS
- Clients were told not to apply by health care providers
- State educating providers in effort to help all those eligible receive CBAS services
- Disability Rights has filed another lawsuit trying to stop October 1 enrollment

Area Agencies on Aging/ADRCs

- Role for Area Agencies on Aging unclear (now administer Older Americans Act programs: meals, Family Caregiver, information & assistance, case management, health promotion, etc.).
- Plans may wish to contract with AAAs or other CBOs for additional, non-mandated home & community based care services.
- CBO's need to develop business-case strategy to document cost avoidance for plans

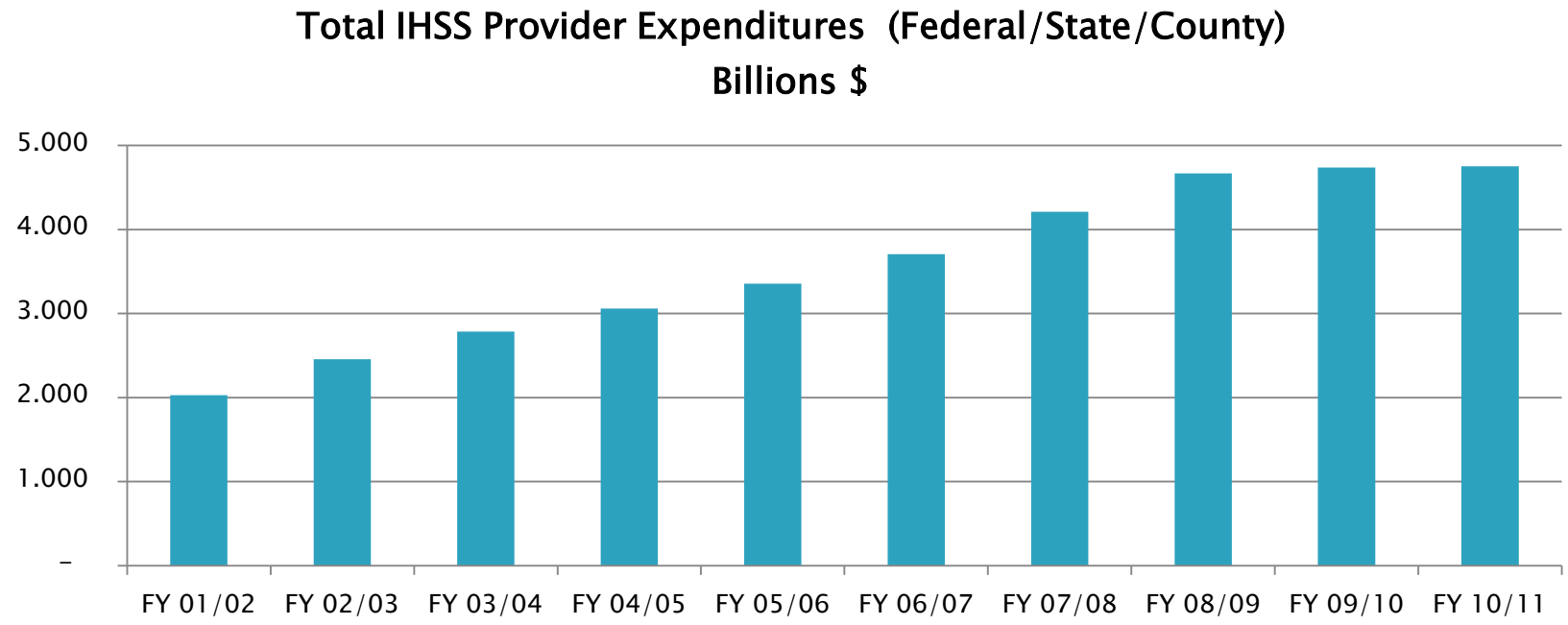
FINANCIAL IMPACT–IHSS

Cost Distribution:

- Current funding: 50% Federal, 32.5% State, 17.5% County
- CFCO funding: 56% Federal, 28.6% State, 15.4% County

FINANCIAL IMPACT–IHSS

History of IHSS Growth



FINANCIAL IMPACT–IHSS

State Authority:

- Negotiation for wages/benefits to be centralized
- Effective date: No sooner than March 1, 2013,
  Upon notification by the Director of Health Care Services that the enrollment of eligible Medi-Cal beneficiaries in the dual demo pilot have been completed in that county or city and county.
- Existing contracts will continue until expiration date

FINANCIAL IMPACT–IHSS

Maintenance of Effort

Base Year:	FY 11/12 To be adjusted for CFCO savings
FY 12/13	Equal to FY 11/12
FY 13/14	3.5% per year growth in MOE Exception: If Statewide growth 0% or less

DISCUSSION OF COUNTY IMPLEMENTATION PLANS

San Diego Implementation Efforts

- Now meeting with health plans to develop MOUs for IHSS & Public Authority
- Formed Health Plan Advisory Committee with 50+ members
- Participating on State workgroup
- Advocating for county interests with CSAC & CWDA
- Participating in Maintenance of Effort discussions
- Learning about managed care operations

Orange County Implementation Efforts

Managed Care for Medi-Cal has been the standard in Orange County since 1993

- Managed Care, IHSS, & PA meeting to develop MOU's
- Utilizing existing workgroups for stakeholder input, including using the IHSS Advisory Committee as the official advisory committee required by CCI

Orange County Implementation Efforts

- Plan to ramp up slowly regarding care coordination teams & development of supplemental services as we learn more about member needs, costs, and funding.
- Counting on CMIPSII to enhance communication between agencies.

QUESTIONS & ANSWERS