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Governor's Coordinated Care Initiative
Long-Term Services and Supports

This document provides details on the Long-Term Services and Supports component of the Governor's Coordinated Care Initiative (CCI). The budget trailer bill language for this component will be released shortly.

The Governor's Budget proposes to include long-term services and supports (LTSS) as managed care plan benefits for all Medi-Cal beneficiaries [dual eligibles and Medi–Cal only Seniors and Persons with Disabilities (SPDs)], using a three-year phased in approach. Medi-Cal managed care health plans would integrate medical services with the full continuum of long-term services and supports (LTSS), including In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Programs (MSSP), nursing facilities, and 1915 (c) home and community-based services waiver programs. This integration would be achieved through enhanced care coordination between managed care plans and LTSS providers, and incorporating all LTSS costs into the capitation rate paid to Medi-Cal managed care health plans.

This proposal would require Medi-Cal beneficiaries to enroll in Medi-Cal managed care plans to access all LTSS. This requirement would be implemented in conjunction with the budget proposal for mandatory enrollment in Medi-Cal managed care for dual-eligible beneficiaries for their Medi-Cal medical benefits, described in trailer bill language previously released. It is important to note that a significant number of Medi-Cal beneficiaries are already enrolled in Medi-Cal managed care plans for their Medi-Cal medical benefits under current law, including SPDs in managed care counties, all beneficiaries in counties with a County-Organized Health System (COHS), and some dual eligible beneficiaries in other counties (on a voluntary basis).

Many of the policy changes described here will require stakeholder discussions to develop additional details and implementation plans.

Additional Note: The implementation timeline for this proposal has been modified from the information provided in early January. Rather than implement LTSS as a Medi-Cal managed care benefit in all managed care counties in 2013, implementation would follow the schedule of counties implementing the dual demonstration project, as outlined below.

County Implementation Schedule for LTSS as Managed Care Plan Benefits

1. **Year 1:** Jan 1, 2013 - Dec 31, 2013: LTSS would be available only as managed care plan benefits in up to 10 counties, the same counties that are selected as dual demonstration project sites. The selection process for those counties is currently underway by the Administration, in conjunction with the federal Centers for Medicare and Medicaid Services (CMS) and stakeholder input. Note that CBAS becomes a managed care plan benefit in all 30 managed care counties July 1, 2012, to conform to the Adult Day Health Care (Darling v. Douglas) settlement agreement.

2. **Year 2:** Jan 1, 2014 - Dec 31, 2014: LTSS will become managed care benefits in the remaining 20 Medi-Cal managed care counties as the Dual demonstration project is expanded to these counties in 2014.

3. **Year 3:** Jan 1, 2015 - Dec 31, 2015: Implementation would be expanded to the 28 current fee-for-service counties. These counties would transition to Medi-Cal managed care beginning in June 2013 and would begin participation in the Dual demonstration project in January 1, 2015.

Enrollment Phase-In and Exemptions

1. **Dual Eligible Enrollment in Medi-Cal Managed Care, Compared to LTSS Managed Care Phase-In:** As described in the previously released trailer bill language, dual eligible beneficiaries in all current managed care counties would be mandatorily enrolled in Medi-Cal managed care for their Medi-Cal medical benefits over 12-month period, beginning Jan 1, 2013. However, Medi-Cal managed care plan benefits would be expanded to include LTSS over a three-year period by county, from Jan 1, 2013 through Dec 1, 2015, per the schedule described in the previous section.

2. **Enrollment Phase-In:** In consultation with stakeholders, the Administration is developing a beneficiary phase-in process for accessing LTSS through managed care plans. This process may vary by year and by county, to reflect the fact that many beneficiaries are already enrolled in Medi-Cal managed care, and dual eligible beneficiaries would complete their enrollment in managed care for medical benefits by the end of 2013. However, in Year 1, for dual eligible beneficiaries in 2-Plan and Geographic Managed Care counties, implementation of LTSS as a managed care benefit would take place concurrent with mandatory enrollment in Medi-Cal managed care, likely phased-in by birth month.

3. **Exempt Beneficiaries:** Certain beneficiaries would not be required to receive LTSS through managed care, including those with other health coverage or in foster care, except in COHS counties where these beneficiaries are already mandatorily enrolled in managed care. Both these beneficiaries and others who have not yet phased-in to Medi-Cal managed care enrollment would continue to access LTSS as fee-for-service benefits. PACE and AIDS Healthcare Foundation participants could choose to remain in their program for LTSS, or switch to another managed care health plan.

LTSS Uniform Assessment Tool

1. **Development:** The Department of Health Care Services, Department of Social Services, and Department of Aging would lead a stakeholder process to develop a Uniform Assessment Tool for all LTSS starting June 2013, to be implemented upon completion of design, development, system testing, and training, no earlier than January 1, 2015.

2. **Purpose:** This tool would be used by managed care health plans, county social service agencies for IHSS, CBAS providers, MSSP sites, other home and community-based providers, and institutional nursing facility providers to assess the need for LTSS. It would incorporate and consolidate the disparate array of LTSS assessment tools. Note that this tool would be separate from and would not replace the assessment process used by managed care plans when beneficiaries initially enroll. That initial assessment process is further described in the previously released CCI trailer bill language in Section14182.17 (b) (2).

Multipurpose Senior Services Program, Community-Based Adult Services, Nursing Facilities, and Home and Community-Based Waiver Programs

1. **MSSP:** In 2013, for Medi-Cal beneficiaries in the ten initial counties in the dual demonstration, MSSP would only be available as a managed care benefit. The current eligibility process would remain in place in 2013, and plans would be expected to contract with MSSP sites. In 2014, the managed care requirement established in 2013 would be applicable to all 30 of the current managed care counties. Additionally, in 2014, managed care plans would be permitted to contract with MSSP sites or hire and incorporate the MSSP staff into the health plan's care management team. In 2015, MSSP would only be available as a managed care plan benefit, in all counties using the uniform assessment tool.

2. **CBAS:** CBAS will become a managed care plan benefit in all managed care counties in July 1, 2012, to conform to the Adult Day Health Care (Darling v. Douglas) settlement agreement.

3. **Nursing Facilities and Home- and Community-Based Waiver Programs**: Starting in 2013, for Medi-Cal beneficiaries in the initial ten counties in the dual demonstration, institutional Nursing Facility and Home and Community-Based Waiver programs would only be available as managed care plan benefits. The plans would authorize institutional nursing facility services in 2013. In 2014 this policy would be expanded to the remaining 20 managed care counties, and in 2015 this policy would be expanded to the remaining counties that are currently under fee-for-service Medi-Cal.

4. **2015: LTSS Uniform Assessment Tool:** Upon completion, a new Uniform Assessment Tool would be implemented in all counties, and would be used for IHSS, MSSP, CBAS, Nursing Facilities, and Home- and Community-Based Waiver programs.

In-Home Supportive Services (IHSS)

The following changes would be implemented over a three year period according to the County Implementation Schedule and Enrollment Phase-In described above. For example, in 2013 the Year 1 provisions below would only apply to the first ten dual demonstration counties. In 2014 the same provisions, along with the IHSS Year 2 modifications, would apply to both the ten initial demonstration counties, plus the remaining current managed care counties.

<u>IHSS in 2013 (10 counties):</u>

1. **Care Coordination Teams:** Health plans would establish care coordination teams that would include the consumer, health plan, and county social service agency, and may include others.

2. **Counties Assess and Authorize IHSS Hours in Coordination with Health Plans**: 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.

3. **Health Plans at Financial Risk for IHSS Costs:** 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.

4. **Additional Assessments for Change in Circumstances:** Health plans and counties would coordinate any additional IHSS assessments as needed, such as upon release from a hospital or other changes in circumstances.

5. **CDSS Continues All Current Payroll Functions and Support Activities:** The state Department of Social Services would continue to perform payroll functions for IHSS providers.

6. **Case Management, Information, and Payrolling System (CMIPS):** CMIPS would continue to track case information and process provider payments. Development and implementation of CMIPS II would continue.

<u>IHSS in 2014 (10 initial counties plus the additional 20 managed care counties):</u>

1. **Continue IHSS Changes in Remaining Managed Care Counties:** The IHSS program changes established in ten counties in 2013, as described above would be implemented in the remaining 20 counties that currently have Medi-Cal managed care.

2. **Joint Determination of 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 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.

3. **Financial Incentives for Improved Care:** IHSS would be funded by health plans, and counties' share of cost would no longer be a fixed percent of all nonfederal costs (see Maintenance of Effort section below). As such, health plans would establish financial incentives for counties to reduce institutional care and achieve other performance objectives, similar to the pay for performance contracts that health plans currently have with some health providers.

IHSS in 2015 (all counties):

1. **Continue IHSS Changes in All Counties:** The 2014 IHSS program changes would be implemented in all remaining counties in 2015, through the expansion of Medi-Cal managed care.

2. **Uniform Assessment Tool:** Upon completion, a uniform assessment tool (see above) would be used by counties and health plans to assess IHSS hours, in all counties.

Funding Structure for IHSS

1. **Overall Funding Structure:** State General Funds appropriated to the Department of Social Services for IHSS would be consolidated at the Department of Health Care Services, and used to pay managed care health plans, as part of the capitation rate, for IHSS provider wages and benefits for plan members. Managed care health plans would remit payment for IHSS costs billed by the Department of Social Services. In addition, managed care plans would contract with counties for IHSS assessment, eligibility, and related activities.

2. **New County Maintenance of Effort (MOE):** To provide managed care plans with full financial risk for all LTSS, including IHSS costs, the county share of cost for IHSS would be used for the managed care capitation payment. In addition, a new MOE for county spending on IHSS would be established, which would take into account current expenditures and trends. The MOE for each county is envisioned to be established by applying an escalation factor to actual expenditures in a base-year.

3. **MOE Transition Timeline:** The new MOE would be implemented on January 1, 2013 in the initial ten counties, on January 1, 2014 for the remaining 20 managed care counties, and on January 1, 2015 for the remaining counties.

4. **IHSS Under Fee-for-Service:** For various reasons, some IHSS consumers would not be enrolled in managed care for LTSS, for at least a portion of a given year. These include consumers that are transitioning to managed care under a phased-in enrollment process. The County MOE would include the county share for all IHSS consumers in a county, regardless of the managed care status of the consumer. The provider payments for these consumers would continue to be administered by the California Department of Social Services for payroll purposes.