Budget Items of Interest:
A Summary of the Olmstead-Related Items Proposed for the 2006-07 Budget

Promoting Community-Based Alternatives to Institutionalization

1. Advancing Community Options through Integration –Access Plus and Access Plus Community Choices

This proposal provides $1.1 million ($526,000 General Fund) to establish Medicare/Medi-Cal pilot projects that will coordinate services in order to improve continuity of care across acute and long-term care settings, and simplify access to home and community-based services for consumers.

Background: The current array of categorical long-term care programs has resulted in multiple stand-alone programs with unique eligibility criteria, assessment processes, and funding sources, each with a limited grouping of service options. Existing long term care systems and supports are organized around single services, fee-for-service funding streams and state and federal reporting requirements. Social services programs are often not in communication with Medi-Cal and Medicare health care plans, programs and services. Consumers with chronic care needs and long-term care needs often must seek services and supports from several distinct health care programs and home and community-based service organizations, each with its own separate assessment process, and care plan.

The pilot projects will include seniors and adult persons with disabilities who are eligible for Medi-Cal or dually eligible for both Medicare and Medi-Cal. Under these coordinated Medicare/Medi-Cal projects, the Department of Health Services' Medi-Cal Managed Care Division (MMCD) and Office of Long Term Care (OLTC) will contract with selected health plans that become CMS approved Medicare Special Needs Plans (SNPs) or Medicare Advantage Plans with Part D coverage. The Department will create four countywide pilot projects with health plans in counties with existing managed care models – County Organized Health System (COHS), Two-Plan and Geographic Managed Care (GMC) –as well as one multi-county project for the Senior Care Action Network (SCAN-see glossary for more information). All contracts for these coordinated Medicare/Medi-Cal plans would be separate and distinct from existing Medi-Cal managed care contracts.

Plan Types: There will be two types of coordinated plans—1) Access Plus which will, at a minimum, cover the traditional Medi-Cal managed care benefits (acute and primary care), Medicare benefits, institutional long term care (nursing facility), and Adult Day Health Care (ADHC); and 2) Access Plus Community Choices, which will include home and community-based services in addition to Access Plus Medicare and Medi-Cal benefits. The Department will select two GMC counties/regions for Access Plus plans. The Department will select a COHS, a Two-Plan Model county and the Senior Care Action Network (SCAN- currently available in three counties) for Access Plus Community Choices plans.

Plan 1: Access Plus: Two geographic managed care counties/regions will be selected for these projects. Medi-Cal Access Plus plans will, at a minimum, cover the traditional Medi-Cal managed care benefits (acute and primary care), Medicare benefits, institutional long term care (nursing facility), and Adult Day Health Care (ADHC). Plan participation and beneficiary enrollment will be voluntary, so beneficiaries may enroll in an Access Plus plan or in a traditional Medi-Cal managed care plan (offering only Medi-Cal primary and acute care). Access Plus Plan requirements will include:

- Comprehensive Medicare Advantage Plan with Part D coverage or Medicare SNP with Part D coverage.
- Knox-Keene licensed or license pending.
- All other state and federal requirements for Medicare and Medicaid managed care, including quality standards and fiscal solvency.

Target Population: Medi-Cal and Medicare dual-eligible, including those under 21.

Plan 2: Access Plus Community Choices: Two countywide projects will be selected for this project (one County Organized Health Services model and one Two-Plan model) as well as the Senior Care Action Network (SCAN) in Riverside, San Bernardino and Los Angeles counties.

The participating Access Plus Community Choices plans will include home and community-based services in addition to Access Plus Medicare and Medi-Cal benefits. Access Plus Community Choices

plans will place a priority on home and community services over institutional placements, and will provide comprehensive care management services designed to identify the supports necessary to allow individuals to remain in their homes as long as possible. Beneficiary enrollment will be mandatory for seniors and adult persons with disabilities in the Two-Plan county and is already mandatory in the COHS county. Enrollment will be voluntary in the SCAN health plan.

IHSS: The IHSS Program is not included as a health plan benefit. Health plan case managers will work to connect qualified recipients with IHSS services.

Access Plus Community Choices Plan requirements will include:

- Medicare SNP with Part D coverage or Comprehensive Medicare Advantage Plan with Part D coverage.
- Knox-Keene licensed or license pending.
- Comprehensive care management across Medi-Cal and Medicare for medical and supportive services.
- All other state and federal requirements for Medicare and Medicaid managed care, including quality standards and fiscal solvency.

Target Population:

- Seniors and adult persons (21 and over) with disabilities and
- Medi-Cal and Medicare eligible and those eligible for Medi-Cal/SSI-only.

Related Proposals

Enrollment for Seniors and Persons with Disabilities into Managed Care: The intended goal of this proposal is to improve access to health care, improve health outcomes, and reduce state costs associated with fragmented care. The Department of Health Services proposes a phased-in approach to enroll Seniors and Persons with Disabilities (SPDs) in Medi-Cal managed care. Phase one establishes the groundwork for services focused on the special needs of the SPD population. Building on recent studies and workgroup recommendations, the State will enhance its infrastructure and develop and implement policies, regulations, performance standards, monitoring practices, and outreach methods and materials to better serve and inform the SPD population. The Department will expand education and

outreach efforts to increase voluntary enrollment of the SPD population in all managed care counties. For the second phase of the project, the Department will build upon its preparedness activities and develop a project to enroll SPDs into Medi-Cal managed care health plans in two counties on a mandatory basis in 2008.

Coordinated Care Management Pilot Projects: The goal of this project is to maintain access to medically necessary and appropriate services, improve health outcomes, and provide care in a more cost-effective manner for two populations enrolled in the Fee for Service (FFS) Medi-Cal Program who are not on Medicare: (1) Seniors and Persons with Disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life; and (2) persons with chronic health condition(s) and Serious Mental Illnesses (SMIs). This demonstration project will offer the State the opportunity to test targeted approaches through the provision of Coordinated Care Management, in order to meet the needs of high-end users of the Medi-cal FFS system. Coordinated Care Management is a model in which a care manager and a primary care provider work together to improve healthcare outcomes and achieve cost effectiveness in the fee-for-service delivery system. This project will be implemented in three to four Fee for Service counties.

2. Supporting Assisted Living Options for Medi-Cal Beneficiaries

This proposal would provide $1.3 million ($505,000 General Fund) to implement a pilot project that requires the Department of Health Services to seek a federal Medicaid waiver to test assisted living as a Medi-Cal benefit. The Assisted Living Waiver application has been approved by the Center for Medicare and Medicaid Services (CMS) and it is anticipated that the project will be implemented with services delivered by the spring of 2006. When implemented, the ALWPP will serve up to 1,000 persons in two settings: Residential Care Facilities for the Elderly and Publicly Subsidized Housing. ALWPP services will be delivered by Medi-Cal licensed and certified Home Health Agencies in the publicly subsidized housing setting, and by Residential Care Facilities for the Elderly staff in the residential care facility setting. These two provider types will deliver an array of services consisting of 24-hour availability of personal care, assistance with laundry, meal preparation, and other activities of daily living. These services form the

core benefit of the ALWPP. In addition, the waiver utilizes a “Care Coordinator” to perform the initial and ongoing client level of care assessments and coordinate any additional waiver benefits, including: environmental accessibility adaptations; community transition for consumers leaving institutions to return to the community; translation and interpretation services; and consumer education. The level of care assessment will determine the level of services required and the financial reimbursement given to the service provider. The ALWPP will serve persons with disabilities who are over 21 years of age, and/or the frail elderly who meet the intermediate care, Nursing Facility A (NF-A), or skilled nursing, Nursing Facility B (NF-B), level of care. Beneficiaries at the NF-A level of care generally need assistance or supervision in personal care, may require special diets, and need intermittent skilled nursing care. Beneficiaries at the NF-B level of care are generally physically disabled and require skilled nursing care to render treatment for unpredictable, unscheduled, and/or unmet needs.

3. Expanding Access to Community-Based Nursing Services

This proposal would provide $1.4 million ($427,000 General Fund) to implement legislation (SB 643, Chesbro, Chapter 551, Statutes of 2005) that requires the Department of Health Services to add 500 more slots to the Nursing Facility A/B waiver that provides nursing facility services to people who would otherwise live in an institution. Of the 500 new slots, 250 will be reserved for residents living in nursing facilities who wish to return to the community. In addition, the waiver will add the following services that will help facilitate transition back into the community:

1. One-time community transition services, up to $5,000; and
2. Habilitation services that include prevocational, educational, and supported employment services.

4. Enhancing Compensation for Care

The Regional Centers contract with several types of service providers that assist in maintaining independence for vulnerable populations, such as residential care, transportation, vocational training and day program providers. These providers have sustained rate freezes during the past three years of severe budget shortfalls. Relief is needed to reduce the stress on the provider system, prevent program closures and maintain high quality of care for consumers and clients. The Governor's Budget

includes $67.8 million ($46.1 million General Fund) to provide a 3 percent cost-of-living increase. The budget also includes $824,000 ($176,000 General Fund) to provide a 3 percent rate increase to habilitation service programs administered by the Department of Rehabilitation, such as job training, job coaching and providing adaptive equipment.

Coordinating Consumer Needs with Appropriate Services

1. Community Options and Assessment Protocol - Developing a Coordinated Assessment System

This proposal provides $595,000 ($295,000 General Fund) for two years to develop and test a coordinated assessment tool that identifies consumer needs across programs for seniors and persons with disabilities, in order to ensure access to necessary services and supports.

Background: Categorical long term care programs offered to seniors and persons living with disabilities in California are provided by a variety of local and state health and social services agencies with multiple funding sources. Each home and community-based program is designed with its own unique state and/or federal requirements, eligibility criteria, and assessment procedures. Individuals needing assistance with activities of daily living are frequently assessed by three or four separate organizations in order to patch together various services and supports that enable him/her to remain in the community instead of being admitted to a nursing facility. A typical plan might include personal care services from county-based In-Home Supportive Services (IHSS), nursing assessments from a home health agency, weekly visits to an Adult Day Health Care Center and visits from a meals on wheels program. Additional assessments would be needed to arrange for home and community-based waiver services, transportation and low-cost housing. Each program has a separate application, assessment and eligibility process and no ability to share information with other programs for the benefit of expediting the delivery of services or eliminating duplication. The long-term care consumer is often confused about who to contact for help, what programs are available in their home community and which eligibility rules apply. In the worst-case scenario, individuals are institutionalized prematurely without the opportunity to be informed of and assessed for various home and community-based alternatives.

Current Assessment Tools: Multiple assessment tools currently in use in California gather data in a way that serves only one specific program

or a narrowly-defined set of services. Current clinical and functional assessments evaluate an individual's cognitive function, physical function to perform activities of daily living (ADL) and instrumental activities of daily living (IADLs), existing social supports, and medical conditions. Programs use assessment tools to authorize and assign eligibility for defined sets of services including personal care services, in-home nursing, durable medical equipment, non-emergency transportation, personal emergency response systems, and other services and supports. A person seeking multiple services must undergo separate, duplicative assessment processes.

This proposal: This proposal directs DHS to contract for the development of a coordinated tool that can be used across home and community-based programs, in consultation with other Health and Human Services departments and stakeholders including the Olmstead Advisory Committee. The coordinated assessment tool would provide a mechanism through which to connect the consumer to other programs. The tool could be used to gather and analyze information needed across programs to develop a broader understanding of the population trends and needs of those using home and community-based services as alternatives to nursing facility care. This proposal does not provide for the implementation of the tool, only for the development of the tool and its protocol.

2. Expanding the Autism Spectrum Disorders Initiative

This proposal provides $2.7 million (General Fund) to develop best practices treatment guidelines and to connect autistic individuals with evidence-based treatment to improve outcomes.

Background: During the past 10 years, the number of individuals with autism has increased dramatically. Over 50 percent of new consumers requesting regional center services have been diagnosed with Autism Spectrum Disorder (ASD). Research demonstrates that the earlier autism is diagnosed and treated, the better the condition can be mitigated, allowing individuals to be more functional in school and in the community. The Department of Developmental Services' Autism Spectrum Disorder Initiative was created in 1997 in response to the increasing numbers of persons diagnosed with ASD.

Proposal: The expanded ASD will provide a vital service framework to meet the major challenges identified in serving Californians with ASD. The significantly disproportionate increase in number of cases of ASD, the complexity of these cases, and the lack of evidence-based approaches to treat this disorder have overwhelmed the regional center system. The 2006-07 Budget includes $2.7 million (General Fund) to develop best practices treatment guidelines and to connect autistic individuals with evidence-based treatment to improve outcomes.

GLOSSARY of terms for the ACCESS PLUS INTEGRATION PROPOSAL
(See page 2)

Special Needs Plan: The federal Medicare Modernization Act (MMA) allows Medicare Advantage Plans to offer a new type of coordinated care plan for Medicare beneficiaries with special needs. SNPs that are approved by CMS can elect to provide care to individuals in one of three categories: 1) those who are institutionalized; 2) those who are dually eligible; or 3) those with severe or disabling chronic conditions. Managed care plans must apply to the CMS for approval to become a SNP or a Medicare Advantage Plan with Part D coverage. Enrollment for Medicare beneficiaries into these plans is voluntary. All federally approved SNPs will also be required to provide Medicare Part-D Prescription Drug coverage. Any Medi-Cal managed care contractor can apply to CMS to become a Medicare SNP or a Medicare Advantage Plan with Part D coverage. Additionally, plans that do not participate in Medi-Cal can be federally approved as a SNP or Medicare Advantage Plan. The federal government does not consult with states in approving these plans.

County Organized Health System Model: A COHS is a health-insuring organization that is organized and operated by the county. All Medi-Cal beneficiaries residing within the county are required to enroll regardless of their eligibility category. There is no fee-for-service option in a COHS county. Five COHS plans operate in the following eight counties: Santa Barbara, San Mateo, Solano, Napa, Orange, Santa Cruz, Monterey, and Yolo Counties.

Two-Plan Model: In each Two-Plan county, the Department contracts with one locally developed health care service plan, known as the Local Initiative, and one Commercial Plan selected through a competitive procurement process. In general, enrollment is mandatory for families and children. The non-mandatory eligible groups access services through traditional fee-for-service. The following twelve counties participate in this model: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

Geographic Managed Care: Under the GMC model, the Department contracts with multiple health plans in the county via a non-competitive application process in which any plan meeting state requirements/standards is permitted to negotiate a contract with Medi-Cal. Medi-Cal beneficiaries have the option of choosing from among multiple commercial managed care plans for their health care services. In these two counties, enrollment is mandatory for families and children. The non-mandatory eligible groups access services through traditional fee-for-service. This model has operated in Sacramento County since 1994 and in San Diego County since 1996.

Specialized Medicare/Medi-Cal Models: In addition to the three primary models, California has some smaller managed care plans that more fully integrate acute and primary Medi-Cal services as well as Medicare-covered services for eligible seniors. These include the Programs of All-inclusive Care for the Elderly (PACE) and SCAN, a Social Health Maintenance Organization (S/HMO). Both models differ from other managed care plans by offering a broader range of benefits including HCB services. PACE also offers long term nursing facility care. The PACE and SCAN models are operational in some of the existing managed care counties (for example On-Lok and San Francisco Health Plan are currently operational in the same county, Sutter Senior Care and Sacramento GMC co-exist in Sacramento County). Both PACE and SCAN focus on keeping people in their own homes and communities through care management focused on providing alternatives to long term nursing facility placements. CMS has indicated that the S/HMO federal demonstration, which has been successfully operated by SCAN, must convert to a Medicare SNP by the end of December 2007.