The Changing Landscape of California's Service Delivery System for Older Adults And Persons with Disabilities

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Summary

California's programs and services for older adults and persons with disabilities are undergoing a rapid and dramatic system change. Driven by state budget deficits as well as incentives to improve offered by health care reform, the programs and services that support long-term living are being re-shaped into a system of managed care. Advocates must understand the complex policy processes that are taking place and pick strategic priorities in order to make a positive impact on the developing system of care.

Background

Four years after the economic recession began in December of 2007, California and many other states continue to struggle to balance their budgets. Despite the official end of the recession in June of 2009, twenty-eight states still project that 2012 tax revenues will come in below pre-recession levels. At the same time, there has been a greater demand for safety net services: in fiscal year 2011, there was a national growth of 5.5 % in Medicaid, slowing only slightly to a projected rate of 4.1% in fiscal year 2012 (Cheek, M., Roherty, M., Finan, L. et al, 2012).

Faced with these challenges, California has cut $15 billion from its health and human services programs since fiscal year 2008/09; consequently losing nearly as much as that in matching federal funding (Health and Human Services Network of California, 2011). According to the California Budget Project, fiscal year 2010-11 General Fund spending was lower as a share of the State's economy than in 33 of the prior 40 years. Reductions to long-term services and supports (LTSS) for seniors and people with disabilities have included cuts to Supplementary Security Income-State Supplementary Payments (SSI/SSP), reductions to health and Medi-Cal services, cuts to Adult Day Health Care, mental health and substance abuse funding, reductions in services for people with developmental disabilities, cuts to In-Home Supportive Services (IHSS), senior services and nutrition programs. Funding for Older Californians Act programs was eliminated, including the Alzheimer's Day Care Resource Center, Brown Bag, Linkages, Respite Purchase of Services and the Senior Companion program.

Unwilling or unable to sustain more cuts to the fragile system of care and incentivized toward change by federal health care reform, this year California and other states are deliberating large-scale redesign, proposing to integrate medical care and LTSS. Managed LTSS is a plan in which a contractor, a managed care organization, is responsible for providing beneficiaries with a defined set of services in exchange for a pre-paid capitation payment. It includes both skilled nursing and home- and community-based services (HCBS). Twelve states have existing managed LTSS programs and thirty-nine more are implementing them, either in their Medicaid program alone or through integrated programs to serve those who are dual eligible for Medicare and Medicaid. To achieve this in California, Governor Brown has advanced a comprehensive "Coordinated Care Initiative" in his 2012-13 proposed budget that, if adopted, would transform the State's service delivery system over a three-year period. Administration officials argue that these changes would allow the State to do more with less, reducing system fragmentation, better aligning fiscal incentives, improving care, reducing institutionalization and increasing home- and community-based services (California Department of Health Care Services, 2012). Significantly, the State and federal governments also hope to achieve these improvements and at the same time reap substantial financial savings.

While there is widespread agreement that California's system of LTSS is "broken" (Little Hoover Commission, 2011), the speed of change combined with the potentially contradictory goals of balancing good policy with achieving fiscal savings present advocates for seniors and persons with disabilities with challenges and opportunities that are unique in the history of California's system of long-term living. This policy brief provides a high-level summary of the proposed changes and suggests options and strategies that could have a significant impact on the developing system.

The Affordable Care Act

The key driver of changes to the broader health care service delivery system was the passage of the Patient Protection and Affordable Care Act (known as the ACA) on March 23, 2010. The ACA reformed both private and public health insurance systems, increased coverage for people with pre-existing conditions, and provided an expansion of health insurance coverage to over 30 million Americans, including an extraordinary expansion of Medicaid eligibility to 138% of federal poverty level. This is expected to provide coverage to 1.4 million previously uninsured Californians by 2016 (Kaiser Family Foundation, 2011). One-fifth of the new enrollees are estimated to have mental health and/or substance use disorder service needs (Ryan, P., 2012). (In 2014 the expansion of coverage is paid 100% by the federal government, but the federal match declines to 93% by 2019). The ACA also set in motion the creation of state health insurance exchanges to provide more affordable coverage, launched integration projects aimed at those who are dually eligible for Medicare and Medicaid services, and created a Center for Innovations (Claypool, H., 2011).

In addition to the significant reforms to the health insurance market, the ACA also included critical elements for LTSS reform. Eleven million Americans need LTSS, and a national total of

$200 billion dollars a year is spent on these programs and services. Medicaid pays for more than half of this cost (Howard, E., 2011), and California spends $13 billion dollars annually on LTSS. The ACA included a number of improvements and innovations in this area, including:

- The Community First Choice Option for Personal Care Services, offering a 6% enhanced federal match to cover community-based attendant services and one-time transition costs.
- Extending the Money Follows the Person Rebalancing Demonstration and improving program rules to assist people to transition from nursing homes to the community.
- Modest expansion of Aging and Disability Resource Centers to provide information and assessment, long-term options counseling, short-term service coordination and care transition services.
- Creating the Medicaid Health Home Program, with a 90% federal match for physician practices to care for persons with chronic medical and mental health conditions.
- Creating the Community Care Transition Program, intended to reduce hospital readmissions, test sustainable funding streams for care transition services and improve cost-effectiveness and quality of care.
- Expanding the 1915(i) state plan option, to provide HCBS services statewide to more individuals.
- Making workforce investments.
- Giving authority to the Secretary of Health and Human Services to emphasize HCBS.
- Creating the Community Living Assistance Services and Supports (CLASS) LTSS insurance program, a voluntary, federally-administered program. (This program has been tabled, although not repealed. Recently, SB 1438 [Alquist] was introduced to explore the feasibility of developing a public long-term care insurance program in California.)
- Establishing the Center for Medicare/Medicaid Innovation within CMS to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in both programs.
- Establishing the Medicare-Medicaid Coordination Office within CMS that brings together officials to more effectively integrate benefits under those programs and improve the coordination between the federal and state governments for individuals who are dual eligible.

Some of the opportunities of the ACA are not without risk for states. Medicaid expenses are a concern as the weak economy continues to drive enrollment growth, as well the expansion to new populations in 2014. The recent loss of federal stimulus funds provided under the American Recovery and Re-investment Act of 2009 was a blow for states, and per capita health care costs are increasing faster than the general economy. There is also uncertainty due to congressional budget actions and the lack of final federal implementation guidance. Pending litigation before the U.S. Supreme Court also makes the fate of the ACA uncertain (Cheek, M., Roherty, M., Finan, L. et al, 2012). However, the incentives of the ACA combined with state

budget distress are driving rapid change, and "Many states are undergoing or are about to undergo a dizzying array of LTSS transformations" (ibid, page 33). California is among them.

California's Bridge to Reform and the Dual Eligible Demonstration Projects

California's integration efforts began in 2010 with a new, 5-year 1115 Medicaid Demonstration Waiver entitled "California's Bridge to Reform." The new waiver began in November, 2011, making approximately $8 billion in federal Medicaid matching funds available for expanding coverage to low-income uninsured adults and preserving and improving the county-based safety net. The waiver also allowed the State to mandatorily enroll Medicaid-eligible seniors and persons with disabilities into Medi-Cal managed health care plans. Enrollment began June 1, 2011 and in the first three months, over 91,000 seniors and persons with disabilities were enrolled in managed care plans for their healthcare (Kaiser Family Foundation, 2011).

Senate Bill 208 (Steinberg, Chapter 714, Statutes of 2010) authorized the Bridge to Reform, and at the same time also provided authority for California to test a new integrated Dual Demonstration. These demonstrations, implemented across four counties with Medi-Cal managed care infrastructure, are to be responsible for all Medicare and Medi-Cal benefits, as well as LTSS and behavioral health services. One of the selected counties is required to be a County-Organized Health System and one is required to be a Two-Plan County. In 2011, California was one of 15 states awarded a $1 million federal CMS planning grant to develop a Demonstration.

The Demonstrations will serve low-income individuals who qualify for both Medicare and Medi-Cal. Thirty-seven percent of these individuals have both chronic conditions and functional limitations. They utilize more Medicare than non-duals, and they are also high utilizers of Medicaid services, representing 18% of the Medicaid population but 46% of Medicaid spending. California has approximately 1.2 million people who are dual eligible; 71% of them are age 65 and older, and 29 % are under 65. Within the Medi-Cal program, approximately 7% of beneficiaries account for 75% of program costs, primarily for institutional services, and many of these participants are dually eligible (California Department of Health Care Services, 2012). Today only about 15% of dual eligible beneficiaries are currently enrolled in managed care plans; the remaining 80-plus percent receive services in the fee-for-service system, so the shift of this population to integrated managed care is seen as a significant opportunity. One of the key goals of the Demonstration is to reduce the cost-shifting between programs so that persons who are dual eligible get the services to which they are entitled, and another is to focus on prevention and providing appropriate home- and community-based services to avoid inappropriate institutional costs. Finally, the Demonstrations have a significant focus on the benefits that can be achieved through better care coordination. The State expects these measures will result in reduced hospitalization, reduced use of emergency rooms, reduced use of nursing facility services, improvements in preventive services, and improvements in beneficiary satisfaction.

In rapid succession, the State has undertaken a number of planning activities for the Dual Demonstration – holding stakeholder meetings and developing policy in the fall of 2011, issuing draft site selection criteria describing the program model for stakeholder input in December, 2011, and issuing a final "Request for Solutions" describing the program and its requirements and soliciting applications from managed care plans in February, 2012. Twenty-two plans in 10 counties have submitted applications, including: Alameda County (2 applications), Contra Costa County (1), Orange County (1), Los Angeles County (3), Riverside (3), San Diego (5), Sacramento (1), Santa Clara County (2), San Bernardino (3), and San Mateo County (1).

Announcement of the sites the State has selected is expected before the end of March. In the spring of 2012 the Centers for Medicare and Medicaid Services (CMS) will review and approve of California's proposal, followed in the summer by development of three-way contracts between the state, CMS and the managed care plans. The State will conduct readiness reviews in August and September of 2012, and the Demonstration will be launched in January of 2013.

The authorizing legislation requires the California Department of Health Care Services (DHCS) to enter into a memorandum of understanding with CMS to develop a process for selecting, financing, monitoring and evaluating the health care models for the demonstration, including a capitated reimbursement methodology in which the demonstration site prospectively receives a blended payment for Medi-Cal and Medicare services, and a cost-sharing arrangement with the state for Medicare savings. (The Demonstrations are expected to generate savings in the Medicare program, and the federal government and the State will share in these savings). Provider network adequacy standards, uniform appeal and hearing processes, and reporting requirements for both Medi-Cal and Medicare services will also be negotiated with CMS.

The design of the Demonstration projects raises a number of problematic questions for senior and disability advocates. Although there was substantial change in response to feedback submitted to the State about the Request for Solutions, which essentially set the program design, a number of significant concerns remain. Chief among these is the State's intention to automatically enroll participants in the program unless they actively "opt-out," and then to require them to be "locked-in" to the new plans for six months before they can change (the "lock-in" provision will require special permission from CMS). In addition, advocates have raised concerns about the lack of detail in the plan, including key issues such as the integration of social services, person-centered assessment, behavioral health, quality measures, fiscal models and financial projections that are perhaps overly optimistic. Finally, the process has become even more challenging because the final program details were not completely determined in the Request for Solutions, but will be announced in trailer bill language in the State budget, making the process of program design that much more complex.

California's Coordinated Care Initiative

One might argue that with the mandatory enrollment of all Medi-Cal eligible seniors and persons with disabilities into managed health care, not to mention the piloting of fully

integrated Demonstrations combining acute, behavioral, and LTSS services in four counties, the State might have its hands full. However, the Governor's Budget Proposal advances a "Coordinated Care Initiative" that dramatically extends these efforts with three new and additional expansions to California's managed care footprint.

The Governor's Coordinated Care Initiative (CCI) includes three significant changes:

1) Expands initial Dual Eligible Demonstration from four counties to ten in year one (2013), to other managed care counties in the second year, and statewide in 2015.
2) Outside of the Dual Demonstration, also requires phased-in mandatory enrollment of all Medi-Cal beneficiaries into managed care to provide the full continuum of services, including LTSS.
3) Beginning June 1, 2013, expands Medi-Cal managed care in rural counties where benefits are currently provided on a fee-for-service basis.

The State indicates that "A key aspect of this initiative is aligning incentives across all government payers and service delivery systems so that decisions are based on what is best for the beneficiary and not on cost shifting" (California Department of Health Care Services, 2012, page 2). The CCI is intended to create a health care model that coordinates all services within a system of organized managed care in which a health plan is responsible for all benefits. The State's goals for the initiative are rebalancing, reducing fragmentation, improving care, removing barriers to home- and community-based services, aligning payment and eligibility methodologies and improving accountability. It moves California, almost overnight, into a full managed care service delivery system.

Options and Strategies to Impact the Developing System

Choosing priorities to make an impact on the complex and rapidly evolving policy landscape for older adults and persons with disabilities is difficult but essential. The most consistent feedback of nearly all stakeholders in the process, to both the State and the Legislature, is to slow down and make good policy rather than make costly mistakes. However, there are proposals on the table and there are also opportunities to make a positive contribution to the system of care that is taking shape. These are some key strategies that the California Area Agencies on Aging may want to consider in shaping a policy agenda for the upcoming year:

1) *Protect Caregiver Resource Centers from Being Cut in State Budget*
   The role of family caregivers in the system of care is not well understood by California officials, who have proposed in the budget the elimination of the Caregiver Resource Centers, previously located in the Department of Mental Health. Even before this proposed cut, the recent national report *Raising Expectations* ranked California 30th among the states in its support for family caregivers (Reinhart, S., Kassner, E. et al, 2011). One action step could be to bring forward a strategic campaign to educate policymakers on the critical role of family caregivers and the cost-effectiveness of

providing them with support, and preserve the services provided by Caregiver Resource Centers in the newly integrated system of care.

2) *Advocate for Re-investment in HCBS & Restoration of Older Californians Act Programs*
As noted, the budget for Older Californians Act programs have been completely eliminated, including the Alzheimer's Day Care Resource Center, Brown Bag, Linkages, Respite Purchase of Services and the Senior Companion program. However, the authorization for these programs remains. Across the country, California is now one of only seven states not operating some form of non-Medicaid, state-only LTSS targeted to older adults and/or persons with physical disabilities. (The others are Arkansas, Mississippi, Montana, New Hampshire, New Mexico, and Rhode Island) (Cheek, M., Roherty, M., Finan, L. et al, 2012). In fact, in 2011-12, despite difficult budgets, 12 states increased funding for these programs, while 17 held funding steady. These programs and services meet a vital need in the system of care, and as cost-savings are realized through improvements in integrated care, one strategy is to advocate for the programs to be restored.

3) *Develop Bridges and Business Models to Contract with Managed Care Plans*
Another strategy employed by state aging and disability agencies is to develop innovative strategies to maintain services, including being included in dual eligible projects, providing services of value to other state agencies, such as Corrections or Departments of Motor Vehicles, or developing business models to contract with private sector partners such as managed care plans (ibid).

4) *Promote Aging and Disability Resource Centers and Person-centered Assessment*
California's developing Aging and Disability Resource Centers (ADRC) can make a valuable contribution to the integrated system of care, bringing the strengths of the aging and disability community network to managed care plans in a formal role. There are financial advantages to the state in terms of federal participation for fully utilizing ADRCs in the system of care. The state of New Jersey's new comprehensive 1115 waiver reinforced the "front-end" role of ADRCs, making them responsible for information and referral, general assessment, screening and referral, financial assessment for benefits qualification, and referral for clinical assessment (State of New Jersey, 2011).

5) *Strengthen the Role of OAA in Managed LTSS Through Federal Reauthorization*
The Older Americans Act (OAA) is due for federal reauthorization, which Bernie Sanders (I-VT) introduced as S. 2037 in January of 2012. The reauthorization addresses significant investments in four key areas. The National Council of Aging (NCOA) is working on this issue. Another potential strategy is to work with NCOA on strategies to systematically strengthen the role of OAA programs within emerging dual eligible and other integrated managed LTSS programs.

Questions for Discussion

1) Is California moving too fast? Is the State giving adequate time for stakeholder input, preserving current system strengths, and developing good public policy?
2) Do policy proposals demonstrate knowledge of and take into account the value and needs of family caregivers? Do policymakers need information and education about the role, contribution and health risks of family caregivers?
3) What are the linkages between the new managed service delivery system and Older Americans Act programs? Are policymakers and managed care plans familiar with Older Californians Act programs that are currently authorized but not funded?
4) What strategies are necessary to begin collaboration with managed care plans and to develop business models for the aging and disability network to create contracting relationships with plans?
5) What role do policymakers envision for Aging and Disability Resource Centers in the developing system, and what are the most effective ways to leverage that role so that the aging and disability network makes a strong contribution to the system of care?

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