

Responses to Request for Information on Pilots for Beneficiaries Eligible for Medi-Cal and Medicare

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The California Department of Health Care Services (DHCS) within California's Health and Human Services Agency is moving forward to design a more effective way to provide physical, behavioral, long-term care, and social services for people who are eligible for both Medi-Cal and Medicare.¹ In April 2011, DHCS issued a Request for Information (RFI) on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare to solicit stakeholder input for developing new models of care and service delivery for this group of beneficiaries. Though these individuals are often described uniformly as "dual eligibles," they are not a homogeneous group. Rather, they represent a diverse population including younger people with disabilities, older people with needs for long-term supports and services, and people with multiple complex conditions. Thus, the RFI sought to identify best practice approaches for the broad array of beneficiaries who might be enrolled in new systems of integrated care under a demonstration approach.

Responses

Thirty-nine organizations responded to the RFI (see appendix on page 5 for list of respondents).² Respondents had the option to answer one or two sets of questions; Part One was aimed at potential contractors and Part Two was for all interested stakeholders. Fourteen organizations responded to Part One; among them are entities that may be primarily interested in serving as subcontractors to other organizations. Most of the respondents (including most who responded to Part One) responded to Part Two, although not to every question. This brief synthesizes the major themes across stakeholder responses.

Part One: Experience of Potential Contractors

Several respondents have experience serving dual eligibles, both under Medi-Cal and through Medicare Advantage-Special Needs Plan (SNP) contracts. These respondents had ideas for improving the currently fragmented system and suggested that integration will result in improved care delivery. Examples of their proposed changes under an integrated model include:

- A seamless enrollment process, with one card for both Medicare and Medi-Cal;
- A streamlined grievance and appeals process;
- Aligned incentives to prevent unnecessary institutional care, e.g., long term nursing facility admissions and emergency department visits;
- Improved access to home- and community-based services;
- Integrated care management; and
- A single set of rules for marketing, member materials, quality and performance measures, and reporting.

IN BRIEF

The California Department of Health Care Services (DHCS) is seeking to develop a more efficient way to provide high-quality, patient-centered, and cost-effective services to people who are eligible for both Medi-Cal and Medicare. In Spring 2011, the state reached out to stakeholder groups for feedback on core elements that should be included in the new model of care delivery for dual eligible beneficiaries. This policy memo summarizes major themes across stakeholder responses.

Suggestions for Model Designs

Several respondents offered their proposed recommendations for program models that would deliver integrated care to dual eligibles. They provided detailed program descriptions, including the following components:

- Initial comprehensive assessment and screening for risk, possibly in the person’s home, with care management for those at higher risk for poor outcomes;
- A multidisciplinary team approach to care;
- Individualized care planning;
- High-tech solutions such as remote monitoring of people in their homes;
- Comprehensive care management with a single point of contact;
- Management of care transitions across different care settings and home; and
- Health home or medical home models.

Target Population

Potential enrollment in the pilots will range from 1,000 to as many as 70,000 in one or two counties to a multi-county model serving up to 60,000 enrollees. Some respondents suggested rolling enrollment, similar to the monthly phase-in used for Seniors and Persons with Disabilities.

Most respondents expressed willingness to serve the entire population of full dual eligibles, including frail elders, younger persons with disabilities, enrollees with intellectual and developmental disabilities, persons with serious and persistent mental illness, and nursing home residents. One respondent stated their strong belief that carve-outs of beneficiary groups should be avoided. In contrast, a few respondents suggested targeting by age group or disease, e.g., those with cognitive impairment, in a specialty SNP model.

Recommended Services

Most respondents expressed willingness to incorporate the full spectrum of services into the pilot program, but a few preferred a phased approach or were only interested in delivering medical care in coordination with separately funded providers. Some respondents cited the need to include services that are either currently unfunded or only available through waivers, e.g., weight-loss counseling, care and service coordination, 24-hour nurse consultation, and home modification. Respondents proposed including the following long-term supports and services in the integrated model:

- Multipurpose Senior Services Program (MSSP);
- Adult Day Health Care (ADHC); and
- In-Home Support Services (IHSS).

Risk and Financial Modeling

Most respondents were open to taking full risk, with a variety of suggestions for how that might work best, from risk-adjusted rates to three-way contracts. Examples include:

- A community care network in which health plans could serve as full-risk contractor;
- A “PACE without walls” model using a fully-blended capitation rate from Medicare and Medi-Cal;
- A shared savings model in which any savings would be reinvested in improved services and care delivery;
- Risk adjustment that is applied at the population level (e.g., Chronic Illness and Disability Payment System) as opposed to the individual risk adjuster used by Medicare;
- Reinsurance for extremely high-cost beneficiaries;
- Shared risk for nursing facility residents; and
- Primary Care Case Management based on fee-for-service with shared savings.

Enrollment

Respondents proposed a variety of enrollment models, from voluntary to mandatory. One response allows local variation in enrollment design among the pilots, determined by local stakeholder support. Specific proposals include:

- The continued use of Health Care Options for enrollment counseling;
- A timeline for enrollment in which beneficiaries receive enrollment materials 90 days in advance of the enrollment date, are given 60 days to choose a plan, and are assigned to a plan with a 90-day opt-out period.

Stakeholder Involvement and Planning

Several respondents already have local support, provider interest, and a clear method for gathering stakeholder input. The timeline seemed the most reasonable to organizations already providing medical, behavioral health, and long-term services and supports (LTSS). Others hoped for 12-16 months to set up data exchange systems and a four-month lead from contracting to the first enrollment.

To help planning activities, most respondents requested both Medicare and Medi-Cal data for the population under consideration for enrollment (including data on enrollment, costs and services). County-specific data that would be helpful include Medi-Cal services for mental health and long-term supports and services.

In addition, most respondents noted that it would be helpful for DHCS to address questions and make policy decisions before they could respond to a Request for Proposals. Unanswered questions include:

- Will DHCS allow the enrollment of non-full dual eligibles into these programs?
- How will the state support sufficient enrollment and address the problem of churning?
- Will the state allow funds to be used for housing?
- Will rules on categorical eligibility be waived?
- Will the state require entities to take risk?
- What contracting options will be available?
- What will the reporting requirements be?

Part Two: General Support for Integration

In general, respondents were supportive of greater integration of care and DHCS' piloting approach. The respondents applauded the goals of improved utilization, beneficiary satisfaction, and health outcomes. Evaluation funding and the need for adequate time to consider pilot evaluation results before spreading the model was strongly recommended (one respondent suggested at least five years).

A few respondents were not specific to the RFI in their comments; rather they provided descriptions of an existing program and an explanation of why the model would fit DHCS' needs. Some respondents offered suggestions along a narrow perspective (e.g., representative of a certain group of providers or pertinent to a specific group of beneficiaries), including some who suggested that DHCS seek input from mental health advocates, e.g., to get a broader perspective on the needs of this complex population.

Enrollment Models

Most respondents who are not potential contractors support voluntary enrollment, although some consumer advocates suggested that the "opt-out" approach may reach otherwise hard-to-enroll populations. Most also offered safeguards that must be in place no matter which enrollment model is chosen (e.g., continuity of care protections and access to an ombudsman). Examples include:

- Provisions to ensure both smooth service as well as provider transitions;
- Policies that do not allow lock-in of enrollees to a specific health plan;
- Robust choice counseling, including translation for member materials and access to alternate modes of information for beneficiaries with diverse communication needs;

- Access to out-of-area providers; and
- Notification of enrollee rights from an independent entity.

Many respondents included suggestions for better addressing the cultural diversity of potential enrollees. These include involving beneficiaries in the design of the program, and developing an outreach approach that recognizes trusted sources of information. Suggestions include:

- Provide Information in locations used by diverse groups of beneficiaries, e.g., community centers;
- Publicize stakeholder events at least one month ahead;
- Make events available by teleconference; and
- Include topics important to beneficiaries, e.g., services, providers, and options available to beneficiaries.

Benefit Package Considerations

Ensuring access to care that is at least as good as the best offered by Medi-Cal or Medicare was a theme throughout many responses. Respondents suggested contractual standards for access to providers that recognize the use of mass transportation in urban areas, the use of Culturally and Linguistically Appropriate Services standards for language access, and the need for specialized providers.

For beneficiaries who need long-term supports and services, respondents supported the ongoing access to the full range of home- and community-based services, e.g., IHSS, MSSP, adult day health, and training for caregivers. Support for person-centered care and the inclusion of nursing facility as well as alternative non-facility care were also themes.

Respondents offered a few suggestions for integrating mental health services, including:

- The use of predictive modeling to identify persons with needs for mental health services;
- An integrated care management approach to those identified with needs or at risk for mental health service use;
- A best practice model featuring contractors with in-house mental health expertise;
- Co-rounding on complex enrollees with physical and mental health providers;
- Shared real-time data between mental health and physical health providers; and
- Advisory panels for contractors that include beneficiaries with serious mental illness and community mental health providers.

Contractor Requirements

Many respondents suggested requirements for contractors, e.g., physical and programmatic accessibility and regular updates of provider network information. Respondents also provided potential topics to address in the contractor procurement and readiness assessment process. For example:

- Experience with with Medi-Cal and Medicare;
- Experience delivering specific services, especially LTSS and mental health;
- Experience with beneficiaries who use self-directed care;
- Contractors' local presence and relationship with local stakeholders;
- Specific plan for offering integrated benefits, e.g., tools, processes, and systems that would be in place;
- Plan to engage stakeholders; and
- Provider network (evidence of actual contracts or commitment of providers to participate).

Beneficiary Protections

A few respondents supported the recommendations of others (e.g., PACE, remote monitoring, telehealth services, and the public position of the National Senior Citizen Law Center [NSCLC]). Because more than one respondent supported the NSCLC position, it is provided below.

The Principles to Guide Design and Implementation of Integration Pilots

Following is an excerpt from the National Senior Citizens Law Center responses that provides a summary of suggested design principles for the HDCS Dual Integration Pilots:

Before answering the specific questions in the RFI, we would like to provide the following general principles for consideration as decisions are made about integration model design and implementation.

Choice. Dual eligibles interacting with integration pilots must retain their right to choose how they receive care, where they receive care and from whom they receive care. The principle of choice begins with a truly voluntary, “opt in” enrollment model, but also includes: the right to choose all of one’s providers, the right to choose whether and how to participate in care coordination services, the right to decide who will be part of a care coordination team, the right to self direct care (with support necessary to do so effectively), and the right to choose, ultimately, which services to receive and where to receive them.

Beneficiary-centered. The integration effort must be focused, at every level, on the beneficiary. The design and implementation process must include feedback from dual eligibles. Models should be developed to provide the maximum benefit to the beneficiary. Care coordination strategies and assessment tools must place the beneficiary at the center. Monitoring and evaluation measures must start with the impact on the beneficiary experience and must include feedback directly from those individuals.

Best of both worlds. Participants in pilots that integrate Medicare and Medi-Cal should receive care that is at least as good as the care they would receive if they were not in the integrated model. When integrating Medicare and Medi-Cal, difference should be resolved to provide enrollees with the stronger consumer protection and/or more generous coverage standard of the two programs.

Increasing access to HCBS. In an environment where home and community based services are being de-funded, this initiative must be focused on increasing access to those services. Systems that are currently in place should be built upon, not dismantled.

Consumer protections. When integrating multiple funding streams and services, the importance of consumer protections is heightened. Protections include: appeals and complaint processes, network adequacy, cultural and linguistic competence, physical and programmatic disability access, transition rights, meaningful notice and information about plan benefits and changes, stakeholder input and more.

Phased approach. The level of integration proposed does not exist in any current model. DHCS and the pilot entities should continue to develop and implement plans thoughtfully and deliberately. Where possible, integration should be done in phases, starting with simple steps that build off of the current structures in place, then progressing towards more significant changes as necessary and appropriate.

Reinvestment of savings. Medicare dollars must not be used to replace Medi-Cal dollars. If savings eventually accrue from the integration efforts, those savings should be reinvested to expand the availability and quality of health and long term supports and services.

Appendix: Respondents for Dual Eligible Request for Information

Organization Name	Organization Type
1. Access to Independence	Independent Living Center
2. Addus Healthcare	Health Plan
3. Aging Services of California	Aging Association/Advocacy
4. AgeTech California	Technology-Enabled Care
5. AIDS Healthcare Foundation	Health Plan
6. Alta Med Health Services Corporation	ADHC/Clinics
7. Alzheimer's Association	Advocacy
8. Amerigroup Corporation	Health Plan
9. California Association of Health Facilities	Nursing Facility Association
10. California Association of Public Authorities	Public Authority Association
11. California Health Advocates	Advocacy
12. California Hospital Association	Hospital Association
13. CalOptima	Health Plan
14. CalPACE	PACE Association
15. CareMore	Health Plan
16. Care1st Health Plan	Health Plan
17. Community Medical Centers, Fresno	Health Provider
18. Contra Costa Health Plan	Health Plan
19. Disability Rights California	Advocacy
20. Disability Rights Education & Defense Fund	Advocacy
21. HealthCare Partners	Medical Group
22. HealthNet / LA Care	Health Plan
23. Health Plan of San Mateo	Health Plan
24. Heritage Clinic	Clinic/Aging Resource Center
25. Heritage Provider Network	Medical Group
26. Humana, Inc.	Health Plan
27. Inland Empire Health Plan	Health Plan
28. Institute on Aging	PACE Subcontractor/MSSP/ADHC in San Francisco
29. Molina Healthcare	Health Plan
30. National Senior Citizens Law Center	Advocacy
31. OnLok Senior Health Services	PACE Provider
32. San Diego County	Geographic Managed Care County
33. SCAN Health Plan	Health Plan
34. SEIU California	Labor Union
35. Shasta Community Health Center	Clinic
36. Southeast Asia Resource Action Center	Advocacy
37. Sutter Health	PACE provider/health system
38. SynerMed	Health Plan
39. United Domestic Workers of America	Labor Union

Endnotes

¹ California successfully applied for funding from the Center for Medicare and Medicaid Innovation Center to design new models of care. The federal contract awarded DHCS one million dollars for the design period; the full proposal can be accessed at: <http://www.dhcs.ca.gov/Documents/State%20Demonstrates%20to%20Integrate%20Care%20for%20Dual%20Eligibles.pdf>.

² See the following link for all responses by county: <http://www.dhcs.ca.gov/provgovpart/Pages/CaliforniaDEIRFIRResponses.aspx>.