



# SENATE CALIFORNIA LEGISLATURE

STATE CAPITOL  
SACRAMENTO, CALIFORNIA  
95814



## **Agenda**

**Joint Hearing of Senate Budget and Fiscal Review and Senate Health  
State Capitol, Room 4202**

**Oversight of the Coordinated Care Initiative**

**10:00 a.m. – 1:00 p.m.**

**February 6, 2014**

### **I. Overview of the Coordinated Care Initiative**

- Toby Douglas, Director, Department of Health Care Services
- Jane Ogle, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- Shelley Rouillard, Director, Department of Managed Health Care

### **II. Enrollment in the Coordinated Care Initiative**

- Amber Cutler, Senior Attorney, National Senior Citizens Law Center
- Jonathan Freedman, Chief of Strategy, Regulatory & External Affairs, L.A. Care
- Donald J. Rebhun, MD, Corporate Medical Director, Healthcare Partners
- Nancy Gibbs, MD, Southern California Regional Medical Director, Kaiser Permanente - Dual Eligible Special Needs Plan (D-SNP)

**III. Integration of Long-Term Care Services and Supports (LTSS) into Medi-Cal Managed Care and Quality in LTSS**

- Richard Chambers, President, Molina Healthcare of California
- Sylvia Yee, Senior Attorney, Disability Rights Education & Defense Fund
- Carol Lee Thorpe, Vice President of Programs and Services, St. Barnabas Senior Services
- Janie Whiteford, In-Home Supportive Services (IHSS) Advisory Board from Santa Clara County and member of the California IHSS Consumer Alliance and the IHSS Coalition
- Denise Likar, Vice President, Independence at Home Division of SCAN Healthplan, Immediate Past President, Multipurpose Senior Service Program Association
- Deborah Doctor, Disability Rights California

**IV. Consumer Assistance for the Coordinated Care Initiative**

- Elaine Wong Eakin, Executive Director, California Health Advocates
- Michelle Melden, Director of Policy, Training & Development, Consumer Center for Health Education & Advocacy, Legal Aid Society of San Diego

**V. Response to Testimony by Department of Health Care Services**

- Toby Douglas and Jane Ogle, Department of Health Care Services

**VI. Public Comment**

# Medi-Cal – Coordinated Care Initiative

## BACKGROUND:

The 2012 budget authorized the Coordinated Care Initiative<sup>1</sup> (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits in eight counties (Alameda, Los Angeles, Orange<sup>2</sup>, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). CCI is composed of three major parts:

- **Long-Term Supports and Services (LTSS) as a Medi-Cal Managed Care Benefit:** CCI includes the addition of LTSS into Medi-Cal managed care. LTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.
- **Cal MediConnect Program:** A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS).
- **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded Seniors and Persons with Disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

The purpose and goal of CCI is to promote the coordination of health and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care).

Under the current system (prior to CCI), dual eligibles must access services through a complex system of disconnected programs funded by different government programs (e.g., federal CMS,

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<sup>1</sup> Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.

<sup>2</sup> At the end of January 2014, the state was notified by CMS that CalOptima in Orange County could not participate in Cal MediConnect until it had corrected issues found in an audit of its Medicare Advantage D-SNP plan. All information contained in this report reflects Orange County as participating in CCI as updated information was not available at the time of this report.

DHCS-Medi-Cal, IHSS-county based). This fragmentation often leads to beneficiary confusion, delayed care, inappropriate utilization, and unnecessary costs.

**Table 1: What is the Difference between Medicare and Medi-Cal?**

- **Medicare.** Medicare is the federally operated health care program for people who are elderly or have disabilities. Medicare is the primary payer for most medical services for dual eligibles, including doctor and hospital visits and prescription drugs.
- **Medi-Cal.** Medi-Cal is California’s Medicaid program, a state-run program that offers insurance coverage to certain people with low incomes, including the aged and persons with disabilities. For dual eligibles, Medi-Cal often is referred to as the “wrap around” benefit. Medi-Cal covers most of dual eligibles’ out-of-pocket costs, such as deductibles and co-pays, and pays for some prescription drugs and durable medical equipment not covered by Medicare. Medi-Cal also pays for most long-term services and supports, including nursing home care and home- and community-based services, such as the In-Home Supportive Services program (IHSS).

**Long-Term Supports and Services (LTSS) as a Medi-Cal Managed Care Benefit**

CCI includes the addition of LTSS benefits into Medi-Cal managed care. LTSS includes short-term and long-term nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS). These benefits, with the exception of CBAS, are currently provided on a fee-for-service basis. (CBAS is already a Medi-Cal managed care benefit.) These benefits will be available to a Medi-Cal enrollee as they enroll into Medi-Cal managed care under CCI.

**Health Plan Readiness to Deliver These New Benefits.** At the state level, the Department of Health Care Services (DHCS), the Department of Social Services (DSS), and the Department of Managed Health Care (DMHC) are responsible for ensuring that health plans are ready to integrate and deliver LTSS as a Medi-Cal managed care benefit. (DSS administers IHSS.) The state is in the process of developing additional contract requirements between DHCS, DSS, and the health plans regarding LTSS.

Additionally, as specified in an interagency agreement between DHCS and DMHC, DHCS is to provide DMHC with a list of all licensed MSSP and CBAS providers in a county and a list of all MSSP and CBAS providers under contract with each plan. DMHC would use this information to assess whether or not the plan has the network and capacity to provide these benefits.

**Table 2: Medi-Cal Long Term Supports and Services in CCI**

- **Nursing Facilities.** Nursing facilities provide continuous skilled and supportive care on a 24-hour basis. Such care is comprised of inpatient treatment, including physician, skilled nursing, dietary, pharmaceutical, and activity services.
- **In-Home Supportive Services (IHSS) program.** IHSS provides personal care services to about 445,000 individuals who are blind, aged (over 65), or who have disabilities.
- **Multipurpose Senior Service Program (MSSP).** MSSP provides case managed services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be age 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services and then work with the clients, their physicians, families, and others to develop an individualized care plan. Services that may be provided with MSSP funds include, but are not limited to: care management, adult social day care, housing assistance, in-home chore and personal care services, respite services, transportation services, protective services, meal services, and special communication assistance.
- **Community-Based Adult Services (CBAS) program.** CBAS is an organized day program of therapeutic, social and health activities and services provided to elderly persons or other persons with physical or mental impairments. The CBAS program replaced the Adult Day Health Care (ADHC) program on April 1, 2012. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit sought to challenge the elimination. A settlement of the lawsuit was reached that establishes a new program, CBAS.

## Cal MediConnect

Cal MediConnect is a three-year demonstration for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, and long-term supports and services through a single organized delivery system. No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS). The state and CMS entered into a Memorandum of Understanding<sup>3</sup> (MOU) on March 27, 2013, for this project. Additionally, CMS, DHCS, and each health plan entered into a three-way contract for this project.<sup>4</sup>

See chart below for information on Cal MediConnect counties and health plans.

<sup>3</sup> <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf>

<sup>4</sup> <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html>

**Table 3: Cal MediConnect Counties and Health Plans**

County	Dual Eligible Population	Health Care Plan(s)
Alameda	32,533	<ul style="list-style-type: none"> <li>Alameda Alliance for Health</li> <li>Anthem Blue Cross</li> </ul>
Los Angeles	288,399 <sup>a</sup>	<ul style="list-style-type: none"> <li>Health Net</li> <li>L.A. Care<sup>b</sup></li> </ul>
Orange	65,537	<ul style="list-style-type: none"> <li>CalOptima</li> </ul>
Riverside	40,040	<ul style="list-style-type: none"> <li>Inland Empire Health Plan</li> <li>Molina Healthcare</li> </ul>
San Diego	55,798	<ul style="list-style-type: none"> <li>Care 1<sup>st</sup></li> <li>Community Health Group</li> <li>Health Net</li> <li>Molina Healthcare</li> </ul>
San Mateo	12,371	<ul style="list-style-type: none"> <li>Health Plan of San Mateo</li> </ul>
San Bernardino	41,930	<ul style="list-style-type: none"> <li>Inland Empire Health Plan</li> <li>Molina Healthcare</li> </ul>
Santa Clara	37,739	<ul style="list-style-type: none"> <li>Santa Clara Family Health Plan</li> <li>Anthem Blue Cross</li> </ul>
<b>Total</b>	<b>574,347<sup>c</sup></b>	

<sup>a</sup> 288,399 are estimated to be eligible for Cal MediConnect in Los Angeles; however, enrollment in Los Angeles County was capped at 200,000 in the MOU.

<sup>b</sup> L.A. Care will be subcontracting with CareMore and Care 1<sup>st</sup> Health Plan.

<sup>c</sup> Enrollment into Cal MediConnect is capped at 456,000 per the MOU.

**Passive Enrollment.** For Cal MediConnect, the state will passively enroll dual eligibles into a health plan that combines their Medicare and Medi-Cal benefits. Passive enrollment is when the state assigns an individual to a Cal MediConnect health plan unless the individual actively chooses not to join and notifies the state of this choice. An individual may opt out of the Cal MediConnect health plan by making this selection on the 60-day notification, calling Health Care Options (HCO), or calling a toll-free Medicare phone number. (HCO assists in Medi-Cal enrollment.)

Dual eligibles who enroll in a Cal MediConnect health plan may opt out or change health plans at any time. If a dual eligible chooses to opt out of Cal MediConnect, it only applies to opting out of Medicare benefits. Dual eligibles, under CCI, must still receive their Medi-Cal benefits through a health plan, as described later.

**Populations Excluded from Cal MediConnect.** The following populations are excluded from Cal MediConnect:

- Individuals under age 21;
- Individuals with other private or public health insurance;

- Individuals receiving services through California’s regional centers, state developmental centers, or intermediate care facilities for the developmentally disabled;
- Individuals participating in certain 1915(c) waivers;
- Individuals with a share of cost (share of cost Medi-Cal is when an individual must spend his or her own funds on medical care to a specified level in order to become Medi-Cal eligible);
- Individuals residing in one of the Veterans’ Homes of California;
- Individuals living in the certain rural zip codes; and
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Alameda, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in another product operated by the health plan. Individuals enrolled in the demonstration who are subsequently diagnosed with ESRD, as with all enrollees, may choose to disenroll from the demonstration or may choose to stay enrolled.

***Populations Excluded from Passive Enrollment in Cal MediConnect.*** The following populations may voluntarily enroll, but may not be passively enrolled into Cal MediConnect:

- Individuals residing in the certain rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates;
- Individuals enrolled in Medicare Advantage, including Dual Eligible Special Needs Plans (D-SNPs), in 2014;
- Individuals in one of the following 1915(c) waivers programs may enroll only after they have disenrolled from that program: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and,
- Individuals may enroll in Cal MediConnect only after they have disenrolled from the Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

***Default Health Plan Assignment.*** On the 60-day notification to the enrollee (in all CCI counties except San Mateo and Orange<sup>5</sup>), the state will suggest a health plan that is based on a beneficiary’s previous visits to a primary care doctor or specialist (referred to as “linkage”). DHCS indicates that it has Medicare Part B (physician services) and D (prescription drug) data to assist in this linkage. An enrollee can accept this default health plan assignment or can change plans at any time.

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<sup>5</sup> San Mateo and Orange counties are County Organized Health Systems with only one health plan.

**Health Plan Readiness Assessment.** In preparation for implementation of Cal MediConnect, the federal CMS and DHCS conducted a readiness assessment for each health plan. This assessment process began in July. As part of this process, CMS and DHCS evaluated each plan to ensure that it could accept the increased enrollment, protect and provide the necessary continuity of care, and ensure access to all benefits. The assessment included a desk review, site visit, and network validation. CMS is responsible for the oversight of health plan networks which deliver Medicare-based services, while DHCS and the Department of Managed Health Care are responsible for Medi-Cal services. At the time of this report, DHCS indicated that health plan readiness assessments were nearing completion.

**Health Risk Assessment.** Cal MediConnect health plans must conduct a health risk assessment for all enrollees. This process, at a minimum, will identify referrals to appropriate LTSS and home- and community-based services; facilitate timely access to primary care, specialty care, durable medical equipment, and medications; facilitate communication across the enrollee's providers, including behavioral health providers; and identify other services that may assist an enrollee.

**Benefits.** Under Cal MediConnect, a health plan is responsible for providing and coordinating Medicare and Medi-Cal benefits (including LTSS, as discussed above). The health plan will receive a blended rate from the state and the federal government for these services.

Additionally, the plan must cover three supplemental benefits (these benefits are not currently covered by Medicare or Medi-Cal):

- Dental Services – This benefit includes Medi-Cal Denti-Cal services.<sup>6</sup>
- Vision – The enhanced vision benefits are \$0 copay for one routine eye exam every year and \$100 for eyeglasses (frames and lenses) or up to \$100 for contact lenses every two years. (Generally, Medicare does not cover eyeglasses or contact lenses unless the beneficiary has had cataract surgery that implants an intraocular lens.)
- Non-Emergency Transportation – This includes transportation to medical services provided by persons not registered as Medi-Cal providers. Members will have access to 30 one-way trips per year. In most cases, prior authorization and/or referrals are not required.

Finally, Care Plan Options (CPO) services are optional services that a Cal MediConnect health plan may provide that are above and beyond LTSS that could enhance a member's care, allowing them to stay in their homes safely and preventing institutionalization. These services could vary based on the needs of the consumer and the care plan developed for this person. Because these optional services are not part of covered Medi-Cal benefits and are at the plan's discretion, they are not subject to the Medi-Cal appeals process. These CPO services may include supplemental

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<sup>6</sup> These services were eliminated in 2009 AB5 X3 (Evans), Chapter 20, Statutes of 2009-10 of the Third Extraordinary Session, and will be partially restored to all Medi-Cal adults effective May 2014 through AB 82 (Committee on Budget), Chapter 23, Statutes of 2013. However, when CCI was enacted, these benefits were not provided by Medi-Cal.



personal care services (above authorized IHSS), nutritional supplements and home delivered meals, home maintenance and minor home adaptation, and medical equipment.

**Care Coordination.** Cal MediConnect is premised on the concept that coordination of services will lead to improved health and cost savings. To facilitate this, health plans will have a care coordinator that is responsible for providing care coordination services, which include assuring appropriate referrals and timely two-way transition of enrollee information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for enrollees moving between settings. The care coordinator serves on one or more Interdisciplinary Care Teams (ICT) and coordinates and facilitates ICT meetings. An ICT is comprised of the primary care provider, the care coordinator, and other providers, at the discretion of the enrollee. Every Cal MediConnect enrollee will have a care coordinator while DHCS estimates that only 10 percent of Cal MediConnect enrollees will require an ICT.

**Contract Management Team.** As part of Cal MediConnect, a team of representatives from DHCS, the CMS regional office, and the CMS national office will be established to provide oversight of the plans participating in Cal MediConnect to ensure compliance with all relevant Medicare, Medi-Cal, and other state requirements, assure compliance with the health plans' contract requirements, and promote plan performance in meeting the needs and preferences of enrollees. DHCS indicates that this team will use a "rapid cycle improvement" process by which, at least initially, this team will assess various factors on a weekly basis. These factors include the number of health risk assessments completed by a plan, the number of enrollments and disenrollments from a plan, and complaints and grievances.

**Continuity of Care.** Pursuant to the requirements of the statutes that established the dual eligible demonstration project, DHCS established a specific continuity of care policy for Cal MediConnect. This policy includes certain consumer protections that are specific to this demonstration. For example, a beneficiary who is a long-term resident of a nursing facility prior to enrollment in Cal MediConnect will not be required to change his or her nursing facility during the duration of the demonstration project (as long as the facility is licensed and meets quality standards). In addition, an enrollee can see an out-of-network physician if the beneficiary has seen an out-of-network primary care provider at least once or an out-of-network specialty care provider at least twice during the 12 months prior to the date of enrollment for a non-emergency visit and the plan and provider are able to enter into a contract or letter of agreement.

**Rates, Risk Corridor, and Shared Savings.** Health plans will receive one blended rate from the state and CMS. DHCS indicates that these rates will be posted on its website. The rates are county-specific and will be categorized into four risk adjustment populations: (1) Institutionalization, (2) Home- and Community-Based Services High Level of Need, (3) Home- and Community-Based Services Low Level of Need, and (4) Community Well. Additionally, risk corridors have been established to provide a level of protection to the health plans and the state against uncertainty in rate-setting that could result in either overpayment or underpayment.

One of the purposes of Cal MediConnect is to lower health care costs by coordinating care. To recognize these cost savings, the state and CMS have developed a savings mechanism. For the

state, savings percentages (at a minimum, the savings percentages are one percent in year one, two percent in year two, and four percent in year three) would be applied to the aggregate health plan payment. Essentially, the state has initially developed a rate for Medi-Cal services based on fee-for-service and some managed care data and will reduce the rate by the savings percentage. This reduction is made because under the demonstration, plans have the flexibility and incentive to ensure that the beneficiary is served, as appropriate, in the lower cost, home- and community-based setting.

**Quality Withhold.** CMS and the state will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid, subject to the health plan's performance, consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures, as well as state-specified quality measures including behavioral health coordination and planning, and ensuring physical access to buildings, services, and equipment.

**Grievances and Appeals.** For at least the first year of the demonstration, each program, Medicare and Medi-Cal, will maintain their existing grievance and appeals processes. However, over the period of the demonstration project, CMS and the state agree to develop a unified set of requirements for health plan grievances and appeals processes that incorporate Medicare Advantage and Medi-Cal managed care requirements and to create a more beneficiary-friendly and easily navigable system.

## **Mandatory Enrollment into Medi-Cal Managed Care**

**Enrollment.** Dual eligibles and most other previously excluded Medi-Cal enrollees (e.g., those receiving long-term services in a nursing facility) must enroll in Medi-Cal managed care for their Medi-Cal benefits. This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.

The Medi-Cal-only enrollees will receive only Medi-Cal benefits from the health plan. These enrollees include full dual eligibles excluded from Cal MediConnect, partial dual eligibles, and senior and persons with disabilities. See table below for enrollment projections by county.

**Table 4: Number of Eligible Medi-Cal-Only Enrollees into Medi-Cal Managed Care in 2014-15**

<b>County</b>	<b>Number of Eligible Medi-Cal-Only Enrollees</b>
Alameda	48,000
Los Angeles	317,000
Orange County	51,000
Riverside	46,000
San Bernardino	54,000
San Diego	64,000
San Mateo	14,000
Santa Clara	38,000
<b>Total</b>	<b>632,000</b>

*Populations Excluded from Mandatory Enrollment into Medi-Cal Managed Care.* The following populations are excluded from mandatory enrollment into Medi-Cal managed care:

- Individuals under age 21;
- Medi-Cal only individuals exempted from managed care due to an approved Medical Exemption Request;
- Individuals living in the certain rural zip codes;
- Individuals receiving services through intermediate care facilities for the developmentally disabled in all counties except Orange and San Mateo;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals in the Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Individuals with HIV/AIDS and American Indian Medi-Cal enrollees will be enrolled into Medi-Cal managed care, but can opt out at any time.

## **GOVERNOR'S PROPOSAL:**

*CCI Savings.* The Governor's budget includes a net General Fund savings of \$159.4 million in 2014-15 as a result of the CCI, including the General Fund savings from the sales tax on managed care organizations (MCO). Without the MCO tax revenue, CCI would have a General Fund cost of \$172.9 million in 2014-15. See table below for more information.

**Table 5: Coordinated Care Initiative Fiscal Summary**

<b>Coordinated Care Initiative (CCI)</b>		
	<b>2013-14</b>	<b>2014-15</b>
(In thousands)	General Fund	General Fund
<b>SAVINGS</b>		
<b>Local Assistance Costs Total</b>	<b>\$13,998</b>	<b>\$440,067</b>
Payments to Managed Care Plans	\$61,273	\$2,022,202
Savings from Reduced Fee for Service Utilization	-\$25,302	-\$1,582,135
<b>Payment Deferrals Total</b>	<b>-\$41,891</b>	<b>-\$269,706</b>
Defer Managed Care Payment	-\$45,054	-\$312,287
Delay 1 Checkwrite	\$3,163	\$42,581
<b>Revenue Total</b>	<b>-\$124,216</b>	<b>-\$332,269</b>
Increased MCO Tax from CCI (All Revenue)	\$0	-\$86,732
Increased MCO Tax from non-CCI (Incremental increase from 2.35 to 3.93 percent)	-\$124,216	-\$245,537
<b>Savings Sub-Total</b>	<b>-\$152,109</b>	<b>-\$161,908</b>
<b>COSTS</b>		
<b>DHCS Administrative Costs Total</b>	<b>\$2,546</b>	<b>\$2,543</b>
<b>Costs Sub-Total</b>	<b>\$2,546</b>	<b>\$2,543</b>
<b>Net Savings Impact to DHCS</b>	<b>-\$149,563</b>	<b>-\$159,365</b>

These figures reflect the following assumptions resulting from CCI: (1) inpatient care will be reduced by 8.9 percent, (2) long-term care institutional services will be reduced by 4.2 percent initially and then grow to a reduction of 10.9 percent annually, and (3) IHSS and CBAS will be increased by 3.5 percent initially and then increase by 2.8 percent annually. Additionally, the Administration estimates that 33 percent of eligible Cal MediConnect enrollees will opt-out of the demonstration; and, consequently, 381,000 dual eligibles will be enrolled in Cal MediConnect.

**Enrollment Timeline.** In addition, the Administration proposes changes to the implementation timeline. (The CCI timeline has been delayed multiple times since enacted in 2012.) Generally, the updated timeline reflects:

- Cal MediConnect dual eligibles in Medicare fee-for-service will be passively enrolled for Medicare and Medi-Cal benefits beginning on April 1, 2014, in Orange, Riverside, San Bernardino, San Diego, and San Mateo counties. Cal MediConnect individuals in these counties received a 90-day notification in January about this change.
- In Los Angeles County, dual eligibles may voluntarily enroll in Cal MediConnect or opt out, beginning April 2014; and the remaining dual eligibles will be passively enrolled into Health Net beginning in July 2014 and into L.A. Care no sooner than December 2014.
- Alameda will passively enroll dual eligibles no sooner than July 2014.
- Santa Clara will passively enroll dual eligibles no sooner than January 2015.

However, this timeline varies on other factors, such as the individual's current coverage. Please see table on the next page for the specific enrollment details.

**Senate Budget & Senate Health Oversight Hearing on Coordinated Care Initiative - Background Paper**

<b>Table 6: Coordinated Care Initiative Timeline</b>										
	<b>Cal MediConnect (CMC)</b>				<b>Medi-Cal Managed Care and LTSS as Managed Care Benefit</b>					
<b>Start Date</b>	Full Duals in Medicare FFS enrolled already in Medi-Cal Managed Care plan <b>(enrolled all in one month)</b>	Full Duals in Medicare FFS and Medi-Cal FFS <b>(enrolled by birth month)</b>	MSSP Benes eligible for Cal Medi-Connect <b>(enrolled in one month)</b>	Full duals in a MA plan / Part D LIS <b>(enrolled in one month)</b>	Full Duals who opt out of CMC and in Medi-Cal FFS <b>(enrolled by birth month)</b>	Full Duals in MA plan or excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal FFS <b>(enrolled by birth month)</b>	Full Duals who opt out of CMC, in a MA plan/Part D LIS, or excluded CMC pop (ESRD, Kaiser, 1915c waiver) in Medi-Cal managed care plan <b>(benefit added in one month)<sup>1</sup></b>	MSSP Beneficiaries in Medi-Cal managed care or Medi-Cal FFS <b>(enrolled in one month)</b>	Partial Dual/SPD already in Medi-Cal managed care <b>(enrolled in one month)<sup>1</sup></b>	Partial Dual/SPD in Medi-Cal FFS <b>(enrolled by birth month)</b>
<b>4/1/2014</b>	Riverside, San Bernardino, San Diego, and San Mateo (Orange members will be enrolled over 12 months)	Riverside, San Bernardino, and San Diego <sup>2</sup>	San Mateo		Riverside, San Bernardino, and San Diego		Los Angeles, Orange, Riverside, San Bernardino, San Diego, and San Mateo	San Mateo - Full Duals in MA plan or excluded CMC pop (ESRD, Kaiser, 1915c waiver)		
05/01/14						Los Angeles, Riverside, San Bernardino, and San Diego <sup>3</sup>				
<b>7/1/2014</b>	Alameda and Los Angeles	Alameda and Los Angeles	Alameda, Orange, Riverside, San Bernardino, & San Diego		Alameda and Los Angeles	Alameda and Santa Clara	Alameda and Santa Clara	Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo (Partials and SPDs), and Santa Clara	Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara	Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara
01/01/15	Santa Clara	Santa Clara	Los Angeles and Santa Clara	Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara	Santa Clara					

1. Enrollees already in a Medi-Cal managed Care plan will receive one notice 45 days prior to the change in benefit.

2. There are no FFS Medi-Cal Enrollees in Orange and San Mateo counties.

3. Enrollees with April and May birthdays will be enrolled in May 2014. Then follow enrollment schedule by birth month.

Acronyms : ESRD-end stage renal disease, FFS-fee-for-service, LIS-Low Income Subsidy, MA-Medicare Advantage, MSSP-Multipurpose Senior Services Program

**Los Angeles Enrollment.** As highlighted in the chart above, the Los Angeles County enrollment strategy differs substantially from the other counties. The Administration proposes a voluntary enrollment period from April – June, followed by passive enrollment into Health Net starting in July, and then passive enrollment into L.A. Care starting no sooner than December 2014.

Since L.A. Care received a Low Performing Icon (LPI) for Medicare Part D services for 2014 (based on service in 2012), the federal CMS does not allow passive enrollment into this plan. Consequently, until the LPI is removed (the soonest would be December 2014) passive enrollment into this plan cannot occur.

**Passive Enrollment of Medicare Advantage Enrollees into Cal MediConnect.** As part of the Governor’s January budget proposal, the Administration indicated that it would be proposing trailer bill language to no longer exempt dual eligible enrollees of Medicare Advantage plans from Cal MediConnect enrollment, effective January 2015. (Medicare Advantage is a Medicare managed care plan and includes D-SNPs which are special types of Medicare Advantage plans offered to dual-eligible individuals.) However, on a recent CCI stakeholder call, DHCS indicated that it is still evaluating its proposal regarding Medicare Advantage plans. Under current law, these individuals are exempt from passive enrollment in Cal MediConnect in 2014.

**Health Care Options – Specialized Call Center.** The Governor’s budget includes “costs” for a specialized call center for CCI. According to DHCS, this call center would have a dedicated toll free number and would direct consumers to a specialized team of CCI experts who will guide them through the enrollment process and be able to answer Medi-Cal and Medicare questions. DHCS expects that this call center will be up and running in February. At the time of this report, no additional information on this call center was available.

**Cal MediConnect Ombudsman Program.** The state has received a federal grant of about \$1.5 million (over three years) to develop a Cal MediConnect Ombudsman Program. The Cal MediConnect Ombudsman Program would assist Cal MediConnect managed care enrollees by resolving issues with Cal MediConnect managed care plans, offering individual advocacy services, and conducting impartial investigations of member complaints. The Department of Managed Health Care intends to award funds mid-February so that this program can be implemented by April 2014.

## **ISSUES TO CONSIDER:**

**Complicated Enrollment Strategy.** As exemplified by the chart above, the Administration’s proposed enrollment strategy is complicated and difficult to explain. Multiple factors would be used to determine when an individual is enrolled in CCI. Perhaps, most importantly, the enrollment dates for the various components of CCI are not the same within a county and depend on an individual’s situation.

The Administration acknowledges that this enrollment strategy is not simple when viewed from the state level and that it is difficult to explain; however, it contends that enrollee notifications

will be very personalized and that each individual will have enough information to understand the changes and take action.

This strategy does not take into account how important it is for the enrollment process to be simple and understandable for providers, patient navigators, consumer advocates, and other individuals, such as family members, who might assist an enrollee. This important lesson was learned during the transition of seniors and persons with disabilities (SPDs) to Medi-Cal managed care. During this transition, SPDs often contacted their providers with questions on the transition and providers did not have the information necessary to assist SPDs in making decisions. Without a simple policy, it will be more difficult to ensure that providers understand the timeline.

A recent report by the UCLA Center for Health Policy Research<sup>7</sup> indicates that many seniors find out about changes to their medical and supportive benefits through a variety of sources, including mail, media, community meetings, providers, and word of mouth. As such, this report highlights the need for this type of information to be disseminated broadly through multiple venues and in multiple formats. Disseminating this complicated enrollment strategy in multiple venues and in multiple formats would appear to be very difficult.

***Confusing Los Angeles County Enrollment Strategy.*** One component of the enrollment proposal that is particularly confusing is the enrollment strategy for Los Angeles County. As stated above, Cal MediConnect and mandatory enrollment into Medi-Cal managed care for LTSS enrollment would be voluntary from April through June. The timeline for notifying individuals of this voluntary enrollment option has not yet been determined (at the time of this report). The passive enrollment period would begin in July for one plan and no sooner than December for the other plan. This strategy appears to be more motivated on getting CCI implemented in Los Angeles County than on making the process understandable and simple for the consumer and for consumer assistors.

***Meaningfulness of Health Plan Readiness Reviews in Question.*** As discussed above, CMS and DHCS have been conducting Cal MediConnect health plan readiness reviews since the summer of 2013. Based on these assessments, CMS, DHCS and the plans have entered into contracts for Cal MediConnect. The signing of these contracts and the notification to about 14,000 individuals about benefit changes occurring in April were portrayed as a signal that CMS, the state, and the health plans were ready for this demonstration and that no significant issues remained outstanding.

However, the state was just notified (at the end of January) that CMS will not permit CalOptima to participate in Cal MediConnect. This is because of CMS's concern that "CalOptima's conduct poses a serious threat to the health and safety of Medicare beneficiaries" with its Medicare D-SNP product (based on an audit conducted in November 2013).

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<sup>7</sup> UCLA Center for Health Policy Research, "Disconnected?: Challenges of Communicating Cal MediConnect to Low-Income Older Californians." January 2014.



Eligible enrollees in Orange County were notified of the Cal MediConnect change occurring in April, but now enrollment in Orange County has been postponed. (The state will be mailing out retracting notifications to these enrollees.)

This situation calls into question the meaningfulness of the health plan readiness review assessment and three-way contract and whether or not these plans are qualified and ready to participate in the demonstration, particularly, given that the audit revealed that “CalOptima’s performance issues are widespread and systematic in nature.”

As a result of CMS’s audit, DHCS plans to do an audit of CalOptima’s Medi-Cal product in the next couple of weeks but has not provided information on how this might impact the implementation of the other components of CCI in Orange County.

***Ready for LTSS as a Medi-Cal Managed Care Benefit?*** It appears that the Administration’s focus has been on preparing for Cal MediConnect, while tasks to evaluate a health plan’s readiness for the delivery of LTSS remain to be completed. For example, contract provisions between the state and the health plans regarding LTSS have not been agreed to or signed. Concerns have been raised that guidance and policies regarding the inclusion of IHSS, in particular, as a managed care benefit are not yet available. DHCS anticipates sending these contract provisions to the plans in February, but this may not provide sufficient time for the plans and IHSS providers to establish policies and procedures.

Additionally, DMHC only recently received CBAS and MSSP provider information from DHCS and has not yet evaluated the overlap of a county’s existing provider network with the networks that a health plan has established (via contracts) with these providers.

As was learned when CBAS became a Medi-Cal managed care benefit in 2012, significant efforts regarding system changes and billing procedures, for example, must be made between the plans and providers to ensure a smooth transition.

***Unprepared and Underfunded Consumer Assistance Programs.*** Concerns have been raised that more resources and attention need to be provided to consumer assistance programs. For example:

- ***Increased Consumer Assistance for Changes to Medi-Cal Managed Care Lacking.*** The new Cal MediConnect Ombudsman Program only applies to individuals enrolled in Cal MediConnect. The Administration does not include any proposal to increase resources related to the existing Medi-Cal Managed Care Ombudsman Program which would be responsible for the approximately 500,000 Medi-Cal-only individuals that would be enrolled in Medi-Cal managed care per CCI. These individuals will have questions regarding the new LTSS benefits in managed care and how this impacts their current eligibility and receipt of these services. In addition, the Medi-Cal Managed Care Ombudsman Program will likely receive additional workload from the increased enrollment resulting from the expansion of Medi-Cal to adults without minor children and the additional Medi-Cal benefits provided under state legislation<sup>8</sup> implementing the federal Affordable Care Act.

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<sup>8</sup> AB1 X1 (Pérez) and SB1 X1 (Hernandez and Steinberg), Chapters 3 and 4, Statutes of 2013

- ***Federal Funding for Consumer Counseling Not Yet Distributed.*** The 2013 budget provided additional expenditure authority to the Department of Aging of \$660,000 to reflect a one-time federal grant to provide training for Health Insurance Counseling Program (HICAP) staff and one-on-one dual eligibility health insurance counseling related to Cal MediConnect. At the time of this report, these funds had not yet been distributed to the local HICAP offices. HICAP provides free and objective information and counseling about Medicare. Volunteer counselors assist individuals understanding their rights and health care options.
- ***Health Care Options (HCO) Not Prepared.*** Concerns have been raised that HCO is not currently prepared to assist consumers in the Cal MediConnect enrollment process. In early January of this year, 14,000 notifications were sent to individuals eligible for Cal MediConnect. On this notification, the HCO phone number and website are listed as a resource for Cal MediConnect questions. However, at the time of this report, no information regarding Cal MediConnect had been posted on the HCO website.

***Continuity of Care Concerns with Mandatory Enrollment of Medicare Advantage Enrollees.***

The Administration indicates that it is still developing its proposal regarding the passive enrollment of Medicare Advantage enrollees into Cal MediConnect in 2015. There are over 150,000 Medicare Advantage D-SNP enrollees who are dual eligibles in the CCI counties. These individuals have voluntarily elected to enroll in a managed care plan for their Medicare benefits. Requiring these individuals to enroll in Cal MediConnect could have major implications for their continuity of care for medical services. These enrollees were exempted from Cal MediConnect passive enrollment in 2014 because the state did not want to disrupt the care of these high-needs patients. It is unclear why the Administration would now want to disrupt the care of high-needs patients.

***Number of Cal MediConnect Enrollees Requiring Interdisciplinary Care Teams Seems Low.***

The Administration's estimate that only 10 percent of Cal MediConnect dual eligibles will require an Interdisciplinary Care Team (ICT) appears low. This underestimate could jeopardize the planning for care coordination as plans and providers estimate and allocate resources to this important function.

When the Administration initially proposed CCI, it argued that dual eligibles represent some of the most expensive and medically complicated health cases and that coordinating care, across the full spectrum, would lead to better health outcomes at lower costs. DHCS estimates that roughly 40 percent of the Cal MediConnect population is age 75 or older, and about 39 percent is disabled, and that these individuals are likely to be suffering from multiple co-occurring chronic conditions.<sup>9</sup> Additionally, it is estimated that 13 percent of the Cal MediConnect population with one or more chronic condition has dementia and other cognitive disorders and 10 percent have schizophrenia. The combination of physical and mental health chronic conditions results in some of the most difficult and complex health care cases.

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<sup>9</sup> RASB, *Medi-Cal's CCI Population: Combined Medicare and Medi-Cal Cost, Utilization, and Disease Burden*, November 2012, <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf>

Designing successful care coordination programs will require careful planning and resources and the collaboration of multiple programs and caregivers throughout the healthcare system.

***Missing Continuity of Care Protections for Medi-Cal Only Enrollees for LTSS.*** A specific continuity of care policy has been established for Cal MediConnect; one of the protections outlined in this policy is the provision that a beneficiary who is a long-term resident of a nursing facility prior to enrollment in Cal MediConnect will not be required to change their nursing facility during the duration of the demonstration. This prevents disruption in care for an individual. This same protection does not apply to a Medi-Cal-only individual who would be required to enroll in Medi-Cal managed care to receive LTSS benefits. It is unclear if DHCS plans to address this missing continuity of care protection for Medi-Cal only enrollees.

***State Has No Authority Over Medicare.*** Cal MediConnect is a joint project with the federal government. Issues regarding Medicare (medical services) are the responsibility of the federal government. The state has no authority and cannot dictate how plans provide Medicare services, the adequacy of these networks, or the rates for these services. Consequently, the success of Cal MediConnect will also rely on the federal government's ability to rapidly address issues that may arise.