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Community Leaders for California's Seniors

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May 31, 2011

Kevin Morrill
Chief
Office of Medi-Cal Procurement
MS 4200
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Request for Information on Pilots for Dual Eligibles

Dear Mr. Morrill,

On behalf of CalPACE, I am submitting the enclosed response to the Department of Health Care Services' Request for Information on Pilots for Beneficiaries Dually Eligible for Medicare and Medi-Cal.

Please contact me if you have questions or need additional information. Thank you for your consideration.

Sincerely,

Robert Edmondson
Chair

CalPACE Response to Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

Response to Part 2 Questions

CalPACE respectfully submits the following response to the Department of Health Care Services' Request for Information on the Pilots for Beneficiaries Dually Eligible for Medicare and Medi-Cal. CalPACE represents five operating PACE (Program of All-inclusive Care for the Elderly) organizations serving frail seniors throughout California and two organizations developing PACE.

PACE integrates Medicare and Medi-Cal covered benefits including, but not limited to, primary and specialty medical care, adult day care, in-home services, home care, prescription drugs, laboratory and diagnostic services, physical and occupational therapies, meals, transportation, mental/behavioral health services, and as necessary, hospital and nursing home care. An interdisciplinary team that includes physicians, nurses, social workers, therapists, and paraprofessionals develops each treatment plan and manages all services. PACE provides aggressive delivery of preventative care and regular access to physicians and other health care professionals. Thus, PACE is able to manage chronic conditions and avoid unnecessary inpatient care, allowing participants to remain in their homes and communities.

Collectively, the five operating PACE programs have over 80 years of experience in delivering fully integrated care to older adults all of whom are eligible for a nursing home level of care. CalPACE members look forward to work with DHCS to develop the pilot projects for dual eligible and to ensure the continued success of PACE as a provider-based managed care model. We believe the pilot program offers a unique opportunity to reduce existing barriers to PACE expansion and make PACE services available to more dual eligible beneficiaries in California. We also believe that the pilot program is an opportunity to implement greater flexibility in the PACE service delivery model and test adapting the PACE model to new populations, such as individuals who are under 55 years of age and individual who are "at risk" of nursing home care but not yet eligible.

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

    - Voluntary enrollment with intensive education on the value of coordinated, integrated care is the preferred enrollment model for the dual eligible pilot program. We believe beneficiaries need to make an informed choice to enroll in the dual pilot rather than required to be enrolled by default. We also believe that the experience of the mandatory enrollment of the senior and people with disabilities (SPDs) needs to be fully evaluated before expanding mandatory enrollment. Furthermore, although most dual eligible beneficiaries are served in Medicare fee-for-service, some beneficiaries are already enrolled in Medicare Advantage plans. Unless DHCS plans to

contract with every Medicare Advantage plan in the pilot area, care for some dual eligible beneficiaries could be disrupted and less coordinated if mandatory enrollment is implemented.

- For the pilot program to succeed, it is essential that a uniform assessment instrument with consistent application standards be developed and implemented statewide. In the pilot counties, a process must be established whereby all beneficiaries who meet a nursing level of care must be notified of their right to choose a PACE program if one is available. This notification must occur when the beneficiary becomes nursing home eligible and are still residing in the community and not after a nursing home stay. For Medicare beneficiaries, offering the availability of a PACE program should be similar to the required notification for the Medicare Hospice benefit.

- If, in contrast to CalPACE's recommendation for a voluntary model, DHCS requires mandatory enrollment for Medi-Cal and passive enrollment with an opt-out for Medicare, it will be critical that beneficiaries receive education on all options available and have the ability to disenroll on 30 days' notice. We recommend a phased-in process similar to the mandatory enrollment for seniors and people with disabilities (SPDs).

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential in this program?

   In addition to medical, dental and vision benefits available to dual eligible beneficiaries, the following long-term supports and services should be included in this program:
   - Care Management/Care Coordination
   - In-home attendant care for personal care and chore services
   - Adult day services
   - Nursing services
   - Restorative and maintenance rehabilitative services (physical, occupational and speech therapy services)
   - Medication management
   - Transitional care
   - Home-delivered meals
   - Non-emergency transportation
   - Emergency telephone response systems
   - Durable medical equipment to facilitate mobility, transferring, etc.
   - Home adaptation and modification (e.g., installing grab bars, wheelchair ramps, etc.)
   - Respite care
   - Custodial nursing home care
   - Palliative and hospice care

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

   - Person-centered care requires full integration of behavioral health services into the pilot projects. PACE is an example of how these services can be integrated into a single model of care. The PACE Interdisciplinary Team (IDT) considers behavioral health needs as part of the comprehensive care planning process and proactively implements interventions that prevent unnecessary emergency room and acute inpatient care utilization. Because Medi-Cal managed care plans carve out behavioral health services, it will be critical that Medi-Cal rates are adequate and cover the cost of providing these services.

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 contracts 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?

   N/A

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

   - **Interdisciplinary Team**: An interdisciplinary team with experience serving the sub-groups of the dual eligible population to coordinate and managed care across care settings. For example, the interdisciplinary team for older adults would include a geriatrician/internist, nurse, social worker, rehabilitation therapist and behavioral health specialist. The size and scope of the interdisciplinary team would vary depending on the care needs of the individual beneficiary.

     The PACE IDT exemplifies an integrated team process. Due to the unique all inclusive nature of the PACE program, each PACE participant is assessed regularly for his/her medical, behavioral, functional and social vulnerabilities and issues. The IDT discusses the changes in the participant's health status and makes timely revisions to the care plan in response to the participant's changing needs. Access to services is available on a 24 hour basis, 7 days per week.

   - **Comprehensive Service Array**: In addition to the long term services and supports identified under question #2, it is essential that the integrated model build on a strong primary care component with timely access to all needed medical services, including medical specialty services, inpatient hospital services, medications, and behavioral health services.

   - **Health Information Technology:** The pilot program should encourage electronic Health Records (EHR) and health information exchange capacity to

allow continuity of information across care settings. DHCS should allow other ways to achieve these goals for applicants who do not have such capacity.

- **Quality Assurance and Improvement Program:** An integrated model covering the full range of medical services and long-term supports and services must have a comprehensive quality assurance and improvement program in place with oversight, reporting and feedback appropriate to the sub-groups of the population and services covered.

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

   - DHCS must evaluate and learn from their experience in mandatory enrollment of seniors and people with disabilities into Medi-Cal managed care. Representatives from PACE organizations participated in every aspect of the stakeholder process during the 1115 waiver; yet, PACE was not included on the enrollment documents used in the mandatory enrollment of SPDs, even though PACE eligible individuals are allowed to select PACE. Given PACE's long history as a pioneer in integrated care, PACE must be given equal weight as an option for beneficiaries and not relegated to secondary status compared to other options.

   - More community meetings and webinars are needed for both community organizations and consumers to educate beneficiaries about the project. DHCS needs to work with community organizations to identify accessible locations and to ensure that the education is culturally and linguistically appropriate and at the appropriate literacy level.

   - DHCS should work with the traditional providers of care for the dual eligible population and use both ethnic and mainstream media sources.

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

   - What experience have you had serving a dual eligible population?
   - What experience do you have in providing integrated care including long-term care services and supports?
   - What is your experience in serving individuals needing behavioral health services? How would you propose integrating these services? What is the organization's history of serving community and, in particular, Medi-Cal beneficiaries?
   - How will this project be sustained after the pilot program ends?
   - How would you ensure quality in your pilot program?

- What have been the results of your consumer and provider satisfaction surveys?
- Please describe your provider network. Is the network sufficient to meet the needs of the dual eligible population in terms of culturally appropriate services, accessible locations, etc.? How will you ensure timely access to appropriate care? What evidence do you have of community participation in your planning process?
- What is your ability to assume full financial risk?

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?

    - Contractors need to be required to hold licenses as risk-bearing entities in California (i.e., Knox-Keene, Department of Insurance or PACE).

    - Contractors need to demonstrate availability of culturally and linguistically competent staff reflecting the different sub-groups served, as well as availability of translation and interpreter services. In particular, contractors should demonstrate sensitivity to the needs of beneficiaries with sensory deficits.

    - Contractors should be required to have a Consumer Advisory Committee as a standing committee of the governing board.

    - Contractors need to be able to demonstrate the ability to deliver directly, or through contact, all Medicare and Medi-Cal services including the following long-term supports and services (previously identified under question #2):
        - Care Management/Care Coordination
        - In-home attendant care for personal care and chore services
        - Adult day services
        - Nursing services
        - Restorative and maintenance rehabilitative services (physical, occupational and speech therapy services)
        - Medication management
        - Transitional care
        - Home-delivered meals
        - Non-emergency transportation
        - Emergency telephone response systems
        - Durable medical equipment to facilitate mobility, transferring, etc.
        - Home adaptation and modification (e.g., installing grab bars, wheelchair ramps, etc.)
        - Respite care
        - Custodial nursing home care
        - Palliative and hospice care

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

    - Since CalPACE is not a potential contractor, CalPACE would be willing to participate in the development of a uniform assessment instrument, to assist in raising awareness on the benefits of integrated care, and to educate beneficiaries about their available options.

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

    - CalPACE is concerned about the aggressiveness of the timeline given the state budget situation and the time it will take to develop new models.

    - CalPACE is concerned that a level playing field is established between the pilots and existing programs, such as PACE, in terms of enrollment, regulatory oversight, etc.

    - Developing the dual pilots will be challenging. DHCS will need have the staffing capacity for managing the project. Without adequate state resources, the project will not be successful.

    - Adequate Medi-Cal rates need to be established to ensure the fiscal solvency of the pilot projects.

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

    - The evaluation needs to have short term and long-term components. For example, enrollment and outcomes related reducing inpatient utilization and increasing use of community services can be evaluated in the short term. In comparison, fully evaluating the pilot's success in diverting institutional placement must be evaluated over a longer timeframe. The evaluation methodology needs to be established before launching project.

    - The measurement of success should include consumer and provider satisfaction, quality indicators and outcome measures appropriate to the sub-groups in the population including reducing inpatient utilization and preventing nursing home placement. Achieving measurable quality outcomes would demonstrate a successful pilot program.

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?

    - Integrating Medicare and Medi-Cal funding streams and pooling resources so that services can be delivered without regard to funding source is essential to the pilot program. This will also achieve the goal of aligning incentives so that services are delivered based on the beneficiaries' needs rather than traditional payment rules.

    - Rate-setting and risk sharing methodologies should create incentives that support quality improvement and desired outcomes.

    - Willingness on the contractors' part to assume full financial risk or phase in financial risk for management of all elements of the care continuum should be incorporated.