

The 2013-14 Budget:

# Coordinated Care Initiative Update



MAC TAYLOR • LEGISLATIVE ANALYST • FEBRUARY 2013

2013-14 BUDGET

## EXECUTIVE SUMMARY

About 1.9 million seniors and persons with disabilities (SPDs) are enrolled in Medi-Cal, the state-federal program providing medical care and long-term services and supports (LTSS) to low-income persons. The majority of SPDs are also eligible for Medicare, the federal program that provides medical services to qualifying persons over age 65 and certain persons with disabilities. The SPDs who are eligible for both Medi-Cal and Medicare are known as “dual eligibles” and receive services paid by both programs.

**State Law Authorizes Coordinated Care Initiative (CCI).** In June 2012, the Legislature authorized CCI as an eight-county pilot project to (1) integrate Medi-Cal and Medicare benefits under managed care for dual eligibles and (2) integrate LTSS—including In-Home Supportive Services (IHSS), the program that provides in-home personal care and related domestic services for many SPDs—under managed care for dual eligibles and Medi-Cal-only SPDs.

**Governor Proposes Implementation Delay and Revised Enrollment Schedule.** The 2012-13 Budget Act assumed implementation of CCI would begin in March 2013. In his 2013-14 budget, the Governor proposes to delay the start date of CCI implementation to September 1, 2013, resulting in lower 2013-14 savings than initially anticipated. The Governor also proposes a one-time enrollment of dual eligibles into managed care in San Mateo County, and a 16-month enrollment period for dual eligibles in Los Angeles County.

**As State Conducts CCI Preparations and Negotiations With Federal Government . . .** The state is preparing for oversight and other activities related to CCI. However, key financing and operational aspects of CCI will be informed by a memorandum of understanding (MOU) between the federal Centers for Medicare and Medicaid Services (CMS) and the state (hereinafter referred to as the “demonstration MOU”). At the time of this analysis, the state and CMS continue to hold MOU discussions without having reached an official agreement.

**. . . CCI Faces Implementation Challenges.** The lack of the demonstration MOU creates uncertainty regarding the timely and successful implementation of CCI. The demonstration MOU will establish the enrollment process for beneficiaries and the rate-setting framework for managed care plans—both crucial determinants of plans’ abilities to effectively manage care for beneficiaries. Further, we believe that under current law, the state’s failure to reach an MOU agreement with CMS, or to receive adequate indication of pending approval, by February 1, 2013, generally renders authorizing language for CCI inoperative on March 1, 2013.

**Integration of IHSS Under Managed Care Is Problematic.** The CCI legislation authorizes managed care plans participating in the eight-county demonstration to provide additional IHSS hours to beneficiaries as needed. However, these plans do not have the authority to reduce IHSS hours assessed by county social workers. We find this problematic because the plans, as risk-bearing organizations, should as a general principle have the authority to determine the level of utilization for services that are factored into their capitated rate payments.

**Analyst’s Recommendations.** We recommend that the Legislature amend the authorizing statute of CCI to clarify the legal status of the project to go forward. To address the concerns we

raise about the integration of IHSS under managed care, we recommend that the Legislature use CCI as an opportunity to test the full integration of IHSS as a managed care benefit with at least one demonstration plan in the third year of CCI. This would enable the Legislature to compare the advantages and trade-offs of two distinct models of integrating IHSS under managed care: (1) in the first two years, a more restrained approach that mainly relies on care coordination between demonstration plans and county welfare departments and (2) in the third year, a fully integrated approach among plans prepared for such a shift.

## Introduction

About 1.9 million SPDs are enrolled in California's Medicaid program (known as Medi-Cal), the state-federal program providing medical and long-term care services to low-income persons. The majority of SPDs are also eligible for Medicare, the federal program that provides medical services to qualifying persons over age 65 and certain persons with disabilities. The SPDs who are eligible for both Medi-Cal and Medicare are known as dual eligibles and receive services paid by both programs.

As part of his 2012-13 budget, the Governor proposed the CCI to (1) integrate Medi-Cal and Medicare benefits for dual eligibles and (2) integrate LTSS into Medi-Cal managed care health plans. The Legislature adopted a modified version of the Governor's CCI proposal in Chapter 33, Statutes of 2012 (SB 1008, Committee on Budget and Fiscal Review) and Chapter 45, Statutes of 2012 (SB 1036, Committee on Budget and Fiscal Review).

Although the Governor originally proposed statewide expansion of CCI to all 58 counties within three years, Chapter 33 provides statutory authorization for up to eight demonstration counties and requires that expansion beyond the initial eight counties be contingent on statutory authority and a subsequent budget appropriation. Chapter 33 also increases the Legislature's oversight of CCI by placing reporting, monitoring, and other requirements on the administration. Chapter 45 primarily makes changes to IHSS, including changes to counties' share of cost for IHSS and a shift to statewide collective bargaining for IHSS provider wages and benefits—beginning with the eight demonstration counties. Chapter 45 also requires a stakeholder workgroup to develop a universal assessment tool for home- and community-based services (HCBS).

This analysis provides an update on CCI implementation, beginning with a brief overview of the Medi-Cal and Medicare programs and the populations they serve. We describe recent opportunities to improve care coordination of SPDs under federal-state partnerships. We then go on to summarize (1) key provisions of CCI as enacted, including oversight requirements, and (2) preparations currently underway to implement these provisions. The Governor has proposed changes to the implementation schedule assumed in the *2012-13 Budget Act* that would affect savings in 2012-13, 2013-14, and future years. We summarize the Governor's proposed changes and their potential effects. Lastly, we analyze important areas of CCI implementation that remain uncertain.

At the time this analysis was prepared, joint federal-state decisions regarding key financing and operational aspects of CCI were pending. We discuss implementation changes and a reevaluation of estimates of savings from CCI implementation that may need to occur depending on the outcome of these decisions. We also recommend the Legislature enact statute to address legal issues raised due to the lack of the demonstration MOU between CMS and the state. Such legislation is needed to clarify and confirm the Legislature's intent to proceed with CCI implementation.

## Background

In this section, we provide a brief overview of the Medi-Cal and Medicare programs and the populations that they serve. (For extensive background information on Medicare, Medi-Cal, LTSS, and managed care—please see our report *The 2012-13 Budget: Integrating Care for Seniors and Persons With Disabilities*.) We also provide an overview of federal-state partnerships to better coordinate care for dual eligibles and discuss CCI in particular.

***Medicare Is a Federal Health Insurance***

**Program.** Medicare is the federal health insurance program for qualifying persons over age 65 and certain people with disabilities, and is overseen by CMS. Medicare pays for most physician and hospital care and pharmacy benefits for program beneficiaries. Medicare also covers certain mental health services, including outpatient community-based treatment and most acute inpatient psychiatric admissions. Medicare beneficiaries generally pay for their benefits through cost-sharing arrangements such as premiums, deductibles, coinsurance, and copayments.

***Medi-Cal Is a Federal-State Health Program.***

As a voluntary joint federal-state health care program, federal funds are available to the state for the provision of health care services for low-income families with children and SPDs. California receives a 50 percent Federal Medical Assistance Percentage—meaning the federal government pays for one-half of most Medi-Cal costs.

Medi-Cal provides a wide range of health-related services, including hospital inpatient and outpatient care, doctor visits, coverage of prescription drugs, and durable medical equipment. Medi-Cal also provides substance abuse treatment services and an array of mental health services for beneficiaries with mild and serious mental illnesses. These benefits are largely provided at the county level through county-administered mental health plans and substance abuse programs.

In addition to the medical goods and services described above, Medi-Cal provides a variety of LTSS that are commonly categorized into two types: (1) institutional care, such as skilled nursing facilities (SNFs), and (2) HCBS aimed at preventing unnecessary hospitalizations and SNF stays and maintaining people in the community. Major Medi-Cal LTSS include:

- ***IHSS.*** The IHSS program provides in-home care for people who cannot safely remain in their own homes without such assistance.
- ***Community-Based Adult Services (CBAS).*** The CBAS program is an outpatient, facility-based service program that provides services to program participants by a multidisciplinary staff, including: professional nursing services; physical, occupational, and speech therapies; mental health services; therapeutic activities; social services; personal care; meals and nutritional counseling; and transportation to and from the participant's residence.
- ***Multipurpose Senior Services Program (MSSP).*** The MSSP benefit provides both social and health care management services for Medi-Cal recipients aged 65 or older who meet the eligibility criteria for a SNF.
- ***SNFs.*** The SNFs provide nursing, rehabilitative, and medical care to facility residents. Generally, SNF residents receive their medical care and social services at the facility.

***Medi-Cal and Medicare Interact.*** Under federal law, Medi-Cal is the payer of last resort for health care. This means that all other third party sources of health coverage for Medi-Cal beneficiaries, including Medicare, must be exhausted prior to any Medi-Cal reimbursement for health care. Accordingly, Medicare pays for most physician, hospital, and prescription drug (pharmacy) benefits for dual eligibles, with Medi-Cal covering a smaller portion of these costs—known as “wraparound coverage.” However, Medi-Cal pays for some benefits that Medicare does not cover, such as extended stays in SNFs.

**Services Are Provided Through Two Main Systems.** Medi-Cal and Medicare provide health care through two main systems: fee-for-service (FFS) and managed care. In a FFS system, a health care provider receives an individual payment for each medical service provided. In a managed care system, managed care plans receive a capitated rate in exchange for providing health care coverage to enrollees. For some Medi-Cal beneficiaries, enrollment in managed care is mandatory. However, for Medicare beneficiaries, enrollment in managed care is voluntary.

**Most Dual Eligibles Currently Receive Care Under FFS System.** Most of the 1.2 million dual eligibles in California currently receive both their medical and LTSS benefits under FFS. Although more than half of the 700,000 Medi-Cal-only SPDs have been mandatorily enrolled in Medi-Cal managed care for their medical benefits, they also continue to receive most LTSS benefits under FFS.

**SPDs Are an Expensive Population to Serve.** Generally, SPDs are more expensive to serve than other Medi-Cal beneficiaries because of the higher prevalence of complex medical conditions and greater functional needs within this population. In 2011-12, SPDs represented 25 percent of enrollment but 60 percent of General Fund expenditures in the Medi-Cal Program. The high cost of SPDs may be exacerbated by the fragmentation of care under the current framework, in which Medi-Cal FFS, Medi-Cal managed care, and Medicare function in silos.

### **Overview of Federal-State Partnerships for Care Coordination**

The federal government has embarked on partnerships with some states, including California, to test demonstrations of new payment and service delivery models for dual eligibles. Broadly, the goal of these “duals demonstrations” is to reduce program costs while improving quality of care for

dual eligibles by aligning financial incentives across Medicare and Medicaid. In May 2012, California submitted its duals demonstration proposal to CMS. Under the proposed demonstration, Medi-Cal and Medicare—subject to an MOU between the Department of Health Care Services (DHCS) and CMS—will jointly contribute to a capitated rate to managed care plans, in exchange for those plans administering and paying for medical care and LTSS for dual eligibles.

### **Overview of CCI**

The CCI will make broad changes to how dual eligibles and Medi-Cal-only SPDs receive health services and LTSS. The CCI will incorporate two sets of benefits into managed care: (1) LTSS for all SPDs and (2) Medicare benefits for dual eligibles.

**Duals Demonstration to Integrate Medicare and Medi-Cal Benefits in Managed Care.** Under Chapter 33, the state’s duals demonstration will take place for three years and involve most dual eligibles residing in eight demonstration counties, as displayed in Figure 1 (see next page).

Chapter 33 specifies that no sooner than March 1, 2013, dual eligibles in the eight demonstration counties will undergo (1) a mandatory shift from Medi-Cal FFS to Medi-Cal managed care plans and (2) a passive—though optional—shift into the same managed care plans for their Medicare benefits, as follows.

- **Dual Eligibles Will Be Required to Enroll in Medi-Cal Managed Care.** The CCI will require most dual eligibles in the eight demonstration counties to enroll in managed care plans to access their Medi-Cal benefits. These plan benefits will include LTSS.
- **Dual Eligibles Will Be Passively Enrolled in Managed Care Plans for Medicare.** The CCI will enable dual eligibles in the

eight demonstration counties to receive their Medicare benefits through the same managed care plans that provide their Medi-Cal benefits. Chapter 33 specifies both (1) *passive enrollment*, in which dual eligibles will be automatically enrolled in managed care plans for their Medicare benefits unless they make the initial choice to opt out, and (2) *stable enrollment*, in which dual eligibles—once enrolled in managed care plans for their Medicare benefits—will be required to remain in the same plans for six months before being allowed to switch to FFS or other plans.

**Shift LTSS for SPDs Into Medi-Cal Managed Care.** In addition to authorizing the duals demonstration, CCI will shift IHSS, MSSP, and SNF benefits from FFS to managed care for most dual eligibles and Medi-Cal-only SPDs in the

eight demonstration counties. We note the CBAS program has been a Medi-Cal managed care benefit in counties that currently have Medi-Cal managed care plans—including the eight demonstration counties—since November 2012. Chapter 33 requires that the shift of the remaining LTSS benefits to Medi-Cal managed care take place no sooner than March 1, 2013.

**CCI-Related Changes to IHSS.** Chapter 45 makes major changes to IHSS, including (1) the creation of a County IHSS maintenance-of-effort (MOE) requirement for all 58 counties, (2) a transition from local to statewide collective bargaining for IHSS provider wages and benefits, and (3) the development of a universal assessment tool for IHSS, CBAS, and MSSP.

- **County IHSS MOE.** Historically, for almost all IHSS recipients, 50 percent of program costs were paid for by the federal government, with 32.5 percent paid for by the state and 17.5 percent by the counties. Chapter 45 alters the historical county contribution by enacting a county IHSS MOE, which replaces the county contribution of 17.5 percent with a requirement that counties generally maintain their 2011-12 expenditure level for IHSS beginning in 2012-13, to be adjusted annually for inflation beginning in 2014-15. All increases in the non-federal share of IHSS costs above the county IHSS MOE are borne

**Figure 1**  
**Dual Eligible Population and Managed Care Plans Participating in CCI in Eight Counties**

Demonstration County	Dual Eligibles Affected by CCI	Plans Participating in CCI
Alameda	31,076	<ul style="list-style-type: none"> <li>Alameda Alliance for Health</li> <li>Anthem Blue Cross</li> </ul>
Los Angeles	271,072	<ul style="list-style-type: none"> <li>L.A. Care</li> <li>Health Net</li> </ul>
Orange	57,060	<ul style="list-style-type: none"> <li>CalOptima</li> </ul>
Riverside	34,477	<ul style="list-style-type: none"> <li>Inland Empire Health Plan</li> <li>Molina Health Care</li> </ul>
San Bernardino	36,368	<ul style="list-style-type: none"> <li>Inland Empire Health Plan</li> <li>Molina Health Care</li> </ul>
San Diego	50,952	<ul style="list-style-type: none"> <li>Care 1<sup>st</sup></li> <li>Community Health Group</li> <li>Health Net</li> <li>Molina Health</li> </ul>
San Mateo	10,652	<ul style="list-style-type: none"> <li>Health Plan of San Mateo</li> </ul>
Santa Clara	35,245	<ul style="list-style-type: none"> <li>Santa Clara Family Health Plan</li> </ul>
<b>Total</b>	<b>526,902</b>	



by the state's General Fund. If the duals demonstration project and the Statewide Authority (described below) become inoperative pursuant to Chapters 33 and Chapter 45, the county IHSS MOE would be discontinued on the first day of the following fiscal year.

- Statewide Collective Bargaining for IHSS Provider Wages and Benefits.*** Collective bargaining over IHSS provider wages and benefits will transition from the local level to an entity known as the California IHSS Authority, or Statewide Authority, beginning with the eight demonstration counties. Chapter 45 stipulates that this transition from local to statewide collective bargaining will occur upon notification by the county's director of health care services that the enrollment of dual eligibles into managed care plans participating in the demonstration (hereinafter referred to as "demonstration plans") has been completed. If the duals demonstration project becomes inoperative, then the employer of record for the purposes of collective bargaining of IHSS provider wages and benefits reverts back to the county. If the Statewide Authority has entered into contracts with IHSS providers, then the Statewide Authority would remain the employer of record until the contract expires or is subject to renegotiation—at which time the employer of record would become the county.
- Universal Assessment Tool for IHSS, CBAS, and MSSP.*** A stakeholder workgroup will convene no later than June 1, 2013 to develop a universal assessment tool for IHSS, CBAS, and MSSP. Under Chapter 45, the workgroup is

required to build on the IHSS assessment process, the MSSP assessment process, and other appropriate HCBS assessment tools to develop a single assessment tool that can be used to determine a person's level of need for all three HCBS programs. Chapter 45 stipulates that a universal assessment tool will be used no sooner than January 1, 2015.

County social workers will continue to assess IHSS applicants (and reassess IHSS recipients) for eligibility and their level of need for service hours. Under Chapter 45, counties and demonstration plans are required to enter into MOUs to share confidential IHSS recipient information with each other to facilitate care coordination.

***Coordination of Behavioral Health Services.*** Under Chapter 33, demonstration plans are responsible for coordinating access to all medically necessary and appropriate behavioral health services, including mental health services and substance abuse treatment services. However, behavioral health benefits covered by Medi-Cal and delivered by county mental health plans and substance abuse agencies will not be included in the capitated rate paid to the plans because these benefits are "carved out" of state-administered Medi-Cal, in that the counties generally pay for these services out of local realignment revenues. Chapter 33 requires demonstration plans and county agencies to jointly coordinate beneficiaries' access to these behavioral health services.

***Requirements for Oversight.*** Chapter 33 imposes a variety of requirements on the administration related to oversight of CCI, including:

- The development of new tools for monitoring and overseeing demonstration plans, such as network adequacy standards and quality measures for LTSS, in consultation with stakeholders.

- The development of a communications plan to notify beneficiaries of their enrollment rights and options, in consultation with stakeholders.
- The requirement that demonstration plans provide, among other benefits, (1) care coordination and (2) a health-risk assessment process that evaluates beneficiaries' needs for medical, LTSS, and behavioral health services.
- An interagency agreement between DHCS and the Department of Managed Health Care (DMHC) to conduct oversight and readiness reviews of demonstration plans.
- The submission of various reports from DHCS, DMHC, and other departments to the Legislature related to CCI preparations, implementation, oversight, and evaluation.

**Poison Pill Provision.** Chapter 33 contains a “poison pill” provision specifying that if, by February 1, 2013, DHCS has not received CMS’ approval or notification of pending approval for (1) a mutual rate-setting process for managed care plans, (2) a six-month enrollment period for dual eligibles, and (3) an agreement on the methodology to share federal savings in the demonstration project—then authorizing legislation for CCI will become inoperative on March 1, 2013. We address this poison pill provision in greater detail later in this analysis.

## Preparation for CCI Is Underway

Following enactment of Chapter 33 and Chapter 45 in June 2012, many activities related to CCI preparation have been jointly undertaken by the administration, federal government, stakeholders, demonstration plans, and counties. At the time of this analysis, the state and its various implementing partners were still conducting

preparations for CCI. However, the state cannot proceed with CCI implementation until it reaches several important milestones—starting with the demonstration MOU between DHCS and CMS. It is our understanding that demonstration MOU discussions between the state and CMS are ongoing. Later in this analysis, we highlight how the terms of the demonstration MOU will influence later preparations for implementation and oversight. Below, we provide an update on the significant steps already undertaken to prepare for CCI.

### DHCS Has Convened Stakeholder Workgroups

Chapter 33 requires the administration to consult with stakeholders while preparing for various aspects of CCI implementation and oversight. The DHCS has convened six stakeholder workgroups to solicit input and develop standards related to the duals demonstration.

**LTSS and IHSS Integration.** The DHCS convened a stakeholder workgroup to provide recommendations for how to preserve and expand existing HCBS (IHSS, CBAS, and MSSP) as plan benefits within demonstration plans, including:

- **Care Coordination Standards.** The LTSS and IHSS integration workgroup has developed draft care coordination standards for dual eligibles involved in the demonstration as well as for Medi-Cal-only SPDs who will receive LTSS benefits through a demonstration plan in the eight demonstration counties. Care coordination standards will be incorporated into a managed care plan readiness tool used by DHCS and CMS to assess plans’ readiness to implement CCI.
- **LTSS Network Adequacy and Readiness Standards.** The LTSS and IHSS integration workgroup has also developed draft LTSS

network adequacy and readiness standards for IHSS, CBAS, and MSSP, as well as SNFs and sub-acute care facilities.

**Behavioral Health Integration.** The DHCS requires demonstration plans to enter MOUs with county mental health plans and substance use agencies to (1) define roles and responsibilities, (2) establish policies and procedures for sharing information and coordinating care, and (3) develop strategies for shared financial accountability contingent upon CMS requirements. The behavioral health integration workgroup has developed standards related to these criteria.

**Beneficiary Notices and Protections.** The beneficiary notices and protections workgroup developed a draft strategy for beneficiary notification, which includes written notification delivered 90 days, 60 days, and 30 days before enrollment begins as well as follow-up phone calls and partnerships with community organizations. The workgroup has also released a draft education and outreach strategy.

**Quality and Evaluation.** The quality and evaluation workgroup provides recommendations on quality and outcome measures for evaluation of the demonstration. The workgroup has released a draft set of quality metrics, which combines (1) current measures commonly reported by managed care plans and (2) new measures proposed for LTSS. It is the state's intent to tie a subset of these metrics to plans' payments for each year of the demonstration (if a plan's performance or outcomes do not meet a specific threshold, then CMS and DHCS will withhold a portion of reimbursement from the plan—known as a “quality withhold”).

**Provider Outreach.** The provider outreach workgroup is tasked with identifying strategies to expand managed care plans' provider networks. At the time of this analysis, the workgroup had not released a draft document.

**Fiscal and Rate-Setting.** The fiscal and rate-setting workgroup is tasked with providing an understanding of program components and capitated rates for managed care plans. At the time of this analysis, the workgroup had not released a draft document.

### Departments Are Preparing for CCI Oversight

In the discussion that follows, we reference three specific concepts that relate to oversight of demonstration plans.

- **Financial Solvency.** The ability of demonstration plans to fully meet their financial obligations. A financially unstable health plan may be unable to provide quality and timely care to beneficiaries.
- **Network Adequacy.** The ability of dual eligibles enrolled in demonstration plans to access medical, behavioral, and long-term care providers within a reasonable timeframe.
- **Quality.** The extent to which demonstration plans meet performance levels—such as the percentage of enrollees who are seen by their physician following a hospital discharge—specified in (1) Chapter 33; (2) the demonstration MOU; and (3) three-way contracts between DHCS, CMS, and demonstration plans. Data on quality may be self-reported from plans or gathered from on-site audits and facility reviews.

To the extent that oversight and monitoring functions change or expand as a result of CCI, it is largely due to shifting LTSS from Medi-Cal FFS to a Medi-Cal managed care plan benefit in the eight demonstration counties. In the case of the Department of Social Services (DSS), for instance, its traditional oversight role for IHSS continues

under CCI—with some expansion of responsibility because of the need to oversee contractual agreements that will now be entered into by demonstration plans rather than counties for the provision of IHSS.

***DHCS Is Lead Department for Oversight.***

The DHCS is the lead state department for CCI oversight. The demonstration MOU between DHCS and CMS will enumerate their shared responsibility for oversight of the duals demonstration in terms of plan readiness reviews, contract monitoring, and tracking quality and cost as follows.

- ***Plan Readiness Review.*** Prior to executing a three-way contract and enrolling any beneficiaries into a demonstration plan, DHCS and CMS will use a jointly developed tool to assess the plan's ability to meet operational requirements, such as network adequacy, data reporting capabilities, and care coordination model.
- ***Contract Management Teams.*** A joint DMHC-CMS contract management team will monitor each demonstration plan's compliance with the three-way contract.
- ***Monitor, Collect, and Track Data on Quality.*** In its demonstration proposal submitted to CMS, DHCS proposes to monitor, collect, and track data on beneficiary experience, access to care, utilization of services, and other metrics.
- ***Monitor, Collect, and Track Data on Cost.*** The DHCS will work in conjunction with CMS to develop three-year financial projections for Medicare and Medi-Cal, including total combined expenditures and savings.

***DMHC Continues Oversight of Managed Care Plans in Expanded Capacity.*** The DMHC is

responsible for regulating managed care plans in several areas, including financial solvency, network adequacy, and consumer protection. Specifically, DMHC ensures that managed care plans follow the regulatory framework set forth under state law, which addresses mandatory basic services, financial stability, availability and accessibility of providers, review of provider contracts, administrative organization, consumer disclosure, and grievance requirements. For the purposes of CCI, DMHC will enter into an interagency agreement with DHCS to conduct the following CCI-related oversight activities.

- ***Consumer Assistance.*** The DMHC operates a Help Center, which provides assistance to consumers with complaints related to their managed care plans. The DMHC expects this service to expand when dual eligibles begin transitioning to demonstration plans. The role of the Help Center under CCI is primarily to assess and refer beneficiaries to the appropriate entity to assist them. For example, most dual eligible issues related to medical services will be handled through existing Medicare channels.
- ***Network Adequacy.*** The DMHC's Division of Licensing will conduct network adequacy reviews every quarter to ensure demonstration plans meet access and capacity standards. The CMS—as the primary regulatory authority for services covered under Medicare—will monitor network adequacy standards related to medical services for dual eligibles, while DMHC will continue to monitor medical network adequacy for Medi-Cal-only SPDs. Because the demonstration plans will now offer LTSS as plan benefits, DMHC will expand its network adequacy reviews to

incorporate these benefits for all SPDs in the demonstration.

- **Medical Surveys.** The CMS—as the primary regulatory authority for services covered under Medicare—will conduct its own evaluation of medical care delivered by the demonstration plans. The DMHC will conduct medical surveys (on-site facility reviews of a plan’s procedures for providing care) every three years related to Medi-Cal benefits offered by the demonstration plans, such as LTSS.
- **Financial Audits.** The DMHC’s Division of Financial Oversight will perform financial audits of the demonstration plans every three years to assess their compliance with financial solvency requirements. These audits will investigate all aspects of the plans’ financial conditions and payment practices, whether they pertain to the Medicare or Medi-Cal portions of the demonstration.

**DSS Continues Oversight Role for IHSS in Expanded Capacity.** Under CCI, DSS retains its existing oversight role for IHSS, including quality assurance and program integrity activities, and administrative and regulatory oversight. The DSS will assume additional oversight activities of demonstration plans that will provide IHSS as a plan benefit in the eight demonstration counties.

By virtue of IHSS shifting from Medi-Cal FFS to a Medi-Cal managed care plan benefit in the eight demonstration counties, demonstration plans rather than counties will be responsible for entering into contracts with qualified entities for the provision of IHSS. The vast majority of IHSS providers are directly employed by IHSS recipients, who are in charge of hiring, firing, and supervising the provider, and this will continue to be the case

under CCI. However, some IHSS providers are employed by public or private entities that will now contract with demonstration plans. The DSS will assume new oversight activities to: (1) certify entities that deliver IHSS under contract with demonstration plans, (2) review and approve new contracts between demonstration plans and entities delivering IHSS, and (3) develop contract templates for entities seeking to enter into contracts with demonstration plans to deliver IHSS.

**California Department of Aging (CDA) Continues Oversight Role for CBAS and MSSP in Expanded Capacity.** The CDA maintains its oversight role for CBAS and MSSP in an expanded capacity because of the shift of MSSP from a Medi-Cal FFS benefit to a Medi-Cal managed care plan benefit in the eight demonstration counties. We note that the CBAS program has been a Medi-Cal managed care benefit in counties that currently operate Medi-Cal managed care plans—including the eight demonstration counties—since November 2012. The CDA’s oversight role under CCI is as follows.

- **CBAS.** The CDA will continue to certify CBAS centers. The CDA will also provide education and training to CBAS providers and demonstration plans as needed.
- **MSSP.** The CDA administers MSSP under an interagency agreement with DHCS. The CDA, in conjunction with the MSSP Site Association, is developing an MOU contract template that will be used by demonstration plans and MSSP sites to define roles and responsibilities and establish policies and procedures for sharing information and coordinating care. The CDA will also provide education and training to MSSP site providers and demonstration plans as needed.

## Preparations for Data Sharing

In both its duals demonstration proposal and programmatic transition plan for CCI (submitted to the Legislature in partial fulfillment of reporting requirements under Chapter 33), DHCS described strategies to share data between departments, demonstration plans, providers, and county agencies.

**Data Sharing Between DHCS and Demonstration Plans.** Demonstration plans have requested to receive data on beneficiary utilization of health care services (with all information that could identify individual beneficiaries removed from the data) and provider data prior to enrollment. Plans will use the data to review the potential scope of their (1) enrollees' health status and needs and (2) staff hiring and provider contract needs. The DHCS has sent Medicare provider data to plans for the purpose of building adequate networks, and is working with CMS to also send Medicare beneficiary data.

**Data Sharing Between DSS and Demonstration Plans.** At the time of this analysis, DSS planned to allow demonstration plans to have access to certain IHSS recipient data and for the plans to provide county social workers with access to data elements relevant for IHSS quality assurance and care coordination activities. The final data-sharing agreement will require an MOU between DSS and demonstration plans.

## Local Preparation Activities

Demonstration plans, counties, and MSSP sites in the eight demonstration counties have undertaken preparations to implement CCI. Plans, county agencies, and MSSP sites have generally entered into discussion about various aspects of the required MOUs, but plans in particular are awaiting details of the demonstration MOU between CMS and DHCS and rate development

information before finalizing and formalizing agreements related to CCI. For example, L.A. Care and Health Net, the two demonstration plans in Los Angeles County, have engaged in meetings with the county but have not finalized MOUs with the county's Department of Public Social Services.

## Governor's Budget Proposes Changes to CCI Implementation

The Governor's budget revises the start date for CCI implementation and the schedule for phased-in enrollment of dual eligibles into managed care. The administration has stated no statutory changes are necessary to implement the revised schedule. Below, we examine the fiscal and policy implications of the revised schedule as presented in the Governor's budget.

### Governor's New Enrollment Timeline . . .

**Start Date Postponed.** Under Chapter 33, the demonstration can begin no sooner than March 1, 2013. When the *2012-13 Budget Act* was enacted, a March 2013 start date was anticipated. The Governor's budget now proposes September 1, 2013 as the start date for both (1) the mandatory transition of dual eligibles and LTSS into Medi-Cal managed care and (2) passive enrollment of dual eligibles into managed care for their Medicare benefits.

**Phasing Schedule Will Differ by County.** The budget outlines a different schedule for phasing enrollment of dual eligibles into demonstration plans. In six of the eight demonstration counties, enrollment will be phased in over 12 months. Two counties have their own phase-in schedule as follows.

- **Los Angeles County.** Enrollment in Los Angeles County will take place over 16 months (September 1, 2013 through December 31, 2014).

- **San Mateo County.** All dual eligibles in San Mateo County are already enrolled in managed care for their Medi-Cal benefits and will enroll in managed care for their Medicare benefits on September 1, 2013.

**... Affects Administration's Fiscal Estimates for CCI**

*Savings From CCI Were Assumed in the 2012-13 Budget Act.* The *2012-13 Budget Act* assumed net savings of \$608 million General Fund from CCI implementation in 2012-13 under the assumption that implementation of CCI would begin in March 2013. These net savings were, however, mostly due to an estimated \$711 million payment deferral to Medi-Cal providers and managed care plans. The Legislature adopted the payment deferral to offset an estimated \$115 million General Fund cost that the state would incur from making both managed care payments and retroactive FFS payments in the same fiscal year as beneficiaries and services transitioned to Medi-Cal managed care.

Under CCI, the state and CMS will jointly contribute to capitated rates that are designed to lower total Medicare and Medi-Cal spending for dual eligibles. The rates will be determined based on the assumption that by integrating LTSS under managed care, demonstration plans can prevent and substitute SNF stays for their SPD members with less costly HCBS. The rates will also assume SPDs use fewer hospital inpatient services under managed care. In future years

when CCI is fully implemented, General Fund savings are expected to result from both (1) LTSS integration, which mainly lowers Medi-Cal costs, and (2) reduced hospitalizations for dual eligibles, which mainly lowers Medicare costs. The budget assumes that under a finalized demonstration MOU with CMS, the state will share 50 percent of any savings resulting from the demonstration that would otherwise accrue to Medicare, including savings from reduced hospitalizations.

It is our understanding that while Chapter 33 stipulates certain categories of dual eligibles in demonstration counties—such as beneficiaries enrolled in Kaiser plans or receiving services under the Developmentally Disabled waiver—are excluded from CCI, the savings assumed in the *2012-13 Budget Act* do not account for these exclusions. The administration has since updated its fiscal estimates to more accurately reflect the population affected by CCI, as well as the Governor's proposed changes to the implementation plan. Figure 2 summarizes major differences between CCI savings assumed in the *2012-13 Budget Act* and the Governor's budget assumptions.

**Revised 2012-13 Net Savings Are Actually Greater Due to Implementation Delay.** Under

**Figure 2**  
**Net Savings Estimates From CCI Implementation**

(In Millions)

	2012-13 Budget Act		2013-14 Governor's Budget	
	2012-13	2012-13	2013-14	Annual, Full-Year <sup>a</sup>
LTSS integration	\$115 <sup>b</sup>	—	\$185 <sup>b</sup>	-\$270
Medicare shared savings	-12	—	-63	-253
Payment deferral	-711	-\$643	-295	—
Administrative costs	1	1	3	—
<b>Totals</b>	<b>-\$608<sup>c</sup></b>	<b>-\$642</b>	<b>-\$171<sup>c</sup></b>	<b>-\$523</b>

<sup>a</sup> Starting in 2015-16.  
<sup>b</sup> Reflects net effect of overlapping fee-for-service and managed care payments in transition period.  
<sup>c</sup> Totals reflect rounding.  
 CCI = Coordinated Care Initiative and LTSS = long-term services and supports.

the previous plan to begin CCI implementation on March 1, 2013, four months of phased-in enrollment in the duals demonstration would occur during 2012-13. Delaying implementation until 2013-14 eliminates partial-year Medicare shared savings in 2012-13. Delaying implementation also results in fewer Medi-Cal beneficiaries enrolled in managed care by June 2013 and accordingly lower 2012-13 savings from deferring a managed care payment to July 2013. The total lost savings (due to these two factors) are more than offset, however, by a decrease in up-front costs from overlapping FFS and managed care payments in 2012-13. The net effect of all three changes is a \$34 million increase in 2012-13 savings compared to that assumed in the *2012-13 Budget Act*—from \$608 million to \$642 million.

***Savings in 2013-14 Reflect Delayed Start for Implementation.*** Under the administration's revised plan to delay CCI implementation to September 1, 2013, ten months (rather than eight months) of phased-in enrollment in the duals demonstration would occur during 2013-14. The revised plan also adjusts the number of beneficiaries enrolling each month, due to the different phase-in schedules for Los Angeles County and San Mateo County. After a number of technical adjustments (including the natural loss of much of the savings from the one-time payment deferral that largely benefitted 2012-13), the Governor's budget estimates savings from CCI implementation in 2013-14 at \$171 million.

***Annual Full-Year Savings.*** The administration projects annual full-year savings from CCI implementation will grow to \$523 million beginning in 2015-16, at which time enrollment will be complete in all demonstration counties.

***Governor's Budget Estimates Still Rely on Risky Assumptions.*** We currently have no issues with the administration's technical adjustments to savings based on the revised enrollment schedule

for CCI. However, we note that the Governor's budget still assumes (1) 50 percent shared Medicare savings and (2) a stable enrollment policy for transitioning dual eligibles into managed care for their Medicare benefits. Later in this analysis, we raise issues surrounding the state's ability to secure these provisions under a final demonstration MOU agreement with CMS.

### **Governor's Revised Implementation Plan Has Merit . . .**

***Postponing Enrollment Is Necessary for Adequate Preparation.*** As we discuss later in this analysis, the demonstration MOU will guide implementation and oversight during all stages of CCI, including the enrollment process. Because the state has not reached a demonstration MOU agreement with CMS at the time of this analysis, we believe postponing the start date is necessary to ensure adequate preparation for enrollment. If the state and CMS reach a demonstration MOU agreement by March 2013, the Governor's revised start date may strike a reasonable balance among several factors for successful enrollment in that it:

- Provides up to six months for beneficiary and provider outreach prior to enrollment, which can facilitate smoother transitions and lessen disruptions to care.
- Avoids confusion that could result from CCI enrollment coinciding with the separate open enrollment period (October through December 2013) for Medicare managed care plans that are not participating in the demonstration.
- Provides the opportunity to implement a longer enrollment period in Los Angeles County.

We emphasize that the Governor's proposal is reasonable only if it allows enough time for the



state, CMS, and demonstration plans to execute key steps leading up to enrollment. Based on a September 1, 2013 start date, the administration has revised its timeline for completing major preenrollment milestones, as shown in Figure 3.

**Phasing Schedule Better Meets Individual County Needs.** We support the Governor’s approaches to phasing enrollment in San Mateo County and Los Angeles County. The Health Plan of San Mateo (HPSM) is a county-organized health system (COHS) that operates the single Medi-Cal managed care plan in San Mateo County. In all 14 counties with COHS plans, most SPDs are already mandatorily enrolled in these plans for their Medi-Cal benefits except for some LTSS (while SNF care and CBAS are included in COHS plans, members of these plans currently access IHSS and MSSP under FFS). Moreover, the majority of dual eligibles in San Mateo County are enrolled in a Medicare managed care plan that is also operated by HPSM. The HPSM’s experience with coordinating medical care for most dual eligibles, combined with the plan’s progress in preparing for LTSS integration, justifies the administrative ease of a single-date rather than a phased-in enrollment for dual eligibles in San Mateo County.

Los Angeles County contains over 50 percent of the dual eligible population in the eight demonstration counties affected by CCI, spread across a geographically diverse region. While there are two Medi-Cal managed care plans operating in the county, these plans delegate a significant amount of care coordination to subcontracted health plans and large provider

groups. The size and scope of CCI in Los Angeles County suggest the advantage of a 16-month enrollment period. (Under CMS requirements for the demonstration, all enrollment activities must end by December 31, 2014.)

**... If Demonstration MOU Agreement Is Reached by March 2013**

If demonstration MOU negotiations extend beyond March 2013, we may have concerns about the state’s ability to successfully manage the transition of dual eligibles and LTSS—even with a delayed start date of September 1, 2013. If the state and CMS do not reach a demonstration MOU agreement by March 2013, we will provide the Legislature with an updated assessment of the Governor’s implementation plan.

**CCI Implementation Challenges**

In this section we raise issues regarding the state’s ability to ensure timely and successful implementation of CCI.

**Lack of MOU Agreement Raises Immediate and Imminent Concerns**

Implementation of CCI in each demonstration county will be governed under the terms of

**Figure 3  
Pre-Enrollment Milestones Under Revised CCI  
Implementation Start Date**

Projected Dates of Completion	Milestone
2/15/2013	Finalize guidelines and standards for HCBS plan benefits
2/15/2013	Share readiness review tool with demonstration plans
2/15/2013 to 5/15/2013	Conduct health plan readiness reviews
2/28/2013	Finalize beneficiary and provider outreach and education plan
3/15/2013	Submit 1115 waiver
3/15/2013	Develop interagency agreement between DHCS and DMHC
4/15/2013	Rate setting and contract negotiations

CCI = Coordinated Care Initiative; HCBS = Home- and community-based services; DHCS = Department of Health Care Services; and DMHC = Department of Managed Health Care.

individual three-way contracts between plans, the state, and CMS. However, these contracts will derive most of their core requirements from the demonstration MOU between the state and CMS. The demonstration MOU will contain many standards and conditions that dictate the overall operation and financing of the demonstration, including, but not limited to:

- Plan readiness standards, which CMS, DHCS, and partner agencies must review before signing three-way contracts with plans. Three-way contracts will also reflect standards dictated by the MOU. The DMHC has indicated it cannot estimate the full scope of its enforcement activities until the contracts are finalized.
- Quality measures that will be tracked throughout the demonstration and applied to quality withholds. We note that the draft quality metrics released by DHCS do not include LTSS-related measures as candidates for the quality withhold.
- Necessary authority to waive certain federal requirements, such as those related to the mandatory enrollment of dual eligibles into Medi-Cal managed care.

The state's demonstration proposal suggested that the administration expected to reach a demonstration MOU agreement with CMS by July 2012. In its programmatic transition plan, the administration revised its projected time frame for reaching an agreement to sometime in the fall of 2012. At the time of this analysis, however, the state and CMS continue to discuss the terms of the demonstration MOU without having reached an official agreement (although the administration has indicated it believes such an agreement is imminent). This ongoing delay has both immediate and pending consequences for

CCI implementation, such as questionable legal authority to continue the demonstration and lack of clarity on the complex and crucial processes for rate-setting and enrollment.

On February 1, 2013—the statutory deadline of the poison pill provision under Chapter 33—DHCS circulated a letter received by the Director of DHCS from the Director of CMS' Medicare-Medicaid Coordination Office related to the status of federal approval of the duals demonstration project. In the discussion that follows, we reference both the letter's content and the questions it raises about the legal status of CCI, as well as discuss other issues stemming from the current lack of a demonstration MOU between the state and CMS.

***CMS May Not Agree to Stable Enrollment Period.*** In our 2012-13 report on the Governor's CCI proposal, we cast initial doubt on the state's ability to secure federal approval for a stable enrollment period for dual eligibles transitioning into demonstration plans for their Medicare benefits. (A stable enrollment period is a period during which beneficiaries passively enrolled into demonstration plans would be required to remain in the same plans—or “locked in”—before being allowed to switch to FFS or other plans.) While the demonstration MOU will reveal the final enrollment policy agreed upon by DHCS and CMS, recent indications have only served to reinforce the notion that stable enrollment is an unlikely prospect under CCI.

None of the three demonstration MOUs finalized in other states authorize stable enrollment, although two MOUs specify passive enrollment with monthly opt-out. Furthermore, the Director of CMS' Medicare-Medicaid Coordination Office has publicly stated that CMS does not plan to approve a stable enrollment period for Medicare managed care under any duals demonstration. We note Chapter 33 requires demonstration plans—over the proposed six-month stable

enrollment period—to reimburse providers who do not contract with the plans but agree to accept Medicare FFS payment. However, we are uncertain as to whether this continuity-of-care provision will alter CMS’ apparent opposition to stable enrollment.

The administration has indicated it views stable enrollment as a means to ensure a sufficient volume of enrollees over the demonstration period. If CMS ultimately does not approve stable enrollment under the demonstration MOU, this raises both fiscal and policy considerations. Here we provide an overview of the policy considerations, and turn to the potential fiscal implications later in this analysis.

***Issues if Stable Enrollment Is Not Approved.***

If CMS does not approve stable enrollment, the state may adopt passive enrollment with monthly opt-out for Medicare managed care. While there may be valid reasons for CMS to deny the state’s proposal for stable enrollment of dual eligibles, such as the need to preserve continuity of care, the lack of an enrollee “lock-in” mechanism may create administrative and financial challenges for demonstration plans.

- First, actuarial calculations to estimate the average characteristics of a population generally become less precise when performed using fewer data obtained from a smaller number of individuals. Such calculations are necessary for developing capitated payments to managed care plans that accurately reflect the cost of providing services. As we describe shortly, passive enrollment with monthly opt-out may result in some plans retaining only a small percentage of their enrollees. Inaccurate rates can either lead to the state overpaying for services, or failing to provide sufficient resources for plans to maintain access to care.

- Second, without a stable enrollment period, the ability of dual eligibles to opt out on a monthly basis may also create short-term volatility, further complicating rate-setting and plans’ efforts to effectively coordinate services for their membership.
- Third, without a stable enrollment period, it is unknown what type of beneficiaries—healthier individuals who see fewer specialists and are less inclined to immediately opt out, or those who are too sick or otherwise unable to make the affirmative choice to opt out—are more likely to remain enrolled over the course of the demonstration.

In summary, without CMS approval of a stable enrollment period, DHCS and demonstration plans may face challenges (1) budgeting and planning for a lower and more unstable enrollment, (2) spreading risk among their membership, and (3) developing accurate capitated rates. All three factors are crucial for maintaining adequate services for dual eligibles who remain enrolled in managed care for their Medicare benefits.

***Prior Plan Experiences Provide Valuable Lessons About Retention of Passive Enrollees.***

It is difficult to generalize about the expected participation rate for all eight demonstration counties under passive enrollment if there were no lock-in period. For example, HPSM in San Mateo County and CalOptima in Orange County are COHS that currently operate both Medi-Cal and Medicare managed care plans. (We note these Medicare managed care plans generally provide only Medicare-covered benefits, and are distinct from the integrated Medicare-Medi-Cal plans that the COHS will operate under CCI.) Both of these COHS passively enrolled (without lock-in) dual eligibles into their Medicare managed care plans between 2005 and 2006. The HPSM retained

90 percent of its enrollees during the first year and reports a current voluntary disenrollment rate of 1 percent. CalOptima ultimately retained only 8,000 of the 45,000 (18 percent) dual eligibles passively enrolled, with most members opting out within the first six months of the enrollment period.

These contrasting experiences underscore certain factors—both under and beyond a managed care plan’s direct control—that can contribute to the final participation rate among passive enrollees. One key difference between San Mateo County and Orange County is the landscape of their respective provider networks. Orange County is mostly represented by large medical groups that contract with health plans under “closed” network arrangements—meaning the ability of providers currently outside these networks to contract with plans is limited. In contrast, HPSM has historically maintained open networks and recruited most providers who are willing to contract with the plan. (It is our understanding that HPSM plans to close its network for primary care providers but maintain an open network for specialist physicians.)

If a plan is able or willing to form more inclusive networks, this may enable the plan to establish relationships with more providers who currently see dual eligibles. This may partially explain HPSM’s relative ease retaining its passive enrollees compared to CalOptima. However, CalOptima has also indicated plans for improved outreach to providers in preparation for CCI implementation.

Below, we list several additional options that DHCS and demonstration plans have put forth to (1) generally bolster the retention rate for passive enrollment under CCI and (2) reduce the rate of monthly opt-out in the event CMS does not approve stable enrollment.

- Offering supplementary benefits—such as vision, dental, hearing, and

transportation—to make the plan a more attractive choice for beneficiaries. We note that CMS’ letter to DHCS cited “additional benefits” as one of the “outstanding policy decisions” to be resolved before an MOU agreement can be reached.

- Targeted marketing efforts to beneficiaries and providers. It is our understanding that the ability for COHS plans to directly market to consumers is limited.
- In Los Angeles County, beginning enrollment with a four- to six-month voluntary “opt-in” period. The goal is to encourage beneficiaries to learn about CCI and proactively select their plan and providers, rather than being passively enrolled and auto-assigned to providers. We note a similar approach has been adopted under Massachusetts’ and Ohio’s demonstration MOUs.

With regard to passive enrollment of dual eligibles under CCI, the recent transitions of (1) Medi-Cal-only SPDs from FFS into managed care and (2) Adult Day Health Care (ADHC) from a FFS benefit to a managed care benefit known as CBAS provide valuable lessons on outreach, continuity of care, and other issues. For more information on these transitions, see the box beginning on page 22.

***Joint Rate-Setting Process—A Key to Implementation—Remains Uncertain.*** The CMS’ letter to DHCS identified “financing” and “rate-setting” as outstanding issues awaiting resolution before a demonstration MOU can be finalized. In June 2012, CMS also released a document describing the envisioned “joint rate-setting process” under the duals demonstrations. As the description suggests, the joint rate-setting process involves CMS and the

state working closely together to develop a single capitated rate for demonstration plans, intended to cover nearly all necessary services under Medicare and Medi-Cal. The June 2012 CMS document also states that key aspects of the rate-setting process will be specified in each state's demonstration MOU, including the overall savings target that will be incorporated into the joint capitated rates. This savings target obviously has ramifications for the state's fiscal outlook under CCI, which we discuss later. As a careful rate-setting process is critical to the successful implementation of CCI, we now turn to a more in-depth discussion of the rate-setting process.

### **Rate-Setting Crucial to Success of CCI**

A crucial element of the demonstration MOU will be the joint rate-setting process. Although DHCS and CMS will negotiate individual three-way contracts with each demonstration plan, these negotiations will proceed under the overall framework of the joint rate-setting process—notably, the baseline spending level, aggregate savings target, and risk adjustment policies established by CMS and the state. These three parameters will influence plans' expected financial margins—as well as the level of risk they are prepared to assume—under CCI.

***Implications of Uncertain Joint Rate-Setting Process.*** As demonstration MOU discussions continue between the state and CMS at the time of this analysis, the uncertainty surrounding the joint rate-setting process may affect demonstration plans' preparations at the local level to serve dual eligibles. Some plans may face challenges building and expanding their networks, as their ability to negotiate payments to providers is limited by their lack of knowledge of what their rates will be. This, in turn, may strain the plans' capacity to demonstrate adequate access to care by the start of enrollment. Plans selected for the demonstration

may reevaluate their choice to participate, depending on their financial outlook under the joint rate-setting process. The degree to which these concerns apply will not be clear until the state and CMS conduct contract negotiations and plan readiness reviews.

Besides plans' overall capability and willingness to implement CCI, the joint rate-setting process will also impact how services are coordinated and delivered by plans that participate in the demonstration. While a capitated rate is generally intended to encourage plans to provide less costly and more effective care than under FFS, the specific structure of the rate can contribute to varying outcomes. For example, if rates are adjusted based on each enrollee's LTSS utilization to help mitigate a plan's level of financial risk, the adjustment may also affect the plan's incentives to transition beneficiaries from institutional care to HCBS. Some reports have recommended states and CMS share financial risk with plans during the initial years of the duals demonstrations to help ensure financial solvency. Rates may also influence plan decisions to offer benefits beyond core medical services and LTSS—such as dental, vision, hearing, and additional HCBS—either by specifically incorporating their expected cost, or assuming a margin of savings that plans may use to broadly invest in such services.

The update that follows on the status of rate development for CCI is based on our (1) discussions with DHCS, (2) conversations with several demonstration plans, (3) review of demonstration MOUs already established in other states, and (4) reading of CMS' preliminary guidance on the joint rate-setting process.

***Components of Rate-Setting Process.*** The joint rate-setting process begins with defining baseline spending on dual eligibles affected by CCI. Baseline spending refers to the estimated total level of Medicare and Medi-Cal spending on

## Key Lessons From Two Transitions to Managed Care

The Department of Health Care Services (DHCS) has recently undertaken two transitions—of Medi-Cal-only seniors and persons with disabilities (SPDs) from fee-for-service (FFS) to Medi-Cal managed care and of the Adult Day Health Care (ADHC) Program from a FFS benefit to a Medi-Cal managed care plan benefit known as Community-Based Adult Services (CBAS). Both the scale of these transitions and the affected population make them instructive for (1) the importance of outreach and education to both beneficiaries and providers and (2) the importance of state policies and procedures that promote continuity of care for beneficiaries.

### Mandatory Enrollment of Medi-Cal-Only SPDs Into Managed Care

From June 1, 2011 through May 2012, the state transitioned more than 380,000 Medi-Cal-only SPDs from FFS to Medi-Cal managed care in 16 counties statewide with the goals of improving care and achieving budgetary savings. We provide an overview of challenges and effective transition strategies reported by stakeholders and other entities involved with the transition.

**Beneficiary Notification and Outreach.** The SPDs have a higher prevalence of complex medical conditions and greater functional needs than other Medi-Cal beneficiaries. Cognitive impairments, low levels of literacy, and non-English or limited-English proficiency are also more common among this population. These challenges had the effect of reducing the informational efficacy of written notifications from DHCS about the mandatory shift to managed care. A recent report assessing the Medi-Cal-only SPD transition to managed care found that beneficiaries had trouble comprehending the complex written notices from DHCS. The report found that “high-touch” outreach activities, such as one-on-one counseling or telephone support, were the most effective strategies for engaging beneficiaries about changes to their health care coverage.

**Education and Outreach to Health Care Providers.** The report on the transition of Medi-Cal-only SPDs to managed care also found that managed care plans undertook a range of activities to prepare health care providers for the transition. The report found that the most effective outreach strategies involved actively engaging providers through in-person meetings, in-service training sessions, and informational sessions at the providers’ offices. It also found that there was insufficient training of health plan staff and the provider community on the needs of persons with mental illness and developmental disabilities. This experience underscores the importance of actively engaging health plan staff and providers on the logistics of the transition of dual eligibles to demonstration plans. In addition, efforts by DHCS and the federal Centers for Medicare and Medicaid Services to provide demonstration plans with data on beneficiaries prior to the transition may help educate health plan staff and providers on the needs of the dual eligible population.

**Network Adequacy and Continuity of Care.** Many of the health plans involved in the transition of Medi-Cal-only SPDs to managed care reported challenges in recruiting Medi-Cal FFS providers to join their managed care networks. These challenges were due in part to delayed and difficult-to-use beneficiary FFS claims data from DHCS. Such claims data enable plans to gauge the adequacy of their provider networks to meet new beneficiaries’ health needs. The report also found that half

of managed care plans reported difficulties caused by unclear or changing policies from DHCS. In particular, the report found significant problems with the state's processing of requests for medical exemption from plan enrollment, which are generally granted to beneficiaries undergoing care for pregnancy or certain medical conditions. Processing errors by a vendor for DHCS caused beneficiaries to have to resubmit the medical exemption request (MER) or to request a state fair hearing to resolve the issue. The MER process will be used again for the transition of dual eligibles to managed care. On a similar note, DHCS will need to establish policies and procedures for dual eligibles seeking to opt out of demonstration plans and remain in Medicare FFS. The experience of the Medi-Cal-only SPD transition to managed care reveals that adequate networks of providers and continuity of care for beneficiaries may be contingent upon timely and accurate information from DHCS to plans and clear DHCS policies on the MER and opt-out processes.

### **ADHC Transition to CBAS**

After the ADHC program was eliminated in March 2012, a class action lawsuit, *Darling et al. v. Douglas*, challenged the elimination. The state reached a settlement agreement with plaintiffs that established the ADHC-equivalent program—CBAS—as a Medi-Cal managed care plan benefit. This transition required ADHC participants to shift from FFS to Medi-Cal managed care plans in 29 counties in order to continue receiving ADHC-equivalent services through CBAS. We provide an overview of challenges and response strategies reported by entities involved with the transition.

**Beneficiary Notification and Outreach.** In an August 2012 memorandum from the California Department of Aging (CDA) to CBAS Center administrators and program directors, the department notified CBAS providers that an “unexpectedly high number” of CBAS participants opted to remain in Medi-Cal FFS rather than transition to managed care in order to receive the CBAS benefit. The memo states that “as many as 5,000 beneficiaries” (or, approximately 16 percent of participants) may opt to remain in Medi-Cal FFS, forgoing the CBAS benefit. In response, DHCS extended the managed care enrollment period for CBAS participants and provided clarifying information to beneficiaries about the consequences of their enrollment choice. The CBAS transition suggests that DHCS and partnering departments may need to conduct extensive outreach to dual eligibles to ensure that they understand the consequences of their decision to opt out of the demonstration, including the potential loss of services—such as care coordination—that may only be offered by demonstration plans.

**Education and Outreach to Health Care Providers.** The memo from CDA goes on to state that some CBAS participants may have received “erroneous information” that guided them to the decision to remain in Medi-Cal FFS. A common misconception mentioned in the CDA memo was the belief that entering Medi-Cal managed care would negatively affect a patient's access to their Medicare providers. To address this concern, DHCS scheduled a series of conference calls for providers in order to provide clarifying information that enrollment decisions about Medi-Cal managed care would not impact Medicare. The DHCS may need to undertake similar education and outreach activities to providers, particularly to Medicare FFS providers, in advance of the dual eligibles transition.

dual eligibles affected by CCI during the first year of the demonstration, had the demonstration not occurred. The state is responsible for submitting historical Medi-Cal cost data for dual eligibles, which CMS' contracted actuaries will incorporate along with Medicare data to develop a baseline spending estimate.

The DHCS has indicated that for the purposes of calculating baseline spending, CMS may consider dual eligibles who opt out of the Medicare portion of the demonstration as the baseline population. That is, CMS assumes that the state would mandatorily transition dual eligibles and LTSS into Medi-Cal managed care regardless of whether the demonstration took place. Under this methodology, CMS will use cost data from Medi-Cal managed care—in addition to or in place of FFS cost data—as the basis for determining baseline spending.

After establishing baseline spending, CMS will work with the state to select an overall savings target that it expects the demonstration to achieve vis-à-vis current total spending on both Medicare and Medi-Cal services.

It is our understanding that CMS and the state will (1) take the lead on developing the Medicare and Medi-Cal components of the joint capitated rates, respectively, and (2) separately pay these components to the demonstration plans. Conceptually, joint capitated rates will be developed by applying the aggregate savings target to total baseline spending. From a plan's perspective, it does not matter which portion of the savings target is applied to the Medicare or Medi-Cal rate components. However, as we discuss later, the apportionment of savings is an important fiscal consideration for the state.

**Dealing With Risk.** Financial solvency of health plans is a general concern under managed care and especially relevant under CCI. The dual eligible population in demonstration counties

is large, expensive, and mostly new to managed care. Small percentage deviations of actual costs above budgeted expenditures can cut deeply into financial reserves, especially for plans that enroll large numbers of dual eligibles relative to their total membership. Without adequate reserves—or arrangements with payers to help control financial risk—some plans may eventually have difficulty paying for the services required by this vulnerable and high-needs population.

Chapter 33 allows DHCS to establish a risk-sharing mechanism, specifically with L.A. Care, one of the two demonstration plans in Los Angeles County. However, the administration has expressed opposition to relying on “risk corridors” or other risk-sharing mechanisms under CCI. (Under a risk corridor, the state and CMS would share in a portion of a limited amount of a demonstration plan's profit or loss relative to the plan's capitated rate.) According to DHCS, CMS may be willing to only share risk up to the estimated level of baseline spending. By agreeing to share additional risk with plans, DHCS would expose the state to a greater portion of uncertain costs above the baseline.

Instead of focusing on risk-sharing mechanisms, CMS and DHCS have proposed incorporating risk adjustments into the joint rate-setting process. Generally, risk adjustments refer to various methods to account for the historical or predicted health status of individuals or groups of enrollees when developing capitated rates.

- ***CMS Will Apply Risk Adjustments to Medicare Rate Component.*** Rate-setting for Medicare managed care currently relies on risk adjustments based on enrollees' medical diagnoses and demographic information. It is our understanding that most demonstration plans, having operated Medicare lines of business, are familiar



with this form of risk adjustment (which has been refined by CMS over the past decade).

- ***DHCS Is Considering Risk Adjustments for Medi-Cal Rate Component.*** The DHCS has proposed dividing enrollees into several risk categories based on previous LTSS utilization. Enrollees residing in SNFs would fall under the highest risk category, followed by enrollees receiving CBAS, MSSP, IHSS, or no LTSS. The DHCS will (1) assign a cost factor to each risk category and (2) calculate the average cost across all enrollees to arrive at a plan-specific “blended” rate. During the first year of the demonstration, DHCS will make monthly retroactive adjustments to blended rates as plans’ LTSS risk profiles fluctuate with enrollment. After the first year, DHCS will decrease the frequency of adjustments to a quarterly and then annual basis, thus delegating more LTSS risk to the plans. However, if a plan’s LTSS profits or losses are greater than a certain percentage of the plan’s blended rate, the state and/or CMS will share in a portion of these profits or losses. The DHCS will also revise cost factors applied to each LTSS risk category to account for changes in average costs within those categories, as beneficiaries transition between SNFs and HCBS.

The state has neither prior experience with DHCS’ proposed risk adjustment methodology nor experience with setting capitated rates for LTSS in general. According to DHCS, other states such as Arizona have successfully implemented similar models to set capitated rates for LTSS. In concept, DHCS’ approach to LTSS risk adjustment appears reasonable to us. However, the untested nature of this approach in California, along with many other

aspects of CCI, highlights the importance of the Legislature’s role in monitoring and evaluating the demonstration—particularly its review of DHCS’ annual quality measure and cost reports under Chapter 33.

The CMS has emphasized that while states participating in duals demonstrations have some flexibility to apply risk adjustments for Medicaid rate components, the overall rate structure should promote care transitions from hospitals and SNFs to HCBS when appropriate. At the time of this analysis, it was unclear whether the state’s current proposal for LTSS risk adjustment meets CMS’ criterion.

***Rates Could Move Towards Incorporation of Functional Status Data.*** To our knowledge, DHCS does not plan—at least for the first year of the demonstration—to directly incorporate data on enrollees’ functional status into the Medi-Cal rate component. Broadly, functional status refers to a person’s ability to complete activities of daily living such as bathing, dressing, and eating. Many HCBS providers and county agencies collect some form of data on functional status when determining eligibility and assessing beneficiaries’ needs for LTSS. Some reports have suggested that states participating in duals demonstrations should include functional status when developing their Medicaid rate components—similar to how CMS currently uses medical diagnoses to perform Medicare risk adjustments. We note that a key provision of CCI is movement toward a universal assessment process for LTSS. As this process evolves and produces more standardized data on functional status, the Legislature may wish to explore how the data on the functional status of SPDs can better inform the capitated rate-setting process for LTSS.

***Are Baseline Spending and Savings Targets Reasonable?*** As we discuss shortly, the state’s influence on the development of baseline spending

estimates and aggregate savings targets remains unclear. Both are critical determinants of whether the joint capitated rates will (1) generally reflect demonstration plans' costs of providing care to enrollees and (2) incorporate realistic assumptions on the achievable level of savings related to hospital inpatient and institutional care.

To the extent the state exerts any control over these aspects of the joint rate-setting process, its recent experience with the Medi-Cal-only SPD transition into managed care may prove instructive. The Governor's 2013-14 budget includes an upward adjustment to the capitated rates for this population. According to DHCS and managed care plans, the initial rate development in 2010-11 may have (1) overly weighted managed care cost data in the baseline spending estimate, despite the population being historically FFS, and (2) included "efficiency factors" such as reduced hospitalizations that were ultimately not attainable within the first year of the transition. As we noted earlier in this analysis, CMS will use cost data from Medi-Cal managed care—in addition to or in place of FFS cost data—as the basis for determining baseline spending.

***Rates Key to Success of CCI, but State's Role May Be Limited.*** As described above, setting rates at an appropriate level is key to the success of CCI because it will affect plans' willingness to participate and the long-term sustainability of the demonstration. However, we are unsure what role the state will play throughout the joint rate-setting process. Formally, CMS may have the final say on the baseline spending and aggregate savings target, with the state mainly providing data and input in a consulting capacity.

### **Integration of IHSS Into Managed Care Should Be Revisited**

***Demonstration Plans Are Financially at Risk but Have No Authority to Reduce IHSS Hours.***

Under CCI, IHSS shifts from FFS to managed care for most dual eligibles and Medi-Cal-only SPDs in the eight demonstration counties. However, county social workers will continue to assess IHSS applicants (and reassess IHSS recipients) for eligibility and their level of need for service hours. Chapter 33 authorizes demonstration plans to provide additional personal care services and related domestic services, but does not grant demonstration plans the authority to reduce IHSS hours assessed by county social workers. We find this problematic because the rate-setting framework proposed by DHCS is based in part on utilization of IHSS among beneficiaries.

As a general principle, we believe that risk-bearing organizations—in this case, managed care plans paid to manage the medical and long-term care of SPDs—should have the authority to determine the level of utilization for services that are factored into the capitated rate they receive to manage the care of beneficiaries. Plans may find that they wish to exercise greater control over beneficiaries' utilization of IHSS, the most commonly utilized form of HCBS among SPDs, in order to better manage their financial risk for long-term care. For example, plans may wish to ramp up IHSS hours immediately following a patient's discharge from the hospital and then may want to closely monitor the beneficiary's recovery and reduce IHSS hours accordingly. Under the current framework, plans would not have the authority to directly alter hours in this manner. Instead, plans would need to work with county social workers to request reassessments after a change in beneficiaries' health status. The degree to which the partnership between demonstration plans and county welfare departments succeeds or fails will depend heavily on the level of coordination and data sharing that occurs between the two entities.

Below, we identify other issues for the Legislature to consider as preparation to integrate IHSS into managed care continues.

***County IHSS MOE May Distort Incentives for County Welfare Departments Partnering With Demonstration Plans.*** Chapter 45 enacted a county IHSS MOE, which replaces the historical county contribution of 17.5 percent to IHSS program costs with a requirement that counties statewide generally maintain their 2011-12 expenditure level for IHSS beginning in 2012-13. All increases in the non-federal share of IHSS costs above the county IHSS MOE are borne by the state's General Fund. Essentially, the county IHSS MOE removes counties' financial liability for all increased IHSS program costs. Chapter 33 further specifies that demonstration plans will develop care coordination teams with LTSS recipients, recipients' authorized representatives, and providers, including county welfare departments. However, without a financial stake in IHSS program costs, it is unclear to what extent county welfare departments will partner with demonstration plans, which bear the risk for the LTSS costs of beneficiaries.

We note that the two HCBS programs besides IHSS that will be coordinated by managed care plans under CCI—CBAS (already a managed care plan benefit) and MSSP—will rely on CBAS providers and MSSP providers, respectively, to assess beneficiaries for their level of need (similar to the manner in which county social workers will assess for IHSS hours). However, in the case of CBAS, the plan has the authority to alter the individual plan of care (IPC) developed by the CBAS provider before authorization for six months of CBAS is granted. The CBAS provider must submit a new IPC every six months to the managed care plan for reauthorization. In the case of MSSP—a Medicaid waiver program with a limited number of slots—the plan will be able to contract for MSSP-like services in cases where a beneficiary

would benefit from such services but MSSP slots are unavailable. The degree to which managed care plans will provide MSSP-like services or CBAS to SPDs will ultimately be decided by plans, rather than an outside entity, such as county welfare departments. We believe the Legislature should revisit the issue of the integration of IHSS into managed care because the current framework may not provide plans with enough flexibility over IHSS hours to adequately manage their financial risk for beneficiaries' long-term care needs. At the end of this analysis, we make recommendations on how the Legislature could proceed on this issue.

### **Unresolved Issues Concerning Opt-Out Dual Eligibles and Medi-Cal-Only SPDs**

At the time of this analysis, DHCS had not yet established a rate development framework for dual eligibles who opt out of the demonstration and for Medi-Cal-only SPDs—two populations that will still receive their LTSS through Medi-Cal managed care under CCI. Dual eligibles who choose to opt out of the demonstration will most likely receive their Medicare services in a FFS environment and their Medi-Cal wraparound coverage via a Medi-Cal managed care plan. Because of CCI, these wraparound services will now include LTSS. For Medi-Cal-only SPDs who have already transitioned to managed care for their medical services, the managed care plan will now manage their LTSS. Given the uncertainty around rate development, it is unclear to what degree these two populations will receive the integrated, person-centered HCBS envisioned under CCI through their Medi-Cal managed care plans.

### **Poison Pill Provision Raises Questions About Continued Implementation**

***Statutory Requirements for Continued Operation of CCI.*** Chapter 33 contains a poison pill provision that makes the enabling statute

for CCI inoperative on March 1, 2013, unless by February 1, 2013, DHCS received federal approval, or notification indicating pending federal approval, of: (1) a mutual state-federal rate-setting process for managed care plans, (2) a six-month enrollment period for beneficiaries, and (3) an agreement on the methodology to share federal savings in the demonstration project. Under Chapter 33 the “shared federal savings” requirement can be met by a methodology that meets one of the following two criteria.

- **Criterion One.** The state and CMS share in combined savings for Medicare and Medi-Cal, as estimated in the *2012-13 Budget Act* for the 2012-13, 2013-14, 2014-15, and 2015-16 fiscal years, and CMS approves provisions of Chapter 33 requiring that upon enrollment in a demonstration site, beneficiaries shall remain enrolled on a mandatory basis for six months from the date of initial enrollment.
- **Criterion Two.** A methodology that in the determination of the Director of Finance, in consultation with the Director of DHCS and the Joint Legislative Budget Committee, will result in the same level of ongoing savings, as estimated in the *2012-13 Budget Act* for the 2012-13, 2013-14, 2014-15, and 2015-16 fiscal years.

**The February 1, 2013 Federal Letter.** In the February 1, 2013 letter from CMS’ Medicare-Medicaid Coordination Office to the Director of DHCS, CMS acknowledged that it had worked in partnership with DHCS to develop the demonstration to integrate care for dual eligibles. The letter stated significant progress had been made and that CMS would continue to work with the state toward finalizing a demonstration MOU that will continue the principles under which

CMS and DHCS will implement and operate the demonstration. According to CMS, the final agreement will be contingent upon resolving outstanding policy considerations, including those related to demonstration financing, rate-setting, and additional benefits. Assuming the remaining policy considerations can be resolved, CMS anticipates finalizing the demonstration MOU in the near term and continuing to work in partnership toward a successful implementation beginning in September 2013.

**Federal Letter May Not Meet Requirements for “Pending Approval” Under Chapter 33.** Based on informal discussions with Legislative Counsel, we have concerns as to whether the CMS letter meets the requirements in Chapter 33 to allow CCI to continue operation beyond March 1, 2013. While the required pending approval of the federal government is subject to interpretation, it does suggest that there is a threshold that must be met for the demonstration to continue. Specifically, while the letter from CMS indicates that the federal government will continue discussions with DHCS, nowhere does it state that approval is pending for (1) a mutual state-federal rate-setting process for managed care plans, (2) a six-month enrollment period for beneficiaries, or (3) an agreement on the methodology to share federal savings—as required by Chapter 33’s poison pill provision. Accordingly, we believe that, absent repeal or modification of the poison pill provision in Chapter 33, the continued implementation of CCI after March 1, 2013 runs the risk of a legal challenge.

**Chapter 33 Language Regarding Shared Federal Savings Requirements Require Clarification.** We find that the provisions in Chapter 33 regarding the savings threshold that must be met in order for the demonstration to go forward require clarification. As described in more detail above, the language requires the state and CMS to share in the combined savings for Medicare

and Medi-Cal, based on a methodology that meets one of two specified criteria. However, neither of the two criteria can be met as the *2012-13 Budget Act* includes neither an explicitly stated estimate of savings for the 2012-13 through 2015-16 fiscal years nor an estimate of ongoing savings in those years under an alternative methodology. (While the administration did provide savings estimates for 2012-13, 2013-14, and subsequent years, these were based upon assumptions and calculations that have not been memorialized in statute.) Therefore, it is difficult to determine the amount of savings that would fulfill the criteria for shared federal savings contained in Chapter 33.

## Savings Remain Uncertain

In our 2012-13 budget report on CCI, we raised significant concerns about the administration's savings estimates associated with CCI (1) during the first year of enrollment and (2) annually under full implementation. Since our report's publication, we have not learned new information that would change our overall assessment that savings associated with full implementation are highly uncertain. Moreover, we have received indications that, in our view, further cloud the administration's fiscal assumptions. Below, we briefly restate the major fiscal concerns from our earlier report. If we receive additional information that causes us to change our assessment—such as the finalized demonstration MOU between the state and CMS—we will provide the Legislature with an updated analysis.

**50 Percent Shared Savings.** The CMS' June 2012 description of the joint rate-setting process states that “by applying the savings target to the Medicare . . . and Medicaid components, both payers proportionally share in the . . . savings achieved through the demonstration . . . That is, regardless of whether savings accrues from

reducing hospitalizations (for which Medicare is primary) or reducing nursing facility placements (for which Medicaid is primary), both payers will benefit under the integrated approach.”

We interpret this statement to mean CMS envisions the same overall savings target to be applied to both the Medicare and Medi-Cal components of the joint capitated rate, with no clear avenue for the state to additionally share in savings accruing to Medicare. For example, suppose the savings target is 2 percent, and average baseline spending for a dual eligible beneficiary is \$25,000 in total funds—\$20,000 from Medicare and \$5,000 from Medi-Cal. Under the administration's assumptions, the state would save \$250 General Fund annually per beneficiary from implementing CCI. Under our reading of the CMS document, the state would save only \$50 annually per beneficiary.

**Participation Rate.** The CMS' likely denial of a stable enrollment period may result in a lower participation rate of dual eligibles in managed care for their Medicare benefits than currently expected (the rate projected by DHCS is 60 percent). Lower enrollment would translate into a lower level of savings from implementation.

**Baseline Spending and Aggregate Savings Target.** These rate-development assumptions may be subject to (1) significant revision and (2) factors that the state has limited control over. If CMS and the state eventually agreed to more modest savings targets under the demonstration, savings would erode.

**Annual Savings.** If initial assumptions regarding savings targets, baseline estimates, or other factors result in inaccurate rates that are insufficient for covering the cost of the affected population, the state and CMS may be required to increase rates to maintain access to care. Savings would erode under this scenario.

## Analyst's Recommendations

While we continue to believe that CCI has merit, we have concerns about specific aspects of CCI implementation. Below, we make several recommendations related to CCI implementation that we believe will enhance the chances of success for achieving the goal of coordinated care for the state's SPDs.

### Address Legal Uncertainty

#### Created by Poison Pill Provision

The Legislature has several options to address the poison pill dilemma. For example, it could simply repeal the section of Chapter 33 that implements the poison pill, allowing the administration to proceed legally with CCI without meeting further requirements. However, we believe the Legislature should preserve its role in ensuring the state's readiness to implement CCI, specifically under the timing, terms, and conditions of federal approval. In our view, a more appropriate course of action for the Legislature would be to enact legislation that revises the deadline for securing federal approval based on the anticipated September 2013 start date and also modifies the criteria for the state to continue with CCI in order to address the uncertainty with the current criteria.

Specifically, we recommend this legislation clarify the level of savings from the demonstration that would fulfill the criteria imposed by Chapter 33 (or any other legislation). We further recommend that this legislation remove a "six-month (stable) enrollment period" as a prerequisite for CCI implementation. While the demonstration MOU has yet to be finalized, we have received no information that would cause us to change our assessment that federal approval of stable enrollment remains uncertain at best. Furthermore, we believe implementation and evaluation of the demonstration continue to have

merit even without stable enrollment. Thus, the Legislature should not make CCI contingent on the improbable notion that CMS will permit stable enrollment. We next recommend how the Legislature could address the various issues we have raised in this analysis regarding implementation without stable enrollment.

### If CCI Proceeds Without Stable Enrollment, Legislature Should Weigh Options

We recommend that DHCS report at budget hearings on options to sustain an adequate volume of participants during the demonstration if CCI ultimately proceeds without stable enrollment. If the participation rate in managed care for Medicare benefits is much lower than expected due to monthly opt-outs, DHCS and demonstration plans may face challenges developing accurate rates and effectively coordinating and delivering services. We recommend that the Legislature enact legislation to clarify that DHCS—through its required reports on plan readiness and annual fiscal and quality outcomes from the demonstration—update the Legislature on the issue of enrollment, unless DHCS indicates its plan to include such information in these reports.

### Health Plan Readiness Report Should Include Readiness to Meet Needs of Opt-Out Dual Eligibles

The DHCS is already required to submit a report to the Legislature on the readiness of managed care plans to address the needs of dual eligibles and Medi-Cal-only SPDs. We recommend that the Legislature enact legislation to clarify that this report on plan readiness also address dual eligibles who opt out of the demonstration, unless DHCS indicates its plan to include such information in the report.

**Recommend Legislature Allow CCI to Test Greater Integration of IHSS Under Managed Care**

We raise concerns in this analysis about the integration of IHSS into managed care. As we discuss, plans do not have the authority to reduce the number of IHSS hours assessed by county social workers in the eight demonstration counties and are dependent upon the county to conduct requested reassessments. We find this problematic because managed care plans are risk-bearing organizations newly charged with managing the long-term care of beneficiaries. In concept, demonstration plans should have the full authority to determine the level of utilization for all HCBS, including IHSS. However, we also recognize that decisions regarding the full integration of IHSS into managed care are particularly challenging, given (1) the size of the IHSS program (more than 400,000 recipients and about 360,000 providers statewide) and (2) the nonmedical nature of the program, in which almost all recipients hire and supervise an IHSS provider of their choice—oftentimes a family member or relative. Demonstration plans have no experience in conducting functional need assessments for this type of program, which differs substantially from the ADHC model of CBAS and the case management model of MSSP—the other two HCBS programs included in managed care under CCI.

The CCI is a three-year demonstration that includes a significant evaluation component, affording an opportunity for the state to draw

valuable lessons on certain models of care coordination. We believe one model worth testing—but currently excluded from the enabling statute for CCI—is full integration of IHSS as a managed care plan benefit. Under this model, plans would assume full responsibility for IHSS assessment, including the authority to conduct reassessments as needed and alter hours as appropriate.

Both the size of the IHSS program and plans' lack of experience in administering this type of benefit raise concerns about whether the state should entrust all 15 demonstration plans with full assessment responsibilities. We therefore recommend that the Legislature enact legislation to test the full integration of IHSS as a managed care plan benefit with at least one demonstration plan in the third year of CCI. This would allow the first two years of CCI to serve as a period for plans to learn and prepare for IHSS assessment responsibilities. Potential candidates for receiving enhanced authority over IHSS include plans that have made the most progress toward LTSS integration. This framework would enable the Legislature to compare the advantages and trade-offs of two distinct models of integrating IHSS into managed care: (1) in the first two years, a more restrained approach that mainly relies on care coordination between demonstration plans and county welfare departments and (2) in the third year, a fully integrated approach among plans prepared for such a shift.

**Contact Information**

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Mark C. Newton	Deputy Legislative Analyst	319-8323	Mark.Newton@lao.ca.gov
Shawn Martin	Managing Principal Analyst	319-8362	Shawn.Martin@lao.ca.gov
Rashi Kesarwani	In-Home Supportive Services	319-8354	Rashi.Kesarwani@lao.ca.gov
Felix Su	Medi-Cal—Aged/Disabled	319-8344	Felix.Su@lao.ca.gov

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