State of California

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Proposal to the Center for Medicare and Medicaid Innovation

Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals

May 30, 2012

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A. Executive Summary

In January 2012, Governor Jerry Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. The three-year demonstration proposal for dual eligible beneficiaries presented here is a critical component of this Initiative. Through this demonstration, which will begin in 2013, California intends to combine a full continuum of acute, primary, institutional, and home-and community-based services for dually eligible beneficiaries into a single benefit package, delivered through an organized service delivery system.

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California has an estimated 685,000 persons who are full benefit Medicare and Medi-Cal dual eligible beneficiaries in the eight counties selected for the demonstration in 2013. Medi-Cal is California's Medicaid program. These beneficiaries are among the state's highest-need populations. They tend to have many chronic health conditions and need a complex range of services from many providers. This fragmentation leads to beneficiary confusion, poor care coordination, inappropriate utilization and unnecessary costs.

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The State looks forward to continue working with CMS and stakeholders to finalize this demonstration proposal. This demonstration proposal builds on many years of stakeholder discussions and state interest in developing a coordinated care delivery system. Additionally, the demonstration builds on groundbreaking work to develop the innovative Program of All-Inclusive Care for the Elderly (PACE), a care coordination and integration program recognized nationally for improving beneficiary outcomes; the longstanding consumer-directed In-Home Supportive Services (IHSS) program, and the state's existing network of experienced Medi-Cal managed care health plans (health plans).

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The demonstration includes the following goals, which were approved by the State Legislature in 2010 and further developed through recent stakeholder engagement:

1. Coordinate state and federal benefits and access to care across care settings, improve continuity of care, and use a person-centered approach.
2. Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
3. Increase the availability and access to home- and community-based alternatives.
4. Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.
5. Optimize the use of Medicare, Medi-Cal and other State/County resources.

California's demonstration will use a capitated payment model to provide both Medicare and Medi-Cal benefits through the state's existing network of Medi-Cal health plans. These plans also have experience providing Medicare managed care. The health plans will be responsible for delivering a full continuum of Medicare and Medi-Cal services, including medical care, behavioral health services, and long-term services and supports (LTSS). LTSS includes home-

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and community-based services such as IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), in addition to care in nursing facilities when needed.

The demonstration will protect and improve the nation's largest personal care services program, IHSS, which serves 450,000 individuals, of whom 75 percent are dual eligible beneficiaries. IHSS developed out of California's Independent Living and Civil Rights movements. It is a prized program rooted in consumers' right to self-direct their care by hiring, firing and supervising their IHSS provider. Throughout the stakeholder process, beneficiaries emphasized the critical role IHSS plays in their ability to have a high quality of life in the community. Additionally, they emphasized the need to self-direct their care. This demonstration aims to enhance the IHSS program's ability to help people avoid unnecessary hospital and nursing home admissions. IHSS will remain an entitlement program and serve as the core home- and community-based service. County social workers will continue determining IHSS hours, and the current fair hearing process for IHSS will remain. The principles of consumer-direction and continuity of care are and will remain key aspects of the beneficiary protections.

In 2013, California intends to implement the demonstration in eight counties. There is current state authority for implementing the demonstration in four counties. The four initial counties selected are Los Angeles, Orange, San Diego, and San Mateo. California proposes to implement the demonstration in four more counties in 2013, with additional counties in 2014 and then statewide in 2015, if the Legislature approves the Coordinated Care Initiative.[1] The State held a rigorous selection process to identify health plans with the requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits for the initial eight counties (see Appendix 6 for health plan application checklist).

California will use a passive enrollment process through which dual eligible beneficiaries may choose to opt out of the demonstration. Those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period, during which they will remain in the same health plan. Enrollment in the demonstration counties will be implemented on a phased-in basis starting in calendar year 2013.

The demonstration will build on lessons learned during the 1115 waiver transition of Medi-Cal only seniors and persons with disabilities into managed care, including the following:

- Continuity of care. Beneficiaries and stakeholders repeatedly have emphasized the importance of care continuity when considering new delivery models. Beneficiaries will be informed about their enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. This information will be delivered in a format and language accessible to enrollees.
- Person-Centered Care Coordination. Health plans will be responsible for providing seamless access to networks of providers across this broader continuum of care, as well as

[1] The CCI also calls for the mandatory enrollment in Medi-Cal managed care for dual eligible beneficiaries, and inclusion of LTSS as each demonstration health plan is phased in.

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upholding strong beneficiary protections established by the state through the stakeholder process. The demonstration model of care will include person-centered care coordination supported by interdisciplinary care teams.

- Beneficiary Protections. The demonstration will include requirements and administrative processes that accommodate both Medicare and Medicaid, including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes.

- Plan Monitoring and Oversight. The State will work closely with CMS, stakeholders and beneficiaries, to provide strong monitoring and oversight of health plans, and to evaluate the demonstration's impacts on changes in quality and satisfaction, service utilization patterns, and costs.

- Provider Outreach and Engagement. The State will coordinate efforts to engage and educate providers about the demonstration leading up to implementation. This work already is underway through the stakeholder work group focusing on provider outreach and engagement.

- Transparency. Transparency and meaningful involvement of external stakeholders, including beneficiaries, has been a cornerstone in the development of this demonstration and will remain so throughout its implementation. California has embarked on a stakeholder workgroup process and will require proof of ongoing stakeholder involvement at the local level that includes, at a minimum: a process for gathering ongoing feedback from beneficiaries and other external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other beneficiary protections.

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Table 1: Demonstration Population and Benefit Summary

Target Population	All full benefit Medicare-Medicaid enrollees in the counties listed below, with specified exceptions.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	1,100,000
Total Number of Beneficiaries Eligible for Demonstration	685,000 in 2013 and increasing in future years
Geographic Service Area	2013: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara Counties. (see Appendix 1 for future year service areas)
Summary of Covered Benefits	Medicare (Parts A, B and D) and Medicaid covered services. Medi-Cal services include long-term care, including institutional care and home- and community-based services such as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), and additional benefits in lieu of institutionalization.

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	County-administered mental health and substance use treatment services will not be included in the capitation rate, but these services will be closely coordinated with shared accountability strategies.
Financing Model	Capitated payment model 2013-2015.

Summary of Stakeholder Engagement/Input	• April 2010: In-depth stakeholder interviews
	• 2010: Two large public meetings
	• 2011: Four large public stakeholder meetings
	  • Aug. 30, 2011
	  • Dec. 2, 2011
	  • Dec. 12, 2011
	  • Dec. 15, 2011
	• 2012: Series of California Health and Human Services Agency-sponsored stakeholder workgroup meetings:
	  • Feb 10, 2012
	  • Feb 24, 2012
	  • March 28, 2012
	• Website posting to www.CalDuals.org; email list with more than 1,500 individuals
	• Email Address for comments and questions: info@CalDuals.org
	• Beneficiary meetings
	• Local stakeholder processes required for health plan participation
	• An extensive policy workgroup process for spring-summer 2012, with ongoing workgroups as needed
	• Key informant interviews on the lessons learned from the 1115 waiver enrollment process
	• Public discussion of the Medi-Cal only Seniors and Persons with Disabilities transition to Medi-Cal managed care, on lessons learned and how those apply to the demonstration
	• Regular reports on the status and result of the demonstration will be submitted to the state Legislature and provided to stakeholders

Proposed Implementation Date(s)	Phased-in enrollment process starting between March and June 2013 in up to eight counties.

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B. Background

Vision

California has an estimated 685,000 persons who are full benefit Medicare and Medi-Cal dual eligible beneficiaries in the eight counties selected for the demonstration in 2013. Medi-Cal is California's Medicaid program. These dual eligible beneficiaries tend to have multiple chronic conditions and complex health care needs, but too often they receive services that are

seniors and persons with disabilities who are dually eligible for Medicare and Medi-Cal.

"fragmented, incomplete, inefficient, and ineffective" in the fee-for-service system.[2] While Medicare is the primary payer for medical services for dual eligible beneficiaries, the state-operated Medi-Cal program plays a significant role in covering most long-term care services, as well as their Medicare premiums and other out of pocket costs. Medicare and Medi-Cal often work at cross-purposes, however, because they have different payment rules and cover different services. For beneficiaries, this means no single entity is responsible for ensuring they receive all necessary care and services – medical, behavioral, social, and long-term services and supports. Furthermore, beneficiaries and their families/other caregivers must navigate these separate, complex systems on their own. This often results in fragmented and inefficient care, and sometimes no care at all. While some beneficiaries may be capable of assembling delicate webs of providers and services, many others are not and report being "bounced from office to office."[3]

This fragmentation has a negative impact on health outcomes and costs.[4] Medi-Cal spending on dual eligible beneficiaries in 2007 was about $7.6 billion, or about 23 percent of total Medi-Cal spending, although dual eligible beneficiaries comprised just 14 percent of the total Medi-Cal population. Total Medicare and Medi-Cal spending on dual eligible beneficiaries in California in 2007 was estimated at $20.9 billion.[5]

Today, fewer than 20 percent of dual eligible beneficiaries in California are enrolled in any kind of organized delivery system. With rare exceptions, the systems that most beneficiaries are currently enrolled in do not offer a full continuum of medical, behavioral, social, and long-term care services. There is a critical need for new organized systems of care that provide beneficiaries with more tailored and supportive benefits in the setting of their choice.

New systems should support and build on existing programs that work well. California's demonstration accomplishes this by pairing experienced health plans with strong home- and community-based service programs:

- The State has an experienced Medi-Cal managed care program and its contracted health plans have acquired significant experience in coordinating beneficiaries' services, as both Medicare and Medi-Cal health plans.

- California's system of home- and community-based services provides support to more than 450,000 individuals each year. These programs include: IHSS, which provides personal care and domestic services; Multipurpose Senior Service Program (MSSP) sites, which provide social and health care management for older adults at risk of needing institutional care; and Community-Based Adult Services (CBAS), which provides services at licensed facilities staffed with registered nurses, physical and occupational therapists, and social workers.

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[2] Chattopadhyay A, Bindman AB. Linking a Comprehensive Payment Model to Comprehensive Care of Frail Elderly Patients. *JAMA: The Journal of the American Medical Association*. 2010;304(17):1948 -1949.
[3] Adding Perspective: Conversations with Dual Eligibles. February 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/stakeholder%20documents/Outreach_Summary.pdf
[4] MedPAC. Coordinating Care for dual-eligible beneficiaries. In: *Report to the Congress: Medicare and the Health Care Delivery System*. Chapter 5; 2011. Available at: http://www.medpac.gov/chapters/Jun11_Ch05.pdf.
[5] California Department of Health Care Services. *Medi-Cal's Dual Eligible Population Demographics, Health Characteristics and Costs of Health Care Services*. Research and Analytics Studies Section; 2009.

Such a new system must be built on a foundation of strong beneficiary protections and ongoing stakeholder engagement. Meaningful involvement of external stakeholders, including beneficiaries, in the development and ongoing operations of the program will be required. Health plans will develop a process for gathering ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other beneficiary protections.

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In addition, the demonstration includes strong beneficiary protections that are proposed to be codified in state law. These protections include preservation of the existing IHSS consumers' rights, as employers, to hire, fire, and supervise their IHSS providers.

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On this foundation of beneficiary protections and strong State oversight, consolidating the responsibility for finances, services, and outcomes for the full continuum of Medicare and Medi-Cal benefits within one health plan will promote:

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1) **Person-centered care planning**. The demonstration will reflect a member-centered, outcomes-based approach to care planning, consistent with the Medicare Model of Care approach. "Person-centered" means the beneficiary has the primary decision-making role in identifying his or her needs, preferences and strengths, and a shared decision-making role in determining the services and supports that are most effective and helpful for the beneficiary. Health plans will provide care management and care coordination for beneficiaries, including interdisciplinary care teams, across the full continuum of medical and social services. Further, beneficiaries' needs no longer will be overshadowed by opportunities to shift costs to a different payer. Health plans will have the flexibility to provide services based on individuals' needs, rather than the categorical program restrictions such as those currently in place for Medi-Cal and Medicare.

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2) **Enhanced home- and community-based services (HCBS).** An integrated approach will create financial incentives for greater use of community LTSS, such as IHSS, for those at-risk of hospitalization and long-term nursing home placement. Under this demonstration, health plans will identify beneficiaries who are currently at-risk or reliant on institutional care and help them stay in or return to their homes and communities or transition to a more independent setting.

   A key impact of enhanced HCBS is reduced hospitalization, particularly because hospitalization is often a precursor to a nursing facility placement. Based on results from the PACE model, the appropriate delivery of home- and community-based services in partnership with primary care physicians can often prevent hospitalizations through proper nutrition, hydration, fall prevention, skin care, medication management, and incontinence management.

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3) **Emphasis on prevention.** Health plans will have a greater incentive to improve the use of preventative services and to provide individuals the services they need in the most appropriate setting of their choice.

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4) **Streamlined and simplified service delivery**. The delivery system will be easier to navigate for both the individuals receiving services and the providers delivering services. Beneficiaries will have one health plan membership.

5) **Enhanced quality monitoring and enforcement**. Incentives in the system will focus on performance outcomes related to better health, better care, and lower costs through improvements in care delivery. The demonstration will include quality measures jointly developed by the State, stakeholders, and CMS, as well as a rigorous evaluation process.

Finally, California's implementation of this demonstration in the coming years will build on the lessons learned from three recent program changes: 1) transition of Medi-Cal only seniors and persons with disabilities into Medi-Cal managed care; 2) statewide assessment of Adult Day Health Care beneficiaries, for the transition to the new Community Based Adult Services (CBAS) program, and 3) closure of the Agnews Developmental Center in San Jose, which resulted in the transition of medically fragile persons with developmental disabilities from institutional to community settings. Each of these transitions required careful planning, collaboration with providers and stakeholders, and a clear and transparent process for public review. The State intends to continue building on these efforts in the implementation of this demonstration.

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Population Description for the Demonstration

Demonstration Population: All full benefit dual eligible beneficiaries in the selected demonstration counties will be eligible for enrollment, with certain exceptions noted below. Full benefit dual eligible beneficiaries are those Medicare beneficiaries with Parts A, B, and D coverage, with full Medi-Cal coverage. Medi-Cal covers Medicare premiums, co-insurance, copayments, and deductibles, as well as services that Medicare does not cover (primarily long-term services and supports).

Share of Cost Beneficiaries: Based on stakeholder feedback, the State intends to include all beneficiaries with a Medi-Cal share of cost in the demonstration. These beneficiaries may opt-out of the demonstration. Those who do not will be enrolled in the demonstration for those months in which they meet their Medi-Cal share of cost. The State will work with health plans and CMS to make the administrative changes necessary to implement this policy.

Based on stakeholder feedback, enrollment in the demonstration will be modified for certain beneficiaries as described below, in the counties where the demonstration is implemented.

Populations Excluded from the Demonstration

Partial-Benefit Dual Eligible Beneficiaries: Partial dual eligibles receive only Medicare premium and cost sharing assistance from Medi-Cal through the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individual (QI) programs. Partial dual eligibles are not eligible for the demonstration.

Beneficiaries with Other Health Coverage: Beneficiaries with other health coverage, including private insurance and non-Medicare public insurance, such as through the Veterans

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Administration, will not be eligible for the demonstration. This definition of Other Health Coverage does not include Medicare Advantage plans or partial coverage plans, such as dental plans.

Children: Based on stakeholder feedback and the specific care coordination needs of dual eligible children, dual eligible beneficiaries under age 21 will not be eligible for the demonstration.

ESRD: California intends to follow the Medicare Advantage policy related to beneficiaries with end-stage renal disease (ESRD). Beneficiaries who have ESRD are not eligible to join the demonstration. Beneficiaries who develop ESRD after enrollment in the demonstration may stay enrolled. Beneficiaries with ESRD who are currently enrolled in demonstration health plans and their subcontracting partners may choose to stay in that plan under the demonstration.

Developmentally Disabled Beneficiaries: Dual eligible beneficiaries receiving services through a California regional center or a state developmental center are not eligible for the demonstration. Although the draft demonstration proposal did not propose to exclude these beneficiaries, subsequent clarification from CMS has resulted in their exclusion, due to the need to include all Medicaid benefits for beneficiaries participating in the demonstration. The State's 1915(c) waiver for the developmentally disabled provides significant Medicaid services, and the demonstration is not proposing to include those services, beneficiaries receiving those services will be excluded.

Home and Community Based Service 1915 (c) Waiver Enrollees: Beneficiaries enrolled in the following waiver programs will not be eligible for the demonstration: Nursing Facility/Acute Hospital Waiver Service, HIV/AIDS Waiver Services, Assisted Living Waiver Services, and In-Home Operations Waiver Services. These beneficiaries are already receiving case management and an expanded array of home- and community-based services, similar to the proposed model. As described below under the "Context within Current State Initiatives," beneficiaries who are on a waiting list for a home- and community-based waiver slot will not be permitted to enroll in the waiver even if a waiver slot becomes available. Beneficiaries on the waiting lists for these waivers will be included in the passive enrollment process.

Beneficiaries in areas not Covered by Managed Care: Medi-Cal and Medicare managed care health plan contracts currently exclude certain rural zip codes of some counties proposed for the demonstration. Beneficiaries living in these zip codes not covered by managed care within the selected demonstration counties will be not be eligible for the demonstration.

Populations Exempt from Passive Enrollment

PACE Enrollees: California has several PACE sites, serving a largely dual eligible population. In demonstration areas where PACE is available, PACE enrollees will not be passively enrolled in the demonstration, and PACE will remain a clear enrollment option for dual eligible beneficiaries that meet the PACE enrollment criteria. Additionally, in counties where PACE is available, several demonstration health plans will coordinate closely with PACE to offer this option to nursing-home eligible dual eligible beneficiaries who wish to remain in the community.

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AIDS Healthcare Foundation (AHF) Enrollees: AIDS Healthcare Foundation will remain a separate program, and existing enrollees will not be passively enrolled in the demonstration.

Non-Demonstration Plan Medicare Advantage Plan Members: Beneficiaries enrolled in Medicare Advantage (Part C) health plans that are not administered by or contracted with the demonstration health plans, are eligible for the demonstration but exempt from passive enrollment.

Non-Demonstration Plan Dual Eligible Special Needs Plans (D-SNP): Beneficiaries enrolled in D-SNPs that are not administered by or contracted with the demonstration health plans will be included in the demonstration but exempt from passive enrollment until January 2014.

Population Exempt from Stable Enrollment Period

Native Americans: If a dual eligible Native American enrolls in the demonstration, that beneficiary will not be subject to the six-month stable enrollment period requirement and may opt out of the demonstration at any time. Dual eligible Native Americans will continue to be able to access services through Indian health programs and providers as provided by current law, regardless of whether they are enrolled in the demonstration.

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C. Care Model Overview

Coordinated Care Delivery through Managed Care Health Plans

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Managed care done well leads to high quality care.[6,7] This demonstration will build on California's existing Medi-Cal and Medicare managed care structure, and its strong system of home- and community-based and behavioral health services.

To select the health plans and counties for this demonstration, the State held a rigorous selection process through which 13 health plans submitted 22 applications and participated in in-person interviews with State officials. The selected plans demonstrate a proven track record of business integrity and high quality service delivery. In addition, each health plan in the selected eight counties has experience operating a Medicare Dual Eligible Special Needs Plan.

The State reviewed each health plan's proposed model for coordinating care for the total needs of beneficiaries, including medical, behavioral, social, and long-term services and supports. While each demonstration health plan may tailor its approach to reflect local priorities, the following fundamental tenets, based on feedback from beneficiaries and stakeholders, will be implemented across all demonstration health plans:

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[6] Bindman AB, Chattopadhyay A, Osmond DH, Huen W, Bacchetti P. The impact of Medicaid managed care on hospitalizations for ambulatory care sensitive conditions. *Health Services Research*. 2005;40(1):19-38.

[7] Graham CL, Kurtovich E, Ivey SL, Neuhauser L. Fee-for-service and managed care for seniors and people with disabilities on Medicaid: implications for the managed care mandate in California. *Journal of Health Care the Poor and Underserved*. 2011;22(4):1413-1423.

- Seamless Service Delivery. Demonstration health plans will provide access to the full range of services currently covered by Medicare Parts A, B and D, as well as State Plan benefits and services covered by Medi-Cal (see full list of benefits in Appendix 4).

- Integration of Medical, LTSS, and Behavioral Health Services. Demonstration health plans will provide seamless coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medi-Cal. This will require a partnership between the health plans and the county agencies that provide IHSS and behavioral health benefits.

- Broad Network Readiness. The demonstration will use Medicare network adequacy standards for medical services and prescription drugs and Medi-Cal network readiness standards for LTSS. Each health plan's network adequacy will be subject to confirmation through readiness reviews before any beneficiary is enrolled.

- Physical and Programmatic Accessibility. All sites must comply with state and federal disability accessibility and civil rights laws, including the provision of communication in alternate formats.

- Person-Centered Care Coordination. All sites will offer person-centered care coordination as an essential benefit. This will start with individual health risk assessments that are used to develop individual care plans.

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Geographic Service Area

California proposes to implement the demonstration in eight counties in 2013. The four counties where the demonstration will be implemented under current state law are: Los Angeles, Orange, San Diego, and San Mateo. Pending further state authority, the demonstration would be implemented in the following four counties: Alameda, Riverside, San Bernardino, and Santa Clara. These counties have met the requirements established by the State's Request for Solutions[8], including the criteria established by the Legislature to consider local support for integrated care and services, and a local stakeholder process.

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Enrollment Process

The State is proposing a passive enrollment process with a stable enrollment period to ensure a sufficient volume of enrollees over the demonstration period and also to promote care continuity. Passive and stable enrollment will encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model.

Enrollment in the demonstration is optional. Beneficiaries will have the choice to enroll in a demonstration health plan or opt out of the demonstration for their Medicare benefits. The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be enrolled into a demonstration health plan. Under California's managed care model, beneficiaries in Two-Plan and Geographic Managed

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[8] The Request for Solutions and stakeholder comments can be found here: http://www.dhcs.ca.gov/Pages/RFS.aspx

Care counties may choose from selected health plans, and in County-Organized Health System (COHS) counties they will be enrolled with the COHS health plan. The State is developing a phased-in enrollment process, beginning no earlier than March 2013 and no later than June 2013 and continuing for 12 months.

Building on and improving the processes developed for the transition of Medi-Cal only Seniors and Persons with Disabilities into organized care, the State will work with CMS and stakeholders to design and implement an enrollment process that provides seamless transitions with no disruptions in care. The State will coordinate with CMS to ensure beneficiaries are meaningfully informed about their enrollment options, plan benefits and rules, and care planning process in an accessible and understandable language and format with sufficient time to make informed choices. The State's Medi-Cal enrollment broker will mail enrollment notices and provide a beneficiary call center to respond to questions. The State will notify beneficiaries 90 days in advance of the passive enrollment effective date, with subsequent mailings occurring 60 and 30 days in advance of the beneficiary becoming enrolled. Stakeholder feedback will be solicited on drafts of the enrollment process and specific notification letters. Please see the beneficiary protections section for more details on enrollment. The enrollment process will include a special focus on enabling benefciaries to obtain information about PACE and how to access the program (see as draft enrollment flow chart in Appendix 3).

Stable Enrollment Period. Further, the State is proposing that once enrolled in a demonstration plan, beneficiaries will have another opportunity to opt-out of the demonstration after a six-month stable enrollment period during which health plans must ensure continuity of care. Beneficiaries may continue receiving services from an out-of-network Medicare provider during this period under circumstances detailed in the beneficiary protections section below. During the stable enrollment period, beneficiaries will remain enrolled with the same health plan for both the Medicare and Medi-Cal portions of the demonstration.

The Governor's Coordinated Care Initiative, which is pending in the state Legislature, proposes mandatory enrollment in managed care for Medi-Cal benefits[9]. Under this proposal, managed care for dual eligible beneficiaries would be voluntary only for Medicare benefits and services, not Medi-Cal. Beneficiaries who opt out of the demonstration would still be enrolled in managed care for their Medi-Cal-only benefits (wrap-around services and LTSS).[10]

Beneficiary outreach. The State intends to design an overarching beneficiary outreach and education strategy, as well as a coinciding provider outreach and education program. The State and the demonstration health plans will leverage existing knowledge and community based organizations, including, but not limited to, local Health Insurance, Counseling and Advocacy Program (HICAP) agencies, Area Agencies on Aging, Independent Living Centers, Aging and Disability Resource Centers, and Health Consumer Centers, as well as county agencies. Health plans have suggested a partnership/contracting relationship with these local organizations to assist with outreach and help potential enrollees understand the importance of active engagement

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[9] The CCI proposed to phase in mandatory Medi-Cal enrollment by county, corresponding to the demonstration implementation schedule.
[10] Details of the mandatory Medi-Cal enrollment are in the proposed trailer bill language available here: http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareIntiatiave.aspx

early in the enrollment process. In addition, health plans may also partner with current providers and case managers to explain the benefits of participating in the demonstration.

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Provider Networks

The demonstration will require health plans to meet Medicare network adequacy standards for medical services and prescription drugs, and Medi-Cal network readiness standards for LTSS. The latter standards are being developed with stakeholder input through a public work group and will be complete in advance of the readiness review process. For areas of overlap, where services are covered under both Medicaid and Medicare, the appropriate network adequacy standard will be determined via MOU negotiation. The requirements will result in a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

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Demonstration health plans will have networks of medical and supportive service providers that are appropriate for and proficient in addressing the needs of their dual eligible members. This includes a broad network of LTSS providers, ranging from those offering home- and community-based services to those in institutional settings, as well as mental health and substance use service providers.

Each health plan will be subject to a joint state-federal readiness review before any beneficiaries are enrolled. The State will monitor the adequacy of provider networks of the health plans. If the State determines that a health plan does not have sufficient primary or specialty care providers and long-term services and supports to meet the needs of its members, the State will suspend new enrollment of dual eligible beneficiaries into that health plan, and for beneficiaries already enrolled, allow and provide education on how to change plans.

The State will ensure health plans are advised of their obligations to comply with the Americans with Disabilities Act and other applicable federal statutes and rules regarding accessibility. In addition, the State will ensure that health plans use the required facility site review tool to inform beneficiaries about the physical accessibility of provider locations. Health plans will have contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment, or other accommodations as a result of their disability or condition.[11]

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Additionally, demonstration health plans will provide 24-7 access to non-emergency help lines staffed by medical professionals. They will be encouraged to also advertise existing community hotlines, including but not limited to, those available through the local county mental health agencies and Alzheimer's Disease Resource Centers. In their Models of Care submitted to the State, most health plans provided a geographic analysis of their medical networks. Health plans also described the analysis they will conduct for cultural competency and for adequacy of non-medical providers, such as those who provide LTSS and mental health services.

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Some health plans have described processes to jointly educate providers on the model of care, and then follow-up with a plan-specific Model of Care, to help foster understanding of the

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[11] Available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf

demonstration among providers and build a stronger provider network.

Finally, demonstration health plans that have not yet achieved National Committee for Quality Assurance (NCQA) Managed Care Accreditation will work to acquire accreditation by the end of the third year of their participation in the demonstration.

Benefit Design and Supplemental Benefits

Demonstration health plans will be responsible for delivering the full range of services under Medicare Parts A, B, and D, including inpatient, outpatient, home health, and pharmacy (see Appendix 3 for the list of Medi-Cal State Plan core benefits).

Pharmacy Benefits: Demonstration health plans will be required to offer Medicare Part D coverage and meet all Medicare Part D requirements. They will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. Beneficiaries will not be subject to any Part D premiums but would continue to be subject to standard low-income subsidy copayment levels. Plans may buy down Part D co-payment levels. Sites will be required to cover medically necessary drugs covered by Medi-Cal and not covered by Part D.

Sites will also be responsible for delivering all Medi-Cal State Plan benefits and services, including long-term services and supports in institutions and in the community, including:

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- In-Home Supportive Services (IHSS)
- Community-Based Adult Services (CBAS, formerly called Adult Day Health Care Services)
- Multipurpose Senior Services Program (MSSP)
- Nursing facility services

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Specialty mental health services, which are county-administered, will not be included in the capitation rate for demonstration health plans. However, as further described in Appendix 2, health plans and county mental health and substance use agencies will develop coordination and integration strategies, which could include full financial integration in later years.

Recognizing the necessity to merge medical and social services, demonstration health plans are required to coordinate with community-based services that are not necessarily a plan benefit but can help beneficiaries remain in their homes and communities, such as home modifications and home delivered meals. Health plans must demonstrate that they are building relationships with community-based organizations and partner or contract for delivery of these services. These organizations include Centers for Independent Living, senior centers, Area Agencies on Aging, Alzheimer's Associations, and Aging and Disability Resource Centers.

Demonstration health plans are eager to offer additional benefits beyond those currently available in most Medicare Part C benefit plans, such as dental, vision, non-medical transportation, housing assistance, and home-delivered meals. Additional benefits may include

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care management interventions, such as specific disease management programs, intensive care management for high-risk populations, and care transition services, and also home modification, access to nutritional counseling, and exercise facilities. The extent of a health plan's ability to offer value-added supplemental benefits such as these will be better understood during the rate development process.

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Demonstration health plans will not be able to limit availability of Medi-Cal and Medicare services using more restrictive medical necessity criteria than exist in the programs today. The state proposes to CMS to allow for greater flexibility in the medical necessity criteria for supplemental benefits than currently permitted under either program, provided that they are in the blended capitated payment to health plans.

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Deleted: criteria.Medi-Cal and Medicare medical necessity standards will not be restricted by health plans, ensuring that individuals have access to any benefits they would have had access to absent the demonstrat

Model of Care

The state will work closely with CMS and health plans during the MOU and three-way contracting processes to fully coordinate the Medicare and Medi-Cal Models of Care and benefit delivery to create a truly seamless experience for enrolled beneficiaries. In their applications, demonstration health plans submitted detailed Models of Care describing the 11 essential care elements and standards currently required by Medicare.[12] These models reflect necessary changes for seamless coordination between medical services, long-term services and supports, and behavioral health services.

The delegated group model has been essential to the success of health plans in California and will play a key role in the delivery of appropriate and timely medical care and coordinated LTSS and behavioral health treatment to beneficiaries in the demonstration. Under this approach, health plans may delegate certain responsibilities, such as utilization management, chronic disease management, and the credentialing of providers, to another health plan and/or a group of physicians, frequently a multi-specialty group practice or independent practice association. Each health plan seeking to participate in the demonstration currently employs this care delivery model to a great extent to carefully manage costs while achieving better quality through:

- Broad, diverse provider networks
- Timely appointments
- Primary care providers who coordinate care using a person-centered approach
- Use of evidence-based medicine to improve outcomes
- Pay-for-performance networks that use information technology to deliver high quality care
- Innovative approaches to the management and treatment of chronic conditions
- Language assistance for beneficiaries

The Model of Care for this demonstration includes: health and functional risk assessment, data mining to identify and continuously stratify health and functional risk, identification of care management level (low, high, complex) and locus of care management (practice level, group

[12] For more background on CMS Model of Care requirements, see the March 2012 letter: Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf.

level, or plan level), utilization management, disease management, and transitional care. Shared assessment data for those who are in need of long-term services and supports will enable plans to include functional and social support needs and strengths in the development of the care plan. In addition, plans will establish contractual arrangements and incentive plans for providers, quality measures, and other components that are described in further detail in this proposal.

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Through the specific activities of stakeholder work groups on LTSS and behavioral health, criteria for demonstration health plan readiness will be developed (see Appendix 3 for details on implementation timeline). Among specific topics to be included in the assessment of plan readiness are: qualifications of care managers and those conducting the assessment; assessment tool used by plans and which common elements will be included; and how the established plan of care will be continued once the beneficiary is transitioned into the demonstration plan.

Person-Centered Care Coordination

Among dual eligible beneficiaries, care coordination needs and preferences vary greatly depending upon factors such as functional, health, and cognitive status, fluctuations in these indicators, and the individuals' ability to independently manage their health and long-term services and supports needs. As such, the State proposes to implement a demonstration that is sensitive to individual health needs and goals to promote person-centered care coordination and planning.

Each of the demonstration health plans will be responsible for achieving optimal health and functional outcomes for the enrolled beneficiary through person-centered care coordination. Recognizing that enrolled beneficiaries require varying levels of care coordination demonstration health plans will be required to plan and implement care management systems capable of assessing and responding to these different levels of need. To adequately address the complex and various needs of individual beneficiaries, care management will require close collaboration with a number of agencies, such as county social service agencies for IHSS, public authorities, county mental health and substance use service agencies, independent living centers, local Area Agencies on Aging, and other community-based organizations.

Participating health plans will educate and train physicians and other providers in delegated medical groups and independent practice associations regarding the availability and usefulness of social services to beneficiaries. Additionally, they will emphasize a "No Wrong Door" approach to needs assessment. This will ensure that beneficiaries have access to full information about their options, especially regarding access to LTSS, behavioral health services, PACE, etc.

Care coordination standards. New standards will be developed in collaboration with public stakeholders. Standards will enable improved monitoring and follow-up to determine whether the services were received, effective, still needed and whether additional intervention is necessary. Stakeholders participating in the LTSS Integration Stakeholder work group will have an opportunity to comment on the care coordination standards that will be developed and submitted to CMS in advance of the readiness review process.

Comprehensive health risk assessments and care planning. Health plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health and functional needs. The multi-tiered process will begin with a health risk assessment of each beneficiary conducted upon enrollment. This will serve as a basis for further assessment needs in a variety of areas including, but not limited to, mental health concerns, substance use concerns, chronic physical conditions, incapacity in key activities of daily living, dementia, cognitive status and the capacity to make informed decisions, as necessary.

This assessment will inform the individual care plan to assist beneficiaries in accessing all necessary resources. Individual care plans will be used to address risk factors, address health disparities, and reduce the effect of multiple co-morbidities. A care plan will be developed for each beneficiary that includes member goals and preferences, measurable objectives and timetables to meet his or her medical, psychosocial and long-term support needs that are identified through the risk assessment process.

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Building on lessons from the transition of seniors and persons with disabilities into Medi-Cal managed care, the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments. In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information via various modes (phone, mail, interactive voice by phone), and web-based care planning tools that allow providers and beneficiaries to view and add to the care plan, etc. Strategies also will include use of care coordinators and team-based meetings that include the beneficiary and service providers, such as county IHSS social workers (and IHSS provider if the beneficiary chooses).

Health plans will also use various strategies to identify the most vulnerable members, including health risk assessments, claims, self-referral, and provider referral. Some plans already conduct outreach to community organizations to reach the most vulnerable members.

Person-centered medical homes and interdisciplinary care teams (ICT). Health plans will offer person-centered medical homes with interdisciplinary care teams. These teams may include the designated primary physician, nurse case manager, social worker, patient navigator, county IHSS social worker (for IHSS consumers), pharmacist, behavioral health service providers and other professional staff within the provider network. The care teams will be built around the beneficiary and will ensure decisions are made collaboratively and with respect to the individual's right to self-direct care. Family members and caregiver participation will be encouraged and promoted, with the beneficiary's permission. For those beneficiaries who participate, the health plans' Models of Care will describe the beneficiary's role on the ICT and how members communicate with each other.

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Health plans are required to provide an active role for members in designing their care plans. Plans' Models of Care reflect the value of the beneficiary and potentially his or her caregivers as integral participants on the ICT. The beneficiary can opt out of the care team and/or choose to limit the role of their caregivers, including their IHSS providers, on the care team. The care team model promotes improved utilization of home- and community-based services to avoid hospitalization and nursing facility care.

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Health plans selected for the demonstration provide a highly integrated approach to care planning: a thorough health risk assessment; use of multiple data sources to identify those at highest risk; an ICT that includes behavioral health and pharmacy expertise; and full involvement of the member.

Care Transitions. Ensuring smooth care transitions will be an emphasis throughout the demonstration, including at initial enrollment and as beneficiaries move between locations and levels of care. Health plans will implement specific care interventions to transition members from one location to another. Health plans will be required to establish a continuity of care team to ensure a smooth transition for each beneficiary into the demonstration. This is described in detail in the beneficiary protections section.

The transition of care process is designed to ensure that both planned and unplanned transitions are identified and managed by an ICT trained to address the member's needs and ensure smooth movement across the care continuum. Health plans will have evidence-based interventions to ensure safe, coordinated care so that beneficiaries remain in the least restrictive setting that meets their health care needs and preferences. Health plans are required to have a process for identifying beneficiaries at risk of complex transitions from one location or level of care to another. This screening may occur during prior authorization and, for unplanned admissions, at the time of admission to a facility (either acute or skilled nursing). Health plans may use a screening tool that incorporates questions about clinical condition, behavioral health status and social condition. Upon receipt of a referral, case managers conduct a comprehensive assessment, and the transition ICT develops or updates the care plan. This team also would ensure that the care plan travels with the member during transition.

Health plans will regularly review transitions to evaluate program effectiveness and identify areas for improvement. These reviews may lead to innovations, such as the creation of transition care coordinator positions at high volume hospitals to provide concurrent linkage to the transition ICT.

Use of Technology. In accordance with federal and state health information privacy laws, health plans will leverage effective use of technology, although technology will not replace critical in-person care coordination activities. These efforts may include:

- Greater use of electronic health records throughout the provider network, including web-based sharing of care management plans and updates to allow primary care providers and specialists, including behavioral health specialists, to securely share clinical information, services approved or initiated, and ongoing updates.
- Remote patient monitoring technologies that enable wellness and continuous care management for high-risk members. Such technologies include home telehealth for frequent measurement of vital signs (e.g., blood glucose, blood pressure, heart rate, weight, etc.), medication adherence reminders and dispensing systems, medical alert safety systems, electronic pens for mobile electronic health record syncing and remote health record access for clinicians.
- A demonstration of meaningful use connectivity through file exchange with disease management and other health information exchanges, e-prescribing, real-time health and

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care status communications to support case management, and reminders to primary care providers to help them target certain patients for preventive or follow-up care.

- A provider portal to provide interactive features permitting individualized physician reporting on quality reports.
- A clear plan for how the health plan will work with any statewide and local non-profits to leverage the greater use of assistive technology, for example the AT Network organized through the California Foundation for Independent Living Centers.
- Individualized pay-for-performance tools for physicians to report progress in meeting organizational quality goals; these reports serve, in effect, as disease-specific registries for physicians to use in ensuring appropriate diabetes care and other preventative care interventions.
- In San Mateo County, a new system is being developed to integrate data elements from the health plan, and county home-and community-based services and behavioral health agencies to capture a full picture of the medical, social, and behavioral health needs of each beneficiary.

Behavioral Health Care Coordination

Mental health and substance use disorders are prevalent among dual eligible.[13] Health plans will be responsible for providing beneficiaries seamless access to the full range of mental health and substance use services currently covered by Medicare and Medi-Cal. Health plans will develop plans with stakeholder input to enhance screening and diagnosis of mental illness, substance use and cognitive limitations, including Alzheimer's disease and related dementias for all beneficiaries enrolled, including those not eligible for county specialty mental health services. Health plans will ensure transfers and follow-up care for needed behavioral health services.

For beneficiaries receiving county-administered Medi-Cal specialty mental health (1915b waiver services) or substance use services (Drug Medi-Cal), close coordination between health plans and county agencies will be necessary. Under this demonstration, health plans will collaborate with county agencies to develop strategies for mental health care and substance use care coordination. These integration strategies will build on the recovery model of care set forth in state statute.[14] The strategies will demonstrate shared accountability based on agreed-upon performance measures and financial arrangements, such as incentive payments or shared savings structures. Please see Appendix 2 for a detailed description of a "Framework for Shared Accountability" for behavioral health services. This is a new section developed with stakeholder input in response to requests for greater detail from stakeholders and CMS.

Health plans will contract with providers experienced in delivering a recovery-based model of care within their networks directly or through contracts with the county behavioral health agencies. The demonstration health plans are coordinating with their behavioral health county agencies through the State-organized mental health and substance use integration work group.

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[13] 4 J. Kasper, M. O'Malley-Watts, and B. Lyons. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured, July 2010. Available at http://www.kff.org/medicaid/8081.cfm
, This includes 16 percent with diagnoses of Alzheimer's or other dementia.
[14] California Welfare and Institutions Code Section 5806

There is an expectation that demonstration health plans, county mental health and substance use agencies, and stakeholders meet on an ongoing basis at a local level.

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LTSS Care Coordination

California spends 53.7 percent of its Medicaid LTSS funding on home- and community-based services, which places it sixth in the nation.[15] Much of California's LTSS expenditures go toward the nation's largest personal care services program, IHSS.

Deleted: California's LTSS system currently ranks fifteenth in the nation, according to the recent Raising Expectations Scorecard report, which ranked states by their LTSS performance across four dimensions: (1) affordability and access; (2) choice of setting and provider; (3) quality of life and quality of care; and (4) support for family caregivers

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IHSS is an entitlement program that serves 450,000 Medi-Cal beneficiaries, of whom 75 percent are dual eligible beneficiaries. IHSS developed out of California's Independent Living and Civil Rights movements. It is a prized program rooted in the consumer's right to self-direct his or her care, including the right to hire, fire, and supervise his or her IHSS provider. The demonstration relies on the strong foundation of IHSS to further rebalance service delivery away from institutions and into community settings. Eligibility for IHSS and assessment and authorization of qualified hours is and will continue to be determined by county social service agencies.

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To promote rebalancing, financial incentives need to align with care that keeps beneficiaries healthy and at home. In today's system, however, too often the financial incentives promote cost shifting between different government payers. Integrating Medicare and Medi-Cal financing and centralizing responsibility for delivering all services and benefits within a single health plan refocuses care delivery decisions on beneficiaries' needs and best levels of care.

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Under this demonstration, health plans will assume responsibility for the provision and payment for all LTSS, in addition to their current provision of medical services. LTSS includes IHSS, MSSP, CBAS, nursing facility care, as well as the provision of services in-lieu of institutionalized care, which will be determined in part by the rate-setting process.

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IHSS program structure under the demonstration. Under the demonstration and the Governor's Coordinated Care Initiative, health plans will develop and expand care coordination practices with counties, nursing facilities, and other home- and community-based services, and share best practices. Care coordination teams for IHSS consumers will be established as determined by the health plans and based on the unique care needs of the individual. In addition, county social service agencies will participate on teams, based on local agreements that will be negotiated between the counties and health plans. County social services agencies will continue to perform their current IHSS functions, including assessment, authorization, and final determinations of IHSS hours in accordance with statutory provisions for IHSS eligibility, on behalf of the Medi-Cal health plans.

Deleted: Further, the Governor's Coordinated Care Initiative would require dual eligible beneficiaries in the demonstration counties to enroll in Medi-Cal managed care to receive LTSS, regardless of whether they enroll in the demonstration.

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Health Plans may authorize IHSS hours above those authorized by the county, as well as additional home- and community-based services, using the funding provided under the capitation payment. There would be no county share of cost for these additional IHSS hours or services.

[15] Reinhard, S., Kassner, E., Houser, A., & Mollica, R., (2011, September), *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.* A report prepared by AARP, The Commonwealth Fund, and The SCAN Foundation, Washington D.C. and New York. Retrieved on 12-24-2011 from http://www.longtermscorecard.org/

Health plans will enter into agreements with counties for care coordination activities and any other enhanced services beyond what IHSS currently provides. Health plans may also enter into performance-based contracts with counties and contract with counties for additional assessments of IHSS hours.

Initially, health plans will contract with Public Authorities for provider registries, training of IHSS providers, provider enrollment (when so delegated by the county), and assistance to consumers with their employer-related responsibilities. The State may, at a future date, work with stakeholders and seek other alternatives for these services.

Information will be shared between the county, the Public Authority and the health plan as negotiated per local agreements, in order to support care coordination teams and maximize home- and community-based services to the IHSS consumer.

The fair hearing process currently in place for IHSS consumer appeals will remain for hours authorized by counties, as will other protections for IHSS consumers. The State may work with stakeholders to develop an appeals process for IHSS hours additionally authorized by health plans in the demonstration. The proposal maintains existing rights and principles of IHSS, including ensuring consumers receive sufficient services to support independent living. (A detailed description of how IHSS will work under the demonstration can be found in the Coordinated Care Initiative Trailer Bill Language developed with input from the county social services agencies and Public Authorities.[16])

Home- and community-based Universal Assessment process. Starting in June 2013, the State will lead a stakeholder process to develop a statewide HCBS Universal Assessment Process. This process will be implemented no earlier than January 1, 2015. Providers, counties, and health plans will use it to assess the need for home- and community-based services. It will incorporate and consolidate the current array of LTSS assessment tools, including the assessment tools used for IHSS. As noted above, this tool will be separate from and will not replace the Health Risk Assessment process used by health plans when beneficiaries initially enroll.

Beginning in 2015, health plans and counties will utilize the new universal assessment process described below for IHSS. The new universal assessment tool will be built upon the IHSS Uniform Assessment process, Hourly Task Guidelines and other appropriate home- and community-based assessment tools, and will be in addition to the health risk assessment process used by health plans when beneficiaries initially enroll in managed care. All other IHSS processes described above will remain the same.

Evidence-based Practices

Participating health plans will apply evidence-based clinical guidelines promulgated by leading academic and national clinical organizations, including the California Guidelines for Alzheimer's Disease Management.[17] Plans will be required to have processes for educating providers on employing evidence-based guidelines and for monitoring providers' use of

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Deleted: IHSS assessments will be conducted by county social workers and information will be shared between the county and the health plan as negotiated per local agreements, in order to maximize home- and community-based services to the IHSS consumerin conjunction with health plan care coordination teams, as needed.

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In 2015, California may also implement the Managed Fee-for-Service (FFS) model for this demonstration, using the guidelines provided by CMS. The State will consider development of this model in further discussions with stakeholders in 2013. This model would be implemented in counties that do not have Medi-Cal managed care health plans. In addition, for beneficiaries who choose not to participate in the capitated payment model, California may extend care coordination and include them in the Managed FFS model.

[16] Coordinated Care Initiative language available at: http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareIntiatiave.aspx
[17] Available at: http://www.cdph.ca.gov/programs/alzheimers/Documents/professional_GuidelineFullReport.pdf

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evidence-based practices. Health plans suggested various strategies for educating providers and staff about evidence-based guidelines, including alerting providers when individual enrollees are not receiving evidence-based care.

Context within Current State Initiatives

1115 Waiver: Managed Care Transition for Medi-Cal Only Seniors and Persons with Disabilities (SPDs)

California's Section 1115 "Bridge to Reform" waiver provides a strong foundation for integrated care service delivery for high-need, complex populations. In November 2010, California obtained federal approval authorizing its expansion of mandatory enrollment into Medi-Cal health plans in 16 counties of more than 400,000 Medi-Cal-only SPDs. Enrollment has been phased in over a one-year period in the affected counties beginning on June 1, 2011, with approximately 25,000 people per month being enrolled. Prior to this, managed care enrollment was mandatory for SPDs in the 14 County-Organized Health System counties.

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A telephone survey of 463 newly transitioned beneficiaries (out of 5,000 called) in February 2012 yielded positive results. Of those who answered questions, 87 percent said their ability to make appointments had improved with managed care membership; 90 percent of those who received services through the health plans were satisfied with the services; and 81 percent of those who received services through managed care were more satisfied than with their previous fee-for-service experience. Four percent of the beneficiaries who were scheduled to transition to Medi-Cal managed care made a Medical Exemption Request to remain in fee-for-service Medi-Cal.

The SPD implementation has offered several valuable lessons, including the need for: improved beneficiary and provider engagement and education, continuity of care provisions, and data sharing between the state and health plans. The State has been incorporating these lessons into its processes to better prepare health plans, providers and beneficiaries for the dual eligible beneficiaries' transition.

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Enhanced outreach and education processes for beneficiaries and providers are needed, particularly around enrollment and continuity of care rights. The SPD transition reinforced that phone calls to beneficiaries, without additional outreach, are not adequate to ensure they understand changes in the enrollment process and their rights. The State is working to develop better processes and protocols for timely and accurate data sharing, noting the challenges plans had in obtaining timely claims data to complete assessments and transmit those assessments to providers.

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Medi-Cal health plans are adapting to the unique needs of the SPD population and have adjusted their networks accordingly. Examples of improved beneficiary services that demonstration health plans described included adopting in-house care management systems; partnering with member advocacy and community groups, such as Independent Living Centers and local promotoras, conducting repeated welcome calls to new beneficiaries, budgeting more time for these calls, enhancing member welcome materials, and developing new ways to disseminate this information.

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County Specialty Mental Health Services and Substance Use Waivers

See Appendix 2 for more background on California's behavioral health service delivery system and related waivers and their coordination in the demonstration.

Home- and Community-Based Services Waiver Programs

Four Home and Community-Based Services waiver programs will not be included in the demonstration: Nursing Facility/Acute Hospital Waiver Service, HIV/AIDS Waiver Services, Assisted Living Waiver Services, In-Home Operations Waiver Services. Although the draft demonstration proposal included these waivers in the demonstration, stakeholder feedback indicated considerable administrative complexity would be involved in including these waivers in the demonstration.

As a result, these waivers will continue to exist outside of the demonstration, and beneficiaries enrolled in these waiver programs will not be included in the demonstration. However, since the intent of the demonstration is for health plans to provide a coordinated array of services and benefits similar to these waiver programs, beneficiaries enrolled in demonstration health plans (including beneficiaries on any waiting lists for these waivers), will not be eligible to transfer to the waivers.

The flexibility in the use of the capitated payment under this demonstration allows health plans to provide an array of coordinated benefits and services similar to the set of benefits available under these waiver programs. This will allow beneficiaries enrolled in the demonstration to benefit from a variety of services offered under that model of care including ongoing care management, supplemental personal care services, etc. to maintain their health and independence and to avoid institutionalization.

Note: To the extent that federal funding for the Money Follows the Person Demonstration is available, a one- time resource to re-establish household will be available to demonstration health plans that successfully transition eligible beneficiaries in institutional settings back into the community.

Multipurpose Senior Services Program (MSSP): This program provides both social and health care management services for Medi-Cal recipients aged 65 or older who meet the eligibility criteria for a skilled nursing facility. Under the demonstration, current recipients of MSSP case management will be enrolled with the health plans and will continue to receive MSSP waivered services. It is anticipated that during the demonstration period, MSSP organizations and plans will jointly develop a coherent, integrated care management approach so that the plan members that are MSSP recipients will have a comprehensive, non-duplicative, personalized medical and LTSS care management process.

In the first year of the demonstration, health plans will contract with MSSP organizations to continue their case management functions in coordination with the plans' care management programs defined by their Models of Care. In the second year, health plans will work in collaboration with MSSP providers to begin development of an integrated, person-centered care management/care coordination model that works within the context of managed care. This collaborative process will explore the portions of the MSSP program model that can be adapted

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Deleted: Through a Section 1915 (b) freedom of choice waiver, all individuals who meet specified medical necessity criteria[18] are mandatorily enrolled in the County Mental Health Plans. This waiver program is referred to as the Specialty Mental Health System. About 27 percent of the 240,000 adults served are dual eligible beneficiaries. County Mental Health Plans are responsible for managing all specialty mental health services (inpatient psychiatric and outpatient services). Counties incur California's mental health "certified public expenditure" (CPE) and draw down matching federal dollars. County Mental Health Plans select and credential their provider network, negotiate rates, authorize services, and pay for qualifying services. The services provided under the Specialty Mental Health Services waiver include: 1) psychiatric inpatient hospital services, 2) targeted case management services, and 3) rehabilitation services, including medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services.

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Deleted: Home-and community-based waiver services for adults with developmental disabilities will be carved-out of the demonstration.

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Deleted: This will allow beneficiaries not enrolled in the waivers to benefit from these models of care. For example, providing an assisted living benefit with occasional home health (similar to the current Assisted Living waiver) may be more satisfying to plan members and less costly to health plans than nursing facility placement.placementThe State is considering options for how new enrollment in these waivers would be treated under the demonstration, and welcomes stakeholder feedback on this issue.

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to managed care while maintaining the integrity and efficacy of the MSSP model. In the third year, MSSP services will transition from a federal waiver to a benefit administered and allocated by health plans. The State will work with stakeholders to develop a transition plan that incorporates the principles of MSSP into the managed care benefit, and includes provisions to ensure seamless transitions and continuity of care. Health plans will partner with local MSSP providers and conduct a local stakeholder process to develop recommendations for the transition plan.

The State intends to renew the MSSP waiver before its expiration in 2014, to provide for continued waiver services for recipients in counties not implementing the demonstration.

Community-Based Adult Services (CBAS): This is a facility-based service program that delivers skilled nursing care, social services, physical and occupational therapies, personal care, family and caregiver training and support, meals, and transportation. Starting in July 2012, CBAS will be a benefit offered by the health plans, including the plans participating in the demonstration. Plans' Model of Care will include eligibility, protocols and guidelines on utilizing CBAS as a substitute for nursing facility care. Plans' care management teams will authorize CBAS services and coordinate CBAS in relation to medical services and other LTSS needed by the beneficiaries.

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Deleted: Other Home and Community-Based Waiver Programs: These programs operate under a waiver of federal requirements and provide various services to recipients who generally meet the level of care required for placement in a nursing, subacute or hospital. The recipients of these waivered services are severely disabled individuals with high intensity of care needs. Specifically, these programs include In-Home Operations, Assisted Living, and Nursing Facility/Acute Hospital waivers. These programs provide care coordination, skilled nursing, personal care services, assisted living and services that assist individuals to remain in the community. During the Demonstration, current recipients of these waivered programs will be eligible for enrollment in the demonstration, and will at least be enrolled in Medi-Cal managed care, according the Coordinated Care Initiative. In addition to medical and other LTSS services offered by the plans, these waivered service recipients will continue to receive waivered services. The State proposes that integration of these waiver programs with demonstration health plans will include the following activities: (1) development and implementation of comprehensive, non-duplicative, personalized care plans and a care coordination process that includes the waivered services and other medical and LTSS services needed by these individuals; (2) transfer of care management functions to demonstration health plans; and (3) integration of waivered services as part of supplemental service offering of the demonstration plans. Upon completion of these activities, the State is considering whether waiver programs would cease to take on new beneficiaries and all waivered services and care coordination would be undertaken by the demonstration plans. In Demonstration counties, the waiver programs would continue to operate until the end of the waiver periods for existing waiver recipients.

D. Stakeholder Engagement and Beneficiary Protections

Design Phase Stakeholder Engagement

The State organized numerous opportunities to learn directly from beneficiaries about their health care experiences, needs, preferences and reactions to proposed system changes. This work was part of a broad stakeholder engagement process to inform the design and implementation of the demonstration.

The State began gathering input from stakeholders on plans for dual eligible integration in April 2010. In a project funded by The SCAN Foundation, the Center for Health Care Strategies (CHCS) conducted a series of in-depth interviews with stakeholders to compile the perspectives of advocacy organizations, provider associations, union officials, and health plans. Following the interview series, the findings were presented at two well-attended public meetings.[19]

Further, in August 2011 Thomson Reuters conducted focus groups with dual eligible beneficiaries in Oakland and Riverside, California. Participants of the "integrated" groups (those receiving both Medicare and Medi-Cal through the same plan) viewed the two programs as a single program delivered by the health plan. Members of the integrated groups reported being pleased with the comprehensive nature of their coverage.[20]

[19] M. Bella, A. Lind, and S. Somers. April 2010. *Options for Integrated Care for Duals in Medi-Cal: Themes from Interviews with Key informants and Community Dialogues.* Available at: http://www.chcs.org/usr_doc/Medi-Cal_Duals_Interview.pdf

[20] Thomson Reuters. Summary of Focus Groups Conducted with Medicare-Medicaid beneficiaries in California. August 2011. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/Public%20Meetings/CA%20Focus%20Group%20Findings.pdf

The State Department of Health Care Services will routinely report to the State Legislature on the demonstration.

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Public Notice of the Demonstration: The state certifies that it released this proposal for a 30-day public comment period during which multiple public stakeholder meetings have been held. This proposal reflects stakeholder feedback. Additionally, the state certifies that it has met its obligation related to appropriate tribal consultation.

Public stakeholder meetings

Four meetings were held in 2011 around the state to seek stakeholder input on key areas of the demonstration. The events were designed to be fully accessible and a toll-free telephone line ensured home-bound beneficiaries could participate.

1. **Request for Information Conference** (August 30, 2011): More than 300 people attended a kick-off public forum, including representatives from health plans, provider groups, county health departments, home health agencies, advocacy organizations, labor unions, and others.

2. **Behavioral Health Integration** (December 2, 2011): About 180 people participated in a discussion on the opportunities and challenges of integrated behavioral health and substance use services into the Duals Demonstration.

3. **Beneficiary Protections** (December 12, 2011): About 200 participated in a discussion on beneficiary protections, including: 1) achieving proper care; 2) creating effective beneficiary communication; 3) achieving proper access and delivery; and 4) launching the system.

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4. **Long-Term Services and Supports** (December 15, 2011): About 210 people participated in the meeting on: 1) LTSS coordination between the state, local entities and demonstration health plans; 2) the roles of the consumer and in-home support services (IHSS) worker; and 3) entry into the care continuum.

Additional stakeholder engagement activities included:

- **Beneficiary Perspective.** Beyond the August 2011 focus groups, the California Department of Health Care Services (DHCS) held meetings with beneficiaries at Centers for Independent Living in four counties, held numerous teleconferences and one-on-one conversations, and attends a weekly call with California's IHSS Consumers Union to discuss the demonstration. A Consumer Experience E-Survey collected input from 120 dual eligible beneficiaries. The State published a summary of these conversations and survey on its website.[21]

[21] Adding Perspective: Conversations with Dually Eligible Beneficiaries. February 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/stakeholder documents/Outreach_Summary.pdf

- **Website and email list**. All demonstration materials, including the health plan demonstration applications, are posted online to a website dedicated to the demonstration, www.CalDuals.org. The State sends regular email notification updates to more than 1,500 people, including hundreds of beneficiaries and caregivers.
- **Staff training on accessibility of materials**. DHCS staff was provided additional training to ensure that materials released in print and posted online are compliant with Section 508 of the Americans with Disabilities Act.
- **Local stakeholder processes**. Demonstration health plans developed local processes to bring stakeholders together and discuss local design and implementation. Additionally, demonstration health plans submitted letters of support from a wide array of stakeholders. This stakeholder engagement is expected throughout implementation.
- **Stakeholder Meetings for Health Plan, Provider, and Advocacy Organizations**. The California Health and Human Services Agency (Agency) organized a series of stakeholder meetings with health plan, provider, and advocacy organizations to discuss the Coordinated Care Initiative, including the demonstration.
- **California Collaborative**. The State regularly participates in discussions at the California Collaborative, a weekly meeting of provider and advocacy organizations that focus on policy issues around long-term services and supports.

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Ongoing Stakeholder Feedback

To support the development and implementation of the demonstration, the State has organized a series of stakeholder workgroups. These workgroups involve departments throughout the California Health and Human Services Agency and will develop policy recommendations in a team setting. Each workgroup is co-chaired by a public stakeholder (for example, an advocate, beneficiary, or plan representative) and a State agency representative.

Throughout the demonstration period, additional workgroups may be added or modified as needed, but the workgroups will initially focus on the following topics:

1. Beneficiary Enrollment, Notification, Appeals, and Protections
2. Provider Outreach and Engagement
3. In-Home Supportive Services Coordination
4. Long-Term Services and Supports Integration
5. Mental Health and Substance Use Services Integration
6. Fiscal and Rate Setting
7. Quality and Evaluation

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Beneficiary participation on governing and advisory boards. The State has reconfigured its 1115 Waiver Stakeholder Advisory Committee to continue serving as an advisory group on the duals demonstration project. Committee membership includes a wide array of stakeholders, including beneficiaries. Additionally, health plans are required to ensure beneficiary and advocate participation on local advisory committees to oversee the care coordination partnerships and progress toward integration.

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Beneficiary Protections

Comprehensive protections, particularly beneficiary self-direction and oversight mechanisms, are important to ensure care quality and beneficiary health and safety. The state has received significant stakeholder feedback on strong beneficiary protections needed to drive success and quality in the design and implementation of the demonstration. The following beneficiary protections reflect stakeholder feedback as well as lessons learned from the transition to managed care for Medi-Cal only Seniors and Persons with Disabilities, and the Medical Exemption Request process utilized in that transition. A summary of the proposed beneficiary protections for California's demonstration is below. Further details are available in the proposed state legislation for the Governor's Coordinated Care Initiative.[22]

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Privacy. The State will require health plans to ensure privacy of beneficiary health records and provide enrollees access to such records as specified in the contracts.

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Customer Service Representatives. The State will require health plans to employ customer service representatives who will answer beneficiary inquiries and respond to complaints and concerns.

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Appropriate Care. Health plans will ensure that all care meets the beneficiary's needs and is provided in a manner that is sensitive to the beneficiary's language and culture, allows for involvement of caregivers, and is delivered in an appropriate care setting, including in the home and the community.

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Self-Directed Care. Participants in the demonstration will continue to have the choice to self-direct their care. Health plans will provide a person-centered, outcomes-based approach to care planning, consistent with the CMS Model of Care approach. Specifically, when appropriate, beneficiaries will:

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- Decide whether, how and what long-term services and supports to receive to maintain independence and quality of life;
- Select their health care providers in the health plan network and control care planning and coordination with their health care providers;
- Have access to services that are culturally, linguistically, and operationally sensitive to meet their needs, and that improve their health outcomes, enhance independence, and promote living in home and community settings; and
- Be able to hire, fire, and supervise their IHSS provider, as currently allowed in California's IHSS program.

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Notification about Enrollment Processes. The State will ensure beneficiaries are meaningfully informed about their care options. Properly informing beneficiaries about enrollment rights and options will be an essential component of the demonstration to allow beneficiaries to be educated about plan benefits, rules, and care plan elements with sufficient time to make informed choices. The State will:

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- Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups.

[22] All Coordinated Care Initiative Documents may be found here: http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareIntiatiave.aspx

- Develop, in consultation with beneficiaries and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.
- Ensure that health plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to the following: assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.
- Ensure that health plans inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures that are offered by the plan or are available through the Medi-Cal program.
- Contingent upon available private or public dollars other than moneys from the General Fund, contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.
- Starting 90 days prior to enrollment, the State's enrollment broker, will inform dual eligible beneficiaries of their enrollment options through a series of mailings written at no more than a sixth-grade reading level in the language the beneficiary understands and available upon request in alternative formats. This information will include, at a minimum: how their system of care would change, when the changes will occur, and how to contact the State's enrollment broker for questions or assistance with choosing a health plan.

Health-Risk Assessment. This is an essential beneficiary protection. Health plans describe their health assessment process in detail in their proposed Models of Care, but the State will require that health plans perform an assessment process that is performed in accordance with all applicable federal and state laws, including:

- Assesses each new enrollee's risk level and needs, based on an interactive process such as telephonic, web-based, or in-person communication with the beneficiary.
- Address the care needs of the beneficiary and coordinates their Medicare and Medi-Cal benefits across all settings.
- Incorporate the preferences of the beneficiary, including the preferred setting for delivery of LTSS.
- Review historical Medi-Cal and Medicare utilization data.
- Assesses an individual's cognitive status and ability to make informed decisions.
- Follows timeframes for reassessment.

Network Readiness. Plans will be required to establish and maintain provider networks that meet Medi-Cal network readiness standards for long-term services and supports, and Medicare network adequacy standards for medical services and prescription drugs. In addition, beneficiaries will have a choice of providers among a broad network of providers including primary care providers, behavioral health providers, specialists, ancillary providers, hospitals, pharmacists, and providers of long-term services and supports. The State, in coordination with stakeholders, is currently developing the network readiness standard for long-term services and supports, which health plans must meet during the readiness review process.

The State will require that health plans:

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- Provide access to the contracted health plan facilities and providers who comply with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.
- Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and Internet web site, upon request.
- Maintain an appropriate provider network that includes an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area.
- Contract with safety net and traditional providers as defined state regulations, to ensure access to care and services.
- Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist dual eligible beneficiaries with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.
- Employ care managers directly or contract with non-profit or proprietary organizations, including organizations that are now operating under MSSP, in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.
- Ensure that each health plan has non-emergency medical transportation available in sufficient supply and accessibility so that individuals have timely access for scheduled and unscheduled medical care appointments.
- Health plan case managers are available to assist with the continuity of care options, access to plan services, and plan authorization processes.

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Continuity of Care Provisions

- The State will require health plans to follow all continuity of care requirements established in current law.
- Beneficiaries will have access to out-of-network Medi-Cal providers, for up to 12 months, for new members enrolled under the demonstration who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.
- During the six-month stable enrollment period for Medicare, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services if all of the following criteria are met: a) the beneficiary demonstrates an existing relationship with the provider prior to enrollment, b) the provider is willing to accept payment from the demonstration health plan based on the current Medicare fee schedule, and c) the health plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns.
- Descriptions of continuity of care rights will be developed in all threshold languages and be distributed to beneficiaries through plans and providers.

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Continuity of Care Teams. Health plans will be required to establish a continuity of care team to ensure a smooth transition for each beneficiary into the demonstration. Planning regarding

continuity of care issues, coupled with dedication to resolving transitional treatment issues faced by each beneficiary, is central to meeting immediate care needs, while also ensuring optimal long-term outcomes. To ensure health plan readiness to implement continuity of care, each plan's continuity of care team will participate in a joint meeting with the Department of Health Care Services and the Department of Managed Health Care prior to commencement of the demonstration project to provide a comprehensive overview of its approach and preparations, including continuity of care for each beneficiary who is, as of his or her transition date:

1. Diagnosed with a life-threatening illness
2. Experiencing an acute medical condition
3. In a course of treatment for a serious chronic condition
4. Pregnant
5. Inpatient in an out-of-network facility
6. Scheduled for a procedure in an out-of-network facility
7. Scheduled for a transplant procedure or on a transplant procedure waiting list
8. Receiving or in need of post-transplant care following a transplant procedure
9. Receiving or in need of follow-up care related to a recent major surgery
10. Taking one or more medications prescribed by their prior physician or PCP
11. Using durable medical equipment
12. Utilizing home health services
13. Receiving home intravenous infusion and/or self-administered injectables
14. Receiving active treatment for behavioral health conditions

Appeals and Grievances. The State will work with CMS and stakeholders to take steps toward a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration. The State proposes to CMS that all current appeals processes will remain in place initially and the intent is that any changes in future years will maintain existing opportunities for appeals. The State will work with CMS to develop a single form to serve as a unified starting point for the grievance and appeals process. This is intended to ease the administrative burden on beneficiaries and providers. There will be ongoing collaboration between the State, CMS and stakeholders to develop a unified state and federal grievance and appeals process by the second year of the demonstration. The Part D appeals process will stay the same under the demonstration. The unified process will be fully articulated and vetted with stakeholders and will be distributed to beneficiaries and providers. Please see the IHSS coordination section for a description of the IHSS appeals process under the demonstration.

Deleted: The demonstration will include a clear, timely, and fair process for complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. The process will also inform beneficiaries of procedures for obtaining Medi-Cal benefits that are offered by the plan. The unified process may initially be a combined Medi-Cal and Medicare notice and process for health plan review of appeals, while maintaining the beneficiary option to use all other current federal and state avenues for appeals

Demonstration health plans are required to have dedicated units to assist beneficiaries and providers with appeals, grievances, authorizations, and claims payments. Beneficiaries will receive notices of their appeals rights in a format and language understandable and accessible to them. On all notices that deny, reduce or otherwise amend a request for services, demonstration health plans are required to notify the beneficiary of the right to appeal the decision.

E. Financing and Payment

Financial Alignment Models and State-Level Payment Reforms

California intends to use the capitated payment model outlined by CMS in the July 8, 2011 State Medicaid Directors letter. The state will work with CMS to develop a capitated rate structure for health plans that provides incentives for high quality, coordinated care that will reduce overall system costs. The blended capitation payment structure is expected to provide plans the flexibility to utilize the most appropriate service for the member.

The capitation model will include the full range of Medicare and Medicaid (both State Plan and aforementioned home-and community-based waiver) services. The State and CMS will make monthly payments to health plans for the Medicaid and Medicare portions of the capitation rate.

Health Plan Payments and Financial Incentives

Rates for participating health plans will be developed by the State in partnership with CMS based on baseline spending in both programs and anticipated savings that will result from integration and improved care management. The Part D portion of the rate will be based on the standardized national average bid amount and will be risk adjusted in accordance with the rules that apply for all other Part D plans. There is a stakeholder work group through which state officials will discuss the rate-setting process in a public forum.

Medi-Cal and Medicare rates will be considered as one total capitation for savings projections and will be fully integrated at the plan level. Rates will continue to reflect any required legislative and policy changes occurring during the demonstration.

CMS indicates it will require a performance-based withhold of 1%, 2%, and 3% respectively for years one, two and three of the demonstration. Health plans will be able to earn back the capitation revenue if they meet quality objectives. Through the quality and evaluation work group, the State will seek stakeholder input on the quality objectives that plans must meet.

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Deleted: The State is also considering quality incentives, in addition to the CMS required withholds. The State may integrate the Medicare withholds with any new measures to be determined under the three-way contract.

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The state is also considering the use of risk sharing and risk corridors, to create a mechanism for sharing the risk of allowable costs between the state and health plans. Risk corridors would mitigate adverse selection and support the state's goal for the health plans to have sufficient incentives to maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports and avoid hospitalizations and institutional care.

A key aim of this demonstration is to reduce cost shifting across delivery systems and promote person-centered care coordination. Thus, it is expected that the demonstration health plans and county behavioral health agencies develop formal financial arrangements based on identified performance measures to improve health outcomes and reduce medical costs. The State will continue exploring these options with stakeholders and CMS, but it is expected that a financial alignment strategy will be in place by year three of the demonstration (see Appendix 2 for more details).

Health plans also have performance-based reimbursement or risk-sharing for their network providers, and plan to implement additional efforts. Examples from health plans include:

- Incentives for physicians participating in a project that focuses on older dual eligible beneficiaries with complex problems and at highest risk, who also receive IHSS services.
- Incentives for physicians offering after-hours clinical operations.
- Pay-for-Performance program geared toward the Healthcare Effectiveness Data and Information Set (HEDIS) measures and preventative care measures such as breast cancer, cervical cancer and colorectal cancer screenings, comprehensive diabetes care, and other measures appropriate for older adults.
- Incentives to reward home- and community-based services agencies for helping members stay healthy and safe in their own homes, avoiding preventable hospital and nursing home admissions.

F. Expected Outcomes

State's Ability to Monitor, Collect and Track Data on Quality and Cost

California certifies that, in partnership with CMS, stakeholders and beneficiaries, it will monitor, collect and track data on key metrics related to the model's quality and cost outcomes for the target population, including beneficiary experience, access to care, utilization of services, etc., in order to ensure beneficiaries receive high quality care and for the purposes of the evaluation.

The Department of Health Care Services (DHCS) has a knowledgeable staff with many years of experience monitoring and tracking Medicaid quality and cost data. In addition, the State contracts with an External Quality Review Organization (EQRO) to audit health plans for quality measures and in the future, encounter data. The State will build on this experience and infrastructure and work with CMS and stakeholders to develop a quality and cost measurement program and strategy for the demonstration. Further, the State is exploring ways to implement a rapid-cycle quality improvement system to monitor, collect, and track data, and use that data to make necessary program adjustments to ensure quality of care and for evaluation purposes.

The State is holding a series of public work group meetings on quality monitoring and the evaluation of the demonstration. Dr. Neal Kohatsu, DHCS Medical Director, and Dr. Kenneth Kizer, Distinguished Professor, University of California Davis School of Medicine and Betty Irene Moore School of Nursing are leading this effort. They will guide discussion of the overall approach to evaluating the program, as well as specific performance measures that will be required in contracts with health plans. Work group participants include researchers, beneficiaries, health plans, advocates, and state agencies. .

Potential Improvement Targets for Performance Measures

California will finalize the performance measures it will use to monitor quality and cost in the demonstration only after significant input from multiple stakeholders. Although the State has not yet developed the potential improvement targets, there are several principles for performance measures that should be noted. Performance measures must:

- Be comparable across all health plans
- Use reliable data

- Respond to an identified problem/issue
- Assist the State with improving an issue/problem that is important to the State
- Reflect important health outcomes, processes of care or beneficiary-set goals around functional level and quality of life that are closely related to improvements in health outcomes
- Be implementable in time for initial enrollment

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Some potential improvement targets include:

- An increase in the number of beneficiaries participating in and receiving care coordination
- An increase in the number of health risk and behavioral health screenings
- An increase in the number of beneficiaries with care plans
- Improved access to home- and community-based services
- Reduced hospital utilization, emergency room utilization, skilled nursing facility utilization, and long-term nursing facility placements
- Improved beneficiary satisfaction

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Demonstration health plans will be accountable for provider performance and health outcomes within their systems. These entities will be responsible for collecting and using performance and outcome data to drive changes in care delivery as necessary to ensure that beneficiaries are receiving high quality care that improves health outcomes. These entities will be required to share performance and outcome data with the State. Additionally, each health plan shall have a process for soliciting and incorporating stakeholder input in its quality improvement process, such as stakeholder committees.

Within their Models of Care, health plans presented a wide range of goal-based performance measurement approaches, including a description of the barrier or root cause analysis conducted to detect the possible origins of, and solutions for, any outcomes that fell short of the health plan goals.

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Specific reporting metrics also will be developed to measure and show evidence regarding the quality of coordination between the health plans and county-administered behavioral health services. These metrics would correspond to the state and national quality and evaluation framework and be phased-in to reflect the unique local context and a tiered approach to joint accountability in achievement of specified measures (see Appendix 2 for additional details.)

Expected Impact of Demonstration on Medicare and Medicaid Costs

The current lack of integration fosters cost shifting and underinvestment. The lack of alignment between Medicare and Medi-Cal coverage rules creates incentives for providers to shift costs by transferring patients from one service or setting to another. In addition to not serving members in the best way possible, this shifting increases both state and federal spending. In the current system, California is not able to share in the acute care savings that would result from investment in expanded home- and community-based care, community support services, and behavioral health care. The effects are an underinvestment in these important cost-effective services, missed

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savings potential and missed opportunities to better coordinate care and improve health outcomes for beneficiaries.

Better coordination and management of care will result in expected savings in the short term associated with reductions in acute care admissions, readmissions, emergency room use, and nursing home stays. The inclusion of behavioral health diversionary services will further offset the cost of inpatient psychiatric and substance use services.

The real potential of this demonstration to affect beneficiaries and Medicare and Medi-Cal as payers will be felt over several years. Savings should grow over time as health plans influence changes in utilization patterns by helping beneficiaries stay well, manage chronic conditions, gain better access to coordinated behavioral health services, and remain in community settings longer.

Fully integrated services and funding will allow beneficiaries to receive the services they need to live in the community and to avoid costly hospital and emergency department visits. Integration of services will improve utilization, beneficiary satisfaction, and health outcomes by ensuring the right services are delivered to the right people at the right time in the most appropriate setting.

Note that the State assumes that the combined Medicare and Medi-Cal federal and state savings from this demonstration will be shared equally between the state and federal governments.

The State will work with CMS and its evaluation contractor, RTI, for the evaluation of this demonstration. The State also will conduct a state-level evaluation, in conjunction with the quality improvement system, to ensure that the state evaluation needs and timelines are addressed.

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California will work with CMS to develop three-year financial projections for Medicare, Medicaid, and total combined expenditures, as well as estimated savings.

G. Infrastructure and Implementation

State Infrastructure/Capacity

The California Department of Health Care Services (DHCS) is the State Medicaid agency in California and the sponsor of this demonstration. DHCS is partnering with the Department of Managed Health Care (DMHC), California Department of Social Services (CDSS), and the California Department of Aging (CDA) to implement the demonstration. The California Health and Human Services Agency (Agency) is coordinating many aspects of the demonstration that affect multiple departments. This collaboration will ensure the state has adequate capacity to implement and oversee the demonstration in eight counties in 2013 and additional counties in future years.

Within DHCS, primary responsibility for the demonstration lies within the Health Care Delivery Systems program. Within this program, the Medi-Cal Managed Care Division develops and administers health plan contracts, monitors contract compliance and health plan quality,

administers the Medi-Cal managed care Ombudsman program, and oversees the state's beneficiary enrollment contractor. This division also administers an interagency agreement with DMHC for additional auditing and financial oversight services. The Long-Term Care Division operates, administers, monitors, and provides oversight for a number of home and community-based service waivers in California, including CBAS, MSSP, and IHSS. This division also administers PACE in California and a federal Money Follows the Person grant. Both of these division report to the Deputy Director of Health Care Delivery Systems and work is done collaboratively within this reporting structure.

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Additional divisions within DHCS provide critical functions for the demonstration. Within the DHCS Health Care Financing program, the Capitated Rates Development Division develops and coordinates capitation rates and monitors health plan expenditures. For behavioral health, the DHCS Mental Health and Substance Use Disorder program provides statewide oversight and administration of county-administered mental health and substance use programs. The DHCS Research and Analytical Studies Section, in coordination with other areas within DHCS, receives and analyzes Medi-Cal and Medicare data.

Among partner agencies, DMHC licenses and regulates managed health care plans, conducts routine and non-routine financial and medical surveys, and operates a Help Center where beneficiaries can lodge complaints and get assistance with problems they are having with their plans. Each health plan seeking to participate in the demonstration holds a current license issued by the DMHC under the Knox-Keene Act. To maintain its license, each health plan is required to continuously meet defined regulatory standards, including timely access to care through adequate provider networks, care coordination, continuity of care, financial solvency, and treatment decisions unencumbered by fiscal or administrative considerations.[23] The DMHC Help Center provides comprehensive beneficiary assistance, including:

Deleted: DMHC licenses managed care health plans, conducts routine and non-routine financial and medical surveys, and operates a consumer services toll-free complaint line

1. A toll-free complaint and assistance line
2. A process for quickly resolving routine health plan issues
3. An urgent nurse process for treatment denials that require immediate assistance
4. External review of medical necessity and experimental/investigational disputes
5. A thorough review process for complaints concerning all other matters, including coverage denials

CDSS provides state-level oversight and fiscal services for the county-administered In-Home Supportive Services Program. CDA administers MSSP and the Health Insurance Counseling and Advocacy Program (HICAP), which offers consumer counseling on Medicare, Medicare supplement policies, health plans, and long-term care insurance. Local HICAP offices provide free community education and confidential individual counseling statewide.

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[23] Subject to oversight by the DMHC, licensed health plans are required to adhere to the following requirements: 1) Geographic access standards regarding the location of PCPs and hospitals; 2) Time-elapsed access standards for urgent, primary, specialty, and ancillary care - PCP ratios and total physician ratios; 3) Extensive onsite medical surveys, including medical surveys conducted under the Section 1115 waiver; 4) Quarterly monitoring of provider networks conducted under the Section 1115 Waiver; 5) Prior approval of network changes that impact 2,000+ health plan members; 6) Financial solvency filings and comprehensive financial examinations of health plans; and 7) Financial solvency filings and financial examinations of risk-bearing medical groups

The State will use a combination of existing resources and additional infrastructure to implement this demonstration. CDA may expand HICAP counselors to assist during the enrollment period for the demonstration counties. CDSS will administer a revised quality-monitoring program for the IHSS program in the demonstration counties; and jointly develop the home- and community-based universal assessment tool.

In addition to state agency staff, the State will use contractors for project management, rate development, data analysis, enrollment planning, demonstration evaluation, provider outreach, and facilitating stakeholder workgroups and external communications.

Further, California's foundation community has provided generous support for this project through contracts with technical experts. The State will pursue additional support for best practice identification and sharing.

The State has used its federal planning grant to support a robust stakeholder process and to develop this demonstration model and proposal.

Medicare or Medicaid Waivers

Six-Month Stable Enrollment Period: In conjunction with the passive enrollment process, the State is seeking federal approval to establish a six-month minimum stable enrollment period for Medicare benefits for beneficiaries who enroll in the demonstration. This is critical to ensure sufficient time for health plans to achieve improved care. Health plans can only achieve the benefits of coordinated care if they have sufficient time to develop a case plan and implement care improvements. Without this stable enrollment period, the demonstration will face an additional barrier of enrollment churning and interruptions in the beneficiaries' continuity of care. Beneficiaries' continuity of care rights during this stable enrollment period are described in the beneficiary protections section.

Section 1115 Waiver: The State anticipates that there may be a need for flexibility around current Medicaid rules and requirements in order to align the enrollment process with Medicare, as well as flexibility related to actuarial soundness if required for the blended payment rate. The State will work with CMS to determine if any amendments to current waivers of rules, such as the 1115 waiver, are needed.

Health Plan Contracts with PACE Providers: Some health plans participating in the demonstration have expressed interest in contracting with PACE providers, to provide an additional option for members that meet the criteria for enrollment in PACE. The State will work with CMS to determine if any amendments to current authority for PACE are needed for this contracting option.

Expansion Plans

The Governor's Coordinated Care Initiative proposes to expand the demonstration as follows:
2013: Up to eight counties with Medi-Cal managed care.
2014: All remaining counties that currently have Medi-Cal managed care.

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Comment: This text on continuity of care was deleted because it was under the beneficiary protections section, as well.

Deleted: The stable enrollment period will be established as follows: Once enrolled in a demonstration health plan, beneficiaries will remain enrolled in the demonstration with that health plan for six months. During the six month period, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services if all of the following criteria are met: a) the beneficiary demonstrates an existing relationship with the provider prior to enrollment, b) the provider is willing to accept payment from the health plan based on the current Medicare fee schedule, and c) the managed care plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns. The State, with stakeholder input, may exempt specific categories of dual eligible beneficiaries from the six month minimum enrollment period.

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2015: All remaining counties, including the 28 current Medi-Cal fee-for-service counties. These counties will transition to Medi-Cal managed care on the same timeline as the demonstration is implemented.

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Implementation Strategy and Timeline

See Appendix 4 for a detailed work plan and timeline.

H. Feasibility and Sustainability

Potential Barriers/Challenges

With California's robust home-and community-based services (primarily IHSS), and its established health plans with both Medi-Cal and Medicare experience, the state already has in place most of the elements required for successful implementation of the demonstration. However, several challenges remain:

Enrollment: Several enrollment challenges must be resolved for the demonstration to meet its goals. First, the enrollment process and materials must be well-designed to give beneficiaries clear information about enrollment choices, opportunities to resolve dissatisfaction with enrollment issues, and the process for maintaining care with an existing out-of-network provider.

Second, health plans will need sufficient enrollment in the demonstration to sustain a capitated model and provide the full range of benefits and services. The passive enrollment process proposed in the demonstration is needed to address this challenge. In addition, the rate structure for this demonstration will help determine whether health plans offer benefits such as dental and vision. These benefits can be an important consideration for beneficiaries in choosing to enroll in a managed care plan.

Third, health plans can only achieve the benefits of coordinated care if they have sufficient time to develop a case plan and implement care improvements. To promote continuity of care and provide sufficient time for health plans to achieve improved care, federal and state authority is needed for a six-month stable enrollment period for those who enroll in the demonstration. To the extent that authority is not provided, it will be more difficult for health plans to achieve the health and care management goals of the demonstration.

Capitation Rate Development and Savings Sharing: The State will seek to develop a capitation rate and savings sharing structure that meets multiple objectives: 1) aligns fiscal and quality incentives; 2) provides adequate funding and incentives for health plans to develop and implement the key features of this demonstration, including supplemental benefits such as non-medical transportation, vision, and dental; 3) slows the cost growth for Medicare and Medi-Cal; and 4) provides savings for the State. Options being considered for the capitation rate and savings sharing structure include risk adjustment, risk corridors, and other financial incentives to achieve the rebalancing goals of the demonstration. In addition, the State assumes that it will receive 50 percent of the combined Medicare and Medi-Cal federal and state savings from this demonstration.

Note also that the Coordinated Care Initiative requires that the demonstration meet quality and fiscal requirements. If the Department of Health Care Services or Department of Finance determine that the Initiative will jeopardize the quality of care for beneficiaries or has caused utilization changes that result in higher State costs than would have occurred absent the Initiative, then the State will discontinue the provisions of the Initiative.

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Data Sharing: Two key issues regarding data sharing must be addressed for the successful implementation of the demonstration:

- Data sharing prior to enrollment: Health plans have requested de-identified beneficiary data in 2012. This information will be used by plans to review the scope of beneficiaries' health status and care needs, which will allow plans to develop staff hiring and provider contract needs. Plans have also asked for member-specific data prior to the effective date of enrollment, to ensure care continuity with existing providers. The State will work with CMS and health plans to ensure the appropriate data sharing processes are in place.

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- Data sharing between health plans and county agencies: Health plans and the county agencies that administer IHSS and provide behavioral health services will need to develop the technical and regulatory protocols to share beneficiary data. This type of data sharing is essential for care coordination and to achieve the goals of the demonstration. The State will work with counties and health plans to provide legal, regulatory, and technological support for data sharing among these organizations.

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Network Adequacy and Provider Collaboration: Sufficient provider participation, engagement, and collaboration in the demonstration will be critical for the success of this program. Some health plans will need to improve their provider networks, particularly in geographic expansion areas for Medicare services within a county, to meet the state and federal readiness review criteria for the demonstration. Health plans will also need to strengthen their engagement and collaboration with providers, as part of the care coordination efforts. Further, some home- and community-based services have been frozen or reduced in recent years as a result of funding reductions. They may not be broadly available in all geographic areas to allow the establishment and enforcement of rational network standards. LTSS network adequacy standards will be developed in cooperation with stakeholders during the work group process, and health plans will be required to meet those standards during the readiness review process.

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Comprehensive Care Coordination in Partnership with County Agencies: In California, community behavioral health services and IHSS are administered by county agencies and are funded in whole or in part by counties. Coordination with acute care or health plans is not generally in place. Incorporating these locally funded and administered programs into a coordinated State model requires careful consideration of how best to serve beneficiaries and align fiscal and programmatic incentives, while also maintaining local flexibility to build on existing successful programs. The State is working with stakeholders and local agencies to develop a coordinated model that calls for accountability and also allows for local flexibility.

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Medicare Star Ratings and Alternatives: The State is concerned that the CMS methodology for evaluating a health plan's past Medicare performance has a substantial flaw, and could inappropriately limit health plan participation in the demonstration. While the State supports efforts to promote quality through health plan accountability, plans dedicated to serving persons eligible for both Medicare and Medicaid are at a significant disadvantage compared with Medicare Advantage plans that serve the general population of Medicare beneficiaries. Those health plans' Medicare STARS ratings are generally lower than other Medicare Advantage plans' ratings because of the higher disease burden among dual eligible beneficiaries compared to other Medicare beneficiaries.

Quality Measurement and Evaluation: Various state and federal programs for dual eligible beneficiaries have a variety of monitoring and oversight mechanisms, as well as output and quality measures that may be complex to aggregate and review, and may not fully reflect the outcome goals of this demonstration. A coordinated and standardized state and federal monitoring/oversight mechanism and a dashboard of appropriate quality and outcome measures is critical for program success, as well as for public oversight. The state will work in collaboration with CMS and established researchers in this field to develop a quality and outcomes dashboard, as well as a state evaluation plan for the demonstration.

Timelines: The State will continue working closely with CMS, health plans and stakeholders to meet the proposed implementation timeline, ensuring there is sufficient beneficiary outreach and that health plans are ready to begin enrollment in 2013. In addition, California will seek partnership and support from CMS to fund the build-out of new infrastructure, IT, staff, and member and provider outreach necessary to implement the demonstration.

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State Statutory and/or Regulatory Changes Needed

Although current state law provides authority to implement the demonstration in up to four counties, the Governor's Coordinated Care Initiative seeks Legislative authority to implement the following aspects of the demonstration:

- Implement the demonstration in up to eight counties in 2013, additional counties in 2014, and statewide by 2015.
- Establish a six month stable enrollment period for the demonstration.
- Establish a county maintenance of effort funding level for IHSS.
- Implement mandatory Medi-Cal managed care enrollment in demonstration counties.
- Develop and implement a HCBS Universal Assessment, implemented as early as January 1, 2015

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State Funding Commitments or Contracting Processes Needed
State Legislative approval is needed for any additional State positions or contracts established above current authorized levels.

Demonstration Scalability and Replicability

Since this demonstration model is built on the foundation of existing Medi-Cal and Medicare health plans in California, plus the robust statewide IHSS personal care services program, this demonstration model is scalable and replicable in other counties in California, as well as other

states with similarly-experienced health plans and existing large-scale personal care services programs.

Appendices

Appendix 1 County Implementation Table for Dual Eligible Demonstration
Appendix 2 Framework for Shared Accountability: Coordination and Alignment Strategies For Integrated Delivery of Behavioral Health Services
Appendix 3 Draft Enrollment Flow Chart
Appendix 4 Medi-Cal Benefit List
Appendix 5 Work Plan and Timeline
Appendix 6 California Dual Eligible Demonstration Request for Solutions Proposal Checklist
Appendix 7 Background on California's Medi-Cal Program
Appendix 8 Graphic with Proposed Monitoring Process
Appendix 9 Letters of Support

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Appendix 1 County Implementation Table for Dual Eligible Demonstration

2013 (8 counties)	2014 (22 counties)	2015 (28 counties)
Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara	Contra Costa, Fresno, Kern, Kings, Lake, Madera, Marin, Mendocino, Monterey, Napa, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Sacramento and Yolo	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba

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Appendix 2 Framework for Shared Accountability: Coordination and Alignment Strategies for Integrated Delivery of Behavioral Health Services

This section proposes a framework for shared accountability for coordinating and aligning the delivery of behavioral health services between demonstration health plans, county-administered mental health plans (MHPs) and county substance use disorder agencies. CMS and stakeholders requested greater detail on this aspect of the demonstration. Specifically, CMS requested a more detailed description of a shared accountability strategy to achieve the demonstration aims of seamless access to services and reduced cost shifting for individuals receiving county-administered specialty mental health and Drug Medi-Cal services, both of which are not proposed to be included in the capitated payments to health plans.

The framework described here recognizes the value of existing service delivery structures and aims to build on this existing infrastructure to improve coordination and meet the demonstration goals. Further details will be developed in the MOU between DHCS and CMS and in health plan contracts. Stakeholders also have an opportunity to comment during the 30-day federal comment period.

Background

Behavioral health conditions, including mental illness and substance use disorders, are prevalent among dual eligible beneficiaries. For Medicaid beneficiaries with common chronic conditions, health care costs are as much as 75 percent higher for those with mental illness compared to those without a mental illness[24] and the addition of a co-occurring substance use disorder results in two- to three-fold higher health care costs.[25] Among dual eligible beneficiaries, national estimates show that 44 percent have at least one mental health diagnosis.[26] The prevalence of serious mental illness among dual eligible beneficiaries under age 65 is at least three times higher than for those age 65 and older.[27] Meanwhile, substance use disorder, with and without co-occurring mental illness, is more prevalent among dual eligible individuals than among Medicare-only beneficiaries.[28]

California's Behavioral Health Services Delivery Infrastructure

Dual eligible beneficiaries in California receive mental health services through three separate funding sources: Medicare, Medi-Cal and programs funded by the Mental Health Services Act

[24]C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin, and L. Martin, *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Center for Health Care Strategies, Inc., December 2010), [http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201].
[25] Ibid
[26] 4 J. Kasper, M. O'Malley-Watts, and B. Lyons. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured, July 2010. Available at http://www.kff.org/medicaid/8081.cfm
. This includes 16 percent with diagnoses of Alzheimer's or other dementia.
[27] Ibid
[28] W. Lin, J. Zhang, G. Leung, and R. Clark, "Twelve-Month Diagnosed Prevalence of Behavioral Health Disorders Among Elderly Medicare and Medicaid Members," *American Journal of Geriatric Psychiatry*. Published Ahead-of-Print November 25, 2010.

(MHSA). Medicare pays for outpatient, community-based treatment and most acute inpatient psychiatric admissions for people who are dually eligible. Medi-Cal and MHSA fund specialty mental health services for individuals with severe and disabling mental illnesses as defined in Welfare and Institutions Code Section 5600.3. These recovery-focused "specialty mental health services" have been realigned to the counties in accordance with the Mental Health Adult and Older Adult System of Care as set forth in Welfare and Institutions Code Section 5806. Dual eligible beneficiaries receive limited substance use services through Medicare and Medi-Cal. Substance use covered benefits are significantly less comprehensive than mental health benefits.

County Specialty Mental Health Services

Through a Section 1915 (b) "freedom of choice" waiver, all individuals who meet specified medical necessity criteria[29] receive specialty mental health services through the County Mental Health Plans (MHPs). Under the provisions of this waiver, the county mental health plans are considered prepaid inpatient health plans (PIHP) because they are responsible for assuring 24 hour, seven day a week access to emergency, hospital and post stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries. California also has two approved state plan amendments (SPAs) that increase the scope of outpatient, crisis and residential and inpatient mental health coverage provided to Medi-Cal beneficiaries when medically necessary, by the mental health plans.

- The first, which was updated and approved by CMS in December 2010, covers targeted case management for persons with mental illness. [30]

- The second, which was updated and approved by CMS in October 2010, covers mental health services available under the Rehabilitation Option, broadening the range of personnel and locations that were available to provide services to eligible beneficiaries. [31]

In June of 2006, the California Code of Regulations (CCR) (Title 9) governing the payment for and delivery of specialty mental health, emergency and psychiatric hospital services to eligible beneficiaries in California became permanent. In addition to the required contract between DHCS and the MHP, these regulations form the basis for the access, beneficiary protection and payment provisions governing operation of the MHPs. Through the process of successive 1915(b) renewal applications it was determined by CMS that the MHPs are subject to Code of Federal Regulation (CFR) Title 42, Part 438 Managed Care requirements. Among other things, these federal requirements specify additional access, beneficiary protection and quality management requirements that the MHP must conform to, many of which are specified in the contract. About 28 percent of the roughly 240,000 adults served by the county mental health plans are dual eligible beneficiaries (see Table 1 for more details).[32]

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[29] Medi-Cal beneficiaries receive specialty mental health services if they meet all of the following medical necessity criteria: 1) Diagnosis – one or more of 18 specified Diagnostic and Statistical Manual of Mental Disorders; 2) Impairment – significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child won't progress appropriately; 3) Intervention: services must address the impairment, be expected to significantly improve the condition, and a physical health care based treatment would not work.
[30] Available here: http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/docs/10_012B_SPA_for_webposting.pdf
[31] Available here: http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/docs/CA_SPA_10_016_for_webposting.pdf
[32] Department of Health Care Services. Analysis of Short-Doyle II claims data. December 2011.

Table 1: Dual Eligible Clients in California's Specialty Mental Health Services

COUNTY	Dual Eligible Clients
Los Angeles	16,829
Orange	1,632
San Diego	3,276
San Mateo	1,979
Alameda	3,488
Santa Clara	3,226
Riverside	3,123
San Bernardino	2,931
8 County Total	36,484
Statewide Total	67,776

Based on Short-Doyle Approved Claims for FY 2009-10

Both federal and state code and regulation require a contract between the State and the MHP specifying the conditions under which the managed care program will operate. State regulation specifies the process for developing changes to the contract, and the current waiver indicates that the contracts shall be in effect for three-year periods subject to amendments, as necessary. The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans. One component of this coordination of care is the requirement that a memorandum of understanding (MOU) be in place between the county and each health plan specifying the respective responsibilities and protocols for timely referral and treatment of the beneficiary's health and mental health conditions.[33] Some demonstration health plans already contract directly with the county behavioral health agencies to ensure seamless care delivery, and others are working with behavioral health administrative service organizations to coordinate services across the care continuum.

Drug Medi-Cal

All Drug Medi-Cal (DMC) services are outpatient services. Services available through DMC include individual and group counseling, narcotic replacement medication and counseling, naltrexone services for opioid dependence, residential and day care rehabilitation treatment for women who are pregnant or within the prescribed postpartum period, and and day care rehabilitation treatment for full-scope Medi-Cal beneficiaries under age 21. Although DMC services are classified as rehabilitative services, they are not provided under the "rehabilitation option," meaning they must be delivered in a certified clinic.

In fiscal year 2010-11 there were 62,004 unique DMC admissions statewide, of which 8,381 were dual eligible beneficiaries. About 44 percent (3,679) were in Los Angeles County.

[33] For more detailed description see: Med-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program PL 00-001 Rev (PDF - 4.3MB)

Currently, Medi-Cal beneficiaries must obtain DMC services through the county, a county-contracted provider or a direct contract provider. Although other providers may have DMC certification, if they do not have a contract with the county or the State, they cannot receive Medi-Cal reimbursement. To provide DMC services with its contracted provider network and assure full compliance with federal requirements, California is pursuing a Medicaid 1915(b) freedom of choice waiver.

Beginning in State Fiscal Year 2011-12, funding and responsibility for DMC and other alcohol and drug services were realigned to the counties. Responsibility for State administration of DMC services is being transferred from the Department of Alcohol and Drug Programs to the Department of Health Care Services. The state-level transfer will be completed by July 1, 2012.

Currently, substance use benefits are not a required benefit for Medi-Cal health plans. Medi-Cal managed care beneficiaries are able to access medically necessary services through their county alcohol and drug (AOD) program office. Formal relationships between the Medi-Cal health plans and the county alcohol and drug office that oversees the delivery of DMC services are not common.

Framework for Shared Accountability

While the existing delivery systems provide vitally important services, notably lacking is effective person-centered care and coordination across the service domains and alignment of financial incentives to reduce cost shifting across payers. Information sharing and coordination between the Medicare and Medi-Cal systems for dual eligible beneficiaries is especially challenging. Without this coordination, access to and the delivery of quality services cannot be assured, and additional cost is incurred to both the Medicare and Medicaid programs because of the inherent inefficiencies.

This demonstration presents an opportunity to promote person-centered care coordination and align financial incentives to drive shared accountability for improving beneficiary outcomes. Successful approaches must take into account the current complexity of financing and service delivery, notably counties' roles in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. The county portion of Medi-Cal funding for specialty Medi-Cal mental health services will be carved out of the capitation rate, at least initially. However, the State intends for health plans and county agencies to work together to coordinate care and develop strategies for shared accountability through local contracts or MOUs. This approach avoids destabilizing the current system and recognizes the value of existing service delivery structures.

Contracts/MOUs

An MOU or contract will be the mechanism for the systems to operationalize and monitor the requirements for coordination. DHCS will oversee these contracts/MOUs by reviewing documentation (copies of the contracts/MOUs) and by using compliance oversight mechanisms and performance metrics to ensure that required activities are conducted. DHCS expects to see solutions that reflect unique local circumstances and vary by county in their structure and timing.

Adoption of the elements is expected to be progressive over the three years of the demonstration. The MOU will include, at least, the following key elements:

1. **Roles & Responsibilities**. Clear delineation of roles and responsibilities are needed to reduce duplication, improve efficiency, and meet the demonstration goals.

2. **Coordination strategies**. DHCS will require evidence of specific coordination strategies to strengthen integration (clinical, administrative, and financial).

3. **Information Exchange Plan**. The health plans and county agencies must put into place strategies to support the flow of information, with assigned lead responsibilities and a standardized approach to patient referral and follow-up.

4. **Performance measures to track accountability**. Specific reporting metrics will measure and show evidence regarding the quality of administrative activity, clinical activity, and patient satisfaction outcomes, as well as evidence of reduced costs. They will correspond to the state and national quality and evaluation framework. In the first year(s), these measures may be process-oriented and represent tangible, measurable activities that indicate collaboration and form the foundation necessary for integrating care. Outcome measures will be developed and used in later years.

5. **Shared Financial Accountability**. DHCS will require outlines for shared financial accountability in the MOU that include specific incentives and/or penalties linked to performance metrics applied to the health plan and county mental health and substance use agencies.

Roles & Responsibilities
Clear delineation of roles and responsibilities in locally developed MOUs/contracts will serve as the foundation for all coordination efforts. This role delineation shall describe clear processes for referrals and payment terms. The Demonstration counties will report to the DHCS-led stakeholder work group and provide evidence of local collaboration. Additionally during the readiness review process, DHCS and CMS will ensure the establishment of MOUs/contracts with the required elements.

Coordination Strategies
As part of their preparation for the readiness review process, demonstration health plans will describe how they will coordinate with county agencies and other stakeholder groups, including but not limited to consumer/family members and network providers, to reduce duplication, improve efficiency, and meet the demonstration goals. Coordination activities will span clinical, administrative and financial areas. Examples of clinical integration at the point of care include but are not limited to: (1) comprehensive physical and behavioral health screening and assessment; (2) triage and assignment of beneficiaries to appropriate care manager; (3) beneficiary engagement; (4) shared development of goal-setting and care plans by the beneficiary, caregivers, and all providers; and (5) care coordination and navigation support.

Information Exchange
Successful coordination is dependent on the ability to collect, report and share relevant patient-level encounter data. Thus, clear data sharing/privacy guidelines need to be established to facilitate information exchange across systems. California's counties and corresponding demonstration health plans have varying capabilities, agreements and legal interpretations related to the sharing of information. Regulatory and other legal barriers (or perceived barriers) to sharing essential information between systems should be identified and addressed as soon as possible. Detailed plans for overcoming these barriers will be necessary. It is expected that information sharing will be phased in. Achievements in this area may correspond to the process measures indicating progress toward integration.

The eventual goal should be developing capability to share accurate and timely information electronically. Such a secure electronic platform may contain: (1) a current integrated problem list; (2) a single integrated person-centered, recovery-oriented plan of care; (3) contact information for lead coordinator(s); (4) a current medication list; and (5) dates of service and servicing providers for most recent provider and service contacts within respective systems. Ideally, the system also would track appropriate patient processes of care and outcome metrics, such as HgA1c and BMI assessment for those on atypical antipsychotics; improvements in standardized scores on depression and anxiety scales, etc.

Performance Measures
Identified performance metrics will serve as the foundation for shared accountability for improving outcomes and reducing costs. These metrics will be subject to agreement with CMS and correspond to state and national evaluation frameworks to allow for comparisons and tracking overall performance. The measures will correspond to the overarching outcomes or goals for the two systems that include, but are not necessarily limited to:

- Delivery of person-centered, recovery-oriented care
- Delivery of care in the most appropriate setting
- Improved quality of life and support for the highest level of recovery and independence
- Reduced avoidable emergency room visits or inpatient hospitalizations
- Reduced total cost of care
- Improved or maintained health outcomes

These metrics would be phased in and reflect the unique local context and a tiered approach to joint accountability in achievement of specified measures. Examples could include:

- Year 1: Measures focus on process improvements and tangible, measurable activities that indicate collaboration. These may include common member assessments, screening, stratification, and information about treatment/medications, jointly developed care plans, and real-time notification of hospital and ED admissions, as well as psychiatric emergency and crisis services utilization.

- Year 2: Measures evolve to capture intermediate outcomes, such as reduced emergency department and psychiatric crisis use and unnecessary inpatient admissions.

- Year 3: Measures may include health outcomes achieved and/or actual calculation of savings based on changes in service and pharmacy utilization.

Shared Financial Accountability
A key aim of this demonstration is to reduce cost shifting across delivery systems and promote person-centered care coordination. Thus, it is expected that the demonstration health plans and county behavioral health agencies develop formal financial arrangements based on identified performance measures to improve health outcomes and reduce medical costs.

The State will continue exploring these options with stakeholders and CMS, but it is expected that a financial alignment strategy will be in place by year three of the demonstration. Further exploration of the following options will occur in cooperation with stakeholders.

- **Incentive Payments**: Health plans and Counties could enter a formal agreement for care coordination. An incentive pool could be established to award bonus payments for meeting set performance measures tied to activities that promote integration and/or outcomes that indicate successful coordination, reduced emergency and crisis services utilization and eventually good health outcomes. Alternatively, the "quality withhold" – the portion of the rates withheld pending the achievement of quality metrics – could include a behavioral health coordination and utilization metric and the health plans could be required to share some or all of this portion related to behavioral health with the county agencies.

- **Shared Savings Pools**: Health plans and Counties could agree to an arrangement that establishes mechanisms for local shared savings (between the plan and county) around benchmarks, such as reduced ED, psychiatric crisis, inpatient utilization, or pharmacological costs. Absent local shared savings agreements, DHCS could coordinate shared savings arrangements, for example, by adjusting a portion of the health plan payments for sharing between the health plan and county agencies.

- **Inclusion in the Capitation Payment**: Counties could provide an inter-governmental transfer (IGT) to the State or appropriate government entity for the portion of the capitated rate related to mental health services for dual eligible beneficiaries with serious mental illness. The IGT could be based on an analysis of the amount of funding the county would have expended through certified public expenditures (CPEs) for enrolled duals. DHCS could include those funds within the capitated rate paid to the plan. The plan could contract back with the county mental health agency for service delivery.

- **Care Coordination Services.** There could be a new benefit/service category(ies) specific to the demonstration's goals of increasing care coordination provided by the county behavioral health agencies and reimbursable by the health plans.

As with the metrics, financial accountability is intended to be phased-in with a focus on process measures in the first year while work is underway to develop outcome and utilization/cost metrics and corresponding incentive mechanisms for future years. The development of final financial alignment strategies is dependent on negotiation with, and requirements of, CMS.

Appendix 3 Draft Enrollment Flow ChartINSERTED GRAPHIC with Proposed Passive Enrollment Process; Applies only to beneficiaries eligible for passive enrollment

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Deleted: List of Medi-Cal State Plan Core Services/Providers

Appendix 4 Covered Services

The following Medi-Cal State Plan benefits are intended to be included in the demonstration under the blended capitation payment. Certain services have limitations. In the case of behavioral health services, county-administered services, as noted, are carved out of the blended capitation payment and coordination between health plans and counties is required.

Table 1 Medical Services

1. Acupuncture Services	26. Nurse Midwife Services
2. Audiology / Hearing Aid	27. Occupational Therapy
3. Audiological Services	28. Optometry Services and Vision Materials
4. Blood and Blood Derivatives	29. Orthodontics
5. Cancer Screening	30. Organized Outpatient Clinic Services
6. Certified Family Nurse Practitioner	31. Out of State Services (Emergency only)
7. Chiropractor	32. Pharmaceutical Services and Prescribed Drugs
8. Chronic Hemodialysis	33. Physical Therapy
9. Dental Services	34. Physician Services
10. Durable Medical Equipment	35. Podiatry Services
11. Emergency Room	36. Prosthetic and Orthotic Appliances
12. Family Planning	37. Reconstructive Surgery (non cosmetic)
13. Genetically Handicapped Persons Program	38. Renal Homotransplantation
14. Health Education	39. Renal Dialysis
15. Hearing Aids	40. Respiratory Care Services
16. HIV Testing	41. Scope of Sign Language Interpreter Services
17. Home Health	42. Skilled Nursing Services (short-stay, rehabilitation)
18. Hospice Care	43. Special AIDS Drugs
19. Indian Health Services (Medi-Cal covered services only)	44. Special Duty Nursing
20. Inpatient Hospital Services	45. Speech Pathology
21. Incontinence Creams and Washes	46. Swing Bed Services
22. Immunizations	47. Transitional Inpatient Care Services
23. Laboratory, Radiological and Radioisotope Services	48. Transportation Services
24. Major Organ Transplant	49. Transportation Services: Non-Emergency
25. Medical Supplies	50. Tuberculosis related services (including DOTS)

Table 2 Long-Term Services and Supports

Benefits
15. Skilled Nursing Services (long-stay)
16. Intermediate Care Services
17. Adult Subacute Services
18. Community-Based Adult Services
19. In-Home Supportive Services
20. Case management / care coordination

Table 3 Community LTSS Benefits "In Lieu of" Institutional Care*

Benefits

1. Respite: in-home and out-of-home
2. Nutritional assessment, counseling and supplements
3. Protective supervision: in-home and out-of-home
4. Skilled nursing care
5. Minor home / environmental adaptations
6. Habilitation
7. Supplemental personal care, chore and attendant care

*Specific medical necessity criteria must be met to quality for these benefits

Table 4 Behavioral Health Services*

Benefit	Included in blended capitation	Excluded from blended capitation
Mental health hospital inpatient services (including emergency department)	X	
Mental health outpatient services	X	
Psychotropic Drugs	X	
Mental health services within the scope of primary care practitioner	X	
Psychologists	X	
Psychiatrists	X	
Alcohol and Drug Detoxification	X	
County-Administered Specialty Mental Health Services (1915b waiver services) A: Rehabilitative mental health services 1) Mental health services (individual therapy, group therapy, assessment, collateral, plan development) 2) Medication support services 3) Day treatment intensive 4) Day rehabilitation 5) Crisis intervention 6) Crisis stabilization 7) Adult residential treatment services 8) Crisis residential treatment services 9) Psychiatric health facility services B. Targeted Case Management		X
Drug Medi-Cal services 1) Outpatient methadone maintenance therapy 2) Day care rehabilitation (for pregnant women), 3) Outpatient individual and group counseling, 4) Perinatal residential services, 5) Levoalphacetylmethadol (LAAM) and Naltrexone treatment for narcotic dependence		X

*Coordination between benefits included and excluded from the blended capitation is required. See Appendix 2 for additional details.

Appendix 5 Work Plan and Timeline

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Timeframe	Key Activities/Milestones	Responsible Parties

August 2011-ongoing	Stakeholder Outreach: • Four large public meetings held in 2011 throughout the state to seek stakeholder input on key areas of the demonstration • Meetings with beneficiaries • E-mail updates	DHCS
December 2011	Draft Request for Solutions (RFS) released for Public Comment.	DHCS
January 2012	Final RFS released.	DHCS
February 2012	Health plan responses due to DHCS for RFS.	Health Plans
March 2012-ongoing	Announcement of stakeholder workgroup process related to seven key areas of policy development and implementation.	DHCS, CDSS
Early April 2012	Demonstration counties announced, and draft demonstration proposal released for 30-day public comment period.	DHCS, CDSS, CDA
Summer 2012	Waiver submitted to implement mandatory Medi-Cal managed care for dual beneficiaries, and six month stable enrollment period.	DHCS
Early May 2012	End of Public Comment period for Demonstration proposal.	Public
Late May 2012	Revised demonstration proposal submitted to CMS. CMS publishes demonstration proposal for 30-day public comment period.	DHCS, CMS
April 2012 -July 2012	Initial State Planning Process: CMS works with State to develop a formal MOU that outlines specific programmatic design elements, technical parameters and approval package for necessary Medicare and Medicaid authorities and payment/financial models. Approved MOU signed by CMS and State.	DHCS, CMS
June-July 2012	State demonstration proposal approved.	CMS
April 2012-Dec 2012	IT/System adaptations developed and implemented.	CMS, DHCS
June 2012-June 2013	Beneficiary and Provider Outreach and Education	DHCS
Sept. – Oct. 2012	Rate setting and contract negotiations	CMS, DHCS, DMHC
Nov. – Dec. 2012	Health Plan Readiness Reviews	CMS, DHCS, DMHC
January 2013	Three-way contracts signed between CMS, State, and Participating Plans contingent on satisfying readiness requirement.	DHCS, CMS
Between March and June 2013	Effective date for passive enrollment phased in over 12 months.	CMS, DHCS

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Deleted: Three-Way Contract development: Contract negotiations take place with Participating Plans, State and CMS.

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Appendix 6 California Dual Eligible Demonstration Request for Solutions Proposal Checklist

This checklist was used in the Request for Solutions process to select health plans for the demonstration. As authorized under current law, DHCS may modify these criteria.

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
1	Applicant has a current Knox Keene License or is a COHS and exempt.		
2	Applicant is in good financial standing with DMHC. (Attach DMHC letter)		
3a	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years.		
3b	Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014.		
4	Applicant has a current Medi-Cal contract with DHCS.		
5	Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.		
6	Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.		
7a	Applicant has listed all sanctions and penalties taken by Medicare or a state of California government entity in the last five years in an attachment.		
7b	Applicant is not under sanction by Centers for Medicare and Medicaid Services within California.		
7c	Applicant will notify DHCS within 24 hours of any Medicare sanctions or penalties taken in California.		
8a	Applicant has listed in an attachment all DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.		
8b	Applicant has listed in an attachment all MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements.		
9	Applicant will work in good faith to achieve NCQA Managed Care Accreditation by the end of the third year of the Demonstration.		
10	Applicant will make every effort to provide complete and accurate encounter data as specified by DHCS to support the monitoring and evaluation of the demonstration.		

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
11	Applicant will fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, shall develop a plan to encourage its contracted providers to do the same, and provide an operational approach to accomplish this as part of the Readiness Review.		
12	Applicant has provided materials (as attachments) to demonstrate meeting three of the five criteria for demonstrating local stakeholder involvement.		
13	Applicant certifies that no person who has an ownership or a controlling interest in the Applicant's firm or is an agent or managing employee of the Applicant has been convicted of a criminal offense related to that person's involvement in any program under Medicaid (Medi-Cal), or Medicare.		
14	If Applicant is a corporation, it is in good standing and qualified to conduct business in California. If not applicable, leave blank.		
15	If Applicant is a limited liability company or limited partnership, it is in "active" standing and qualified to conduct business in California. If not applicable, leave blank.		
16	If Applicant is a non-profit organization, it is eligible to claim nonprofit status. If not applicable, leave blank.		
17	Applicant certifies that it has a past record of sound business integrity and a history of being responsive to past contractual obligations.		
18	Applicant is willing to comply with future Demonstration requirements, requirements, which will be released timely by DHCS and CMS to allow for comment and implementation. Applicant will provide operational plans for achieving those requirements as part of the Readiness Review.		

	Criteria for Additional Consideration	Answer	Additional explanation, if needed
1a	How many years experience does the Applicant have operating a D-SNP?		
2	Has the Plan reported receiving significant sanction or significant corrective action plans? How many?		
3	Do the Plan's three –years of HEDIS results indicate a demonstrable trend toward increasing success?		
4	Does the Plan have NCQA accreditation for its Medi-Cal managed care product?		
5	Has the Plan received NCQA certification for its D-SNP Product?		
6	How long has the Plan had a Medi-Cal contract?		
7	Does the plan propose adding supplemental benefits? If so, which ones?		
8	Did the Plan submit letters from County officials describing their intent to work together in good faith on the Demonstration Project? From which agencies?		
9	Does the Plan have a draft agreement or contract with the County IHSS Agency?		
10	Does the Plan have a draft agreement or contract with the County agency responsible for mental health?		
11	Does the Plan express intentions to contract with provider groups that have a track record of providing innovative and high value care to dual eligible beneficiaries? Which groups?		

Appendix 7 Background on California's Medi-Cal Program

Medi-Cal, California's Medicaid program, provides health care to 7.5 million low-income individuals and families in the state. Medi-Cal is available through fee-for-service and managed care models. Medi-Cal managed care is available in 30 counties, and currently serves about 60 percent of the total Medi-Cal population.

Managed Care: California has three delivery models of managed care:

1. County Organized Health Systems (COHS) currently serve about 885,000 beneficiaries through six health plans in 14 counties. In the COHS model counties, the State contracts with a health plan created by the County Board of Supervisors. The County runs the single health plan in which all county beneficiaries are enrolled..
2. Two-Plan Models serve about three million beneficiaries in 14 counties. In most Two-Plan model counties there is a "Local Initiative" (LI) and a "commercial plan" (CP). The State contracts with both plans. Local stakeholders are able to give input when the LI is created, and it is designed to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries.
3. Geographic Managed Care (GMC) models serve about 450,000 beneficiaries in two counties: Sacramento and San Diego. In GMC counties, the State contracts with several commercial plans.

In November 2010, California obtained federal approval authorizing expansion of mandatory enrollment into Medi-Cal managed care plans in 16 counties of over 300,000 low-income seniors and persons with disabilities who are eligible for Medi-Cal only (not Medicare). Enrollment has been phased in over a one-year period in the affected counties. This new mandatory enrollment began on June 1, 2011 and approximately 20,000 people per month are being enrolled. Prior to this, enrollment was mandatory for children and families in 16 counties and for SPDs in 14 counties.

Dual eligible beneficiaries have remained exempt from mandatory enrollment in Medi-Cal managed care, though currently some voluntarily enroll in managed care. For dual eligible beneficiaries, Medicare generally is the primary payer for benefits covered by both programs. Medi-Cal is then available for any remaining beneficiary cost sharing. Medicaid may also provide additional benefits that are not (or are no longer) covered by Medicare. For example, Medicare covers Skilled Nursing Facility (SNF) services when a dual eligible beneficiary requires skilled nursing care following a qualifying hospital stay. During this time, Medicaid benefits may be available for amounts that are not paid by Medicare. Once the beneficiary no longer meets the conditions of a Medicare skilled level of care benefit, Medicaid may cover additional nursing facility services, including custodial nursing facility care. In California, most state General Fund dollars spent on dual eligible beneficiaries are for long-term services and supports. In 2007, dual eligible beneficiaries accounted for 75% of the $4.2 billion spent by Medi-Cal on long-term care.

Long-Term Services and Supports (LTSS) include home- and community-based services (HCBS) and long-term custodial care in nursing facilities. California home and community base services include In-Home Supportive Services (IHSS), Community-Based Adult Services Center

(CBAS Center, formerly called Adult Day Health Care Services), and a number of specific HCBS waiver programs. Currently, all LTSS are provided on a fee-for-services basis and carved-out of the two-plan or geographic managed care counties. The COHS benefits include custodial care in nursing facilities.

Deleted: The latter include: Multi-Purpose Senior Services Program (MSSP), Developmentally Disabled Services waivers, Assisted Living waiver, In Home Operation waivers, and AIDS waivers.

In-Home Supportive Services: California's In-Home Supportive Services (IHSS) program serves over 430,000 Californians. A cornerstone of the state's long term care services, the IHSS program allows beneficiaries (consumers) to select providers to deliver a range of assistances with activities of daily living, and instrumental of daily living including housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. IHSS consumers control the selection, management and supervision of their providers, who are usually family members (72 percent). State statute requires each County to establish a public authority or similar entity to be the employer for collective bargaining purposes for the care provider; currently 56 counties have a Public Authority. Public Authorities provide provider registries, urgent back-up attendant services, training of IHSS providers, provider enrollment (when so delegated by the county), and assistance to consumers with their employer-related responsibilities. The local social service agency in each county evaluates consumers to determine the number of authorized IHSS hours required and, annually, performs a recertification of those hours. Providers' time sheets, signed by consumers, are submitted to the state and entered into a payroll system that generates a payment to the provider. On average IHSS recipients receive 82 hours of services each month. Up to 283 hours of service may be authorized per month. IHSS is a Medicaid program, funded by Federal, State, and County sources.

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Community-Based Adult Services: The new Community-Based Adult Services (CBAS) will become operational on April 1, 2012. Based on the Adult Day Health Care (ADHC) model, CBAS has a higher eligibility standard for beneficiary participation. CBAS is established as an alternative to nursing facility placement and is for beneficiaries who meet the State's nursing facility level of care requirements, have a developmental disability, have a diagnosed cognitive impairment, or are members of the County Specialty Mental Health Plans. CBAS offers attendance at a licensed facility staffed with registered nurses, physical and occupational therapists, social workers and other trained personal care workers. The CBAS program and standards of participation for both providers and beneficiaries were developed during the settlement process in the Darling v. Douglas lawsuit. Plaintiffs representing ADHC clients worked closely with DHCS to create a program that will meet with the needs of the most vulnerable ADHC clients. Almost 82% of the ADHC clients are dual eligible beneficiaries, and a large percentage of the CBAS clients will also be dual eligible beneficiaries. Under the settlement agreement, CBAS will be available as a benefit only through managed care beginning no sooner than July 1, 2012. DHCS will continue to set the daily rate for CBAS services and Plans will contract with CBAS centers at those rates. If beneficiaries want to use a CBAS service, they must join managed care plans to access the centers. In counties where managed care is not available or for those CBAS clients who do not qualify for managed care, CBAS will be available through FFS. In areas where CBAS centers are not available, health plans will be expected to provide beneficiaries the constellation of services encompassed by the CBAS centers that will help the beneficiary maintain independence and avoid institutionalization.

Multipurpose Senior Service Program: Local Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certified for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care. Clients eligible for the program must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff make this certification determination based upon Medi-Cal criteria for placement.

Nursing Facilities: Nursing facilities provide nursing care and/or skilled rehabilitation services, and other related health services to facility residents. Facilities may be part of a nursing home or hospital. In general, Medicare funds short-term nursing facility placement after a hospitalization, and Medi-Cal funds long-term placement, known as custodial care. Medicare does not cover custodial care if it is the only type of service needed from a nursing facility. Long-term placement has usually been excluded from Medi-Cal managed care and paid via fee-for-service.

Program of All-Inclusive Care for the Elderly (PACE) is a privately operated comprehensive model of care that integrates Medicare and Medi-Cal financing to provide all needed preventive, primary, acute and long-term services and supports for older adults who are determined eligible for nursing home level of care. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model allows eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment. California has five PACE programs, serving a largely dual-eligible population.

Deleted: Other Home- and Community-Based Waiver Programs: These programs operate under a waiver of federal requirements and provide various services to recipients who generally meet the level of care required for placement in a skilled nursing facility. Specifically, these programs include In-Home Operations, Assisted Living, and Nursing Facility/Acute Hospital waivers. These programs provide assistance with such things as personal care services, nursing assistance, and care coordination.

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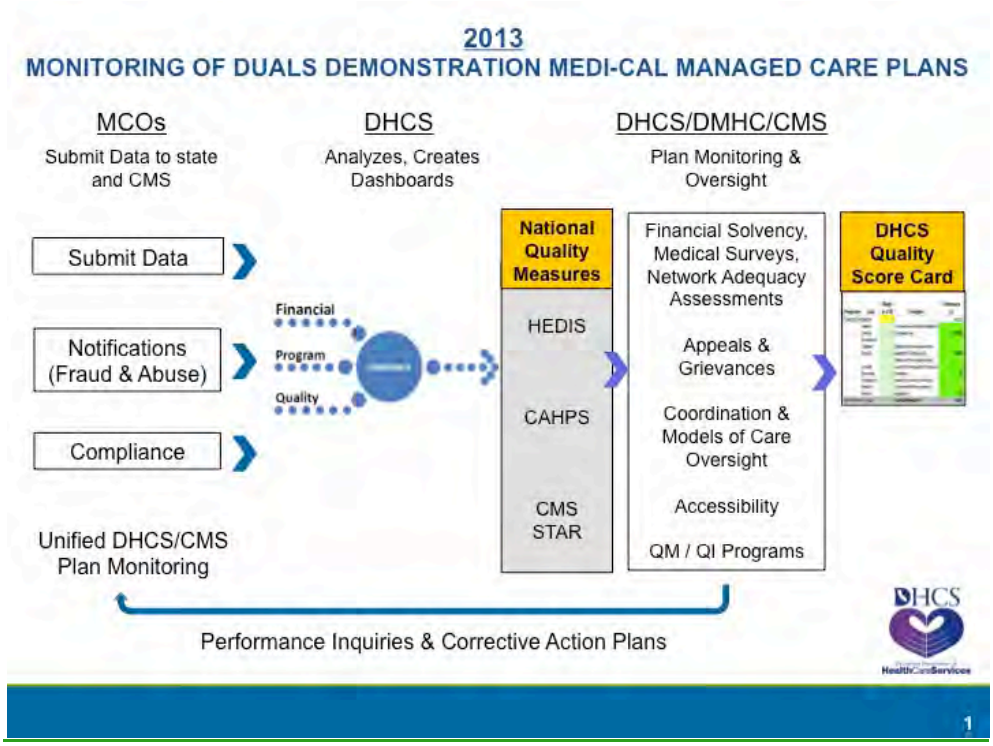
California's Specialty Mental Health System: Through a Section 1915 (B) freedom of choice waiver, all individuals who meet specified medical necessity criteria[34] are mandatorily enrolled in the state's County Mental Health Plans. This waiver program is referred to as the Specialty Mental Health System and serves an estimated 445,000 individuals. About 27 percent of the 240,000 adults served are dual eligible beneficiaries. These County Mental Health Plans are responsible for managing all specialty mental health services (inpatient psychiatric and outpatient services). County Mental Health Plans select and credential their provider network, negotiate rates, authorize services, and pay for qualifying services. The portion of services provided directly by the County's own providers versus contracted private providers varies between counties. The services provided under the Specialty Mental Health Services waiver for eligible adult beneficiaries include: (1) Psychiatric inpatient hospital services, (2) targeted case management services, and (3) rehabilitation services, including medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services.

Non-Specialty Mental Health Services: DHCS is responsible for all mental health care needs for Medi-Cal beneficiaries not meeting the criteria for specialty services and for all pharmaceutical costs. In such cases, Medi-Cal fee-for-service or Medi-Cal managed care plans cover the services. In fee-for-service, these services are subject to a limit of two visits per month and available for diagnoses that the SMHS waiver does not cover; mental health impairments not considered significant; and/or impairments that general physical health care practitioners can treat and do not require the services of a licensed mental health care practitioner. Medi-Cal managed care plans must have appropriate mechanisms to coordinate with County Mental Health Plans. DHCS requires them to negotiate in good faith and to execute a memorandum of ... [4]

Appendix 7 Graphic Of Proposed Duals Demonstration Monitoring Approach



Appendix 8 Letters of Support

Letters of support for the demonstration were submitted from the following organizations. Those letters are attached.

1. Anthem Blue Cross
2. California Association of Health Plans
3. California Department of Aging
4. California Department of Managed Health Care
5. California Department of Rehabilitation
6. California Department of Social Services
7. California Health and Human Service Agency
8. Care 1st Health Plan
9. Community Health Group
10. Health Net
11. Health Plan of San Mateo
12. LA Care Health Plan
13. Santa Clara County Board of Supervisors
14. SEIU

Demonstration Health Plan Letters of Support

During the Request for Solutions application process, health plans submitted letters from the following organizations with their applications. The letters indicate local support for a specific health plan and/or county participation in the demonstration and do not necessarily indicate support for all the details in this demonstration proposal.

All letters are included in the plan applications posted online at this link http://www.dhcs.ca.gov/provgovpart/Pages/RFSApplications.aspx

Alameda County

- Alameda County Adult Day Services Network
- Alameda Social Services Agency
- Center for Elders Independence
- Center for Independent living Berkeley
- City of Fremont, HHS Department
- Community Health Center Network
- DREDF
- Health Net Alameda County (Anthem)
- LifeLong Medical Care
- On-Lok
- Senior Services Coalition of Alameda County

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Los Angeles County

- Providers: CareMore, HealthCare Partners, AltaMed, Community Clinic Association, Heritage Provider Network
- CA Foundation of Independent Living Centers
- California Association of Adult Day Services
- California Association of Area Agencies on Aging
- County of LA, CEO
- Jewish Family Services of LA
- North LA County Regional Center
- Partners in Care Foundation
- Services Center for Independent Living
- St. Barnabas Senior Services
- The Center for Aging Resources
- Western University, Harris Family Center

Orange County

- Abrazar
- Area Board XI, Office of the CA State Council of Developmental Disabilities
- Arta, Western Medical Group
- Assembly Member Allan Mansoor
- Assembly Member Chris Norby
  Assembly Member Jim Silva
- Assembly Member Curt Hagman
- Assembly Member Diane Harkey
- Assembly Member Tony Mendoza
- CalOptima Member Advisory Committee
- Community SeniorServ
- Congresswoman Loretta Sanchez
- Dayle McIntosh Disability Resource Centers
- Family Choice Medical Group
- Family Support Network
- Goodwill of Orange County
- Monarch HealthCare
- OC Aging Services Collaborative
- OC Adult Day Services Coalition
- Orange County IHSS Public Authority
- Rhys Burchill, Parent of a young dual eligible
- St. Jude Medical Center
- State Senator Lou Correa
- State Senator Tom Harman
- The Coalition of Orange County Community Health Centers
- UC Irvine's Center of Excellence on Elder Abuse and Neglect
- United Care Medical Group

Riverside County

- Riverside County Mental Health Department
- Riverside Family Physicians
- Inland Empire Disabilities Collaborative
- Inland Regional Center (IRC)
- Community Access Center
- Belen R. Lopez, Member
- Letter from Community Access, Center for Independent Living in Riverside County

San Diego

- Access to Independence
- American Association of Services Coordinators
- CA Foundation of Independent Living Centers
- California Association of Adult Day Services
- California Association of Area Agencies on Aging
- Consumer Center for Health Education and Advocacy
- Council of Community Clinics
- County of San Diego, HHS (letter to work in good faith)
- Family Health Centers of San Diego
- IHSS Public Authority, San Diego (letter to work in good faith)
- Neighborhood Healthcare
- Partners in Care Foundation
- San Diego Coalition for Mental Health
- San Diego Regional Center
- SHARP Healthcare

Deleted:

San Mateo County

- San Mateo County Health System
- Mills- Peninsula Senior Focus
- Lesley Senior Communities
- Carlmont Gardens (SNF)
- Legal Aid Society of San Mateo

Santa Clara County

- Santa Clara Valley Health and Hospital System
- Catholic Charities of Santa Clara county
- Community Health Partnership
- San Andreas Regional Center
- Mariner Health Care
- Daljeet Rai, MD General Family Practitioner

San Bernardino County

- Inland Empire Disabilities Collaborative
- Inland Regional Center (IRC)
- Community Access Center
- Belen R. Lopez, Member
- Letter from Rolling Start, Inc. Center for Independent Living in San Bernardino County