SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
DUAL ELIGIBLES TECHNICAL WORKGROUP
Meeting #3 – Thursday, June 3, 2010
10:00am – 3:00pm
Sacramento Convention Center, Room 104

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: Maya Altman, Health Plan of San Mateo; Richard Chambers, California Association of Health Insuring Organizations and CalOptima (by phone); Bonnie Darwin, California Culture Change Commission; Sandi Fitzpatrick, California Commission on Aging; Brad Gilbert, Inland Empire Health Plan; Nancy Hayward, California Association of Health Facilities; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority (by phone); Cynthia Jackson Kelartinian, Heritage Clinic, Pasadena (by phone); David Kieffer, SEIU; Jackie McGrath, California Council of the Alzheimer's Association/Chronic Care Coalition; Cheryl Phillips, On Lok/PACE; Brenda Premo, Harris Family Center for Disability and Health Policy; Kevin Prindiville, National Senior Citizens Law Center; Dawn Myers Purkey, Woodland Healthcare/Yolo Adult Day Health Center; Timothy Schwab, SCAN Health Plan; Linda Shugarman, SCAN Health Foundation; Jennifer Spalding, AltaMed Health Services; Patricia Sussman, Contra Costa Health Plan; Suzanne Tavano, California Mental Health Directors Association; Ed Walsh, Area Agencies on Aging; Mary E. Whitehead, Scripps Health (by phone); Casey Young, AARP.

Others attending: David Maxwell-Jolly, Director, DHCS; Gregory Franklin, Director of Medi-Cal Operations; Melanie Bella, CHCS; Alice Lind, CHCS; Margaret Tatar, CalOptima; Paul Miller, DHCS; Brian Hansen, DHCS; Eileen Carroll, DSS; Lora Connolly, CA Department of Aging; Giang Nguyen, CDMH; Carol Risley, CA Department of Developmental Services;

Public in Attendance: 8 individuals attended in person, and 23 people called in on the listen-only telephone line.

Welcome and Introductions

Bobbie Wunsch, PHCG, welcomed the group and members of the public participating in person and by phone, and reviewed the agenda.

Group Discussion

Bobbie Wunsch, PHCG, asked Workgroup members and members of the public to answer the following questions and post their comments on the wall:

- What is the biggest advantage of integration for dual eligibles?
- What one question is still unanswered about how integration for dual eligibles would work effectively?

Tim Schwab, SCAN Health Plan, asked for a definition of integration. *Paul Miller, DHCS,* said that integration in this context means enrolling Medicare and Medi-Cal dual eligibles into a system of care that provides the full range of health services. *Lisa Shugarman, SCAN Foundation,* clarified that the questions refer to the concept of integration, not to any specific model in which integration will happen. *Pat Sussman, Contra Costa Health Plan,* added that integration refers not only to health services but also to home- and community-based services (HCBS).

Giang Nguyen, CDMH, cited a definition of integration in the behavioral health context, from the Hogg Foundation, and suggested it could be useful:

> *"…integrated healthcare is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served…"* (Cited in DHCS Medicaid Waiver Behavioral Health Pilot Project Proposal, available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/BHTWG_pilot_approaches.pdf)

What is the biggest advantage of integration for dual eligibles?

Workgroup members posted the following responses:

- Ability to leverage all services and levels of care, including inpatient, behavioral health (BH), outpatient, preventive services, HCBS, long-term care (LTC) etc. to deliver services to individuals that keep them at optimal health and in best setting.
- Access to services
- Access
- People have access to the full range of social and health services they need and want.
- Will the provider have full access to all Medicare and Medicaid dollars and will the provider and person have the freedom to use those dollars for the most appropriate care in the most appropriate settings?
- Provides beneficiary with a single coordination model for all Medicare and Medi-Cal benefits and connected providers
- Better coordination of services and cost savings
- Help with navigating a *very* complicated system and lining up the right services in a timely manner
- Better consumer understanding of health plan
- Increased likelihood people remain at home longer
- Potential for alignment of full spectrum of services (medical, social support, HCBS) with financial incentives
- Seamless provision of services
- Hopefully LTC services for all Medi-Medi's
- Development of a single system of provision of access services
- More likely to be offered HCBS that will enable persons to live at home rather than in an institution
- Coordination of benefits to maximize access and range of services

- Coordinated care allows for comprehensive approach: increase better outcomes, more effective use of funds, savings potential
- Wrapping HCBS around medical/behavioral services and keeping patient and family at the center: resulting communication at all levels contributes to quality outcomes for patient and family
- Utilizing HCBS (such as IHSS and ADHC) will ensure reduced costs to Medi-Cal while increasing access to needed services that prevent expensive medical incidents
- Through integration we achieve combination of benefits/services while reducing cost, eliminating redundancies while improving access to comprehensive care
- Integration is efficient and preferred by consumers as long as integration is not synonymous with rationing
- Better support for family care services
- More efficient delivery of services to this population to achieve better value (quality and price) health care
- Person-centered care for the individual, i.e., a person can easily access whatever s/he needs to stay as health and as independent as possible
- Blending of funding with the hope that benefit will be greater than the sum of the funds and programs separately
- Limits or minimizes cost shifting from Medicare/Medi-Cal
- Better health outcomes and more effective maintenance of health
- Increased care coordination
- Care coordination leading to cost savings
- Potential for more care management, designed to provide preventive, HCBS services
- Having an improved opportunity for coordinated care, a better likelihood of that with a single provider who manages care across settings and providers

Comment from member of the public:

- It creates the imperative for a patient- (client-) centered system

Bobbie Wunsch, PHCG, summarized the comments on the <u>biggest advantage of integration</u>:

1) Access to the full continuum of services
2) Better consumer understanding of health plans and more assistance to consumers in navigating the system
3) Increased care coordination
4) Blended funding
5) Alignment of services -- medical, mental health, substance use, HCBS, LTC: Bringing them together to make a full and better system with better supports for the consumer
6) HCBS generally
7) Better support for family caregivers

Workgroup members participating by phone added the following comments:

Mary Whitehead, Scripps Health, added that in addition to blended funding, there is the potential for cost savings for the state. *Richard Chambers, CalOptima,* said that integration

promotes person-centered care. *Cynthia Jackson Kelartinian, Heritage Clinic,* said that one advantage is multiple providers and the service recipient him or herself having a shared clear understanding of the whole person and his or her needs at multiple levels, including but not limited to behavioral, physical, and social needs with an ability to meet those needs without duplication or service.

What one question is still unanswered about how integration for dual eligibles would work effectively?

Workgroup members posted the following questions:

- Can we really access appropriate savings from inpatient, LTC, etc. so that we can *enhance* HCBS, prevention, primary care, etc. to improve care and care settings
- How people can maintain choice of providers and long-term relationships with existing providers
- Application of social integration approach as opposed to medical model
- Integration with HCBS at the county level is undergoing major cost reductions, leading to layoffs. How would they manage/afford new coordination workload and costs?
- Given the lack of empirical evidence regarding the cost savings created by HCBS, how will consumers be ensured access to these services?
- What is the plan to understand and respond to consumer preference (given cost savings is already assumed)?
- Who will be in charge?
    - When Medicare and Medicaid are integrated, how do we set standards for coverage of benefits?
    - Who will handle oversight? Compliance?
- What is the state role?
    - Oversight? Extent of financial responsibility? Consumer protection? What is the "value added" from the state?
- How to integrate the inconsistencies between the two systems, i.e., Knox-Keene Act independent second opinion and fair hearing system generally, DME, home health, behavioral health, medical necessity standard for things only covered by Medi-Cal, Medicaid and Medicare approaches to investigational services and DME …
- How will state and federal governments create a single program with no confusion for beneficiaries, blended funding, and efficient and effective oversight
- Process for dual certification of programs and integration of documentation standards
- IHSS has many statutory requirements above and beyond SPA requirements: how to resolve conflicts?
- Balancing consumers' interests with adequate incentives for providers to participate
- How do we incent primary/acute care providers to consider and incorporate HCBS into an individual's care plan?
- How are providers reimbursed for Medicare services: hospital rates? NF rates? Physician rates?
- Will personal care services/HCBS be capitated?

- Financing mechanism?
- Integrated funding: so that the most appropriate service can be provided and in the right setting. Allows for service delivery in the least restrictive setting. Can redirect acute care savings to HCBS.
- How precisely will financial arrangements work to ensure access, create incentives to provide care in the right setting, right time, by the right provider, and minimize gaming of the system?
- How Medicare savings will be captured and used
- If payment is combined between state and CMS, how would it work? CMS risk adjustment and Medi-Cal risk adjustments are different.
- How will the money work? Will *all* of the money in the LTC continuum (HCBS to SNF) be available to support the full range of services?
- The funding and structure of HCBS, including IHSS, are very different. How would these systems work with managed care or even medical models?
- This will require multiple models: how?
- Will state require a similar selection of HCBS for all plans?
- How will current programs or options fit in a mandatory enrollment world?
- Given that we can anticipate diversity in systems of integration throughout the state, how will care equity (rural v. urban, for example) be assured?

Members of the public posted the following questions:

- Will networks provide optimal and adequate access to both inpatient and outpatient transitional and rehabilitative services (e.g., therapies, home health) to enable patients to return home?
- If the state continues to scale back Medi-Cal benefits and reduce or eliminate HCBS, how will the population access these essential services?
- In measuring success of the pilots, how do we deal with the gross underfunding of FFS provides? Should we have a pilot that allows Medicare rates for FFS providers in a county?
- How do we identify a useful standard against which we measure success, other than FFS (given how underfunded FFS providers have been)?
- How can we put significant federal (Medicare) resources behind HCBS?

Melanie Bella, CHCS, summarized responses regarding <u>unanswered questions</u>, grouping them by topic in order of frequency in five primary categories:

1) Financing: rates, combining programs, redirection of savings to HCBS
2) Incentives: how to get providers to participate and how to balance medical and non-medical services
3) Access/choice/consumer preference
4) Logistics: Who is the integrator? Whose rules prevail? (Melanie noted that this category and the access/choice/consumer preference category speak to the need for clear consumer protections.)
5) How multiple models will work, equity in services, how the options fit into mandatory environment, equity across the state

Workgroup members on the phone had the following comments and questions:

Cynthia Jackson Kelartinian, Heritage Clinic, asked who will manage care for people with progressive dementia, and how mental/behavioral health can be part of a solution leading to increased quality of life and reduced long term care costs. *Mary Whitehead, Scripps Health*, asked how the state will ensure access to primary and specialty care and a strong provider network, given that we already see fragmentation and the lack of available services in the present managed Medi-Cal network, and that Medi-Medi patients will infuse an increased volume of patients into the already weak network. *Richard Chambers, CalOptima,* asked what successful integration would look like.

Bobbie Wunsch, PHCG, asked participants to continue to add comments and questions, and said that the unanswered questions are particularly important in that they remind the group what remains to be discussed and decided.

<u>The Beneficiary Experience: What would an integrated system look like from the beneficiary perspective?</u>

Kevin Prindiville, NSCLC, and *Casey Young, AARP,* led a discussion of the beneficiary perspective on integration. Materials prepared for the SPD Workgroup by WCLP and Health Access were circulated to the Workgroup (and are available on both Workgroups' web page); they were not discussed in detail but were assumed as a starting point for the discussion, as were previous discussion in the dual-eligibles Workgroup.

Kevin Prindiville, NSCLC, said that, from the perspective of a beneficiary who goes to access services, important elements for the integration pilots include:

Consumer protections:

- The SPD group did a lot of work on consumer protections, and many of the same issues arise for the dual eligibles: enrollment, network adequacy, grievances, etc.
- Integration adds a layer of complexity: when there are two sets of rules for consumer protections, which set applies? The basic principle should be no loss or reduction of services: anything that was available from either Medicare or Medi-Cal should be available from the integrated system, with the beneficiary receiving the benefit of the better/more protective system.
- While this principle sounds simple, it is extremely difficult to implement. How can California build an integrated system that contains all the relevant information? Protections should exist not only in contract but also in statute or regulation, so that they are enforceable.

Programmatic elements:

- Care management and assessment require careful definition. From a beneficiary perspective, integration provides an opportunity to define real care management, with standards. California has health care plans that do creative and good things that can serve as models, and models also exist in other states.
- Flexibility is important, so that plans can try new things, but so are clear guidance and standards.

- Currently, there is wide variation in what Advantage plans and SNPs provide – originally, there were no standards, now there are some but it is difficult to figure out what plans are really doing.

Accountability/Oversight:

- Who is in charge of the integrated program? The State would have that responsibility as an integrated entity, but what does the State need in terms of knowledge and expertise, resources for oversight, etc. in order to fulfill that role?
- Where should enforcement live?

Duals in FFS:

- In the effort to improve care for people in organized systems, it's important not to forget about people who remain outside these systems. What lessons can be used in places where people aren't in organized care and where the infrastructure may not allow for the development of these systems?

Beneficiary Experience:

- How does the beneficiary see an improved system? Will they notice? What has to be in place to improve their experience?

Brad Gilbert, IEHP, commented that he liked the highest common denominator approach to consumer protections. He said that it is daily struggle to figure out which system to use for dual eligibles, and having a single standard would be very helpful. On the topic of care management, Brad commented that while there were no standards in the early days of the SNPs, Model of Care standards are now well defined, and incorporate almost everything discussed in the Workgroup. NCQA is driving monitoring of those standards. It's true that plans may be applying the standards inconsistently, but the standards themselves are strong: they are a reach for many plans, which is a good thing.

Jackie McGrath, Alzheimer's Association, said that she appreciated the emphasis on care coordination and improvement in care delivery. She said she hoped that the dual eligibles pilots would mark a return to real *pilots,* with testing, tweaking, evaluation, and replication of models that work. It is important to define some data points that will come out of this project, and to collect the data from the beginning, so as to measure the things of real interest.

Tim Schwab, SCAN Health Plan, echoed the previous comments, and cautioned that no matter how carefully standards are defined, they may not always fit the beneficiaries' expectations or experience. If the state adheres to strict Model of Care standards and rolls people into the system, they may still be unhappy, even though these high standards are met. Many people are happy with their current system of care, even though it's objectively far from ideal and meets few quality standards. Beneficiaries

Kevin Prindiville, NSCLC, agreed in part, saying that not everyone needs highly managed care, and that plans will likely need to stratify their services according to beneficiary need.

Carol Risley, CA DDS, agreed with Tim Schwab, saying that among the population of people with developmental disabilities, many of those with established providers are happy with their care and fear losing established relationships with providers. Conversely, many

other people can't get the services they want in the FFS system. She said it was difficult to envision how HCBS would be integrated into a medical model. Many beneficiaries like the current social model, and would not like having everything become part of health care.

Suzanne Tavano, CMHDA, asked whether consumer stakeholder groups have been part of the dual eligibles process. Greg Franklin, DHCS, said that in 2009 there were discussions with stakeholders, including consumers, prior to the development of the original concept paper. There has also been some consumer participation on the Technical Workgroups.

Brenda Premo, CDHP, mentioned the need to recognize how many individuals with disabilities and activity limitations become dual eligibles at some point in their lives. Typically, these are not people with sensory disabilities, but those with chronic physical and psychiatric conditions. They are often much younger than other dual eligibles, and have very different needs from older individuals. There is not as much research on Medi-Medi's as on Medi-Cal beneficiaries, but in general, medical needs don't change, only who is going to pay and when.

Cheryl Phillips, PACE, said that dually eligible beneficiaries should be directly involved in the design and evaluation of the pilots – having institutional stakeholders and providers is not enough.

Maya Altman, HPSM, addressed the issue of beneficiaries' perceptions. In the HPSM SNP, one big difference is in access to basic Medicaid and Medicare coverage. Some people constantly lose their Medicaid, but HPSM is able to discover eligibility changes immediately and works closely with the local legal aid program make sure that individuals (especially those with Medi-Cal share of cost) retain their Medi-Cal eligibility. She said that the closer that accountability can be to the place of service the better. The issue of translating state-level consumer protections into local accountability to beneficiaries requires a lot of work.

Kevin Prindiville, NSCLC, pointed to HPSM's collaboration with legal aid as a good example of what an integrated plan can do. A structure that is locally-based and more responsive can be a real benefit.

Marilyn Holle, DRC, said that she hopes that integration will mean getting the best from both programs. She said she is dismayed that California has been so passive regarding Medicare, even though Medicare inappropriately shifts costs to the state. For example, a client needs an oximeter: Medicare says that it is inappropriate for home use, so Medi-Cal ends up paying. The state doesn't seem to understand that it has a financial stake in what Medicare covers, and that it doesn't need to be as restrictive as it is. California should be more aggressive in asserting its rights to have services paid by Medicare. Other states (CT in particular, NY a little) are more engaged in challenging Medicare's rules, but California could really benefit. Medicare, unlike Medicaid, also does not recognize the behavioral health needs of mentally retarded people.

Casey Young, AARP, asked the group to think about what information they would want to have from the pilots. Depending on how the "up to four" pilot projects are shaped and evaluated, we will know different things. What should we make sure we know at the end of four years, when it is time to seek another waiver?

Kevin Prindiville, NSCLC, said he would want to know that changes occurred on the ground, not only in systems. Beneficiary-level changes -- assessment tools, new systems set up to assure access to appropriate benefits, etc. – should be evaluated.

Bonnie Darwin, CCCC, said that a pilot may work because the particular organization that is selected has already done a lot of groundwork and has experience with the model – but then replications don't go as well. She said she would want to figure out what it takes to transition a population into organized care.

Tim Schwab, SCAN Health Plan, said that he hopes that California can look back and see that the pilots did not reinvent the wheel. While every place is unique, there has already been a lot of work on this in other states and other countries. A study several years ago concluded that full integration is difficult to accomplish, and that in some cases they best case may be seamless coordination.

Ed Walsh, AAA, said that the state should learn from others' experiences. What was the transition like for PACE models? What did consumers in other states like and dislike?

Brenda Premo, CDHP, said evaluation should focus on HCBS and whether integration/coordination means that from pre-hospital to hospital to post-hospital care there are choices of placement for people. The measure of success should be how far the state has come in allowing people to stay in the most appropriate environment for them, based on their health conditions and preferences. If California is still sending everyone in to nursing homes, then integration will be a failure. In addition, services like interpretation should be available across the system, regardless of who is paying.

David Kieffer, SEIU, suggested that the appropriate comparison is to measure the pilots against the current FFS system. Data collection must be built in from the beginning: the state can't decide in four years to measure something for which no data has been collected. He said he would also want to compare California's experience to that of other states, particularly the mature models in MN, WI, and MA.

Marilyn Holle, DRC, said she hoped that services would be standardized, so there would not be calls coming in from people complaining that they're in the wrong zip code for MSSP, for example.

Brad Gilbert, IEHP, said that the research abstracts circulated in advance of the meeting were not very impressive, unfortunately, and that he hopes California's pilots show better results. He suggested objective, quantitative evaluation of the following (among other issues):

- whether or not LTC has been shifted into the community (via an increase in HCBS)
- whether people are getting more preventive services
- where people with significant BH needs are getting primary care
- whether people with diabetes and other chronic illnesses are getting what they need

Carol Risley, CA DDS, said that the pilots should be evaluated based on their success in deflecting people from inpatient and institutionalized care to HCBS. She also commented on the need for clear and accurate beneficiary information. With the Part D transition, DDS did

not publish enough information that really responded to what people really wanted to know. Written materials require more graphics and plainer language, and AV tools are also important: this is a large diverse population, and culture and language needs are critical.

Cheryl Phillips, PACE, said that the pilots offer the opportunity to look at new payor-provider relationships. Federal HCR and the 1115 waiver offer a chance to look at tiers of risk and gain-sharing tied to quality measures. California can be a national leader in models of integrated service delivery.

Jackie McGrath, Alzheimer's Association, said that she hopes the pilots will provide a new appreciation of the role and value of the family caregiver, and at the same time that family care giving comes to be seen as a risk factor, for dual eligibles and for SPD populations. Without a better sense of the risk factors for dementia, it is difficult to do a good job managing people's chronic conditions. She said she is concerned about the difference in scope and detail between this proposal and that for mandatory enrollment of SPDs, and that given the aggressive timetable for SPD transition, she expects that California will learn painful lessons early on that may at least be useful in designing the dual eligibles pilots.

Lisa Shugarman, SCAN Foundation, suggested the following evaluation item:

- Consumer and caregiver satisfaction
- Quality of Life

Cost savings should not be the only or the primary outcome under consideration. Even if politicians still tout the cost savings benefits of increasing HCBS, for the consumer this translates to improved experience of care, which is what we should be valuing.

Casey Young, AARP, suggested that since enrollment in the Medicare piece of the integration is envisioned as voluntary, evaluation should explore why some people join and some do not. He said he also wants to understand how the evaluation of people's social as well as medical needs was done, and how services were or were not provided and funded. He said that the cost implications of the pilots *are* important, as are others, and, echoing Jackie McGrath, said that he is concerned about the waiver proposal for SPDs but hopes for changes that will improve that process.

Kevin Prindiville, NSCLC, thanked Workgroup members for their input and summarized the discussion. He suggested looking at how the pilots could be used to improve care for areas that don't have organized systems; *Casey Young, AARP,* noted that some counties will not have pilots and could be used for comparison.

<u>Review of Dual Eligibles Trailer Bill Language</u>

Paul Miller, DHCS, and *Brian Hansen, DHCS,* reviewed the budget trailer bill containing the dual eligibles pilots proposal. Paul Miller explained that budget trailer bills are so named because they trail the enactment of the state budget. The Governor's budget as proposed has multiple implications for the law, and the trailer bill is drafted to implement certain of the budget provisions. The bill tracks the budget proposals through the spring to the final budget. This year, the 1115 waiver proposals debuted in the May Revise. The legislature

referred the language to policy committee, and the Administration was directed to prepare a policy bill.

Brian Hansen, DHCS, reviewed the trailer bill language related to dual eligibles, available at http://www.dhcs.ca.gov/provgovpart/Documents/DRAFT%201115%20Waiver%20Dual%20Eligible%20Integration%20Projects%20Trailer%20Bill.pdf.

David Maxwell-Jolly, DHCS, said that the Department is interested in any potential improvements or changes to the language. Procedurally, the Legislature will be establishing discussions around the dual eligibles proposal as well as other elements of the waiver.

David Kieffer, SEIU, asked what it would mean to build a geographic model around PACE, SCAN, or another plan that is not county-based. David Maxwell-Jolly said that the Department has thought of the pilots in terms of existing Medi-Cal managed care plans, particularly those that have taken the initiative to establish a Medicare plan as a product. They have not thought so much about the PACE/SCAN contexts, but this is a good question.

Brian Hansen, DHCS, noted that the language in the trailer bill is purposely broad, with many of the "may's" intended to be flexible and not restrictive.

Carol Risley, CA DDS, asked about the trailer bill statement regarding the option to forgo receiving Medicare benefits via the pilot project. Brian Hansen, DHCS, replied that the gist of the language is that there is an opt-out for individuals, who could then revert to FFS Medicare. Carol Risley said that the wording makes it sound as though some benefit is being lost. She also asked what happens to institutionalized beneficiaries. David Maxwell-Jolly said that the Department does not anticipate enrolling them on either side.

Casey Young, AARP, asked why language regarding exemption from the Administrative Procedures Act (APA) is necessary. David Maxwell-Jolly, DHCS, said that the intent is that the Department be exempt from promulgating regulations in the context of pilot projects, which have limited application. Casey Young, AARP, noted that the SPD trailer bill includes the same language, despite more general application, and said that it is a concern to his organization. David Maxwell-Jolly said that the exemption is consistent with the implementation authority under AB 4x6.

Maya Altman, HPSM, noted that the Legislature had referred the waiver trailer bill language to policy committee, and asked what the impact would be on timing and what concerns had prompted this step. David Maxwell-Jolly said he could not answer for the Legislature, but that since the waiver proposals have important policy content, the Legislature may want more time to consider them than is available through the budget process alone.

Suzanne Tavano, CMHDA, asked who would manage the Medicare benefit for consumers who opt out of an integrated pilot. David Maxwell-Jolly said that the federal government would continue to administer the FFS Medicare benefit for those individuals, as in the current system, although they would be enrolled in a Medi-Cal managed care plan for their Medi-Cal benefit.

Expanding Integration of Dual Eligibles: Potential Models

Representatives of health care plans that currently enroll dual eligibles discussed their experiences and what they have learned to date.

Margaret Tatar and Richard Chambers (by phone), CalOptima:

Over the past five years, CalOptima (a COHS), has:

- Developed a Medicare SNP, which offers the opportunity to integrate acute care for duals. CalOptima has 400,000 enrollees overall, with 100,000 in the SNP. Dual-eligibles account for 65,000 enrollees, and 10,000 in the SNP.
- Expanded its MSSP footprint, adding a second site to one that has been in operation for 10 years.
- Working with the County, has become the county's ADRC.

Going forward, CalOptima plans to:

- Apply to become a PACE site for Orange County
- Be a pilot site under the waiver proposal, building on what's already in the SNP.
- Completely integrate HCBS into the SNP and/or pilot in order to build on the processes and care planning currently ongoing in the SNP
- Develop a team-based approach to care management, to include family and caregivers. CalOptima proposes to get there by working with local stakeholders in an existing coalition as well as with the advisory committee for the ADRC.
- Evaluate the extent to which CalOptima has succeeded in making it easier to navigate the system: can members access services better/more easily? Are HCBS/social model services stronger?
- Manage Medicaid LTC services. In combination with the integration pilot or PACE, management of HCBS on the Medicaid side would be an interesting menu to provide in a county-based system. Ideally, it would maximize opportunities for members and playing into the strengths of community partners.

Marilyn Holle, DRC, asked which services would be part of a Medi-Cal HCBS integration. Margaret Tatar replied that personal care, ADHC, and MSSP are the services not currently included in CalOptima's contract. Although the plan is already an MSSP provider, they hope to provide the services in a more flexible manner. Marilyn Holle asked whether such an integration would retain the current MSSP age limitations. Margaret Tatar said that CalOptima would like to go to 55 (from the current 65 in MSSP).

Nancy Hayward, CAHF, asked what would change with respect to nursing home clients and providers. Margaret Tatar said that CalOptima currently has responsibility for nursing home and room and board services within their Medi-Cal contract, but does not have HCBS. They do not expect that many clients currently in nursing facilities would be diverted, but rather that people who are aging in place would have a full spectrum of options and choices, up to and including nursing home care. Nancy Hayward asked whether there were opportunities to prevent rehospitalization for Medicare beneficiaries. Margaret Tatar said that CalOptima

and the state would want to look at quality indicators on the health side, including rehospitalization, institutionalization, and consumer satisfaction. Orange County's population is aging very quickly, with the biggest bubble yet to come and with significant housing challenges. The pilot program offers a good opportunity to explore responses to this situation.

Richard Chambers, CalOptima, said that the plan has to distinguish their Medi-Cal-only and dually-eligible populations. CalOptima has approximately 4500 members monthly in nursing homes, of whom approximately 4200 are dual eligibles. Of those, all but 50 are in FFS Medicare – very few are enrolled in the SNP, so CalOptima has no ability to coordinate and manage acute services for the large majority of nursing home residents. Through an integration pilot, CalOptima could potentially set up something that would allow the plan to better manage acute care.

Tim Schwab, SCAN Health Plan, asked whether there was anything in current law that prevents CalOptima, as a COHS, from expanding MSSP –type services and IHSS to the entire enrolled population. Does such a change have to be through a pilot? Margaret Tatar said she deferred to DHCS on a complete answer, but said that some things, such as integration of Medi-Cal LTC services, could probably be done through a Medicaid 1915 (b) or (c) waiver. That would not allow for integration of the Medicare piece, however.

Maya Altman, HPSM, noted that it is difficult to address housing options under a 1915 (b) or (c) waiver.

Brad Gilbert, Inland Empire Health Plan:

[Returning to an earlier discussion of beneficiary perceptions, and possible preferences for a FFS system, Brad Gilbert noted that the counterargument is that, if an organized care system can ensure that someone gets a mammogram, they might be diagnosed with breast cancer that's amenable to treatment. The member herself might not be able to recognize the counterfactual, however, and might not "prefer" the organized care.]

Inland Empire Health Plan would look at an integration pilot as an opportunity to take two sets of regulations and processes, and move to the highest common denominator of those two processes, working then under one set of rules.

Under the pilot, IEHP hopes to:

1) Streamline some of those processes in order to make decisions in the best interest of patients and the provider network.
2) Have the ability to shift dollars around in order to provide care rationally, shifting care from inpatient and LTC sites into the community.

For example, Medicare doesn't pay for marriage and family therapists (MFTs). IEHP has brought behavioral health (BH) in house for some populations, and employs a large number of MFTs. Although they may be the most logical providers, and IEHP uses them for its Medicare beneficiaries, the plan can't bill for those visits.

Referring to the list of core elements to be included in an integrated system (distributed at the meeting and based on the Center for Health Care Strategies document *Options for Integrated Care for Duals in Medi-Cal: Themes from Interviews with Key Informants and Community Dialogues* (April 2010), available at http://www.dhcs.ca.gov/Documents/CA%20Dual%20Options%20Interviews.042110.pdf, Brad Gilbert described IEHP's status in the following areas:

- Assessment – IEHP asks about a person's caregivers and their competency, but not about the client as a caregiver him or herself. The pilot would allow IEHP to test an intake assessment, in an effort to target care management to those that need it.
- Person-centered care plan – IEHP's SNP provides supplemental benefits, including dental and vision services
- Multidisciplinary care team – IEHP wants to measure progress we make through that.
- HCBS – IEHP needs stronger relationships with HCBS providers. The plan has strong disability connections and processes, but needs to better understand the needs of seniors, and this would be among the goals for the pilot.
- Data – A requirement as well as a goal of the pilot would be to have claims and other individual data before enrollment in order to respond to individuals who need transition or network help.
- Financial incentives – Integration of financing is necessary. Returning to the MFT example, if IEHP took the Medicare requirements literally, the plan would not have MFTs in its network – and thus would not have Spanish or Vietnamese-speaking BH providers.

Brad Gilbert closed by saying that IEHP's first priority assuming that mandatory enrollment of SPD aid groups happens is to care for those members, and as a result IEHP might or might not participate in a dual-eligibles pilot.

Marilyn Holle, DRC, asked whether IEHP gets Medicaid administrative funds for transportation. Some counties are technically responsible for it and get administrative money to pay for it. Brad Gilbert replied that transportation is included in the medical portion of the plan's bid.

Ed Walsh, AAA, noted that Riverside County AAA is an ADRC, and works closely with IEHP.

Dawn Myers Purkey, Woodland ADHC, said that the core elements document is helpful, but that the HCBS discussion should refer to required components, not only options. Bobbie Wunsch clarified that the core elements are from the CHCS Options document, enhanced by interviews, and that the HCBS language is not intended to suggest that these services are optional.

Cheryl Phillips, On Lok/PACE:

PACE is for people 55 or older who meet the state determination for nursing home eligibility. PACE integrates Medicare and Medi-Cal with expanded benefits. It integrates payors, providers, and family caregivers in a unique way, and integrates mental health, medical,

social, and HCBS services, with no carve-outs. Client satisfaction is high: 95% stay in the program until their "celestial discharge."

Every one of the existing PACE sites, with the exception of Sacramento, is looking to expand, and has capacity to expand. Several new PACE sites, including CalOptima, the LA Jewish Home, and three rural entities, are in the works.

Barriers to further PACE expansion include the capital outlay ($2 – 3 million), the slow application process, and the process for determining level of care, which creates major confusion for referring agencies and clients. DHCS is working to deal with both the interpretation of Title 22 and staffing challenges, both of which affect the determination process, but potential PACE sites are loathe to spend millions to develop a program when they may not be able to enroll people quickly.

COHS are inadvertently barred from PACE participation, a problem that the state could potentially address in the waiver. Another barrier is the public's lack of awareness of PACE. California should include including PACE messaging in its waiver work

It is possible to expand the PACE concept outside PACE programs *per se*, for instance, departing from the center-based model in rural areas. Cheryl said she is also intrigued by opportunities to apply the team-based, integrated care model to targeted populations, including veterans and some chronically ill children (vent-dependent children at home).

Marilyn Holle, DRC, asked whether level of care regulations are harder to meet for PACE than for nursing homes. Cheryl Phillips said that on paper they should not be, but in reality it is possible to admit people to nursing homes who cannot be admitted to PACE. Over the last few weeks, DHCS has been working closely with PACE programs, but the fact that Title 22 is written with institutions in mind still creates a barrier, and it is harder to get into PACE and other waivered programs than into some nursing homes.

Giang Nguyen, CDMH, asked the respondents how they proposed to integrate with county mental health programs under the pilots. Cheryl Phillips, PACE, said that in that model everything is wrapped together, and PACE takes financial risk for mental health. PACE enrollees have to be safe to live in the community, so some people with SMI would be excluded, but at least 2/3 of PACE participants have cognitive and behavioral issues, and the programs are working more on substance abuse integration. Margaret Tatar said that CalOptima is working with Orange County to integrate BH services into the plan, so that CalOptima will be the ASO for the county and then integrate BH into acute care side. By the time a pilot comes up, CalOptima expects to have a more integrated BH response.

Jennifer Spalding, AltaMed:

Jennifer Spalding provided an overview of FQHC funding, organization, and function, and discussed how FQHCs might work with an integrated pilot for dual eligibles.

- Many FQHCs work closely with ADHCs, and provide social services as part of a team. Because they can manage that care they see less ED use and hospitalization.

- Requiring dual eligibles to have a medical home will be problematic in some cases. People will opt out on the Medicare side in an effort to retain provider relationships, despite the fact that FQHCs rank high in consumer satisfaction. A complicating issue is that many providers will want to retain the option to bill Medicare and Medi-Cal directly. Education will be essential.

Tim Schwab, SCAN Health Plan, asked whether Workgroup members were concerned about Medicare and Medi-Cal funding in an integrated model (either FQHC or PACE).

Brenda Premo, CDHP, asked whether community clinics were ready to meet the standards for SPDs that were identified in the CHCF report. Do clinics have TTYs, qualified sign language interpreters, accessible sites, etc.? Jennifer Spalding replied that not all clinics are ready, but some are. AltaMed is further along than many, but still needs training and preparation.

Small Group Discussions

Workgroup members met in three smaller groups to discuss the following questions:

- What questions should DHCS ask of plans who want to be dual eligible pilots in the 1115 waiver to determine specifically how they would integrate the core elements into their work?
- What do we want to learn from the experience of the Dual Eligibles Pilot Projects?

Group 1

What questions should DHCS ask of plans?

- Provider network.
    - What is the existing relationship with community providers (e.g., ILC, PACE, HHAs)?
    - Do you have letters of support from these organizations?
        - Minimally, an MOU is needed
        - Will need a business associate agreement if sharing personal health data
    - What is the definition of a comprehensive provider network?
        - State needs to establish standards for a network.
        - SNP standards may be a good model for the medical provider network.
        - Need a blend of social/medical – a model that provides both.
    - Need to know how they will refer to providers that are not paid for through contract, e.g.:
        - Home delivered meals (e.g. meals on wheels)
        - How they will access transportation
        - Links to housing authorities – need certificates for affordable housing.
    - Relationship with county and its programs:
        - Similar to IEHP, need a relationship with regional center
        - Different dynamic between counties and nonprofits

    - How do the contractors work with county mental health system?

- Integrated model?
    - Discussion in group that advocates would “fight tooth and nail” against integrating IHSS into managed care because it is considered “medicalizing” a social program. Coordination more acceptable than integration.
    - Other opinion expressed that ideally, all providers would be under a single integrated entity.
    - PACE cited as an example – organization hires home care workers but not IHSS. Some felt that it would not be good to have IHSS compete with other paid home care workers, but others thought the contractor could hire IHSS workers to provide personal care (outside of IHSS).

- Comprehensive assessment (questions to be asked in RFP):
    - How is it administered?
    - Is it done in person (preferred)?
    - How soon is the initial assessment done and how soon afterwards is the periodic reassessment done?
    - What triggers a non-routine reassessment?
    - What procedures do you follow now, and what would you change to serve duals?
    - The state needs to set standards, with support of stakeholders.
    - Ideally should look for an integrated information system.
    - Would be best to have “portable” assessment results, which would be supported by some state-mandated minimum data collection standards.
    - There could be flexibility around the assessment, but the core data elements should be in common across the pilots.
    - Consider including memory loss assessment.
    - Duals demos and PACE may have good models to use. San Mateo may have something close to final.
    - In creating the standard assessment, need to think about what you are assessing – the need for services, qualification for a program? The structure of the tool will be different depending on the answer. Do you want the tool to predict a need or identify a need? A needs-based assessment answers the question, what services do you need to help maintain independence?
    - Who performs the assessment? Discussion that it should be (only) the physician, but performed by non-physician and then integrated with clinical data.
    - In creating the standard assessment tool, the state needs to establish a timeline and stick to it.

- Range of benefits
    - The state and Medicare will set the minimum set of benefits.
    - The contractor should be allowed to go above that minimum (e.g. in DME, frequently a health plan will provide equipment that is more expensive than what Medicare would cover). Other examples are, e.g., paying to flea dip pets so the patient does not keep showing up in the ER with cellulitis.

    - Criteria need to be fairly applied so that everyone at same level of need gets the same benefits.
    - Question for contractor: What "creative care solutions" would they offer beyond Medicare and Medicaid (including HCBS)?
    - May also require contractors coordinate benefits that they are not providing.
    - How do you do the referral, and then follow up to make sure the referral happened?

- Multidisciplinary Care Team
    - Consider changing this term to "interdisciplinary care team" to emphasize that the team works together, not just side-by-side.
    - Questions for contractor: Who is on the team for a given individual, and how do you decide? How do you structure the team based on individual's needs? (Some healthy duals may not need much.)
    - Mental health should include marriage and family therapists (MFTs).
    - Memory loss specialist should be part of team.
    - Support for family member needs to be considered.
    - Care coordination should be built in for those who need it (and with separate funding).
    - Discussion about whether some members of the team would need funding to participate in case conference meetings. Need to have all views represented and may need to pay for participation.
    - Separate discussion about whether the IHSS model works for people with dementia, since it is based on individual's ability to make decisions and be empowered.

- Care plan
    - True test of the care plan is whether the person would recognize themselves in it if they read it.

<u>What do we want to learn from the pilots?</u>

- How do we expand this model (or these models) statewide?
- Will we learn enough that the pilots will be replicable in counties where there is not much infrastructure to build on, or are we picking the places that are already the best?
- What capacity is needed to be successful?
- What does a dual model look like in different systems?
- Need some pilots that are very different from COHS counties.
- Can state replicate PACE and make it available to more people?
- How do different models work together as options within the same county?

Group 2

What questions should DHCS ask of plans?

- If we are building on the SNP, then most of the core elements are already required in a SNP. Biggest difference is how well it is done. Also H&CBS is not covered. Would want the state to thoroughly evaluate these services.
- Mental health: How do you handle care coordination inside pilot? What about emergency access for mental health?
- How do you handle anyone who opts out of the pilot? This is even more complex.
- What is the level of partnership – current relationship between plan and other big entities that will now be coordinated thru pilot? E.g. IHSS, Regional Centers
- How are you dealing with the incompatibility between the systems of Medicare and Medicaid? We need a Medicare waiver to create more flexibility. SNP is the current way around this but Medicare waiver would be better. Medicare waivers are rigid and not likely. Go for Medicare savings agreement rather than a full Medicare waiver.
- Many concerns about both payment and care coordination for mental health services. These may be better with the pilot. Care manager is critical to better quality of care – need to assess the plan's depth of care management process. How does the plan assure care coordination across all the providers?

- IHSS
    - Need lots of information about the care coordination relationships, for mental health and IHSS especially. Heavy on information without being too prescriptive, because it is a pilot.
    - What is the structured process to gain information from the home-based staff? How do we make this part of the process?
    - It may be that many of the IHSS recipients receiving personal care are not the clients that require lots of assessment, care coordination. For the 10% receiving multiple services, then they need to be fully integrated.
    - Important to include the moderate level as well because we can prevent secondary disability in this group. Need to assess the plan proposal for each level of consumer need – not just the high risk.
    - Contract with public authority that is different (another layer) from the individual care givers.
    - Need to add more payment for IHSS to be a full team member: attend medical appointments, receive training on the medical conditions, etc.
    - Does the health plan understand the limitations of the current IHSS system and how would the plan enhance the system to offer more comprehensive response to needs of the consumer?

- Social model programs: How have the providers enhanced their services to respond in a timely manner (MSSP)? Most have long waits to enroll.
- How would plan handle personal care service contracting? Is the public authority the only entity to provide these under the plan?
- MOU not very useful – it is necessary but need to ask past demonstration/examples of working together.

- Network adequacy: Need information about internal med and specialists compared to family med. Appointment availability important to assess.
- How will the plan ensure data sharing/communication system across the network? Will hospital talk to mental health, etc? What barriers have been overcome – which remain?
- What does the plan have in place as a system for denials and appeals? Is it transparent on their website and easily available? Often the problems are not disputes but navigation problems and the more accessible the information is, the faster it is solved. (Cal Optima has a good record on this.) Contract could require plans to post all information.
- How will the savings be redirected at the local level? How will the plan use the alignment of finances to better serve the client? How will plan operationalize the alignment? How will the plan work to reduce hospitalization?

- Plans need to ask the state
    - How will you make Medi-Cal align?
    - Will there be a payment for frail to incentivize keeping them out of hospital? If the state payment is same for high use patients as for other dual eligibles, plans can't be successful. (Same issue at provider level.)
    - How can state prevent adverse selection?
    - Should state adopt the model of the Medicare Advantage rates? (It still misses HCBS but is better than a flat rate that does not account for acuity.)

<u>What do we want to learn from the pilots</u>?

- Take a sample of the population and do a longitudinal study to measure experience over time. How did utilization patterns change? Look back at TANF population and use the experience of that transition to managed care for a study of this population.
- What do we want to know about family caregiver/informal care network? Look at the extent of this care; whether they have a support system in place; respite, etc.

Group 3

<u>What questions should DHCS ask of plans</u>?

- Are plans prepared to address new delivery issues (housing, transportation, etc.) that exceed a traditional health plan offering?
- Will plans do this in-house or contract out for non-traditional services? If contracted out, these must be collaborative relationships, not just vendor relationships.
- How will plans communicate with beneficiaries effectively? Need to tell people about the available services without confusing them with rhetoric about the structure.
- What will it take in California to "un-silo" the menu of services?
- What regulatory relief do plans need to do what they want to do?
- What exists today that would prevent plans from achieving success?
- How can plans serve dual eligibles who don't have full Medicare coverage?

What do we want to learn from the pilots?

- Why are some counties more ready than others?
- What has been done in leadership in those counties that make it work?
- Can we assess what pilots have learned in order to avoid making the same mistakes?
- How did successful pilots create a culture that continues despite changes in personnel?
- How can integration work in rural areas?
- What are the key performance standards for replication in other areas?

State as Integration Entity

Melanie Bella, Center for Health Care Strategies, discussed the following questions related to California as the integrating entity for Medicare and Medi-Cal:

- What would CMS and stakeholders likely want to see in a proposal for this to work, e.g. standards/regulations, savings sharing, consumer protections, etc.?
- What benefits does the State offer as an integrating entity to the beneficiary, plans, and the federal government?

Her presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA_TWG%20Meeting3_M%20Bella.ppt.

Melanie Bella said that CHCS initially became involved in SNPs because they were "the only game in town" -- Medi-Medi demonstration projects had ended. However, they recognize that SNPs don't work for everyone. In addition, resources matter: it is important to be clear and realistic about what the state in order to achieve this kind of integration.

- It is difficult at best for beneficiaries to navigate the worlds of FFS Medicare, Medicaid, and Part D.
- In MA, MN, WI, dually eligible beneficiaries have one card, one EOB – but it is not easy to accomplish this integration and have one set of rules, one set of policies and procedures. In addition to the Medi-Medi pilots, it has been accomplished in PACE and SCAN.
- In general, Medicaid morphs around Medicare in an integrated approach. The premise is that the integrated plan must default to the more protective program – the highest common denominator.
- However, even the Medi-Medi states did not make much progress in CMS with grievance and appeals processes.
- The federal government benefits from integration because under FFS it pays twice – for the Medicaid match and for Medicare. In addition, FFS Medicare does not offer many options for high-need duals.

State as Integrated Entity

- Allows state to act as administrator of Medicare/Medicaid clinical care delivery and coordinate payment, coverage and benefits for duals.

- Complete blending of funds
- More potential savings can accrue to state
- State can reinvest savings to better coordinate care
- Flexibility to provide state-specific options
- Increased accountability to improve care
- Should provide more uniform, integrated set of rules for plans to follow

Integrated Models

- Integrated care models arrange for all Medicaid and Medicare services (including long-term supports and services).
- Core elements include:
  - Comprehensive assessment to determine needs, including screening for cognitive impairment/dementia;
  - Personalized (person-centered) plan of care, including a flexible range of benefits;
  - Multidisciplinary care team that puts the individual beneficiary at the center;
  - Involvement of the family caregiver, including an assessment of needs and competency;
  - Comprehensive provider network, including strong primary care base;
  - Strong home- and community-based service options, including personal care services;
  - Adequate consumer protections, including ombudsperson;
  - Robust data-sharing and communications system; and
  - Aligned financial incentives

Benefits of Integration

- Creates a single point of accountability for the delivery, coordination and management of primary/preventive, acute, behavioral, and long-term care supports and services
- Promotes and measures improvements in health outcomes
- Promotes the use of home and community based long term- care supports and services
- Uses performance incentives to providers to improve coordination of care
- Blends and aligns Medicare and Medicaid's services and financing to streamline care and eliminate cost shifting
- Slows the rate of both Medicare and Medicaid cost growth

Critical Components

Key issues include:

- Administrative/Operational
  - Enrollment: How to deal with passive enrollment on the Medicaid side and opt-out on the Medicare side
  - Medicaid-Medicare policy alignment
  - Contracting options: managed care, PCCM, county alternatives
- Financing
  - Level of risk (including stop loss/risk corridors)
  - Gain sharing
  - Discouraging adverse selection

- Beneficiary and Provider Issues
    - Choice
    - Consumer protections (PACE has “Participant Bill of Rights”)
    - Network overlap
    - Payment levels (integration is not designed to fill a budget gap)
    - Credentialing (including LTSS providers)
- Measurement and evaluation
- Education
    - Role of state in educating/advocating re: integrated models
- Other areas
    - How best to solve challenge of areas in the state where coordinated/integrated infrastructure doesn’t exist?
    - If only options are SNP/PACE, can those work? Or can there be county alternatives/Enhanced PCMH models?
    - Is there value to the state giving blended money to non-traditional structures?

Melanie Bella recommended that the Workgroup address the following issues:

- Harmonization across policy, purchasing, regulation: is there value in that?
- Person-centered delivery systems – what’s out there, what’s working, what’s not.
- Reinvestment and rebalancing in non-medical services
- Leveraging the strength of California’s diverse system: does having the state act as integrated entity allow opportunities to take advantage of these strengths?
- Getting people what they need, when they need it, regardless of whether it’s a covered benefit under *any* program

David Maxwell-Jolly, DHCS, asked for ideas on how to structure integration so that it does not become a budget-cutting exercise. Melanie Bella replied that she had discussed this in some of her California interviews, and that it is a difficult issue. One way to “protect” the savings from integration would be to have a separate, quasi-governmental, entity whose purpose is to allow for strategic reinvestment of savings. North Carolina uses a separate 501(c) (3) to accomplish this task. Melanie said that CMS will likely ask DHCS the very same question. At the same time, everyone is sensitive to the fact that California does not necessarily need or want another bureaucracy.

David Maxwell-Jolly, DHCS, said that the state does have an actuarial rate-setting process on the Medi-Cal side that sets rates based on historical records projected forwards. That mechanism allows plans to retain expenditures within their overall spending packages even if they change how they’re delivering care along the way. Notwithstanding the overall question of rates, it might be possible to retain savings with a rate methodology like that and a guarantee of Medicare rates.

David Kieffer, SEIU, said that in discussions with providers, particularly the hospital community, there is great hostility to the idea of a separate bureaucracy. Hospitals have done everything they can to suppress discussion of the issue. CalPERS may be a model: it has a structure by which it sends a bill to the state, and that system has generally worked. It could be a model when it is in better shape.

Marilyn Holle, DRC, noted that CalPERS is in the state constitution, which helps. She asked whether there is any way for CMS to build a requirement into the waiver that the savings be reinvested, and unavailable for diversion. She said her concern is not so much for the first few years, but related to diminishing resources down the line.

Tim Schwab, SCAN Health Plan, said that the real success of the pilots is in the integration of Medi-Cal and Medicare. He asked about David Maxwell-Jolly's statement that people who opt out of organized care for Medicare would remain in FFS and have their care paid through the federal Medicare system. He said he had thought that the state would manage that care as well, with funding provided to the state by the federal Medicare system. If that were the case, it would be possible to create differential benefits on the Medicare side that incentivize people to dually enroll. David Maxwell-Jolly said that he had not thought about California controlling all the funding, including for FFS Medicare. Melanie Bella said that it was important to think incrementally, with the initial pilots within existing organized systems. Over time, there might be a menu of options in different geographic areas. She said she understood why the option of taking on responsibility might be attractive to the state, and noted that CMS does not benefit as much from integration if the state isn't able to take on some of the administrative burden.

Tim Schwab, SCAN Health Plan, noted that marketing is very challenging: it is difficult to convince a dually-eligible beneficiary to enroll in an organized system for both programs. Anything that can be built into the integration to provide better benefits and thus provide incentive for beneficiaries to make the switch allows for the building of much more infrastructure.

Melanie Bella, CHCS, said that an integrated system, particularly if it includes services like dental, can serve as an inducement to enroll. SNPs in other states, however, are saying that they don't know if they can continue, or maintain the optional benefits they have been providing. California should try and insulate its integration pilots from whatever may or may not happen with the SNPs. *Maya Altman, HPSM,* agreed, saying that her plan won't be able to offer supplemental benefits beyond 2011. She suggested that integration would require a rethinking of the rate-setting process. Under the current system, reductions in spending on the acute side would count against plans in the long-run. While they might see one-time savings, these would be canceled by the need for continued investment on the HCBS side, and in services like housing. The current rate-setting process is not adequate to this kind of complexity.

Casey Young, AARP, said that the only model he knows that protects from General Fund raids is CalPERS – and that is safe only because of a constitutional amendment enacted after a raid.

Suzanne Tavano, CMHDA, asked for clarification on whether non-enrollees would have their benefit managed by the state, saying she had heard both yes and no. David Maxwell-Jolly said that he had not thought that the state would be in the business of replacing the Medicare fiscal intermediary and receiving for instance, a capitation from the federal government, but that Melanie was raising new ideas. There could be situations where there isn't a managed care organization in the community, and benefit management by the state might be the best option in that case. While DHCS is not pushing the idea currently, it is potentially attractive.

Kevin Prindiville, NSCLC, said that the state should proceed carefully around enrollment. SNPs have had a number of marketing problems, and plans should not be able to advertise misleading incentives. He asked for thoughts on the larger Medicare politics of the integration pilots, given public protectiveness of the program and concerns about the viability of the Trust Fund.

Melanie Bella, CHCS, replied that the Centers for Innovation and the Office of Duals in CMS, both established by HCR, change that calculation a lot. There has been some discussion of using Innovation dollars to test new models, so that Trust Fund dollars are only used for proven models. Medicare staff at CMS require additional education: they don't see why SNPs and PACE aren't good enough. However, the current CMS leadership is sending positive signals, and she feels optimistic about politics within the agency.

Conclusion and Next Steps

David Maxwell-Jolly, DHCS, thanked the SCAN Foundation for supporting the dual eligible workgroups, and the Workgroup members for their participation. He recognized a consensus that there is something worth working on in the area of dual eligible integration, and said he had a good sensitivity to the group's concerns and anxieties about the proposal.

The next steps will come slowly: working with the legislature, educating policymakers in Sacramento and Washington about the value of trying pilots. DHCS will have to develop a solicitation that describes the pilot standards, and will need to figure out how to evaluate the pilots. He said that while he initially approached this project with limited enthusiasm, but that the more he learns about the administrative hassles for dual eligible beneficiaries and their providers, the more he sees real value in integration. David Maxwell-Jolly said that DHCS would be calling on the Workgroup members for assistance as the process goes forward.

Bobbie Wunsch, PHCG, thanked Melanie Bella and Alice Lind of CHCS, the presenters, and DHCS staff for their work.

The meeting was adjourned at 3:00 pm.