

BACKGROUND

"LONG-TERM CARE INTEGRATION AND MEDI-CAL MANAGED CARE: THE FUTURE FOR BENEFICIARIES, THE WORK FORCE, AND OUR HEALTH CARE SYSTEM"

PART I: OVERVIEW OF CALIFORNIA'S LONG-TERM CARE SYSTEM

California's financial and program configuration for providing medical and long-term services/supports (LTSS) to seniors and people with disabilities (SPD) is fragmented. This means that no single authority has the capability along with the financial incentives to direct the continuum of services relied upon by seniors and people with disabilities ("SPDs"). Fragmentation leads to little or no service/support coordination, reduced or conflicting accountability, increased costs and consumer dissatisfaction. There are an estimated 1.9 million SPDs, which includes 1.2 million people who are eligible for both Medi-Cal and Medicare, referred to as "dual eligibles" and described in more detail below.

The SPD beneficiaries receive services/supports, and care from a variety of sources and typically do not benefit from a single entity that coordinates the medical services and LTSS needed to maintain independence and health. Typically, SPDs must coordinate their own services and supports. They must act as their own advocates and attempt to navigate the myriad of authorities, eligibility standards, and available combinations of services in order to fashion a network of supports that meets their individual needs. This complicated and confusing delivery system contributes to poor health outcomes and increased costs as beneficiaries are less likely to receive preventative medical care and specialized LTSS services that will maintain or improve their health, and allow them to live independently.

Medi-Cal

Medi-Cal is California's version of the federal Medicaid program. Medicaid is a joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, and people with disabilities. States have discretion to arrange benefits, eligibility, delivery, and payment under requirements of federal law. Medicaid spending is "matched" by the federal government, at a rate averaging about 57 percent. California uses a combination of state and county funds, augmented by a small amount of private provider tax funds, as the State match for the federal funds.

Medicaid is the single largest health care program in the United States. In 2011, the average monthly enrollment exceeded 55 million, and roughly 70 million people, about 20 percent of Americans, are covered by the Medicaid program for one or more months during the course of a year. In California, the estimated average monthly enrollment is eight million or roughly one seventh of the total national enrollment. Approximately 29 percent of Californians are on Medi-Cal.

The Medi-Cal program utilizes a variety of service delivery and payment systems. Originally the primary payment mechanism was fee-for-service (FFS) Medi-Cal, which means that a Medi-Cal enrollee obtains services from an approved Medi-Cal provider who is willing to take him/her as a patient for the service and accepts the Medi-Cal payment rate set by the State and governed by federal law. The provider then bills Medi-Cal directly when there is a claim. In addition to FFS, many beneficiaries receive care through managed care plans that have contracts with the Medi-Cal program. Under managed care, which is available in 30 counties, beneficiaries obtain services from providers who are part of the provider network made up of providers with contracts with the managed care plan. The plans receive a per person per month capitated payment from the State regardless of the amount of care the individual needs or receives.

Medicare

Medicare is the United States' national health insurance program, administered by the U.S. federal government and fully federally funded. It guarantees access to health insurance for Americans aged 65 and older, younger people with disabilities, and people with end stage renal disease (ESRD). Medicare was established to provide health insurance regardless of income or medical history. Before Medicare, only about half of older adults in the U.S. had health insurance, with coverage either unavailable or unaffordable to the other half.

Medicare has four parts: A, B, C, and D. Part A (the Hospital Insurance program), covers inpatient hospital, skilled nursing facility, home health, and hospice care. Part B (the Supplementary Medical Insurance program), covers physician, outpatient, home health, and preventive services. Medicare Parts A and B cover all "reasonable and necessary" medical services and hospital services, including lab tests, skilled nursing and some home health care -- excluding vision, hearing, dental and long-term care. Medicare employs a single-payer health care model with a standard benefit package, which is accepted by nearly every doctor and hospital. Part C (Medicare Advantage), allows Medicare enrollees to participate in private health plans that must cover all the Part A and B benefits as an alternative to traditional Medicare. Part D covers outpatient prescription drugs, also through private plans.

Medi-Cal and Medicare differ in many ways, including different services, program rules, reimbursement levels, and provider networks. This fragmented relationship contributes to a lack of coordination of services for people known as "dual eligibles," people who are impoverished and therefore qualify for Medi-Cal, while also older or disabled and qualify for Medicare. The fragmented relationship between the two programs incentivizes the programs to "cost shift." Cost shifting is when one entity or program makes decisions with limited consideration for how those decisions might increase costs for other entities or programs. For example, FFS Medi-Cal pays for the majority of LTSS costs for dual eligibles, but a relatively small portion of the acute medical care costs, such as hospitalizations. Therefore, the State has limited financial incentive to provide additional LTSS that would potentially reduce acute care utilization for dual eligibles, since the savings that would result from avoided hospitalizations would largely accrue to the federal government. Counties, which bear a portion of the costs of the In Home Supportive Services (IHSS) Program have little incentive to prevent nursing home admissions, since an IHSS consumer who is admitted to a nursing home actually reduces the county's share of cost in IHSS. This financial

misalignment is one of the major barriers to making meaningful improvements in the quality and cost of care being provided to dual eligibles, including the design of alternative delivery systems such as managed care.

Medi-Cal Long-Term Services and Supports (LTSS)

In addition to preventative and acute medical services, Medi-Cal provides a variety of LTSS for SPDs. Below, is a description of the main LTSS that are part of the Medi-Cal Program.

- **IHSS:** The IHSS program provides in-home care for persons who cannot safely remain in their own homes without assistance. In order to qualify for IHSS, a recipient must be aged, blind, or disabled and generally have an income below the poverty level. Social workers throughout the State's 58 counties perform assessments to determine the number of hours to authorize a recipient to receive each month. Public Authorities (PA) assist consumers with greater access to IHSS providers; investigate qualifications and background of potential providers; establish a referral system to connect providers with consumers; train consumers and providers; and provide other supports to assure the IHSS program functions effectively.
- **Multi-Purpose Senior Services Program (MSSP):** MSSP provides social and health care coordination for Medi-Cal recipients over the age of 65 who are eligible for care in a skilled nursing facility. Besides care coordination, MSSP also supports "purchase of services;" or funds for services that can help maintain individuals in their homes, such as home modifications or retrofitting to adapt the home environment for persons living with mobility challenges.
- **Community-Based Adult Services:** The Community-Based Adult Services (CBAS), formerly known as the Adult Day Health Care (ADHC) program, is a facility-based program that offers intermittent health supervision, social services, therapies, personal care, family and caregiver training and support, meals, and transportation on a day basis. CBAS is scheduled to be activated on April 1, 2012.
- **Other Community-Based Waiver Programs:** There are multiple of home and community-based services (HCBS) programs operating under a waiver of federal requirements that provide various services to recipients who are typically eligible for care in a Skilled Nursing Facility (SNF). These programs include the In-Home Operations, Assisted Living, and Nursing Facility/Acute Hospital waivers. They provide assistance with personal care services, nursing assistance, and case management services. In the case of the Assisted Living program, services are provided in an assisted living environment, or subsidized independent living facilities.
- **Skilled Nursing Facilities:** Skilled nursing facilities or "SNFs" provide nursing, rehabilitative, and medical care to facility residents. Generally, SNF residents receive their medical care and social services at the facility, by trained health care staff.

PART II: CURRENT MAJOR LONG-TERM CARE INITIATIVES

Adult Day Health Care

Adult Day Health care (ADHC) will be renamed the Community-Based Adult Services (CBAS) program. The CBAS program will replace the Adult Day Health Care (ADHC) program on April 1, 2012. AB 97 (Budget Committee), 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. The Administration estimates that approximately 15,000 of the 35,000 people that were formerly eligible for ADHC will be eligible for CBAS. (There is no cap on enrollment). ADHC/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.

2011 Reforms. The 2011-12 Budget proposed by Governor Brown sought the elimination of the Adult Day Health Care (ADHC) optional benefit, a Medi-Cal funded community-based program for low-income elderly and disabled adults designed to support individuals who live at home or in licensed residential care facilities to avoid unnecessary hospitalization or institutional long-term care settings. ADHC centers provide nursing services, personal care services, social services, therapy, case management, medication management, meals and transportation to participants up to five days per week, depending on their needs. Approximately 38,000 Californians utilize ADHC services each year. Caregivers find the ADHC program important because it offers a working, informal caregiver the ability to hold down a job while caring for a loved one with complex medical needs.

In an attempt to offer a compromise to the Administration's proposed elimination, the Legislature passed AB 96 (Blumenfeld) which provided a framework for a "capped" program (limited to roughly one-half the enrollment of the ADHC program) called "Keeping Adults Free from Institutions." On July 25, 2011, AB 96 was vetoed. Subsequently, seven plaintiffs filed suit against the Department of Health Care Services (DHCS) seeking relief for violation of, among other laws, due process guaranteed by the U.S. Constitution, the ADA, (Americans with Disabilities Act), and federal rights to Medicaid services.

On November 17, 2011, the State and the plaintiffs settled the lawsuit. The settlement agreement extended ADHC until March 1, 2012. On February 17, 2012, DHCS extended the ADHC program until March 31. At that time the ADHC program will 'transition' from a Medi-Cal state plan optional benefit to the "Community Based Adult Services" program (CBAS).

Under the settlement agreement, CBAS will be provided through an 1115 waiver: there will be no cap on the number of individuals who can be served, and services will be

provided at no cost to recipients. CBAS will be provided through Medi-Cal managed care plans where Medi-Cal managed care exists. In counties where Medi-Cal managed care is not available, and for people who are not eligible for managed care, CBAS will remain a fee-for-service benefit. Those living where Medi-Cal managed care exists will be required to enroll in a managed care plan in order to utilize the benefit.

Assessments. The transition process from ADHC to CBAS was designed to be ‘seamless.’ ADHC participants and individuals who wish to receive CBAS services are eligible if they meet skilled nursing care (NF-A) criteria, or have a cognitive impairment, a brain injury, chronic mental illness, or are developmentally disabled with certain medical necessities.

Since the settlement agreement, ADHC participants have been assessed for CBAS eligibility. Not all former ADHC enrollees are eligible for CBAS. ADHC participants found not to be eligible for CBAS are provided “Enhanced Case Management” to assist them to transition to other community-based services. Enhanced Case Management includes person-centered planning and complex case management, through either their managed care plan or APS Healthcare Inc., which will help them to connect to other home and community-based services when ADHC is eliminated. Individuals dissatisfied with their assessment can file for a fair hearing to challenge the assessment and the resulting decision.

Community Based Adult Services (CBAS). CBAS is designed to be similar to ADHC. CBAS is an outpatient, facility based service that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS will be available at former ADHC centers that are approved by DHCS as CBAS providers.

Individuals who are eligible for CBAS and live in counties with Medi-Cal managed care plans (and are not enrolled in one) will have to enroll into Medi-Cal managed care to receive CBAS. For Medicare recipients, enrollment into Medi-Cal managed care will not affect ADHC participant’s choice of Medicare physicians. For individuals in counties with no Medi-Cal managed care option, they will receive CBAS through FFS Medi-Cal. Individuals who are in County Operated Health Systems (COHS) will receive CBAS through the COHS.

By July 1, 2012, DHCS will convert CBAS from a fee-for-service benefit to a managed care benefit. Current ADHC providers have the opportunity to apply to become CBAS providers and continue operating their programs if they are approved by DHCS, and agree to become not-for-profit entities. In counties where a Medi-Cal managed care plan is available, CBAS providers must provide services through a contract with the plan once CBAS becomes a managed care benefit. In Counties where no Medi-Cal managed care arrangements exist, CBAS will be available as a fee-for-service benefit.

DHCS will work to prevent service gaps by waiving the not-for-profit requirements upon providers in order to assure geographic coverage, and service coverage, if necessary.

As of February 28, 269 providers have been approved according to California Department of Aging officials.

Questions on ADHC/CBAS Transition:

1. What does DHCS see as their responsibility to ensure access to CBAS to all ADHC participants found eligible, and if CBAS is not available, what are the Department's specific plans to provide the comparable services required by the settlement agreement?
2. What percentage of appeals to the determination process does DHCS anticipate?
3. The presumptive eligibility protocol set forth by the settlement guarantees coverage pending final eligibility determination. Would the DHCS please describe their success with adhering to this condition of the settlement?

SPD Transition

In November of 2010, California obtained federal approval for a Section 1115(b) Medicaid waiver from the Centers for Medicare and Medicaid Services (CMS) authorizing, among other provisions, expansion of mandatory enrollment into Medi-Cal managed care (MCMC) plans in 16 counties of over 600,000 low-income SPDs who are eligible for Medi-Cal only (not Medicare). The DHCS decided to phase in enrollment over a one-year period in the affected counties. This new mandatory enrollment began on June 1, 2011 and approximately 20,000 people per month are being enrolled. Prior to this, enrollment was mandatory for children and families in 30 counties and for SPDs in 14 counties.

Under SB 208 (Steinberg), Chapter 714, Statutes of 2010, and the Special Terms and Conditions imposed by CMS, there are a number of requirements relating to enrollment intended to ensure a seamless transition. For instance, DHCS was required to develop a SPD sensitivity training manual and all appropriate plans and state staff were required to receive training. There are requirements to conduct outreach activities including community presentations, involvement of stakeholder groups and to make available materials in multiple languages and formats and to provide in-person assistance.

In order to minimize disruption in care for those who do not choose a plan, CMS also directed DHCS to make repeated efforts to contact individuals and encourage choice. Secondly, DHCS is required to utilize claims data to make a default selection into a plan based on the person's usual and known providers, including specialty providers. Finally, SB 208 also provided an opportunity for extended continuity of care that allows an enrollee to continue to receive services from a current Medi-Cal FFS provider, including specialists, who is not in one of the plan networks. Health plans are required allow the enrollee to have access to this provider for 12 months as long as there is an ongoing prior relationship and the provider agrees to accept the health plan's contracted rate or the FFS rate, whichever is higher. If the provider does not agree, the plan must work with the enrollee to find in-network alternatives. On September 21, 2011, the DHCS Medi-Cal Managed Care Division notified plans of the details of this continuity of care policy in an All Plan Letter.

Medical Exemption Request (MER). A person who is receiving Medi-Cal FFS treatment or services for a complex medical condition from a provider who is participating in the Medi-Cal program but does not contract with one of the plans available through mandatory enrollment, may request a medical exemption to continue FFS Medi-Cal for the purposes of continuity of care up to 12 months or until the medical condition has stabilized to a level that would enable the individual to change physicians without deleterious medical effects. Nevertheless, advocates have reported on the failure of this process, citing numerous examples of medically-fragile SPDs who have faced significant disruptions in care, such as the inability to access kidney dialysis for several days or weeks. The Assembly and Senate Health Committees held an oversight hearing on December 7, 2011 where substantial testimony was provided detailing these failures as well as allegations of inaction and unresponsiveness by the State in response to these reports.

Questions Related to the SPD Transition:

1. What is the Medical Exemption Request (MER) process? What are the grounds for approving or denying a MER? How is the policy communicated? What population does it apply to?
2. How has the DHCS responded to reports from legal advocates regarding individual patients experiencing significant disruptions to care as a result of the transition process?
3. What lessons have been learned from the SPD transition that should be applied to a transition of dual eligibles?

Duals Pilot

About 1.9 million SPDs are enrolled in Medi-Cal and, of these, about 1.2 million are also enrolled in Medicare. These recipients are referred to as dual eligibles. The SPDs who are not enrolled in Medicare, also known as Medi-Cal-only SPDs, typically have not met the 24-month disability waiting period or the minimum work requirements necessary to qualify for Medicare.

National studies have found that dual eligibles are more likely than other Medicare beneficiaries in their age group to suffer cognitive impairment from conditions such as Alzheimer's disease or dementia. They are also more likely to require assistance with activities of daily living, such as moving, bathing, dressing, eating, and toileting. They may be unable to fully care for themselves, and may require LTSS in institutional (typically, nursing home) or home and community-based settings. Dual eligibles often suffer from multiple chronic illnesses, such as diabetes, pulmonary disease, and hypertension at higher rates than Medi-Cal-only beneficiaries. While dual eligibles represent only 15 percent of all Medi-Cal beneficiaries, they account for 27 percent (\$2.4 billion) of annual Medi-Cal General Fund spending on medical and LTSS provided outside of managed care. The vast majority of dual eligibles receive these services outside of managed care.

Among other things, SB 208 (Steinberg), Chapter 714, Statutes of 2010, authorized the State to implement a coordinated care pilot project for dual eligibles (the "demonstration") in up to four counties. The legislation requires that the demonstration include at least one county that provides Medicaid under a COHS, and at least one county that provides Medicaid services through a Two-Plan model. Specifically, the stated goals of the legislation are as follows:

- Coordinating Medi-Cal benefits, Medicare benefits, or both, across health care settings and improving continuity of acute care, long-term care, and HCBS for dual eligibles.
- Coordinating access to acute and long-term care services for dual eligibles.
- Maximizing the ability of dual eligibles to remain in their own homes and communities with appropriate services and supports in lieu of institutional care.
- Increasing the availability of and access to home and community-based alternatives for dual eligibles.

In selecting the sites for the demonstration, the legislation requires that DHCS consider: 1) local support for integrating medical care, long-term care, and HCBS networks; and, 2) a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the demonstration.

In order to select the potential sites for the demonstration, the DHCS released a document, known as the request for solutions (RFS), that details the requirements for participating in the demonstration. The final RFS was released on January 27, 2012. Sites interested in participating in the demonstration are asked to respond to the RFS by February 24, 2012. The final RFS was released after several months of public meetings and stakeholder comment. The announcement of the selected sites is expected in mid to late March. Once the sites are selected, DHCS will release a draft of the demonstration proposal. After a period of public comment, the proposal will be submitted to the CMS for approval, sometime in late April or early May. The demonstration is scheduled to begin in January 2013.

The RFS states that the demonstration "will support the creation of such organized systems of care that are responsive to beneficiaries' needs and overcome existing fragmentation and inefficiencies created by categorical funding and service structures. This RFS reflects DHCS' aim to rebalance care away from institutional settings and into the home and community when possible. It promotes the development of coordinated care models that provide seamless access to the full continuum of services dual eligible need to maintain good health and a high quality of life in their homes and communities for as long as possible."

On monitoring and evaluation of these outcomes, the RFS states, “All sites will be required to participate in an evaluation process organized by DHCS and CMS. All sites will be required to participate in quality assurance and improvement initiatives. CMS and DHCS shall work together to develop applicable standards, and jointly conduct a single comprehensive quality management process and consolidated reporting process to ensure strong, consistent, quality oversight and monitoring. Quality requirements will be integrated, and include a unified minimum core set of reporting measures, to evaluate quality improvement of sites during the Demonstration period. An external evaluator will be contracted to measure quality and cost impacts to both Medicare and Medicaid in this Demonstration. Detailed reporting on numerous process and outcome measures will be required.”

Questions on Duals Demonstration Pilot:

1. What tools is DHCS using to evaluate plan readiness for the pilot county sites? How is this tied to your proposal for evaluation?
2. How will DHCS use the information from the evaluation of the Demonstration as it implements the Coordinated Care Initiative included in the Governor’s proposal?
3. Is the Demonstration effectively replaced by the Governor’s proposal to transition all duals into managed care on a two to three-year timeframe, or by January 1, 2015?

PART III: GOVERNOR'S LONG-TERM CARE PROPOSAL

The Administration is proposing a complex array of changes to the way medical care and LTSS are delivered to SPDs and specifically dual-eligibles. The proposal includes the following key pieces:

1. Expands the existing 4-county dual pilot program to up to 10 counties (in year 1) and eventually statewide within three years; this would transition dual eligibles into Medi-Cal managed care and integrate both Medi-Cal and Medicare services and funding into one managed care plan. This dual eligible demonstration would be expanded to twenty more counties on January 1, 2014, and the remaining 28 counties would participate in this demonstration as of January 1, 2015.
2. Integrates long-term supports and services into Medi-Cal managed care benefit starting January 1, 2013, and phased in over three years for all SPDs.
3. Expands managed care into the remaining 28 rural counties that are now fee-for-service-only beginning in June 2013.

The Administration is assuming that in Year-1 (2013) they would transition the ten counties with the greatest dual eligible populations, comprising 74 percent of the total transition population, or 722,000 enrollees. Transition efforts in Year-2 (2014) would focus on the remaining managed care counties comprising 16 percent of the total transition population and Year-3 (2015) transition efforts would focus on the remaining, primarily rural, FFS counties comprising 10 percent of the total transition population.

Since federal law prohibits the mandatory enrollment of Medicare enrollees into managed care, the Administration is proposing a passive enrollment of these individuals whereby, dual eligibles would be enrolled into managed care but given the option to return to fee-for-service for Medicare benefits.

Estimated Budget Savings

The Administration is estimating approximately \$1 billion in annual cost savings as a result of this proposal in the out-years beyond the budget year. According to the Administration, these savings will result primarily from reduced hospital and other provider utilization, savings primarily within Medicare (for the federal government), which is anticipated to be shared with the State. In the budget year (2012-13), in order to achieve savings and avoid increased costs that would result from overlapping FFS payments and new managed care capitated payments, the Administration proposes to delay one managed care payment from the end of the budget year in June 2013 to the beginning of the following budget year in July 2013. Without this payment delay, the Administration estimates costs would increase by approximately \$124 million in the budget year, due to overlapping payments. The overall net General Fund savings is anticipated to be \$679 million in savings in 2012-13.

Shared Medicare Savings. Specific to shared Medicare savings, the Administration estimates \$42 million in General Fund savings in 2012-13, \$412 million in General Fund savings in 2013-14, and growing savings in out years. To determine the Medicare Shared Savings, the Administration made the following assumptions (among others):

- The State will share savings 50:50 with the federal government;
- Inpatient hospital utilization will drop by 15 percent in 2012-13, and 20 percent annually thereafter;
- Skilled Nursing Facility (SNF) utilization will drop by 5 percent in 2012-13 and annually thereafter;
- Physician utilization will increase by 4 percent in 2012-13, and 5 percent annually thereafter; and,
- Pharmaceutical utilization will increase by 2 percent in 2012-13 and annually thereafter.

These assumptions are generally based on DHCS' rate development experience for Medi-Cal-only SPDs transitioning from fee-for-service into managed care and reflect a two-year phase-in of savings for hospital and physician utilization. Furthermore, DHCS assumes: 1) managed care plans need time to gain experience, with this new Medicare rate structure before they can achieve full savings; 2) a number of months of increased care coordination may need to take place before savings are achieved; and, 3) most of the savings from SNF utilization for this population are reflected in the proposal to integrate LTSS into managed care.

Estimated General Fund Savings

	2012-13 (six months)	2013-14	2014-15	2015-16
Medicare Shared Savings	(\$42,125,000)	(\$412,734,000)	(\$556,108,000)	(\$651,929,000)
Integrating LTSS	(\$579,669,000)	(\$545,833,000)	(\$428,915,000)	(\$408,132,000)
Aligning COHS	(\$56,984,000)	\$7,598,000	\$7,597,000	\$7,597,000
TOTAL	(\$678,778,000)	(\$950,969,000)	(\$977,425,000)	(\$1,052,463,000)

ISSUES FOR CONSIDERATION

Administration Has Foregone Pilot and Opportunity to Evaluate Demonstrations. The purpose of SB 208 was to develop dual eligible pilot projects in order to develop effective health care models that integrate Medicare and Medi-Cal services and to learn from these pilots. Under SB 208, the Administration is required to conduct an evaluation to assess outcomes and the experience of dual eligibles in these pilot projects and is required to report to the Legislature after the first full year of pilot operation and every year after. With this proposal, the Administration has forgone this pilot stage and the ability to learn from the demonstration projects by proceeding with the *statewide* enrollment of dual eligibles into managed care.

Challenges of Mandatory Enrollment of SPDs into Managed Care. The mandatory enrollment of SPDs into managed care that is still underway has identified challenges with ensuring that enrollees receive uninterrupted and coordinated care. For example, policies allowing enrollees to remain with their fee-for-service provider because of medical instability for 12 months appear to have been misunderstood and inconsistently applied. Additionally, given that about 60 percent of SPDs are defaulted into a managed care plan, it is likely that more beneficiary and provider outreach and education are necessary to ensure continuity of care.

Consumer Protections and Continuity of Care Assurances are Paramount. The Administration's goals of enrolling dual eligibles into managed care include: (1) improving the beneficiary's health care, quality of life, and satisfaction with the health care system by eliminating fragmentation and inefficiencies that result from the incongruities between Medicare and Medi-Cal; (2) developing financial models that drive streamlined and coordinated care through shared savings and the elimination of cost shifting; and, (3) promoting and measuring improvements in health outcomes. While these are important goals, it is critical to ensure that consumer protections and quality measures are in place to ensure that a beneficiary receives uninterrupted quality care especially given that dual eligibles have significant health care needs.

Dialogue with Federal Government Demands Time and Detail. Integrating Medicare and Medi-Cal services and financing will require a considerable amount of time and effort. These programs have different policies, standards, and appeals processes. Although representatives from CMS have been involved in the discussions regarding the dual eligible pilots, navigating the differences between these programs will be challenging.

Credibility of Shared Medicare Savings Questionable. Detailed information on the assumptions listed above are not yet available. For example, it is not clear why the Administration estimates that inpatient hospitalization will drop by 15 percent. Nor does the State have a guarantee of 50 percent of the shared savings. Changes to these assumptions could have major impacts to the projected General Fund savings.

Governor's Proposal To Integrate Long-Term Care Into Medi-Cal Managed Care

The Administration's goals for incorporating LTSS into managed care, are to promote the coordination of health and social care for Medi-Cal enrollees 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 HCB care and the rates for hospital and nursing home care are set by the State). Consequently, in the first year the Administration anticipates that savings would result from changes that include a 22 percent reduction in inpatient hospital services and a 12 percent decrease in long-term care nursing facility services in the first year. These reductions would be offset by a six percent increase in HCB services in the first year, as well as increases in primary health care. Overall, the Administration estimates savings equivalent to three percent of the total that would otherwise be spent under the fee-for-service health care model in 2012-13. The Administration indicates that these estimates are based on prior experience with shifts from fee-for-service to managed health care, including data from other states such as Arizona and Tennessee.

Phase-in of Proposed Integration: Under a February revision to the Governor's proposal, the inclusion of institutional long-term care, IHSS, MSSP, and other community-based services (except for CBAS) would begin January 1, 2013 with the 10 counties selected to be part of the dual eligibles demonstration in the first year and be phased in over three years. Starting January 1, 2014, these services would become managed care benefits in the remaining 20 Medi-Cal managed care counties as the dual eligibles demonstration project is expanded to those counties. Finally, on January 1, 2015 the remaining 28 counties would transition to include these LTSS as part of the Medi-Cal managed care benefit. To conform to the Adult Day Health Care (*Darling v. Douglas*) settlement agreement, CBAS would become a managed care plan benefit in all managed care counties sooner- on July 1, 2012. The details that follow regarding proposed changes during these timeframes are based on a conceptual description from the Administration. Detailed trailer bill language and updated fiscal estimates have not yet been made available.

Proposed Creation of a Uniform Assessment Tool: Currently, each LTSS proposed to be included in managed care has its own assessment process. The Administration proposes to have the Departments of Health Care Services, Social Services, and Aging lead a stakeholder process to develop of a uniform assessment tool that would replace these multiple processes and be used for IHSS, MSSP, CBAS, Nursing Facilities, and Home- and Community-Based Waiver programs. The stakeholder process would begin in June 2013, and the new assessment tool would be implemented upon completion of design, development, system testing, and training, no earlier than January 1, 2015. This assessment tool would be separate from and would not replace the assessment process used by managed care plans when enrollees initially enroll.

Proposed Integration of MSSP: The Administration proposes to maintain the current eligibility process for MSSP in 2013, and plans would be expected to contract with MSSP sites. In 2014, the managed care requirement established in 2013 would be applicable to all 30 of the current managed care counties. Additionally, in 2014, managed care plans would be permitted to contract with MSSP sites or hire and incorporate the MSSP staff into the health plans' care management teams. In 2015, MSSP would only be available as a managed care plan benefit in all counties and would use the uniform assessment tool.

Proposed Integration of Nursing Facilities and Home - and Community-Based Waiver Programs: Starting in 2013, for Medi-Cal enrollees in the initial 10 counties in the dual demonstration, institutional nursing facility and Home and Community-Based Waiver programs would only be available as managed care plan benefits. The plans would authorize institutional nursing facility services in 2013. In 2014, this policy would be expanded to the remaining 20 managed care counties, and in 2015 this policy would be expanded to all other counties.

Proposed Integration of IHSS: In 2013, the Administration proposes that counties would continue to assess recipients' needs and rely on current statutory provisions as the basis for authorizing service hours. In the 10 counties then participating in the proposed dual eligibles demonstration project, this work would be performed on behalf of and in coordination with managed health care plans. The plans could authorize an increase (but not a decrease) in IHSS hours and could provide or coordinate other needed services. DSS would continue to perform payroll functions for IHSS providers. Additionally, health plans would establish care coordination teams that include the consumer, health plan, county social service agency, and others whom the consumer chooses to include.

In 2014, in the 10 initial counties plus 20 additional managed care counties, the Administration proposes that IHSS assessment and authorization would be made through a "joint assessment process with health plans and counties, in accordance with the current statutory provisions for IHSS eligibility." Also beginning in 2014, counties would no longer have a share of overall non-federal IHSS costs. There would instead be a newly established county Maintenance of Effort requirement (MOE). This MOE would be based on current expenditures and trends and would be used to support managed care capitation payments. Further, health plans would establish "financial incentives for counties to reduce institutional care and achieve other performance objectives." The uniform assessment tool would be used as the basis for assessing IHSS hours in all counties beginning in 2015.

The Administration has also indicated its intent to preserve the ability of IHSS consumers to hire, fire, and direct their care providers. However, the Administration has not indicated whether or how other aspects of the employment relationships under the current IHSS program (e.g., the role of Public Authorities as employers of record and the process for setting wages) might change.

ISSUES FOR CONSIDERATION

Meritorious Goal of Long-Term Care Integration. Long-term care has traditionally been dominated by the medical model, in which focus is placed primarily on an individual's disease or condition rather than their overall needs. However, this model fails to take into account the effect an individual's behavioral health and social supports has on their physical health. Some of the most successful long-term care programs are those that integrate medical and social services, and in doing so, improve a person's health status and overall quality of life. Furthermore, most studies have found that managed long-term care programs reduce the use of institutional services and increase the use of home and community based services relative to fee-for-service programs. In addition, the current fragmented system of programs and services can leave enrollees on their own to link their needs with available services. Making a health plan responsible for the delivery of all benefits, health and social, could lead to better care coordination. However, this integration is a complex endeavor and there are significant programmatic and implementation issues that must be addressed.

Stakeholder Engagement. The Administration notes that they have had extensive stakeholder discussions regarding the dual eligible pilots; however, the primary focus of these discussions was not the integration of long-term care services statewide. Several stakeholders have thus far expressed concerns regarding or opposition to the broad scope and short timelines included in the Governor's LTSS integration proposal.

Additional Information Needed. Many policies governing eligibility for and the provision of LTSS, including IHSS in particular, are detailed in state statutes and state plans that have developed over the course of decades. And while recent changes to the Administration's proposal provide some additional information regarding proposed policy changes and estimated savings and phase implementation in more slowly, many details are still unaddressed. In addition, the phase-in does not currently require Legislative action over time to incorporate and build upon experiences gained as the changes roll out. The Administration is seeking upfront authority for all of the phases.

Detail of Monitoring and Evaluation Unaddressed. If LTSS were to become managed care benefits, it would be important for the State to develop measures to evaluate enrollee outcomes to ensure that managed care plans are not cutting Long-term care services and costs inappropriately. Additionally, it would be important for the capitation payment to be set at the right level to encourage plan behavior that leads to improved health outcomes.

Legislative Analyst's Office Identifies Significant Implementation Issues. The Legislative Analyst's Office's (LAO) review of the Administration's proposal found that in concept coordinating care for these enrollees has merit because it attempts to address the problems with the fragmented system of delivering medical care and LTSS. But the LAO also identified implementation issues that must first be addressed, such as ensuring proper oversight and rate development for managed care plans, maintaining continuity of care for enrollees, and determining the level of program control granted to plans. As a result, the LAO recommends against making decisions at this time to expand the dual eligible demonstration statewide and make LTSS managed care benefits statewide.

PART IV: RELATED BUDGET PROPOSALS

The Governor's proposed 2012-13 budget includes various provisions, which if adopted, might have a negative impact on the State's ability to successfully implement the proposed Care Coordination Initiative. They include the following:

IHSS Domestic and Related Services

The Governor's budget proposes to eliminate domestic and related services to recipients who are living with others in a shared-housing situation effective July 1, 2012, with an exception for households consisting entirely of IHSS recipients, and IHSS recipients whose need cannot be met by a household member due to a Medically-verified condition. For children receiving IHSS benefits and living with their parent(s), domestic and related services would no longer be allowed under any circumstance. This cut was proposed in previous budget proposals and, as in the past, raises significant legal questions since in many cases there is no legal obligation for other individuals who happen to be living with the IHSS recipient to provide them with this care. This proposal is expected to impact 254,000 recipients, and will cut IHSS services by \$461.5 million (\$163.8 million General Fund).

20 Percent Trigger Reduction for IHSS

The Governor purposed as part of his January budget to make the 20 percent January 1, 2012 "trigger" reduction in IHSS operational by April 1, 2012 unless inhibited by a court decision. The budget adjusts its projected savings resulting from the delayed implementation of the 20 percent across-the-board reduction that was to implement January 1, 2012 but was delayed due to the court injunction. The budget instead assumes implementation on April 1, 2012 of the 20 percent cut, for a savings of \$39.4 million General Fund (GF) in the current year, and \$179 million in the budget year. The budget also includes a set-aside to fully fund the program in the event that the court rules in favor of the plaintiffs and against the state.

Department of Developmental Services

Current Year Trigger Cuts. The current year decrease in the Department's budget reflects a \$100 million GF reduction due to the revenue triggers in the FY 2011-12 enacted budget. AB 121 authorized the Department of Finance to reduce up to \$100 million GF from the Department's budget if State revenues were insufficient. Senate Bill 73 directs the Department to consider a variety of strategies including savings attributable to caseload and expenditure adjustments, unexpended contract funds, or other administrative savings to meet the target. For FY 2011-12, DDS will look to achieve these savings within the statutory authority provided by SB 73.

Budget Year Trigger Cuts. For the triggered reduction of \$200 million GF in 2012 13, DDS plans to engage with stakeholders to discuss reduction proposals, which may include extending the 4.25 percent reduction to provider and regional center operations, reductions in the developmental center budget, and other potential savings options in the department's budget. The DDS is in the course of conducting six stakeholder meetings throughout the State to gather input from various organizations representing consumers, providers, families, and other service categories.

Elimination of Caregiver Resource Centers

The Governor's budget proposes the elimination of funding for the Caregiver Resource Centers (CRCs) for GF savings of \$4.1 million (\$2.9 million Local Assistance). The CRCs provide supportive services to caregivers of people with acquired brain impairment such as Alzheimer's, Stroke, Parkinson's, Huntington's, traumatic brain injury and related dementia. CRC services include: mental health support, respite, legal counseling, support groups, and education. There are 11 CRCs throughout the state, serving approximately 12,000 caregivers.

The CRC system in California was the first of its kind in the nation, and was looked to as a model for the development of similar services now available in all fifty states. State funding for CRCs was reduced by 74 percent in 2009. State funding qualifies for a 33:1 federal-state match. While eligibility for CRC services is not means-tested, CRC services are unique and generally not available elsewhere, even for people of middle or high-income who have health insurance. Individuals also pay fees on a sliding scale. These services are a critical piece of California's overall safety net that allows caregivers to continue providing care, thereby enabling many disabled Californians to continue living in the community rather than in institutions, and thereby also creating substantial savings for the State in reduced institutional care costs. States that have prioritized and invested in community-based care, as a preferred alternative to nursing homes and other institutional care settings, generally support these types of services. For example, the State of Washington recently doubled its state funding support for its CRCs. As a result of budget reductions to California's CRCs, particularly in 2009, all 11 CRCs maintain waiting lists for various services; the Los Angeles CRC has a waiting list of over 900 people just for respite services. Eliminating CRCs will increase, rather than decrease, California's dependence on high-priced institutional care.