# Aging Services of California

## Dual RFI Response Summary

*Improving Care through Integrated Medicare and Medi-Cal Delivery Models*

Stakeholder Meeting
August 30, 2011

# Organization Background

- Aging Services of California is the leading advocate for quality nonprofit senior living and care in the state.
- Represent more than 400 nonprofit providers of aging services – including affordable housing, continuing care retirement communities, assisted living, skilled nursing, and home and community-based care – that collectively serve more than 100,000 seniors.

# Existing Problems that Should be Addressed by Demonstrations

- Comprehensive, timely, information about the details of the plans and options available to beneficiaries.
- Identify and provide "safeguards" against "perverse incentives" in the reimbursement system to under-treat.
- Increasing needs for dementia and behavioral care services.

# Overview of Demonstrations

- Comprehensive benefits, with an emphasis on managing beneficiary care across multiple lines of services.
- Educating beneficiaries and providers about their rights and responsibilities under the Plan.
- Strong authority for the State to enforce providers' obligations under the Plan in a prompt manner.
- Availability of beneficiary counseling
  - ✓Need for something like HICAP

# Overview of Demonstrations con't

- Long Term Care supports and services
  - ✓ The Plans must develop a continuum of LTC supports & services to adequately and effectively care for the range of chronic conditions that characterize the dually eligible population.
  - ✓ For some beneficiaries, a nursing home placement is the appropriate locus of care. But for many, a range of services , like adult day health care, in-home supportive services, in-home health care services, meals on wheels, etc. are the kinds of services necessary to have viable community-based care.
  - ✓ Perhaps even transportation services to make sure these beneficiaries can get to the doctor, the drug store, and the other places of support and services necessary for sustaining community-based care.
- Use of telehealth and eCare technologies

# Consumer Protection Considerations

- Beneficiaries must be able to raise access and/ or treatment issues and get timely help from the State.
- Law must provide beneficiaries a process for requiring timely enforcement of their rights as well as to ensure plans' are accountable to the promises made when contracting to be a Medi-Cal managed care provider.
- Beneficiaries' complaints must be investigated and resolved in a timely fashion.

# Specific Care Integration Challenges

- How should the pilot project integrate:

  - ✓ Mental & Behavioral Health Care

    As people are living longer the incidence of mental and behavioral health issues is on the rise. Dually eligible beneficiaries are no exception. Plans must be proactive and deliberate about how mental and behavioral health practices are folded into mandatory coverage by managed care plans serving this population. State personnel monitoring plan's coverage and policies must be authorized to require a plan to adhere to the "best practices" in mental and behavioral health care.

# Specific Care Integration Challenges

- How should the pilot project integrate:
  - ✓ Long Term Care Supports and Services:
    - As people are living longer and as the elderly population continues to grow larger, there will be an increasing need for long-term care supports and services.
    - Medi-Cal skilled nursing providers are concerned that managed care plans may pay at lower than Medi-Cal rates and have cumbersome billing and authorization processes.
    - Direct Medi-Cal coverage for nursing home stays longer than 60 days might minimize potential payment and process issues.
    - All plans serving retirees must have well thought-out and transparent protocols incorporating a continuum of long-term care supports and services for this population of beneficiaries.

# Measures for Success

- Please list the key metrics that should be used to evaluate the success of any pilots.

1. Beneficiary/Family satisfaction survey
2. Number of beneficiary “confirmed” complaints
3. Number of beneficiary calls to help line
4. Volume of mandated beneficiary services provided 3 month and 9 months after enrollment into the plan.