



Coordinated Care Initiative

Program Readiness Report

April 2014

**Department of Health Care Services
Medi-Cal Managed Care Division**

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Executive Summary

Governor Brown signed Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012) and SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), as part of the Budget Act of 2012, which established the Coordinated Care Initiative (CCI). Further updates and clarifications to this initiative were enacted in June 2013 through SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013). This legislation requires the Department of Health Care Services (DHCS) to submit two written reports on the status of readiness criteria and associated activities pursuant to Welfare and Institutions (W&I) Code Section (§) 14182.17(e)(4)(E). The first report was submitted to the Legislature in January 2013. The first report can be found at the following link: <http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCIProgram-Readiness.pdf>.

This is the second and final report due to the Legislature regarding the status of readiness criteria and associated activities. Enrollment for the Coordinated Care Initiative (CCI) started on April 1, 2014 for the following counties: San Mateo San Bernardino, San Diego, Los Angeles and Riverside. Enrollment for the remaining counties (Alameda, Santa Clara and Orange) will start in accordance with the implementation schedule titled, “CCI Enrollment Timeline by Population and County” that can be found at the following link: <http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/> under the heading Enrollment Chart.

As required by W&I Code § 14182.17(e)(4)(E)(i-xi), this report provides an update on the status of the following readiness criteria and activities:

- (i) Contract/Funding for Consumer Counseling and Education Services
- (ii) Demonstration Beneficiary Communications
 - I. Beneficiary Enrollment Options and Rights
 - II. Enrollment Notices
 - III. Beneficiary and Provider Outreach Plan
 - IV. Health Plan Benefits Package
 - V. Notification of Copays and Covered Services applicable to Seniors and Persons with Disabilities (SPDs)
 - VI. 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 completed all program and plan readiness activities for the following CCI counties which were approved to start accepting enrollments in April 1, 2014: San Mateo, San Bernardino, San Diego, Los Angeles, and Riverside. Readiness activities for the remaining counties are in progress and will be complete prior to the targeted start date in each county. Los Angeles County started accepting voluntary enrollments on April 1 2014 for Healthnet and LA Care Cal MediConnect plans; and passive enrollments will start no sooner than July 1, 2014 for all health plans in LA County. Orange, Alameda and Santa Clara counties are scheduled to start no sooner than January 1, 2015. DHCS will continue ongoing stakeholder participation in the development of policies relating to the CCI.

Introduction

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income SPDs, including dual-eligibles (individuals eligible for Medicaid and Medicare), while achieving 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 through SB 1008(Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036(Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013).

The three major components of the CCI to be implemented in 2014 addressed in this report are¹:

1. A three-year demonstration project (Cal MediConnect) for dual-eligibles 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-eligibles; and
3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD dual-eligibles.

CCI will become effective in the counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara according to the implementation schedule titled, “CCI Enrollment Timeline by Population and County” that can be found at the following link: <http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/> under the heading Enrollment Chart.

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(e)(4)(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 worked with the California Department of Aging (CDA) to prepare an application for funding from CMS through the State Health Insurance Assistance Program and Aging and Disability Resource Center Options Counseling for Medicare-Medicaid individuals in states with approved Financial Alignment Models (FA grant). CDA secured \$1.0 million in FA grant funding for State Fiscal Years 2013-2014 and 2014-2015. CDA released contracts with the nine Area Agencies on Aging serving the eight CCI Cal MediConnect counties to enable them to use grant funds to support their local Health Insurance Counseling and Advocacy Programs (HICAP) in addressing the information needs of dual-eligible beneficiaries. The local HICAPs serving Cal MediConnect counties will use these funds to provide outreach, education, and counseling to dual-eligibles regarding their CCI health care coverage options. CDA, in collaboration with DHCS, has been working with these HICAPs to develop consumer materials and training resources to support the HICAPs' efforts.

II. Demonstration Beneficiary Communications

DHCS has developed a draft Beneficiary and Provider Outreach Plan to ensure that audiences have accurate, actionable information for their own decision-making processes (Appendix C – Draft Beneficiary and Provider Outreach Plan – December 2013 Version).

Communications and outreach materials have been developed to address the following:

a) Beneficiary Enrollment Options and Rights

The overarching goal of the outreach work is to ensure that beneficiaries are informed about their enrollment options and rights. Recognizing California's network of existing support for this population through Community-Based Organizations, advocacy organizations, and social service agencies, the outreach plan builds on that foundation to ensure that information is available in places that are easily accessible to beneficiaries and their families. This plan will continue to be updated and revised as needed and with stakeholder input.

b) Enrollment Notices

DHCS has developed notices and enrollment materials for Cal MediConnect and for mandatory Medi-Cal managed care enrollment. Generally, notices will be mailed 90, 60, and 30 days prior to a beneficiary's effective enrollment date.

DHCS worked with CMS to develop and test beneficiary notices. DHCS sought stakeholder input on the content of these enrollment notices, with the draft notices being emailed to a list of more than 1,000 interested stakeholders. Many notices were distributed for stakeholder comment twice. All the notices will be posted prior to their mailing to beneficiaries on both the DHCS Dual Eligibles

Coordinated Care Demonstration – Cal MediConnect website and on CalDuals.org.² At least 90 days prior to enrollment, dual-eligibles will receive written notification on how and when their Medi-Cal system of care will change, and who they can contact for assistance with choosing a Medi-Cal managed care health plan. These notices are available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate.

The enrollment notices explain that the beneficiary may choose to stay in fee-for-service (FFS) Medicare or their current Medicare Advantage (MA) plan; but must contact DHCS's Health Care Options (HCO) enrollment broker, MAXIMUS, to indicate their choice to opt out of Cal MediConnect. If the beneficiary does not actively opt out of Cal MediConnect, the State will assign the beneficiary into a Cal MediConnect health plan. The beneficiary notices will be modified to reflect any future changes to enrollment policy, as appropriate, and will include a public stakeholder review.

c) Draft Beneficiary and Provider Outreach Plan

As discussed above, DHCS has developed a draft Beneficiary and Provider Outreach Plan (Appendix C). This outreach plan has been shared with stakeholders and will be continuously updated as additional opportunities for education and training are identified prior to and throughout the CCI transition.

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 outreach plan also recognizes the diversity of the target population and that the majority in many counties does not speak English as their first language. Also, per statutory requirements, specific provisions have been made to educate beneficiaries on Program of All-Inclusive Care for the Elderly (PACE) options.

Much of this outreach will happen on a local level in the participating counties. At the heart of the local outreach effort will be two teams of people based across the eight CCI counties, technical advisors, and outreach coordinators. Both technical advisors and outreach coordinators will build bridges between the local resources, community based organizations, various stakeholders, the health plans, and the individuals making decisions on how to participate. Activities will include:

² The notices can be found on the following websites: and <http://www.dhcs.ca.gov/Pages/CCI-Info-Bene.aspx> and <http://www.calduals.org/implementation/cci-documents/notices/>.

- Participating in local stakeholder coalitions, particularly as they relate to communications and outreach to the beneficiary population;
- Providing informational presentations to beneficiaries and providers;
- Delivering “train the trainer” presentations to organizations who regularly interact with the beneficiary population and need support understanding and explaining the CCI; and
- Ensuring there is good information flow between the counties and the state, particularly to identify information and outreach needs in local communities.

d) Health Plan Benefits Package and Plan Selection Process

DHCS has developed educational materials to help beneficiaries make an informed choice based on a complete understanding of their enrollment options and benefits. Generally, 60 days prior to a beneficiary’s effective enrollment date, DHCS will mail an enrollment packet that includes:

- A letter describing the pending changes and actions required of the beneficiary;
- A resource booklet that describes the health plans and what it means to be enrolled in a health plan, particularly member rights and responsibilities; and
- A choice booklet that includes an enrollment choice form and pre-stamped envelope, and detailed plan benefit comparison charts, and details regarding in-person presentations.

These materials were provided to stakeholders for feedback prior to being finalized, a process which included beneficiary testing.

Each prospective health plan selected to participate in the CCI had to undergo a readiness review in order to be eligible to accept CCI enrollments. The readiness review process evaluated each prospective health plan’s ability to comply with CCI requirements, including but not limited to:

- The ability to quickly and accurately process claims and enrollment information;
- Accept and transition new beneficiaries; and
- Provide adequate access to all Medicare and Medi-Cal covered services that are medically necessary with beneficiary protections, including LTSS.

At a minimum, each readiness review included a desk review and a site visit to the prospective health plan’s headquarters. Only those health plans that passed the readiness review will participate in the CCI.

e) Notification of Copays and Covered Services Applicable to SPDs

With the exception of the following, cost-sharing is not permitted in Cal MediConnect:

- Copays charged for Medicare Part D drugs must not exceed the applicable amounts for brand and generic drugs established annually by CMS under the Part D Low Income Subsidy. Plans may establish lower cost-sharing for prescription drugs than the maximum allowed.
- Copays charged for supplemental dental benefits.

f) Health Plan Auto-Assignment Process

DHCS developed a process to assign beneficiaries to a 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 Cal MediConnect. If a beneficiary does not notify MAXIMUS of his/her choice to opt out of Cal MediConnect enrollment, he/she will be automatically enrolled into a health plan. Health plan contract provisions allow a beneficiary to disenroll at any time.

The health plan assignment process focuses on promoting continuity of care by evaluating a 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 an 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 to promote continuity of care in that facility. The individual's providers will be matched to providers in the participating health plan's network. A health plan will be selected for each beneficiary that best matches the current medical needs of the individual. If a beneficiary does not make an affirmative choice, and cannot be matched to a plan through medical history and primary provider utilization history data, he or she will be assigned to a health plan through an equitable distribution process. This auto-assignment methodology will be used for all counties where more than one Cal MediConnect is available: Alameda, San Diego, San Bernardino, Riverside, Los Angeles and Santa Clara. For San Mateo and Orange, the beneficiary will be passively enrolled in Cal MediConnect unless the beneficiary chooses to opt out.

III. Health Plan Capitation Rates and Contracts

In March 2013, DHCS and CMS signed the Memorandum of Understanding (MOU) that describes the major policies for Cal MediConnect. Though the MOU remains a high-level document in some respects, the MOU includes general provisions around eligibility, enrollment, benefits, beneficiary protections, care coordination, shared savings, appeals, oversight, and quality measures.

DHCS, CMS, and the health plans signed three-way contracts in early December 2013. The contracts require the health plans to offer quality, accessible care and to improve care coordination among medical care, behavioral health, and LTSS to those dual-eligibles who qualify. The contracts comply with all applicable provisions of federal and state laws, the MOU, regulations, guidance, waivers, Cal MediConnect terms and conditions, including the implementation of a compliance plan. The health plans must comply with the MA requirements in Part C of Title XVIII, and 42 Code of Federal Regulations Part 422 and Part 423, except to the extent that variances from these requirements are provided in the MOU.

In addition, CMS and DHCS developed a 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. CMS and DHCS issued county-specific rates.

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

For purposes of this report, the methodology and processes of rate development for Cal MediConnect are described in Appendix D.

IV. Health Plan, Provider, and County Agency Agreements

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

Similarly, DHCS in collaboration with CDA, provided template contract language to the health plans and MSSP sites to adopt during their contract development process.

During the readiness review process for the CCI the health plans fulfilled the requirement to provide evidence of all executed agreements.

V. Network Adequacy Standards

In consultation with stakeholders, CMS and DHCS developed network adequacy standards for medical care and LTSS that reflect the provisions of W&I Code § 14182.17(d)(5). Each health plan selected to participate in the CCI had to undergo a readiness review in order to be eligible to accept CCI enrollments, and health plan compliance with the network adequacy standards was part of this readiness review process. The readiness review process included a desk review and a site visit to the prospective health plan's headquarters. During the readiness review, health plans were found to be in compliance with network adequacy standards.

VI. Issue Resolution Procedures

DHCS and the Department of Managed Health Care (DMHC) will employ dedicated staff to provide comprehensive assistance to Cal MediConnect beneficiaries, during normal business hours, regarding any issues or disputes with the health plans. Further, as part of the readiness review, the health plans were required to show evidence that they had staff available to answer any inquiries regarding, among other things, issues of continuity of care.

A rigorous curriculum was developed to ensure that the State, Cal MediConnect Ombuds Program being administered by the Legal Aid Society of San Diego, a primary independent entity, and health plan staff are sufficiently trained to answer, respond to, and resolve issues or disputes. The Cal MediConnect Ombuds Program is a local ombudsman program that will operate in each Cal MediConnect county overseen by DMHC to ensure advocacy independent of DHCS and CMS on behalf of Cal MediConnect beneficiaries. The Cal MediConnect Ombuds Program became operational by April 1, 2014, and is staffed with consumer advocates familiar with the processes and procedures relevant to Cal MediConnect beneficiaries. The health plans have trained staff available to address and resolve complaints and to answer any beneficiary inquiries regarding, among other things, issues of continuity of care, and grievances/appeals processes. Beneficiaries will continue to be able to access ombudsman at DHCS and other State agencies as well as utilize all avenues for resolution of grievances and appeals including State Fair Hearings and Independent Medical Reviews.

VII. Appeals and Grievances Tracking System

DHCS, in collaboration with DMHC, CDSS, CDA, the California Department of Public Health (CDPH), and the participating health plans is developing a unified tracking and reporting process for consumer grievances and appeals. This system became operational on April 1, 2014. DHCS, CMS, health plans, and the Cal MediConnect Ombuds Program will use the Complaint Tracking Module to track grievances and

appeals from initial filing to final resolution. Various State agencies will be requested to report information regarding inquiries and complaints for beneficiaries enrolled in Cal MediConnect. The information gathered through the State appeals process will be consolidated along with information obtained from the various State departments, the Cal MediConnect Ombuds Program, and the health plans for purposes of monitoring and publicly reporting the outcomes of complaints.

DHCS has developed a Medi-Cal managed care dashboard template that will be used to monitor complaints including the number and type of grievances and appeals filed and the resolution of both grievances and appeals. The dashboard will also monitor enrollment, quality, network adequacy, beneficiary choice of health plan, and financial issues. Monitoring will be conducted on the health plans at the individual, plan model, and statewide aggregate level. A copy of the dashboard template can be found at the following link:

http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_2013.pdf.

VIII. Customer Service Training Plan

MAXIMUS, DHCS's HCO enrollment broker, developed a comprehensive training program to ensure newly hired and existing Customer Service Representatives (CSRs) assigned to assist the CCI eligible population have the knowledge and communication skills to respond quickly, accurately and compassionately to questions and concerns about the transition and changes to the CCI population's health care delivery options. DHCS is responsible for reviewing and approving all HCO training materials and call center scripts as part of their oversight role. Because of the size and unique needs of the CCI population, HCO has implemented a separate call center, with a dedicated phone line, and dedicated staff that will be assigned solely to the CCI transition. Existing CSRs and support staff will also receive intensive training on all facets of the CCI so that they may be available to assist during peak call volume periods.

The following modules are included as part of the training for new and existing HCO staff:

- Medicare overview;
- CCI overview;
- Cal MediConnect;
- Medi-Cal Managed Care Long Term Care Services and Supports;
- PACE; and
- Grievances and appeals.

This training includes detailed information on various CCI enrollment options including mandatory Medi-Cal managed care enrollment for LTSS and how to opt-out of Cal MediConnect. The training also includes information on how to transfer beneficiaries to other CCI dedicated call centers and resources such as the Medicare 1-800 call center, HICAP, and the Cal MediConnect Ombuds Program which became operational on April 1, 2014.

In addition to CCI specific training, all dedicated CCI call center CSRs will receive enhanced customer service soft skills training, which includes:

- Introduction to customer service;
- Active listening;
- The right attitude;
- Empathy/sympathy;
- Call control;
- First call resolution;
- De-escalation and negotiation;
- Managing change and uncertainty; and
- Sensitivity training.

Hiring and training for new CCI call center staff began in December 2013. The new staff, which includes 60 CSRs, is currently receiving training on existing HCO processes and new CCI specific processes. The following provides the staff hiring and training schedule by month through April 2014, which marks the beginning of the CCI transition period:

December 2013:

- Cross-training of selected existing HCO CSRs, supervisors, and managers (this started the week of December 16, 2013, and will continue through March 2014);
- New hire class of 30 CSRs;
- Hire and training of two supervisors and one manager for the Contact Center;
- Hire and training of one forms processor;
- Hire and training of one mailroom clerk; and
- Hire and training of enrollment services representatives in the field.

January 2014:

- Hire and training of two trainers;
- Hire and training of one communications specialist;
- Hire and training of two quality assurance specialists; and
- Hire and training of two mailroom clerks.

February 2014:

- Hire and training of two supervisors for the Contact Center;
- Hire and training of 30 additional CSRs;
- Hire and training of three CSR IIs;
- Hire and training of two work force management team;
- Hire and training of two research specialists;
- Hire and training of three forms processors;
- Hire and training of one reporting specialist;
- Hire and training of one part-time facilities coordinator
- Hire and training of a part-time human resource specialist; and

- Hire and training of one PC technician.

March 2014

- Hire and training of one administrative assistant.

As part of the enrollment notice development process, DHCS developed materials to train MAXIMUS call center staff so they are familiar with the health plan choice packets and are prepared to answer questions. Additionally, these materials will be made available to all potential intake points for a provider and/or beneficiary.

DHCS will ensure that the Cal MediConnect Ombuds Program and MAXIMUS receive up-front and on-going support to provide effective and accessible assistance to Cal MediConnect enrollees. DHCS will offer training information and web links to other departments within the State, such as the Office of the Patient Advocate, CDSS, and CDA.

IX. Continuity of Care Procedures

DHCS, in consultation with stakeholders and in collaboration with CMS, developed 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 12 months after enrollment (W&I Code §14182.17 (d)(5)(G)). To be eligible, providers and health plans must meet the following criteria:

- The provider accepts 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.

Beneficiaries who are long-term residents of a nursing facility prior to enrollment into the CCI will remain with their nursing facility during the duration of the CCI, if the following conditions are met:

- The facility is licensed by CDPH;
- The facility meets acceptable quality standards; and
- The facility and the health plan agree to Medi-Cal rates in accordance with the three-way contract.

Medicare Continuity of Care: Beneficiaries may have access to out-of-network Medicare providers for up to 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 the health plans provide an appropriate transition process for newly enrolled beneficiaries who are prescribed

Medicare Part D drugs that are not on the health plan's formulary (W&I Code §14182.17 (d)(2)(F)).

DHCS has developed descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and will distribute these materials to beneficiaries in their respective health 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

In November 2013, CMS published the “Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements” which contains the quality evaluation measures that all states participating in Cal MediConnect will report. These core measures address the full range of services and benefits for Cal MediConnect, including medical, pharmacy, LTSS, and behavioral health, as well as care coordination and consumer satisfaction. A copy of the “Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements” are available on the CMS website at: <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf>

Over the course of the last two years, DHCS, in consultation with CMS and stakeholders, has developed a list of State-specific quality and utilization measures to evaluate Cal MediConnect and the individual health plans. There will be one additional public comment period in the first quarter of 2014 to obtain additional stakeholder feedback prior to this list of measures being finalized and made publically available.

As mentioned previously, DHCS is developing a dashboard to provide the Legislature and stakeholders access to enrollment, appeals, utilization, and other short- and long-term process measures, as well as quality outcome measures. A copy of the dashboard template will be publically available in early 2014.

XI. Health Plan Reporting Requirements

CMS and DHCS have defined and specified in the three-way contracts, a consolidated reporting process for participating health plans to enable oversight of each plan's performance. This reporting process ensures the provision of the necessary data on diagnosis, quality outcomes, such as Healthcare Effectiveness Data and Information Set measures, enrollee satisfaction and other information that may enable monitoring of each participating health plan's performance. Participating health plans will be required to meet all reporting requirements that are established for the CCI.

APPENDIX A: State Readiness Review Statute – Reporting Requirement

W&I Code §14182.17(e)(4)(E):

(e) The department shall do all of the following:

(1) Monitor the managed care health plans' performance and accountability for provision of services, in addition to all other statutory and contractual monitoring and oversight requirements, by doing all of the following:

(A) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the dual eligible subset of enrollees. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance structure and process measures, or other performance measures identified or developed by the department.

(B) Implement performance measures that are required as part of the contract to provide quality assurance indicators for long-term services and supports in quality assurance plans required under the plans' contracts. These indicators shall include factors such as affirmative member choice, increased independence, avoidance of institutional care, and positive health outcomes. The department shall develop these quality assurance indicators in consultation with stakeholder groups.

(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.

(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 and from the Department of Managed Health Care, to the Legislature summarizing information from both of the following:

(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.

(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.

(2) Monitor on a quarterly basis the utilization of covered services of beneficiaries enrolled in the demonstration project pursuant to Section 14132.275 or receiving long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(3) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual eligible beneficiaries.

(4) Submit to the Legislature the following information:

(A) Provide, to the fiscal and appropriate policy committees of the Legislature, a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.

(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. The plan shall include, but is not limited to, the following components:

(i) A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

(ii) Explanations of the operational steps, timelines, and key milestones for determining when and how the components of paragraphs (1) to (9), inclusive, shall be implemented.

(iii) The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

(iv) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plan, and how their feedback shall be taken into consideration after transition activities begin.

(C) The department, together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, convene and consult with stakeholders at least twice during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. Continued consultation with stakeholders shall occur on an ongoing basis for the implementation of the provisions of this section.

(D) No later than 90 days prior to the initial plan enrollment date of the demonstration project pursuant to the provisions of Sections 14132.275, 14182.16, and of Article 5.7 (commencing with Section 14186), assess and report to the fiscal and appropriate policy committees of the Legislature 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), inclusive.

(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 (CMS) 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. To the extent permitted by CMS, the plan rates and contract structure 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 Code Citation	Reporting Requirements	Frequency	Report Due Date ³
Evaluation Outcome Report	W&I Code §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	May 1, 2015
Duals Enrollment, Quality Measure and Cost Report	W&I Code §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	June 1, 2014 Combined with LTSS Enrollment, Quality Measure and Cost Report (see below)
Health Plan Quality Compliance Report	W&I Code §14182.17(e)(1)(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	February 10, 2015

³ Report due date is based on April 1, 2014 start date for Mandatory Medi-Cal enrollment for Medi-Cal only benefits and April 1, 2014 start date for Cal MediConnect

Report Name	W&I Code Citation	Reporting Requirements	Frequency	Report Due Date ³
Plan Audit and Financial Examination Summary Reports	W&I Code §14182.17(e)(1)(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: (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. (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	July 1, 2015
Programmatic Transition Plan	W&I Code §14182.17(e)(4)(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	Complete http://www.dhcs.ca.gov/provgovpart/Documents/Duals/Implementation%20documents/CCITransitionPlanFinal.pdf
Health Plan Readiness Report	W&I Code §14182.17(e)(4)(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	January 2014

Report Name	W&I Code Citation	Reporting Requirements	Frequency	Report Due Date ³
Program Readiness Report	W&I Code §14182.17(e)(4)(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	Report 1 Complete http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCIProgram-Readiness.pdf Report 2: January 2014
MSSP waiver Transition Plan	W&I Code §14186.3(b)(4)(B) and (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	Report 1: November 1, 2014 Report 2: August 1, 2015
LTSS Enrollment, Quality Measure and Cost Report	W&I Code §14186.4(f)(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 article.	Annual	June 1, 2014 Combined with Duals Enrollment, Quality Measure and Cost Report (see above)

APPENDIX C: Draft Demonstration Beneficiary and Provider Outreach Plan

As of December 2013

The federal Centers for Medicare & Medicaid Services (CMS) worked with the California Department of Health Care Services (DHCS) to establish a demonstration project, referred to as Cal MediConnect, in certain California counties. Cal MediConnect 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.

The State is committed to the implementation of a robust Beneficiary and Provider Outreach Plan that ensures beneficiaries will 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 outreach plan works to ensure that all audiences that have relationships with beneficiaries, especially caregivers and providers, will 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 outreach 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 Cal MediConnect 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: 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.

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 dual-eligible 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 California Department of Social Services (CDSS) and the California Department of Aging (CDA).

3. Supporting community organizations. HICAP Counselors have received training on the CCI and are prepared to assist dual-eligible beneficiaries with understanding their health care coverage options.

- CDA and DHCS have established a State-level workgroup with the Department of Managed Health Care (DMHC) and the Office of the Patient Advocate to develop an approach for triaging and responding to beneficiary inquiries and related support materials.
- CDA and DHCS also have established a workgroup that includes California Health Advocates, the National Senior Citizens Law Center, and the HICAPs serving CCI Cal MediConnect counties. This work group is developing outreach and training materials to assist HICAPs and partner agencies in conducting beneficiary outreach, education, and options counseling.

4. Toolkit development – will be available approximately in January 2014. Develop a training materials “toolkit” to educate DHCS, health plan staff, beneficiaries, CBOs, 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 – will be available approximately in January 2014.* 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, CBOs, such as Centers for Independent Living or Aging and Disability Resource Centers, physician offices, hospital staff, Community-Based Adult Services [CBAS] centers, community clinics, county behavioral health agencies, public authorities and county In-Home Supportive Services [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 CBOs (CBO and Provider Coordination). Support and help existing communication channels that are available through local Area Agencies on Aging (AAA) and other CBOs. Examples include: Meals on Wheels Programs, para-transit agencies, Senior Centers and Senior Centers without Walls

6. *DHCS/MAXIMUS call-center staff training – complete (see Section VIII. above).* 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 Uniform Resource Locator or gateway, depending on program naming convention.)

8. *Monthly conference calls with advocacy groups at the statewide level.* DHCS will 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 will host these calls on a similar date each month to ensure proper coordination and to help flag issues.

10. *Coordination with provider associations.* DHCS will 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 will be 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 health 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 CBOs, advocacy organizations, and social service agencies. The coordinators will play a support role; local health 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.

Success will be based in part by the coordinator’s 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. Coordinators 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” Cal MediConnect.

More specifically, DHCS Outreach Coordinators will:

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

- *Support local/CBOs*, including, but not limited to, local HICAP agencies, AAAs, Independent Living Centers (ILCs), Aging and Disability Resource Centers, 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, 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 Health Care Options 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 Cal MediConnect 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 through 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 decisions 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 Cal MediConnect.	Beneficiaries make an informed choice based on their unique needs when selecting a health plan and/or opting into or out of Cal MediConnect. Beneficiaries understand how the integration of Long-Term Services and Supports (LTSS) and/or Cal MediConnect 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 health plan and/or opting into or out of Cal MediConnect. Caregivers understand how the integration of LTSS and/or Cal MediConnect will or will not impact their services.	This is important given the role of IHSS.
Providers	Ensure that this population has information about joining the managed	Understand the benefits of managed care organizations from a provider	<ul style="list-style-type: none"> From CMA, discussing another transition: "It is equally important to

	<p>care networks and participating in managed care, as well as a clear understanding of the values and goals of the CCI.</p> <p>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 Cal MediConnect).</p>	<p>perspective.</p> <p>Understand details of a transition to managed care, including but not limited to quality metrics, reporting, encounter data and continuity of care.</p> <p>Assist or advise beneficiaries on making an informed choice based on beneficiaries' unique needs when selecting a health plan and/or opting into or out of Cal MediConnect.</p> <p>Providers understand how the integration of LTSS and/or Cal MediConnect will or will not impact their services.</p>	<p>eliminate or minimize uncertainty on how this will affect providers going forward.</p> <ul style="list-style-type: none"> • Specifically around payment, processes and contracting/provider group affiliation options.” • 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.
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Attachment C-2: Supporting Training Program Toolkit

The toolkit will be available for download online and the State will 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 LTSS, and other topics, as needed.

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

- Beneficiaries;
- Caregivers;
- Providers; and
- The “Guides” - CBOs, HICAP staff.

Components

1. Consumer-focused Fact Sheets and Frequently Asked Questions (FAQs);
2. Infographics that show:
 - a. The difference between Medicare and Medi-Cal;
 - b. How managed care works and how it is different than what they have now; and
 - 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; and
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, CBOs, and Cal MediConnect 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, and provider relations;
- County officials;
- HICAP managers;
- AAA directors;
- ILC managers;
- Case-management and enrollment staff from managed care plans;
- Leaders of key consumer advocacy organizations;
- Dual-eligible beneficiaries; and
- 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; and
 - Any other opportunities to speak with independent physicians.
- Hospitals;
 - Private;
 - County public hospitals; and
 - Community clinic associations.
- Nursing homes/skilled nursing facilities;
- IHSS workers and their unions;
- CBAS providers;
- Multipurpose Senior Services Program providers;
- Ancillary provider groups; and
- Case management and enrollment staff from managed care plans.

APPENDIX D: Cal MediConnect – 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 Cal MediConnect rates. Additionally, California will use this same general methodology to develop a blended, risk-adjusted rate for the dual-eligibles who opt-out of Cal MediConnect, in order to maintain consistency in rate-setting within and outside of Cal MediConnect.

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 Cal MediConnect eligible population in the county. However, because a member can opt out of Cal MediConnect, and since there are two or more plans in six of the eight Cal MediConnect counties, there is some unpredictability related to the estimation of members enrolled in Cal MediConnect 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 (Long-Term Care [LTC]): These are individuals who are residing in a LTC facility for 90 or more days and/or are in LTC aid codes.
- Members identified as high utilizers of home- and 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 (MSSP) sites; and
 - 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 HCBS (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 residents in LTC 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 six 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 Cal MediConnect. 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 six 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 six 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 health 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 health plan for the year has resulted in a greater than a 2.5 percent impact to the rate, then the health plan and the state/federal government would share in any cost/profit beyond the 2.5 percent.

If Cal MediConnect 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 four 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 actuaries will determine RCFs for the four identified populations. This determination will be based on an evaluation of the per member per month (PMPMs) costs 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:

<i>Example RCFs</i>			
	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 actuaries 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 LTC 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 actuaries 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 plan's 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 actuaries 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 actuaries.

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
<i>Health Plan RFM- adjusted rate</i>	<i>\$1,108.90</i>	<i>\$1,367.40</i>

APPENDIX E: Acronyms

AAA	Area Agencies on Aging
CBAS	Community-Based Adult Services
CBO	Community-based organizations
CCI	Coordinated Care Initiative
CDA	California Department of Aging
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CMA	California Medical Association
CMS	Centers for Medicare and Medicaid Services
CSR	Customer Service Representative
Cal MediConnect	Dual-Eligible Demonstration Project
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
Dual-Eligible	Eligible for Medicare and Medicaid
FA Grant	Options Counseling for Medicare-Medicaid Individuals in States with Approved Financial Alignment Models Grant
FAQ	Frequently Asked Questions
FFS	Fee-For-Service
HCBS	Home- and Community-Based Services
HCO	Health Care Options
HICAP	Health Insurance Counseling and Advocacy Program
IHSS	In-Home Supportive Services
ILC	Independent Living Center
LTC	Long-Term Care
LTSS	Long Term Services and Supports
MA	Medicare Advantage
MLTSS	Managed Long Term Services and Supports
MOU	Memorandum of Understanding
MSSP	Multipurpose Senior Services Program
NSI	Not Severely Impaired
PACE	Program of All-Inclusive Care for the Elderly

PMPM	Per Member Per Month
RCF	Relative Cost Factors
RMF	Relative Mix Factors
SB	Senate Bill
§	Section
SI	Severely Impaired
SPDs	Seniors and Persons With Disabilities
Waiver	Federal Bridge to Reform 1115 Waiver
waiver	(lower case refers to all other waivers)
W&I	Welfare and Institutions