California State Senate

COMMITTEE
ON
BUDGET AND FISCAL REVIEW

ROOM 5019, STATE CAPITOL
SACRAMENTO, CA 95814

SENATOR
MARK LENO
CHAIR

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Agenda

February 23, 2012
9:30 a.m. or Upon Adjournment of Floor Session
Room 4203

Governor's Proposals on Medi-Cal Managed Care: Expansion of Dual Eligible Pilot Projects and Integration of IHSS into Managed Care

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Expansion of Dual Eligible Pilot Projects and Integration of
In-Home Supportive Services (IHSS) into Managed Care

I. Administration's Proposals on Medi-Cal Managed Care Expansions and Long-Term Care Support and Services Integration

- Michael Wilkening, Undersecretary, California Health and Human Services Agency
- Toby Douglas, Director, Department of Health Care Services
- Will Lightbourne, Director, Department of Social Services
- Ross Brown, Felix Su & Virginia Bella, Legislative Analyst's Office

II. Discussion and Comment on Proposal to Expand Dual Eligible Pilot Projects Statewide *(20 minutes)*

- Maya Altman, Chief Executive Officer, Health Plan of San Mateo
- Dr. Richard Bock, Chief Medical Officer, Molina Health Plan
- Vanessa Cajina, Legislative Advocate, Western Center on Law and Poverty
- Dr. Bradley Gilbert, Chief Executive Officer, Inland Empire Health Plan
- Kevin Prindiville, Deputy Director, National Senior Citizens Law Center

III. Discussion and Comment on Proposed Integration of IHSS into Medi-Cal Managed Care *(20 minutes)*

- Frank Mecca, Executive Director, County Welfare Directors Association
- Deborah Doctor, Legislative Advocate, Disability Rights California
- Rebecca Malberg, Homecare Director, Service Employees International Union/United Healthcare Workers
- Kristina Bas Hamilton, Assistant Director, United Domestic Workers
- Karen Keeslar, Executive Director, California Association of Public Authorities
- Casey Young, Associate State Director-Advocacy, AARP
- Nancy Becker Kennedy, IHSS Consumer Union

IV. Closing Comments from Administration

V. Public Comment

PLEASE NOTE: *Only* those items contained in the agenda for today's hearing will be discussed. *Please* see the Senate File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

Medi-Cal Background Paper for February 23, 2012 Hearing

Governor's Proposals on Medi-Cal Managed Care: Expansion of Dual Eligible Pilot Projects and Integration of In-Home Supportive Services (IHSS) into Managed Care

I. INTRODUCTION

The Governor's budget includes a Coordinated Care Initiative for Medi-Cal enrollees. With this initiative, the Administration intends to improve service delivery for the 1.2 million people eligible for both Medi-Cal and Medicare (dual eligibles) and the 330,000 Medi-Cal enrollees who rely on long-term services and supports (LTSS). To achieve these improvements, the Administration proposes to combine the full continuum of medical services and LTSS into a single benefit package delivered through the Medi-Cal managed care delivery system starting on January 1, 2013. As a result, the Administration estimates that the state would realize $621 million General Fund savings in 2012-13 and $958 million General Fund savings in 2013-14.[1] Additionally, the Administration estimates that the proposal would generate $400 million in new revenue between 2012-2016 through the gross premium tax.

This background paper provides overviews of the Medi-Cal program, efforts underway to expand Medi-Cal managed care, and the state's LTSS programs, with a particular focus on the In-Home Supportive Services (IHSS) program. The paper also outlines the Governor's proposals and discusses how the Administration has rightly identified a need to better coordinate care and align fiscal incentives with best practices. Finally, the paper raises critical issues to consider in reviewing these proposals, including significant policy and implementation-related questions and concerns.

II. BACKGROUND ON MEDI-CAL

The Medi-Cal program provides health care services to about 7.7 million low-income Californians, including children, seniors, and people with disabilities. The 2011-12 Medi-Cal budget includes total expenditures of $50.2 billion ($15.3 billion General Fund). Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government. Medi-Cal is administered by the Department of Health Care Services (DHCS).

Medi-Cal Delivery and Payment Systems. Medi-Cal uses a variety of service delivery and payments systems. Originally, the primary payment mechanism was fee-for-service (FFS). Under FFS, a Medi-Cal enrollee obtains services from an approved Medi-Cal provider who is willing to take him/her as a patient for the service and accepts the Medi-Cal payment rate set by the state. In contrast, under Medi-Cal managed care, the Medi-Cal enrollee receives a defined package of benefits through a managed care plan. The plan is paid a per member capitated rate for each enrollee. Medi-Cal managed care currently covers approximately 4.3 million Medi-Cal enrollees in 30 counties.

Medi-Cal managed care is delivered through three models for its full-scope of services. These are:

- **County Organized Health System.** A County Organized Health System (COHS) is a local agency created by a county board of supervisors to contract with the Medi-Cal

[1] The savings estimates in this document reflect the Governor's January proposal and do not reflect a phase-in of the integration of long-term supports and services proposed by the Administration in February. Updated estimates are not yet available.

program. There are 14 counties in the COHS model. (COHS counties are: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo.)

- **Two-Plan Model.** Under the Two-Plan model, each designated county has two managed care plans: a local initiative and a commercial plan. (Two-Plan counties are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.)
- **Geographic Managed Care.** There are two Geographic Managed Care (GMC) counties in the state. In both counties (Sacramento and San Diego), the Department of Health Care Services (DHCS) contracts with several commercial plans to provide choices to the enrollees.

Mandatory Enrollment of Seniors and Persons with Disabilities into Managed Care. In November 2010, California received federal approval for a Section 1115(b) Medicaid waiver from Centers for Medicare and Medicaid Services (CMS) authorizing (among other provisions) expansion of mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This mandatory enrollment began on June 1, 2011, and will last 12 months. Approximately 20,000 people per month are being enrolled. Prior to this, enrollment into managed care was mandatory for children and families in the 30 counties with managed care and SPDs in the 14 COHS counties.

III. GOVERNOR'S 2012-13 PROPOSALS FOR MEDI-CAL MANAGED CARE

The 2012-13 Medi-Cal budget includes total expenditures of $57.7 billion ($14.8 billion General Fund). It also includes multiple proposals to expand Medi-Cal managed care and to contain costs for this delivery system.

General Fund Savings (dollars in thousands)

Proposal	2012-13
Medi-Cal Managed Care Expansions	
Managed Care Expansion to Dual Eligibles and Long-Term Care Integration	-$621,793
Healthy Families Program Transition to Medi-Cal Managed Care	-$64,377
Federally Qualified Health Center Payment Reform	-$26,046
Managed Care Expansion into Rural Counties	-$2,680
Eliminate the Sunset Date for the Gross Premium Tax	-$161,843
Medi-Cal Managed Care Cost Containment	
Value Based Purchasing	-$75,000
Align Managed Care Policies	-$56,984
Lock-In of Annual Open Enrollment	-$3,568
Managed Care Default Assignment	-$2,409

The Administration notes that many of these proposals generate savings immediately; however, since DHCS is budgeted on a cash basis, the incorporation of wrap-around payments for these

proposals into the managed care capitation rates will result in an initial first year cost to DHCS, with savings achieved in each subsequent year. To address this cost, the Administration is proposing to delay about $812 million in managed care payments and check-write to the next fiscal year.

A. Enrollment of Dual Eligibles into Medi-Cal Managed Care

i. BACKGROUND ON DUAL ELIGIBLES

About 1.2 million Medi-Cal enrollees are enrolled in both Medicare and Medi-Cal and are referred to as "dual eligibles." Medicare is the primary payer for dual eligibles and covers health services, such as physician and hospital services and short-term skilled nursing. Medi-Cal is the secondary payer and typically covers Medicare cost sharing and services not covered by Medicare, as well as services delivered after Medicare benefits have been exhausted. Most long-term care costs are paid for by Medi-Cal including longer nursing home stays and home and community based services designed to prevent institutionalization.

Dual eligibles tend to be low-income seniors and persons with disabilities with multiple chronic conditions and are among the state's highest-need and highest-cost users of health care services. As of January 2011, 70 percent of the dual eligibles were age 65 or older and 30 percent were between 22-64 years of age. Additionally, the vast majority of IHSS recipients (85 percent) are dual eligibles.

In 2007, California's spending on dual eligibles was about $7.6 billion, representing 23 percent of total Medi-Cal expenditures. The vast majority (about 85 percent) of these enrollees access services through the "fee-for-service" delivery system. It is estimated that about 16 percent (175,000) of dual eligibles are in a managed delivery system, such as the Program for All-Inclusive Care for the Elderly (PACE), Two-Plan Model managed care, or COHS. (PACE is a capitated benefit provided primarily to certain Medi-Cal and Medicare enrollees that offers a comprehensive service delivery system and integrates Medicare and Medicaid financing. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care.)

Dual Eligible Pilot Projects. Chapter 714, Statues of 2010 (SB 208), directs the California Department of Health Care Services (DHCS) to create new models of coordinated care delivery for dual eligibles through four pilot projects. To assist with this process, California received a $1 million planning grant from CMS' Office of the Duals and the federal Center for Medicare and Medicaid Innovation.

To implement SB 208, DHCS is planning the California's Dual Eligibles Demonstration Project (demonstration), a three-year demonstration launching on January 1, 2013. Sites interested in participating in this demonstration must submit their response to a Request for Solutions (RFS) by February 24, 2012. The announcement of the selected sites is expected in mid to late March. Once the sites are selected, DHCS will release a draft demonstration proposal for a 30-day public comment period. After the 30-day public comment period and the incorporation of comments on

the proposal, as needed, DHCS will submit the proposal to CMS for approval -- likely in late March or early April. Once the proposal is approved, it is anticipated that DHCS would enter into a Memorandum of Understanding (MOU) with CMS in July. The MOU would outline the specific requirements of the demonstration.

The RFS requires that applicants have, among other requirements, (1) a Knox-Keene license, (2) experience operating a Medicare Advantage Dual Eligible Special Needs Plan, (3) a current contract with DHCS to operate a Medi-Cal managed care contract in the same county as the proposed dual eligible site, and (4) a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders.

Five public stakeholder meetings were held throughout the state and were intended to inform the design and implementation of this demonstration.

ii. GOVERNOR'S 2012-13 BUDGET PROPOSALS RELATED TO DUAL ELIGIBLES

The Administration is proposing to expand the enrollment of dual eligibles into Medi-Cal managed care (dual eligibles in COHS counties are already in managed care) from the four demonstration pilots described above to statewide. The transition of this population and Medicare benefits into Medi-Cal managed care would be phased-in. Starting January 1, 2013, dual eligibles would be mandatorily enrolled into Medi-Cal managed care and would receive their Medi-Cal benefits via managed care. Also starting January 1, 2013, but only in 10 counties, Medicare benefits for dual eligibles would be provided via managed care. Medicare benefits would be phased-in to managed care throughout the state over three years. Twenty more counties would join the dual eligible demonstration on January 1, 2014, and the remaining 28 counties would participate in this demonstration as of January 1, 2015.

Medicare and Medi-Cal funding would be combined into a single payment to a managed care plan with this transaction. Furthermore, as discussed later, the Administration proposes to integrate long-term supports and services into the Medi-Cal managed care benefit starting January 1, 2013, and phased in over three years. Finally, the budget proposes to expand managed care into the remaining 28 rural counties that are now fee-for-service only beginning in June 2013.

Expansions to Medi-Cal Managed Care Timeline

	January 2013	June 2013	January 2014	January 2015
Dual Eligibles (Medi-Cal benefits)*	phase in over 12 months			
Dual Eligibles (Medicare Benefits)*	phase in over three years starting with 10 counties			
Long-Term Care Services*	phase in over three years starting with the 10 counties selected for the Dual Eligibles Demonstration			
Rural Counties		phase-in starting 2014-15		

*Enrollees in counties with managed care would be transitioned on the timeline above. Enrollees in non-managed care counties would begin their transition to managed care in 2014-15.

The Administration is assuming that in Year-1 (2013) they would transition the ten counties with the greatest dual eligible populations, comprising 74 percent of the total transition population, or 722,000 enrollees. Transition efforts in Year-2 (2014) would focus on the remaining managed care counties comprising 16 percent of the total transition population and Year-3 (2015) transition efforts would focus on the remaining, primarily rural, FFS counties comprising 10 percent of the total transition population.

Since federal law prohibits the mandatory enrollment of Medicare enrollees into managed care, the Administration is proposing a passive enrollment of these individuals whereby, dual eligibles would be enrolled into managed care but given the option to return to fee-for-service for Medicare benefits.

Medicare Shared Savings

The Administration estimates $42 million in General Fund savings in 2012-13, $412 million in General Fund savings in 2013-14, and growing savings in out years. To determine the Medicare Shared Savings, the Administration made the following assumptions (among others):

- The state will share savings 50:50 with the federal government.
- Inpatient hospital utilization will drop by 15 percent in 2012-13, 20 percent in 2013-14, 20 percent in 2014-15, and 20 percent in 2015-16.
- Skilled Nursing Facility (SNF) utilization will drop by 5 percent in 2012-13, 5 percent in 2013-14, 5 percent in 2014-15, and 5 percent in 2015-16. This applies only to those enrollees not enrolled in a Long-Term Care aid code.
- Physician utilization will increase by 4 percent in 2012-13, 5 percent in 2013-14, 5 percent in 2014-15, and 5 percent in 2015-16.
- Pharmaceutical utilization will increase by 2 percent in 2012-13, 2 percent in 2013-14, 2 percent in 2014-15, and 2 percent in 2015-16.

General Fund Savings from Medicare Shared Savings

	2012-13 (six months)	2013-14	2014-15	2015-16
Medicare Shared Savings	$42,125,000	$412,734,000	$556,108,000	$651,929,000

These assumptions are generally based on DHCS' rate development experience for Medi-Cal-only SPDs transitioning from fee-for-service into managed care and reflect a two-year phase-in of savings for hospital and physician utilization. Furthermore, DHCS assumes 1) managed care plans need time to gain experience with this new Medicare rate structure before they can achieve full savings, 2) a number of months of increased care coordination may need to take place before savings are achieved, and, 3) most of the savings from SNF utilization for this population are reflected in the proposal to integrate LTSS into managed care.

iii. ISSUES TO CONSIDER

Administration Has Foregone Pilot Phase and Opportunity to Learn From Demonstrations. The purpose of SB 208 was to develop dual eligibles pilot projects in order to develop effective health care models that integrate Medicare and Medi-Cal services and to learn from these pilots. Under SB 208, the Administration is required to conduct an evaluation to assess outcomes and the experience of dual eligibles in these pilot projects and is required to report to the Legislature after the first full year of pilot operation and every year after. With this proposal, the Administration has forgone this pilot stage and the ability to learn from the demonstration projects by proceeding with the *statewide* enrollment of dual eligibles into managed care.

Challenges Identified in Mandatory Enrollment of SPDs into Managed Care. The mandatory enrollment of SPDs into managed care that is still underway has identified challenges with ensuring that enrollees receive uninterrupted and coordinated care. For example, policies allowing enrollees to remain with their fee-for-service provider because of medical instability for 12 months appear to have been misunderstood and inconsistently applied. Additionally, given that about 60 percent of SPDs are defaulted into a managed care plan, it is likely that more beneficiary and provider outreach and education are necessary to ensure continuity of care.

Consumer Protections and Continuity of Care Assurances Are Critical. The Administration's goals of enrolling dual eligibles into managed care include: (1) improving the beneficiary's health care, quality of life, and satisfaction with the health care system by eliminating fragmentation and inefficiencies that result from the incongruities between Medicare and Medi-Cal, (2) developing financial models that drive streamlined and coordinated care through shared savings and the elimination of cost shifting, and (3) promoting and measuring improvements in health outcomes. While these are important goals, it is critical to ensure that consumer protections and quality measures are in place to ensure that a beneficiary receives uninterrupted quality care especially given that dual eligibles have significant health care needs.

Significant Work Needs to Be Done with Federal Government. Integrating Medicare and Medi-Cal services and financing will require a considerable amount of time and effort. These programs have different policies, standards, and appeals processes. Although representatives from CMS have been involved in the discussions regarding the dual eligibles pilots, navigating the differences between these programs will be challenging.

Details on Shared Medicare Savings Not Yet Available. Detailed information on the assumptions listed above are not yet available. For example, it is not clear why the Administration estimates that inpatient hospitalization will drop by 15 percent. Nor does the state have a guarantee of 50 percent of the shared savings. Changes to these assumptions could have major impacts to the projected General Fund savings.

iv. QUESTIONS

1. How will care for dual eligibles under a managed care system be improved? What quality of care performance metrics will be used to evaluate this initiative?

2. How is the department working with stakeholders to ensure that lessons learned from the recent and ongoing transition of seniors and persons with disabilities to managed care will be incorporated into this transition?

3. What steps is the department taking to engage and educate the provider community to help ensure that care is uninterrupted and coordinated with these proposals?

4. Why does the Administration feel that the state should forgo the four pilot demonstrations and the opportunity to learn from these implementations?

B. Integration of Home and Community Based and Long-Term Care Services, including IHSS, into Medi-Cal Managed Care

i. BACKGROUND ON LONG-TERM CARE SUPPORTS AND SERVICES

Medi-Cal provides long-term care services in both institutional (nursing home) and home and community-based settings.

California's long-term care services include:

- **Nursing Facilities.** The 2011-12 Medi-Cal budget includes over $4 billion (total funds) in nursing facility expenditures. Nursing facilities provide continuous skilled and supportive care on a 24-hour basis. Such care is comprised of inpatient treatment, including physician, skilled nursing, dietary, pharmaceutical, and activity services.
- **In-Home Supportive Services (IHSS) program.** IHSS provides personal care services to about 445,000 individuals who are blind, aged (over 65), or who have disabilities. The 2011-12 IHSS budget includes $5.0 billion total funds ($1.4 billion General Fund). See below for more detailed background on IHSS.
- **Multipurpose Senior Service Program (MSSP).** With a budget of $40.5 million ($20.2 million General Fund), MSSP provides case managed services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be age 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services and then work with the clients, their physicians, families, and others to develop an individualized care plan. Services that may be provided with MSSP funds include, but are not limited to: care management, adult social day care, housing assistance, in-home chore and personal care services, respite services, transportation services, protective services, meal services, and special communication assistance. The California Department of Aging currently oversees operation of the MSSP program statewide and contracts with local entities that directly provide MSSP services. The program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services Waiver and serves approximately 12,000 clients per month.
- **Community-Based Adult Services (CBAS) program.** The CBAS program will replace the Adult Day Health Care (ADHC) program on April 1, 2012. AB 97 (Chapter 3, Statutes of 2011) eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit sought to challenge the elimination. A settlement of the lawsuit was reached that establishes a new program, CBAS. The Administration estimates that approximately 15,000 of the 35,000 people that were formerly eligible for ADHC will be eligible for CBAS. (There is no cap on enrollment.) ADHC/CBAS is an organized day program of therapeutic, social and health activities and services provided to elderly persons or other persons with

physical or mental impairments. The ADHC/CBAS budget for 2011-12 is $289 million ($144.5 million General Fund).

- **Home- and Community-Based (HCB) Waiver programs.** HCB waiver programs are alternatives for individuals who would otherwise require care in a nursing facility or hospital. For example, the In-Home Operations Waiver provides home and community based services to Medi-Cal eligible persons with severe disabilities requiring acute care in a hospital for more than 90 days.

Currently, Medi-Cal managed care health plans bear limited financial risk for enrollees who are placed in long-term care institutions, such as nursing homes, and for the most part, do not currently cover home and community based services. These institutional services currently are only covered under Medi-Cal FFS.

ii. ADDITIONAL BACKGROUND ON IHSS

With a 2011-12 budget of $5.0 billion ($1.4 billion GF), the IHSS program provides personal care services to approximately 440,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. IHSS services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings. The maximum number of monthly hours a beneficiary can receive is 283.

Funding and Oversight: IHSS is funded with federal, state, and county resources. Recently, the state opted to implement the program under a new federal Medicaid waiver option called the Community First Choice Option (CFCO), which offers an enhanced rate of 56 percent federal financial participation (six percent over the base rate of 50 percent). The state is also benefitting from an additional enhanced rate of 75 percent for a period of one year for IHSS recipients transitioning from nursing facilities to community-based settings. The state and counties split the non-federal share of IHSS funding at 65 and 35 percent, respectively. The average annual cost of services per IHSS client is estimated at $11,420 for 2012-13. The Department of Social Services oversees local administration of the program, which is usually managed by county social services agencies and public authorities.

Program Structure and Employment Model: County social workers determine eligibility for IHSS after conducting a standardized in-home assessment, and periodic reassessments, of an individual's ability to perform specified activities of daily living. Once eligible, the recipient is responsible for hiring, firing, and directing an IHSS provider or providers. The counties or public authorities must conduct a criminal background check and provide an orientation before a provider can receive payment. At the end of 2011, there were just over 366,000 working IHSS providers. County public authorities are designated as "employers of record" for collective bargaining purposes, while the state administers payroll, workers' compensation, and benefits. Hourly wages for IHSS providers vary by county and range from the minimum wage of $8.00 per hour in nine counties to $12.20 in one county. The state participates in the costs of wages up to $12.10 ($11.50 plus $.60 for health benefits) per hour, with counties paying the difference if

they negotiate a higher wage. In approximately 72 percent of cases, IHSS recipients choose a family member to provide care (including roughly 45 percent of providers who are a spouse, child, or parent of the recipient). In around half of cases, IHSS providers live with the recipients. Public authorities also maintain registries of approved caregivers for recipients who want assistance finding a provider.

Recent Changes: The last three budgets included significant changes to IHSS. The following are in effect or pending implementation (savings are annual for 2012-13 unless otherwise noted):

Additional **program integrity measures**, including background checks and criminal records exclusions for providers, more training for social workers, changes to time sheets, and directed mailings or unannounced home visits when there is a concern.
Savings of $151.1 million General Fund from a requirement for recipients to obtain from a licensed health professional **a certification of their need** for services to prevent risk of out-of-home care.
Savings of $145.1 million General Fund from the federal **CFCO waiver** option.
Upon federal approval, savings of $95.5 million General Fund as a result of a **sales tax on supportive services** and matching funds for the use of the tax revenues.
Current year savings of $64.4 million General Fund from an **across-the-board reduction** of 3.6 percent in all recipients' authorized hours until July 1, 2012.
Increases in **out-of-pocket costs for consumers** (resulting from elimination of what was called a "share-of-cost buy-out").
Reductions in administrative funding for Public Authorities.

The following changes were also enacted, but federal courts have stopped them from taking effect as a result of ongoing litigation:

Savings of approximately $222.0 million General Fund (full year impact) from an **across-the-board reduction**, subject to specified exemptions and exceptions, of 20 percent of authorized hours. This reduction was triggered by lower than anticipated 2011-12 revenues.
Savings of $65.5 million General Fund from reducing to $10.10 ($9.50 plus $.60 per hour for health benefits) the maximum provider **wages** the state participates in.
Elimination of **eligibility**, subject to exemptions, for domestic and related services or all services, for individuals whose needs were assessed to be below a specified threshold.[2]

[2] This reduction has been statutorily delayed until July 1, 2012, subject to a final court order upholding the policy. No updated estimate of the savings associated with the policy is available at this time.

iii. GOVERNOR'S 2012-13 BUDGET PROPOSALS RELATED TO INTEGRATION OF LONG-TERM CARE INTO MEDI-CAL MANAGED CARE

The Governor's January budget proposes $580 million General Fund savings in 2012-13 (achieved via a payment deferral because Medi-Cal is budgeted on a cash basis) from integrating long-term supports and services (LTSS), which include long-term institutional care and home and community based services (HCB), into Medi-Cal managed care. For 2013-14, the Administration estimates $546 million in savings from this proposal (dropping to $429 million and $408 million in the following two fiscal years, respectively).

The Administration's goals for incorporating LTSS into managed care are to promote the coordination of health and social care for Medi-Cal enrollees and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than HCB care and the rates for hospital and nursing home care are set by the state). Consequently, in the first year the Administration anticipates that savings would result from changes that include a 22 percent reduction in inpatient hospital services and a 12 percent decrease in long-term care nursing facility services in the first year. These reductions would be offset by a six percent increase in HCB services in the first year, as well as increases in primary health care. Overall, the Administration estimates savings equivalent to three percent of the total that would otherwise be spent under the fee-for-service health care model in 2012-13. The Administration indicates that these estimates are based on prior experience with shifts from fee-for-service to managed health care, including data from other states such as Arizona and Tennessee.

Phase-in of Proposed Integration: Under a February revision to the Governor's proposal, the inclusion of institutional long-term care, IHSS, MSSP, and other community-based services (except for CBAS) would begin January 1, 2013 with the 10 counties selected to be part of the dual eligibles demonstration in the first year and be phased in over three years. Starting January 1, 2014, these services would become managed care benefits in the remaining 20 Medi-Cal managed care counties as the dual eligibles demonstration project is expanded to those counties. Finally, on January 1, 2015 the remaining 28 counties would transition to include these LTSS as part of the Medi-Cal managed care benefit. To conform to the Adult Day Health Care (*Darling v. Douglas*) settlement agreement, CBAS would become a managed care plan benefit in all managed care counties sooner- on July 1, 2012. The details that follow regarding proposed changes during these timeframes are based on a conceptual description from the Administration. Detailed trailer bill language and updated fiscal estimates have not yet been made available.

Creation of a Uniform Assessment Tool: Currently, each LTSS proposed to be included in managed care has its own assessment process. The Administration proposes to have the Departments of Health Care Services, Social Services, and Aging lead a stakeholder process to develop of a uniform assessment tool that would replace these multiple processes and be used for IHSS, MSSP, CBAS, Nursing Facilities, and Home- and Community-Based Waiver programs. The stakeholder process would begin in June 2013, and the new assessment tool would be implemented upon completion of design, development, system testing, and training, no earlier

than January 1, 2015. This assessment tool would be separate from and would not replace the assessment process used by managed care plans when enrollees initially enroll.

Integration of MSSP: The Administration proposes to maintain the current eligibility process for MSSP in 2013, and plans would be expected to contract with MSSP sites. In 2014, the managed care requirement established in 2013 would be applicable to all 30 of the current managed care counties. Additionally, in 2014, managed care plans would be permitted to contract with MSSP sites or hire and incorporate the MSSP staff into the health plans' care management teams. In 2015, MSSP would only be available as a managed care plan benefit in all counties and would use the uniform assessment tool.

Integration of Nursing Facilities and Home- and Community-Based Waiver Programs: Starting in 2013, for Medi-Cal enrollees in the initial 10 counties in the dual demonstration, institutional nursing facility and Home and Community-Based Waiver programs would only be available as managed care plan benefits. The plans would authorize institutional nursing facility services in 2013. In 2014, this policy would be expanded to the remaining 20 managed care counties, and in 2015 this policy would be expanded to all other counties.

Integration of IHSS: In 2013, the Administration proposes that counties would continue to assess recipients' needs and rely on current statutory provisions as the basis for authorizing service hours. In the 10 counties then participating in the proposed dual eligibles demonstration project, this work would be performed on behalf of and in coordination with managed health care plans. The plans could authorize an increase (but not a decrease) in IHSS hours and could provide or coordinate other needed services. DSS would continue to perform payroll functions for IHSS providers. Additionally, health plans would establish care coordination teams that include the consumer, health plan, county social service agency, and others whom the consumer chooses to include.

In 2014, in the 10 initial counties plus 20 additional managed care counties, the Administration proposes that IHSS assessment and authorization would be made through a "joint assessment process with health plans and counties, in accordance with the current statutory provisions for IHSS eligibility." Also beginning in 2014, counties would no longer have a share of overall non-federal IHSS costs. There would instead be a newly established county Maintenance of Effort requirement (MOE). This MOE would be based on current expenditures and trends and would be used to support managed care capitation payments. Further, health plans would establish "financial incentives for counties to reduce institutional care and achieve other performance objectives." The uniform assessment tool would be used as the basis for assessing IHSS hours in all counties beginning in 2015.

The Administration has also indicated its intent to preserve the ability of IHSS consumers to hire, fire, and direct their care providers. However, the Administration has not indicated whether or how other aspects of the employment relationships under the current IHSS program (e.g., the role of Public Authorities as employers of record and the process for setting wages) might change.

iv. ISSUES TO CONSIDER

Integration of Medical and Social Services Valuable Goal. Long-term care has traditionally been dominated by the medical model, in which focus is placed primarily on an individual's disease or condition rather than their overall needs. However, this model fails to take into account the effect an individual's behavioral health and social supports has on their physical health. Some of the most successful long-term care programs are those that integrate medical and social services, and in doing so, improve a person's health status and overall quality of life. Furthermore, most studies have found that managed long-term care programs reduce the use of institutional services and increase the use of home and community based services relative to fee-for-service programs. In addition, the current fragmented system of programs and services can leave enrollees on their own to link their needs with available services. Making a health plan responsible for the delivery of all benefits, health and social, could lead to better care coordination. However, this integration is a complex endeavor and there are significant programmatic and implementation issues that must be addressed.

Need for Stakeholder Engagement. The Administration notes that they have had extensive stakeholder discussions regarding the dual eligible pilots; however, the primary focus of these discussions was not the integration of long-term care services statewide. Several stakeholders have thus far expressed concerns regarding or opposition to the broad scope and short timelines included in the Governor's LTSS integration proposal.

Need for Additional Information. Many policies governing eligibility for and the provision of LTSS, including IHSS in particular, are detailed in state statutes and state plans that have developed over the course of decades. And while recent changes to the Administration's proposal provide some additional information regarding proposed policy changes and estimated savings and phase implementation in more slowly, many details are still unaddressed. In addition, the phase-in does not currently require Legislative action over time to incorporate and build upon experiences gained as the changes roll out. The Administration is seeking upfront authority for all of the phases.

Must Monitor Outcomes. If LTSS were to become managed care benefits, it would be important for the state to develop measures to evaluate enrollee outcomes to ensure that managed care plans are not cutting long term care services and costs inappropriately. Additionally, it would be important for the capitation payment to be set at the right level to encourage plan behavior that leads to improved health outcomes.

Legislative Analyst's Office Identifies Significant Implementation Issues. The Legislative Analyst's Office's (LAO) review of the Administration's proposal found that in concept coordinating care for these enrollees has merit because it attempts to address the problems with the fragmented system of delivering medical care and LTSS. But the LAO also identified implementation issues that must first be addressed, such as ensuring proper oversight and rate development for managed care plans, maintaining continuity of care for enrollees, and determining the level of program control granted to plans. As a result, the LAO recommends

against making decisions at this time to expand the dual eligible demonstration statewide and make LTSS managed care benefits statewide.

v. QUESTIONS

1. How has the Administration engaged stakeholders in developing its proposal for integrating LTSS into managed care? How does the Administration plan to engage stakeholders going forward?

2. Research indicates that there is an absence of standard outcome measures for LTSS. What is the Administration doing or what does it plan to do to develop these outcome measures to ensure that health plans would be held accountable for managing and coordinating care?

3. What are the relevant experiences in California and in other states that form the basis of the Administration's estimated savings and how well do they apply to the current proposal?

4. In January, the Administration proposed to integrate long-term supports and services into managed care for all Medi-Cal managed care enrollees starting in January 2013. However, this week the Administration has updated its proposal to phase in the integration of these services starting with the 10 counties selected to be part of the dual eligible demonstration. Please explain the rationale for changing the proposal.

5. What is the relationship with respect to LTSS, including IHSS, that the Administration envisions between counties and health plans in 2015 and beyond? Who does the Administration propose to have conduct assessments for and ultimately to authorize LTSS at that time?

6. Would IHSS consumers in 2015 and beyond retain the right to hire, fire, and direct their caregivers under the Administration's proposal? How might the rest of the employment relationships under the current program change (or not change) at that time?

7. How do these proposals strike the right balance between managing care and managing costs?

8. Given that most of the savings related to these proposals are a result of deferred payments, why is the Administration moving so quickly to undertake such major changes in the delivery of services?