

The Department of Health Care Services (DHCS) so far has received the following questions related to the Administration's proposed Coordinated Care Initiative (CCI). In its commitment to a transparent process, DHCS has posted the following responses to questions.

**1. When will the stakeholder process to develop the details for these proposals occur and how will participants be selected?**

DHCS has organized a broad stakeholder engagement process to inform the design and implementation of California's Dual Eligibles Demonstration Project. This has included the following:

- Four large public meetings with more than 300 people at each in person and on the phone. A toll-free teleconference line made sure homebound beneficiaries could participate.
- More teleconference calls this year on the CCI with hundreds of people.
- Beneficiary meetings at Centers for Independent Living in four counties.
- Posting all materials online at [www.CalDuals.org](http://www.CalDuals.org).
- Email list that goes to nearly 700 people, including roughly 100 consumers and caregivers.
- Additional training for DHCS staff to ensure that our materials in print and on the web are compliant with the Americans with Disability Act.

DHCS also is launching a stakeholder workgroup process for preparing the duals demonstration launch in 2013. Details about these workgroups can be found at [www.CalDuals.org](http://www.CalDuals.org).

**2. As a disabled person, will I keep my own caregivers and the ability to hire my own non-plan caregivers after the "continuity of care" period.**

IHSS consumers will maintain the right to hire, schedule, direct, supervise and fire their IHSS care provider.

**3. Currently the counties are very involved with the administration of the IHSS program. They verify eligibility into the program, assess clients for IHSS hours, and conduct fair hearings. What role do you see the counties playing with the changes upon us?**

The CCI will continue managing the process for those who qualify for

IHSS enroll through the county social services office. The IHSS social worker will continue to assess psychosocial, home situation, functional status and IHSS needs per current statute. The county social worker will continue using the IHSS Task Guidelines to allocate hours. This means the social worker will still determine the number of IHSS hours one received. In terms of the fair hearing process, the current IHSS procedure will continue.

In 2013, County social service agencies would continue to assess and authorize IHSS hours, using current statutory provisions to determine the number of hours. This work would be performed on behalf of and in coordination with managed care health plans, to improve care coordination. Plans could authorize an increase in IHSS hours, or provide or coordinate other medically necessary home and community based services, but could not require a decrease in IHSS hours.

In 2014 health plans would coordinate even more closely with county social service agencies to assess IHSS hours, in all 30 managed care counties. IHSS determinations would be made through a joint assessment process with health plans and counties, and in accordance with the current statutory provisions for IHSS eligibility. While counties would continue using existing assessment and authorization processes, health plans would provide additional information to support the determination of IHSS hours and determinations would continue to be subject to a grievance and appeals process.

It is anticipated that health plan information would be used primarily to address a change in condition or other services that the county may not be aware of, or to improve an ongoing or increased health risk. Health plans would be able to authorize a different combination of LTSS and medical services that would better meet the IHSS consumer's needs. Counties would still follow existing processes that allow for reductions in services, such as overpayment recovery, appropriate program rules for use of authorized hours, error rate studies, etc. A grievance and appeals process and other protections for IHSS consumers would remain in place.

- 4. Within the years 2012-2013 and beyond will consumers have a choice to continue to hire their own attendants if they choose?**

IHSS consumers will maintain the right to hire, schedule, direct, supervise and fire their IHSS care provider.

Consumer choice of IHSS provider is one of the many consumer protection elements of CCI.

**5. Is the expectation that in years 2 and 3 of the pilots that IHSS services will be part of an at-risk, capitated payment structure?**

Health plan capitation payments would include IHSS funding (along with all other LTSS costs); as such, health plans would be financially at risk for any increases in IHSS provider payment costs and would have a financial incentive to reduce institutional LTSS.

In 2014, health plans would coordinate even more closely with county social service agencies to assess IHSS hours, in all 30 managed care counties. IHSS determinations would be made through a joint assessment process with health plans and counties, and in accordance with the current statutory provisions for IHSS eligibility. While counties would continue existing assessment and authorization processes, health plans would provide additional information to support the determination of IHSS hours and determinations would continue to be subject to a grievance and appeals process. It is anticipated that health plan information would be used primarily to address a change in condition or other services that the county may not be aware of, or to improve an ongoing or increased health risk. Health plans would be able to authorize a different combination of LTSS and medical services that would better meet the IHSS consumer's needs. Counties would still follow existing processes that allow for reductions in services, such as overpayment recovery, appropriate program rules for use of authorized hours, error rate studies, etc. A grievance and appeals process and other protections for IHSS consumers would remain in place.

**6. What is the strategy to pay for the County's costs to administer IHSS (this is a separate allocation for counties that is currently part of the administrative expense claim and covers social workers/admin)? Will these costs be covered by the plan, the State and feds (as it is now) or through some other mechanism**

The Administration is still developing details on this aspect of the proposal.

- 7. Regarding the proposed County maintenance of effort (MOE), it is not clear how the county shares of cost would be utilized and how a new MOE would be established. How would costs for administrative staff be handled and how would this differ from the County providing a share of cost for IHSS provider wages?**

The Administration is still developing details on this component of the proposal.

- 8. Will plans be required to contract with the IHSS public authorities at the local level?**

The Administration does not have an answer at this time.

- 9. How do you intend to protect the MSSP program providers from becoming insolvent once the managed care providers take over the MSSP program?**

The nurses and social workers in MSSP program perform a valuable care management function for the elderly population. They have a skill set and knowledge of the long-term services and supports community that health plans will need in order to be successful in CCI.

Beginning in 2013, the health plans will contract with the organizations that operate MSSP program to secure the care management function for their members who need care management. As Dual Eligible beneficiaries enroll with the health plans, current MSSP consumers will be phased in as well. The nurses and social workers will provide care management to these MSSP consumers, as well as accepting new health plan members referred by the plans. Overtime, the caseload of nurses and social workers will be filled with managed care plan members who will benefit from care coordination and management.

Resources currently available and controlled by MSSP nurses and social workers will be part of the capitation payment to the health plans and will be available through the health plans to help members to remain in the community. Organizations that operate currently MSSP program will be funded by health plans.

**10. What is a "gross premium tax (\$400 million in new revenue over three years)?"**

The Governor separately proposes to eliminate the sunset date for the tax on Medi-Cal managed care organizations (MCO tax). The MCO tax extends the state's Gross Premiums Tax to Medi-Cal managed care plans. The revenue from the MCO tax is used to leverage additional federal monies and offset General Fund costs in the Healthy Families Program. As LTSS are integrated and dual eligible are mandatorily enrolled with Medi-Cal health plans, the administration estimates that the Care Coordination Initiative would increase revenue for Medi-Cal managed care plans, and thereby significantly increase revenues generated through the MCO tax.

**11. For the duals that are NOT enrolled in the demo, will they still be able to access LTSS including CBAS and IHSS?**

This CCI would require Medi-Cal beneficiaries (including duals) to enroll in Medi-Cal managed care plans to access all LTSS. This requirement would be implemented in conjunction with the proposal for mandatory enrollment in Medi-Cal managed care for dual-eligible beneficiaries for their Medi-Cal medical benefits.

**12. Will people with developmental disabilities who are served by regional centers be carved out of the demonstration projects?**

People with developmental disabilities will be included in the duals demonstration for their medical and LTSS. However, the services offered through the regional centers, intermediate care facility services for people with development disabilities, and Development Center will not be included as benefits through Medi-Cal managed care. These services for people with development disabilities will continue to be available through Regional Centers, Development Centers and other services offered under the Lanterman Act.

**13. My family member depends on a Day Treatment program to remain stable in LA County. What does the Duals plan intend for these people?**

Day Treatment program for mental health clients are not part of the

benefits covered by Medi-Cal health plans, like LA Care. The CCI would require Medi-Cal health plans and county specialty mental health plans to coordinate benefits, services and care delivery closely to avoid the unintended service gap or disruption to services.

14. **I understand that there are comparatively few children with special health care needs that are dually eligible. However, the state seems interested in pursuing these models of managed care coordination. Do you see this as the future for all Californian Children in all public programs? And if so, how can we make sure children with special health care needs are appropriately given access to services and specialty care?**

Children with special health care needs receive coordinated services through California Children's Services (CCS). Fewer than 700 children are dually eligible across the state. Currently there are CCS demonstration models are being development in five counties. It is appropriate to wait to contemplate future changes until after the CCS demonstrations are operational and reviewed for their impact on children's health.

15. **When open enrollment comes up in October 2012, concerning transportation and if you have to mark x or y, what happens if you do not select either, will you automatically be placed in one or the other?**

As currently proposed, a beneficiary would have a choice during the open-enrollment period. If the beneficiary does not make an affirmative choice, the beneficiary would be enrolled into demonstration program. This is called "passive enrollment."

16. **If beneficiaries opt out of the passive enrollment process, are they allowed to opt into FFS or another dual pilot plan only? Are they prohibited from opting into another Medicare Advantage/DSNP plan that is NOT participating in the dual pilot?**

Full-benefit dual eligible beneficiaries in demonstration counties would have a choice to opt out of the demonstration and also which health plan to join, if there is more than one available. If they do not opt out, they will be enrolled in the demonstration. If the beneficiary opts out of the demonstration, he or she could choose a fee-for-service or managed

care plan (Medicare Advantage) for Medicare benefits. In some cases the beneficiary could choose PACE. The department is developing further details on the enrollment options for DSNP plans in demonstration counties.

**17. Are you considering any special provisions for working consumers?**

The Administration does not have an answer at this time.

**18. Once there has been a policy defined regarding consumer protections, how will you enforce compliance to that policy so that service providers do not take away consumer rights (or authorized hours) in order to increase profits?**

The goal of the CCI is to focus on coordinated care delivery of medical and LTSS (including IHSS services) to maintain consumers' ability to stay in the community and avoid unnecessary emergency room visits, hospitalizations and nursing home placements. Health plans would not want to disrupt in-home care (like authorized IHSS hours) that might result in costly medical care. Moreover, the CCI has explicit requirements that health plans cannot reduce IHSS hours that have already been authorized by County IHSS social workers. Further, under the CCI, County IHSS social workers would continue to assess and authorize IHSS hours and would be part of the care management team of the health plans.

**19. When will MCOs begin to receive capitated payments from the state and federal governments for dual eligible enrollees?**

Beginning in January 2013, as the dual eligible beneficiaries are enrolled with the Medi-Cal health plans under the Demonstration, the health plans will receive capitation payments.

**20. I don't see how a Primary Care Physician will have the time to "Advocate" all access issues for Consumer's with multi-disabilities? Please explain?**

CCI would require Medi-Cal health plans to develop sophisticated care management systems to support the primary care physicians and to coordinate service delivery and care that consumers with multi-

disabilities would need. Such care management systems would also respect consumers who can self-direct their own care.

- 21. Will counties be required to run an IHSS program for any of individuals exempted from the managed Medi-Cal whose current service does not include LTSS?**

For individuals exempted from enrollment into Medi-Cal health plans, their eligibility access to, and coverage by Medi-Cal benefits, including IHSS, are unaffected by CCI.

- 22. Would plans be locked into the current number of MSSP slots now available? This should be clarified as plans may wish to buy additional slots/services via this available care coordination program.**

No, there is no MSSP slot or MSSP slot limitation in CCI. It is in the health plans' best interests to have a care management capacity to assist members to maintain their health status and remain living in the community.

- 23. If dual pilot plans have to offer all the LTSS services in the pilot, are non-pilot DSNPs going to be required to offer the same LTSS services to avoid risk-selection?**

No, non- demonstration D-SNPs will not be required to offer all the LTSS as the demonstration site manage care plans.

- 24. Will managed care organizations have to contract with Community Care Transitions (CCT) lead organizations to provide transition services or if they will be free to contract with other community-based organizations doing transitions?**

Community Care Transitions program (or Money Follows Person) is a federal program that provides short-term, additional resources to assist Medi-Cal beneficiaries in long-term nursing facilities to re-establish independent living in the community. CCT will continue to work directly with lead organizations to facilitate transition from nursing facility to community living. To the extent that such federal funding is available, CCT eligible Medi-Cal beneficiaries enrolled in Medi-Cal health plans will be able to utilize this resource.

**25. Will the state require Quality Improvement Reports [QIOs] to be conducted by separate, outside, independent contractors to evaluate the managed care entity's performance?**

DHCS is creating a series of workgroups to help with the implementation of the Demonstration. The issue of QIOs will be address in the Quality Measurements work group.