



IMPLEMENTATION UPDATE #2 ■ DECEMBER 2010
Managed Care Enrollment for Seniors and Persons with Disabilities

KEY ACTIVITIES IN IMPLEMENTATION OF MANDATORY MANAGED CARE		
ACTIVITY	CURRENT STATUS	NEXT STEPS
1. Legislative Action	<ul style="list-style-type: none"> ▪ SB 208 passed and signed ▪ Analysis completed 	
2. Member Data Exchange with Health Plans	<ul style="list-style-type: none"> ▪ One set of de-identified data was provided in July providing 12 months of utilization data for the Medi-Cal only SPDs. ▪ Additional provider detail related to the de-identified data was delivered to plans in November 	<ul style="list-style-type: none"> ✓ Member data to be shared with plans in March 2011.
3. Provider Network Analysis	<ul style="list-style-type: none"> ▪ Data re: FFS providers serving Medi-Cal only SPDs shared with plans including plan-specific crosswalk reports. 	<ul style="list-style-type: none"> ✓ Plan –specific Network evaluation packets were delivered to plans on November 19 with a due date of December 20.
4. Readiness Assessment	<ul style="list-style-type: none"> ▪ Policies and procedures under review 	<ul style="list-style-type: none"> ✓ Criteria for access being developed
5. Contract Language	<ul style="list-style-type: none"> ▪ Draft requirements to plans on November 12 	<ul style="list-style-type: none"> ✓ Revised draft requirements to plans on December 3 ✓ See highlight for details.
6. Capitation Rates	<ul style="list-style-type: none"> ▪ Mercer developed rates ▪ Rates were shared with plans on November 22 	<ul style="list-style-type: none"> ✓ Rates to be finalized with the plans
7. Network Adequacy Review	<ul style="list-style-type: none"> ▪ DHCS and DMHC meeting on standards 	<ul style="list-style-type: none"> ✓ Interagency agreement under review
8. Facility Site Review	<ul style="list-style-type: none"> ▪ Facility site review tool has been revised 	<ul style="list-style-type: none"> ✓ All-plan letter out in December
9. Risk Assessment	<ul style="list-style-type: none"> ▪ See new language in SB 208 and waiver approval documents 	<ul style="list-style-type: none"> ✓ All-plan letter out in April ✓ Plans will submit in March
10. Provider Sensitivity Training	<ul style="list-style-type: none"> ▪ Training being developed 	<ul style="list-style-type: none"> ✓ To be finalized by January
11. Outreach and Education	<ul style="list-style-type: none"> ▪ Informational letters to clients have been developed and reviewed 	<ul style="list-style-type: none"> ✓ SPDs receive 90-day notice ✓ 60 days prior to enrollment choice packet will be sent out ✓ 30 days prior to enrollment an intent to default letter will be sent out



		<ul style="list-style-type: none"> ✓ SPDs will receive two telephone calls to provide education and answer questions about the enrollment changes ✓ County presentations March – May
12. Health Plan Links for Non-Choosers	<ul style="list-style-type: none"> ▪ Process developed with input from stakeholders 	<ul style="list-style-type: none"> ✓ Members will be linked to plans based on their highest utilized provider, based on Fee-For-Service claims data.
13. CMS Approval	<ul style="list-style-type: none"> ▪ Approval received November 2 	<ul style="list-style-type: none"> ✓ See highlight for details
14. Performance Measures	<ul style="list-style-type: none"> ▪ Under development 	<ul style="list-style-type: none"> ✓ Will share (conceptual) draft in December
15. Implementation Monitoring	<ul style="list-style-type: none"> ▪ Under development 	<ul style="list-style-type: none"> ✓ Will share draft in December

ADDITIONAL UPDATES

Draft Contract Language:

On November 12, DHCS shared draft contract language with the health plans based on SB 208. Among the new draft requirements are these:

- ✓ A mechanism for SPDs to request a Primary Care Physician, including specialists as PCPs;
- ✓ Continued access to out-of-network providers for SPDs who have an ongoing relationship with a provider;
- ✓ Language allowing DHCS to set new EQRO requirements for performance measurement;
- ✓ Appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area.
- ✓ New terms on informing enrollees about accessible and closed locations of providers.
- ✓ New Basic Case Management requirements for primary care providers (and/or plans):
 - Initial Health Assessment (IHA) and Initial Health Education Behavioral Assessment (IHEBA);
Identification of needs and referral to appropriate community resources and other agencies (such as medical, rehabilitation, and support services) as needed...;
 - Direct communication between the provider and member/family;
 - Patient and family education, including healthy lifestyle changes when warranted;
 - Coordination of carved out and linked services.
- ✓ New Complex Case Management Services for primary care providers (and/or plans):
 - Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team;
 - Intense coordination of resources to ensure member regains optimal health or improved functionality;
 - With member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.



- ✓ Methods to identify members who may benefit from complex case management services, such as: prospective data (UM, MET), retrospective data (claims or encounter data, UM, hospital discharge data), as well as self and physician referrals.
- ✓ Services for Persons with Developmental Disabilities: requirement for dedicated regional center liaison.
- ✓ Health risk assessment for SPDs: includes requirements for a health risk stratification mechanism or algorithm to identify SPDs with higher risk and more complex health care needs; to consult with stakeholders and consumers; approval is by DHCS.
- ✓ Definition of medical home added to contract.
- ✓ Allows DHCS to restrict enrollment of SPD beneficiaries if DHCS determines that contractor does not have sufficient primary or specialty providers to meet the needs of SPD beneficiaries.

CMS Waiver Approval

CMS issued the approval of the 1115 waiver on November 2, 2010, along with Special Terms and Conditions (STC). Among the STCs are these specific to the mandatory enrollment of SPDs:

- ✓ SPD Specific Progress Reports. Quarterly, to include:
 - Progress in completing enrollments and completing steps outlined in the Quality Assurance and Quality Improvement Plan (encounter data and performance measures);
 - An aggregation and analysis of encounter data for SPD population;
 - A discussion of trends or issues identified through the review of such analysis;
 - A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
 - Aggregated information on all measures utilized to assess the plan performance and outcomes for seniors and persons with disabilities;
 - Notable accomplishments and areas for improvement, including findings from Quality Assurance and Quality Improvement Plan, participant survey and evaluation activities, and review of plan grievance process results and State Fair hearing information;
 - Reports on ongoing data collection and analysis of required measurement elements, including HEDIS and other measurement; and
 - Problems/issues that were identified, steps taken to correct them, how they were solved, and if any progress has occurred in the resolution of the issue.
- ✓ Plan Readiness and Contracts:
 - Network adequacy plan/methodology and plan to address insufficient networks;
 - Contract amendments;
 - Monitoring plan;
 - Submissions for readiness assessment to include the following:
 - Care coordination;
 - Standard assessments, including health risk assessments and screening using claims;
 - Continuity of care;
 - Person-centered planning and service design;
 - Specialty access sufficient for needs of the population;
 - Geographic accessibility;
 - Physical accessibility;
 - Interpreter services/information technology;



- Specialized transportation;
- Fiscal solvency;
- Actuarially sound capitation rates;
- Transparency of clinical and administrative decision-making, including use of stakeholder advisory committees;
- Timeliness of appointments with providers; and
- Access to non-network providers.
- Additional contract requirements include:
 - Including SPDs in quality improvement and advisory committees;
 - Transition services for appropriate discharge to home/community settings.

FEEDBACK? Please e-mail suggestions, questions, etc. to Alice Lind (alind@chcs.org) at the Center for Health Care Strategies.