

# Alameda County Board of Supervisors Health Committee's Community Dialogue on Preparing for Health Reform

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## Session 3: Improving Care Delivery for Dual Eligibles

January 12, 2011

This session focused on proposed changes for delivering care to the county's "dual eligibles" – individuals who receive both Medicare and Medi-Cal benefits. Alameda County has about 47,000 dual eligibles, and these individuals tend to have multiple medical conditions and complex health needs. The conversation examined the opportunities and challenges ahead as the state of California works with the Federal government to promote coordinated health care delivery for dual eligible beneficiaries. The speakers offered overviews of:

- Integrated care for dual eligibles by **Sarah Steenhausen**, senior policy advisor at The SCAN Foundation;
- California's Duals Demonstration Project by **Sarah Arnquist**, of Harbage Consulting;
- Launching a duals demonstration in Alameda County by **Ingrid Lamirault**, CEO, Alameda Alliance for Health;
- Coordinated care for dual eligibles by **Peter Szutu**, CEO, PACE Center for Elders Independence; and
- Opportunities and challenges for integrating services by **Gary Passmore**, director of the Congress of California Seniors.

### Integrated Care Overview

Sarah Steenhausen of The SCAN Foundation began by explaining the challenges of offering services to dual eligibles in today's fragmented system. In California, dual eligibles account for about 1.1 million people. About 37 percent have chronic conditions and functional limitations, and generally dual eligibles tend to be high users of Medicare, the federal health program for people who are 65 and older, blind or disabled, and Medicaid, the state-run health care program for low-income and disabled people. The Affordable Care Act (ACA) included several initiatives to improve care coordination across medical and supportive services and also provides new opportunities for payment and delivery reforms geared toward improving health care quality and slowing cost growth.

Many dual eligibles rely on a vast array of long-term services and supports. This includes skilled nursing facilities and home- and community-based services that help people live at home for as long as possible. Medical care services and long-term supports rarely are coordinated. Steenhausen said there are numerous challenges to coordinating care in this population. For one, there is a serious lack of communication between the medical care system and programs offering long-term supportive services, which results in poorly managed care and hurdles for beneficiaries trying to access necessary services. The dearth of coordinated care too often leads to unnecessary hospitalization or placement in nursing homes. This, in turn, creates potentially worse outcomes for beneficiaries and is dramatically more expensive. Increased coordination offers the potential for improved outcomes and cost savings, Steenhausen said.

The federal government and the state of California are promoting new efforts to coordinate the delivery of long-term supports and services with medical care, Steenhausen said. In 2011, California was one of 15 states that received a \$1 million planning grant from the Medicare-Medicaid Coordination Office to design new programs that fully integrate primary, acute care, behavioral health services, and LTSS for dual eligibles. The California Department of Health Care Services currently is developing its Dual Eligibles Demonstration proposal.

## **California's Dual Eligibles Demonstration**

Sarah Arnquist of Harbage Consulting provided a more detailed overview of California's efforts to integrate care for dual eligibles. Less than 20 percent of the approximately 1.1 million dual eligibles in the state are enrolled in coordinated care delivery systems, and Arnquist noted that, as it stands today, dual eligible beneficiaries face a confusing landscape for health coverage. Understanding which entity pays for what treatment is challenging, and confusion over this can lead to gaps in care.

The Medicare-Medicaid Coordination Office aims to improve coordination between the federal government and states and support the development of innovative care coordination and integration models for dual eligibles. These "demonstration projects" aim to eliminate financial misalignments that lead to poor quality and cost shifting. Arnquist explained that for the first time the federal government, through this special office, was offering flexibility in several programs and the opportunity for the state to share Medicare savings that accrue from avoided institutionalization as a result of enhanced home- and community-based services funded by the state.

Arnquist described what California's Dual Eligibles Demonstration Project entails. Working closely with the federal government, California's Department of Health Care services is designing a three-year demonstration to examine the benefits of integrating Medicare and Medi-Cal benefits for dual eligibles. SB 208 (Steinberg, 2010) provides state authority for demonstration sites in up to four counties, with at least one county using a two-plan model and one with a county-organized health system.

The demonstration aims to accomplish two key things. For one, the project will examine how financial incentives can drive streamlined person-centered care. Additionally, the goal is to rebalance the current health care system, moving it away from avoidable institutionalized services, such as hospitals and skilled nursing facilities, and toward home- and community-based services.

Financing and benefits will be integrated through three-way contracts between CMS (federal), DHCS (state) and health plans. The state is planning for a passive enrollment process in which beneficiaries in the chosen counties could voluntarily opt-out but would otherwise be assigned to a health plan offering the integrated benefits. Enrollment would be phased in over 12 months in 2013. Plans may offer supplemental benefits, such as dental and vision, no longer available through Medi-Cal. California will submit a Demonstration Proposal to the federal government for approval later this spring. Following a public comment period on the proposal at the state and federal levels, CMS and DHCS will work with health plans to ensure they comply with strong beneficiary protections.

At the end, Arnquist quickly described the Brown Administration's proposal to expand the duals demonstration to up to 10 counties and enroll all dual eligibles into Medi-Cal managed care if it exists in their county. Currently, dual eligibles are the only group of Medi-Cal beneficiaries not required to enroll in Medi-Cal managed care. Brown's Coordinated Care Initiative also proposes to incorporate long-term supports and services into a Medi-Cal benefit and expand managed Medi-Cal statewide.

## **A Duals Demonstration in Alameda County**

The next speakers were Ingrid Lamirault, CEO of the Alameda Alliance for Health, and Marty Lynch, an Alliance board member and CEO of LifeLong Medicare Care. Lamirault said the Alliance planned to apply to be a duals demonstration site and was holding community meetings to get stakeholder input. The Alliance is a public, not-for-profit managed care plan that provides coverage to Medi-Cal beneficiaries. For Alameda County to be selected for the demonstration, both the Alliance and the Blue Cross Medi-Cal managed care plan would have to participate. Additionally, Kaiser Permanente has thousands of dual eligibles enrolled. Lamirault said all health plans in the county would need to coordinate "so that we're acting in concert."

Lamirault said Alameda County should apply to be among the early demonstration sites so it has greater ability to implement a model that works locally. She stressed that this model should build on existing systems that work well, such as the In Home Supportive Services (IHSS) program. The Alliance sees opportunities to augment IHSS services as part of the long-term care continuum, but it is not interested in taking over the IHSS program, she said.

Lynch said the state was sending clear signs that it wanted to move toward more coordinated care. "Care has been so fragmented that it's hard for consumers to get the services they need," Lynch said. "The governor's budget proposal coming after this

demonstration indicates that the state is going to move this way. We have the opportunity to do something creative that meets disabled and elder needs in AC in a proactive way.”

Following Lamirault’s presentation, Randy Morris, deputy director at the Alameda County Department of Social Services, commented on the role of IHSS in the demonstration. Alameda County has about 18,000 IHSS recipients and nearly as many workers. DSS, Morris said, is at the table discussing how this integration could possibly happen, but he emphasized the magnitude and complexity of coordinating IHSS with medical services through a managed care organization.

## **Lessons Learned About Coordinated Care Delivery**

The next speaker was Peter Szutu chief executive officer of the Center for Elders’ Independence, which delivers care under the Program of All-Inclusive Care for the Elderly (PACE). PACE is the nation’s longest-running model of integrated care for dual eligibles. Eligibility for PACE is limited to the elderly who are 55 and older and sick and frail enough to live in a nursing home but who, with help from PACE, remain living at home. A typical patient is female, 80 years old, has nearly eight medical conditions and must be limited in at least three activities of daily living. Nearly half have been diagnosed with dementia.

Like others, Szutu noted that the current landscape for health care is fragmented, providers drive demand, and the fee-for-service system provides incentives that don’t always take into account the needs of the beneficiaries. Instead, he said he would like to see a future that aims for improved outcomes, lower costs, and improved patient satisfaction. That will come, he said, from care coordination that is patient-centered and with payment reforms that reward providers for keeping beneficiaries well. “What we have learned from PACE is that [the model] has to be patient-centered, meaning starting by asking ‘What is it that people need?’ If we don’t keep them healthy, happy and functional it costs a lot more money.”

Szutu had recommendations for Alameda County as it creates a new model of managed care for dual beneficiaries. He said the county needs an ongoing task force on duals and that it should utilize the expertise at the local Center for Elder Independence under PACE. He added that managed care for recipients of both Medi-Cal and Medicare “is a good concept.” It can work, he said, but it will be difficult in the “very aggressive time frame” the state has set forth.

## **Opportunities and Challenges for Integrating Services**

Gary Passmore of the Congress of California Seniors said that Alameda County is an excellent place for a duals demonstration project, noting that the current system is no system at all. “Now people have to go to five or six agencies that are not consumer friendly. It’s not a system; it’s a set of programs.” Unlike other states, California has

never integrated long-term supports and services with medical services on a large scale. It is time to take that step, Passmore said.

But Passmore also echoed some of Szutu's concerns about rolling out a completely new program in a year. "It's a massive plan, bringing in folks who haven't always worked well together," he said. "It's a very aggressive time schedule. We're not just talking about doctor's visits. (We're talking about) long-term care services, all mental health, all substance abuse put into only one or two managed care plans."

He noted there is "a fine line between coordinating care and forcing people into care that doesn't serve them." Passmore said he is skeptical of the savings estimates the state believes will result from improved care coordination and less institutionalized care. In fact, he said, "Better care may be more expensive care."

## Public Comments

It was clear that the discussion tapped into a well of anxiety from both beneficiaries and providers.

One speaker from San Leandro said he has been a dual beneficiary for ten years. "Although there's a lot of lip service toward consumer control, it seems that the goals talked about most are about capitation...I get really nervous when they talk about managed care, and I'll continue to be nervous."

He also questioned why the state is pushing for an "opt-out" enrollment model – whereby beneficiaries would be placed in a plan they could later choose to leave – rather than making an active decision to join. "Why (are they doing that) if they're so confident it's going to be good for us?" he said.

An IHSS consumer spoke about her fear of achieving savings by cutting IHSS hours. The lack of information on how exactly IHSS might move into managed care has created significant anxiety among IHSS consumers and their workers, she said. "We get lost in the shuffle," she said. "I really urge you to explain things to consumers and their workers."

Donald Waters, Executive Director of the Alameda-Contra Costa Medical Association, also expressed apprehension on behalf of physicians. He noted that many doctors are not currently able to accept beneficiaries in fee-for-service Medi-Cal and if the reimbursements set by the health plan are similarly low to current Medi-Cal rates, doctors won't be able to continue seeing their dual eligibles patients. "There's a huge amount of anxiety among doctors that there will be only one provider of services," Waters said. "If mandated, a single program could have an effect on doctors' ability to participate."