RFI Respondent Meeting Summary

August 30, 2011
Prepared by Harbage Consulting

On Aug. 30, 2011, Harbage Consulting, a private health care consulting firm, in coordination with the California Department of Health Care Services (DHCS) organized a meeting around integrating care delivery for individuals eligible for both Medicare and Medicaid. The meeting was held at the Sheraton Grand Hotel in downtown Sacramento and designed to accommodate more than 300 people who registered online. The meeting developed from DHCS' Request for Information (RFI) regarding interest in the demonstration projects to deliver integrated care to dual eligibles. Nearly 40 organizations responded to the RFI, and the purpose of the Aug. 30 meeting was to give those respondents an opportunity to summarize their proposals and concerns in a public forum. To that end, 40 people presented summaries of their RFI responses. They included representatives from health plans, provider groups, county health departments, home health agencies, advocacy organizations, labor unions and more (see the agenda for a list of all speakers and their organizations.)

On the day of the meeting, 286 people signed in and another 47 called into the conference line. Attendees came from all parts of the state and represented the diversity of stakeholders interested in care delivery for dually eligible beneficiaries. Attendees came from DHCS, the Centers for Medicare and Medicaid Services (CMS), private health plans, County Organized Health Systems (COHS), disability rights group, aging services, provider groups and many more organizations.

This event also served as a kick-off to a stakeholder working process planned for the fall. It marked the beginning of a transparent process through which officials from the DHCS will listen to input regarding coordination of care delivery for Medicare and Medi-Cal beneficiaries. Future meetings will take a "deep dive" into the key issues areas around integrated care delivery.

Welcome

Toby Douglas, DHCS director, welcomed and thanked everyone for attending. This meeting would be the beginning of a participatory dialogue regarding integrating care for dual eligibles. He then addressed DHCS' plans to deal with the elimination of adult day health care (ADHC) as Medi-Cal benefit. Douglas acknowledged that the process for transitioning ADHC beneficiaries to managed care was moving faster than is ideal, but necessary given the deadline of benefit elimination on December 31. In contrast to the speed of that transition, Douglas indicated that the Duals Integration Demonstration would be the product of a thoughtful and inclusive discussion about the best plan for dual eligibles.

DHCS will move toward a model that maintains choice, consumer-directed control over organized delivery systems, and a better system of integrated care. The fee-for-service system is fragmented and too expensive. Care can be integrated in a better way. DHCS wants to have an interactive discussion with stakeholders to create a better delivery system for dual eligibles. The fact that the state has never moved forward on integrated care before is not a reason not to do it now. This is the beginning of a fresh start to bring all stakeholders together.

In particular, Douglas touched on two key areas of integration that are a significant focus in the state legislation on the Dual Eligibles SB 208. The first is mental health integration. There is a need for a way to better integrate medical care with mental health and substance use services, especially given the high prevalence of mental illness among the target population. In addition, integrating home and community based services as part of the process will require thoughtful consideration.

The next speaker was **Melanie Bella**, director of the Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office. The office, she said, was created through health reform and has three focus areas:

1. Program Alignment – To find the areas where Medicaid and Medicare bump against each other and figuring out how to make them work together. The programs were never designed to work together and they don't work together well.
2. Data Analytics – To get a better sense of who is in the population and how to understand their needs better to design better delivery systems. CMS has made Parts A, B and D Medicare data available to states for care coordination purposes.
3. Integrated Care Pilot Demonstration – Currently, nationwide, only about 100,000 out of about 9 million dually eligible beneficiaries are enrolled in *fully* integrated care systems. The demonstration project hopes to help states expand integrated care to at least 1 million beneficiaries by 2012. California was one of 15 states that received funding to design a demonstration proposal.

CMS proposed two new financial alignment demonstration models to blend Medicare and Medicaid funding and fully integrate care. States are required to submit a letter of intent to CMS by October 1, 2011 if they are interested in pursuing either or both financial model. The two models are:

1. Capitated model.
2. Managed Fee-for-Service model.

(While the models were not discussed in detail, explanations of those approaches are available on the CMS website here: http://www.cms.gov/medicare-medicaid-

coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp#TopOfPage)

Bella said she is committed to helping California make this effort work because the opportunity and number of people that can be helped in California are so great.

CMS is looking for systems that address and are accountable for the total needs of a person – medical and nonmedical. That includes behavioral health, social supports, medical care, and long-term care. CMS is not looking for carve outs or plans that shift risk or incentives from one entity to another. CMS wants models that balance the needs of people who rely on these programs and that deliver services in a coordinated manner.

These demonstrations are opportunities to find working models for improving care. The goal is to validate that care integration produces better health outcomes and, over time, lowers costs. Bella expressed concern that policymakers are looking everywhere for cost savings and this population is seen by many as significant cost driver. The goal and opportunity for the demonstrations is to develop thoughtful models that will improve care, protect patients, and lower costs.

Bella stated that CMS will not accept proposals that lack the necessary beneficiary protections. CMS will expect to see certain things in the proposal and so a robust stakeholder outreach process is a key component to a successful proposal.

Next, **Kevin Prindiville**, deputy director of the National Senior Citizens Law Center (NSCLS), provided an overview of the consumer rights and protections that should be considered in the design of any integrated care delivery models. Prindiville's comments were based on an NSCLC Issue Brief released in July. The full brief can be found here: http://www.nsclc.org/areas/medicare-part-d/consumer-protection-for-dual-eligibles-important-in-new-integrated-care-models

Among the key principles Prindiville mentioned were:

1) Choice: Beneficiaries should direct their own care and choose how, where, from whom they receive services. That choice starts at enrollment.
2) Beneficiary-centered models: Care coordination, assessment tools, provider networks and monitoring and evaluation metrics should be built around the beneficiary.
3) Shared savings should be reinvested in improving care for dual eligibles.
4) Consumer protections: Key protections include having an integrated appeals, process, care continuity and transition rights, stakeholder input, and meaningful notice.
5) Oversight and monitoring: The state needs to dedicate sufficient resources to ensuring beneficiary protections. The stricter policies between Medicare and Medi-Cal should be adopted.

6) Models should be designed around financial incentives that emphasize keeping people in the community.
7) Phased approach: The models should build toward full integration slowly as the system is able accommodate the changes.

Prindiville concluded his remarks by suggesting success for this demonstration project should be defined through the lens of the beneficiaries whose care and lives will be affected.

Panel 1

The first panel included six representatives from health plans and a staff attorney from the Disability Rights Education and Defense Fund. Each panel participant summarized his or her RFI response before taking questions. (PDFs of all PowerPoint presentations can be found at http://www.dhcs.ca.gov/provgovpart/Pages/CaliforniaDEIRFIResponses.aspx)

During the question and answer period, one question related to measures that could be used to evaluate model effectiveness. Panelists suggested a range of measures, including avoidable emergency room visits, reducing hospital recidivism, specific health outcomes related to disease processes, medication compliance, and complaints. Enrollment satisfaction and dissatisfaction were also mentioned.

Another questioner asked about integration of substance abuse and suggested not lumping it within behavioral health language, where it could get lost. Another question related to how beneficiaries would be informed of the changes and their rights. Someone asked if dental benefits would be included in the delivery model.

Panel 2

California has six County-Operated Health Systems (COHS) in 12 counties that provide managed care to the Medi-Cal population. The second panel included representatives from two of those COHS – CalOptima and Health Plan of San Mateo. CalPACE and Disability Rights California also had representatives on the panel. CalPACE has provided a model of integrated Medicare and Medi-Cal services since 1983.

The panel raised points about uniform assessment tools and a single point of entry and care management, stressed the importance of non-medicalized models, need for adequate payment rates to attract a broad cadre of providers, the need for collaboration with county mental health services, and need to eliminate long-term care carve outs. Finally, the advocate stressed that these should be seamless care delivery models and that the new models need to be better than the existing systems not merely a substitute for mediocre care. The scope of the care assessments and that they include medical and social issues were raised as additional concerns.

Panel 3

The third panel focused on acute and post-acute care. Panelists discussed the role of skilled nursing facilities and post-hospital care and rehabilitation services. The need for adequate payment rates to hospitals and nursing homes was raised again. One panelist stated the need for models to include access to robust medical care to help people with chronic illness or disabilities stay in the community. Regarding mental health services, a panelist pointed out the high prevalence of mental illness among the dually eligible population. County mental health systems funded through Medi-Cal provide a wider array of services than Medicare and should be maintained. Dementia-specific care plans also should be considered. The final panelist highlighted the specific needs of the Southeast Asian dually eligible population as an example of a minority group with limited English and high rates of disability. He pointed out that models must be designed that address the needs and challenges of such subgroups.

Following lunch, **John Shen**, DHCS Deputy Director for Long-Term Care Services, introduced the afternoon panels. Shen highlighted some of the unique challenges that have long impeded true care delivery integration for dual eligibles, including opposing financial incentives, distinct provider cultures, and unique rules. He explained that this effort is an opportunity to create new models that simplify and improve the beneficiary experience.

Panel 4

The afternoon panel started off with more health plans describing their proposals to integrate care delivery. They reviewed the current challenges of integrating the two systems but expressed interest in implementing new models. One plan representative talked about the opportunity to give beneficiaries a single ID card for a single set of comprehensive benefits managed by a sole provider. A patient advocate mentioned the need for patient choice that started with the option for enrollment and necessity of patient-centered delivery models.

A larger discussion about passive enrollment with the option to opt out versus completely voluntary enrollment developed. Several advocates representing beneficiaries with HIV advocated against passive enrollment. Plans mentioned that without passive enrollment it would be hard get sufficient enrollment numbers even with intense marketing.

When asked whether they considered the demonstration an opportunity to try something new and different versus expand what they were already doing, several panelists said they were hoping to expand what was already working well for them as well as develop new delivery models.

Panel 5

The fifth panel focused on home and community based services. Six panelists presented their proposals for integrating these services into care delivery for dual eligibles. Additionally, two panelists representing unions for domestic home workers addressed their concerns and principles for successful care integration.

A representative from the County of San Diego spoke about their efforts to integrate long-term care over the past decade. She emphasized the need for local, county-driven discussions about the process to get all the important stakeholders on board. Several panelists stressed the need for reimbursement rate sufficient to attract willing providers. The union representatives suggested a phased approach and need for consumer satisfaction measurements that reflect the diversity of the population being served. The presenter from Age-Tech addressed the opportunities to save money and improve home-based care through various technologies. The Veterans Administration already has tested some of these technologies and found them to be cost effective solutions. Following the panelists presentations, one questioner mentioned that groups have been talking about integration for 30 years, but this demonstration offers a renewed opportunity. Another speaker mentioned the need to include durable medical equipment in the benefits package.

Another commenter mentioned that consumers will need resources where they learn about their options and rights as the demonstration moves forward. Another attendee mentioned her fear of having too much care management, leading to greater confusion. There should be one lead care manager for each beneficiary. Someone mentioned the need for flexibility in benefits and need to substitute them for the claims process. Finally, discussed the need for evaluation that goes beyond medical analysis but cautioned not to overburden providers with more reporting requirements.

Panel 6

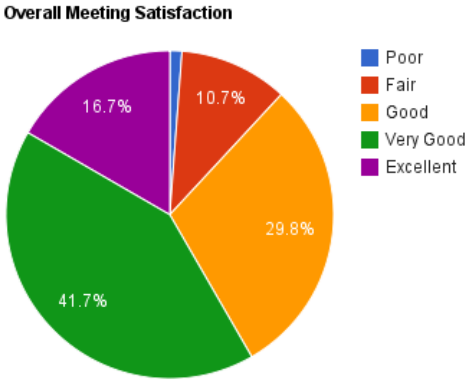
The final panel included representatives from six provider organizations and an advocate. The providers described their models and strengths that would allow them to provide integrated care to dual eligibles. One provider from Fresno and another from Shasta urged decision makers to consider their counties for the demonstration. One provider said the providers should also benefit from the “shared savings.”

One respondent suggested considering the model of California’s Public Authorities, which oversee IHSS and include consumer representation. Another respondent remarked asked about case management to consumer ratios. There was a brief discussion on whether providers could implement the demonstrations pilots by direct contracting with the state. One panelists said, “Plans should do what they do best and provider groups should do what they do best.” Another said it was important to get rid of duplicate services between plans and providers. Providers could assume full risk and

take care of patients. When talking about enrollment, providers said they were cautious about voluntary enrollment resulting in adverse selection and also of beneficiaries coming in and out of the program if their eligibility changed.

Participant Feedback

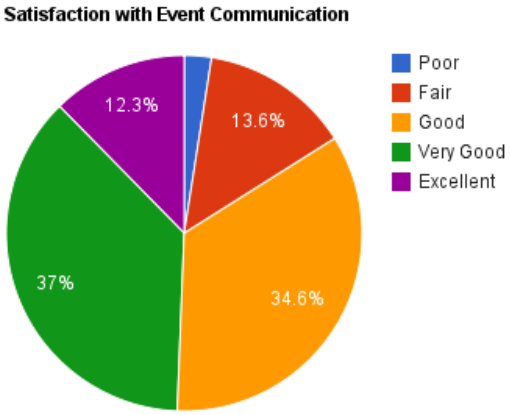
Eighty-four meeting attendees completed an event evaluation asking them to rate their overall satisfaction with the event, satisfaction with communications, usefulness of the information, and to offer suggestions for future stakeholder meetings.



Of the 84 completed the evaluation, 58 percent rated the meeting "excellent" or "very good." Another 30 percent rated it "good." Only one person rated the meeting as "poor."

Attendees reported that the meeting provided a good overview of the issues and variety of perspectives. They indicated this was a good start to frame the forthcoming stakeholder process, but subsequent meetings should be more detailed regarding what integrated care delivery would look like and how implementation of the demonstrations would actually occur. Future meetings should have clear goals and objectives and be a dialogue with the stakeholders.

Communication



Of 81 participants who rated their satisfaction with communication about the event, 49.3 percent rated it "excellent" or "very good," and 35 percent rated it good.

For future meetings, people reported they would like more advanced notification with materials to prepare. People indicated email was a good method of communication and also suggested posting all materials on the state website as they became available.