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CA Dual Eligible Pilots Request for Information (RFI)
County of San Diego Long Term Care Integration Project (LTCIP)
Part 2-Response by Interested Party

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

A model that requires mandatory enrollment (perhaps with an opt-out option) for those aged, blind and disabled Medi-Cal and Medicare recipients (dual eligibles) in the target population would ensure that all targeted individuals and associated costs are part of the program. This is essential to the success of acute and long term care integration for both care management and actuarial reasons. While there is some opposition to mandatory enrollment, the successes of many of the County Operated Health Systems in both managing costs and improving the quality of care can be replicated and enhanced with a combination of mandatory enrollment and long term care integration. There is precedence for successful implementation of mandatory enrollment models elsewhere in the country. For example, the successful mandatory enrollment that occurred on a large scale during 2006 in the Louisville, Kentucky area and in Minnesota could be replicated by pilots in California.

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

The integrated model should include at a minimum the following long-term supports and services for the target population:

- Long-term care services (skilled nursing facility services, intermediate care facility services, sub-acute services)
- Care Transitions
- In-Home Supportive Services (IHSS)/personal care services
- Homemaker/chore services
- Home modification, repairs, maintenance

- Translation/communication/emergency response devices
- Health management devices
- Home health/personal and respite care above regular Medi-Cal scope
- Counseling
- Money Management
- Adult day care
- Emergency moves/temporary shelter
- Nutrition
- Assistive devices
- Legal assistance
- Transportation
- Dental services
- Multipurpose Senior Services Program (MSSP)

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

Fragmented systems of care deliver expensive treatment in an inefficient manner to the detriment of beneficiaries as well as the providers. Integrating physical health, behavioral health and social services into an enhanced Patient-Centered Medical Home (PCMH) service delivery model would provide better, more efficient care for dual eligibles. Reimbursement methodologies that support adequate and appropriate funding for behavioral health services must be developed and implemented in the model design, as this will be a significant step toward delivering effective, integrated services.

Given the timeframe for implementation of the pilots, it might be prudent to consider a multi-phased inclusion of behavioral services into the established model. The 65+ population is a reasonable starting point for phase I implementation. Integrating behavioral health services with a small, manageable group would provide experience in and build network capacity for providing population-based, integrated behavioral health services to all beneficiaries. Phasing-in behavioral health services for younger beneficiaries (64 and under) at a later date allows time to (a) gain expertise in providing behavioral health services, (b) monitor & evaluate phase I to identify problems and make necessary system improvements; and (c) effectively address the unique needs, systematic requirements and other concerns regarding the under 65 age group.

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?**

The County of San Diego, Health and Human Services Agency (HHSA), Aging & Independence Services (AIS) is the local Area Agency on Aging as well as the umbrella agency for more than thirty different programs for older adults and adults, over the age of 18, with disabilities. The Aging and Disability Resource Connection (ADRC), one of the first established in the country, provides a no wrong door, integrated service delivery system for information and assistance and is the gateway to AIS programs and services.

AIS is a recognized leader in the state and nation in providing advocacy, information and safety, and was the recipient of the 2010 National Area Agencies on Aging (n4a) *Leadership as Innovators in Aging Programs Award* for fostering groundbreaking programs. Established in 1999 under the leadership of AIS, the Long Term Care Integration Project (LTCIP), which is comprised of more than 800 stakeholders, has provided the overarching framework to create an integrated, continuum of health and social services across all settings, an improved service delivery system for dual eligibles, and the infrastructure for community engagement and partnerships in San Diego County.

As a result of its pioneering work in integrated service delivery, AIS is prepared to contract with managed health plans, Accountable Care Organizations (ACO) or other integrated service delivery systems to provide support services including but not limited to care management; evidence-based prevention, education, health promotion and care transition programs; options counseling; short term service coordination; congregate and home delivered meals; In-Home Supportive Services (IHSS) assessment; and caregiver support. AIS staff are experienced, degreed social workers and nurses, many with advanced degrees, who are proficient in assessment, care planning, counseling, case management and advocacy. As County staff, they are able to streamline access to benefits and services, and leverage well established community partnerships that include hospital systems and community-based organizations.

As the AAA and umbrella agency for public programs for older adults and adults with disabilities in San Diego County, AIS would continue to administer all programs and services that an AAA

or County agency are mandated by federal or State law or funded to provide in addition to any established sub-contractual arrangements.

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

The essential services for an integrated delivery system for dual eligibles include all Medicare covered services, all Medi-Cal State Plan services, behavioral health services, all long term care services and supports identified above in question #2, paraprofessional health coaches for wellness, nutrition and chronic disease self-management, care transitions, care coordination and case management. The model must afford the flexibility for the care manager to authorize services outside of the defined benefits to provide the right service, at the right time and in the right setting, based on the consumer needs and preferences.

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

At a minimum the following outreach and education should be provided prior to implementation:

Beneficiaries

- What the integrated model can offer outside of traditional Medicare, Medi-Cal, and fee-for-service healthcare
- How to enroll
- Their role in developing a person-centered care plan
- Their rights and responsibilities
- Benefits of early intervention and preventive services as well as disease-specific chronic disease self-management and healthy lifestyle choices
- Available community services, resources and supports
- Obtaining a referral to an out-of-network specialist
- Importance of care transitions
- Supervision of care providers, hiring and firing of care providers
- Employment options
- Importance of a personal health record and advance health directive

Providers

- Overview of integrated model and goals
- Referral and enrollment protocols and procedures

- Beneficiary-directed care: sensitivity training on assessing and responding to each beneficiary's preferences for settings, services, interaction, etc. with the goal of making the system accessible and responsive to the beneficiary
- Working with persons with disabilities: physical disabilities and cognitive disabilities, self-determination, other impacts on health and wellness of persons with disabilities such as environment, architecture, logistics, society, and culture
- Americans with Disabilities Act: medical facility and practitioner requirements for access and accommodation
- Normal vs. abnormal aging
- Complaint, grievance, and fair hearing processes/incident reports
- Diversity
- Behavioral health issues
- Terminal illness and palliative care
- Abuse (physical, emotional, and financial)
- Locating community services and resources

Stakeholders

- Scope of covered and allowed services
- Referral/enrollment protocols and procedures
- Complaint, grievance, and fair hearing processes/incident reports
- Provider network
- Contract requirements
- Quality assurance/quality improvement
- Beneficiary responsiveness
- Physical accessibility
- Cultural competence
- Care coordination
- Outreach and education

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

The following questions should be answered by all dual eligible pilot potential contractors:

- What comprehensive preventive, diagnostic, therapeutic, rehabilitative and long term care services, including home and community-based services will be provided to

beneficiaries? What services, assistive devices and resources that are not covered by Medicare or Medi-Cal will be provided to beneficiaries based on their needs and preferences?

- How will services be coordinated across healthcare and social service providers and what training will be conducted to ensure a full continuum of care across all settings?
- How will initial and ongoing screenings be conducted to identify members with special needs and begin assessment, treatment planning and care coordination consistent with beneficiaries needs and preferences?
- Will services for the developmentally disabled including but not limited to: rehabilitative, family planning services, behavior management, rehabilitative and therapeutic services, pain management, and genetic counseling be covered?
- How will contractor ensure the adequacy of the provider network?
- How will the facility site reviews ensure that the specialized equipment, communication and access needs of people with all functional limitations are met?
- What training and outreach will be provided to beneficiaries, providers, contractor staff, physicians and stakeholders?
- How will contractor address the community and cultural diversity of beneficiaries?
- What assessment, care planning and care coordination tools will be used? How will information be shared across all providers and settings?
- What programs/services will be instituted for acute care transitions, nursing home diversion and de-institutionalization?
- How will timely and geographic access be ensured?
- How will complaints and grievances be addressed?
- How will personal care services be provided in the integrated model?
- What is the rate setting methodology that will be used?
- What data sharing and information systems will be used to promote care coordination?
- How will Medicare and Medi-Cal funding be aligned yet invisible to the beneficiary?
- How will local and regional diversity and strengths be leveraged?
- Will enrollment be voluntary or mandatory?

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?

Generally speaking, DHCS should require contractors to establish expansive, integrated, provider networks that include a wide array of health, behavioral health and social service providers across the acute and long term care continuum. The contractors should clearly demonstrate their qualifications and commitment to care for all dual eligibles including those with functional and cognitive impairments. Most critically, the contractors must ensure that the various delivery system elements will be integrated into an effective network that meets the diverse needs of all dual eligibles in the service area.

The following minimum standards for accessibility, sensitivity, and cultural competence are recommended:

- All forms, documents, educational, outreach and enrollment materials must be made available in alternative formats in threshold languages, at an appropriate comprehension level based on community standards for persons with sight or hearing impairments or for people who do not speak English. All potential contractors must provide interpreter services that are available on a 24-hour basis.
- All eligible applicants must be enrolled without regard to marital status, age, sex, gender, sexual orientation, national origin, English proficiency, ancestry, race, color, religion, socio-economic status, political beliefs, genetic characteristics, physical or mental diagnosis, condition, ability or disability, except as required by law.
- Physically and geographically accessible services and providers must be available to meet the unique and diverse needs of the dual eligible population.
- Recruitment, hiring, and retention efforts must strive for workforce diversity that reflects the enrolled population.
- Training to staff, providers and others must include valuing diversity, cultural competence, linguistic and disability sensitivity.

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

As stated in # 4 above, as the Area Agency on Aging (AAA) for San Diego County, Aging & Independence Services (AIS) is a potential subcontractor for an integrated service delivery

model for dual eligibles in San Diego. AIS can also contribute years of experience in working with a large stakeholder group to develop a comprehensive, integrated continuum of acute and long-term care services for dual eligibles as authorized by AB 1040. AIS was awarded three planning grants and two development grants from the State Office of Long Term Care (OLTC) to envision and recommend a better model of care for low income older adults and persons with disabilities in our community, recognizing the difficulty these individuals and their caregivers have in navigating the existing fragmented and duplicative network of acute and long-term care services.

In San Diego County there are many other flourishing programs that could contribute to the success of a dual eligible pilot as either a subcontractor or a collaborator. For example, the Public Authority, a quasi-governmental entity, assists IHSS recipients to find care providers through a registry, investigates the qualifications and background of care providers on the registry, refers recipients to providers, and provides training to both providers and recipients. The Public Authority also enrolls all new providers into IHSS by performing a criminal background check, providing orientation and viewing identification in-person. This entity serves as the employer of record for 21,000 IHSS providers that serve 25,000 IHSS recipients in San Diego. The experience, expertise, and established credibility of the Public Authority would be a tremendous asset to any integrated service delivery model. San Diego County is also home to a very successful and expanding PACE Program operated by St. Paul's Senior Homes and Services. PACE provides integrated services through a blended Medicare/Medicaid capitated rate and could certainly inform best practices in integrated service delivery.

San Diego County, in partnership with the State, has a long history of success in the San Diego Geographical Managed Care program, Healthy San Diego. The experience, community partnerships and strong stakeholder engagement that have been established in the county would certainly contribute to the success of an integrated pilot in San Diego County.

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

The type of pilot that is proposed in any region must be approved by a broad array of local stakeholders (including consumers, caregivers, health, social and supportive service providers, advocates, and others), and represent the needs, preferences and vision of the stakeholders prior to implementation. The rate must be developed locally and be based on sound, county-specific, actuarial data.

It is critical that any pilot that is proposed clearly demonstrate readiness to meet the specialized needs of the population served by the pilot prior to implementation. Readiness includes physical and non-physical accessibility to network providers; adequacy of network to provide personal care services and other home and community-based services; provision and coordination with out of network services including behavioral health; and specialized staff and provider training to understand and respond to the unique needs of the dual eligibles. Local stakeholders must agree that the pilot demonstrates the expected level of readiness prior to implementation.

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

The pilot's quality management and improvement system must focus on outcomes. The contractor should operate an ongoing quality management program that includes quality assessment and performance improvement, in accordance with federal and State requirements. Contractors should be expected to review for under-utilization as well as over-utilization with the highly vulnerable population in the pilot. The contractor's quality management and continuous quality improvement program should:

- Measure performance on standards including but not limited to network adequacy, access to information, and physical accessibility to provider sites
- Recognize that opportunities for improvement are unlimited and continually seek to improve quality and beneficiary satisfaction
- Be data driven
- Seek and incorporate beneficiary input
- Seek and incorporate input from all employees of the contractor and its subcontractors
- Require measurement of effectiveness, continuing development, and implementation of improvements as identified

While fiscal outcomes are important to ensure that no more is spent on pilot beneficiaries under the proposed program than would be spent under the current FFS arrangement, it must be anticipated that there will be higher costs initially but that these will be offset in future years by efficiencies achieved from prevention of unnecessary hospital, emergency room and nursing home utilization and improved health of the beneficiaries. Thus, given the short timeframe of the pilots, the success of the pilot cannot be evaluated on cost savings. Instead, the success of the pilot should be evaluated on other outcomes including how the program maximizes consumer-

centered care to improve health outcomes and assures fair provider compensation to improve access and quality. Outcomes should be monitored and evaluated quarterly by DHCS, but an overall evaluation should be conducted annually over the life of the pilot by at a minimum an External Quality Review Organization, stakeholders, and beneficiaries.

11. 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?

Setting per member per month (PMPM) rates at a percentage of the cost of unmanaged care is recommended. For example, the PMPM may be set at 92% of FFS spending. The rate should reflect the savings a pilot should be able to achieve by managing a broad array of services more efficiently. The PMPM payment must be actuarially sound; developed in accordance with generally accepted principles and practices for rate development; appropriate for the population and services included in the contract; and certified by an actuary as meeting federal requirements. The rate should be based on historic expenditures prior to the implementation of the pilot or based on a comparable population not enrolled but also include risk adjustment based on health status and diagnoses. To facilitate the establishment of an appropriate rate for a county pilot, it is essential that the State provide timely response to county requests for Medi-Cal and IHSS data, and work with CMS immediately to obtain release of Medicare data. Lastly, in an integrated model that incorporates IHSS, it is imperative that the County shares in the overall savings realized by the pilot.