Summary of DHCS Informational Meeting on Dual Eligibles

December 8, 2010

Presenting: Paul Miller, Department of Health Care Services, and
Alice Lind, Center for Health Care Strategies

Paul Miller: Background information

DHCS originally intended to include a program for people who are eligible for both Medicare and Medi-Cal ("dual eligibles") in the 1115 waiver. However, the dual eligible population was retracted from the waiver by CMS' request, which has allowed DHCS to pursue this project in a different fashion. A new opportunity has emerged, through CMS' Office of the Duals and the Center for Medicare and Medicaid Innovation (CMMI). CMMI has a solicitation opportunity, just published (see addendum, "Updates since December 8 meeting"), through which states can bid for planning/design contracts of up to one million dollars. Up to 15 states will be awarded contracts.

Alice Lind from the Center for Health Care Strategies (CHCS) was introduced. She , along with other CHCS staff are providing assistance to DHCS through funding from The SCAN Foundation. CHCS will support the development of the duals pilot framework as well as provide technical assistance to DHCS in its response to the CMMI contract opportunity. This summer, The SCAN Foundation supported several meetings with stakeholders, including a series of technical workgroup meetings on the design of pilots for dual eligibles. Currently, a Technical Advisory Panel of 13 – 14 people is providing input to the state. At DHCS' waiver website, there is a handout (see page 5, and also found at DHCS waiver website for dual eligible information: http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupDE.aspx)

SB 208 provided authority for DHCS to design pilots for duals. The language states that, no sooner than March 2011, the state must identify models to be included in a pilot project and to begin to develop those pilots. The Director is authorized to enter into contracts to implement the pilots. (See description beginning page 11).

Prior to the CMMI opportunity (described in Addendum), DHCS was going to take the next few months to revise and publish the duals pilot framework, and then proceed to identify counties in which to implement pilots and issue procurement documents. Because of the contract opportunity, there is a less than two-month window to develop a more detailed pilot description. DHCS will ensure stakeholder involvement through the following activities:

- A draft proposal to CMS will be shared with stakeholders;
- DHCS will hold a webinar meeting to allow stakeholder comment in January;
- The draft will be revised and published for input prior to submission to CMS;
- A Request for Information will be developed in 2011 allowing additional opportunity for input.

DHCS has an opportunity to provide an integrated program of medical and home- and community-based services (HCBS) through amending its 1115 waiver. This would go on a separate track and provide DHCS experience with rate development for HCBS. With nearly 1.2 million dually eligible individuals in CA, this is a great opportunity to provide better care and bend the cost curve.

Alice gave an update based on CHCS' work with other states working on integrated care for duals. First, CMS created the "Office of the Duals" that is focusing on several priority activities:

- Program alignment across Medicare and Medicaid, especially focused on health plans, such as Special Needs Plans. These plans are tied to two separate sets of rules and regulations. CMS is looking for suggestions of how to streamline program requirements.
- Data on duals for states, health plans, and advocates. CMS is working on analytics and making matchable or blended data sets available to states.
- A CMMI-solicited request for proposals for state demonstration design contracts for integrated care for dual eligibles. Funding for the design of programs will be available through contracts to states via a competitive process. California is ahead of many states because of the stakeholder meetings this summer. The deliverable for this contract is that the state will have a fully fleshed out demonstration proposal. CMS' intention is that when the year of planning is over, and no later than December 2012, states will implement integrated programs.

CMS is looking for integration programs that will create a "seamless journey of care" for beneficiaries that encompass primary and acute medical care, long-term services and supports, and behavioral health services. Specifically, they want to use this demonstration for new program options, e.g., to allow blended funding for Medicare and Medicaid. The ideal program will provide a seamless continuum of services and allow recipients of funds to use them in a much more flexible way. CMS is also interested in rapid cycle evaluation to send program information back to the entire nation.

Through CHCS, other states, and stakeholders, we know certain elements are essential for any program for duals:

- ► Comprehensive assessment and person-centered care planning;
- ► Multidisciplinary care team and broad provider network;
- ► Involvement of the family caregiver when appropriate;
- ► Strong home- and community-based service options, including personal care services; and
- ► Honoring of member choice and member rights.

Paul referred to the timeline in the handout. It should be considered draft, and has changed already, based on the requirement to implement a program in 2012. Send comments and questions to Paul.miller@dhcs.ca.gov

Questions and comments from the audience (in person and on phone):

- Are geographic managed care plans excluded?
    - Response: No
- Comment from a dual eligible. "Currently, I see my doctor through FFS Medicare and Medicaid. Medicare pays the bill and Medi-Cal hardly pays anything. What will this program do for me?" The speaker said he does not want to be subordinate to someone in managed care telling him what services he can use.
    - Response: Ideally, you will have someone looking out for you through care management, you will have more choices and options.
- Dual eligible person who lives in a small town where they don't have any doctors: what will the impact be to their access to care? She does not want to change the geographical area where she receives services.
    - Response: DHCS hopes that through the pilots they will have a better idea of how it will impact rural areas – but they probably won't start there.
- Medi-Cal eligibles fall on and off the program – unless DHCS establishes continuous eligibility, people will fall on and off the pilot program.
- Does SB 208 provide adequate authority for these pilots?
    - Response: Yes, and the federal project will provide CA the opportunity to have more resources to plan the CA project in 4 locations.
- CA Hospital Association: questioned whether SB 208 allows mandatory transition of duals into managed care.
    - Response: Read section from SB 208 on enrollment. It states enrollment is mandatory for Medi-Cal and the member can choose FFS Medicare. DHCS needs to clarify what CMS will allow re: mandatory/opt-out enrollment for Medicare.
- Speaker stated that he has seen a statistic that 45% of duals are on anti-psychotic medications. They get SSI and Medi-Cal and then two years later they become Medicare. Parity for behavioral health payments should be required. He is concerned that Medicare may not pay for the type of behavioral services that people need, and has not seen anything in writing about this.
    - Response: It is envisioned through global funding that all services would be covered through the "payer pot." Appreciate comments and we will follow up on this population.
- More conversation about how voluntary Medicare enrollment would work. Do you anticipate any change that would remove that restriction as a pilot for everyone? How could you determine savings if the population is so unstable?
    - Response: There is some confusion around options for enrollment. A few states were able to grandfather in the duals as enrollees into integrated programs when SNPs were created. Auto-enrollment into Medicaid programs (with opt-out to FFS a possibility) is considered voluntary by states. But states should over-communicate to make sure that people know what is going on. Almost anything that we think is a rigid rule is now up for consideration. This will evolve quickly over the next few months. It is helpful to have stakeholder input at this time. Under ACA, the CMMI has the authority to waive rules for the demos.

- How will the state outreach to people who are not duals yet to show that the program worked? The speaker heard that the PACE program is being cut.
    - Response: PACE programs will continue. People will still be able to enroll in PACE and not the pilot. The pilot project will be in up to 4 counties; if the pilot is in a COHS county, the county will enroll people. The money will be comingled so that it is a pot of money paying for services to ensure better health outcomes.
- Comment from the Medical Association: concerned about effect on the federal incentive funding for electronic health record implementation. $44,000 per physician is the maximum incentive, and that is only based on Medicare part B charges. Moving people to Medicare Part C will cause physicians to lose federal incentive funding for providers and possibly even hospitals.
    - Response: Thanks for alerting DHCS to possible unintended consequences.
- A speaker asked about clients who are dual eligibles, and are eligible for Medi-Cal because of the monthly premium they pay to their Medicare plan. Concern that mandatory enrollment would kick them off of Medi-Cal enrollment.
    - Response: DHCS needs to check out this possibility.
- A speaker asked whether CMS Medicare data would be matched with Medicaid data, or whether the state will need to link the data sets. Question about availability of Medicare or blended data. Will this information be available for COHS that are possibly interested in this population?
    - Response: whether CMS will give states blended data or how it will be provided is not clear. To the extent that the data can be synthesized and provided to plans, and to the extent HIPPA allows, it would be very helpful for stratifying and understanding population. (DHCS will follow up.)
- Comment on access to rehab services: Under fee-for-service Medicare, rehab services are good. Medi-Cal doesn't have a good rehab benefit. The level of reimbursement and services provided are limited. Ideally, rehab includes making sure that the caregiver gets the training needed to help the patient stay in the community.
    - DHCS thanked the speaker for the comment.

Paul concluded the meeting with an offer to stay afterwards if there are other questions, and a reminder that there will be a future meeting in January.

Save the date! DHCS Webinar on Dual Eligible Pilots

January 12, 1:00 p.m. – 2:30 p.m.

Details for how to register will be sent in January and posted to DHCS waiver website.

DRAFT Handout for December 8 Meeting

California's Waiver Pilot Programs for Duals:

Better Coordination, Integration and Outcomes

Pilot Background

As part of California's effort to provide organized systems of care for vulnerable populations, the Department of Health Care Services (DHCS) will identify pilot projects to test integration of Medicare and Medicaid services including long-term services and supports (LTSS) for dual eligible beneficiaries in up to four counties. This is a first step toward California's goal of providing better coordination and integration of services for all 1.1 million Duals in California.

Accompanying Legislation

Senate Bill (SB) 208 added Section 14132.275 to the Welfare and Institutions Code. This section, in part, requires DHCS, not sooner than March 1, 2011, to:

- Identify health care models that may be included in a pilot project
- Develop a timeline and process for selecting, financing, monitoring, and evaluating these pilot projects
- Provide this timeline and process to the appropriate fiscal and policy committees of the Legislature.

Section 14132.275 also allows the Director to enter into exclusive or nonexclusive contracts on a bid or negotiated basis, and allows the pilots to be implemented in phases.

Strategic Fit

This project aligns itself directly with the Department's Strategic Plan goals and objectives, as follows:

Goal #1 – Organize Care to Promote Improved Health Outcomes

- Objective B – Provide care in settings that promote community integration
- Objective E – Increase care management for those with the highest health burdens and costs

Goal #2 -- Promote Comprehensive Health Coverage

- Objective A – Enroll eligible individuals
- Objective B – Retain eligible persons in health coverage

Goal #3 – Measure Health System Performance and Reward Improved Outcomes

- Objective A – Measure health outcomes and provide information to providers, individuals and the public

Goal #4 – Increase Accountability and Fiscal Integrity

- Objective A -- Establish and monitor performance metrics for DHCS
- Objective C – Improve relationships with business partners, stakeholder groups and policymakers
- Objective E – Act in accordance with State and federal statutes and regulations
- Objective F – Identify and secure federal policy and rule changes that support DHCS programs

Goal #5 – Ensure Viability and Availability of Safety Net Services

- Objective A – Identify mechanisms to maximize federal reimbursement for safety net services
- Objective B – Maintain availability of and access to safety net services

Pilot Goals, Areas, and Enrollment

Pilot Goals – The Dual pilots will coordinate Medi-Cal and Medicare benefits across care settings and maximize the ability of duals to remain in their homes and communities with appropriate services and supports in lieu of institutional care. The goals include mitigating or eliminating cost-shifting between the Medicare and Medicaid programs.

Areas of Operation – State legislation allows pilots to operate in up to four counties through Medi-Cal managed care plans. The pilots will include at least one Two Plan county and one County Organized Health System county.

Pilot Selection Criteria -- When selecting the pilots, DHCS will review evidence of local support for integration and local stakeholder involvement in pilot development, implementation, and operation. The county/other contracted entity must also demonstrate readiness to integrate additional services. Readiness criteria will be developed with stakeholder input.

Current Counties Showing Interest –Through an upcoming Request for Information (RFI) process, DHCS will be able to better gauge the interest of other counties. The RFI will seek information about the interested parties' experience with managing LTSS, their existing network, consumer protections in place, and methods of assessment for LTSS-related needs and strengths.

Beneficiary Enrollment – Duals in the selected counties will be enrolled into the new pilot based on the participating plan's capacity to serve new enrollees. Ideally, and subject to potential contractors' interest and CMS authority, , beneficiaries will be passively enrolled in the pilot to ensure the best integration of care. If they choose, a

beneficiary can opt-out of receiving their Medicare benefits through the pilot, in which case they will receive benefits through Medicare fee-for-service (FFS).

Relationship to PACE* - Per SB 208, Persons meeting requirements for Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14590), may select a PACE plan if one is available in that county. Additionally, DHCS may encourage potential contractors to collaborate with local PACE sites.

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*Program of All-inclusive Care for the Elderly – PACE is a comprehensive model of care that integrates Medicare and Medi-Cal financing to provide all needed preventive, primary, acute and long-term care services for older adults who are determined by DHCS as eligible for nursing home level of care. PACE began in California as a waiver demonstration project in 1980s and was established as a permanent Medicare provider and a voluntary state option under Medicaid as part of the Balanced Budget Act of 1997 (BBA). Five PACE programs currently exist in California serving a largely a dual-eligible population. In counties implementing pilot projects, individuals meeting the eligibility requirements for PACE will have the option of selecting PACE in counties where PACE is available.

Beneficiary Protections

The purpose of these pilots is to improve Duals' experience and outcomes. To further that goal, the pilots will maintain existing consumer protections available through managed care, and will additionally adopt performance standards that are at least as rigorous as those specified in the Seniors and Persons with Disabilities (SPD) section of the 1115 Waiver Proposal, including:

- Medical home – Duals will have an established, assigned medical home either through a physician or clinic.
- Access – The pilots will ensure access to provider networks, information, and physical accessibility of provider locations.
- Transition – A carefully phased-in transition will include outreach and education, and access to existing providers.
- Care coordination – Integration will include early assessment of health care needs, cultural competency training, and coordination of behavioral health and other services.
- Expanded monitoring – Performance measures, audit efforts, and complaint and grievance procedures will be expanded to drive continuous quality improvement.

Pilot Framework

A pilot framework document will lay out the broad operating structure, financing, services, standards and consumer protections that would govern the selection and operation of the various pilot programs. This document will be the baseline that the Director will use to select pilot programs. The stakeholder workgroup will provide input on the development of this document with the goal of maximizing program quality and

cost effectiveness. CHCS will develop this framework and provide research about appropriate framework components based on best-practices from other state programs and federal government input.

Pilot Evaluation Development

Evaluation development should begin immediately and should include both a contracted technical expert in Dual integration strategies, such as CHCS, as well as a group that has experience in operating such evaluations, such as UCLA. These two expert perspectives, in conjunction with input from the stakeholder workgroup, will create an expertly tailored evaluation framework. It is critical to design the evaluation, with input from an evaluation operator, concurrent with program development to design a program that can be properly evaluated. Evaluation development work could be separated from the operation of the evaluation, so that an evaluation expert could be contracted initially to just participate in the development of the framework. At a later date, a group can be selected to operate the actual evaluation. It will also be necessary to track and evaluate outcomes for the Dual population that remains in Medicare Fee-for-Service (FFS) to determine methods to integrate care for this population.

Report to the Legislature

DHCS will provide a report to the Legislature after the first full year of pilot operation, and annually thereafter.

Integrated Long-Term Care Services

A primary goal of the pilots is to integrate new plan responsibility and capitation payment for LTSS, so that Medicare Special Needs Plans (SNPs) can coordinate and integrate a set of Medi-Cal services that are currently provided outside the plan's responsibility. Better coordination and integration should improve the beneficiary's experience and outcomes as compared to a FFS or non-integrated system.

There may be some variation in the newly-integrated/capitated services depending on the readiness of the individual pilot areas and plans. The following will be considered for integration into the plan's responsibilities:

1. Institutional Long Term Care;
2. 1915(c) Home and Community-Based Services, including the Multipurpose Senior Services Program, Assisted Living Waiver Pilot Program, and the Nursing Facility/Acute Hospital Waiver;
3. Personal care services and adult day health care;
4. Paramedical and nursing services, and physical, speech, and occupational therapies; and
5. Home modification and meals.

The inclusion of Specialty Mental Health Waiver or Developmentally Disabled Waiver services in the pilots will be determined through discussion with CMS and stakeholders.

Financing Arrangements

Depending on the opportunities afforded by CMS, California may act as the administrator of the Medicare benefit, or may pursue savings-sharing with Medicare. Financial integration of Medicare and Medi-Cal services will allow funds to be spent on needed services as determined by the health plans.

Other Possible Projects

Through preliminary discussions, both CalOptima and Health Plan of San Mateo have strongly expressed an interest in providing a full range of home and community-based long-term care services to the Medi-Cal only and duals population. This project may proceed on a separate timeline and with separate procurement efforts.

Current Efforts and Next Steps

Capitation Rate Development

DHCS is currently engaged in preliminary discussions with Mercer to explore developing rate methodologies for monthly capitation rates. Ideally, Medicare and Medi-Cal funds would be blended into a single capitation rate.

UPDATED DRAFT TIMELINE	
Calendar Year 2010	
Timeframe	**Activity/Deliverables**
October - December	Form Technical Advisory Panel; Develop Draft Framework of Duals Integration Pilots; Hold introductory meeting with stakeholders.
Calendar Year 2011	
Timeframe	**Activity/Deliverables**
January - February	Gather input from stakeholders. Develop and submit response to contract opportunity through Center for Medicare and Medicaid Innovation.
March - April	Draft Request for Information (RFI) soliciting interest from counties.
May - June	Revise duals RFI based on stakeholder input; Revise framework based on stakeholder input; Incorporate draft evaluation plan into framework document.
August - September	Release RFI; Provide opportunity for stakeholder input.
October - December	Draft Request for Proposals. Develop a timeline and process for selecting, financing, monitoring and evaluating pilots. Identify health care models and provide a timeline and process to fiscal and policy committees of the Legislature.
Calendar Year 2012 (TBD with CMS input)	
Timeframe	**Activity/Deliverables**
January 15	Interested counties/other bidders submit proposals to DHCS
January 15-March 31	Evaluate RFP submissions
March 31	Director announces pilot counties
April 1 – December 31	Work closely with Mercer, selected pilots, CMS and others to finalize pilot development.
During 2012	Begin operating pilots (Revised post meeting)

ADDENDUM: REQUEST FOR PROPOSALS EXCERPTS

From CMMI Opportunity to Contract for Duals Integration, accessed at following link: https://www.fbo.gov/index?s=opportunity&mode=form&tab=core&id=7ffe8a7ccbd80dffeccfbb55d7ae7d62&_cview=0.
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B.1 DESCRIPTION OF SERVICES

State Demonstrations to Integrate Care for Dual Eligible Individuals

B.4 Implementation PHASE

States receiving a contract for program design are not guaranteed to move into the implementation phase of the contract. It is the intent of CMS to structure the implementation phase as an optional follow-on to the design phase of this contract. The CMS shall make a determination as to which states will move forward with the implementation option at the end of the eighteen (18) months of the design phase of the contract. Pending availability of funding, states selected to move into the implementation phase may be eligible to receive funds to support development of state infrastructure/implementation. **At such time the successful states will be requested to submit their proposed costs to prepare state infrastructure for conducting implementation of the model design demonstration.** These development and infrastructure cost may include systems change costs at the state-level for testing a new payment approach, development of a more efficient data exchange feed for real–time tracking of claims, and additional resources that may be required to ensure successful implementation of the state model demonstration.

SECTION C - DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C.1 STATEMENT OF WORK

Background

Created by the Affordable Care Act, the Center for Medicare and Medicaid Innovation (Innovation Center) aims to explore innovations in health care delivery and payment that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through improvement. There is perhaps no better opportunity to test innovative service delivery and payment models than for individuals who are eligible for both Medicare and Medicaid (the "dual eligibles"). Dual eligibles account for 16 to 18 percent of enrollees in Medicare and Medicaid, but roughly 25 to 45 percent of spending in these programs respectively. With the vast majority of these nine million individuals still receiving care through fragmented care at an estimated cost of over $300 billion in state and federal spending, improving care for this population is ripe for innovation.

Purpose

The Innovation Center is fostering interaction with a diverse group of stakeholders, including hospitals, doctors, consumers, payers, states, employers, advocates, relevant federal agencies and others to obtain direct input and build partnerships for its upcoming work. Given the partnership that exists between federal and state governments with respect to dual eligible individuals, the Centers for Medicare and Medicaid Services (CMS), through the Innovation Center, will provide

funding for states to support the design of innovative service delivery and payment models that integrate care for this population. CMS is interested in identifying, supporting, and evaluating person-centered models that integrate the full range of acute, behavioral health, and long-term supports and services for dual eligible individuals.[1]

Under this solicitation CMS may award up to 15 (fifteen) contracts for up to $1 million each to support the design of state demonstration models. The primary deliverable of the initial design period is a demonstration proposal that describes how the State would structure, implement, and evaluate an intervention aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible individuals. Only states that receive the initial contract award may be eligible for receipt of the implementation phase of this contract, pending the approval of the States' demonstration design and the availability of funds. Technical assistance and related tools will be provided by the Federal Coordinated Health Care Office (FCHCO), created by Section 2602 of the Affordable Care Act, to support both the design and implementation efforts. It should be noted that receipt of an initial design contract does not guarantee that those States will be eligible to move into the implementation phase of this contract. Under this solicitation, CMS shall not be obligated for reimbursement of any design costs beyond the Fixed-Price design contract amount.

Deliverables

Over the course of the contract, the following deliverables will be required:

- **Monthly Conference Calls.** States shall participate in monthly conference calls with the CMS project officer and other CMS staff. These calls shall be used as a mechanism for discussing and managing administrative and project issues as they arise.

- **Progress Reports.** States will be responsible for submitting interim and final progress reports that document the development process and lessons learned as part of the design contract.

- **Innovation Demonstration Model.** The main deliverable of the design contract will be a demonstration proposal that describes how the state would structure, implement, and evaluate an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligibles. CMS will provide states with the exact requirements in the Demonstration Proposal Instructions at the time of contract award; however, the demonstration proposal will be expected to contain at a minimum:

    - Explanation of how the proposed demonstration will achieve the overall goals of better health, better care, and lower costs through improvement.

[1] Potential models could include those that enhance existing integration vehicles such as the Program for All-Inclusive Care for the Elderly (PACE) and Medicare Advantage Special Needs Plans (SNPs) as well as those that test new/emerging models such as health homes or accountable care organizations (ACOs).

- Problem statement describing how or why changes to current policy would lead to improvements in access, quality, and reductions in Medicare and Medicaid expenditures over time.

- Discussion of how the proposed model will improve the actual care experience and lives of eligible beneficiaries, including findings from any beneficiary focus groups the state conducted to inform its proposed design.

- Detailed description of the dual eligible population, including key subpopulations (e.g., individuals with nursing facility level of care, serious mental illness, Alzheimer's/dementia, multi-morbidities, etc.); utilization patterns; service settings; costs; etc.

- Description of proposed delivery system/programmatic elements, including: benefit design; geographic service area; enrollment method; and provider network/capacity.

- Description of plans to expand to other populations and/or service areas if the model is focused on a subset of dual eligibles or is less than statewide.

- Description of proposed payment reform, including payment type (e.g., full-risk capitation, partial cap, administrative PMPM); methodology for blending Medicaid and Medicare funding; financial incentives; risk sharing arrangements; etc.

- Discussion of the expected impact of the proposed demonstration on Medicare and Medicaid costs, including specific mention of any effect on cost-shifting occurring today between the two programs.

- Description of state infrastructure/capacity to implement and monitor the demonstration proposal.

- Identification of key performance metrics, including how these data will be used to continuously improve access, quality, satisfaction, and efficiency as well as how they will fit within existing Medicaid and Medicare performance and quality measures.

- Plan for engaging internal and external stakeholders, including a process for gathering and incorporating feedback on an ongoing basis.

- If applicable, description of how the proposed model fits with: (a) current Medicaid waivers and/or state plan services available to this population; (b) existing managed long term care programs; (c) existing integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs; and (d) other health reform efforts underway in the state (e.g., accountable care organizations, bundled payments, multi-payer initiatives, etc.).

- Discussion of the scalability of the proposed model and its replicability in other settings/states.

- Description of proposed evaluation design, including key metrics that could be used to examine the model's quality and cost outcomes for the target population, beneficiary experience, access to care, etc.

- Description of the overall implementation strategy and anticipated timeline, including: a) the activities associated with building the infrastructure necessary to implement proposed demonstration (e.g., staffing needs, actuarial support, etc); and b) any funds needed to support the development of such infrastructure (e.g., systems change costs at the state-level for testing a new payment approach, development of a more efficient data exchange feed for near real-time tracking of claims, etc.).