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CCI,Cal MediConnect and Managed Care: What Providers Need to Know Today

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Beginning on April 1st of this year, California embarked on a transformation of the manner in which Medi-Cal benefits will be delivered to beneficiaries in eight of its most populous counties. At the same time, it has combined this transformation with a partnership with the federal government to integrate and jointly administer the benefits of those individuals who are who are dually-eligible for Medicare and Medi-Cal programs (DEs). While these programs will be rolled out over the course of 2014 and into 2015 (see timeline, below), this transformation represents one of the largest and most far-reaching moves taken in California as to the financing and delivery of benefits in these programs. Simply put, the benefits of these significant health care programs will be administered either partially or totally by managed care organizations. Over time, we expect that this will expand to most, if not all, counties in California.

The Coordinated Care Initiative

Known as the Coordinated Care Initiative (CCI) and principally implemented through Senate Bills 1008 and 1036 (July 2012) and Senate Bill 94 (June 2013), this program is intended to cover the Southern California counties of Los Angeles, Orange, Riverside, San Bernardino and San Diego and the Northern California counties of Alameda, San Mateo and Santa Clara (See participating health plans below). Within those counties, virtually all Medi-Cal health care services will be officially designated as managed care benefits, including Long Term Services and Supports (LTSS). That means that the financing and delivery of these health care services will be organized by participating health plans rather than the Department of Health Care Services (DHCS) or its fiscal intermediary, Xerox State Healthcare, LLC. Rather, DHCS will contract with participating health plans and pay them pre-determined capitated

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rates for Medi-Cal services and the plans will be responsible for organizing and paying for care through their designated networks of contracted health care providers.

Cal MediConnect

Within these same counties, CMS and DHCS have also partnered with these same health plans to jointly administer the Medicare and Medi-Cal benefits of "full" DEs through a program known as Cal MediConnect (CMC). CMC was established through the above-referenced legislation as well as a Memorandum of Understanding between DHCS and CMS (MOU) and a Three-Way Contract executed between DHCS, CMS and the participating health plans. Under this program, CMS will pay the health plans capitated rates for their provision of Medicare services. Some of these plans will likely be delegating risk to contracted Independent Practice Associations (IPAs), medical groups and other provider-based entities for Medicare services. These entities will likewise be developing their own networks.

The CMC program is a three-year demonstration organized by the Medicare-Medicaid Coordination Office, established as part of the Affordable Care Act. There are a number of other states that have also partnered with CMS and health plans for similar demonstrations for the integration of DEs but, given the size and scope of the demonstration in California, it will represent the largest demonstration of its type in the nation.

CCI and Medi-Cal

The Medi-Cal component of the CCI is mandatory and the vast majority of Medi-Cal beneficiaries have no practical ability to "opt out." In contrast, for DEs enrolled in CMC, they are free to "opt out" of the portion of the program regarding the administration of their Medicare benefits and remain in the fee-for-service system. Assuming that there is more than one health plan in their county, they may also change health plans monthly. However, if individuals do not "opt out," they will be "passively enrolled" into a single health plan that will be responsible for the administration of all of their health care benefits under Medicare and Medi-Cal. They may also receive additional vision and transportation services. DEs who receive their Medicare benefits through a Medicare Advantage plan will only be able to keep that plan until January 1, 2015. At that point, they must move to a CMC plan or move to the fee-for-service system. However, a May 1, 2014

"policy proposal" issued by DHCS would eliminate this requirement.

Early estimates projected eventual savings from the CMC program of $1 billion in shared savings to both the State and Federal governments. The State anticipates that these savings will largely be derived from increased coordination of care. Through the CMC program, the State projects increased use of physician services (by approximately 5%) and prescription drugs (by approximately 2%) and reduced use of inpatient services (by approximately 20%) and skilled nursing facility services (by approximately 5%). One similar dual eligible program experienced reduced inpatient services in part from reduced inpatient admissions from the emergency department.

LTSS Finance and Delivery Transformed

While these programs will impact all California health care providers, it will significantly transform the financing and delivery of LTSS. LTSS includes in-home supportive services (IHSS), community-based adult services, multipurpose senior services programs (MSSP) services and skilled nursing services. It does not include services provided by any category of intermediate care facility for the developmentally disabled.

Unless already working with county operated health systems in Orange and San Mateo, most long-term care providers in these counties have not experienced significant managed care penetration for the vast majority of their Medi-Cal residents. While the managed care program for Seniors and Persons with Disabilities (SPD) did impact long-term care providers in these and other counties , the managed care benefit in the SPD program was limited to a maximum of sixty (60) days. However, with the CCI, managed care coverage is permanent and all-inclusive. This represents an enormous change for the operators of skilled nursing facilities (SNFs), their ancillary vendors and other providers of LTSS in these eight counties. Though the implementing legislation provides for certain protections for ensuring "continuity of care," these provides will need to have contracts with the participating health plans and be part of their networks in order to serve Medi-Cal beneficiaries.

As to Medicare, SNFs and all other types of providers will also need contracts with the participating health plans to serve beneficiaries whose Medicare benefits are covered by the CMC program. As a result, all providers that have historically served high proportions of dually-eligible individuals will need contracts to continue to serve this population. Among

other providers, it is of the utmost importance to SNFs providing post-acute services to contract with participating health plans in order to participate on their networks.

Understanding Implementing Legislation Imperative for Providers

In order to contract with the health plans, SNFs and other providers will need to understand the specifics of the legislation implementing the CCI as well as the MOU and Three-Way Contract. They will also need to appreciate how the program and its legal elements impact their rights and responsibilities. For example, the legal aspects of the Medi-Cal portion of the program are governed by state law and a variety of other sources, including the contractual relationships between DHCS and the plans. In contrast, though modified by various sources unique to the program and certain aspects of state law, the legal aspects of the Medicare portion of the CMC program are governed by the statutes and regulations that apply to the Medicare Advantage program. In either respect, the intent of the program is that savings from the program are supposed to be achieved through changes/reductions in utilization and not through the reduction of rates. Beyond the rate of payment paid for services covered by the CCI and other important contractual issues, providers should pay particular attentions to authorization and claims payment provisions. There may be significant cash flow issues that could result from the implementation of the CCI.

Understanding the specifics of the CCI and working within managed care systems will be critical to the success of providers serving these affected populations. Beneficiaries and their families will inevitably have questions about the program and what it means for them. In responding to such questions, providers will need to pay particular attention to the Medicare marketing guidelines and any related contractual requirements that govern their communications with health plan enrollees. Moreover, some providers will need to evaluate or create solutions to better perform case management and business office practices to meet the demands associated with this transition. Finally, providers will need to become more familiar with and/or achieve greater effectiveness in the dispute resolution processes of these payors. Among other things, this will involve a thorough and working knowledge of plan appeals processes as well as those in place for the Medi-Cal managed care and Medicare Advantage programs.

Many of our attorneys are experts in managed care areas. Moreover, a number of our attorneys have been involved in representing providers and related trade associations regarding the CCI since its inception. We are

currently advising our clients on the CCI, including marketing to health plans, network credentialing and participation, managed care contracting, communications with patients/enrollees, systems development in the areas of case and authorization management, claims processing, back-office functions and dispute resolution and appeals. We would be happy to assist any health care provider with questions about this significant program.

For additional information, please contact Mark Reagan or Felicia Sze in San Francisco at 415.875.8500; Robert Lundy or Lloyd Bookman in Los Angeles at 310.551.8111; or Mark Johnson in San Diego at 619.744.7300.

Participating Plans

- San Mateo – Health Plan of San Mateo (Care Advantage CMC)
- Riverside/San Bernardino – Inland Empire Health Plan (IEHP) Dual Choice/ Molina Dual Options
- San Diego – Health Net Cal MediConnect/Molina Dual Options/Care 1st Cal MediConnect Plan/Community Health Group (CommuniCare Advantage)
- Los Angeles – Health Net Cal MediConnect/Molina Dual Options/Care 1st Cal MediConnect Plan/CareMore Cal Mediconnect Plan (Anthem)/ LA Care Cal MediConnect Plan (only passive enrollment for existing enrollees and voluntary CMC and LTSS until their Medicare Advantage performance improves)
- Santa Clara – Santa Clara Family Health Plan/Anthem Blue Cross
- Alameda – Alameda Alliance Complete Care/Anthem Blue Cross
- Orange County – Cal Optima Cal MediConnect
- [Note: Kaiser Health Plan will be subcontracting for LTSS only in Riverside, San Bernardino, Los Angeles and Alameda counties.]

Summary Timeline for the Coordinated Care Initiative		
Date	Location	Action
April 1, 2014	San Mateo	Moved all DEs into Cal Mediconnect (CMC) and Managed Long Term Supports and Services (MLTSS)
April 1, 2014	Riverside/San Bernardino/San Diego	Moved most DEs into CMC and LTSS on May 1, 2014 by Birth Month (although April and May Birthdays were enrolled in May). [Exception: DEs already enrolled in Medi-Cal Managed Care enrolled in LTSS on April 1, 2014.]
July 1, 2014	San Mateo/Riverside/San Bernardino/San Diego/Los Angeles/Santa Clara	Moving to LTSS on July 1, 2014 (for existing Medi-Cal managed care enrollees) and August 1, 2014 (FFS enrollees).
July 1, 2014	Los Angeles	Moving most DEs into CMC and LTSS on July 1, 2104 by Birth Month with 200k "cap." [Exception: DEs already enrolled in Medi-Cal Managed Care enrolled in LTSS on April 1, 2014.]
January 1, 2015	Santa Clara	Moving most DEs into CMC and LTSS on January 1, 2015 By Birth Month. [Exception: DEs already enrolled in Medi-Cal Managed Care enrolled in LTSS on July 1, 2014.]
January 1, 2015	Alameda/Orange County	Moving most DEs into CMC and LTSS on January 1, 2015 by Birth Month. [Exception: Orange County may be further delayed based on CalOptima Medicare Advantage audit performance. Alameda County could be subject to delay based on the conservatorship of Alameda Alliance.]