



*Supporting People,
Health and
Quality of Life*

May 31, 2011

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Department of Health Care Services
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Sacramento, CA 95899-7413
Submitted by email to omcprfp9@dhcs.ca.gov

**Subject: Request for Information on Pilots for Beneficiaries Dually Eligible
for Medi-Cal and Medicare**

Dear Mr. Morrill:

The California Association of Health Facilities (CAHF) is a non-profit professional association founded in 1950 to serve as a statewide organization for long-term care providers. CAHF's membership is comprised of more than 1,300 licensed non-profit and proprietary long-term care facilities serving a wide spectrum of needs in settings which include skilled nursing, intermediate care, subacute, mental health, and services for persons with developmental disabilities. Nearly 100,000 trained medical professional and support service staff care for 300,000 Californians in these facilities each year.

California currently has 3.5 million people over the age of 65—the largest older adult population in the nation. This number is expected to increase to more than 6 million by 2020. The greatest growth will be among the age cohort most reliant on nursing facility services—the elderly population aged 85 years and older. Our members play a leading role in the continuum of care that has evolved to meet the short- and long-term medical needs of this population. Medi-Cal and Medicare comprise 80 percent of the revenue for skilled nursing facilities, and Medi-Cal funds almost 100 percent of the care for people with developmental disabilities who reside in institutions.

While the elderly population was growing rapidly, between 1998 and 2008, the number of freestanding nursing facility beds in California dropped from over 113,000 to 95,000, with occupancy rates staying around 85 percent. Concurrently, utilization of community-based options, including personal care (In-Home Supportive Services Program), Medi-Cal waivers services, residential care facilities for the elderly (assisted living), and adult day health programs, grew

rapidly to care for the growing elderly population. The viability of the existing nursing facilities needs to be maintained to assure that the increasing numbers of elderly have access to short-term rehabilitation services through Medicare and long-term placement, if necessary, for Medi-Cal. While care at home continues to be the preferred choice of most individuals, nursing facilities provide an essential service for those people who cannot be safely or cost-effectively cared for at home.

When considering expansion of community and home-based care, it is important to recognize that a paradigm shift has already occurred within the long-term care continuum. Evidence of this shift includes California's conservative approach to nursing facility development, aggressive utilization controls, additional availability of home and community care options and earlier acute hospital discharges. Nursing facilities have evolved over the years to care for two distinct populations: short-term rehabilitation and medically complex patients and long-stay chronic care patients.

- Short-term patients are usually younger and require rehabilitative services following surgery, such as a hip or knee replacement, or comprehensive care to recover from cardiac, pulmonary and neurological conditions before returning home. Skilled nursing facilities have become the dominant provider of these types of post-acute services in the Medicare program. According to Office of Statewide Health Planning and Development data from 2009, 70 percent of patients in nursing facilities are discharged within three months. In addition, 47 percent of patients are discharged to home or a residential care setting.
- The availability of community-based options has allowed individuals with less complex care needs to remain at home or in an assisted-living environment. Consequently, residents in nursing facilities have complex medical needs or severe behavioral health issues such as dementia.

In general, we expect the pilot programs to recognize that nursing facilities play a critical role and represent a "lower cost" provider for post-acute care reimbursed by the Medicare program. Skilled nursing facilities reduce the cost to care for patients that would otherwise continue their care in the general acute care setting. While CAHF agrees and supports the premise that people have the right to stay in their homes as long as possible, we believe that there are people who cannot receive adequate care in the community.

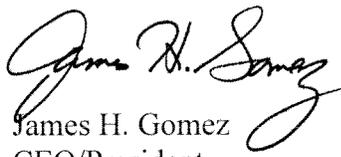
In addition, there are other savings beyond utilization of nursing facilities that should be evaluated and tested in the pilots. Case management of diseases and appropriate drug utilization should result in fewer emergency room visit and hospital admissions. The pilots should also focus on reducing hospital readmissions from both the community and the nursing facilities. Strengthening case management and care coordination is an essential step toward allowing individuals to remain in and/or return to the community whenever possible. In order to be effective, case management must start early in the course of care, in the acute hospital.

Focusing on discharges and/or admissions with the highest potential for successful community/home care makes great sense.

Lastly, the importance of data in providing the capability to case manage and track episodic care and services must be prioritized and considered critical to success when selecting contractors in the RFI process. DHCS needs to play a more active role in partnering with providers throughout the continuum to facilitate access to development of Electronic Health Records (EHR) by sharing data through current systems, funding, and other means.

Attached are CAHF's responses to the RFI. Should you have any questions, please contact Nancy Hayward, Assistant Director of Reimbursement, (916) 441-6400, extension 106.

Sincerely,

A handwritten signature in black ink, appearing to read "James H. Gomez". The signature is fluid and cursive, with the first name "James" and last name "Gomez" clearly legible.

James H. Gomez
CEO/President

Attachment

cc: Paul Miller, Chief
Long Term Care Division
Department of Health Care Services

ATTACHMENT

Part 2: Questions for Interested Parties (including potential contracted entities): (please limit to 10 pages)

1. What is the best enrollment model for this program?

As provided in Senate Bill 208, mandatory enrollment should only be applicable to the beneficiary's Medi-Cal benefits. Dual-eligibles should have the option to enroll in the pilots for the Medicare benefits. In the event that the DHCS interprets this statute differently to require mandatory enrollment for both Medicare and Medi-Cal, there needs to be an exemption process to prevent enrollment because of continuity of care and/or medical reasons.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

The full continuum of care should be funded through the pilots:

- Short-term post-acute care in a nursing facility
- Long-term care in a nursing facility
- Therapies including physical, speech and occupational therapies
- Personal care services, including IHSS services
- Subacute services
- Intermediate care for the developmentally disabled, including residential care in ICFs/DDH and ICFs/DD-N
- Case management services
- Home health agency services
- Hospice services
- Durable medical equipment
- Hearing aids
- Dental services for institutionalized individuals
- Transportation services, both emergency and non-emergency
- ADHC
- HCBS waiver services
- Any and all other LTSS services presently available under the Medicare and Medi-Cal system
- Beneficiary access to reasonably priced housing and/or family support to live at home

3. How should behavioral health services be included in the integrated model?

According to the Kaiser Foundation, almost 2 in 5 duals have both a physical and a mental health disease or condition. If the beneficiary is to be treated effectively, both of areas need to be treated. Also, services related to substance abuse treatment services should be available.

4. If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

CAHF represents institutional providers of long-term care.

Beneficiaries should continue to be given the option of choosing a provider. Any willing and able provider should be able to provide care through the pilot. The savings from pilots should not accrue because of reduced reimbursement to providers, but as a result of changes in utilization.

CAHF recommends that nursing facilities be reimbursed for “skilled nursing services” that would qualify under Medicare Part A at the established Medicare rates. They should also be reimbursed for Part B services that may be billed separately by the nursing facility under consolidated billing requirements. The pilots should have the ability to process and pay in the same manner as the Medicare Administrative Contractor.

Reimbursement for Medi-Cal nursing facility services should be at the AB 1629 reimbursement rates and authorization criteria. In addition, the pilots should cover Medi-Cal subacute services.

Reimbursement for ICFs/DD, ICFs/DD-N and ICFs/DD-H should be at the established Medi-Cal reimbursement rates and similar authorization criteria.

In addition, pilots should consider financial incentives for nursing facilities that hire nurse practitioners or physician assistants. Alternatively, pilots should consider having these practitioners or a physician available for 24-hours a day for onsite consultation for post-acute care in both the home and in the nursing facility. The availability of medical case manager during weekends and evenings will result in reduced re-hospitalizations, which would generate significant savings.

There should be a provision in the pilot’s contract that providers will be paid in a timely manner. Any increases in Medicare and Medi-Cal reimbursement rates will not be delayed because of DHCS delays in paying capitated reimbursement that to the pilot.

On admission, nursing facilities are required to complete a comprehensive resident assessment (Minimum Data Set--“MDS”) for each resident within the first 14 days of

admission. One portion of the MDS, Section Q, records the participation of and the expectation of the resident, family members or significant others in the assessment and identifies the resident's general expectation for the nursing home stay. The resident or the resident's decision maker is also asked about his or her own expectations regarding return to the community and goals of care. If the resident expresses an interest in learning more about returning to the community, the facility is required to make a referral to the state's designated local contact agency (LCA). Under the pilot, this referral process should include a referral to the contractor so that the contractor is responsible for coordinating HCBS placement, if possible.

5. Which services do you consider to be essential to a model of integrated care for duals?

All benefits presently provided by Medi-Cal and Medicare, including personal care services. In addition, case and disease management through a medical home is critical to assisting duals to obtain the appropriate services in a timely manner. Case managers should also focus on specific diseases/conditions to prevent hospital readmissions, emergency room visits, and delay of admission to nursing facilities. Unlike FFS Medi-Cal, services should include access to extensive post-acute rehabilitation services (physical therapy, occupational therapy and speech therapy), with the goal of improving the health status of the beneficiaries so that they can return to their homes. Also, behavioral health and substance abuse services should be accessible. Beneficiaries may need assistance with non-emergency transportation to medical appointment, in addition to emergency transportation services.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

Beneficiaries need to be informed of their rights under the pilot and benefits of participating in the pilot. Providers need to understand their contractual obligations, the anticipated impact that the pilot will have on their business because of the proposed savings, and the evaluation criteria.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

How will the contractor implement and assure compatibility of electronic health records for all categories of service? Are these records systems capability to assure continuity of care across the full continuum of patient care. If not available, how will the contractor implement?

What is the data capability of the contractor in order to evaluate success of the program?

What systems are in place to pay nursing facilities under the Medicare PPS system?

What quality measures would the contractor use to assure quality of care in the nursing facility/institutional setting?

What quality measures would the contractor use to assure quality of care throughout the provider network.

What quality measure would the contractor use to measure that beneficiaries are receiving appropriate care in the community?

What assurances can the contractor provide that they have an adequate network to properly care for these fragile and medically complex beneficiaries? Can they assure access in a timely manner? How will that be measured?

What post-acute services will be available in the network? Are there sufficient therapy providers, along with adequate reimbursement, to provide rehabilitation services?

What are the contractor's plans to assess beneficiaries' health care needs? Do they plan on utilizing a uniform assessment tool?

What patient satisfaction data will the contractor to collect and through what means?

How will medications be provided? What drug utilization controls are in place? Will the pilots have a limited formulary that requires utilization of generics? What exceptions to the formulary are in place? How will this compare to the medications available through Medicare and Medi-Cal?

How will the contractor assure continuity of care for beneficiaries with established primary care physicians?

How will the contractor assure that beneficiaries have a medical home?

Will the beneficiary have a 24-hour toll free number for medical advice? What is the average waiting time?

What is the contractor's plan for targeting specific diagnoses for case management with the goal of reducing hospitalizations and emergency room visits?

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual-eligible population, accessibility, etc., prior to enrolling beneficiaries?

DHCS should establish patient-to-provider ratios to the extent that similar services are available to the Medicare populations. It is critical that contractors be able to prove that they have an adequate network of providers, including both primary-care providers and specialty providers. It is essential that these services be available to the dual-eligible

population to the same extent that they are available to the non-dual Medicare population. Primary care and case management provided in a medical home will be essential to realized savings.

DHCS should have standards for waiting times to see specialists and primary care physicians.

Contractor should provide 24-hour access to medical advice through a toll-free phone line. Standards should be established for waiting times and busy signals to assure access.

Contractors should demonstrate experience dealing with elderly and disabled populations. Alternatively, they should have adequate specialists, including gerontologists included in the network.

Contractors should provide interpreter services and/or assistive services to assure the dual-eligibles understand enrollment. In addition, these services should be available through the contractor for medical visits.

Contractors should be able to identify and demonstrate linkages to non-medical services in the community, including identification of assisted-living facilities where duals reside, personal care services, meal on wheels, etc.

Contractors should address their plans to coordinate care with regional centers for clients that are developmentally disabled.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

CAHF can assist potential contractors in negotiating with and developing educational programs to assist CAHF members.

10. What concerns would need to be addressed prior to implementation?

From CAHF's perspective, data are essential prior to implementation to establish goals to evaluate. Specifically, we would like to see the following statistics:

- Medicare expenditures for duals in a skilled-nursing facility
- Data related to hospital readmissions for duals after both Medicare and Medi-Cal stays in a nursing facility

- Medicare expenditures for duals who are admitted to an acute-care hospital after a Medi-Cal stay in a skilled-nursing facility. In addition, expenditures by Medicare for skilled-nursing facility care (Medicare Part A) for these beneficiaries.
- Data related to Medicare ancillary billing for patients where Medi-Cal is the primary payer for the Medi-Cal stay.
- For duals who do not reside in a nursing facility (meaning Medi-Cal has not reimbursed), the number of duals who received Medicare skilled-nursing facility services who returned home.
- The number of developmentally disabled clients who reside in DD facilities or nursing facilities who are dually eligible. If the number is significant, CAHF will express additional concerns because of the unique needs to these patients.
- Drug utilization data
- Data related to diagnosis with the intent of potential targeting of specific diseases such as COPD, congestive heart failure, etc.
- County-specific data on the dual population including:
 - Demographics on patients residing in nursing facilities
 - ADLs for patients residing in nursing facilities
 - Diagnoses for patient residing in nursing facilities
 - Medi-Cal patient residing in nursing facilities where Medi-Cal has reduced reimbursement rates because they have determined that the patient is not at the skilled level of care (potential HCBS placement)
 - Hospital administrative day utilization rates because the patient cannot be placed in a nursing facility
 - Nursing-facility patients in a distinct-part nursing facility and freestanding facilities
 - Number of DD clients who are dually eligible and place of residence
 - Number of subacute patients
 - Average length of stay for acute care

11. How should the success of these pilots be evaluated, and over what timeframe?

Evaluation and data publication should be annual.

- Beneficiary and family satisfaction.
- Number of Medicare beneficiaries who opted not to participate in the pilot and why.
- Number of beneficiaries who formerly resided (Medi-Cal reimbursed) in a nursing facility who were transitioned to home or residential care.
- Number of beneficiaries who the pilot could not transition to home or residential care and why.
- Changes in utilization and cost of personal care services for clients who would otherwise reside in a nursing facility.

- Change in utilization and cost of personal care services for clients who were “at risk” of placement in a nursing facility.
 - Changes in re-hospitalization rates for patients residing in the community.
 - Change in re-hospitalization rates for patients in nursing facilities.
 - Changes in utilization and cost of emergency room visits.
 - Changes in utilization and cost of general-acute-care hospitals.
 - Changes in utilization and cost of nursing-facility utilization, both for Medicare and Medi-Cal levels of care.
 - Changes in utilization and cost of primary care services.
 - Changes in utilization and cost of specialized medical services, i.e. neurology, cardiology, etc.
 - Changes in utilization and cost of behavioral health services.
 - Changes in utilization and cost of drugs.
 - Changes in utilization and cost of Medicare therapies provided in nursing facilities and outpatient settings.
 - Changes in utilization and cost of home health services.
 - Changes in utilization personal care services.
 - Administrative costs for pilot.
 - Changes in utilization and cost for specific diseases, such as congestive heart failure, COPD, stroke
 - Change in utilization and cost for rehabilitation-type skilled nursing care, such as knee replacements, hips replacements, wound care.
12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

According to the RFI, one goal of these pilots is to reduce the cost of nursing-facility care by assuring that more beneficiaries return home after an acute-care setting. The RFI does not recognize that nursing facilities also reduce the cost of the full continuum of care because they provide a lower cost alternative by rendering post-acute care. The pilots could be designed in such a way that nursing facilities would share in the savings of reduced acute care length of stay (consider eliminating the three-day hospital stay for “skilled” nursing services) and reductions in readmission to hospitals.

CAHF recommends that the managed care pilots NOT be allowed to change the reimbursement methodologies paid for both Medi-Cal and Medicare services. The purpose of integration is to provide the full continuum of patient-driven care and to remove the financial incentives that previously existed to shift the cost of care between Medi-Cal and Medicare. In order to fairly evaluate this theory, changes/reductions in reimbursement should not be considered.