Summary of Approach to Seniors and Persons with Disabilities (SPDs)

Goals:

- Improve access to and coordination of the most appropriate, cost effective care for SPDs; improve health outcomes and contain costs.
- Provide SPDs with a choice of organized delivery models through which to receive these services.
- Support and strengthen the local safety net and its integration into organized systems of care.
- Align financial incentives to support providers in delivering the most appropriate care and containing costs.
- Maximize federal investment in and support for transformation of the Medi-Cal delivery system and expanded coverage to the medically indigent adults (MIAs).

Approach:

1. Under the renewed Medi-Cal waiver, the state will ensure that SPDs, who are not currently required to enroll into managed care, enroll in organized systems of care, as authorized by ABx4 6.

2. In consultation with stakeholder partners, the state will develop enhanced standards/requirements that organized systems of care must meet to ensure their standards reflect the needs and circumstances of the SPD population.

3. To maximize federal investments, the state will begin implementation in the first year of the five year waiver by enrolling SPDs into existing managed care plans upon approval of the waiver. This approach builds on the state's existing infrastructure of managed care plans that has been developed over the past 20 years. This approach requires existing managed care plans to comply with new SPD-specific standards developed by the state in consultation with stakeholder partners.

4. Managed care counties (excluding County Organized Health System (COHS) counties) will have the option to establish an additional organized care delivery model that reflects and meets unique local needs and circumstances. This additional choice will be offered along with existing plans as an additional option for SPDs required to enroll in organized systems of care, per ABx4 6.

Organized Delivery Systems for SPDs:

California's waiver proposal will provide our senior and disabled beneficiaries with access to care that is better organized than the care that is currently available from the fee for service (FFS) payment system. The target population is 380,000 Medi-Cal SPDs who are not enrolled in Medicare or who do not have an unmet share of cost or other health coverage.

The entities providing services to SPDs will be required to provide essential elements of organized care delivery including arrangement of medical home providers, care management and member supports, home and community-based services, provider supports, and value based purchasing.

The state will begin implementation in the first year of the five-year waiver by enrolling SPDs into existing managed care plans upon approval of the waiver. The use of organized delivery systems will create more accountable coordinated systems of care, strengthen the health care safety net, reward health care quality and improve health outcomes, and slow the long-term expenditure growth rate of Medi-Cal.

Building on Existing Managed Care Foundation:

Existing Medi-Cal managed care plans have experience providing care for seniors and persons with disabilities (SPDs) and offer an existing infrastructure that can be used to meet the goals outlined above. Managed care plans provide services in 26 counties in California; today, these plans serve about 26 percent of Medi-Cal's SPD beneficiaries residing in these counties. Existing managed care plans in California operate under contract with the state. In consultation with stakeholders, the state is reviewing existing plan contract requirements to identify additional elements that will be added to these contracts to ensure appropriate care and plan readiness and accountability as enrollment expands under mandatory enrollment of SPDs.

Role of Safety Net Providers in Managed Care for SPDs:

As essential providers of care to SPDs, public hospitals and safety net providers will be supported and integrated into organized delivery systems through the waiver. Based on input from consumers, plans, and safety net providers, the state will take actions such as new plan contractual requirements and financial and enrollment incentives so that existing Medi-Cal managed care plans in counties with public hospitals integrate public hospitals into their networks, as is the case today, ensuring an ongoing role for these institutions in the delivery of care to the Medi-Cal population. These state actions will also aim to prevent the expansion of managed care from destabilizing the public hospital patient population or the hospital financing structure. In addition, existing managed care plans will also be required to establish similar arrangements with private disproportionate share hospitals and Federally Qualified Health Centers in order to preserve and enhance their role in serving Medi-Cal beneficiaries. The state will work with counties that have public hospitals and UC hospitals to develop financing arrangements to mitigate General Fund cost pressure.

Option to Establish an Alternative Model:

In some managed care counties, the county and local stakeholders may want to further build on the existing managed care infrastructure and offer SPDs the choice to enroll in an alternative organized delivery system in addition to existing managed care plans. Non-COHS managed care counties will have the option to develop an alternative organized delivery system. The department will establish a process and requirements for counties to propose an alternative model.

Any county-developed alternative must provide an organized system of care that can deliver the improved outcomes and greater cost control that California is seeking. New systems must provide the essential elements of organized systems of care defined above. County-developed alternatives must address the needs of the local delivery system and must concretely identify and address the unique local needs and circumstances that an alternative model is required to address.

County development of an alternative plan would occur as the state is preparing to initiate mandatory enrollment, i.e., within the first year of the waiver. Timing of enrollment of SPDs could be phased to ensure that any additional organized care delivery model can receive the opportunity for adequate enrollment.

The alternative organization will contract with the state to provide services to beneficiaries and will have to meet state-determined standards similar to the requirements placed on other managed care plans. The county-developed alternative must be cost neutral to the state General Fund.

Enrollment in Organized Delivery Systems:

In order to improve care coordination and maximize savings due to better organized and integrated care delivery, the state will begin enrolling beneficiaries in managed care plans in the first year of the waiver. For counties that develop alternative models, mandatory enrollment in organized delivery systems, including managed care, will take place by the end of the first quarter of the second year of the waiver. SPDs will have the opportunity to choose the organized delivery system in which they will enroll including a county alternative where available. SPDs who do not make an active choice will be assigned to an organized delivery system through a process that directs beneficiaries to a specific organized delivery system based on factors such as the organization's quality outcomes and support for the local safety net system.

Value Based Purchasing Reforms:

Over the life of the waiver, payment reforms will be implemented to ensure that mandatory enrollment of SPDs into organized delivery systems improves the quality of care and the health outcomes and reduces costs. Payment reforms will include public hospital financing reform, pay for performance, transition from a per diem payment system to an acuity-based system for inpatient hospital services, and nonpayment of adverse events in inpatient settings.

The state is also undertaking planning and implementation efforts to ensure that providers achieve the meaningful use requirements under the HITECH Act. Organized delivery systems will be expected to play a role in supporting their provider networks in planning IT investments that result from the availability of HITECH incentive payments. The organized delivery systems will invest in building provider infrastructure and capability to use Health Information Technology (HIT) in order to increase data collection for outcome and performance measurement and to facilitate provider level care coordination and care management.