

April 4, 2012

Invitation to Provide Public Comment

Coordinated Care Initiative: California's Dual Eligibles Demonstration

The State of California is pleased to release this draft proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals. This draft proposal is being published for a 30-day public comment period, prior to submission to the Centers for Medicare and Medicaid Services (CMS).

The proposal describes how California will structure, implement and monitor an integrated delivery system and payment model for dual eligible (Medicare and Medi-Cal) beneficiaries. The goals of the demonstration are to improve health outcomes, promote a more efficient health care system and allow more beneficiaries to stay in their homes and communities for as long as possible.

The proposal offers a vision for coordinated care models in California that provide seamless access to the full continuum of medical, social, long-term and behavioral supports and services that dual eligible beneficiaries need to maintain good health and a high quality of life. The proposal reflects rounds of input provided by a wide array of consumers and stakeholders during numerous conversations and public meetings over the past year.

The State welcomes any comments, questions, and suggestions for the demonstration proposal. Please submit your comments by 5 p.m. on Friday, May 4, 2012. Please format your comments using the template that can be downloaded at this link: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/Proposal_Documents/Comment%20Template.xlsx

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After making any needed changes to reflect public comments, the State will submit the final demonstration proposal to CMS in early May. CMS will then provide an additional 30-day public comment period on the State's final proposal.

Further details for the demonstration will be developed through the workgroup process that will begin in April 2012, as well as the joint state-federal Memorandum of Understanding for the demonstration. The target enrollment effective date for this new coordinated delivery model is January 1, 2013. For more information please visit the demonstration website: www.CalDuals.org.

State of California



EDMUND G. BROWN JR.
Governor



**Proposal to the Center for Medicare and Medicaid
Innovation**

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

April 4, 2012

Draft for Public Comment

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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 the Initiative. Through this demonstration, which will begin in January 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.

California has roughly 1.1 million people dually eligible for services through Medicare and Medi-Cal, the state'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.

This demonstration proposal builds on many years of stakeholder discussions and state interest in developing a coordinated care delivery system, as well as groundbreaking work to develop the innovative Program of All-Inclusive Care for the Elderly (PACE), 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). 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 managed care health plans. These plans also have experience providing Medicare managed care. The health plans will be responsible for providing beneficiaries a full continuum of Medicare and Medi-Cal services, including medical care, behavioral health services, and long-term services and supports (LTSS). LTSS include home- and community-based services such as IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) in addition to care in nursing facility services when needed.

As noted above, the demonstration is informed by the experience of the California-pioneered PACE program, a nationally recognized care coordination and integration program that has achieved significant success in improving beneficiary outcomes.

The demonstration also will include the nation's largest personal care services program, IHSS, which serves over 430,000 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 the consumer's right to self-direct his or her care by hiring, firing and managing 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 fair hearing process will remain. The principles of consumer-direction and continuity of care will be key aspects of the beneficiary protections.

In 2013, California intends to implement the demonstration in ten counties. Four counties, Los Angeles, Orange, San Diego, and San Mateo, are authorized under current state law. In addition, California will implement the demonstration in six additional counties if it receives State Legislative approval of the Coordinated Care Initiative. This Initiative proposes to implement the demonstration in up to 10 counties in 2013, additional Medi-Cal managed care counties in 2014, and statewide by 2015. The State held a rigorous selection process to identify health plans with the requisite qualifications and resources best suited to participate as demonstration sites.

California also is considering the Managed Fee-for-Service (FFS) model for this demonstration in 2015, under the guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The State will further develop this model through discussions with stakeholders in 2013.

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. Enrollment in the demonstration counties will be implemented on a phased-in basis throughout 2013.

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. Furthermore, 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 importance of beneficiaries choosing their health plan, having continuity of care with existing providers, and receiving early

and frequent contact from the State and their new health plan.

Health plans will be responsible for providing seamless access to robust networks of providers across this broader continuum of care, as well as 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. The demonstration will include unified requirements and administrative processes that – to the extent possible – accommodate both Medicare and Medicaid, including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes.

The State will work closely with CMS 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.

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 external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

Table 1: Demonstration Population and Benefit Summary

Target Population	All full benefit Medicare-Medicaid enrollees, with specified exceptions in the counties listed below.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	1,100,000
Total Number of Beneficiaries Eligible for Demonstration	800,000
Geographic Service Area	2013: Alameda, Contra Costa, Los Angeles, Orange, Riverside, Sacramento, 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 including long-term care institutional and home- and community-based services such as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and five waiver services: Multi-Purpose Senior Services Program (MSSP), Nursing Facility/Acute Hospital Waiver Service, HIV/AIDS Waiver Services, Assisted Living Waiver Services, and In-Home Operations Waiver Services. County-administered mental health and substance use services will not be included in the capitation rate, but by 2015 these services will be closely coordinated, and

	potentially integrated at a local level. Home- and community-based waiver services provided through the Department of Developmental Services for the developmentally disabled population will remain as currently available and are carved out.
Financing Model	Capitated payment model 2013-2015. The State may consider implementation of the Managed Fee-for-Service Model in 2015.
Summary of Stakeholder Engagement/Input	<ul style="list-style-type: none"> • April 2010: In-depth stakeholder interviews • 2010: Two large public meetings • 2011: Four large public stakeholder meetings <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Feb 10, 2012 • Feb 24, 2012 • March 28, 2012 • Website posting – www.CalDuals.org; email list with more than 700 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 • Key informant interviews on the lessons learned from the 1115 waiver enrollment process • Summit planned on the Medi-Cal only Seniors and Persons with Disabilities transition to Medi-Cal managed care, to discuss lessons learned and how those apply to the demonstration
Proposed Implementation Date(s)	Phased-in enrollment process starting January 1, 2013 in up to ten counties.

B. Background

Vision

California has 1.1 million low-income seniors and persons with disabilities who are dually eligible for Medicare and Medi-Cal. These dual eligible beneficiaries tend to have multiple chronic conditions and complex health care needs, but too often they receive services that are “fragmented, incomplete, inefficient, and ineffective” in the fee-for-

service system.¹ 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, 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.”²

This fragmentation has a negative impact on health outcomes and costs.³ Medi-Cal spending on dual eligible beneficiaries in 2007 was about \$7.6 billion, or about 23% 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.⁴

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 managed care plans with strong home- and community-based service programs:

- The State’s Medi-Cal managed care program and its partner health plans have acquired significant experience in coordinating beneficiaries’ services, as both Medicare and Medi-Cal managed care plans.
- California’s system of home- and community-based services provides support to more than 400,000 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; Community-Based Adult

¹ 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.

² Adding Perspective: Conversations with Dual Eligibles. February 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/stakeholder%20documents/Outreach_Summary.pdf

³ 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.

⁴ 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.

Services (CBAS), which provides services at licensed facilities staffed with registered nurses, physical and occupational therapists, and social workers; and several other specific home- and community-based waiver programs.

Such a new system must be built on a foundation of strong beneficiary protections and ongoing stakeholder engagement. Meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required. Stakeholders have defined “meaningful” to mean, at a minimum, that 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 consumer protections.

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 manage their IHSS providers.

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

- 1) **Person-centered care planning.** The demonstration will reflect a member-centered, outcomes-based approach to care planning, consistent with the CMS Model of Care approach. 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 will no longer 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.
- 2) **Enhanced home- and community-based services (HCBS).** An integrated approach will create financial incentives for greater use of HCBS, 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 their homes and communities or transition to a more independent setting.

A key impact of enhanced HCBS is reduced hospitalization, particularly since 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.

- 3) **Emphasis on Prevention.** Managed care organizations 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.
- 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 card.
- 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 transitions: 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.

Population Description for the Demonstration

Demonstration Population: All full benefit dual eligible beneficiaries in the selected demonstration areas will be eligible for enrollment, with certain exceptions noted below. Full benefit dual eligible beneficiaries qualify for Medicare Parts A, B, and D coverage, and Medi-Cal coverage for Medicare premiums, co-insurance, copayments, and deductibles, as well as additional services that are covered by Medi-Cal that Medicare does not cover (QMB+ individuals, SLMB+ individuals, and other full benefit dual eligible beneficiaries). No beneficiaries will be excluded from the demonstration based on specific diagnostic categories.

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. The State is seeking additional stakeholder feedback on this section.

Share of Cost Beneficiaries: Under federal law, the majority of beneficiaries with a Medi-Cal share of cost in long-term care facilities are assumed to have met their share of cost each month. The State intends to include these beneficiaries in the demonstration. However, the State is considering excluding some or all of the remaining Share of Cost beneficiaries from the demonstration, due to the administrative complexity of adjusting the Medicare capitation payment mid-way through the month, after the beneficiary has met his or her share of cost.

Children: Based on stakeholder feedback and the specific care coordination needs of children, dual eligible beneficiaries under age 18 will not be enrolled in the demonstration.

Beneficiaries with Other Health Coverage: Beneficiaries with Other Health Coverage, including private insurance and non-Medicare public insurance, will be excluded from the demonstration. This definition of Other Health Coverage does not include Medicare Advantage plans or partial coverage plans, such as dental plans.

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.

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

Dual Eligible Special Needs Plan (D-SNP) Enrollees: Beneficiaries enrolled in Medicare Advantage D-SNPs will be included in the demonstration. The State is developing further details for the D-SNP contracting policy and beneficiary enrollment process under the demonstration.

Developmentally Disabled Beneficiaries: Demonstration health plans will be responsible for the provision of all medical services and long-term services and supports for enrolled developmentally disabled beneficiaries. However, Regional Center Services, home- and community-based waiver services⁵ and Intermediate Care Facility and Development Center services provided through the California Department of Developmental Services for beneficiaries with developmental disabilities will remain as currently available, and these benefits will be carved out of the demonstration. The demonstration will not affect eligibility for regional center benefits among dual eligible beneficiaries.

⁵ Home- and Community-Based Waiver Services for the Developmentally Disabled include: Homemaker, Chore Services, Home Health Aide Services, Respite Care, Habilitation, Pre-Vocational Services, Supported Employment, Environmental Accessibility Adaptations, Skilled Nursing, Specialized Medical Equipment and Supplies, Transportation, Personal Emergency Response Services, Family Training, Adult Residential Care, Supported Living Services, Vehicle Adaptations, Communication Aides, Crisis Intervention, Nutritional Consultation, Behavioral Intervention, and Specialized Therapeutic Services.

C. Care Model Overview

Proposed Delivery System: Coordinated Care Delivery through Managed Care Organizations

Managed care done well leads to high quality care. This demonstration will build on California's existing Medi-Cal and Medicare managed care structure, and its strong system of home- and community-based 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, at least one health plan in each of the selected counties has experience operating a Medicare D-SNP managed care 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 site may tailor its approach to reflect local priorities, the following fundamental tenets, based on feedback from beneficiaries and stakeholders, will be uniform across all demonstration sites:

- **Seamless Service Delivery.** Demonstration sites will provide access to the full range of services currently covered by Medicare Parts A, B and D, as well as all State Plan benefits and services covered by Medi-Cal.
- **Integration of Medical, LTSS, and Behavioral Health Services.** Demonstration sites will provide seamless coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medi-Cal. For some benefits this will require a partnership with the county agencies that provide IHSS and behavioral health benefits.
- **Broad Network Adequacy.** Demonstration sites shall ensure availability of all services in a member's care plan.
- **Physical and Programmatic Accessibility.** All sites must comply with state and federal disability accessibility and civil rights laws, including communicating 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 inform individual care plans.

Geographic Service Area

California proposes to implement the demonstration in the following ten counties: Alameda, Contra Costa, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Santa Clara Counties. The four counties where the demonstration will be implemented under current state law are: Los Angeles, Orange, San Diego, and San Mateo Counties. These counties have met the requirements established by the State's Request for Solutions, including the criteria established by the Legislature – to consider local support for integrated care and services, and a local stakeholder process.

Enrollment Process

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 automatically enrolled into a demonstration health plan. Enrollment will be implemented on a phased-in basis throughout 2013.

The Governor's Coordinated Care Initiative, which is pending in the state Legislature, proposes mandatory enrollment in managed care for Medi-Cal benefits. 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). Managed care for dual eligible beneficiaries would only be voluntary for Medicare benefits and services, not Medi-Cal. Only those enrolled for both Medicare and Medi-Cal in the demonstration health plans will participate in the demonstration.

Stable Enrollment Period. Further, under the proposed Initiative, once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out 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 State is proposing a passive enrollment process with a stable enrollment period to ensure a sufficient volume of enrollees over the demonstration period. Passive and stable enrollment will encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model. Based on stakeholder feedback, the State will identify any beneficiary categories that may opt out during the six-month stable enrollment period.

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. Beneficiaries will be informed of their enrollment rights and options, plan benefits and rules, and the care planning process in an accessible format and with sufficient time to make informed choices.

Health plans have suggested a partnership/contracting relationship with local advocacy organizations to assist with outreach, to help potential enrollees understand the importance of active engagement 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.

Provider Networks

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.

The State will ensure health plans are advised of their obligations under 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. (See <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf>)

Additionally, demonstration health plans will provide 24-7 access to non-emergency help lines staffed by medical professionals. In their Models of Care submitted to the State, most health plans provided a geographic analysis of their medical networks. Innovative 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.

Some health plans will jointly educate providers on the model of care, then follow-up

with a plan-specific Model of Care, to help foster understanding of the 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 the full range of services under Medicare Parts A, B, and D, including inpatient, outpatient, home health, and pharmacy. Sites will also be responsible for all Medi-Cal State Plan benefits and services, including long-term institutional, and home- and community based services, including:

- In-Home Supportive Services (IHSS)
- Community-Based Adult Services (CBAS, formerly called Adult Day Health Care Services)
- Multipurpose Senior Services Program (MSSP)
- Other Section 1915 (c) home- and community-based services

See Appendix 2 for the list of Medi-Cal State Plan core benefits and Appendices 3 and 5 for further descriptions of the benefits listed above.

Home- and community-based waiver services provided through the Department of Developmental Services for the developmentally disabled population will remain as currently available and are carved out of the demonstration.

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

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. 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.

Additional benefits include care management interventions, such as specific disease management programs, intensive care management for high-risk populations, and care transition services. Other additional benefits could include home modification, access to nutritional counseling, and exercise facilities.

Recognizing the necessity to merge medical and social services, demonstration sites 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 will build 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, and Aging and Disability Resource Connections.

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 demonstration.

Model of Care

The Model of Care for this demonstration includes: health risk assessment, data mining to identify and continuously stratify health risk, identification of care management level (low, high, complex) and locus of care management (practice level, group level, or plan level), utilization management, disease management, and transitional care. In addition, plans will establish contractual arrangements and incentive plans for providers, outcome measures, and other components that are described in further detail in this proposal.

Person-Centered Care Coordination

Among dual eligible beneficiaries, care coordination needs vary greatly depending upon factors such as functional, health, and cognitive status, fluctuations in these indicators, and the individual's 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 outcomes for the enrolled beneficiary through person-centered care coordination. Recognizing that enrolled beneficiaries require varying levels of care coordination, if any, demonstration sites will be required to plan and implement care management systems capable of assessing and responding to these different levels of need. Care management will require close collaboration with a number of agencies, such as county social service agencies for IHSS, county mental health agencies, local Area Agencies on Aging and community-based organizations, to adequately address the complex and various needs of individual beneficiaries.

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.

Comprehensive health risk assessments and care planning. Demonstration plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health needs. 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, prevent 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 in a comprehensive risk assessment.

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), web-based care planning tools that allow providers and beneficiaries to view and add to the care plan, etc.

Health plans will also use various strategies to identify the most vulnerable members: Health Risk Assessment, 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). Demonstration plans will offer person-centered medical homes with multidisciplinary 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, 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 his or her care.

Health plans are encouraged 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.

Some of California's health plans already 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. Health plans will implement specific care transition interventions. 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 have implemented 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.

For example, the transition of care process ensures that members are screened to identify risk for complex transitions. This screening occurs during prior authorization and, for unplanned admissions, at the time of admission to a facility (either acute or skilled nursing). The screening tool incorporates questions about clinical condition, behavioral health status and social condition. Members identified as high-risk members are referred to the transition ICT. Upon receipt of the referral, case managers conduct a comprehensive assessment, and the transition ICT develops or updates the care plan. This team also ensures 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. For one health plan, these reviews have already resulted in the creation of transition care coordinator positions at the two highest-volume hospitals in the county. The coordinators, who are stationed at the hospital, provide concurrent linkage to the transition ICT.

Use of Technology. Demonstration sites will leverage effective use of technology, although technology will not replace critical in-person care coordination activities. Current health plan efforts and proposals include:

- Greater use of electronic health records throughout the provider network, including web-based sharing of care management plans and updates. These applications allow primary care providers and specialists, including behavioral health specialists, to securely share clinical information, services approved or initiated, and ongoing updates. Electronic consultation between primary care providers and specialists offers improved collaboration, increases efficiency of specialty care visits, and facilitates resolution of members' unmet needs and issues.
- Electronic notices 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.
- 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.
- A new system 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

Health plans will be responsible for providing enrollees 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 abuse and cognitive limitations, including Alzheimer's disease and related dementias. Health plans will ensure warm hand-offs

and follow-up care for coordinating needed behavioral health services. Several innovative health plans contract directly with the county behavioral health agencies to ensure seamless care delivery. Several are supporting efforts to co-locate behavioral health and primary care services, and others are working with behavioral health administrative service organizations to coordinate services across the care continuum.

For seriously mentally ill beneficiaries receiving care from county specialty mental health plans (1915b waiver services), or beneficiaries with substance use issues, 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, which, in future years, could include full integration of county services through an integrated capitated payment.

These integration strategies will build on the recovery model of care set forth in state statute. Health plans will contract with providers experienced in delivering that model of care within their networks directly or through contracts with the county mental health agency, which currently funds these programs. The strategies will demonstrate shared accountability based on agreed-upon performance measures and financial arrangements, such as incentive payments or shared savings structures.

LTSS Care Coordination

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.⁶ California spends 53.7% of its Medicaid LTSS funding on home- and community-based services, which places it sixth in the nation on the Scorecard's rankings. Much of California's LTSS expenditures go toward the nation's largest personal care services program, IHSS.

IHSS is an entitlement program that serves more than 430,000 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 manage their 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.

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

⁶ 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/>

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 managed care organization realigns financial incentives around the beneficiary.

Under this demonstration, managed care 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, and other home- and community-based waiver services. 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.

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 needed, and will include the consumer, health plan, and county social services agency, and may include others. 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 Med-Cal managed care health plans. A grievance and appeals process and other protections for IHSS consumers will remain in place. IHSS assessments will be conducted in conjunction with health plan care coordination teams, as needed.

Health plans may authorize additional home- and community-based services, including IHSS hours above the statutory limits, using the funding provided under the capitation payment. The demonstration and the Coordinated Care Initiative would allow health plans to enter into performance-based contracts with counties, and contract with counties for additional assessments of IHSS hours.

Beginning January 1, 2015, managed care 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 managed care health plans when beneficiaries initially enroll in managed care. All other IHSS processes described above will remain the same.

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 shall be implemented no earlier than January 1, 2015. Providers, counties, and managed care 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 managed care plans when beneficiaries initially enroll.

Managed Fee-for-Service Model

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.

Evidence-based Practices

Participating health plans will apply evidence-based clinical guidelines promulgated by leading academic and national clinical organizations. Plans will be required to have processes for educating providers on employing evidence-based guidelines and for monitoring providers' use of 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 managed care plans in 16 counties of more than 300,000 Medi-Cal only seniors and persons with disabilities. Enrollment was 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.

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% said their ability to make appointments had improved with managed care membership; 90% of those who received services through the health plans were satisfied with the services; and 81% 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 enhanced 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.

Enhanced outreach and education processes for beneficiaries and providers are needed, particularly around enrollment rights and the medical exemption review process in the duals demonstration to guarantee continuity of care. 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.

Medi-Cal managed care health plans will have had many months to adapt to the unique needs of the SPD population and to adjust 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.

County Specialty Mental Health Services and Substance Use Services

Through a Section 1915 (b) freedom of choice waiver, all individuals who meet specified medical necessity criteria⁷ 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.

Currently, Medi-Cal managed care plans must have appropriate mechanisms, including an MOU, to coordinate with County Mental Health Plans for individuals not needing specialty mental health services. Specialty Medi-Cal mental health services and funding

⁷ 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.

will be carved out of the capitation rate. Health plans and county agencies, however, must establish systems for mental health screening and increase care coordination and integration.

Additionally, health plans will have to develop screening and coordination mechanisms for dual eligible beneficiaries with substance use service needs. Currently, substance use benefits are not a required benefit for Medi-Cal managed care. There is no “rehabilitation option” for Drug Medi-Cal, and services must be provided in a clinic setting.

Home- and Community-Based Services Waiver Programs

Five Home and Community-Based Services waiver programs will be included in the demonstration: Multi-Purpose Senior Services Program (MSSP), Nursing Facility/Acute Hospital Waiver Service, HIV/AIDS Waiver Services, Assisted Living Waiver Services, In-Home Operations Waiver Services. Home- and community-based waiver services for adults with developmental disabilities will be carved-out of the demonstration.

The five waiver programs included in the demonstration allow Medicaid enrollees to receive services in the community or in their homes, rather than in an institutional setting. Each waiver offers a different set of services designed for individuals who are assessed to require nursing facility level of care.

Beneficiaries enrolled in these waiver programs in demonstration counties will be eligible for enrollment in the demonstration, and will continue to receive services as specified under the waiver provisions. Further, under the Governor’s Coordinated Care Initiative, these waiver programs would become managed care benefits available only through enrollment in Medi-Cal managed care health plans, in counties where the demonstration is implemented.

The flexibility in the use of the capitated payment under this demonstration allows managed care 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 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. The State is considering options for how new enrollment in these waivers would be treated under the demonstration, and welcomes stakeholder feedback on this issue.

The State intends to renew the MSSP waiver before its expiration in 2014, to provide for continued waiver services for recipients in counties without managed care. Other waivers were recently renewed for five years, and will be reexamined at a later time in the context of the demonstration.

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.

Multi-Purpose 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 demonstration plans and will continue to receive MSSP waived services. During the demonstration, demonstration plans will contract with MSSP organizations to continue their case management functions in coordination with the plans' care management as defined by their Model of Care. 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. By the second year of the demonstration, MSSP and managed care plans' care management will be fully integrated. By the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the plans' care management operation.

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. CBAS is a benefit offered by the managed care 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.

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 waived 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 waived programs will be eligible for enrollment in the demonstration, and will at least be enrolled in Medi-Cal managed care, according to the Coordinated Care Initiative. In addition to medical and other LTSS services offered by the plans, these waived service recipients will continue to receive waived 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 waived 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 waived 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 waived 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.⁸

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.⁹

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): Nearly 40 organizations responded to the State’s original Request for Information, and the purpose of the Aug. 30 meeting was to give those respondents an opportunity to summarize their proposals and concerns in a public forum. Presenters included representatives from health plans, provider groups,

⁸ 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

⁹ 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>

county health departments, home health agencies, advocacy organizations, labor unions, and others. More than 300 people attended.

2. **Behavioral Health Integration** (December 2, 2011): About 80 people attended the meeting in Sacramento and another 100 called in to discuss the opportunities and challenge of integrated behavioral health and substance use services into the Duals Demonstration.
3. **Consumer Protections** (December 12, 2011): About 80 people attended the meeting in San Francisco and another 122 called in to discuss consumer protections. This meeting consisted of two roundtables of about 15 stakeholders and beneficiaries who led discussions on: 1) achieving proper care; 2) creating effective beneficiary communication; 3) achieving proper access and delivery; and 4) launching the system.
4. **Long-Term Services and Supports** (December 15, 2011) About 80 people attended the meeting in Los Angeles and another 130 called in to the meeting focusing on: 1) LTSS coordination between the state, local entities and demonstration sites; 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.¹⁰
- **Website and email list.** All demonstration materials, including the health plan demonstration applications, are posted online. The State sends regular email notification updates to more than 700 people, including roughly 100 consumers and caregivers.
- **Staff training on accessibility of materials.** DHCS staff were provided additional training to ensure that materials released in print and posted online are compliant with Section 508 of the Americans with Disability Act.
- **Local stakeholder processes.** Demonstration sites had to develop local processes to bring stakeholders together and discuss local design and implementation. Additionally, demonstration sites submitted letters of support from a wide array of stakeholders.

¹⁰ Adding Perspective: Conversations with Dually Eligible Beneficiaries. February 2012. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/stakeholder_documents/Outreach_Summary.pdf

- **Stakeholder Meetings for Health Plan, Provider, and Advocacy Organizations.** The California Health and Human Services Agency (Agency) is sponsoring 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 aging.

Ongoing Stakeholder Feedback

To support the development and implementation of the demonstration, the State has organized a series of stakeholder workgroups. These workgroups will develop policy recommendations in a team setting. Each workgroup will be 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. Integrated Care Systems
4. Long-Term Services and Supports Integration, Network Adequacy
5. Mental Health and Substance Use Services Integration
6. Fiscal and Rate Setting
7. Data, Quality, and Evaluation

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.

Beneficiary Protections

Comprehensive protections, particularly beneficiary self-direction and oversight mechanisms, are important to ensure care quality and beneficiary health and safety. Strong beneficiary protections are essential to driving success and quality in the design and implementation of the demonstration.

The State is proposing beneficiary protections that reflect 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:

<http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/617%20CCI%20TBL.pdf>

Self-direction of care. Participants in an integrated care program will continue to have the choice to self-direct their care. Managed care plans will provide a member-centered, outcomes-based approach to care planning, consistent with the CMS Model of Care approach. Specifically, when appropriate, beneficiaries will:

- Decide how to receive care in a home- and community-based setting to maintain independence and quality of life;
- Select their health care providers in the managed care 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 or limitations, and that improve their health outcomes, enhance independence, and promote living in home and community settings; and
- Be able to hire, fire, and manage their IHSS provider, as currently allowed in California's IHSS program.

Notification about Enrollment Process. 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:

- 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.
- Develop, in consultation with beneficiaries and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.
- Ensure that managed care 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 managed care 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.
- At least 90 days prior to enrollment, inform dual eligible beneficiaries through a notice written at no more than a sixth grade reading level that includes, at a minimum: how their Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance with choosing a managed care health plan or with any problems they encounter.

Health-Risk Assessment. This is an essential consumer protection; the State will require that managed care health plans perform an assessment process that:

- 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.
- Addresses the care needs of the beneficiary and coordinates their Medicare and Medi-Cal benefits across all settings.
- Reviews historical Medi-Cal and Medicare utilization data.
- Follows timeframes for reassessment.

Network Adequacy and Care Continuity. Plans will be required to establish and maintain provider networks that at least meet Medi-Cal access standards for long-term services and supports (currently under development by the State), and joint state and federal access standards for medical services and prescription drugs. In addition, beneficiaries will have a choice of providers from 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 will require that health plans:

- Provide access to 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.
- Monitor 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.

In addition:

- 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 managed care 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 site 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.

Appeals and Grievances. The State will work with CMS and stakeholders to develop a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration. 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.

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 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.

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. 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.

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.

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 it will, in partnership with CMS, 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 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.

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 or processes of care that are closely related to improvements in health outcomes
- Be implementable by the State in time for initial enrollment in January 2013

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

Demonstration sites 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. The most innovative health plans included 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.

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 over time. 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 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 is also exploring an additional state-level evaluation, in conjunction with the quality improvement system, to ensure that the state evaluation needs and timelines are addressed.

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.

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.

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 managed care health plans, conducts routine and non-routine financial and medical surveys, and operates a consumer services toll-free complaint line. 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, managed care plans, and long-term care insurance. Local HICAP offices provide free community education and confidential individual counseling statewide.

The State will use a combination of existing resources and additional infrastructure to implement this demonstration. CDA may expand HICAP counselors for the 2012 Open 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 proposed under the Coordinated Care Initiative.

In addition to the state agency staff, the State will use contractors for project management, rate development, data analysis, enrollment planning, demonstration evaluation, 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 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.

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.

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 ten counties with Medi-Cal managed care.
- 2014: All remaining counties that currently have Medi-Cal managed care.
- 2015: All remaining counties, including the 28 current Medi-Cal fee-for-service counties. These counties will transition to Medi-Cal managed care beginning in June 2013. The State may also implement the demonstration using the Managed Fee-for-Service model in counties without Medi-Cal managed care.

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 well-established managed care 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 provider who is not in the health plan's network.

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 determining whether 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) align fiscal and quality incentives, 2) provide 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) slow the cost growth for Medicare and Medi-Cal, and 4) provide 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 provides that if the California Department of Finance determines, annually on September 1, that the Initiative has caused utilization changes that result in higher State costs than would have occurred absent the Initiative, after fully offsetting implementation administrative costs, then the State will discontinue the provisions of the Initiative.

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 by June 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.
- 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 member 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.

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. It is anticipated that LTSS network adequacy measures will be established during the three-year demonstration.

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 managed care 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.

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 an evaluation plan for the demonstration.

Ambitious Timelines: Tight CMS timelines will require an ambitious approach to implementation. California will continue working with CMS to ensure that the demonstration and the sites selected are ready to begin January 1, 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.

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 10 counties in 2013, additional counties in 2014, and statewide by 2015.

- Maintain beneficiary enrollment for the first six months after initial enrollment.
- Establish a county maintenance of effort funding level for IHSS.
- Mandatory Medi-Cal managed care enrollment in demonstration counties.
- HCBS Universal Assessment, implemented as early as January 1, 2015

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 managed care 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 managed care plans and existing large-scale personal care services programs.

I. CMS Implementation Support – Budget Request

The federal budget request for the demonstration is under development.

Appendices

- Appendix 1 County Implementation Table
- Appendix 2 List of Core Medicaid-Covered Services
- Appendix 3 List of Included Home and Community-Based Waiver Services
- Appendix 4 Work Plan and Timeline
- Appendix 5 Background on California's Medi-Cal Program
- Appendix 6 Request for Solutions Proposal Qualifications Checklist
- Appendix 7 Letters of Support

Appendix 1 County Implementation Table for Dual Eligible Demonstration

2013 (10 counties)	2014 (20 counties)	2015 (28 counties)
Alameda, Contra Costa, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Santa Clara	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, 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

Appendix 2 List of Medi-Cal State Plan Core Services/Providers

State Plan Core Benefits Package*:

Acupuncturists
Assistive Device and Sick Room Supply Dealers
Audiologist
Blood Banks
Child Health and Disability Prevention (CHDP)**
Chiropractors
Clinical Laboratories or Laboratories
Comprehensive Perinatal Providers (CPSP)
Dental School Clinics
Dentists
Dispensing Opticians
Early Periodic Screening, Diagnosis and Treatment Providers (EPSDT)**
Fabricating Optical Laboratory
Hearing Aid Dispensers
Home Health Agencies
Hospices
Hospital Outpatient Departments
Hospitals
Incontinence Medical Supply Dealers
Intermediate Care Facilities
Intermediate Care Facilities for the Developmentally Disabled **
Local Education Agency Providers (Schools)**
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Nurse Facilities
Occupational Therapists
Ocularists
Optometrists
Orthodontists
Organized Outpatient Clinic (Public Health Clinics, Community Clinics)
Organized Heroin Detoxification Providers
Personal Care Service Providers
Pharmacies/Pharmacists
Physical Therapists
Physicians
Physician Assistants
Podiatrists
Portable X-ray Services

Prosthetists
Providers of Medical Transportation
Psychologists
Radiologists
Rehabilitation Centers
Renal Dialysis Centers and Community Hemodialysis Units
Rural Health Clinics
Short-Doyle Medi-Cal Providers (Mental Health Division)
Skilled Nursing Facilities
Speech Therapists
Supplemental EPSDT Providers (Mental Health)**
Targeted Case Management Services
Trained Health Care Aide Services
X-Ray Technicians

* This list includes all core Medicaid State Plan services. For dual eligible beneficiaries, Medicare is the primary payer for many of these services.

** Not included in the demonstration

Appendix 3 List of Included Home- and Community-Based Waiver Services

1. Nursing Facility / Acute Hospital Waiver Service

- Case Management/Care Coordination
- Habilitation Services
- Home Respite
- Waiver Personal Care Services
- Community Transition Services
- Environmental Accessibility Adaptations
- Family Respite
- Family Caregiver Training
- Medical Equipment Operating Expense
- Personal Emergency Response System (PERS)
- Private Duty Nursing - Including Home Health Aide and Shared Services:
 - Registered Nurse
 - Licensed Vocational Nurse
- Congregate Living Health Facility (CLHF)
- Transitional Case Management

2. Multipurpose Senior Services Program Waiver Services

- Care Management
- Respite
- Supplemental Personal Care
- Adult Day Care
- Adult Day Support Center
- Communication (device, translation)
- Housing assistance (Restoration of Utility, Emergency Move, Non-Medical Home, Temporary Lodging, Minor Home Repair/Maintenance)
- Nutritional Services
- Protective Services (Therapeutic Counseling, Money Management, Social Support)
- Purchased Care Management
- Supplemental Chore
- Supplemental Health Care
- Supplemental Professional Care Assistance
- Supplemental Protective Supervision
- Transportation

3. HIV/AIDS Waiver Services

- Enhanced Case Management
- Homemaker
- Attendant Care
- Home Delivered Meals / Nutritional Supplements
- Minor Physical Adaptations to the Home / Specialized Medical Equipment and Supplies
- Non-Emergency Medical Transportation
- Nutritional Counseling
- Psychotherapy

4. Assisted Living Waiver Services

- Care Coordination

- Nursing Facility Transition
- Environmental Accessibility Adaptations
- Assisted Living Services in Residential Care Facilities for the Elderly (RCFE);
Homemaker, Home Health Aide, Personal Care
- Assisted Living Services in Public Subsidized Housing; Homemaker, Home Health Aide,
Personal Care

5. In Home Operations Waiver Services

- Case Management/Care Coordination
- Habilitation Services
- Home Respite
- Waiver Personal Care Services
- Community Transition Services
- Environmental Accessibility Adaptations
- Facility Respite
- Private Duty Nursing - Including Home Health Aide and Shared Services

Appendix 4 Work Plan and Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
August 2011-ongoing	Stakeholder Outreach: <ul style="list-style-type: none"> 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
April 2012- June 2012	Capitation Rate Setting: DHCS and CMS establish rate-setting parameters to determine rates.	DHCS, CMS
April/May 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
Early May 2012	Final 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 2012	State demonstration proposal approved.	CMS
April 2012-Dec 2012	IT/System adaptations developed and implemented.	CMS, DHCS
June 2012-July 2012	Readiness Reviews.	CMS, DHCS, DMHC

July 2012	Waiver approved.	CMS
August 2012	Three-Way Contract development: Contract negotiations take place with Participating Plans, State and CMS.	DHCS, CMS
September 2012	Three-way contracts signed between CMS, State, and Participating Plans contingent on satisfying readiness requirement.	DHCS, CMS
September 15, 2012	Enrollment materials sent to beneficiaries.	DHCS
October 2012- December 2012	Medicare open enrollment.	CMS, DHCS
January 2013	Enrollment effective date for initial phase of beneficiaries.	CMS, DHCS
February – December 2013	Phased-In enrollment effective dates for beneficiaries.	CMS, DHCS

Appendix 5 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 health plan is run by the County, and everyone is in the same managed care plan.
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. The latter include: Multi-Purpose Senior Services Program (MSSP), Developmentally Disabled Services waivers, Assisted Living waiver, In Home Operation waivers, and AIDS waivers. 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.

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, 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%). Legislative statute requires each County to establish a public authority or similar entity to be the employer of record for the care provider; currently 56 counties have a Public Authority. 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.

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, managed care 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.

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.

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 is usually excluded from Medi-Cal managed care, and is paid via fee-for-service.

Behavioral Health services include mental health and substance use services. Medi-Cal beneficiaries with severe mental illness or substance use issues receive services organized and managed by county specialty systems. Counties use realignment funds (composed of ½ cent sales tax and vehicle license fees); Mental Health Services Act (1% income tax on millionaires); and a fixed annual allocation of state general funds (until 2013), based on historical Medi-Cal billings, to incur California's mental health "certified public expenditure" (CPE) and draw down matching federal dollars. Funding for specialty mental health services is capped for adults, but not for children age 21 and younger.

California's Specialty Mental Health System: Through a Section 1915 (B) freedom of choice waiver, all individuals who meet specified medical necessity criteria¹¹ 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 understanding (MOU) with their local County Mental Health Plan.

Substance use services "Drug Medi-Cal" is California's substance use benefit for Medi-Cal beneficiaries. Drug Medi-Cal Benefits include methadone maintenance, day care rehabilitation, outpatient individual and group counseling, and perinatal residential services. Substance use benefits are not a required benefit for managed care Medi-Cal. There is no "rehabilitation option" for Drug Medi-Cal and services must be provided in a clinic setting. Currently, much of Drug Medi-Cal spending on dual eligible beneficiaries goes toward the methadone maintenance program. Until 2011, the California Department of Alcohol and Drug Programs (ADP) reimbursed providers directly for Drug Medi-Cal services. Starting in FY 2011-2012, however, counties assumed this responsibility under realignment. California spent about \$131 million on Drug Medi-Cal services in 2010-2011.

¹¹ 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.

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.

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.		

	Mandatory Qualifications Criteria	Check box to certify YES	If no, explain
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.		
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 eligibles? Which groups?		

Appendix 7 Letters of Support

Letters of support for the demonstration will be included with the final demonstration proposal.

*Note: The following letters were received in support of a specific plan or county participating in the demonstration. The letters do not necessarily reflect support for the specific Coordinated Care Initiative described in this 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

Contra Costa:

- CC Employment and Human Services
- CC Health Services
- Contra Costa Crisis Center
- David Thayer, IHSS Advisory Commissioner
- Guardian ADHC
- Mt. Diablo Center (ADHC)
- Ombudsman Services of CC
- Western Contra Costa Transit Authority

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

Sacramento County:

- Area 4 Agency on Aging
- Alta California, Regional Center
- Easter Seals Disability Services
- Western University, Harris Family Center for Disability and Health Policy
- Partners in Care Foundation
- ULTCW SEIU

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