

**Department of Health Care Services
Proposed Trailer Bill Language**

Coordinated Care Initiative for Medi-Cal Beneficiaries

FACT SHEET

The Department of Health Care Services is committed to improving care coordination for Medi-Cal beneficiaries. Currently, beneficiaries too often encounter fragmented services that result from multiple funding sources and uncoordinated delivery of medical, long-term care, home and community based, and behavioral health services. Beneficiaries with the greatest needs suffer most from this fragmentation. This coordinated care initiative aims to improve service delivery for all Medi-Cal beneficiaries, but particularly those who need coordination the most: the 1.1 million people eligible for both Medicare and Medi-Cal coverage (“dual eligible beneficiaries”) and the 160,000 Medi-Cal-only beneficiaries who rely on long-term services and supports (LTSS). LTSS includes institutional long-term care and home and community-based services.

Combining the full continuum of services into a single benefit package, and delivering those services through an organized managed care delivery system will promote accountability, create efficiencies, and improve care coordination. This initiative will enhance health outcomes and beneficiary satisfaction while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Further, by increasing the number of beneficiaries served through managed care plans, the proposal will generate \$400 million in additional General Fund savings from 2012-2016 through the gross premium tax, a tax imposed upon Medi-Cal managed care plans that enables the state to draw down federal monies to fund children’s health services under the State’s Healthy Families Program. The additional savings will help preserve essential services.

Why changes are necessary

The current system encourages Medicare and Medi-Cal to shift costs to one another and thereby causes beneficiaries to be caught in the middle. The fractured funding streams and administrative responsibilities make it difficult for seniors and persons with disabilities and dual eligible beneficiaries to navigate program benefits associated with this uncoordinated fee-for-service care environment. Instead, without the benefits of care coordination and case management, they must navigate a web of complex systems of care on their own in order to remain in their communities and/or to access needed care. For beneficiaries unable to self-direct their care, the challenge can be overwhelming and can increase the risk of institutionalization.

Fragmented funding and services at federal, state, county, and programmatic levels creates:

1. Unnecessary institutionalizations and higher costs.

2. Multiple eligibility criteria, assessment processes, and programmatic limitations that become barriers to accessing home and community-based services. For example, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) each has unique eligibility, assessments, program requirements, limitations and funding sources.
3. Incentive misalignment that discourages helping Medi-Cal beneficiaries live at home or in the community of their choice. For example, limited access to home and community-based services becomes a barrier to discharge from a nursing home or hospital.
4. Fragmented accountability in which no single entity or provider is responsible for providing care and optimizing federal and state resources to maximize a beneficiary's potential to stay in the community.

Background

California's 1.1 million dual eligible beneficiaries often have serious and chronic medical conditions, reside in nursing homes, frequently use emergency room services, and suffer from functional or physical impairments. Medicare is the primary payer for dual eligible beneficiaries and covers medically necessary acute health services such as: physician services, hospital services, and rehabilitative skilled nursing stays. Medi-Cal is the secondary insurer/payer and typically covers Medicare cost sharing and services not covered by Medicare, as well as services delivered after Medicare benefits have been exhausted. Most long-term care costs for duals are paid for by Medi-Cal, including longer nursing home stays and home and community-based services designed to prevent institutionalization. In addition, many of these beneficiaries are eligible for IHSS, which is locally administered and includes a county share of cost. Consequently, the current system attempts to address the health care needs of the most chronically ill and vulnerable beneficiaries through a variety of providers that receive funding from multiple government sources. A key aspect of this initiative is aligning incentives across all government payers and service delivery systems so that decisions are based on what is best for the beneficiary and not on cost shifting.

Medi-Cal managed care plans have been successful in managing and coordinating medical services for many Medi-Cal beneficiaries. Yet, LTSS, particularly home and community-based services like IHSS, CBAS, and MSSP have been carved out of their current scope of benefits. This exclusion provides little capacity or incentive for the managed care plans to keep their members out of institutional care.

As a result, seniors and persons with disabilities and dual eligible beneficiaries would benefit from a health care model that coordinates all their services within a system of organized managed care in which the health plan is responsible for all benefits. This would achieve significant efficiencies and improve care for beneficiaries by eliminating incentives to shift costs between different programs. It also would enhance patient care

management, continuity of care, quality assurance and improvement activities, and help beneficiaries remain in their homes and communities.

Summary of proposed trailer bill language (TBL)

This proposed TBL promotes coordinated care models in which seniors and disabled Medi-Cal beneficiaries receive all their benefits in an organized delivery system, including medical services, LTSS and behavioral health services. Coordinating all of these services through Medi-Cal managed care plans will improve care for beneficiaries and help them remain in their homes and communities, while achieving significant efficiencies and reduce costs from unnecessary hospital and nursing home admissions. This TBL would implement a strategy to improve beneficiary-centered, coordinated care over three years, starting on January 1, 2013. Specifically, the initiative will:

- Improve care coordination by integrating Medicare and Medi-Cal services and financing in coordinated care models in demonstration projects in up to 10 counties beginning in 2013, and additional counties in subsequent years.
- Enhance home and community-based services by enrolling Medi-Cal beneficiaries, including dual eligible beneficiaries, into managed care systems that provide the full continuum of needed services, including LTSS and behavioral health services.
- Implement strong beneficiary protections by requiring DHCS to engage with stakeholders throughout the development and implementation of the TBL, provide ongoing oversight and monitoring, and ensure Medi-Cal managed care plans follow state and federal beneficiary protection laws.
- Build on the development of integrated models of care by, beginning on June 1, 2013, expanding the provision of Medi-Cal benefits through managed care health plans in counties in which Medi-Cal benefits are provided on a fee-for-service basis.

Dual Eligible Beneficiary Integration Demonstration Project Expansion

Existing law, pursuant to SB 208 (Steinberg, Chapter 714, Statutes of 2010), establishes demonstration projects in four counties under which dual eligible beneficiaries are enrolled into coordinated systems responsible for all Medicare and Medi-Cal benefits, as well as LTSS and behavioral health services. This TBL would increase the number of demonstration sites in the first year from four to up to 10 counties. In a three-year demonstration project starting January 1, 2013, the proposal would enroll dual eligible beneficiaries into coordinated health care delivery systems and test a model of patient-centered care delivery. After January 1, 2014, the proposal would allow DHCS to expand the demonstration into additional counties that meet the terms and conditions established by the department and the federal Centers for Medicare and Medicaid Services (CMS). By year three, the Demonstration would be active in all 58 counties.

This TBL would require all full-benefit dual eligible beneficiaries residing in a demonstration county to enroll in the demonstration. DHCS would have the authority to require a beneficiary, upon enrollment into a demonstration site, to remain in the plan

for a period of six months from the time of initial enrollment. During the six-month enrollment period the beneficiary may continue to receive services from an out-of-network Medicare provider for primary and specialty care services, as specified. After the six month period, beneficiaries would have an opportunity to opt out of enrollment in the demonstration for their Medicare benefits only. They would remain mandatorily enrolled in a Medi-Cal managed care plan for their Medi-Cal benefits.

The proposal expands upon the current provisions of SB 208 and adds new provisions needed to ensure program integrity and appropriate beneficiary protections. For example, the proposal would require DHCS to enter into a memorandum of understanding (MOU) with CMS in developing the process for selecting, financing, monitoring and evaluating the health care models for the demonstration project. The MOU would need to contain various elements, including a capitated reimbursement methodology in which the demonstration site prospectively receives a blended payment for Medi-Cal and Medicare services. Additionally, any federal savings that result from improved and less costly provision of Medicare services would be shared with the State. Other MOU terms and conditions that may be negotiated by the department include provider network adequacy standards, uniform appeal and hearing processes, and uniform encounter data reporting requirements for both Medi-Cal and Medicare Services.

The expertise to deliver this fully integrated system must build on existing capabilities. DHCS will look to plans that have significant experience in both Medicare and Medi-Cal as the foundation for integrating LTSS, medical services, and behavioral health services. Plans that currently operate Medicare Special Needs Plans for duals or that have operated such plans in the recent past would be the most likely candidates to become a demonstration site.

The State would provide oversight of both the Medicare and Medi-Cal benefit delivery and quality of care. Quality indicators, such as reduced hospitalizations, reduced use of emergency rooms, reduced use of nursing facility services, improvements in preventive services, and improvements in beneficiary satisfaction will all be evaluated in defining the outcomes of the demonstration. Under the terms of this proposal, the DHCS would be required to provide the Legislature with a copy of any MOU mandated report submitted to CMS that covers the January 1, 2013 to December 31, 2015 time period.

By expanding the duals demonstration project, DHCS will work with CMS to combine Medicare and Medi-Cal authorities to test a new payment and service delivery model that would reduce program expenditures while preserving or enhancing the quality of care furnished to dual eligible beneficiaries. The organized delivery system model would better serve dual eligible beneficiaries by providing them with a single point of contact for all of their benefits; and, the organized delivery systems will offer higher quality and more cost effective services than the current fee-for-service system.

LTSS integration as a managed care benefit

This TBL would state that it is the Legislature's intent that Medi-Cal managed care plans assume responsibility for the provision of and payment of LTSS, in addition to their current provision of medical services. LTSS would include IHSS, CBAS, MSSP, nursing facility care, and other home and community-based services, and would be available only through managed care health plans in Medi-Cal managed care counties.. DHCS would pay managed care plans using a capitation rate-setting methodology that includes all Medi-Cal benefits and services covered under the managed care plan contract, including LTSS.

LTSS integration as a managed care benefit would occur over a three-year transition process in all managed care counties. The transition of Medi-Cal benefits to managed care would occur in the first year, with the benefits becoming a more integrated plan responsibility over the subsequent two years.

Mandatory dual eligible beneficiary enrollment into Medi-Cal managed care

With certain exceptions, this TBL would authorize DHCS to require dual eligible beneficiaries and Medi-Cal beneficiaries with a share of cost in Medi-Cal fee-for-service to be assigned as mandatory enrollees into new or existing Medi-Cal managed care health plans. In doing so, dual eligible beneficiaries would be required to access LTSS as a managed care benefit. This will help ensure they receive their medical and LTSS in a coordinated system of care provided by a managed care plan.

In addition, starting June 1, 2013, this TBL would also authorize DHCS to expand Medi-Cal managed care into counties in which Medi-Cal benefits are currently provided on a fee-for-service basis.

Consumer Protections

DHCS would be required to develop a stakeholder engagement plan for the implementation of mandatory enrollment and submit that plan to the Legislature within 30 days of enactment of the TBL. DHCS would also develop and implement an outreach and education program for dual eligible beneficiaries not currently enrolled in managed care to inform them of their enrollment and option rights. The department would be required to provide written notice to inform dual eligible beneficiaries about changes to their delivery of Medi-Cal services at least 90 days prior to enrollment. This will include notice of when changes will occur and who they can contact for help in choosing a managed care health plan, asking questions, or lodging complaints.

DHCS would be required to develop an enrollment process that enrolls dual eligible beneficiaries into one of the available Medi-Cal managed care plans. To the extent available, the plans shall match their Medicare Advantage plan. If a dual eligible beneficiary is in fee-for-service, they would have a choice of health plans, if applicable. If the dual eligible beneficiary does not choose a plan, he or she would be enrolled into a plan assigned by the department.

The TBL would also require DHCS to take a number of actions pertaining to plan readiness assessments, plan oversight and monitoring, and development of plan performance measures. DHCS would ensure that the plans do not interfere with a beneficiary's choice of primary care provider under Medicare, and that plans provide a mechanism for dual eligible beneficiaries to request a specialist or clinic as a primary care provider when these services are provided through Medi-Cal managed care. The TBL would allow for a specialist or clinic to serve as a primary care provider if qualified to do so.

The TBL would ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries who are seniors and persons with disabilities and dual eligible beneficiaries. Beneficiaries would be informed of their enrollment options and right to continuity of care in a timely, culturally, linguistically, and physically appropriate manner.

Medi-Cal managed care plans would have to provide new Medi-Cal members access to out-of-network primary and specialty Medi-Cal providers for up to 12 months for their Medi-Cal benefits, so long as the providers accept the health plan's rate, meet applicable professional standards, and have no disqualifying quality of care issues.

DHCS would be required to develop performance measures as part of the plan's contract. These measures would provide quality indicators for the Medi-Cal population enrolled in managed care and for the dual eligible subset of enrollees. Additionally, plans would be required to meet a host of requirements designed to protect dual eligible beneficiaries, including requirements pertaining to provider network adequacy and access to medical care, LTSS and behavioral health services; enrollee health care needs assessments; coordination of Medi-Cal benefits across all settings, including outside the plan's provider network; care management and coordination; and processes for enrollees' complaints, grievances, and disenrollment requests. Plans would also be required to monitor quality and health outcomes of beneficiaries and comply with all quality assurance and consumer protection measures required by federal and state laws.

Plans would be required to administer a DHCS-approved risk-assessment process. Managed care plans would develop individual care plans for higher risk beneficiaries that include identification of LTSS needs, caregiver involvement, and care management and coordination.

DHCS would be required to develop a stakeholder engagement plan and requirements for managed care plans to solicit stakeholder and member participation in advisory groups for the planning and development activities related to the services for dual eligible beneficiaries. DHCS also would be required to provide the fiscal and policy committees of the Legislature with a copy of any required report submitted to CMS.

Repeal Medication Dispensing Machine Pilot Program

This TBL would repeal the Home- and Community-Based Medication Dispensing Machine (MDM) Pilot Project. The MDM Pilot Project was established by SB 72 (Committee on Budget and Fiscal Review, Chapter 8, Statutes of 2011), and aimed to assist Medi-Cal recipients at high risk of medication non-adherence with taking their prescribed medications through the use of an automated medication dispensing machine that includes remote monitoring and telephonic reporting services.

After analyzing the potential of this program, DHCS concluded that the predicted savings and costs were too uncertain, indicating a significant likelihood of program losses rather than savings. DHCS also concluded that significant additional investigative investment would be required before the program prescribed by SB 72 could be considered for implementation.

Require Enactment of Coordinated Care Initiative to Implement Medi-Cal Payment Deferral

This TBL would authorize the department to defer Medi-Cal managed care payments during the final month of fiscal year 2012-13, but would prevent the department from making those deferrals unless the proposed Coordinated Care Initiative is enacted by July 1, 2012.

Summary of Arguments in Support:

The proposal is a continuation of California's effort to rebalance service delivery away from institutional care and toward home- and community-based care and to optimize the use of Medi-Cal resources. These combined efforts will help manage health care costs as California's population continues to age. National experience in states like Wisconsin, Massachusetts, Oregon and Washington, as well as California's own experience through PACE (Program of All-inclusive Care for the Elderly), have shown that integrating and coordinating medical care and LTSS will help Medi-Cal beneficiaries avoid unnecessary hospitalization and placement in nursing facilities.

This proposal addresses the current fragmentation of services, funding, and accountability for health outcomes by integrating all funding sources into capitated payments to managed care plans. The plans will be held accountable for ensuring their enrollees' health and well-being. Moving toward increased use of capitation also addresses the current incentives under the fee-for-service model that maximize provision of, rather than coordination of, services.

This proposal would achieve savings of approximately \$678.8 million General Fund in 2012-13 and \$950 million General Fund in 2013-14.

Additionally, this proposal would:

- Establish care management programs for Medi-Cal beneficiaries that coordinate services; better align benefits, delivery, financing, and administration; improve care continuity and coordination across medical, LTSS and behavioral health services.

- Create a coherent delivery system that is specific and responsive to beneficiaries' needs and eliminates fragmentation and inefficiencies created by current categorical funding, services structures, and regulatory requirements.
- Create much-needed savings for the state by lowering utilization of high-cost acute and long-term care services, shifting beneficiaries from institutional services to home- and community-based services, and establishing shared savings between Medicare and Medi-Cal.

Is there a BCP associated with this language? – No.

Legislative History:

AB 1040 (Bates, Chapter 875, Statutes of 1995) required the Department of Health Services (DHS, now DHCS) to establish a pilot program (of up to 5 pilot projects) to integrate the delivery and funding of long-term care services and to evaluate the results. The bill also required setting a capitated rate for payment unless the department determined one or more integrated programs could not be capitated. The bill also repealed the establishment of a long-term care integration pilot program enacted in Chapter 305 of the Statutes of 1995.

AB 2780 (Gallegos, Chapter 310, Statutes of 1998) contained provisions to implement the 1998-99 Budget that directly affected the Department of Developmental Services, Department of Mental Health, Department of Alcohol and Drug Programs, Managed Risk Medical Insurance Board, and DHS (now DHCS). Among other provisions, the bill authorized DHS to contract with a non-profit entity to facilitate the development of community-based long-term care integration pilot projects.

AB 3054 (Committee on Aging and Long-Term Care, Chapter 537, Statutes of 2002) required DHS (now DHCS) to develop at least, but not limited to, one alternative model to the Long-Term Care Integration Pilot Program and allowed the department to consult with an established waiver technical advisory committee to assist in the development of the alternative model(s). The bill also required DHS to report the recommendation of the waiver technical advisory committee to the Legislature on or before December 1, 2003.

SB 208 (Steinberg, Chapter 714, Statutes of 2010) implemented several changes to the Medi-Cal Program as proposed in the State's application to renew the state's Section 1115 Medicaid Waiver. This legislation also gave DHCS the authority to establish the dual eligible beneficiary demonstration project to give those eligible for Medicare and Medi-Cal a continuum of services and maximize coordination of benefits.

SB 72 (Committee on Budget and Fiscal Review, Chapter 8, Statutes of 2011) established the MDM Pilot Project requiring DHCS to identify Medi-Cal fee-for-service beneficiaries who are at high risk of not taking their prescribed medications, and to

procure automated medication dispensing machines to be installed in the participants' homes.