Duals Demonstration

In-Home Supportive Services Work Group

May 11th 2012

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Agenda

- Workgroup Purpose and Objectives
- Purpose of the Duals Demonstration
- What IHSS will look like under the Duals Demo and Managed Care
- IHSS Intake Process
- Managed Care Intake Process
- What are the touch points between systems/process?
- Wrap up and next steps

IHSS Coordination and Integration with Managed Care

Work Group Purposes and Objectives

Purpose of the IHSS Integration Duals Work Group

The goal of this work group is to identify the essential elements required for successful coordination and integration of In-Home Supportive Services and Managed Care Health Plans in the four demonstration counties.

Work Group Objectives

- Develop recommended implementation readiness criteria for IHSS and Plans in the demonstration counties.
- Outline Options for Touch-points between systems and care planning - that identify ways to develop an integrated IHSS/Managed Care Health Plan intake process in the Duals Demonstration.

Work Group Objectives (con't)

- Construct guidelines for the creation of care coordination teams (CCT) to ensure coordination, access and quality care plans for all services, including In-Home Supportive Services.

- Provide and share information and obtain input from all stakeholders and recipients about IHSS and managed care.

Purpose of the Duals Demonstration

The Duals Demonstration Project Hopes to Solve Serious Problems

Medi-Cal

- Services not covered by Medicare (i.e. transportation, vision, dental, mental health services)
- Medicare cost-sharing
- Long-term skilled nursing
- Personal care services, and other home-based services

- **Lack of coordinated Care**
- **Siloed Programs**
- **Misaligned Incentives**

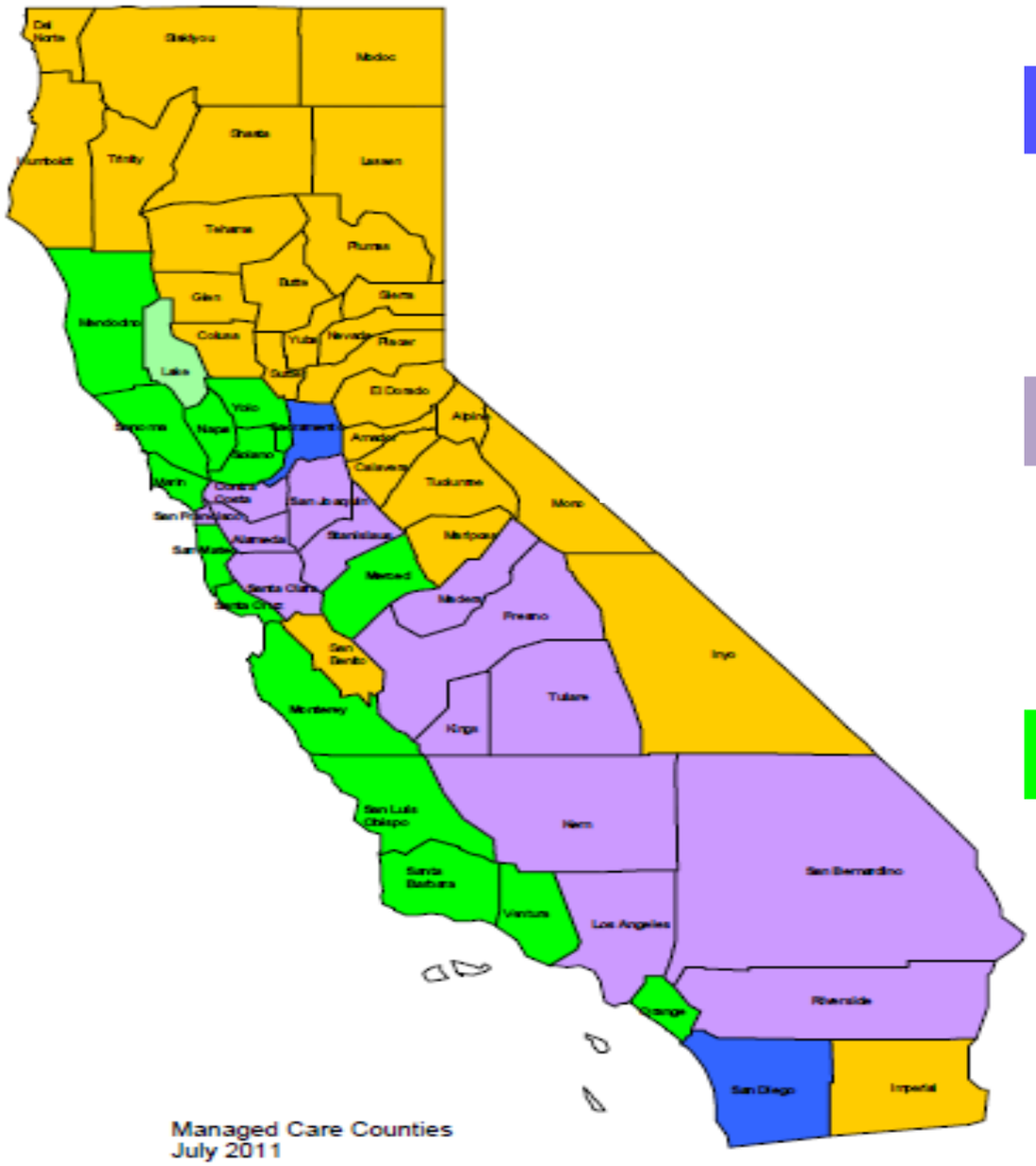
Medicare

- Hospital services
- Physician services
- *Temporary* skilled nursing facility
- Rehabilitation services
- Home health services
- Dialysis
- Durable medical equipment
- Prescription drugs
- Hospice

Demonstration – Goals

- **Improve health and quality of life.** We want recipients to get the right care at the right time and place.
- **Keep people at home.** We want to help keep recipients where they want to be – in their homes and communities.
- **Align incentives to create efficiencies.** We want to streamline financing and align incentives to promote seamless access to beneficiary-centered care delivery models.

Medi-Cal Managed Care Models



Managed Care Counties
July 2011

Geographic Managed Care (GMC)

- State contracts with various commercial plans in county (2 Counties)

Two Plan:

- State contracts with one local public plan and one commercial plan (14 Counties)

County Organized Health System:

- State contracts with a local public plan (14 Counties plus one proposed County)

Of the 7.6 million Medi-Cal beneficiaries, 4.3 million are enrolled in a Medi-Cal Managed Care Plan

Coordinated Care Initiative Timeline

Duals Demonstration Work Plan 2012

Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec

Announce Demo Sites (April)
State Posts Draft Demo Proposal for Public Comment (April)

Stakeholder Workgroups Meet (April – June)
Demo sites Develop Local Stakeholder Process (April - ongoing)

State Submits Demo Proposal to CMS (May)
CMS posts CA Demo Proposal for Public Comment (May)
Release matched data to downstream users (May)

CMS Approval of Demo Proposal (June)

Rate negotiations with CMS (Summer)

State Budget Passes (July)
CMS – DHCS Finalize MOU (July)
Demo sites receive readiness tool and draft rates (July)

DMHC/DHCS Conduct Readiness Reviews (July-August)

Demos Execute 3-way contracts (Eary Sept)
1st beneficiaries notices mailed (Mid-Sept)
Enrollment materials mailed (October)
Enrollment starts (Jan.1)

The Duals Demonstration and Managed Care Timeline Under CCI

IHSS under Care Coordinated Initiative

- The Long Term Services and Support (LTSS) section of the CCI trailer bill is a major change for the home and community based service programs, and,
- Continues to require further discussion and stakeholders' input for new approaches in coordination, partnership and integration of services and funding.

IHSS under Care Coordinated Initiative

Intent language continues on the benefits of the CCI proposal – such as –

- Reduced fragmentation between health and social services between Medi-Cal and Medicare;
- Outlines what managed care plans will be required to do; and
- Identifies outcomes such as prevention and reduction of hospital stays and nursing home stays for this population.

IHSS under Care Coordinated Initiative

CCI defines LTSS Programs as:

- IHSS
- CBAS
- MSSP
- Other HCBS Waivers
- Nursing Facilities

IHSS under Care Coordinated Initiative

LTSS Timeline and Activities

- Integration begins July 1, 2012 with CBAS becoming an integrated benefit under managed care.
- Integration begins Jan. 2013 with IHSS, MSSP, Nursing Facilities and other HCBS waiver becoming managed care benefits in the Dual Demonstration Counties.
- This process continues in 2014 - as part of the expansion of Medi-Cal Managed Care in the remaining managed care counties.
- This is completed in 2015 as the 28 fee-for-services counties phase into managed care.

IHSS under Care Coordinated Initiative

IHSS:

- The CCI structure is designed to preserve the current IHSS program's core principles, protections and services for which the program has been known for-- over the last 30 years.
- The LTSS section identifies key operational areas in IHSS – and specifically how these components will be integrated into Managed Care.

What IHSS will look like under Managed Care – **What is the same?**

Recipient Role:

- Recipients will continue to be the employer with the ability to hire, fire and direct their service providers.
- Recipients will continue to be able to request an IHSS needs assessment any time they have a change in condition or living arrangement.
- Recipients will continue to be able to appeal any decision concerning their services in which they disagree.

What IHSS will look like under Managed Care – **What is the same?**

Provider Role:

- IHSS providers will still be fingerprinted and go through the provider enrollment process.
- IHSS providers will continue to be paid by CDSS through the Case Management Information and Pay-rolling System (CMIPS), and all the other functions will continue such as direct deposit, taxes, etc.

What IHSS will look like under Managed Care – **What is the same?**

County Role:

Counties will continue their traditional role in the IHSS Program:

- IHSS social workers will perform all assessments and make the final determination of Recipient authorized hours.

What IHSS will look like under Managed Care – **What is the same?**

Public Authority:

- Public Authority will continue to administer the health benefits for IHSS providers, maintain a provider registry, train providers, and engage in collective bargaining for the purposes of wages, hours, and other terms and conditions of employment.

What IHSS will look like under Managed Care – **What is the same?**

State Role:

- CDSS and DHCS will continue their roles providing Quality Assurance and program oversight.
- CDSS will continue to perform all payroll activities.

What IHSS will look like under Managed Care – **What is new?**

Care Coordination Teams

- County Social Workers will work with Managed Care Plans and participate on Care Coordination Teams.
- These teams will be used as needed for complex care cases to assist in an overall plan that will improve health outcomes. Also,
    - It would be the recipient's choice to have a Care Team
    - It would be their choice if they wanted to participate on the team
    - It would be their choice to have their IHSS provider on the team.

What IHSS will look like under Managed Care – **What is new?**

Care Coordination Teams (Con't)

- We plan to discuss with counties, managed care plans and stakeholders the details of how the teams will be structured at the next IHSS Integration Workgroup.
- Our second meeting convenes May 17th.
- After these meetings we will be able to provide greater clarity.

What IHSS will look like under Managed Care – **What is new?**

HCBS Universal Assessment:

- In 2015 CCI proposes transitioning to a Universal Assessment for all Home and Community Based Services.
- Development of the Universal HCBS Assessment tool will reflect a robust stakeholder workgroup process that is scheduled to start June 1, 2013.
- Many aspects of the tool and how it will be used will be developed in the workgroup, but it will be built on:

What IHSS will look like under Managed Care – **What is new?**

HCBS Universal Assessment (Con't):

- The existing IHSS Uniform Assessment, Hourly Task Guidelines and other appropriate HCBS assessment tools and designed in CMIPS II.
- Health Plans will contract with the counties for the assessment and counties continue to make the final determination of authorized hours and services
- Health plans will use the Universal HCBS Assessment tool for other non-IHSS services such as MSSP, CBAS, and HCBS Waiver services.

What IHSS will look like under Managed Care – **Issues to be finalized**

IHSS Appeals Process:

Each CCI program has its own appeals and grievance process:

- Medicare, Medi-Cal, Managed Care Plans, and IHSS
- CMS, DHCS and CDSS are working to clarify what appeals and grievance process will be implemented in the LTSS

What IHSS will look like under Managed Care – **Issues to be finalized**

IHSS Appeals Process (Con't):

- Counties issue IHSS NOA and right to Appeal through CMIPS – and it would take a great deal of work to modify.
- In the short term, the current IHSS Appeals process will remain the same.
- In the future, streamlining these processes maybe a viable option.

QUESTIONS?

BREAK

IHSS Intake Process

How IHSS Works today - Intake

Please refer to supplemental IHSS flow chart

IHSS Assessment

- The State provides IHSS assessment training to social workers to help for consistency in authorization of hours for staff performing assessments across the state.

- An IHSS assessment includes:
  - Face-to-face interview in home
  - Functional index scale
  - Performance based assessment
  - Reviewing other resources for information

Managed Care Intake Process

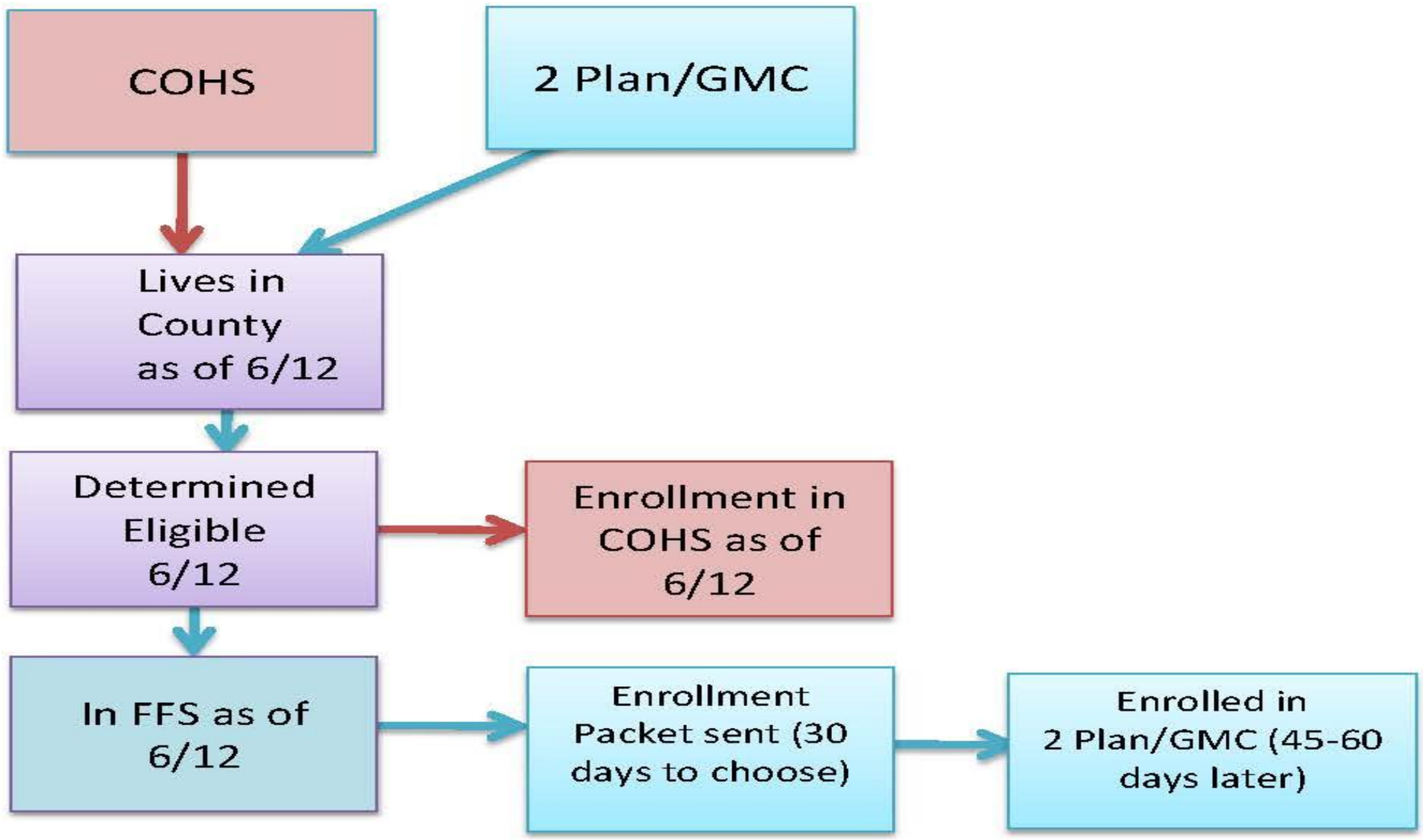
Why Managed Care?

- Provides a “Point of Accountability”, by contract that:
  - Requires a plan to provide access
  - Holds plan accountable for quality care
  - Holds plan accountable for maintaining financial sustainability within a state determined, fixed per member per month premium

- Provides a structure to align incentives to improve quality, outcomes and community health status

- Improves budget predictability and potential for cost savings

Managed Care Enrollment Process



Enrollment Process: Two-Plan/GMC Counties

- In Two-Plan/GMC counties, all eligibles are sent an enrollment packet after being determined Medi-Cal eligible.

- Mandatory beneficiaries must choose a plan within 30 days.

- Voluntary beneficiaries (dual eligibles) can remain in Fee-for-Service (FFS) or enroll in a plan.

Enrollment Process: Two-Plan/GMC Counties

- Not eligible for enrollment – Other Healthcare Coverage (OHC), Share of Cost (SOC), Limited Scope

- Enrollment in the plan is prospective. Prior services received are covered through FFS.

- If no choice is made, beneficiary is defaulted into a plan.

Enrollment Process: COHS Counties

- In COHS counties, all full-scope beneficiaries are enrolled in the sole Medi-Cal plan that operates in the county, upon determination of Medi-Cal eligibility.

- Plan enrollment can be retroactive depending on when the beneficiary was determined eligible for Medi-Cal.

- No enrollment packet sent, system enrollment.

- Plan sends a welcome packet 10 days after initial enrollment.

Health Risk Assessment (HRA)

- Medi-Cal only beneficiaries classified as Seniors and Persons with Disabilities (SPD) receive a health risk assessment upon initial enrollment.

- This requirement currently only applies in Two-Plan/GMC counties, but will be in place in COHS counties in November 2012.

- FFS and member-submitted information is provided to the plans to allow them to stratify high- and low-risk SPDs within 44 days.

Health Risk Assessment (HRA)

- For members classified as high-risk, the assessment must be completed within 45 days.

- For members classified as low-risk, the assessment must be completed within 105 days.

- The plan develops an individual care plan that best meets the member’s needs, including care management.

Health Risk Assessment (HRA)

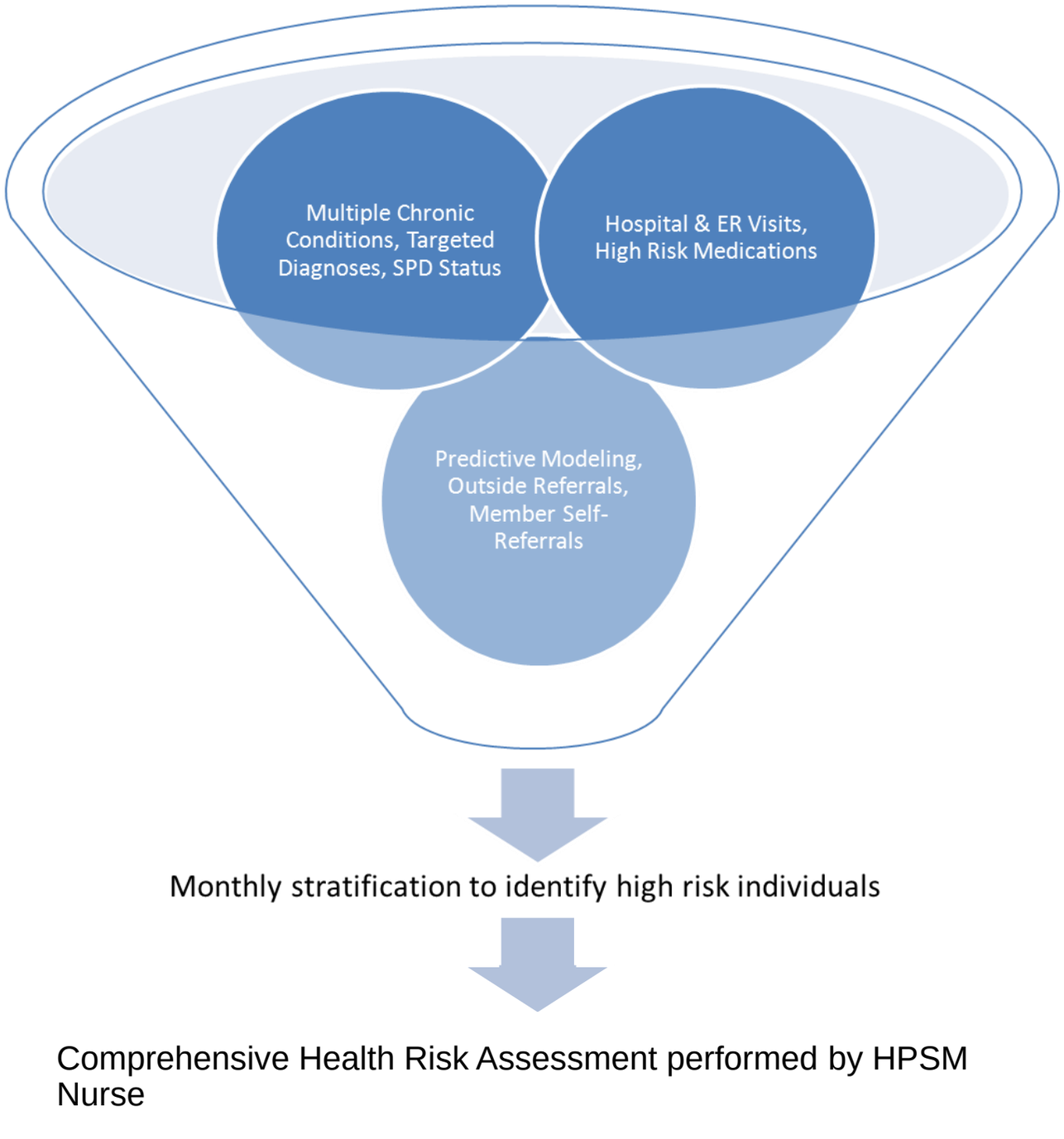
- The care management provided is either basic or complex, based on each member's assessment.

- Additional information on the HRA can be found in Managed Care Policy Letter 11-007.

- http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-007.PDF

How a Recipient Accesses Care - Intake

HPSM Medicare Special Needs Plan Current Dual Eligible Risk Identification



How a Recipient Accesses Care - Intake

Risk-Based Interventions

Case Management for High Risk Duals

(~25% of population)

- Entry into Case Management Program (member may decline participation)
- Member notified of single point of contact at HPSM
- Patient-centric care plan with short- and long-term goals by interdisciplinary care team, coordinated by Nurse Case Manager
- Patients followed through continuum of care, including post-acute follow-up to ensure timely access to essential services (home health, physician follow-up, etc.)
- Dynamic care plans updated with change in health status
- Communication with members and PCPs to ensure coordinated care
- Add-on services based on need (in-home physician, LTC clinical management, Medication Therapy Management Program with on-site pharmacist, Behavioral Health, Aging and Adult Services, etc.)
- Nurse Case Manager support with services and medical referrals
- Member education on health maintenance, health promotion, and community resources

Some of the Touch-points between the systems that can be built on?

- Application/referral to and from covered service
- Confirm Medi-Cal eligibility
- Confirm Medical Necessity for IHSS, Paramedical and Protective Supervision
- Assess functioning and assign Functional Index Ranking
- Advocacy
- Discharge planning from hospital and SNF/ICF
- Identify Alternative Resources and make referrals

What's Next?

<u>Meeting #2</u>: Thursday, May 17, 10:30am to 1pm

Intake Processes & Coordinated Care Teams (CCT)

1. Panel on Intake Process with the Plan and County Perspective
2. Coordinated Care Teams

<u>Meeting #3</u>: Thursday, June 14, 2 to 4pm

System Readiness

1. Readiness- What does County and Plan readiness look like?
2. Data- What data is needed for coordination?
3. Outcomes- What evaluation outcomes should be looked at for IHSS?