

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Mark DeSaulnier

**Senator Elaine K. Alquist
Senator Bill Emmerson**



April 26, 2012

**9:30 AM or
Upon Adjournment of Session**

**Room 4203
(John L. Burton Hearing Room)**

(Michelle Baass and Jennifer Troia)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily 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.

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VOTE ONLY CALENDAR

4260 Department of Health Care Services

The following issues were discussed at the Subcommittee #3 Hearing on March 22, 2012 (http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/3222012Sub3AgendaMRMIB_DHCS.pdf):

1. **Lock-In at Annual Open Enrollment for Medi-Cal Managed Care**
 - Subcommittee Staff Recommendation—Reject Administration’s proposal.
2. **Federally Qualified Health Center/Rural Health Clinic Payment Reform**
 - Subcommittee Staff Recommendation—Reject Administration’s proposal.
3. **Redirecting Unpaid Stabilization Funding**
 - Subcommittee Staff Recommendation—Approve Administration’s proposal.

As discussed at the March 22, 2012 hearing, the hospital quality assurance fee and the intergovernmental transfer program have resulted in billions of additional revenue being provided to these hospitals. See table below for the Administration’s estimates of the net benefits of these programs in comparison to the proposed loss in stabilization funding.

	4/2009-12/2010	1/2011-6/2011	7/2011-12/2013	Total Net Benefit of QAF and IGT	Proposed Loss in Stabilization Funding
Private Disproportionate Share Hospitals					
Hospital Quality Assurance Fee (QAF) Net Benefit	\$1.3 billion	\$600 million	\$3.2 billion	\$5.1 billion	\$107 million
Non-Designated Public Hospitals (District)					
Hospital QAF Net Benefit	\$60 million		\$46.5 million	\$198 million	\$2 million
Intergovernmental Transfer (IGT) Program Benefit		\$17 million	\$75 million		

4. **Access Monitoring Program**
 - Subcommittee Staff Recommendation—Approve Administration’s proposal.

ISSUES FOR DISCUSSION

A. 4260 Department of Health Care Services

1. Default Managed Care Plan Assignment

Budget Issue. The Administration intends to change how it selects a default managed care plan when a Medi-Cal enrollee does not make a health plan selection. The Administration proposes to consider health plan cost in addition to quality of care and safety net population factors as part of the default algorithm. Specifically, the default algorithm would be adjusted to increase defaults to low cost plans by 5 percent.

Savings would be recognized based on the shift of beneficiaries that would have been defaulted to the higher cost plans under the normal default ratios to lower cost plans. General Fund savings for 2012-13 are projected to be \$2.4 million and \$5.8 million for 2013-14.

This default algorithm would be implemented for Geographic Managed Care (GMC) and Two-Plan counties with the exception of Kings and Madera counties. Managed care is new in these counties and consequently, plans in these counties are currently paid the same capitation rate since health plan quality data is not yet available. It is anticipated that beginning on January 1, 2013, plans in these two counties would use the proposed default algorithm (as health plan quality data would be available).

Background. When a Medi-Cal enrollee does not select a Medi-Cal managed care plan, a default health plan is assigned. Currently, the default algorithm defaults beneficiaries into a plan based health plan quality (6/8 of the weighting, using six HEDIS measures) and safety net population factors (2/8 of the weighting). This algorithm is based on Family and Seniors and Persons with Disabilities (SPD) aid categories. DHCS has regulatory authority to determine how assignments of default beneficiaries are to be made.

In 2011, 40 percent of new Medi-Cal managed care enrollees were defaulted into a health plan. See table below for more specific information.

Table: New Medi-Cal Managed Care Enrollee Health Plan Assignment for 2011

Plan Type	New Enrollment	Choice		Defaults					
				Linked to Prior Plan		Auto Assigned Using Algorithm		Combined Defaults	
				Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll
GMC	230,801	143,974	62%	26,440	11%	60,387	26%	86,827	38%
Two-Plan	1,336,706	796,620	60%	189,135	14%	350,951	26%	540,086	40%
Combined	1,567,507	940,594	60%	215,575	14%	411,338	26%	626,913	40%

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue regarding the Administration’s proposals to expand Medi-Cal managed care.

Questions. The Subcommittee has requested the Administration respond to the following question:

1. Please provide an overview of this proposal.

2. Align Managed Care Policies for Retroactive Medi-Cal

Budget Issue. The Administration proposes to shift a County Organized Health System (COHS) health plan's responsibility for the retroactive period of Medi-Cal to the Fee-For-Service (FFS) system. This proposal would result in a one-time savings of \$57 million General Fund in 2012-13 and annual ongoing savings thereafter of \$7.6 million General Fund.

DHCS is working with the COHS health plans to adjust their capitation rates to no longer account for the retroactive period (since these costs would now be paid under FFS).

Background. Medi-Cal covers the costs of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal.

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 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.

The three models of Medi-Cal managed care handle payment for retroactive periods differently. Currently COHS health plans receive an adjustment in their capitation rates for the cost of the retroactive period. In contrast, Two-Plan and Geographic Managed Care health plans do not receive an adjustment to their capitation rates for this cost. Instead, these costs are paid by the FFS system.

Subcommittee Staff and Recommendation—Approve. It is recommended to approve this item. No issues have been raised.

Questions. The Subcommittee has requested the Administration respond to the following questions:

1. Please provide an overview of this proposal.
2. What is the status of the department's discussions with COHS health plans on the rate adjustment?

3. Eliminate Gross Premium Tax Sunset Date for Medi-Cal Managed Care Plans

Budget Issue. The Administration proposes trailer bill language that eliminates the sunset date for the existing gross premiums tax (GPT) imposed on Medi-Cal managed care plans. The Administration estimates that this will generate \$161.8 million in General Fund savings in 2012-13 and \$259.1 million in General Funds savings in 2013-14.

The GPT is expected to generate \$352 million in revenues. Half of the revenues, or about \$176 million, will be matched with federal funds to provide for an increase in capitation payments to Medi-Cal managed care plans.

The revenue under the GPT will continue to increase in 2012-13 and 2013-14 with the expansion of managed care to Seniors and Persons with Disabilities, the proposed integration of long term care benefits into managed care, the proposed transition of Healthy Families Children into Medi-Cal, the proposed integration of Federally Qualified Health Center (FQHC) payments into managed care and the expansion of Medi-Cal to childless adults in 2014 (as required by federal health care reform).

Table: Gross Premium Fund Transfer to the General Fund (in millions)

Gross Premium Tax Applications	
Base Medi-Cal Managed Care Program	\$106.5
SB 335 - Hospital Fee	31.2
2012-13 Budget Proposals	
Coordinated Care Initiative	\$10.7
Healthy Families Program Transition to Medi-Cal	5.9
FQHC Payment Reform	7.5
Total	\$161.8

Background. The GPT on Medi-Cal managed care plans was authorized by AB 1422 (Statutes of 2009) for the period of January 1, 2010 through December 31, 2010 and is a GPT on the total operating revenue of Medi-Cal managed care plans. The GPT was extended through July 1, 2011 by SB 853 (Statutes of 2010). Subsequently, ABX1 21 (Statutes of 2011) extended the sunset date to July 1, 2012.

The GPT provides a funding source for the Healthy Families Program (HFP) by adding managed care plans to the list of insurers subject to California’s GPT of 2.35 percent. The GPT enables the state to draw down federal moneys, allocated according to the federal medical assistance percentage (FMAP), to fund children’s health services under the HFP.

SB 335 (Statutes of 2011) implemented a new hospital quality assurance fee (QAF) program on hospitals from July 2011 to December 2013. The new QAF program provides for increased payments to managed health care plans which will increase the total operating revenue of the Medi-Cal managed care plans.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions regarding proposals that directly impact the GPT, such as the transition of Healthy Families children to Medi-Cal and the Coordinated Care Initiative, are still open.

Questions. The Subcommittee has requested the Administration respond to the following question:

1. Please provide a summary of this proposal.

4. Community-Based Adult Services Program

Budget Issue. The Administration proposes \$289.1 million (\$144.6 million General Fund) for the transition of Adult Day Health Care (ADHC) benefits in 2011-12 and \$166.3 million (\$83.1 million General Fund) in 2012-13. The current year estimate accounts for continuing ADHC benefits until March 1, 2012.

Background. AB 97 (Statutes of 2011) eliminated ADHC as an optional Medi-Cal benefit to provide for an estimated \$170 million in General Fund savings in 2011-12. The 2011 budget provided \$85 million (General Fund) to provide for a temporary transition program for existing ADHC enrollees to other Medi-Cal appropriate services. As part of this transition, the Legislature provided for the development of policy legislation to create a federal Waiver program, but the Governor vetoed this budget bill language.

Settlement Agreement. Consequently, through the summer and fall of 2011, the Administration developed a transition plan for existing ADHC beneficiaries. However, as part of the settlement of a lawsuit that challenged the elimination of the ADHC benefit, an agreement was reached between the state and the plaintiffs to phase out the ADHC program and replace with a new program called the Community-Based Adult Services (CBAS) that will provide necessary medical and social services to those with the greatest need. CBAS will be provided as a Medi-Cal managed care benefit no sooner than July 1, 2012.

CBAS Eligibility. At the time of the settlement, DHCS had estimated that roughly half of the “settlement class” (approximately 40,000 individuals who received ADHC services on or since July 1, 2011 through February 29, 2011) would qualify for CBAS; however, it is now estimated that approximately 80 percent of the class would be eligible.

Eligibility to participate in CBAS would be determined by state medical professionals on the basis of medical need, and the benefits provided would be coordinated with managed care plans. The CBAS program was originally expected to be implemented on March 1, 2012, but was not implemented until April 1, 2012, because of delays in getting federal CMS approval.

CBAS Providers. Additionally, as part of the settlement, DHCS will primarily use non-profit providers for CBAS services. CBAS Standards of Participation require, after July 1, 2012, a CBAS provider to convert to a non-profit entity unless it meets one of the following exceptions:

1. The for-profit CBAS provider offers program specialization that meets the specific health needs of CBAS-eligible participants not otherwise met by any other CBAS provider in the participants' geographic area.
2. The for-profit CBAS provider's operation is necessary to preserve an adequate number of CBAS providers for CBAS-eligible participants to transition without interruption in services due to wait lists.

3. DHCS determines that a provider needs additional time beyond July 1, 2012, to complete its conversion to non-profit status.

After July 1, 2012, DHCS retains the discretion to reexamine whether one of the above-listed exceptions for a for-profit CBAS provider still applies to that CBAS provider, and in doing so, DHCS may withdraw the exception as needed.

With the CMS delay of the state's waiver approval by one month, DHCS delayed advising CBAS centers on specific criteria related to the non-profit exceptions until April. DHCS has started conversations with provider representatives and will release additional information about these requirements to providers/stakeholders in the coming weeks.

DHCS has received 275 CBAS provider applications. Of these, 268 have been approved, 3 have been denied, and 4 have been withdrawn. As of April 16, 2012, there are 260 open CBAS centers in the state. (In December 2011, there were 271 ADHC centers in the state.) Of the 268 approved centers, 193 are for-profit CBAS providers and 75 are non-profit CBAS providers.

Contempt Motion. At the end of March 2012, Disability Rights California (DRC) filed a contempt motion stating that DHCS had not been following the terms of the settlement agreement. Since then, DRC and DHCS have come to agreement on the following:

- Both sides agree that DHCS will not be required to conduct further presumptive eligibility reviews.
- Both sides agree that a denial of presumptive eligibility is not appealable at a fair hearing.
- Both sides agree that the 37,000 people with disabilities and seniors who are part of the settlement class and were determined ineligible for the new CBAS program prior to April 1, 2012, who were not eligible to receive CBAS-pending, but who prevail at their respective fair hearings, will be deemed eligible CBAS retroactive to the date of CBAS implementation, April 1, 2012.
- The DHCS will coordinate with DRC and the California Department of Social Services State Hearings Division to offer optional telephonic hearings for the settlement class.

The other issue discussed in the contempt motion is the quality assurance process for the more than 315 eligibility determinations from 13 ADHC centers. A workgroup from DHCS and ADHC representatives have met and are still working toward an agreement. If an agreement is not reached, a court hearing is scheduled for April 27, 2012.

Subcommittee Staff Comments and Recommendation—Hold Open. As discussed above, there was a one month delay in the implementation of CBAS and 80 percent (rather than 50 percent) of those who received ADHC services are estimated to be eligible for CBAS. As a result, the estimates for the transition period will be updated by DHCS at May Revise. Consequently, it is recommended to hold this item open.

Questions. The Subcommittee has requested the Administration respond to the following questions:

1. Please provide a brief review of the transition of ADHC to CBAS.
2. Please provide an update regarding the contempt motion and the outstanding issue to be resolved.

5. Expand Medi-Cal Managed Care to All Counties

Budget Issue. Beginning in June 2013, the Administration proposes to expand Medi-Cal managed care into the 28 rural counties that are now Fee-For-Service (FFS) (see table below). This proposal would result in General Fund savings of \$2.7 million in 2012-13 and \$8.8 million in 2013-14.

Table: Medi-Cal Fee-For-Service Counties

County	Number of Medi-Cal Eligibles	County	Number of Medi-Cal Eligibles
Alpine	204	Modoc	1,866
Amador	4,095	Mono	1,143
Butte	47,834	Nevada	10,452
Calaveras	6,106	Placer	28,269
Colusa	4,271	Plumas	2,971
Del Norte	7,706	San Benito	9,334
El Dorado	17,216	Shasta	38,039
Glenn	6,610	Sierra	458
Humboldt	25,208	Siskiyou	9,759
Imperial	54,563	Sutter	21,724
Inyo	3,213	Tehama	16,049
Lassen	4,544	Trinity	2,628
Lake	16,556	Tuolumne	7,511
Mariposa	2,599	Yuba	18,857
		Total	369,785

Request for Information. On March 30, 2012, DHCS released a Request for Interest (RFI) in providing Medi-Cal managed care services in the 28 FFS only counties. In the RFI, DHCS is requesting managed care health plans to express their interest in providing Medi-Cal covered services (with a complete provider network) in five ways: (1) in the 26 contiguous county region, (2) in a combination other than in all 26 contiguous counties, (3) in three regions (Northern, Central, and Border), (4) in San Benito and/or Imperial counties, and (5) in an alternate proposal. Responses to this RFI must be submitted by April 23, 2012.

Previous Geographic Managed Care Expansions. The Budget Act of 2005 authorized the DHCS to expand the Medi-Cal managed care program to 13 new counties: El Dorado, Imperial, Kings, Lake, Madera, Marin, Merced, Mendocino, Placer, San Benito, San Luis Obispo, Sonoma, and Ventura. Expansion to all of these counties has not yet occurred and in some of the cases where it did occur, it took three years longer to implement. For example, Ventura County’s original implementation date was April 1, 2008; however, the implementation did not occur until July, 1, 2011. Expansion has not occurred in Imperial, San Benito, and El Dorado Counties based on consultation with the counties’ local stakeholders, nor has it

occurred in Placer County because two of the three interested health plans were unable to participate.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue between the Administration and stakeholders on the feasibility of expanding managed care throughout the state. Given the past difficulties in expanding managed care into rural counties; it is unclear how the Administration’s proposal is feasible.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Please provide a summary of this proposal.
2. What is the proposed timeline to implement this proposal?
3. Has the department received any responses to the RFI (which were due April 23, 2012)?
4. What lessons did the department learn from the past geographic managed care expansion?

B. 4260 Department of Health Care Services & 5180 Department of Social Services

1. Coordinated Care Initiative

Budget Issue. 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 1.1 million people eligible for both Medi-Cal and Medicare (dual eligibles) and 330,000 additional Medi-Cal enrollees who rely on long-term services and supports (LTSS).

The Coordinated Care Initiative is composed of the following proposals:

- A. Expansion of Dual Eligible Demonstration Project.** Expand the enrollment of dual eligibles into Medi-Cal managed care from the four demonstration pilots (as provided under SB 208, Statutes of 2010) to up to 10 counties in 2013 and statewide by 2015.

- B. Integration of Long-Term Supports and Services into Medi-Cal Managed Care.** Integrate home- and community-based long-term supports and services (LTSS) into Medi-Cal managed care for Medi-Cal enrollees in up to 10 counties in 2013 and statewide by 2015.

It should be noted that although these proposals are intertwined as proposed by the Administration, they could be acted upon separately by the Legislature.

The Administration’s January proposal assumed that Medi-Cal LTSS benefits would be included as part of the managed care benefit for *all* Medi-Cal beneficiaries (dual eligibles and Seniors and Persons with Disabilities) starting in January 2013 with 1/12 phased-in per month. The phase-in would have been completed by December 31, 2013.

Under a February revision to the Governor’s initiative, the Administration proposes to phase LTSS into the Medi-Cal managed care system beginning January 1, 2013, with the 10 counties selected to be part of the dual eligibles demonstration in the first year. Starting January 1, 2014, these services would become managed care benefits in the remaining 20 Medi-Cal managed care counties (or any number of sites as determined by DHCS) as the dual eligibles demonstration project is expanded to those counties. Finally, on January 1, 2015, the remaining 28 counties (or as many as are left) would transition to include these LTSS as part of the Medi-Cal managed care benefit

The Administration’s savings estimates (in the chart below) reflect the January proposal’s timeline for integrating LTSS. These estimates will be updated at May Revision.

The Administration estimates that the state would realize \$621.7 million General Fund savings in 2012-13 and \$1 billion General Fund savings in 2013-14.¹ Savings in the budget year are a result of the deferral of Medi-Cal payments until the next fiscal year.

Coordinated Care Initiative Savings (dollars in millions)

Coordinate Care Initiative Components	2012-13		2013-14	
	Total Funds	General Fund	Total Funds	General Fund
Medicare Shared Savings	-\$42.1	-\$42.1	-\$543.7	-\$543.7
Integration of LTSS into Medi-Cal Managed Care	332.4	166.2	-287.4	-143.7
Defer Managed Care Payment	-1,102.5	-568.1	-625.1	-312.6
Delay FFS Check-write	-355.5	-177.7	-104.2	-52.1
Total	-\$1,167.7	-\$621.7	-\$1,560.4	-\$1,052.1

Since DHCS is budgeted on a cash basis (expenses are counted when they are paid, not when the service was delivered), 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 a one-time deferral of managed care payments to the next fiscal year.

Please also note that the Coordinated Care Initiative was discussed at the Senate Budget and Fiscal Review Committee hearing on February 23, 2012. The materials for that hearing can be found at:

<http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/2232012SBFRHearingAgendaMediCal%20ManagedCareHSSIntegration.pdf>

Additionally, there is a detailed discussion of the Administration’s January proposal in the Senate Budget and Fiscal Review Committee’s Overview of the 2012-13 Budget Bill, starting on page 3-1:

http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/OverviewOfThe2012_13BudgetBillSB957.pdf

¹ The savings estimates in this document reflect the Governor’s January proposal and do not reflect a more gradual phase-in of the integration of long-term supports and services proposed by the Administration in February. Updated estimates will not be available until the May Revise.

A. Expansion of Dual Eligibles Demonstration Project

BUDGET PROPOSAL

The Administration proposes to expand the enrollment of dual eligibles into Medi-Cal managed care from the four demonstration pilots (as provided under SB 208, Statutes of 2010) to up to 10 counties in 2013, to the remaining 20 Medi-Cal managed care counties (or any number of sites as determined by DHCS) in 2014, and to the remaining 28 counties (or as many as are left) in 2015.

BACKGROUND

Medi-Cal uses a variety of service delivery and payment 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 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.

Dual Eligibles Demonstration Project. Chapter 714, Statutes 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, a three-year demonstration launching on January 1, 2013. Sites that were interested in participating in the demonstration had to submit their applications to DHCS by February 24, 2012.

Demonstration Sites. On April 4, 2012, DHCS announced that Los Angeles, Orange, San Diego, and San Mateo counties were selected to participate in the demonstration project. Additionally, it was announced that contingent on approval of the Administration’s Coordinated Care Initiative proposal, as well as readiness reviews and preparations, the state’s proposed demonstration project materials call for implementing the demonstration in up to six additional counties: Alameda, Contra Costa, Riverside, Sacramento, San Bernardino, and Santa Clara.

Table: Dual Eligible Demonstration Counties

County	Model	Dual Eligible Population	Health Care Plan(s)
Demonstration Counties			
Los Angeles	Two-Plan	373,941	L.A. Care and Health Net
Orange	COHS	71,588	CalOptima
San Diego	GMC	75,724	Care 1 st , Community Health Group, Health Net, and Molina Healthcare
San Mateo	COHS	13,787	Health Plan of San Mateo
Subtotal		535,040	
Potential Demonstration Counties			
Alameda	Two-Plan	47,247	Alameda Alliance for Health and Anthem Blue Cross
Contra Costa*	Two-Plan	22,182	Contra Costa Health Plan and Anthem Blue Cross
Riverside	Two-Plan	49,635	Inland Empire Health Plan and Molina Healthcare
Sacramento*	GMC	45,588	Anthem Blue Cross, Health Net, Kaiser Permanente, and Molina Healthcare
San Bernardino	Two-Plan	53,279	Inland Empire Health Plan and Molina Healthcare
Santa Clara	Two-Plan	49,757	Santa Clara Family Health Plan and Anthem Blue Cross
Total		802,728	

*It should be noted that Sacramento County and Contra Costa County did not meet the mandatory requirements to be considered a qualified applicant. As a GMC county, Sacramento was required to submit applications from at least two health plans, but only one application was submitted by Molina Healthcare Plan. Similarly, as a Two-Plan county, Contra Costa County was required to submit applications from both plans, but only Contra Costa Health Plan submitted an application. Consequently, it is unclear how these two counties could qualify to participate in this demonstration.

Timeline. The table below reflects the Administration’s proposed timeline to implement the Demonstration Project.

Month	Activities
April 2012	<ul style="list-style-type: none"> • Announce Demonstration Sites • Post Draft Demonstration Proposal for 30-day public comment period • Stakeholder Workgroups meet (April – August) • Demonstration Sites develop local stakeholder process
May 2012	<ul style="list-style-type: none"> • State submits Demonstration Proposal to federal CMS • CMS posts Demonstration Proposal for 30-day public comment period
June 2012	<ul style="list-style-type: none"> • CMS approves Demonstration Proposal • Rate negotiations begin with CMS
July 2012	<ul style="list-style-type: none"> • CMS and DHCS finalize Memorandum of Understanding • Demonstration Sites receive readiness tool and draft rates
August 2012	<ul style="list-style-type: none"> • DHCS and the Department of Managed Health Care conduct readiness review (July – August)
September 2012	<ul style="list-style-type: none"> • Demonstration Sites execute 3-way contract with DHCS and CMS • First beneficiaries’ notices mailed
October 2012	<ul style="list-style-type: none"> • Enrollment materials mailed
January 2013	<ul style="list-style-type: none"> • Enrollment begins in up to 10 counties (those identified in the table above)
January 2014	<ul style="list-style-type: none"> • Enrollment begins in the remaining 20 Medi-Cal managed care counties
January 2015	<ul style="list-style-type: none"> • Enrollment begins in the 28 counties that are currently fee-for-service

Memorandum of Understanding. It is anticipated that in July 2012, DHCS and CMS will finalize the Memorandum of Understanding (MOU). This MOU will define how the demonstration project will be implemented and operated and detail requirements such as the procedures related to state and federal contract management, uniform appeals and hearing processes, and uniform encounter data reporting. It is very important to note that this MOU, as proposed by the Administration, would take precedence over existing state statute and regulations. There would be no opportunity for Legislative oversight of this final agreement.

Demonstration Stakeholder Workgroups. To support the development and implementation of the Dual Eligibles Demonstration, DHCS is collaborating with state offices and external

partners on the development of a series of stakeholder workgroups. These workgroups have started meeting and are expected to meet through August. These workgroups include:

- ***Beneficiary Notifications, Appeals, and Protections*** - This workgroup will make recommendations on the enrollment process for the demonstration project including specific text and design principles for beneficiary notices. The workgroup will also provide feedback on coordinated appeals and grievance procedures in order to ensure a more coordinated process, while maintaining beneficiary protections.
- ***Provider Outreach and Engagement*** - This workgroup will make recommendations about provider participation in demonstration sites, and will identify strategies to expand managed care plans' provider networks.
- ***Mental Health and Substance Use Integration*** - This workgroup will focus on understanding and summarizing essential elements required for successful implementation of integrated mental health and substance use services in the demonstration counties.
- ***In-Home Supportive Services Coordination*** - This workgroup will focus on the development of contract requirements between health plans and county In-Home Supportive Services (IHSS) entities to ensure the readiness and functioning of the new integrated program. The goal of the workgroup is the development of a patient-centered care model that ensures consumer protections.
- ***Long-Term Services and Supports Integration*** - This workgroup will provide recommendations for how to integrate Home and Community-Based Services (HCBS) in an organized system of care, including recommendations for LTSS network adequacy standards and coordination of community resources. In particular, the group will consider issues around Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP), and other HCBS waivers.
- ***Fiscal and Rate Setting*** - This workgroup will support actuaries' understanding of program components and capitation rates for managed care plans, while recognizing that rate setting is fundamentally a proprietary and confidential effort between plans, the state, and federal government.
- ***Quality and Evaluation*** - This workgroup will develop recommendations on quality and outcome measurements and design of the evaluation for the demonstration.

BUDGET IMPACT

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 currently in a SNF.
- 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.

While CMS has indicated its intent to share Medicare savings with the state, it is unclear how these savings will be split. Almost half of the out-year savings (over \$400 million General Fund) is attributable to sharing savings with Medicare. If CMS does not agree to share savings 50:50 with the state, there could be a major reduction in the savings achieved with this proposal.

General Fund Savings from Medicare Shared Savings (in millions)

	2012-13 (six months)	2013-14	2014-15	2015-16
Medicare Shared Savings	\$42.1	\$412.7	\$556.1	\$651.9

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.

These project savings are similar to the experience of the Health Plan of San Mateo (HPSM) when it coordinated its care for high-risk Medicare Special Needs Plan members in 2008. According to HPSM’s application to become one of the demonstration projects, it indicated that its coordination of services for high-risk Medicare Special Needs Plan members revealed:

- A 45 percent decrease in the percent who had at least one non-psychiatric hospitalization;
- A 31 percent decrease in the percent who had at least one emergency room visit;
- An 11 percent decrease in the average length of stay; and
- A 42 percent decrease in the number of emergency room visits per member.

Subcommittee Staff Comments and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue and as the proposal is refined. As previously raised, the Legislature should consider the following issues as it evaluates this proposal:

- **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 beneficiaries receive uninterrupted and coordinated care. For example, policies allowing beneficiaries to remain with their fee-for-service provider because of medical instability appear to have been misunderstood and inconsistently applied. Additionally, given that about 60 percent of SPDs were 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 enrollees receive 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. For example, since federal law prohibits the mandatory enrollment of Medicare beneficiaries into managed care, the Administration is proposing a passive enrollment of these individuals whereby if the enrollee does not opt-out upon initial enrollment then the dual eligible would be enrolled into a managed care plan and given the option to return to FFS for Medicare benefits after six months.
- **Need for Implementation Monitoring Plan.** The Administration's proposal does not include details on how it plans to monitor the implementation of the demonstration project. As was learned from the mandatory enrollment of SPDs into managed care and the transition of ADHC benefits, it is critical to develop a process to monitor and assess the rollout of new policies. Monitoring helps determine the need for further action, possible changes, and actions for improvement.

Although DHCS has initiated workgroups to begin to address these issues, the final policies on continuity of care, beneficiary notification, enrollment, health plan readiness, performance measures, and the medical exemption process, for example, will not be defined until later this year. This timing does not provide any guarantees to the Legislature as it currently considers this proposal. Consequently, the Legislature may want to consider developing checkpoints and mechanisms to ensure that the implementation of the demonstration project has a process

to observe and learn from actual experiences that may need to be changed or unintended consequences that need to be avoided.

Questions. The Subcommittee has requested the Administration respond to the following questions:

1. Please provide an overview of the dual eligibles demonstration proposal.
2. Please highlight some of the public comments regarding the draft proposal.
3. Has the Administration considered developing a process to observe and learn from the implementation of the demonstration project to inform the future transition of additional counties? If so, please describe.
4. Please describe the key factors that will be used to assess whether a health plan is ready to participate in the demonstration project.
5. Has CMS signaled any willingness to share 50 percent of the Medicare savings with the state?

B. Integration of Long-Term Supports and Services into Medi-Cal Managed Care

BUDGET PROPOSAL

Under a February revision to the Governor’s Coordinated Care Initiative, the Administration proposes to phase long-term supports and services (LTSS) into the Medi-Cal managed care system beginning January 1, 2013, with the 10 counties selected to be part of the dual eligibles demonstration in the first year. Starting January 1, 2014, these services would become managed care benefits in the remaining 20 Medi-Cal managed care counties (or any number of sites as determined by DHCS) as the dual eligibles demonstration project is expanded to those counties. Finally, on January 1, 2015, the remaining 28 counties (or as many as are left) 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 no sooner than July 1, 2012.)

The Administration’s January proposal assumed that Medi-Cal LTSS benefits would be included as part of the managed care benefit for all Medi-Cal beneficiaries (dual eligibles and SPDs) starting in January 2013 with 1/12 phased-in per month. The phase-in would have been completed by December 31, 2013. The Administration’s savings estimates (in the chart above) reflected that timeline. Those estimates will be updated at May Revision.

LTSS Programs Proposed to be Included as Managed Care Benefit. The following LTSS programs are proposed to be included in the Medi-Cal managed care benefit:

- In-Home Supportive Services (IHSS)
- Multi-purpose Senior Services Program (MSSP)
- Inpatient nursing facility and subacute care facility
- Nursing Facility/Acute Hospital Waiver Service
- HIV/AIDS Waiver Services
- Assisted Living Waiver Services
- In-Home Operations Waiver Services

Home-and community-based waiver services for adults with developmental disabilities are carved-out of this proposal.

Integration of IHSS. Recently, the Administration has indicated that its proposal would not change the counties’ roles with respect to assessing, authorizing, and making determinations related to IHSS eligibility or with respect to enrolling providers and conducting quality assurance activities. This work by the counties would, however, be accomplished under contract with and on behalf of managed care health plans. Health plans would also be able to authorize additional IHSS hours. The Administration has additionally indicated that there would be a grievance and appeals process for IHSS consumers (although details related to that proposed process are not yet specified).

The Administration's recently proposed trailer bill language also does not alter the existing rights of IHSS consumers to hire, fire, and manage their care providers. In some cases ("as needed"), the Administration proposes for counties, consumers, health plans, and potentially others to additionally participate in "care coordination" teams.

Finally, under the Administration's proposal, counties would continue to participate in the non-federal share of costs for the IHSS program. The Administration intends for counties' shares to be equal to what they would have been in the absence of changes under the Care Coordination Initiative. To that end, its proposed trailer bill directs the Department of Finance, in consultation with the California State Association of Counties, to establish a base year and annual growth factor to determine each county's maintenance of effort requirement. To the extent that total IHSS expenditures increase as a result of changes other than growth in caseload or authorized hours, the Administration proposes for counties to bear the full costs of the non-federal portion of the increase.

Integration of MSSP. In the first year (2013), the Administration proposes to have demonstration counties contract with existing MSSP sites to provide continuing care coordination to plan enrollees who are MSSP participants. In years two and three (2014 and 2015), as managed care plans and the Demonstration expand to all counties, MSSP programs' care coordination functions would become more fully integrated into the plans' care coordination systems. In other words, the plans would have flexibility to determine how best to meet those needs (e.g., by continuing to contract with MSSP sites or integrating MSSP case managers into the plans' staff), and MSSP may not necessarily continue to exist as a discrete program.

Populations Affected. The LTSS integration into managed care would apply to most Medi-Cal enrollees, including dual eligibles and Medi-Cal only SPDs. The following Medi-Cal enrollees would continue to receive Medi-Cal services, including LTSS, on a FFS basis:

- Individuals who have other health care coverage,
- Children in the state's Foster Care Program,
- Enrollees of Program of All-inclusive Care for the Elderly (PACE),
- Enrollees of the AIDS Healthcare Foundation, and
- Other populations as determined by the Department of Health Care Services (DHCS).

LTSS Universal Assessment Tool in 2015. In conjunction with Departments of Social Services and Aging, DHCS proposes to establish, no later than June 1, 2013, a stakeholder workgroup to design, develop, and test a Universal Assessment tool. The universal assessment process would be used for all home and community-based services, including IHSS. It would build upon the IHSS Uniform Assessment process, Hourly Task Guidelines, and other appropriate home and community based services assessment tools. The stakeholder workgroup would include, but not be limited to, beneficiaries and their representatives, managed care health plans, counties, providers, and legislative staff.

Beginning January 1, 2015, or upon completion of design, development, testing, and training related to the universal assessment tool, managed care plans, counties, and home- and

community-based service providers would be required to use the tool to determine the home and community based service needs of their members. Counties would use this tool to continue performing the IHSS assessment and authorization processes, including final determinations of IHSS hours, on behalf of the Medi-Cal managed care health plans and in accordance with statutory provisions for IHSS eligibility.

This universal assessment process for home- and community-based services would be in addition to the assessment process used by managed care health plans when beneficiaries initially enroll in managed care.

Outcome Evaluation. The Administration intends to evaluate this initiative and be able to compare outcomes and performance across counties. Additionally, the federal government intends to evaluate the related dual-eligible demonstration project and compare it to similar initiatives taking place in other states. At the same time, the Administration intends to finalize performance measures to monitor quality and cost only after significant input from multiple stakeholders. It notes that there are several principles that will guide the development of these measures, including that they must be implementable in time for initial enrollment in January 2013.

Some potential improvement targets identified by the Administration include:

- An increase in the number of beneficiaries participating in and receiving care coordination
- An increase in the number of health risk and behavioral health screenings
- An increase in the number of beneficiaries with care plans
- Improved access to home- and community-based services
- Reduced hospital utilization, emergency room utilization, skilled nursing facility utilization, and long-term nursing facility placements
- Improved beneficiary satisfaction.

Demonstration sites will be accountable for provider performance and health outcomes within their systems. These entities will be responsible for collecting and using performance and outcome data to drive changes in care delivery as necessary to ensure that beneficiaries are receiving high quality care that improves health outcomes. These entities will also be required to share performance and outcome data with the State. Additionally, each health plan shall have a process for soliciting and incorporating stakeholder input into its quality improvement process, such as stakeholder committees.

Administration's Proposed Authority to Discontinue Integration. The Administration's proposed trailer bill language grants the Director of DHCS sole discretion to terminate some or all of the changes to LTSS described above if she or he determines that quality of care, efficiency, or cost effectiveness of services is being jeopardized. If such a termination were to occur, all contracts executed pursuant to the proposed statutory provisions would also be terminated. In addition, if the Director of Finance determines, on September 1 of any year, that the proposed statutory provisions have caused utilization changes that increase state costs,

the Director would notify the Joint Legislative Budget Committee and the affected state Departments would be required to discontinue implementation of the proposed provisions.

BACKGROUND ON LTSS

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.
- **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. Currently, 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. At the end of 2011, there were just over 366,000 working IHSS providers. In approximately 72 percent of cases, IHSS recipients chose a family member to provide care.
- **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 and develop an individualized care plan. The core MSSP service is care coordination, but other services, such as housing assistance or adult day social care, can also be provided with MSSP funds. The Department of Aging currently oversees MSSP and contracts with local entities that directly provide services. The program 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. CBAS is a community-based day program providing health, therapeutic, and social services designed to serve those at risk for being placed in a nursing home.
- **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. Long-term institutional services currently are only covered under Medi-Cal FFS.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue and as the proposal is refined. As previously raised, the Legislature should consider the following issues as it evaluates this proposal:

- **Integration of Medical and Social Services Valuable Goal, but Complex.** 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. For example, blending federal, state, and local funding streams into a health plan rate payment would be challenging. It would be important to ensure transparency of this process.

- **Need for Ongoing Stakeholder Engagement.** Several stakeholders have expressed concerns regarding or opposition to the broad scope and short timelines included in the Governor's LTSS integration proposal. While the Administration has begun a workgroup process that is expected to last until July to engage stakeholders in the refinement of this proposal, it would also be important to ensure that there is a process for ongoing stakeholder engagement as the proposal is implemented.
- **Need to Monitor Outcomes and Make Informed Decisions.** If LTSS were to become managed care benefits, it would be important for the state to develop measures to evaluate enrollee outcomes and to ensure that managed care plans are not cutting long-term care services and costs inappropriately. It would also be important for the capitation payment to be set at the right level to encourage plan behavior that leads to improved health outcomes. Additionally, even with recent changes to propose a slower

initial phase-in of implementation, the Administration's proposal does not require Legislative action over time to incorporate and build upon experiences gained and outcomes monitored as the changes roll out. The Administration is instead seeking upfront authority for all of the phases.

- **Legislative Analyst's Office (LAO) Identifies Significant Implementation Issues.** The LAO's review of the Administration's January 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 recommended against making decisions at this time to expand the dual eligible demonstration statewide and make LTSS managed care benefits statewide.

Questions. The Subcommittee has requested the Administration respond to the following questions:

1. Please provide a summary of this component of the proposal.
2. Are the proposed changes to the delivery of long-term care supports and services intended to be a demonstration or permanent policy changes?
3. When would care coordination teams be utilized and who would decide upon the participants in those teams? What decisions might the teams make?
4. How might the proposed appeal and grievance processes applicable to IHSS be different than existing processes?
5. What would happen in the event that the Directors of DHCS or Finance used their sole discretion to terminate all, or part, of the proposed changes to the delivery of long-term supports and services?