Sacramento Medi-Cal Managed Care Advisory Committee

Meeting Minutes

April 22, 2013, 3:00 PM – 5:00 PM

DHHS Administration

7001A East Parkway

Sacramento, CA 95823

Conference Room 1

	COMMITTEE MEMBERS		
X	Chair – Sandy Damiano, PhD		Hospital – Robert Waste, PhD
X	Advocate – Stacey Wittorff	X	Hospital – Rosemary Younts
X	Advocate – Sujatha Branch	X	IPA – Ted Fong
X	Clinic – J. Miguel Suarez, MD		PHAB – Marty Keale - *excused*
	Clinic – Jonathan Porteus, PhD		Pharmacy – Frank Cable - *excused*
X	DHA – Paul Lake	X	Physician – Marvin Kamras, MD
X	DHHS – Sherri Heller, EdD	X	Physician – Nathan Allen, MD
X	Health Plan – Cathy Lumb-Edwards		**EX-OFFICIO MEMBERS**
X	Health Plan – Janice Milligan		County Board of Supervisors – Cecilia Coronado
	Health Plan – Steve Soto		County Board of Supervisors – Ted Wolter
X	Health Plan – Sean Atha	X	State DHCS – Keith Parsley
X	Hospital – Ellen Brown	X	Health Care Options – Lili Zahedani

Sacramento Medi-Cal Managed Care Advisory Committee

PANEL MEMBERS - *not on the committee*
Sarah Arnquist, Harbage Consulting Jaime Mulligan, Harbage Consulting Debbi Thomson, County In-Home Supportive Services (IHSS)

Public in Attendance: 15

Topic	Minutes
Welcome and Introductions	Sandy Damiano, PhD, welcomed the committee, members of the public, and facilitated introductions. Sandy announced that advocate John Tan stepped down from the Advisory Committee. He will continue his work on the Beneficiary Recruitment Subcommittee. Stacey Wittorff has assumed his seat. Sandy was very pleased to announce that Sujatha Branch has agreed to become the new Co-Chair. She currently facilitates the Beneficiary Recruitment Subcommittee. She has been a highly invested and active member. She will assume duties in a month or so due to her current workload. Today's meeting focused on the Coordinated Care Initiative (CCI). Harbage Consulting presented an overview of CCI, Sean Atha from Anthem Blue Cross discussed the plans' work with CCI, and Debbi Thomson from Sacramento County In-Home Supportive Services discussed IHSS as a part of Long Term Care Supports and Services.
Healthy Families Transition Update *See "Healthy Families Transition Enrollment" Data Sheet on webpage.*	People in the Healthy Families program transitioned to Medi-Cal managed care in March and April. A chart of enrollment by plan was distributed and reviewed. As expected, Health Net and Kaiser had the largest enrollment. Keith Parsley from DHCS has not heard about any issues with the Healthy Families transition. The biggest concern is to keep as many providers as possible to retain continuity of care for Healthy Families patients. The Healthy Families website is a good resource for those who need more information. DHCS continues to report to the legislature on the transition. Members did not note any problems or specific concerns.

Coordinated Care Initiative (CCI) *See "California's Coordinated Care Initiative" Power Point Presentation by Harbage Consulting for more detail.*	Sarah Arnquist and Jaime Mulligan, Harbage Consulting, provided the CCI Overview. Harbage is under contract with State DHCS. The Power Point is posted on the webpage. CCI is a way to increase accountability and coordination to create the best system of care for beneficiaries. The goal is to keep the beneficiaries at home as long as possible, improving health and quality of life for all beneficiaries. To date, CCI will be the largest transition to Medi-Cal Managed Care. There are two parts to CCI, managed Long Term Services and Supports (LTSS) and the duals demonstration called Cal MediConnect. LTSS includes In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), and nursing home care. LTSS is a managed care benefit and services must be obtained through a Medi-Cal Managed Care health plan. Cal MediConnect is the duals demonstration that will be implemented in 8 counties in October 2013 (Los Angeles, Orange, San Diego, San Mateo, Alameda, Santa Clara, San Bernardino, and Riverside). For individuals who are already in managed care plans, they will notice little to no difference in services other than the inclusion of LTSS in their managed care plan. For those beneficiaries who have Medi-Cal only, they will transition to managed care over a 12 month period. For those beneficiaries who are eligible for Cal MediConnect, they will be passively enrolled into a Cal MediConnect health plan. Beneficiaries may opt out, but they will need to enroll in a Medi-Cal Managed care plan in order to continue to receive LTSS and wrap-around benefits. The Cal MediConnect MOU between California and CMS was approved in April. The operational details of the MOU will be found in the contracts between CMS, DHCS, and the plans. Contracts are projected to be completed in May. Plans have submitted readiness review materials to start the desk review process to ensure systems for enrollment are in place and to verify network adequacy. Plans must pass all reviews before they can begin to enroll beneficiaries. Counties are anticipating an expansion of Cal MediConnect, but this will not occur until after the three year pilot is complete. However, the LTSS portion may expand before the three year pilot program is complete through additional legislation. Plans are building relationships with community organizations now, and are working more closely with counties regarding IHSS and

Coordinated Care Initiative (continued)	behavioral health. There are model MOUs available on the DHCS website and at www.calduals.org which can help plans and counties develop or revise their IHSS and behavioral health agreements. The State has learned from previous transitions that beneficiary, provider, and caregiver outreach in the CCI transition is critical. Outreach will be done in phases prior to the noticing periods. A toolkit is being developed with fact sheets, including step-by-step instructions of what beneficiaries should ask when making decisions on new plans. Outreach will be catered specifically to individual counties. Harbage Consulting has a tentative plan in place to have staff in each county to assist with transitions and outreach. This has not been implemented yet. Communication between beneficiaries, providers, plans, and educating all involved continue to be the priorities. Questions from the Committee: *What happens to those providers who have long-term patients but the patient is contracted to another plan and/or IPA?* Patients have continuity of care rights to see a non-contracted provider for up to 6 months as long as the provider and the plan can reach an agreement on payment. After 6 months, patients will need to see contracted providers. They also have the option to opt out of Cal MediConnect. *What if the plan does not offer the provider a contract?* This could happen, but it is in the provider's best interest to preserve connections with their patients. They should start to connect with managed care plans and IPAs now. Sean Atha also shared that some providers do not want to contract with Medi-Cal managed care. *Is the intent of CCI to simplify health care at the system level by consolidating services?* Yes. Beneficiaries will have one point of contact (the plan) to work with that can answer all of their questions and provide all services. *When would a dual not be eligible for CCI?* Slide 16 discusses those who are ineligible for Cal MediConnect. For the most part, individuals under 21, those with a developmental disability waiver, those enrolled in PACE or the AIDS Health Care Foundation waivers, and those that live in certain rural zip codes are ineligible.

Coordinated Care Initiative (CCI) (continued)	*Is there any indication when this will come to Sacramento?* There is no specific date. Cal MediConnect has 3 years of federal approval, so that program would not have the potential to expand until 2016. LTSS integration could come sooner, although this expansion would need additional state authority and legislation. *How will the payments work for plans and IPAs?* There will be one capitation payment that is based on a blended rate of federal and state funds made to health plans. Plans would pay IPAs for Medicare and Medi-Cal services, and the actual structure for these payments will differ based on the IPA's contract with the plan. The member will see all services as one product. Janice Milligan shared that most of the counties participating in the pilot will provide plan-based services rather than IPA-based services (i.e., long term skilled nursing facilities). Plans will have financial responsibility for IHSS and MSSP. It is possible that IPAs will play a role in these programs in the future, but not until after the pilot. *The Special Needs Plan (SNP) model appears to be similar to LTSS. Was the SNP used as a model?* LTSS is taking SNPs to the next level with full integration of Medi-Cal services. Some SNP beneficiaries are not currently on managed care. Sujatha Branch shared that Disability Rights California and its partners have been doing extensive advocacy on the CCI issue. They have been raising awareness to reduce the size of the demonstration, set realistic timeframes for implementation, and require public access to spending reduction data. Advocacy groups have also requested that the enrollment process be voluntary for a period of time in all counties. A California Health Care Foundation report showed that people who voluntarily enroll are more satisfied with managed care than those who are passively enrolled. Advocates are also looking for better continuity of care protections and ensuring that beneficiaries know about these rights, and have requested that a strong ombudsman or independent community assistance process be developed to provide individual assistance.
Coordinated Care Initiative (CCI): Plan Preparation	Sean Atha, Anthem Blue Cross, presented on the Coordinated Care Initiative (CCI), the role of the plans in the 8 demonstration counties, and how CCI will allow plans to provide a more comprehensive level of care. The CCI program will extend Medi-Cal managed care benefits to the dual eligible population. Medi-Cal managed care plans have historically served women,

Coordinated Care Initiative (CCI) / Plan Preparation (continued) *See "California Duals Plan Perspective" Power Point Presentation. Available on the website.*	children, blind, and disabled. With the transition of Seniors and Persons with Disabilities (SPDs) and the upcoming CCI transition, plans are serving a new population and looking for solutions to manage member services and care. The CCI program has been designed more comprehensively than anything that preceded it. It looks at the whole individual and their required care. Many people in the duals population have mental health problems, serious health issues, and other critical issues that were historically "carved out" and not treated by health plans. Now, plans are looking at the complete person and finding more opportunities to provide better care management. Through this process, plans are collaborating with counties and community partners. Historically, plans never worked with IHSS. Plans want to learn more about how IHSS providers assist recipients, and plans want to develop services and trainings to help providers improve. Plans are considering creating a toolkit for providers that would include contact information for emergencies, a help line, and ways to improve care and services for recipients. Plans are developing contracts with Long Term Care Supports and Services (LTSS) and Area Agencies on Aging to link beneficiaries to services, prevent ER visits, and ensure that people have better health outcomes. Because of CCI, plans are looking at health care from a different perspective. By improving coordination and education between plans and community partners, beneficiaries will be more likely to remain healthy and live independently in their homes with a higher quality of life. This will translate into a lower cost to the state and the plans than if the beneficiary required housing in a skilled nursing facility or other institution. CCI is also leading partners to proactively engage one another in a social service model rather than a health service model. This creates linkages between the programs by proactively contributing to a better system of care. Although there are only 8 pilot counties for the Cal MediConnect implementation, many counties are preparing for the transition. Counties are asking plans for assistance in preparation. Sacramento will have its own challenges, but is in a good position to learn from the pilot counties and from other counties who have prepared models for an eventual transition.

In-Home Supportive Services Coordinated Care Initiative (CCI) In-Home Supportive Services (cont.)	Debbi Thomson, Sacramento County In-Home Supportive Services (IHSS), provided an overview of IHSS and its role in CCI. The purpose of IHSS is to provide domestic and personal care services to low income, aged, blind, and disabled individuals so these individuals can remain safely at home. Recipients of IHSS must meet financial eligibility requirements; 99% receive IHSS as a Medi-Cal benefit. Recipients can also be considered under residual income and are evaluated under SSI/SSP. In order to apply, a health care provider must sign a form stating that the recipient needs services in order to stay in their home before qualifying for IHSS. A social worker completes a home assessment. The social worker evaluates the recipient's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These include domestic services, preparing meals, laundry, and personal care services. A uniform assessment tool is used to evaluate the recipient on the 25 ADLs and IADLs. The recipient is ranked from 1 to 5 (1- independently perform task, 2- need verbal coaching to perform task, 3- hands on assistance required, 4- substantial assistance is required, and 5- unable to perform at all). Paramedical activities can also be authorized, but this is authorized by a health care provider. Protective supervision is also authorized through a clinician, and allows for a maximum of 283 hours per month, averaging to 9 hours per day. Protective supervision is for those people who have the physical capacity to do something that would harm themselves, and the mental capacity to not understand that the activity would put them at risk. There is always a written agreement in place to ensure there is care for the person for the remaining hours of the day that are not paid for through IHSS. Recipients can obtain services in three ways: 1. Individual provider – The recipient chooses the provider. The recipient does all hiring, training, scheduling, oversight, etc. This is the most common option in Sacramento. 2. Contract mode – The county contracts with an agency that sends providers to recipients. The contracting agency completes all oversight and pays the provider, then bills the county for payroll costs. Only 3-4 counties utilize this option currently, and less than 5% of recipients actually use this option. 3. Homemaker – The provider is a county employee and provides services to recipient. Only 3 counties have this option, and very few recipients use it. Over 70% of recipients use family members or friends as their providers.

In-Home Supportive Services (continued)	Legislation changes went into effect in 2009/2010. These required that all providers go through an enrollment process that included an orientation, signing a form stating that the provider would follow all rules and requirements, and undergoing a DOJ background check. Providers would be excluded from working in IHSS if they had been convicted of Medi-Cal fraud, adult abuse, or child abuse in the last 10 years. Some violent felonies also exclude providers from working for IHSS, but recipients can request a waiver to hire the provider anyway. Often times, the provider is a family member and the recipient is aware of their criminal background. There are 430,000 IHSS recipients statewide, and approximately 360,000 providers. Providers can work for multiple recipients. In Sacramento County, there are 19,000 recipients. About 75% of these recipients are dual eligibles. Sacramento County also established a Public Authority as mandated in 2003 to act as the employer of record for providers for collective bargaining purposes. Prior to 2003, providers were paid minimum wage. Most counties established a Public Authority as the employer of record. The Public Authority in Sacramento also operates a registry of available providers, provides trainings for providers, completes the orientation process, and processes background checks. In CCI, IHSS will be included in LTSS and become a managed care benefit like CBAS. All recipients must be on a Medi-Cal managed care plan to receive IHSS benefits. Plans are required to complete MOUs with counties for coordination of the program. Social workers will continue to complete home assessments to assign hours. Plans have the option to add hours, but they cannot reduce hours. This is an ongoing issue that must be resolved. To the recipient, the IHSS program will not change. They will have the same hearing rights when contesting hours and the right to aid paid pending. The state is starting a stakeholder workgroup in June 2013 to develop a universal assessment tool that will determine benefits for MSSP, IHSS, and CBAS. This tool will not be put into effect until January 2015. The state is also implementing statewide collective bargaining for providers. Public Authorities will no longer be considered employers of record. In July 2012, IHSS funding changed. Federal funds cover 50% and the county pays a Maintenance of Effort (MOE) amount based on actual costs for 2011/2012. The State pays the

In-Home Supportive Services (continued)	difference. The state is also developing voluntary provider training curriculum to ensure consistency, accountability, and increase the quality of care. Questions from the Committee: *Is there a point in time where the aggregate cost of IHSS services would exceed the cost of having the patient in a group environment?* In Sacramento County, the hourly wage for providers is $10.40 per hour. The maximum hours per recipient are 283 for a cost of roughly $2900 a month. The average cost for a skilled nursing facility stay is much higher. The average number of hours per recipient statewide is only 87 hours per month. Sujatha Branch also shared that her advocacy group is completing a lawsuit on IHSS and the website, www.disabilityrightsca.org, has a lot of information on IHSS that could be useful to the group. IHSS is more cost effective than institutionalization. Also, if someone receives a home or community based waiver, the cost of IHSS is taken into account when calculating the cost of services. *Is IHSS protected against the sequester or is it subject to a 2% cut?* IHSS is not included in the sequester because it is a Medi-Cal benefit; Medi-Cal is excluded from the cuts. *How are plans capitated for IHSS?* The program is described as a pass-through. IHSS will be paid for at actual cost. *How are plans financially at risk if funding for IHSS comes from federal, state, and county sources?* The pilot will be in place for three years, and this will be the first opportunity for plans to do comparisons on hours of care versus how long a recipient was in the hospital, etc. The intent is for plans to utilize IHSS services in more appropriate ways to keep beneficiaries safely in their homes. The specifics for how this will be worked out will be developed over the entire pilot period. Sean Atha also shared that plans still need clarity on how they will be paid and how to pay for claims. Plans are also aware of patients who do not currently qualify for IHSS but could use some services, especially when being released from the hospital or a nursing facility. Plans are considering contracting with other companies to provide some of these services for beneficiaries.

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In-Home Supportive Services (continued)	*Since IHSS is a Medi-Cal benefit, who requests authorization and submits claims for payment?* IHSS is not a claim-based system. It is based on timesheets submitted by the provider. The state processes timesheets and pays providers. *If people must be in Medi-Cal Managed Care to be on IHSS, would they still have a share of cost?* People would still have share of cost, and they will be enrolled in Medi-Cal Managed Care.
Public Comment	No public comment
Meeting Closure	Sandy discussed starting a Coordinated Care Initiative workgroup that includes representation from Plans, IHSS, mental health, advocates and others. She asked Committee members to contact her with their interest in participating. She also discussed potential topics for the May meeting. Topics: committee updates, including charter and member expectation revisions and a discussion with each member describing their preparation for health care reform including innovations. Can also touch on the state budget May revise which should be released mid-month. Sandy thanked everyone for their participation and closed the meeting. Meeting adjourned at 4:50 pm.
Next Meeting	Monday, May 20, 2013 3:00 – 5:00 PM DHHS Administrative Building 7001A East Parkway