
# Program Readiness Report

Coordinated Care Initiative

January 2013

Submitted by the Department of Health Care Services
In Fulfillment of Requirements of
Senate Bill 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012)

# Table of Contents

## Executive Summary

Governor Brown signed Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012), as part of the Budget Act of 2012, which established the Coordinated Care Initiative (CCI). SB 1008 requires the Department of Health Care Services (DHCS) to submit a written report on the status of readiness criteria and associated activities pursuant to Welfare and Institutions (W&I) Code §14182.17(d)(10)(E). This report must be submitted five months prior to the commencement date of beneficiary enrollment into the Duals Demonstration project, or Demonstration, as specified in W&I Code §14132.275. As of the date of this report, the Demonstration is scheduled to begin enrollment no sooner than September 1, 2013.

As required by SB 1008 under W&I Code §14182.17(d)(10)(E)(i-xi), this report provides an update on the status of the following readiness criteria and activities (see Appendix A for the full statutory language):

- (i) Contract/Funding for Consumer Counseling and Education Services
- (ii) Demonstration Beneficiary Communications
  - a) Beneficiary Enrollment Options and Rights
  - b) Enrollment Notices
  - c) Beneficiary and Provider Outreach Plan
  - d) Health Plan Benefits Package
  - e) Notification of Copays and Covered Services applicable to Seniors and Persons with Disabilities (SPDs)
  - f) Health Plan Assignment Process
- (iii) Health Plan Capitation Rates and Contracts
- (iv) Health Plan, Provider and County Agency Agreements
- (v) Network Adequacy Standards
- (vi) Beneficiary and Health Plan Issue Resolution Procedures
- (vii) Appeals and Grievances Tracking System
- (viii) Customer Service Training Plan
- (ix) Continuity of Care
- (x) Quality Evaluation Measures
- (xi) Health Plan Reporting Requirements

DHCS has made substantial progress on these activities, and expects to complete all activities prior to the commencement of the Demonstration. Further, DHCS continues to ensure ongoing stakeholder participation in the development of policies relating to CCI.

This report serves as the second of numerous legislative reports required under SB 1008 and SB 1036. DHCS submitted the first CCI legislative report on September 28, 2012 entitled, "*Programmatic Transition Plan – Coordinated Care Initiative Beneficiary Protections*." A complete list of CCI legislative reporting requirements is provided in Appendix B.

# Introduction

In January 2012, Governor Brown announced the CCI with the goals of enhancing health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs), including dual eligible beneficiaries, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though SB 1008 and SB 1036.

The three major components of the CCI to be implemented in 2013 addressed in this report are[1]:

1. A three-year demonstration project (Demonstration) for dually eligible Medi-Cal and Medicare beneficiaries that combines the full continuum of acute, primary, institutional, and home- and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system.
2. Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries.
3. The inclusion of LTSS as Medi-Cal managed care benefits for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD beneficiaries eligible for both Medicare and Medi-Cal (dual eligibles).

The CCI will be effective in eight counties, pending federal approval, no sooner than September 1, 2013. SB 1008 also expresses the intent that these provisions be implemented statewide within three years of initial implementation. The eight counties for 2013 implementation are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The following sections of this report provide a status update for each of the readiness criteria and activities specified in W&I Code §14182.17(d)(10)(E)(i-xi).

[1] SB 1036 also authorizes the creation of a Statewide Public Authority for In Home Supportive Services (IHSS) collective bargaining and a county Maintenance of Effort for funding IHSS. However, statute does not require that these provisions be included in the scope of this report.

# I. Contract/Funding For Consumer Counseling and Education Services

DHCS is working with the California Department of Aging (CDA) to prepare a grant application for the State Health Insurance Assistance Program (SHIP) and Aging and Disability Resource Center (ADRC) Options Counseling for Medicare-Medicaid Individuals in States with Approved Financial Alignment Models. CDA anticipates submitting the grant application in spring 2013. States cannot apply for this funding until they have a signed Memorandum of Understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS) granting approval of the state's proposed Financial Alignment Model. DHCS expects that this MOU will be in place in time for the grant submission.

# II. Demonstration Beneficiary Communications

DHCS is in the process of preparing a Beneficiary and Provider Outreach Plan that is committed to ensuring that both audiences have accurate, actionable information for their own decision-making processes. The outreach efforts aim to ensure that information is available to beneficiaries in places easily accessible to beneficiaries and their families. (Appendix C includes a draft of the Beneficiary and Provider Outreach Plan.)

Communications and outreach materials are being developed to address the following:

**a) Beneficiary Enrollment Options and Rights**

The Beneficiary and Provider Outreach Plan will work to ensure beneficiaries are informed about their enrollment options and rights. Recognizing California's network of existing support for this population through CBOs, advocacy organizations, and social service agencies, the outreach plan builds on that foundation to ensure that information is available in places that easily accessible to beneficiaries and their families. The outreach plan has been shared with stakeholders for their input and refinement.

**b) Enrollment Notices**

DHCS is developing notices and enrollment materials for the mandatory Medi-Cal managed care and voluntary Demonstration. Notices will be mailed at 90, 60 and 30 days prior to a beneficiary's effective enrollment date.

For the Demonstration, DHCS is working with CMS to develop and test beneficiary notices. DHCS will seek stakeholder input on the content of these enrollment notices for all Demonstration counties. Per statute, the enrollment notices will be available to the public at least 60 days prior to the first mailing of notices to beneficiaries. At least 90 days prior to enrollment, dual beneficiaries will receive written notification on how and when the Medi-Cal system of care will change, and who they can contact for assistance with choosing a managed care health plan. These notices will be written at a sixth-grade reading level and will

be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate.

Enrollment notices will clearly explain that the beneficiary may choose to stay in fee-for-service Medicare or Medicare Advantage, but must contact the DHCS enrollment broker to indicate their choice to opt out of the Demonstration. However, if the beneficiary does not actively opt out of the Demonstration, the state shall assign the beneficiary (passively enroll) to a health plan through which all Medicare and Medi-Cal benefits will be available.

**c) Beneficiary and Provider Outreach Plan**

As discussed above in Section II Part A, DHCS has developed a draft Beneficiary and Provider Outreach Plan (attached in Appendix C). This draft outreach plan has been shared with stakeholders and is being refined. The primary goal of the outreach plan is to ensure that beneficiaries, their caregivers and providers have the information they need about this program, including specific materials for persons in nursing and group homes, family members, conservators, and authorized representatives of beneficiaries, as appropriate. Recognizing the significant role that providers play in informing and guiding beneficiaries, the outreach plan emphasizes the importance of that role to providers. The plan also recognizes the diversity of the target population and that the majority in many counties does not speak English as their first language. Per statutory requirements, specific provisions are being made to educate beneficiaries on PACE options.

**d) Health Plan Benefits Package and Plan Selection Process**

DHCS is developing education materials that will inform beneficiaries of their health plan covered options and benefits. 60 days prior to a beneficiary's effective enrollment date, DHCS will mail an enrollment packet that includes: 1) a letter describing the pending changes and actions required of the beneficiary; 2) a resource booklet that describes what health plans are and what it means to be enrolled in a health plan, particularly member rights and responsibilities; and 3) a choice booklet that includes an enrollment choice form and pre-stamped envelope, detailed plan benefit comparison charts, and details for in-person presentations. These materials are intended to help beneficiaries make an informed choice based on a complete understanding of their enrollment options. These materials will be shared with stakeholders before being finalized, a process which includes beneficiary testing.

**e) Notification of Copays and Covered Services applicable to SPDs**

Participation in the Demonstration will not require that beneficiaries pay copays; this information will be included in beneficiary notices and training programs. In addition, the notification and training materials will clearly describe the services covered by the Demonstration plans and information. All beneficiary notices and

training materials will be subject to stakeholder review to ensure the language is clear and easily understood by beneficiaries and their advocates.

### f) Health Plan Auto-Assignment Process

DHCS is currently developing and finalizing a process, subject to CMS review and approval, to assign beneficiaries to a managed care health plan if they do not make an affirmative choice within the prescribed timeframe. A beneficiary will have approximately 60 days to decide if he or she wants to join the Demonstration program. If beneficiaries do not notify DHCS' enrollment broker of their choice to opt out of the Demonstration, they will be automatically enrolled into a demonstration health plan. The health plan assignment process focuses on promoting continuity of care by evaluating the beneficiary's medical history and primary provider utilization history. The automatic assignment process will use the most recent 12 months of Medicare and Medi-Cal claims history data to identify the individual's most frequently utilized providers. The providers may be individual physicians, medical groups and/or clinics. The process will also determine if an individual is currently residing in a long-term care facility and promote continuity of care in that facility. The individual's providers will be matched to providers in the participating plan's network. A health plan will be selected for each beneficiary that best matches the current medical needs of the individual.

## III. Health Plan Capitation Rates and Contracts

DHCS is working with CMS to complete the MOU that describes the major policies for the Demonstration. Though the MOU remains a high-level document in some respects, more details will be forthcoming in specific state or federal policy guidance, as well as the Demonstration three-way contracts between CMS, DHCS and the participating health plans. The MOU will include general provisions around eligibility, enrollment, benefits, beneficiary protections, care coordination, shared savings, appeals, oversight, and quality measures.

In addition, CMS and DHCS are working to develop the payment methodology for health plan capitation rates, including the methodology for baseline costs, and the estimated savings target percentages that will be incorporated into the rates. After completion of the MOU, CMS and DHCS will issue plan-specific rates.

Upon completion of the MOU, CMS and the State will review health plans for their compliance with federal and state requirements, and readiness to begin accepting new members for the Demonstration. Prior to enrolling any beneficiaries, health plans must undergo and pass a detailed assessment of their readiness to implement and provide high quality care to Demonstration participants. CMS and DHCS are working together to develop a readiness tool that will guide the review process. The readiness review will include a desk review and an on-site visit.

DHCS expects to develop two types of health plan contracts for the CCI. The first is a Demonstration three-way contract between CMS, the State, and each participating health plan. DHCS anticipates a template for this three-way contract will be completed in spring 2013. It must be executed by health plans prior to the distribution of beneficiary enrollment choice materials.

DHCS also expects to develop addendums to existing Medi-Cal managed care contracts that reflect the addition of LTSS as managed care benefits. LTSS includes, but is not limited to, In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing facility care.

To the extent permitted by CMS, plan rates and template contracts will be provided to the appropriate fiscal and policy committees of the Legislature and posted on the DHCS website.

For purposes of this report, the methodology and processes of rate development for the Demonstration is described in Appendix D.

## IV. Health Plan, Provider and County Agency Agreements

DHCS has provided template MOUs to health plans for agreements with their County Social Service Agencies and Public Authorities for IHSS, and for agreements with their County Mental Health Agencies, and County Alcohol and Other Drug Agencies. Those template MOUs reflect feedback from health plans, other state departments such as the California Department of Social Services (CDSS), mental health and substance abuse advocates and stakeholders, and local county agencies and associations. Note that health plans already have agreements with their local county mental health agencies, but DHCS has provided additional language that can be adopted to reflect the requirements of the CCI.

In addition, the readiness review process for the CCI will include a requirement that plans provide evidence of all executed agreements.

## V. Network Adequacy Standards

In consultation with stakeholders, CMS and DHCS have developed network adequacy standards for medical care and LTSS that reflect the provisions of W&I Code §14182.17(d)(5)). CMS has established the network adequacy standards for medical care, and will confirm plans' compliance with those standards through the readiness review process, prior to enrollment in the Demonstration. DHCS is finalizing network adequacy standards for LTSS, and will confirm plans' compliance during the readiness review process. DHCS' LTSS network adequacy standards are developed, have been released for stakeholder comment and are in the process of being revised and finalized per the comments received. Once finalized, the standards will be posted for public view on the CalDuals website (www.calduals.org).

For purposes of this report, the current draft LTSS standards are in Appendix E.

## VI. Issue Resolution Procedures

DHCS and Department of Managed Health Care (DMHC) will employ dedicated staff to provide comprehensive assistance to health plan beneficiaries, during normal business hours, regarding any issues or disputes with the health plans. Further, as part of the readiness review, the health plans will be required to show evidence that they have staff available to answer any state inquiries regarding, among other things, issues of continuity of care. A rigorous curriculum will be developed to ensure that both state and health plan staff are sufficiently trained to answer, respond to, and, resolve issues or disputes.

## VII. Appeals and Grievances Tracking System

DHCS, in collaboration with DMHC, CDSS, CDA, the California Department of Public Health, and the participating health plans will develop a unified tracking and reporting process for consumer grievances and appeals. The information obtained from the various state departments and health plans will be consolidated and assessed for purposes of monitoring and publicly reporting the outcomes of complaints. DHCS is creating a Medi-Cal managed care dashboard that will be used to monitor key measures on complaints including the number and type of grievances and appeals filed. The dashboard will also address enrollment, quality, network adequacy, beneficiary choice of plan, and, among others, finance issues. The dashboard will evaluate and monitor health plans on individual, plan model, and statewide aggregate levels. It is expected that DHCS will have developed an initial version of this dashboard by late 2013.

## VIII. Customer Service Training Plan

As part of the enrollment notice development process, DHCS will develop materials to train the enrollment broker call center staff so they are familiar with choice packets and prepared to answer questions. Additionally, these materials will be made available in some permutation to all potential intake points for a provider and/or beneficiary, such as the Ombudsman's office.

## IX. Continuity of Care Procedures

DHCS, in consultation with stakeholders and in collaboration with CMS, is developing specific continuity of care procedures to reflect the following policies:

- Medi-Cal Continuity of Care: Beneficiaries shall have access to out-of-network Medi-Cal providers for up to twelve months after enrollment. (W&I Code §14182.17 (d)(5)(G)). However, the following criteria must be met:

- The provider will accept health plan or Medi-Cal FFS rates; and
- The health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from DHCS, including all-plan letters.

- Medi-Cal Continuity of Care for Nursing Facility Care: For nursing facility care, managed care health plans will recognize any prior treatment authorization made by DHCS for not less than six months following enrollment of a beneficiary into the health plan. (W&I Code §14186.3(c)(3))

- Medicare Continuity of Care: Beneficiaries may have access to out-of-network Medicare providers for a minimum of the first six months of enrollment. (W&I Code §14132.275 (l)(2)(A))

- Medicare Part D Continuity of Care: DHCS and CMS will implement and enforce Medicare Part D transition of care provisions to ensure that health plans provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Part D drugs that are not on the health plan's formulary. (W&I Code §14182.17 (d)(2)(F))

DHCS will develop descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and distribute these materials to beneficiaries through plans and providers in their respective plan guides.

Note: Out-of-network FFS providers can include physicians, surgeons and specialists, but do not include providers of durable medical equipment, transportation, other ancillary services, or carved out services.

## X. Quality Evaluation Measures

DHCS, in consultation with CMS and stakeholders, has developed a list of quality and utilization measures to evaluate the Demonstration and individual health plans. These measures address the full range of services and benefits for the Demonstration, including medical, pharmacy, LTSS, and behavioral health, as well as care coordination and consumer satisfaction. The list of measures has been posted to the CalDuals website.

In addition, as discussed above, DHCS is developing a dashboard of measures to provide the Legislature and stakeholders access to enrollment, appeals, utilization, and other short- and long-term process measures, as well as quality measures. The dashboard will be developed with stakeholder input, and is expected to be available by the beginning of enrollment in the Demonstration.

## XI. Health Plan Reporting Requirements

CMS and DHCS shall define and specify in the three-way contracts, a consolidated reporting process for participating plans that ensures the provision of the necessary data on diagnosis, Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures, enrollee satisfaction and evidence-based measures and other information that may enable monitoring of each participating plan's performance. Participating plans will be required to meet the encounter reporting requirements that are established for the CCI.

## APPENDIX A: State Readiness Review Statute

W&I Code §14182.17(d)(10)(E), as established under SB 1008:

(E) The department shall submit two reports to the Legislature, with the first report submitted five months prior to the commencement date of enrollment and the second report submitted three months prior to the commencement date of enrollment, that describe the status of all of the following readiness criteria and activities that the department shall complete:

(i) Enter into contracts, either directly or by funding other agencies or community-based, nonprofit, consumer, or health insurance assistance organizations with expertise and experience in providing health plan counseling or other direct health consumer assistance to dual eligible beneficiaries, in order to assist these beneficiaries in understanding their options to participate in the demonstration project specified in Section 14132.275 and to exercise their rights and address barriers regarding access to benefits and services.

(ii) Develop a plan to ensure timely and appropriate communications with beneficiaries as follows:

(I) Develop a plan to inform beneficiaries of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups described in clause (i), consistent with the provisions of paragraph (1).

(II) Design, in consultation with consumers, beneficiaries, and stakeholders, all enrollment-related notices, including, but not limited to, summary of benefits, evidence of coverage, prescription formulary, and provider directory notices, as well as all appeals and grievance related procedures and notices produced in coordination with existing federal Centers for Medicare and Medicaid Services guidelines.

(III) Design a comprehensive plan for beneficiary and provider outreach, including specific materials for persons in nursing and group homes, family members, conservators, and authorized representatives of beneficiaries, as appropriate, and providers of services and supports.

(IV) Develop a description of the benefits package available to beneficiaries in order to assist them in plan selection and how they may select and access services in the demonstration project's assessment and care planning process.

(V) Design uniform and plain language materials and a process to inform seniors and persons with disabilities of copays and covered services so that beneficiaries can make informed choices.

(VI) Develop a description of the process, except in those demonstration counties that have a county operated health system, of automatically assigning beneficiaries into managed care health plans that shall include a requirement to consider Medicare service utilization, provider data, and consideration of plan quality.

(iii) Finalize rates and comprehensive contracts between the department and participating health plans to facilitate effective outreach, enroll network providers, and establish benefit packages. The plan rates and contracts shall be provided to the appropriate fiscal and policy committees of the Legislature and posted on the department's Internet Web site so that they are readily available to the public.

(iv) Ensure that contracts have been entered into between plans and providers including, but not limited to, agreements with county agencies as necessary.

(v) Develop network adequacy standards for medical care and long-term supports and services that reflect the provisions of paragraph (5).

(vi) Identify dedicated department or contractor staff with adequate training and availability during business hours to address and resolve issues between health plans and beneficiaries, and establish a requirement that health plans have similar points of contact and are required to respond to state inquiries when continuity of care issues arise.

(vii) Develop a tracking mechanism for inquiries and complaints for quality assessment purposes, and post publicly on the department's Internet Web site information on the types of issues that arise and data on the resolution of complaints.

(viii) Prepare scripts and training for the department and plan customer service representatives on all aspects of the program, including training for enrollment brokers and community-based organizations on rules of enrollment and counseling of beneficiaries.

(ix) Develop continuity of care procedures.

(x) Adopt quality measures to be used to evaluate the demonstration projects. Quality measures shall be detailed enough to enable measurement of the impact of automatic plan assignment on quality of care.

(xi) Develop reporting requirements for the plans to report to the department, including data on enrollments and disenrollments, appeals and grievances, and information necessary to evaluate quality measures and care coordination models. The department shall report this information to the appropriate fiscal and policy committees of the Legislature, and this information shall be posted on the department's Internet Web site.

# APPENDIX B: CCI Legislative Reporting Requirements

| Report Name | W&I Citation | Reporting Requirements | Frequency | Initial Report Date[2] |
|---|---|---|---|---|
| Evaluation Outcome Report | W&I 14132.275(m) | The department shall conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of dual eligibles in these demonstration sites and shall provide a report to the Legislature after the first full year of demonstration operation, and annually thereafter. | Annual | February 1, 2015 |
| Duals Enrollment, Quality Measure and Cost Report | W&I 14132.275(q)(1) | Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this section. | Annual | May 1, 2013 |
| Health plan quality compliance report | W&I 14182.17(d)(8)(C) | Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts. | Annual | April 10, 2014 |

[2] Initial Report Date is based on March 1, 2013 state date for Mandatory Medi-Cal enrollment for Medi-Cal only benefits and June 1, 2013 start date for the Demonstration Project

| Report Name | W&I Citation | Reporting Requirements | Frequency | Initial Report Date[2] |
|---|---|---|---|---|
| Plan Audit and Financial Examination Summary Reports | W&I 14182.17(d)(8)(D) | Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a joint report, from the Department of Health Care Services and from the Department of Managed Health Care, to the Legislature summarizing information from both of the following:<br>(i) The independent audit report required to be submitted annually to the Department of Managed Health Care by managed care health plans participating in the demonstration project authorized by Section 14132.275.<br>(ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and completed for the previous calendar year by the Department of Managed Health Care and the department. | Annual | September 1, 2014 |
| Programmatic Transition Plan | Sec. 4, W&I 14182.17(d)(10)(B) | Together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, in consultation with stakeholders, develop a programmatic Transition Plan, and submit that plan to the Legislature within 90 days of the effective date of this section. | One time based on the June 27, 2012 bill chapter date | October 1, 2012<br><br>Submitted on September 28, 2012 |
| Health Plan Readiness Report | Sec. 4, W&I 14182.17(d)(10)(D) | No later than 90 days prior to the initial plan enrollment date of the demonstration project, assess and report on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9). | One time | June 1, 2013 |

| Report Name | W&I Citation | Reporting Requirements | Frequency | Initial Report Date[2] |
|---|---|---|---|---|
| Program Readiness Report | Sec. 4, W&I 14182.17(d)(10)(E) | The Department of Health Care Services shall submit two reports to the Legislature, with the first report submitted five months prior to the commencement date of enrollment and the second report submitted three months prior to the commencement date of enrollment, that describe the status of all of the following readiness criteria and activities that the department shall complete. | 2 reports | January 1, 2013<br><br>March 1, 2013 |
| MSSP waiver Transition Plan | Sec. 6, W&I 14186.3(b)(4)(B)(C) | No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a Transition Plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the Transition Plan. | 2 Reports | January 1, 2014<br><br>90-days prior to implementation |
| LTSS Enrollment, quality measure and cost report | Sec. 6, W&I 14186.4(g) | Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this article. | Annual | May 1, 2013 |

# APPENDIX C: Demonstration Beneficiary and Provider Outreach Plan

[DRAFT]

The federal Centers for Medicare & Medicaid Services (CMS) is working with the California Department of Health Care Services (DHCS) to establish a demonstration project in certain California counties. The project aims to promote coordination of care and enhance the quality of home- and community-based services (HCBS) among Medicare and Medi-Cal enrollees, also called dual eligible beneficiaries. This project is part of the California Coordinated Care Initiative (CCI) and is taking place, once federal approval is given, in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The state is committed to the implementation of a robust Beneficiary and Provider Outreach Plan that ensures beneficiaries have accurate, actionable information for their own decision-making processes. The overarching goal of the outreach work is to help beneficiaries make informed choices based on their needs and have a good understanding of their options. The plan works to ensure that all audiences that have relationships with beneficiaries, especially caregivers and providers, have the information they need about this program. Recognizing California's network of existing support for this population through community-based organizations (CBOs), advocacy organizations, and social service agencies, this plan aims to build on that foundation. The goal is to ensure that information is available in places that are natural touch points for the beneficiary population.

## I. Target Audiences and Clarity of Reference

The outreach approach recognizes as its foundation that the Duals Demonstration population today receives their information from established routes of communication. The state will help support and supplement those existing pathways with accurate information and also with resources, as they are made available. The state will focus on facilitation and coordination, with direct contact with beneficiaries, caregivers, and providers as an important priority. The state will work to develop accurate, accessible materials, including notices. The state will then work to support the effort of community groups to inform individuals of their options. This means the state will have county-based representatives (called Outreach Coordinators, discussed below) to ensure robust outreach and information connections on a local level.

### *Key Audiences*

There are four key groups of audiences that need to be supported:

- Tier 1 – Direct Action Takers: Beneficiaries, caregivers and providers [See Attachment C-1 for a more detailed chart.]
- Tier 2 – Guides: Community-based organizations (CBOs), unions, medical societies, the Health Insurance Counseling & Advocacy Program (HICAP), legislative aides (all offices, including regional), insurance agents/brokers, county governments, tribes and tribal leaders.

- Tier 3 – Leadership: Advocates, policymakers (in California and nationally) and opinion leaders.
- Tier 4 – Public At-Large.

***Clarity of Reference***

It is preferable that the Duals Demonstration be given a name to ensure all audiences are discussing the same component of the CCI. This process is underway within DHCS.

**II. Implementation: DHCS Project Lead from Sacramento**

The following tasks are being executed at a leadership level to ensure appropriate infrastructure and support for all outreach activities.

*1. Ensure that all beneficiary notifications are in clear, consumer-friendly language – in process.* This is an absolutely critical part of the outreach effort. Confusing notices could negatively impact any complementary efforts to ensure Tier 1 audiences are clear on their corresponding actions.

- This includes updating the "What Are My Medi-Cal Choices?" booklet and required enrollment notices to target the duals population. As in all outreach materials, close attention will be paid to cultural competency and the development of accessible materials, including available alternative formats.

*2. Coordinate with other state entities on outreach – in process.* This includes Covered California, the Department of Social Services and the Department of Aging.

*3. Supporting community organizations.* Federal funding is needed for outside groups such as HICAP and Area Agencies on Aging (AAA) needs to be budgeted and secured. DHCS will support securing federal funding.

*4. Toolkit development – in process.* Develop a training materials "toolkit" to educate DHCS, health plan staff, beneficiaries, community based organizations and advocate groups. The toolkit will also supplement the enrollment notices. See Attachment C-2 for more details on the toolkit. There will be a special focus on developing materials for community organizations that support limited English proficiency individuals.

*5. Supportive training program development – in process.* Create and implement an educational program and toolkit to support local organizations that can train their staff to assist beneficiaries and providers. [Potential locations for these trainings include: health plan locations, community-based organizations, such as Centers for Independent Living or Aging and Disability Resource Centers, physician offices, hospital staff, CBAS centers, community clinics, county behavioral health agencies, public authorities and county IHSS departments.] In some areas, plans are developing these efforts already, and DHCS can support those efforts as needed.

- This program will include assisting and developing a plan for outreach through Benefits Counselors and Legal Advocates.
- This program will also work for community-based organizations (CBO and Provider Coordination). Support and help existing communication channels that are available through local AAA and other community-based organizations. Examples include: Meals on Wheels Programs, Para-transit agencies, Senior Centers and Senior Centers without Walls.

*6. DHCS/MAXIMUS Call-center staff training – in process.* Develop materials to train DHCS/MAXIMUS call center staff so they are familiar with choice packets and prepared to answer questions. It is critical that these materials are available in some permutation to all potential intake points for a provider and/or beneficiary.

*7. User-friendly website – in process.* Continue to update and refine CalDuals.org, a consumer friendly website through which beneficiaries and their advocates can access relevant information. [Potentially add an additional URL or gateway, depending on program naming convention.]

*8. Monthly conference calls with advocacy groups at the statewide level.* DHCS would host these calls on a similar date each month to help flag implementation issues and feedback advocates are receiving from their constituencies during the initial outreach period. This is designed to ensure a continuous communication loop and to keep everyone on the same page.

*9. Monthly conference calls with health plan communications staff.* DHCS would host these calls on a similar date each month to ensure proper coordination and to help flag issues.

*10. Coordination with provider associations.* DHCS would work with provider associations to ensure that information flows in a timely manner for gatherings and publications, as well as work to assist with routine member inquiries and clarification.

*11. Specific Approaches for the following populations –in process:* Institutionalized beneficiaries, ethnic/minority beneficiaries and physician groups. DHCS is working with various organizations, including groups such as the Network of Ethnic Physician Organizations and New America Media, to develop these strategies. The goal is to ensure that information about the program reaches these populations through their unique communications touch points.

## III. Implementation: Outreach Coordinators in the Counties

At the heart of the outreach effort will be the development of a team of individuals called "Outreach Coordinators" to serve as outreach staff in the field who will be supported by federal funds through DHCS as CalDuals consultants are supported today. While part of their role is direct provider and beneficiary contact, the primary function is to support local county groups to ensure they have the support they need, as it is requested by

local entities. In line with the overall aims of this plan, coordinators will build bridges between the local resources, the plans, and the individuals making decisions on how to participate. To the extent organizations want to understand the state position and information, the coordinators will help DHCS to ensure that beneficiaries, caregivers and providers have the information they need about this program. Coordinators will play a supportive role to local community-based organizations (CBOs), advocacy organizations, and social service agencies. The coordinators will play a support role; local plans and CBOs have their own governance structures that will have to decide on their own what support—if any—they want from DHCS. It is to be expected that the role of the coordinator will be slightly different in each county so as to meet the needs in that county.

Their success will be based in part by their ability to serve as the DHCS resource on the ground while helping local groups. Coordinators will know how to answer beneficiary, caregiver, and provider questions and refer to relevant sources and supplement any gaps that may exist for the group.

Outreach Coordinators will ideally have backgrounds in community organizing and/or communications skills. Experience with health policy – on an advocate or personal level – is preferred but not required. Individuals with experience reaching out to an elderly, disabled, or provider populations will also be given preference. They will go through an intensive training program that reviews the relevant policy as well as outreach principles.

Coordinators will operate under the established approach of inclusiveness and accessibility. Overall, they will serve to help support community work and educate both beneficiaries and providers in the community. Their role is to ensure the availability of accurate information that will allow beneficiaries to make an informed decision—not to "sell" the Demonstration.

More specifically, DHCS Outreach Coordinators will:

- *Assist with an initial landscape assessment.* [See Attachment C-3 for more information.]

- *Support local/community based organizations,* including, but not limited to, local Health Insurance, Counseling and Advocacy Program (HICAP) agencies, AAAs, Independent Living Centers, Aging and Disability Resource Centers (ADRC), Caregiver Resource Centers, Public Authorities, and Health Consumer Centers, as well as local advocates, local senior centers, and county agencies.

- *Work in cooperation with health plans* to clarify benefits options packages for providers and beneficiaries. (In this capacity, staffers will also flag issues to be addressed at a policy level.)

- *Work with and inform physician groups,* including but not limited to the California Medical Association (CMA), CMA county affiliates, California Association of Physician Groups (CAPG), ethnic and specialty medical societies, and local hospitals associations. (Working with ethnic medical societies will be particularly important to reach beneficiaries from specific cultural and linguistic minority communities.)

- *Conduct direct outreach employing various mechanisms, including:*
    - Discussions with key stakeholders, beneficiaries, and providers in their 'home' settings, including places like senior centers, low-income housing complexes, churches and care centers (as well as settings such as nursing homes).
    - Attendance at health fairs and other pre-organized events, including an information booth.
    - Supporting the HCO enrollment specialists that are stationed at the county eligibility offices to help them advertise their weekly enrollment sessions.
    - One-on-one listening sessions for relationship building purposes.
    - Group meetings as needed for dual eligible beneficiaries in each county using the DHCS-approved presentation materials.

- *Create a meeting structure for county leaders.* The Coordinators will develop an infrastructure to support leadership meetings in each Demonstration county for representatives of all major areas of interest—including but not limited to hospitals, physicians, county health/mental/social services leaders, representatives from the health plans, and advocates. The goal will be for each local group to become self-sustaining.

- *Assist with media events as needed.* There should be an effort to reach people though the media.

Note: Coordinators will also conduct outreach to ethnic/minority communities, particularly by working with CBOs. Efforts will be made to hire coordinators with appropriate language capabilities throughout the regions. They will work in tandem with the specific ethnic/minority strategy.

**Attachment C-1: Tier 1 Audience Chart: Beneficiaries, Caregivers, Providers**

| Tier 1 Audience Chart: Beneficiaries, Caregivers, Providers | | | |
|---|---|---|---|
| It will be critical to ensure that these audiences have information about the pros and cons of various decision involved, as well as any logistics needed for their actions, such as deadlines, phone numbers, etc. | | | |
| Audience | Need | Action | Notes |
| Eligible Beneficiaries | Ensure that this population can make an informed and accurate choice about their participation in the demonstration. | Beneficiaries make an informed choice based on their unique needs when selecting a plan and/or opting into or out of the demonstration.<br><br>Beneficiaries understand how the integration of long term support services (LTSS) and/or the demo will or will not impact their services. | Dual Eligible population is diverse and messages may need to be tailored to subgroups for maximum impact. |
| Caregivers /Family members | Ensure that this population is clear on the changes occurring and can help beneficiaries make informed choices. | Assist or advise beneficiaries on making an informed choice based on their unique needs when selecting a plan and/or opting into or out of the demonstration.<br><br>Caregivers understand how the integration of long term support services (LTSS) and/or the demo will or will not impact their services. | This is important given the role of In-Home Support Services (IHSS). |
| Providers | Ensure that this population has information about joining the managed care networks and participating in | Understand the benefits of managed care organizations from a provider perspective. | • From California Medical Association, discussing another transition: “It is equally important to |

| | | | |
|---|---|---|---|
| | managed care, as well as a clear understanding of the values and goals of the initiative.<br><br>Ensure that this population is clear on the changes occurring and can help beneficiaries make informed choices. (Including understanding the difference between Managed Long Term Supports and Services [MLTSS] and the demonstration.) | Understand details of a transition to managed care, including but not limited to quality metrics, reporting, encounter data and continuity of care.<br><br>Assist or advise beneficiaries on making an informed choice based on beneficiaries' unique needs when selecting a plan and/or opting into or out of the demonstration.<br><br>Providers understand how the integration of long term support services (LTSS) and/or the demo will or will not impact their services. | eliminate or minimize uncertainty on how this will affect providers going forward.<br>• Specifically around payment, processes and contracting/provider group affiliation options."<br>• Both research and experience confirm that providers have a very influential status with beneficiaries themselves and will play a role in their decision-making process on whether to participate. |

**Attachment C-2: Supporting Training Program Toolkit**

The toolkit should be available for download online (make provisions to mail documents to low-income beneficiaries with no Internet access). The toolkit will include a series of fact sheets that explain policy issues, such as the enrollment policy, changes to long-term supports and services, and other topics, as needed.

The toolkit will have tailored materials for different levels of audiences:

- Beneficiaries
- Caregivers
- Providers
- The "Guides" - CBOs, HICAP staff

**Components**

1. Consumer-focused Fact Sheets and FAQ
2. Infographics that show:
    a. The difference between Medicare and Medi-Cal
    b. How managed care works and how it's different than what they have now
    c. A timeline that explains deadlines to make choices
3. One-pagers with different scenarios: Quick stories that help people relate to an example and put their situation into context.
4. PowerPoint presentation slides and instructions for local organizations to present them.
5. Worksheets to help Guides clarify choices for people.

**Attachment C-3: Landscape Assessment**

An initial step will be collecting an inventory of assets, resources and partnership opportunities within: DHCS, other departments of the California Health and Human Services Agency, CMS, community-based organizations and demonstration health plans.

The beneficiary target assessment will begin with interviews with at least the following:

- Health plan executives including but not limited to individuals in the following areas: marketing, member services, community education, provider relations
- County officials
- HICAP managers
- AAA directors
- Centers for Independent Living managers
- Case management and enrollment staff from managed care plans
- Leaders of key consumer advocacy organizations
- Dual eligible beneficiaries
- Nursing homes

If funded, this may also include the survey designed to establish a baseline of beneficiary awareness of issues in the current system.

The provider target assessment will begin with interviews with at least the following:

- Physicians
  - Groups
  - Specialty physician societies
  - County medical societies
  - Ethnic medical societies
  - Any other opportunities to speak with independent physicians
- Hospitals
  - Private
  - County public hospitals
  - Community clinic associations
- Nursing homes/skilled nursing facilities
- IHSS workers and their unions
- CBAS providers and staff
- MSSP site directors and staff
- Ancillary provider groups
- Case management and enrollment staff from managed care plans

# APPENDIX D: Dual Demonstration Project – Medi-Cal Blended Rate & Risk Adjustment Methodology


**Summary**
This document describes the methodology California will use to develop the blended, risk-adjusted Medi-Cal component of the Duals Demonstration rates. Additionally, California will use this same general methodology to develop a blended, risk adjusted rate for the Dual eligible who opt-out of the demonstration, in order to maintain consistency in rate-setting within and outside the demonstration.


California intends to pay a single, blended rate for dual eligible members enrolled in a health plan (versus separate rates for different rate cells). The single blended rate will take into account the relative risk of the population actually enrolled in the health plan and be weighted accordingly. The rate development process will be based on the entire demonstration eligible population in the county. However, because a member can opt out of the demonstration and since there are two or more plans in six of the eight Dual Demonstration counties, there is some unpredictably related to the estimation of members enrolled in the demonstration and each individual contracted health plan. The risk adjustment process is designed to account for differences in actual selection risk related to the mix of the four identified populations. Thus, the final payment rate will likely not be the original established capitation rate (which was based on the risk of the entire eligible population in the county) but instead will be the risk adjusted rate specific to the mix of the population enrolled in the health plan. California envisions operating the risk adjustment methodology in three phases to account for the differences in enrollment stability due to the proposed phase-in of enrollment.

## Risk Adjustment Population Categories

California has determined that the dual eligible population can appropriately be categorized into four identified populations.

- Institutionalized members (LTC): These are individuals who are residing in a long-term care facility for 90 or more days and/or are in long-term care aid codes.
- Members identified as high utilizers of home & community based services (HCBS high): These are individuals who meet one or more of the following criteria:
  - Members who receive community based adult services (CBAS)
  - Members who are clients of Multipurpose Senior Service Program sites (MSSP)
  - Members who receive in home supportive services (IHSS) and are classified under the IHSS program as “Severely Impaired” (SI).
- Members identified as low utilizers of home & community based services (HCBS low): These members are IHSS recipients and classified under the IHSS program as “Not Severely Impaired” (NSI).

- All other members living in the community with no HCBS services (Community well): These are all other members who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

These categories provide the ability to appropriately group members with similar risk together and are able to be clearly identified/defined by available data.

**Frequency of Risk Adjustment**
California has determined that the risk adjustment process should operate in three distinct phases in order to both recognize the impact on the stability of enrollment due to the planned enrollment phase-in as well as establish appropriate financial incentives for health plans.

*Phase 1*
The first phase will occur during each county's phased-in enrollment period (generally 12 months). During this phase, the risk adjustment methodology will be applied each month to match actual enrollment and will be retroactively applied. In addition, to ensure ease of operations in the future, this phase will continue beyond the phased-in enrollment period as necessary to ensure that this phase ends with the end of a fiscal quarter. For example, for a county where phased-in enrollment begins September 2013 and will continue for 12 months (last month of phased-in enrollment is August 2014), this phase of risk adjustment will apply through September 2014, and phase 2 would begin October 1, 2014. There will be no trigger requirement to meet before an adjustment is made.

*Phase 2*
The second phase will be a short single quarter transition phase. This phase will begin at the start of the fiscal quarter after the end of phase 1 and will occur for only a single quarter. This single quarter transition phase before moving to the annual adjustment for phase 3 is intended to recognize the need for additional time after the last month of phased-in enrollment for enrollment to stabilize. During this phase of risk adjustment, an adjustment will be made at the start of the quarter and will be prospective only. For example, for a county that has 12 months of phase-in, this phase 2 will be for the October - December 2014 quarter. The relative mix factor (weighting in the risk categories) will be done based on a September 2013 enrollment snapshot. In order to use the enrollment based on the immediate month prior to the quarter, the actual adjustment for the prospective quarter will not occur until 6 months after the preceding quarter ends, but will be applied retroactively to that period. There will be no trigger requirement to meet before an adjustment is made.

*Phase 3*
The third and final phase will be ongoing for the remainder of the demonstration. This represents a shift away from the ongoing risk adjustment methodology proposed for the first two phases, and would establish a rate for the health plan for the fiscal year. If phase 3 begins during a fiscal year, the first year of this phase will continue through the end of that fiscal year, if there are more than 6 months remaining in that fiscal year, otherwise the first year of the phase will continue through to the end of the following

fiscal year. For example, for a county on a 12- month phase-in enrollment that had begun in September 2013, phase 3 would begin January 2015 and the first year of phase three would end September 2015.

The relative mix of the population as of the month prior to the start of the phase 3 year for a health plan will be the starting point for the development of the health plan's capitation rate for the year. In order to use the enrollment based on the immediate month prior to the quarter, the actual adjustment for the prospective quarter will not occur until 6 months after the preceding quarter ends, but will be applied retroactively to that period. DHCS will utilize that relative mix and project a targeted relative mix for the plan for the year based on assumptions about the health plan's ability to shift populations from one risk group to another (e.g. targeting a reduction in the LTC category to HCBS high). The rate would not be adjusted during the year. However a relative mix risk sharing approach would be in place such that if the actual population mix for the plan for the year has resulted in a greater than a 2.5% impact to the rate, then the plan and the state/federal government would share in any cost/profit beyond the 2.5%.

If the demonstration were to be extended and for the ongoing rate setting for the dual eligible population that will continue only on the Medi-Cal side even absent a demonstration, DHCS and its actuaries would evaluate to determine what an appropriate risk mix sharing percentage would be for future years.

***Risk-Adjustment Methodology Steps***

The calculation of the capitation rate under this risk adjustment methodology consists of three-steps:

1. Establishment of actuarially derived relative cost factors (RCF) for each of the 4 identified populations
2. Computation of health plan specific relative mix factors (RMF) based on health plan enrollment
3. Determination of the health plan RMF capitation rates

*Step 1: Establish RCFs*

DHCS and its actuary will determine RCFs for the four identified populations. This determination will be based on an evaluation of the per member per month costs (PMPMs) for these populations, relative to the total blended rate. The RCFs will be rounded to the fourth decimal point. An example of this step is shown below:

| ***Example RCFs*** | | | |
|---|---|---|---|
| | **Population Mix** | **Expected Cost** | **RCF** |
| **LTC RCF** | 5.5% | $6,100.31 | 6.1003 |
| **HCBS High RCF** | 4.0% | $3,570.07 | 3.5701 |
| **HCBS Low RCF** | 9.0% | $2,218.29 | 2.2183 |
| **Community Well RCF** | 81.5% | $395.13 | 0.3951 |
| *Total RCF* | ***100.0%*** | ***$1,000.00*** | ***1.0000*** |

In determining the RCFs for the four population categories, DHCS and its actuary will determine the expected cost after adjusting for the assumed shifts in the population that are projected to occur. DHCS plans to adjust the RCFs periodically to ensure that the relative costs of each group are appropriately being accounted for. It is necessary to adjust the RCFs as population shifts occur as these shifts will cause the underlying costs for the members in those categories to change. For example, the movement of individuals currently in a long-term care facility into the community with the provision of HCBS to the member is projected to be possible for the lower cost LTC members. These previously LTC members would likely be higher cost than the existing HCBS high members, and the remaining LTC members would be higher cost due to the shift of the lower cost members to HCBS high. Similarly, health plans may assess that some of the higher cost community well people would more appropriately be served by HCBS benefits, thus resulting in a decrease in both the HCBS low category due to the movement of lower cost members into that category and the community well category due to the movement of higher cost members out of that category. An example of this effect is shown below:

| ***Example Adjusted RCFs*** | | | |
|---|---|---|---|
| | Adjusted Mix | Adjusted Cost | Adjusted RCF |
| **LTC RCF** | 5.3% | $6,169.60 | 6.1696 |
| **HCBS High RCF** | 4.2% | $3,582.50 | 3.5825 |
| **HCBS Low RCF** | 12.2% | $1,843.80 | 1.8438 |
| **Community Well RCF** | 78.3% | $379.60 | 0.3796 |
| *Total RCF* | ***100.0%*** | ***$1,000.00*** | ***1.0000*** |

*Step 2: Compute health plan-specific RMF*

Health plan-specific RMFs will be computed by DHCS and its actuary through the use of the RCFs established in step 1 and the proportion of each of the population category enrollees in each health plan. The point-in- time data utilized for this calculation will be done as described in the phases above, including for phase 3 the projection of targeted relative mix for the health plan. The RMFs will be computed by multiplying each health plans' distribution of each of the population categories (i.e., calculating a weighted average) Member distribution percentages will be rounded to the nearest hundredth of a decimal point. The resulting health plan RMF will be rounded to the fourth decimal.

| ***Example RMFs –*** | | | | |
|---|---|---|---|---|
| | **HP A Mix** | **RCF** | **HP B Mix** | **RCF** |
| LTC Members | 7.00% | 6.1696 | 9.00% | 6.1696 |
| HCBS High | 6.00% | 3.5825 | 10.00% | 3.5825 |
| HCBS Low | 9.00% | 1.8438 | 10.00% | 1.8438 |
| Community Well Members | 78.00% | 0.3796 | 71.00% | 0.3796 |
| ***Health Plan RMF*** | | ***1.1089*** | | ***1.3674*** |

Please note, as described above, in phase 3 of the risk-adjustment, the additional step will be taken of projecting a targeted relative mix that DHCS and its actuary estimate to be achievable by the health plan in the phase 3 year. Therefore the phase 3 health plan RMF will not match the actual enrollment at the beginning of the phase 3 year, rather it will represent the assumed target RMF set by DHCS and its actuary.

*Step 3: Determine health plan RMF adjusted capitation rates*

Using the health plan RMFs derived in step 2, DHCS will adjust the established capitation rate by multiplying the established rate by the respective RMF. This step will result in the risk-adjusted demonstration capitation payment rate.

| **Example RMF-adjusted rates** | | |
|---|---|---|
| | HP A | HP B |
| **Established Capitation rate for the County** | $1,000.00 | $1,000.00 |
| **Health Plan RMF** | 1.1089 | 1.3674 |
| *Health Plan RFM- adjusted rate* | ***$1,108.90*** | ***$1,367.40*** |

# APPENDIX E: Draft LTSS Standards

**California Duals Demonstration**
**Long-Term Services and Supports Network Adequacy and Readiness Standards**
**January 17, 2013**

These Standards, in conjunction with the companion Care Coordination Standards, are part of the requirements that the Centers for Medicare/Medicaid (CMS) and the California Department of Health Care Services (DHCS) will use to assess Demonstration Health Plan readiness. CMS and the State are currently developing a joint Readiness Review Tool, which will assess whether the Health Plan is compliant with the State/federal criteria for readiness, and able to deliver quality service and coordination.

The State will also require participating Health Plans to meet these standards for their non-Demonstration Medi-Cal managed care for Long-Term Services and Supports (LTSS). LTSS includes:

- In-Home Supportive Services (IHSS);
- Community-Based Adult Services (CBAS);
- Multipurpose Senior Service Programs (MSSP); and
- Nursing Facilities, Sub-Acute Care Facilities (NF/SCF).

## Provider Network and Contracting

For IHSS, Health Plans shall develop policies and procedures to:

1. Develop and execute Memorandum of Understanding (MOU) with county agencies that reflects an agreement between the Health Plan and county agency regarding roles and responsibilities for the first year of the Demonstration and Medi-Cal LTSS. Subsequent MOUs for future years will be jointly developed with the Health Plan and stakeholders. The provisions of the MOU shall be consistent with state law, including the provisions of WIC 14186.35. The MOU shall be completed four months prior to the effective date of the Demonstration.

   An MOU shall maintain the role of county social service (or health service) agencies and a separate MOU will explain the ongoing role of the Public Authority in IHSS, as appropriate, for:

   a. Assessing, approving, and authorizing each current and new member's initial and continuing need for services.

   b. Enrolling providers, conducting provider orientation, and retaining enrollment documentation.

   c. Conducting criminal background checks on all potential providers.

d. Providing assistance to IHSS recipients in finding eligible providers through an established provider registry.

e. Until the function transfers to the California In-Home Support Services Authority (the Statewide Public Authority), acting as employer of record, and providing access to trained IHSS providers and backup providers.

f. Performing quality assurance activities.

g. Sharing confidential data as necessary.

h. Appointing an advisory committee.

i. Continuing to perform other functions as necessary, as defined by statute and California Department of Social Services (CDSS) regulation, for the administration of the IHSS program.

2. Maintain the consumer-directed model for IHSS, which allows the member to self direct his or her care by being able to hire, fire, and manage his or her IHSS provider. (WIC 14186.35(a)(2))

3. Determine whether the recipients' desires to have their IHSS providers involved in care planning or coordination, and if so, obtain express consent from the recipient or his or her authorized representative."

4. Provide information and referral of members who have complaints, grievances, or appeals related to IHSS, to the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS. (WIC 14186.35(c))

5. Support a member who is at risk for out-of-home placement in obtaining IHSS services.

6. Ensure compliance with WIC 12302.6, regarding agencies, approved by CDSS, that provide IHSS personal care, attendant care or chore services in the home for emergency back-up services, as necessary.

7. Report documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to IHSS for staff or contractors. The Health Plan also provides documentation that it has trained personnel of IHSS organizations regarding the Health Plan's covered benefits and policies and procedures to access services and coordinate care.

For CBAS, Health Plans shall develop policies and procedures by no later than August 2014 to:

1. Arrange and show availability of providers of HCBS for members whose level of care needs correspond to CBAS benefit eligibility requirements, when CBAS centers are unavailable, inaccessible, limited in capacity, or cannot meet members' cognitive, cultural and linguistic needs.

2. Contract with all willing licensed and certified CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members and for addressing loss of licensing or certification or closure of a contracted CBAS center.

3. Every effort should be made to ensure that Members receive CBAS services that are linguistically, culturally, and cognitively competent, when available.

4. Collaborate with CBAS centers to discuss at least annually on areas of collaboration and improvement.

5. Govern how the Health Plan will: 1) make referrals to CBAS (consistent with the waiver Special Terms and Conditions), 2) communicate generally with CBAS centers, 3) share the member's health information, and 4) coordinate care between the Health Plan and the CBAS center.

6. Work in collaboration with CBAS organizations and contracted providers to develop protocols for coordinating the Member's Interdisciplinary Care Team (ICT) with the CBAS Multi-Disciplinary Teams, and delineating roles and responsibilities among the entities.

7. Support any member who is at risk for out-of-home placement in obtaining CBAS services, when appropriate as determined by the Health Plan.

For MSSP, Health Plans shall develop policies and procedures to:

1. Execute agreements with all MSSP organizations in the Health Plan's covered zip code areas for providing MSSP waiver services to eligible members, or have demonstrated that they have negotiated, in good faith, to attempt to secure executed contracts, in anticipation of plan readiness review, in order to have MSSP serve as a provider to the health plan.

2. Work with their contracted MSSP organizations to develop a care coordination and management model that supports appropriate referral of Health Plan members to the MSSP organization for assessment, eligibility determination, and services.

3. Establish, convene, and consider the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the MSSP contract.

4. Govern how the Health Plan will make referrals to MSSP and define the respective care management roles and duties of the Health Plan's ICT and MSSP care managers.

5. Govern MSSP assessment and eligibility determination as part of the Health Plan's care coordination process.

6. Contract with MSSP sites/organizations to provide Health Plan members who are MSSP waiver participants, MSSP case management services, and as needed, receive MSSP waiver services (such as supplemental personal care, respite, ramp, nutrition services, maintenance type, etc.).

7. Demonstrate the Health Plan has incorporated the use of MSSP services and other LTSS into its policies and procedures regarding:
   - Use of MSSP waiver resources for plan members.
   - Use MSSP sites to manage additional services outside of the scope of the MSSP waiver, at the discretion of Health Plans and MSSP sites.
   - Incorporation of features or elements of the MSSP care management approach.

8. Refer MSSP eligible plan members to the MSSP sites if there is an open waiver slot available, and to allow for eligible Health Plan members to receive the needed benefits if there is no available waiver slot.[3]

For NF/SCF, Health Plans shall develop policy and procedures to:

1. Govern authorization of NF/SCF services for members. Such policies and procedures shall cover criteria and authorization/reauthorization for placement in contracted facilities. These policies and procedures should be based on Medicare criteria for Medicare NF/SCF placement or Medicaid criteria for Medi-Cal nursing facility placement.

2. Offer and explain facility options to the member.

3. Ensure members have opportunities to transition from NF/SCF to community settings, as specified in the Care Coordination Standards.

4. Provide Health Plan members post-transition care coordination, as specified in the Care Coordination Standards.

[3] Note that if no MSSP slot is available that plans must provide MSSP-like services through a network of providers selected by the health plan.

5. Contract with licensed and certified nursing facilities. Health Plans must contract with a sufficient number of facilities located in the Health Plans' covered zip code areas. If NF/SCF facilities within the covered zip code areas cannot meet the member's medical needs, the Health Plan must contract with the nearest NF/SCF outside of the covered service area. Health Plans are responsible for all covered services even if their members are placed on short or long-term basis in NFs outside of their target service areas or contracted network. (WIC 14186.3(c))

   Reimburse NF/SCFs for Medi-Cal bed holds and leave of absences consistent with federal and state requirements (California Code of Regulations, Title 22 Section 72520)

6. A comprehensive policy on occurrence reporting, including, but not limited to unusual occurrences and quality issues impacting its members.

7. Provisions on how the Health Plan will accommodate the transfer of members residing in a contracted NF/SCF facility who experiences a loss of licensure, or any expected or unexpected closure.

8. Provisions on how the Health Plan will provide training to NF/SCF staff on working with the Health Plan.

For all LTSS, Health Plans shall develop policies and procedures to train:

1. All health plan staff involved in care coordination:
   - the person-centered planning processes;
   - linguistic, cultural, and cognitive competence;
   - core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate;
   - accessibility and accommodations; independent living;
   - wellness principles;
   - criteria for safe transitions, transition planning, care plans after transitioning; and,
   - along with other required training as specified by DHCS—both initially and on an annual basis.

2. Specially designated care coordination staff in dementia care management including but not limited to:
   - understanding dementia;
   - its symptoms and progression;
   - understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,
   - community resources for patients and caregivers.

3. Specially designated care coordination staff in MSSP including but not limited to:
   - an overview of the characteristics and needs of MSSP's target population;
   - MSSP's eligibility criteria;
   - assessment and reassessment processes, services, and service authorization process; and,
   - refer members to MSSP for assessment and eligibility determination.

4. All Health Plan staff generally on the addition of LTSS and social services to Health Plan operations. For all trainings, Health Plans shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

For all LTSS referrals, Health Plans will comply with current contractual standards for all covered services.

**Financial Information/Claims Processing**

For MSSP, Health Plans shall develop the following policy and procedures to:

1. Allocate, for nineteen months following the start date of the demonstration, funding for the capitation for MSSP slots as established in the three-way contracts with DHCS and CMS that will be the same level of funding (as estimated by DHCS) as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA). (SB 1008)

For CBAS, MSSP, and NF/SCF, Health Plans shall develop the following policy and procedures to:

1. Ensure claims processing systems pay MSSP, contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers. Documentation of system readiness must be provided prior to enrollment beginning.

2. Resolve any disputed claims for CBAS, MSSP, or NF/SCF reimbursement consistent with any other contracted health plan providers and to avoid disruption in care to Health Plan members.

3. Report individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from facilities.

4. Ensure readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations under Medi-Cal and Medicare law and regulation, as evidenced by testing of claims submissions and successful payment; instructions and training for

contracted providers on the accurate submission process, including the use of required claim forms; required fields; availability of electronic fund transfer, and a Plan contact for resolving claims submission problems or errors. (Payments by the plan will be made using Medi-Cal standards for Medi-Cal benefits and Medicare standards for Medicare benefits.)This shall include any system design change to ensure the timely processing of authorizations. Specific documentation of this must be provided to DHCS prior to any enrollment.

**Management Information System**

For MSSP, Health Plans shall develop policy and procedures for the following:

1. Data sharing agreements, through MOU or contract, with CDA and DHCS for exchanging confidential and other information about Health Plan members who are enrolled in MSSP.

2. Data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s), consistent with state and federal privacy rules.

3. Policies, procedures, and systems to identify Health Plan members who should be evaluated for MSSP eligibility and a protocol and mechanism for transmitting data and sharing care plans and other information relevant to these Health Plan members' care between the Health Plan and the contracted MSSP organization(s).

**Quality Improvement System**

For LTSS, Health Plans shall develop policy and procedures to:

1. Detail how their contracted CBAS centers will adhere to Health Plan-established quality assurance provisions, to be developed in collaboration with CBAS leaders, and consistent with state quality and ICT metrics as specified in the demonstration. Health Plans will seek technical assistance from the State as is necessary.

2. Define how it will adhere to quality assurance provisions and other standards and requirements as specified by CDSS, as well as any other state or federal requirements. (WIC 14186.35(a)(7))

## Provider Relations

Health Plans shall develop policies and procedures to:

1. Secure authorization from members or their legal representative to include IHSS provider of their choosing in the Interdisciplinary Care Team for that member, as deemed appropriate by the Health Plan.

2. Have assigned and trained staff specifically to address and expeditiously and process grievances, appeals, and complaints from contracted LTSS providers (CBAS centers, MSSP sites, and NF/SCFs) on all relevant areas of concern under the demonstration, including payment.

3. Develop and conduct initial and periodic orientation and training programs to familiarize contracted LTSS providers with Health Plans' operations, methods for provider communications, members' rights, plan-specific policies and procedures, claims submission and payment, coordination of benefits for the various types of beneficiaries reporting requirements, and conflict resolution process including how frequently such training will be conducted.

## Member Grievance System

For IHSS, Health Plans shall develop policies and procedures to:

1. Inform beneficiaries that they will continue to be able to utilize the State Fair Hearing process with the County Social Service Agencies for issues of appeals to authorized IHSS hours.

2. Update contact lists for LTSS providers on a quarterly basis.

For CBAS, MSSP, and NF/SCF, Health Plans shall develop policies and procedures to:

1. Describe how Health Plan members' grievances regarding eligibility determinations, assessments, and care delivered by the Plan's contracted CBAS centers, MSSP sites, or NF/SCF should be submitted and will be adjudicated.

## Member Services

For all LTSS, Health Plans shall develop policies and procedures to:

1. Train Health Plan staff to answer any service related questions or direct members to appropriate agency.

2. Ensure that all Health Plan members and/or authorized representatives are fully aware and informed of their rights, and that those rights are not violated.

3. Create and maintain a list of available LTSS providers; the list will be update no less than quarterly.

4. Demonstrate how authorizations and Individual Plans of Care will be transferred from one plan to another plan when a member disenrolls from one plan and enrolls in another to ensure no interruption in services to the member and no interruption in reimbursement to the CBAS provider responsible for the transferring member's care.

**Health Insurance Portability and Accountability Act (HIPAA)**

For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall develop the following policy and procedures to:

1. Ensure compliance with the Health Insurance Portability and Accountability Act of 1996.

For IHSS, Health Plans shall develop the following policy and procedures to:

1. Ensure consistency with HIPAA to allow IHSS providers to speak on behalf of member, if the member has so authorized.

## APPENDIX F: Acronyms

| | |
|---|---|
| AG | Advisory Group |
| ADRC | Aging and Disability Resource Center |
| AIS | Aging and Independence Services |
| AOA | Agency on Aging |
| CalHR | California Department of Human Resources |
| CBAS | Community-Based Adult Services |
| CBO | Community-based organizations |
| CCI | Coordinated Care Initiative |
| CDA | California Department of Aging |
| CDI | California Department of Insurance |
| CDMH | California Department of Mental Health |
| CDPH | California Department of Public Health |
| CDSS | California Department of Social Services |
| CHHS | California Health and Human Services Agency |
| CMIPS | Case Management, Information and Payrolling System |
| CMS | Centers for Medicare and Medicaid Services |
| CPT | Common Procedure Terminology |
| DCA | Department of Consumer Affairs |
| Demonstration | Dual Eligible Demonstration Project |
| DHCS | Department of Health Care Services |
| DME | Durable Medical Equipment |
| DMHC | Department of Managed Health Care |
| DOR | Department of Rehabilitation |
| D-SNP | Dual Eligible Special Needs Plan |
| DSH | Department of State Hospitals (formerly Department of Mental Health) |
| EQRO | External Quality Review Organization |
| ESRD | End Stage Renal Disease |
| HCBS | Home- and Community-Based Services |
| HCDS | Health Care Delivery Systems |
| HCO | Health Care Options |
| HFCIS | Health Facilities Consumer Information System |
| HICAP | Health Insurance Counseling and Advocacy Program |
| HPSM | Health Plan of San Mateo |

| | |
|---|---|
| ICT | Interdisciplinary Care Teams |
| IHSS | In-Home Supportive Services |
| IPA | Independent Physician Associations |
| IT | Information Technology |
| ITSD | Information Services Technology Division |
| LTSS | Long Term Services and Supports |
| MBC | Medical Board of California |
| MEDS | Medi-Cal Eligibility Data System |
| MMCD | Medi-Cal Managed Care Division |
| MOU | Memorandum of Understanding |
| MSSP | Multipurpose Senior Services Program |
| NCQA | National Committee for Quality Assurance |
| NEMT | Non-Emergency Medical Transportation |
| OPA | Office of the Patient Advocate |
| PACE | Program of All-Inclusive Care for the Elderly |
| PCP | Primary Care Physician |
| RFS | Request for Solutions |
| SB | Senate Bill |
| SHIP | State Health Insurance Assistance Program |
| SPDs | Seniors and Persons With Disabilities |
| Waiver | Federal Bridge to Reform 1115 Waiver |
| waiver | (lower case refers to all other waivers) |