CALIFORNIA COLLABORATIVE FOR LONG TERM SERVICES & SUPPORTS

Coordinated Care Initiative (CCI) Policy & Financing Recommendations

BACKGROUND: THE COORDINATED CARE INITIATIVE

Enacted as part of California's 2012-13 budget, the Coordinated Care Initiative (CCI) changes how medical care and long-term services and supports (LTSS) are provided to older adults and adults with disabilities who qualify for both Medicare and Medi-Cal (dual eligible individuals) as well as older adults and adults with disabilities who qualify for Medi-Cal only. The goal of the CCI is to integrate and coordinate the delivery of health benefits, including behavioral health and LTSS. The CCI is available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. More information on the health plans available in each county is available online at http://calduals.org/by-county/.

The CCI is comprised of the following three components:

1. Cal MediConnect (CMC), which combines the delivery of Medi-Cal and Medicare benefits through participating Medi-Cal managed care plans in the seven CCI counties. CMC was authorized as part of the federal Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative and has been approved through 2022.
2. Managed Long-Term Services and Supports (MLTSS) for dual eligibles and Seniors and Persons with Disabilities (SPDs) beneficiaries that reside in the seven CCI Counties, which includes coordinating access to Community-Based Adult Services (CBAS), the Multipurpose Senior Services Program (MSSP), In Home Supportive Services (IHSS), and coverage for long-term nursing facility care.
3. Mandatory enrollment of dual eligibles into a Medi-Cal Managed Care Plan (MMCP), which means that dual eligible individuals in CCI counties are required to enroll in a MMCP for their Medi-Cal benefits, but have a range of options for their Medicare coverage, including CMC, opting into original Medicare or a Medicare Advantage plan.

The following recommendations were developed by the California Collaborative for Long Term Services and Supports (CCLTSS) CCI workgroup and include thoughtful policy and financing recommendations that will improve care for members, deliver on the promise of the CCI, and build a more sustainable program.

Data & Reporting

The State should report data on access to and utilization of MLTSS for the following populations:

- Dual eligibles in Cal MediConnect (CMC)
- Dual eligibles receiving MLTSS but not enrolled in CMC
- SPDs receiving MLTSS

DHCS should use this data to develop measures that will ensure beneficiaries with higher needs, particularly those who are nursing home eligible, are prevented from experiencing extended nursing home stays and unnecessary or avoidable hospitalizations.

Cal MediConnect (CMC) Program data should be make public and standard reporting by the health plans should be required so that policymakers can make informed decisions based on credible data. Additionally, the data should be broken out by the populations noted above: *Dual eligibles in Cal MediConnect (CMC), Dual eligibles receiving MLTSS but not enrolled in CMC, and SPDs receiving MLTSS*

Specifically, the following data should be publicly reported, in a standardized format, and by population:

1. Outcome data on hospitalizations:
    a. Hospital days
    b. ER visits
    c. Average length of stay in hospitals
        i. Outlier cases with extraordinarily long stays should be collected and reported as well to identify any systematic issues

2. Nursing facility admission and discharge data
    a. Average length of stay in nursing homes
        i. Outlier cases with extraordinarily long stays should be collected and reported as well to identify any systematic issues

3. Indicators of success in keeping beneficiaries with higher needs in the community
    a. Rates of nursing home days over time to identify increases/decreases
    b. Percentage of population in nursing homes by county and plan
    c. Percentage of beneficiaries receiving MLTSS that are admitted into a nursing home for over 90 days

4. Access to carved-out services, such as behavioral health and dental;
    a. Rates of referrals to specialty mental health services/dental
    b. Percentage of referrals that result in a visit with a provider

5. Evaluation of the member experience
    a. A breakdown of the "other" category in appeals and grievances
    b. An analysis of the grievance data by demographics/race/ethnicity

6. Care Plan Options *(note: we thank DHCS for including information on total CPO spend in its most recent dashboard reports)*
    a. Dollar amounts expended by health plans for such services
    b. Breakout of the types of services by county and plan (respite/nutrition/home modifications etc.)

7. Data on the standardized LTSS questions on the Health Risk Assessments
    a. A summary of the responses/aggregate data
    b. Data on referrals to LTSS that were completed as a result of standardized questions

Addressing Premium Slide & Incentivizing Care Coordination

Premium slide occurs when plans pay for services that are not considered eligible to be included in the capitation rates paid by the state but result in cost savings and reduced spending on unnecessary care. For example, a plan may pay for a home modification in order to keep a beneficiary out of an institution and under the current structure the plan's capitation rate is then lowered because the total cost of care went down. However, there is no mechanism to recognize the cost of the home modification and so the plan is experiencing an erosion of its capitation rates over time because it still incurs those costs even if they are not included in the rates. This creates a disincentive for plans to invest in services that are appropriate, cost effective, and reduce unnecessary nursing home stays or emergency room visits and hospital days.

Updating the reimbursement structure to recognize and include the value of these services in the capitation rate paid to the health plans will appropriately incentivize the provision of the appropriate services and reduce premium slide.

DHCS should work with stakeholders and report back to the legislature on the steps that can be taken to implement a reimbursement methodology by January 10, 2020 that includes reimbursement for specified non-traditional Medicaid services that provide the community supports and MLTSS necessary to keep beneficiaries in the lowest level of care. In CMC these services are referred to as Care Plan Option (CPO) services and the health plans pay for them with no reimbursement from the state.
In addition to looking at proper reimbursement for services the state should also consider adding a rate component that is specific to care coordination. This would recognize that there is an additional cost to the system to provide the intensive care coordination required to ensure access

to long-term services and supports and address social determinants of health. It would also likely lead to increased use of the care coordination benefit by better defining what is covered and what is expected of health plans and providers.

Creation of a Stakeholder Planning Council

DHCS should establish a formalized stakeholder workgroup –a planning council- that monitors implementation of the CCI, including both CMC and MLTSS. The council would provide input and insight on CCI implementation issues with considerations for planning for integrated care beyond the demonstration's sunset 2022.

The council, comprised of health plans, consumers, advocates and providers, could be charged with exploring and analyzing emerging issues and challenges, with recommendations for system-wide improvements. This stakeholder process could be used to inform not only CMC, but the delivery of MLTSS services and more integrated care for dual eligibles more broadly across the state. Other states engaged in financial alignment demonstrations, such as Massachusetts, have created similar stakeholder workgroups that have proven effective in creating partnership and engagement that drives positive program change. As the largest financial alignment demonstration California should be a leader in engaging all stakeholders in a meaningful way.

The planning council would create a stakeholder process that is more than just checking the box on sharing new policies or guidance and would have real value in creating partnership between regulators, providers, health plans, and consumer advocates. It could be used to discuss issues such as those raised in a recent UCSF report that examined levels of satisfaction, confidence, and continuity of care among race, language, ability and county and found some significant differences in beneficiary access and satisfaction rates. It could also be used to examine the state's enrollment broker pilot and provide an opportunity for stakeholders to engage how that pilot is working and what its impact has been. Using the planning council to have a collaborative discussion on these types of policy issues will provide an opportunity to develop informed strategies and policies to improve the CCI and CMC programs.

Workgroup Members

Denny Chan, Justice in Aging
Athena Chapman, Chapman Consulting
Brianna Novelli, SEIU
Peter Hansel, CalPace
Lydia Missaelides, Alliance for Leadership and Education
Amber Kemp, CA Hospital Association
Marty Lynch, LifeLong Medical
Denise Likar, MSSP Site Association
Wendy Soe, CA Association of Health Plans
Sarah Steenhausen, The SCAN Foundation
Eli Gelardin, CA Foundation for Independent Living Centers

About the California Collaborative for LTSS

The California Collaborative advocates for the dignity, health and independence of Californians regardless of age who experience disabilities, functional limitations or chronic conditions and who use long-term services and supports. California needs a system of high-quality, cost-effective long-term services and supports that strengthen the person, his or her family, caregivers, circles of support, and the community at large. That system must promote the person's well-being and social participation, promote economic independence, prevent impoverishment and remove barriers to employment.

The Collaborative Endorses a System of Long-Term Services and Supports Based on the following Ten Principles:

- ***Dignity:*** *The services are grounded in respect for the person who uses them and driven by the preferences of that person.*
- ***Choice:*** *Access to all types of services is provided on an equal footing.*
- ***Flexibility:*** *The services are comprehensive and flexible enough to meet changing needs and incorporate new modes of service and supports.*
- ***Quality:*** *Public funding and oversight that values and rewards high-quality care.*
- ***Legality:*** *The services are consistent with the legal rights of individuals who use them.*
- ***Cultural Competence:*** *The services are appropriate and responsive to the needs of unserved and underserved populations.*
- ***Accessibility:*** *The services and information about them are easy to locate and use and are physically and programmatically accessible.*
- ***Affordability:*** *The services are cost-effective for the person and the system.*
- ***Inclusive:*** *The system recognizes and supports the crucial role of high-quality paid and unpaid caregivers, including family caregivers, and emphasizes the importance of workforce development and training.*
- ***Independence:*** *The services support maximum independence, full social integration and quality of life.*