# Questions from DHCS Dual-Eligibles Webinar

# March 30, 2010

## General

In your opinion, what state or governmental entity has the best record in accurate and adequate rate setting?

What will these proposals do to address racial and ethnic disparities?

Is having an HMO and Medicaid the same as Medicare/Medicaid dual eligible?

What does the acronym SNP stand for?

How have other states addressed incompatibility of Medicare and Medicaid behavioral health?

Does this change with my senior advantage plan I have with Kaiser?

## Overall Waiver Issues/CMS

Why would CMS authorize State control over Medicare funds?

Has CMS ever provided savings sharebacks where a Medicaid cost that saves Medicare money is reimbursed to the state or a private provider?

How does this paper relate to the papers on the DCHS website such as *State of California's Concept for a Comprehensive Section 1115 Waiver to Replace the Current Medi-Cal Hospital/Uninsured Care Demonstration Project.* Are they related? Are they different concepts? Are they mutually exclusive or complementary?

How would or could Medicare demonstration be used in 1115 for SNP or another dual option?

Who will be in the technical workgroup?

Why is this through the waiver process instead of a separate effort?

Which of these proposals do you think CMS has legal authority to approve? Which do you thing they are likely to approve?

Is the state expecting/aiming to save money through this effort?

When does DHCS plan to submit a proposal to CMS? When would an approved plan become effective?

## Financing

How will beneficiaries with a share of cost be addressed?

When evaluating for cost savings or increases are “carve-out” costs factored in as part of total costs?

How does financial “alignment” compare to global budgeting/full integration of budgeting?

CA accounts for about 12% of the duals nationally but around 8% of the costs of caring for duals. Why? What does this say about or potential to save money on care for duals?

In *California*, is 46% of Medicaid used by duals? What’s the difference between CA and US on this measure? Nationally, what part of that 46% is institutional LTC? In CA?

$3.2B in LTC costs = 75% of LTC spending (p. 5): Does that include HCBS or is that exclusively institutional services?

## Models

How important is it to incorporate a social component (outside church, clubs, meetings, etc.) into an integrated model?

How open are funding models to building ramps, widening doors, placing grab bars, etc. to keep consumers in their homes?

Bob Master's plan is very special but also unfortunately very rare. Where are California health plans in relation to beginning to meet the ‘Bob Masters level’?

Are SNPs ready for full implementation?

You mentioned that different models could operate in different regions within a state. Could you envision different models operating side by side in the same region with targeting to different populations with different characteristics such as acuity?

Can a County Organized Health System (COHS) serve as a PACE entity?

Under the 1115 waiver, will CA recognize that institutional LTC services, for both Medicare and Medi-Cal, are a necessary and vital part of the continuum of care?

How will ICF/DD or NFs be reimbursed under an integrated dual system?

Have you seen any models that do an excellent job of ensuring readiness to serve people with disabilities? (Including all the access issues.)

Can you speak to the use of mandatory v. voluntary enrollment in fully integrated dual eligible programs? Mandating enrollment in a single plan v. offering enrollees choice?

How do states with dual eligible plans handle current nursing home residents? Are they enrolled or only community-dwelling duals?

Should integration systems limit participation to non-profit organizations like the community care alliance?

Are any SNPs in CA truly integrated care right now?

What is the managed care infrastructure across the state?

What do the MIPPA contracts DHCS has with SNPs now look like?

## Option 3

There was a lot of talk about Option 3 through plans. There are many large integrated networks in CA that could directly contract with the state and CMS. What barriers exist for this to occur?

What kind of infrastructure is necessary for option 3? How close are we in California?

Does Option 3 involve a capitation?

Re: Option 3: Could any of these plans bring back the Medi-Cal optional benefits lost in the budget?

## Option 4

You say that option 4 is an emerging model.  In what state has this model emerged? Does it exist anywhere?

To clarify on option 4, are you saying that it would be voluntary for any dual? Duals would continue to have the choice of FFS?

Would the payment reductions for Medicare Advantage plans that are part of Health Reform law affect state's ability to pursue Option 4?

Under Option 4, in California can the county be the "Integrated Entity"?

Clarify Option 4: Are you saying it would be voluntary for any dual? Would FFS be available?

Option 4: What transition protections need to be in place for duals? How do we avoid a repeat of Part D?

## Beneficiary Protections

What Medicaid protections do beneficiaries lose when enrolling in a SNP?

Lack of compliance with disability access laws and lack of oversight by the state to that compliance is a part of the resistance to forcing people with disabilities into managed care. Have you seen any models which have done an excellent job of ensuring actual readiness to serve people with disabilities - including all the access issue?

In our experience, SNPs that enter a state market without substantial prior experience providing services to duals have failed to offer wide and deep enough provider networks and have failed to offer adequate consumer protections. What kinds of requirements can be placed on SNPs who wish to offer services under a waiver in order to avoid those problems?

How do we make sure the needs of beneficiaries are not lost in this process?

## Medi-Cal Issues

In California, assisted living and board/care facilities aren't covered Medi-Cal benefits (except on a very limited pilot basis). To what extent can integrated approaches be successful without the benefit of the full spectrum of home and community based supports?

How do you get MD's to participate and at what rate are they paid? California is having great difficulties in getting MD's to participate in Medi-Cal, especially specialists.

## Regional Centers

Adults with developmental disabilities have very specific health needs and must often access regional clinical resources. A single county doesn't have a critical mass of patients with developmental disabilities to develop the full range of health care services needed. Also, the geographic boundaries of health plans don't match up with geographic boundaries of the Regional Centers. This creates problems with integrating services. How can we get CMS to budge on this to allow us to enroll all clients of a single regional center into a single health plan (e.g. a SNP/County Organized Health Plan) (e.g. a pilot, allowing San Francisco Regional Center clients to have mandatory enrollment in Health Plan of San Mateo)? This would allow medical and social services to be more efficient and work together.

## Adult Day Health Services

How will integrating dual eligibles affect adult day health services?

## IHSS

There seems to be some tension between California's current, consumer-directed IHSS personal care services program and a more "coordinated" alternative in which the consumer is a participant but not a "director" of their personal care needs. How would a waiver ensure that IHSS recipients remain able to self-direct care?

Could Medicare funds be used to fund IHSS?