CALIFORNIA DEPARTMENT OF HEALTH SERVICES

MEDI-CAL ACUTE AND LONG TERM CARE INTEGRATION (ALTCI)

Overview

A cornerstone of the Administration's Medi-Cal Redesign effort is the expanded use of managed care delivery systems. The Administration is proposing to increase access to care and improve health outcomes through expansion of Medi-Cal managed care plan options. This will be accomplished by expanding the geographic areas in which managed care is available and the population groups within Medi-Cal who are enrolled in managed care.

Today, managed care is available to Medi-Cal beneficiaries in 22 counties. When Medi-Cal Redesign is fully implemented, managed care plans will be available to Medi-Cal beneficiaries in 35 counties. Families and children in 13 additional counties will enroll in managed care plans; seniors and persons with disabilities will enroll in managed care plans in all counties in which managed care is available (seniors and persons with disabilities are currently required to enroll in the existing 8 counties served by a County Organized Health System (COHS)). One component of the Medi-Cal managed care proposal includes establishing Acute and Long Term Care Integration health plans in three counties, as discussed in this paper.

The Current Long Term Care System and the Need for Integration

The current array of categorical long term care programs has resulted in multiple stand-alone programs with unique eligibility criteria, assessment processes, and funding sources, each with a limited grouping of service options. Existing long term care systems and supports are organized around single services, fee-for-service funding streams and state and federal reporting requirements. Social services programs are often not in communication with Medi-Cal and Medicare health care plans, programs and services. Consumers with chronic care needs and long term care needs often must seek services and supports from several distinct health care programs and home and community-based service organizations, each with its own separate assessment process and care plan. Seniors and persons with disabilities in most counties have not been required to enroll in Medi-Cal managed care plans and for the most part, have accessed health care through the Medi-Cal fee-for-service program. For example, it would not be uncommon for an individual needing home and community-based supports to find themselves applying separately for personal care services, Multipurpose Senior Services Program, the Area Agency on Aging for home-delivered meals, a transportation provider organization in order to shop or do errands, and Adult Day Health Care and home health agency services, each with differing application and assessment processes. In a fully integrated service delivery system "one-stop shopping" becomes the norm with a care management team working with the consumer to proactively identify the most effective and appropriate mix of health and social services enabling the individual to live independently as long as possible while avoiding costly and unnecessary institutional care.

Balancing Long Term Care Infrastructure

The federal Medicaid program has been criticized for creating a fiscal incentive for inpatient nursing facility care instead of providing incentives for less restrictive, home and community-based services. Under Medicaid, (Medi-Cal in California) nursing facility care is an entitlement for all who are eligible. Home and community-based services are available only through capped enrollment waiver programs and are restricted currently to those services named in the federally approved waiver application. Integrated models and capitated financing help states balance long term care service delivery through health plan incentives to increase the networks for and use of home and community-based services and avoid higher cost, institutional care. Over the past decade, the number of Medi-Cal paid nursing facility days has stayed virtually the same (1.7 percent increase).[i] Concurrently, there has been a substantial increase in the utilization of home and community-based services that allow individuals with functional limitations to remain in their homes. [ii]

Summary of the ALTCI Proposal

ALTCI plans will provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities and will incorporate primary, acute and long term care services, including home and community-based services and providers in their networks. Integration of medical and social supports across the full scope of Medi-Cal benefits and Medicare benefits (for those who are eligible) will provide the consumer the option of enrolling in one health plan instead of seeking out multiple programs and services to meet various health and social services needs. Integration of medical and social supports also provides the State the opportunity to streamline the funding and administration of multiple programs and to reduce overlapping services while improving efficiency. The ALTCI plan standards will be designed specifically around the health, social and supportive service needs of seniors and adults with disabilities.

Integration of Medi-Cal and Medicare funding and services will occur at the health plan level. The State has no role in the administration of Medicare funding. ALTCI health plans must be approved as Medicare Plans (referred to as Medicare Advantage plans) that include the new Medicare prescription drug coverage. The state will be working with potential ALTCI plans and with the federal Centers for Medicare & Medicaid Services (CMS) to determine the appropriate federal agreements to provide ALTCI consumers with the most efficient coverage of drugs under an integrated Medi-Cal and Medicare system. By requiring ALTCI plans to also be Medicare plans, the State provides the opportunity to ensure the best use of the member's federal Medicare benefit. ALTCI plans will be reimbursed through a capitated payment from the State for Medi-Cal services and a capitated payment from the federal Centers for Medicare and Medicaid Services (CMS) for Medicare services for eligible members. The Medi-Cal rate setting methodology will be carefully structured to assure appropriate reimbursement and incentives for health plan success in meeting the goals of the ALTCI model.

Coverage under the integrated plans will be comprehensive and will expand on the successes of traditional Medi-Cal managed care models. The following table displays the expanded coverage:

Traditional Managed Care Coverage	ALTCI Coverage
Primary Care	Primary Care
Hospital Care, Emergency Room Services, Surgeries	Hospital Care, Emergency Room Services, Surgeries
Case Management of Medical Services	Case Management of Medical Services
Medi-Cal Scope of Benefits *(see list at the end of this paper)*	Medi-Cal Scope of Benefits *(see list at the end of this paper*)
	Expanded Care Management across medical, social and supportive services with consumer participation as a priority and with interdisciplinary team support. Care Management will have a priority to avoid institutional placements.
	Nursing Facility Services
	Adult Day Health Care
	Personal Care Services
	Mental Health Services
	Home and Community-Base Services (home modifications, personal emergency response systems, nutrition, others necessary to avoid or delay inpatient nursing facility care.)

Integrated Medi-Cal and Medi-Cal/Medicare plans provide new opportunities to address the unique health care needs of seniors and adult persons with disabilities who are generally high-cost and high frequency users of health care. ALTCI health plan comprehensive coverage will be designed to help individuals maintain independence and avoid the need for inpatient nursing facility care whenever possible. The intended goal of these health plans will be to keep people healthy and actively involved in their homes and communities for as long as possible. Additionally, participating health plans will be designed to assist those currently in nursing facilities to pursue community living and supports in an independent living environment.

The ALTCI model will be implemented in three counties to facilitate modifications on a smaller scale should they become necessary and to validate the model before it is implemented statewide. The ALTCI proposal also includes the development and testing of a Long Term Care Diversion and Assessment Protocol to assess and divert individuals from costly long-term nursing facility care (*discussed later in this paper*).

Long Term Care Integration (LTCI) Background

Several counties throughout California have been actively engaged in Long Term Care Integration (LTCI) planning and development of integrated local service systems. The Legislature authorized LTCI grants as a result of state and local interest in creating more efficient delivery of medical, social and supportive services. The first state funded LTCI grants were awarded July 1999. Grants supported the establishment of local stakeholder groups followed by feasibility reviews that included evaluating the availability of local community LTC services, and service gap analysis. A total of $2,658,021 has been awarded to 16 counties between 1999 and 2004. Many early grantees generated significant local interest for integrated systems but lacked sufficient resources and expertise to support the development of LTCI projects. A state-level approach is needed to allow for consistent criteria including performance standards and measures for all participating health plans, which will improve oversight options and will also improve probability for federal approval. Both Contra Costa and San Diego counties have sustained ongoing planning and development activities and succeeded in earning the first Implementation Grant awards totaling $897,507 for the 2004-2005 Budget Year. See Attachment 4 for a summary of the major milestones these two grantees will meet in order to implement integrated programs in their counties.

Other Efforts to Coordinate Services

Several counties have independently developed coordinated social services delivery systems that expedite referrals across programs. However, fully integrated Medicaid and Medicaid/Medicare models depend on financing mechanisms that can only be implemented from the state Medicaid agency level. Implementation of the integrated services and financing model in California will greatly advance state policy objectives to ensure the health and well-being of seniors and persons with disabilities. Health care cost inflation, the increasing numbers of aging Californians, and the US Supreme Court's Olmstead decision create the urgent need for the state to take a proactive role now in setting a state policy framework for Medi-Cal and Medicare systems to be redesigned with the health care and social service needs of senior and disabled consumers in mind.

Managed Care Standards and ALTCI Plan Features

Under the managed care expansion proposal, state policy, including standards for the health plans and safeguards for the enrolled population, will be developed by the Department of Health Services (DHS) based on recommendations and input from stakeholders and consumer groups. Each current managed care requirement will be re-visited and modified as necessary, to address the needs of the target population.

The DHS will work with stakeholders to ensure plan readiness to meet the diverse health care needs of this population. The process will begin with an exploration of the lessons learned from prior implementations of Medi-Cal managed care. The stakeholder process will be used to examine current managed care program standards and determine what augmentations are necessary to both protect and ensure quality improvement for seniors and persons living with disabilities. The stakeholder process

will be a 9 to 10 month process with the goal of developing recommendations in early 2006. Identified program changes can then be adopted, implemented, and included in health plan contracts as appropriate.

The policy, standards and measures, and safeguards for the ALTCI plans will be developed through the same stakeholder process for all managed care plans. ALTCI plans will be required to meet the requirements for Knox-Keene licensing. ALTCI plans will be required to have agreements with the federal Centers for Medicare and Medicaid Services (CMS) to also provide Medicare services as a Medicare Advantage Plan (or Special Needs Plan) that will include a Prescription Drug Plan. Stakeholders will be involved in the identification of additional elements to address the added ALTCI plan features of home and community based service options and priorities.

DHS has a long-standing process for determining if a health plan is prepared to meet the standards for delivery of services to all individuals covered under the plan, including services to seniors and persons living with disabilities. Plan readiness reviews are carried out in a systematic manner. Readiness reviews consist of both documentation reviews as well as on-site visits to both health plan headquarters and provider offices. Any new standards that result from the stakeholder process will be included in DHS's ongoing systematic approach.

ALTCI Implementation

Health Care Costs and Reimbursement

ALTCI plans will be at financial risk through a comprehensive per member, per month capitated rate under Medi-Cal. Plans will assume risk for a comprehensive array of services including acute hospital care, nursing facility care and home and community based services and supports. ALTCI plans will be required to be Medicare plans (Medicare Advantage Plans), providing members with the full-array of Medicare-covered services. Federal rules require that Medicare eligible individuals be allowed to choose to enroll in a Medicare health plan. It is expected that with appropriate health plan information, most enrollees will elect to enroll to receive their Medicare benefit through their Medi-Cal ALTCI plan. The comprehensive benefit package will provide a fiscal incentive for plans to create effective home and community-based provider networks, early intervention with chronic conditions, preventive health services and care management across disciplines. Capitated rates across the entire health and social support continuum creates fiscal incentives for the plans to provide proactive and preventive services to avoid higher cost acute care, nursing facility care and emergency care. Whenever possible, services will be provided in community settings and on an out-patient basis. Financing ALTCI plans through actuarially determined rates that cover the full array of services will provide the state with predictable state budgeting for high cost health care services, such as nursing facility care, where integrated ALTCI plans are available.

Expected Enrollment into ALTCI Plans

Statewide, over 1.5 million seniors and persons with disabilities receive health coverage through the Medi-Cal program. Approximately 280,000 of these individuals receive their coverage through Medi-Cal managed care plans. Medi-Cal Redesign will bring managed care to approximately 554,000 additional seniors and persons with disabilities. Of the eligible adults in each of the three designated counties, DHS estimates that about 85 percent will select enrollment in the ALTCI plan option. DHS estimates the following enrollment numbers in each of the proposed ALTCI counties:

- Orange County 74,139
- Contra Costa 27,092
- San Diego 89,417

The Acute and Long Term Care Integration proposal focuses on adults with disabilities and seniors. Children with special health care needs are served with care coordination options through the California Children's Services Program and through the Lanterman Act via the Regional Centers.

Enrollment Options

In Contra Costa and San Diego counties, ALTCI plans will be offered as a substitute for traditional Medi-Cal managed care plans (primary and acute coverage). In Orange County, CalOptima, will serve as the ALTCI plan. In the three ALTCI counties individuals meeting participation requirements for the Program for All-Inclusive Care of the Elderly (PACE) may select a PACE plan if one is available in that county. Seniors and adult persons with disabilities not selecting a particular plan during the Medi-Cal enrollment process will be automatically enrolled in an ALTCI plan. During the first year of operation, enrollment of existing Medi-Cal eligibles will be spread over twelve months so that individuals will enroll at the time of Medi-Cal eligibility redetermination.

Medi-Cal-only Eligible Seniors and Adult Persons with Disabilities: Roughly 40 percent of the senior and persons with disabilities are eligible for Medi-Cal only and do not have Medicare coverage. Medi-Cal only adult individuals will have the options listed below in Contra Costa and San Diego counties where ALTCI is available:

- Stay in a traditional Medi-Cal managed care plan, if they are already enrolled.
- Enroll in a traditional Medi-Cal managed care plan.
- Enroll in an ALTCI plan.
- If no choice is made, the Medi-Cal "default" plan will be an ALTCI plan.
- Enroll in a PACE plan where one is available and the individual meets the age and level of need criteria.

Dually Eligible Seniors and Adult Persons with Disabilities: Roughly 60 percent of SPDs are dually eligible for Medi-Cal and Medicare. Dually eligible individuals will have the options listed below in Contra Costa and San Diego counties where ALTCI is available:

- Enroll in an ALTCI plan and maintain Medicare coverage separately.
- Enroll in an ALTCI plan and enroll in the same plan for Medicare coverage and Medicare Drug coverage through a Prepaid Drug Plan.
- If no choice is made, the Medi-Cal "default" plan will be an ALTCI plan.
- Enroll in a PACE plan where one is available and the individual meets the age and level of need criteria

Orange County Dually Eligible and Medi-Cal Only Eligible Seniors and Adult Persons with Disabilities:

- Enroll in the County Organized Health System ALTCI plan and maintain Medicare coverage separately.
- Enroll in the County Organized Health System ALTCI plan and enroll in the same plan for Medicare and Medicare Drug coverage.
- If no choice is made, the Medi-Cal "default" plan will be the County Organized Health System ALTCI.
- Enroll in a PACE plan where one is available and the individual meets the age and level of need criteria

Start dates:

- Orange County (COHS) September 1, 2006
- Contra Costa County (Two-Plan) January 1, 2007
- San Diego County (GMC) March 1, 2007

Why These Three Counties – Orange, Contra Costa and San Diego?

The counties identified for the ALTCI roll-out were selected because:

- Each represents one of the three models of Medi-Cal managed care service delivery—COHS, Two-Plan Model, and Geographic Managed Care. (*See the resource pages at the end of this paper for definitions)*
- Each has substantial county government involvement and commitment to developing integrated health care and social support networks.
- Each has an array of home and community-based supportive services.
- Each has an active stakeholder process that engages health plans, medical providers, community programs and consumers in ALTCI plan readiness activities.

Selection of ALTCI Health Plans

The approach to the State selection of ALTCI health plans will differ by type of Medi-Cal managed care model existing in each county. For example, CalOptima is the health plan for Orange County (a COHS county). In Orange County, CalOptima, will develop a service delivery system that will serve as the ALTCI plan.

Contra Costa is a two-plan model county. For ALTCI, the local initiative Contra Costa Health Plan will be given the option to be an ALTCI plan and a competitive procurement will be completed to select the second ALTCI health plan for that county. Should Contra Costa Health Plan decline to participate as an ALTCI plan the competitive procurement will select two ALTCI plans.

San Diego is a GMC county. The State selection process for GMC counties is a Request for Applications (RFA) process. The State will release specifications and requirements for ALTCI plans through the RFA process and will review and select participating ALTCI plans based on how well they meet State and County requirements. Consistent with the GMC RFA process, the number of participating plans will be determined by the number of successful applicants. Interest from probable qualified health plans suggests that the number of successful applicants will be sufficient to provide consumer choice of plans. Conversely, due to requirements that all ALTCI plans also be Medicare Advantage and Medicare Prescription Drug Plans and have the capacity to offer home and community based services and multidisciplinary care coordination, the number of plans is expected to be small enough to assure sufficient enrollment numbers to allow plans to be financially viable.

Long Term Care Diversion and Assessment Protocol

Currently, there are multiple assessment tools and protocols used in the state, none of which can be used across services and across programs. To address this issue, the ALTCI plans will work with the state and a contractor on the development and implementation of a uniform Long Term Care Diversion and Assessment Protocol ("Protocol") for seniors and persons with disabilities. The Protocol will be used to determine functional needs and preferences and to ensure that seniors and persons with disabilities receive care that supports maximum community integration and self-direction. The Protocol will be developed by a contractor who will work with the State on the planning, development and implementation of this tool. The development process will involve stakeholders, including consumers, advocates and representatives from home and community based programs. The development and implementation of ALTCI plans and the Protocol are consistent with the US Supreme Court's Olmstead decision in terms of offering choice to individuals and promoting maximum community integration.

Once the protocol has been developed, all ALTCI plans will be required to use it. The ALTCI care management team will use the Protocol to identify when an individual begins to have chronic care needs that may affect their ability to live independently. In the three ALTCI counties, non-ALTCI plans will also be required to use the Protocol to identify when and how individuals need to be referred and have their services

coordinated with existing local community based organizations. After it is fully validated, the Protocol could serve as the model to be used by all managed care plans prior to consideration of placement into long-term care institutions. Use of the Protocol to assess and match individuals with appropriate home and community based services and supports has the potential to improve quality of life for Medi-Cal beneficiaries by helping them to remain as independent as possible.

Federal Approval for ALTCI Plans

Approval from the federal CMS will be necessary to implement the ALTCI plans. Discussions to date with CMS regarding ALTCI indicate that federal waivers will be required as part of overall implementation. It is anticipated that federal approval will require multiple waivers of statewideness and comparability requirements under Medicaid rules in order for the state to offer home and community based services in lieu of institutional services – generally referred to as section 1915(b) and 1915(c) waivers. It is possible that CMS will require a section 1115 federal demonstration waiver. While this type of waiver offers substantially more flexibility, it comes with more compliance provisions and increased federal oversight.

Other Considerations:

Persons with Disabilities and with Managed Care

Limited data are available regarding the experience of persons with disabilities in managed care. Many states require persons with disabilities who receive Medicaid benefits to enroll in managed care programs. The consensus among states and health plans is that some form of managed care is the best path to take in meeting the needs of seniors and adult persons living with disabilities. Consumers, while less sure, also agree that managed care offers the potential for better access and increased quality.[iii] Findings in another study reveal that individuals enrolled in managed care organizations were more likely to be highly satisfied in three domains—global quality, access to care, and technical skills—compared with individuals in the local and national fee-for-service study groups but fewer were highly satisfied with the interpersonal manner of their providers.[iv] California will be building on lessons learned through programs in California and in other states and on input from stakeholders and potential consumers to ensure that enrollment into managed care will improve access, satisfaction, and quality of care.

Medi-Cal and Medicare for Dually Eligible Individuals

Medicaid is the primary payer for nursing facility care in the nation. Medi-Cal covers nursing facility care for those who meet specific state regulatory requirements; for example, the need for access to twenty-four hour per day nursing assessments and services. For dually eligible individuals, Medicare provides limited coverage of nursing facility stays; typically 90 days in a calendar year. Those who enter a nursing facility often exhaust the limited Medicare benefit and then spend their private resources in order to qualify for Medi-Cal long term care benefits. Coverage under Medi-Cal for home and community-based services is limited to an array of Medi-Cal waiver programs, community-based adult day health care centers, personal care services, or

other services that are limited in scope and/or capacity. Medicare coverage of home and community-based services is limited to home health services under certain conditions; for example, recent release from the hospital.

The existing long term care delivery system requires dually eligible individuals to access different programs for social supports, health care services and Medicare benefits.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a federally defined program that successfully integrates Medi-Cal and Medicare programs. PACE is available only to persons who are fifty-five (55) years or older and who have been determined ready for nursing facility. The ALTCI plans will serve not only seniors and persons with disabilities who are determined ready for a nursing facility, but also seniors and persons with disabilities who do not need nursing facility level of care. By serving a broad population, the ALTCI plans will have the flexibility and incentives to provide integrated services as efficiently and as effectively as possible for a diverse and large enrolled group of seniors and persons with disabilities and will delay or prevent the need for institutional placements. PACE is designed around a multidisciplinary team staffing model that uses Adult Day Health Care, primary care clinic services and comprehensive care management as basic required features at each site. The proposed managed care expansion assures that PACE plans will continue to have the opportunity to enroll eligible individuals and fully recognizes the value of the PACE organizations that serve a specific need for frail seniors.

Olmstead

The July 1999, Supreme Court's Olmstead Decision challenged federal, state and local governments to develop alternative choices for individuals living with disabilities through more accessible systems of cost-effective community based services that prevent or delay early institutionalization. The Olmstead Decision interpreted Title II of the Americans with Disability Act and its implementing regulations requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Given the precedent set by the Olmstead Supreme Court decision and the subsequent CMS State Medicaid Directors' Letters giving states guidance on policy development on this matter, several state agencies have taken opportunities to pursue initiatives that are consistent with Olmstead principles. A few examples of efforts undertaken by state agencies include the Real Choice Systems Change grants (for developing alternatives to institutional placement), the Assisted Living waiver, and the In-Home Services Plus waiver. ALTCI plans will be designed to be consistent with Olmstead goals of avoiding unnecessary institutional care, maintaining the highest level of independence and enabling services and supports to be provided in the most integrated community setting possible.

Endnotes

i. AARP, 2002.

ii. USC/UCLA Center for Long Term Care Integration.

iii. USC/UCLA Center for Long Term Care Integration, *Medi-Cal Long Term Care: Shift from Nursing Home to Home and Community-Based Services*, Policy Issue Brief, May, 2003.

iv. Ibid.

v. Adults with disabilities in Medi-Cal Managed Care: Lessons from Other States, Nicki Highsmith and Stephen Somers, Center for Health Care Strategies, 2003

vi. Health Care Finance Rev 2001 Summer; 22(4): 175-8 Burton LC, Weiner JP, et al. Health Services Research and Development Center, John Hopkins University School of Hygiene and Public health, Dept of Health Policy and Management, USA. lburton@jhsph.edu

References

Med-Cal Managed Care Models

California utilizes three managed care delivery models to provide health care to 3.2 million Medi-Cal beneficiaries. These models, the Two-Plan, the County Organized Health Systems, and Geographic Managed Care, are described below:

Two-Plan

The Two-Plan model of Medi-Cal managed care is available in twelve counties. In 1996 Alameda County became the first Two-Plan managed care county. The other Two-Plan counties include Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. In each Two-Plan county, the Department contracts with one locally developed health care service plan known as the Local Initiative and one Commercial Plan selected through a competitive procurement process. Fresno County did not develop a Local Initiative and therefore has two Commercial Plans. In general, enrollment is mandatory for families and children. The non-mandatory eligible groups (mostly seniors and persons with disabilities) access services through Medi-Cal's fee-for-service delivery system or can choose to enroll in a health plan. Individuals who are Medicare/Medi-Cal dual eligibles are excluded from enrollment.

County Organized Health Systems

County Organized Health Systems are health-insuring organizations that are organized and operated by a governing board appointed by the county's Board of Supervisors. The first plan was implemented in Santa Barbara County in 1983. All Medi-Cal beneficiaries residing within the county are required to enroll regardless of their eligibility category, including individuals who are Medicare/Medi-Cal dual eligibles. There is no Medi-Cal fee-for-service delivery system in these counties. Five County Organized Health Systems plans operate in eight counties: Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo.

Geographic Managed Care

Under the Geographic Managed Care approach, the Department contracts with multiple health plans in the county. In contrast to the competitive procurement for the commercial plans in the Two-Plan model, contracts for Geographic Managed Care are secured via a non-competitive application process in which any plan meeting specified state requirements/standards is permitted to negotiate a contract with the state. In counties with the geographic managed care approach, Medi-Cal beneficiaries choose from among the multiple commercial managed care plans. This model has operated in San Diego County since 1996 and in Sacramento County since 1994. In these two counties, enrollment is mandatory for families and children. The non-mandatory eligible groups access services through the Medi-Cal fee-for-service system. Individuals who are Medicare/Medi-Cal dual eligibles are excluded from enrollment.

Lessons Learned From Other States

Some data suggest that the actual experience other states have had with providing services to persons with disabilities under managed care has been good. An Oklahoma survey shows significant satisfaction after managed care became mandatory for persons with disabilities).

Experience of Oklahoma Persons with Disabilities after Enrollment in Medicaid Managed Care

(http://www.hrsa.gov/financeMC/disability/ppt/default.htm)

ASPECT OF SERVICE	Some or Much BETTER	About the SAME	Some or Much WORSE
▪ Ease of obtaining prescriptions	60 percent	31 percent	10 percent
▪ Satisfaction with services received	57 percent	32 percent	8 percent
▪ Ease of seeing a doctor	61 percent	36 percent	18 percent
▪ Rating of doctors and providers	43 percent	49 percent	8 percent

Texas: In the Texas Star Plus program (2002), over seventy-five percent of surveyed managed care enrollees reported that it was easy to get help from their care coordinator, and that they had no problem getting needed home health or attendant care. In fact, inpatient services decreased by twenty-eight percent and the number of Texas enrollees receiving adult day care services and personal assistance services increased by thirty-eight and thirty-two percent, respectively, with managed care. (http://www.hhsc.state.tx.us/medicaid/) Texas identified the following lessons learned from the Texas Star Plus program:

- Educate and inform providers and stakeholders to help ensure a successful transition to managed care.
- Simplify administrative processes to improve provider satisfaction.
- Care coordination is key for integrating acute and LTC services.
- Care coordinators are useful in reducing the challenges of coordinating care for dual eligibles (Medicare/Medicaid), for whom HMOs are only responsible for long term care.
- Prompt enforcement of contract provisions is crucial.
- Nursing facility admissions from STAR+PLUS have remained low, as members choose community-based alternatives.

Arizona Long Term Care System: In a report entitled "*Now and the Next Generation Long Term Care 2002*" consumers stated that they were extremely satisfied with their services and as a result, the state has expanded consumer choice of plans based on

the report's findings. The state has decreased nursing facility stays and has increased the proportion of members living in their own homes by 4.9 percent. Arizona uses a comprehensive care management to reduce hospital length stays from 7 to 5 days. http://www.ahcccs.state.az.us/Services/Overview/ForArizonans.asp

Massachusetts implemented Senior Health Care Options (SHCO), which is the largest, integrated Medicare and Medicaid demonstration project in the country. MASS SHCO emphasizes maintaining an optimal level of independence in all settings and providing flexible services beyond those available under FFS Medicaid. MASS SHCO provides primary, acute and long-term care services to approximately 4,500 dually eligible (Medicare and Medicaid) enrollees who are at risk for institutionalization.

Minnesota provides Minnesota Disability Health Options (MNDHO), an integrated self-directed health management program for working age individuals with disabilities. Under MNDHO, 90 percent of the members reported satisfaction with their health care services. Minnesota also provides Senior Health Options (MSHO), which increased access to home and community-based services for under-served and ethnically diverse populations. MSHO has experienced a dis-enrollment rate of less than 3 percent, low complaint and appeal rates, high consumer satisfaction, and enrollment growth. MSHO enrollees reported more satisfaction with a health plan than with regular Medicaid. http://www.dhs.state.mn.us/agingint/

Florida operates two separate Medicaid programs. Health and Home Connections serves enrollees over the age of 65. Currently 446 voluntary enrollees whose health care needs are managed through extensive care coordination programs and services. ElderCare serves persons over the age of 21 at risk of institutionalization due to chronic illness, disability and/or in need of assistance with activities of daily living (ADL). There are 3,700 voluntary enrollees. The program has successfully cared for clients with higher impairment in community settings than has been the case with the state's FFS system due to the degree of care coordination and other services. ElderCare individuals with 4.5 ADL deficiencies (high compared to Florida's nursing facility population's 3.8 ADL need) have been able to avoid inpatient nursing facility care.

Wisconsin Partnership Program assesses quality by using member outcome measures to demonstrate quality of life experience for enrolled individuals. Some of these measures recently showed:

- People are treated fairly (85.7 percent).
- People have personal dignity and respect (88.6 percent).
- People participate in the life of the community (63-78 percent).
- People remain connected to informal support networks (68 percent-75 percent).

These measures focus on self-determination and choice of supports. Hospital admissions were reduced for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Kidney/Urinary Tract Infection, and other conditions. 88 percent of the physicians reported that membership in the plan made it easier to provide individualized care. www.dhfs.state.wi.us/WIpartnership

Medi-Cal Redesign

Acute and Long Term Care Integration (ALTCI) Benefit Summary

Services
Acupuncture
Acute care services: medical and psychiatric inpatient, outpatient & ER
Adult day health care (ADHC)
Ambulatory Surgical Clinic Services
Audiology
Comprehensive & Interdisciplinary Care Management
Chiropractor
Clinic services
Dental services
Diagnostic services (lab, x-ray, etc.)
Durable medical equipment
Hearing aids
Hemodialysis (chronic)
Home health agency services
Home and community-based services in lieu of institutional services (for example, personal care services, home nursing services, home modifications, personal emergency response systems, and others.)
Hospice
Hospital inpatient care
Hospital outpatient services and organized outpatient clinic services
Intermediate care facility (ICF)
Medical and surgical services furnished by a dentist
Medical supplies, prescribed
Medical transportation - emergency
Medical transportation - non-emergency
Non-physician medical practitioner (nurse practitioner, etc.)
Occupational therapy
Optometry services
Organ Transplants
Other Medi-Cal covered outpatient services (e.g. heroin detox)
Personal care services
Pharmaceutical services
Physical therapy
Physician services
Podiatry
Pregnancy related services
Prosthetic & orthotic devices related services
Psychiatric & psychological services (limited)

Services
Rehabilitative mental health services
Rehabilitative services, physical
Respiratory care services
Rural health clinic services (including Federal Qualified Health Center (FQHC))
Sign language interpreter services
Skilled nursing facility (SNF)
Special tuberculosis related services
Speech therapy services
Subacute facility care
Substance abuse treatment Services
Vision services (eyeglasses, optician, optical fabricating laboratories, ophthalmology services)
Others, depending on new Medi-Cal policy

Acute and Long Term Care Integration - Major Milestones
Contra Costa Health Plan (CCHP)

	30-Jun-05	Dec-05	Jun-06	Dec-06	Jan-07
Application to CMS to become a Medicare Advantage Plan (subject to CMS timelines for Medicare applications).			By March 2006		
Assess current home and community-based services (HCBS) provider capacity and utilization in the county. Develop recommendations to the State regarding ALTCI HCBS provider networks.	Report recommended HCBS core provider types for ALTCI provider network and capacity to DHS by June 30, 2005.	Build HCBS provider capacity	HCBS provider capactity network finalized by June, 2006.	Recruit & enroll HCBS provider network.	
Evaluate curent Contra Costa Health Plan (CCHP) care management, four-level care management protocol. Expand and draft ALTCI Care Management Protocols. Submit to DHS.	Report to DHS recommendations for care management protocol for ALTCI by June 30, 2005.	Work with stakeholders. Incorporate feedback.		Finalized policy and procedures for ALTCI *	
Establish policies to operationalize Quality Assurance (QA) Measures that ALTCI plans must meet to serve the enrolled population.	Report recommendations to the State by June 30,2005	Work with stakeholders. Incorporate feedback.	Submit QA Plan to DHS byJuly 2006	Make Final & approved by Sept 2006	Begin QA system upon enrollment of members.
Identify assessment tool/protocol and ALTCI service authorization guidelines	Develop and Participate with the State. Submit proposed guidelines to DHS by June 30, 2005	Work with stakeholders. Incorporate feedback.	Adopt implementation guidelines.	Finalize policy and procedures for ALTCI *	
Assess and build Information Technology (IT) support for comprehensive care management across medical and social services providers/functions	Submit proposed System guidelines to DHS By June 30,2005	Build IT care management system capacity.		Finalize and test system functions.	
Enroll members					**Enroll by 1/1/2007**

** Policies & Procedures for ALTCI Implementation*

Acute and Long Term Care Integration - Major Milestones

County of San Diego

	30-Jun-05	Dec-05	Jun-06	Dec-06	Mar-07
Local health care plans application to CMS to be Medicare Advantage plans. (subject to CMS application timelines for 2007 Plans)			By March 2006, if not before		
Participate with the State on Quality Assurance (QA) measures for enrolled populations.	Develop and participate with other ALTCI counties and State to review best practice, other national models. Submit recommendations to DHS	Stakeholders review and revise standards with the Board of Supervisors and State.	Include proposed quality requirements in Request For Statement of Qualifications (RFSQ). Forward to potential health plan partners after approval by Board of Supervisors early in 2006; responses anticipated by June 2006.	Trainings for health plans and providers planned and implemented by Dec. 06.	
Local RFSQ* to DHS per W&I sec. 14089.05.	Complete draft RFSQ to be used to screen/identify ALTCI health care plans. Submit to DHS by June 30, 2005.	Stakeholders review and revise RFSQ with the Board of Supervisors and State	Finalize RFSQ, gain necessary approvals, and send RFSQ to interested health plans. Screen Responses by Dec. 06	County submits pre-qualified health plan list to DHS for contract process based on RFSQ response.	
Assess home and community-based provider capacity (HCBS). Develop aging and disabled specialist provider capacity based on utilization under FFS Medi-Cal.	Summary of recommendations for HCBS and aging and disabled specialists in the Provider Network By June 30, 2005	Stakeholders review and revise recommendations with the Board of Supervisors and State	Board and State finalize RFSQ language for provider network requirements.	Health plan partners develop HCBS and aging and disabled specialists provider network.	

	30-Jun-05	Dec-05	Jun-06	Dec-06	Mar-07
Develop care management model and process with performance standards and measures to be included in RFSQ	Recommendations for care management RFSQ language by June 30, 2005	Stakeholders review and revise the standards with the Board of Supervisors and State	Board and State approval to finalize RFSQ language for care management requirements.	RFSQ care mangagement requirement language included in contract with DHS	
Establish cultural competency standards including age and disability issues for enrolled population	Recommendations for cultural competency RFSQ language by June 30, 2005	Stakeholders review and revise the standards with the Board of Supervisors and State	Board and State to finalize RFSQ language for cultural competency requirements.	Enrollment counselors and health plan partners develop required cultural competency standards.	
Develop web-based IT system linking all Healthy San Diego Plus** care managers and providers on a 24/7 basis.	Survey with recommendations completed by June 30, 2005	Stakeholders review and revise the recommendations in conjunction with the Board of Supervisors and State	Board and State finalize RFSQ language for IT system requirements.	County and health plan partners implement IT system design and test for accuracy and 24/7 linkage between care managers and providers.	
Begin enrolling ALTCI Members					3/1/2007

* *RSFQ is San Diego County statutorily required process to screen qualified health plans in coordination with the State's process of procuring health plan for Medi-Cal managed care.*

** *Health San Diego Plus is parallel to the current Healthy San Diego initiative. Healthy San Diego refers to current Medi-Cal managed care in that county. Healthy San Diego Plus will refer collectively to Medi-Cal managed care expansion in that county.*