Lessons Learned from the Dual Eligibles Demonstrations

Real-Life Takeaways from California and Other States
Introductions

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Webinar Goals

• Gain an understanding about the Financial Alignment for Duals Demonstrations
• Learn about the California Coordinated Care Initiative as an early adopter of integrated care for Medicare-Medicaid Eligibles
• Provide lessons learned and best practices for other states seeking to better serve this vulnerable and costly population
• Look ahead to where demonstration projects may go in the future
Overview of States Participating in Demonstrations

- MAXIMUS assisted states:
  - California
  - Colorado
  - Illinois
  - Massachusetts
  - Michigan
  - New York
  - South Carolina
  - Texas
  - Virginia

- Differences among demonstrations:
  - InfoCrossing Interfaces – State or MAXIMUS responsibility
  - Outreach – State or MAXIMUS responsibility
  - Some states transitioning duals from Fee For Service while others are transitioning them from an existing MCO – where there is existing MCO, the plans have no financial incentive to move people from MLTSS to the Duals Plan
Why states participate in the Duals Demonstration?

- Streamline the consumer experience....one card, one program, one plan
- Unify member protections
- Allow for state oversight of all program benefits
- Guarantee state saving

![Pie chart showing beneficiaries by state](chart.png)

Total beneficiaries: 1,499,265
California Coordinated Care Initiative Overview

- 1.1 million dually eligible beneficiaries in California
- More than 70% are over 65
- 34% have 1 or 2 chronic illnesses and 15% have 5 or more
- Less than 20% were in organized delivery system
- Account for about 25% of overall Medi-Cal spending versus about 15% of Medi-Cal population.
Overview: The Coordinated Care Initiative

• **Cal MediConnect** - Combines Medicare and Medi-Cal benefits into one managed care plan

• **Managed Long-Term Services and Supports** - Provides Medi-Cal benefits, including Long-Term Services and Supports through a managed care health plan.

**Goals:**

• Maximize the ability of beneficiaries to remain in their homes and communities, with appropriate services and supports in lieu of institutional care.

• Coordinate state and federal benefits across care settings for better health outcomes.

• Optimize the use of state and federal resources.
Overview (continued)

- Beneficiaries are passively enrolled into Cal MediConnect plan, unless they choose to opt out
- Beneficiaries are notified about the program 30, 60, and 90 days before they are enrolled
- Phased-in enrollment over 12 months in each county, starting with San Diego, San Bernardino, and Riverside in May 2014
- Enrollment in San Mateo occurred all at once, in April 2014
- 7 demonstration counties, with an estimated 650,000 dually eligible beneficiaries.
Network Strategy – The Delegated Model

• Health plans delegate certain functions (e.g., care management) to another health plan or physician group.

• Delegation is a way to share risk and allows for a reasonable division of administrative and clinical management.

• Delegated entities are paid a capitated rate and take on responsibility and risk for delivering all services in a contract.
Network Strategy

- **Organized care delivery system**
  - Built off Medi-Cal Managed Care & Medicare Dual Eligible Special Needs Plan (D-SNP) Model for traditional medical services
  - Behavioral Health integration

- **Long-Term Services & Supports (LTSS) provider network**
  - Including Long-Term Care facilities, Multi-Purpose Senior Services Programs (MSSP), Community Based Adult Services (CBAS), In-Home Supportive Services (IHSS) and other community-based organizations
  - Intended to mirror current system (at least initially)

- **Plans had to meet state and federal requirements for readiness reviews, including but not limited to:**
  - Network capacity
  - Geo-access – services available where Duals beneficiaries live
  - Timeliness
  - Cultural and linguistic capabilities
  - Accessibility
Network Strategy (continued)

- Contracting with medical groups and hospitals
  - Contract documents/amendments, inclusive of participation requirements
    - Health Risk Assessment (HRA) / In-Home Assessment (IHA) requirements
    - Specific requirements for encounter reporting
    - Specific requirements for quality measures reporting (STARs-like)
    - Risk sharing related to LTSS
  - Compliant network contracted and submitted to CMS annually
    - Medical groups encouraged to expand their network of contracted physicians
    - Similar contract methodology as Medicare Advantage
    - Collection of member-level coding data is critical
    - Professional and institutional capitation (dual risk)
    - Delegation for D-SNP model of care
Implementation of the Coordinated Care Initiative

- **Stakeholder Engagement**
  - Statewide and local stakeholder coalitions funded by The SCAN Foundation
  - Beneficiary and provider outreach conducted by state contractors
  - Online clearinghouse with resources for beneficiaries, providers, and stakeholders
  - Regular stakeholder calls and weekly e-mail update

- **Contracted Health Plans**
  - Competitive selection process
  - Plan readiness evaluations
  - Previous experience serving dually eligible beneficiaries

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- Coordinated Care – Crucial for better healthcare
Key Aspects of the Coordinated Care Initiative

• Person-Centered Care Coordination
  – Health Risk Assessments (HRAs) and care planning
  – Interdisciplinary Care Teams
  – Integration of medical care, behavioral care, and long-term services and supports

• Beneficiary Protections
  – Multiple notices, dedicated call center, and tele-town halls
  – Continuity of care
  – Cal MediConnect Ombudsman Program
  – Enhanced quality monitoring and enforcement
Integration of Long-Term Services and Supports

• Pre-CCI:
  – Medicare paid for: office visits, hospitalizations, and prescription drugs
  – Medi-Cal paid for: LTSS and cost sharing
  – No mechanisms or incentives to manage utilization or keep beneficiaries out of institutional long-term care

• CCI:
  – Cal MediConnect plans assume risk for both medical care and LTSS
  – Incentivized to provide comprehensive services that keep beneficiaries healthy and in the community
  – Managed care health plans provide LTSS coverage for all dually eligible beneficiaries, even if they opt out of Cal MediConnect, and also provide LTSS coverage for Medi-Cal-only
Care Planning: Health Risk Assessments (HRA)

- Health plans are required to complete an HRA for every Cal MediConnect member

- Medicare and Medicaid claims data is shared with health plans prior to coverage effective date

- Plan-specific risk stratification process based on utilization and health outcomes:
  - Lower-risk beneficiaries – 90 days for plan to complete HRA.
  - Higher-risk beneficiaries – 45 days for plan to complete HRA

- Health plans required to report data to CMS & State each quarter
Provider Group Support: Data Exchange

- Data are used by provider groups to incorporate into their:
  - Case management systems
  - Electronic medical records
  - Workflow tools
  - Analytics engines.
Current Enrollment Data for Cal MediConnect

- **122,520** dually eligible beneficiaries enrolled as of April 1, 2015
- **49%** of beneficiaries opt-out before they are passively enrolled as of March 2015
- **63%** of beneficiaries with IHSS services opt-out
- Passive enrollment goes through June 2015 in Los Angeles
- Santa Clara went live in January 2015 and passive enrollment in Orange County will begin in August 2015
- DHCS releases an enrollment dashboard each month on [http://www.calduals.org/enrollment-data](http://www.calduals.org/enrollment-data)
Successes

- Created a system that is easier to navigate
- Reduced fragmentation, confusion, waste for highest-need clients
- Member Coordinated Care and Satisfaction
- Provider Group Engagement
- Coordination with County Agencies
- Extensive Training – internal, provider, stakeholder
- Data Integration – CMC Provider Portal
Challenges and Opportunities In California

• **Opt-outs**
  – Confusion around managed care and misinformation campaigns
  – Ongoing provider outreach and education
  – Ongoing beneficiary and stakeholder engagement

• **Care Coordination**
  – Locating beneficiaries for the HRA process
  – Integrating LTSS providers into care teams.

• **LTSS Provider Engagement**
  – Continuing Policy Changes
  – Fluid quality measurement and outcome evaluation criteria
  – High/early disenrollment leaves insufficient time to develop care plan/implement care improvements
Other Dual Demonstration States
Key Challenges – Opting Out

• Opting-out by part of population:
  – Beneficiaries are confused or do not want to change
  – Providers are actively “opting-out” for their patients – mass opt-outs
  – Providers have limited time to understand the benefits to their patients and are concerned this will affect their bottom lines
  – More money in FFS - not all providers participate in the Integrated Care Plan networks
  – Advocates are literally providing training sessions for their communities to help people opt-out
  – Beneficiaries can call 1-800-Medicare and opt-out, not enabling MAXIMUS to talk with them about the benefits of participation
Feedback from the Projects on Opt-Out

- **Period of Opt-Out:**
  - Biggest opt out rate between 60-day and 30-day notice
  - 60-day letter often drives the opt-out
  - Limited opt-out after enrollment

- **Key opt-out reasons:**
  - Suggestion from nursing facility, PMP, or specialist
  - “It’s all too confusing…”
  - Status quo - No reason to change their existing plan, especially in states where they already have managed care
  - Elderly have an issue with whether the new coverage will actually provide what they need
  - Existing providers do not participate in the Integrated Care Plans
Key Challenges – Communication with Stakeholders

- Communication with Key Stakeholders
  - Beneficiaries
    - Elderly are not easily located
    - Notices may be too complex and dense, so active outreach is really needed
    - Many are fearful and do not want to change from their current plans
  - Providers
    - Do not understand the rationale or benefit for their patients
    - Many providers are not within the new Integrated Care networks
    - Fearful that it will affect their livelihood
    - Plans make more money from the MLTSS than the Duals Demonstration plans and prefer to keep people in their existing plans
  - States
    - Excluded populations may result in data inconsistencies
    - Need better coordination on scheduling of notices, messages, and outreach strategies
Key Challenges – Data Management

- System interfaces, data integrity, and data reconciliation
  - Excluded groups (Vets, HIV/AIDS, ID/DD populations and others)
  - Reconciliation with Federal, State, and vendor systems
Best Practices – Incorporate Early Feedback

- Better define the benefits to the beneficiary and provider of participating in these programs
  - “One card” argument is not enough
  - Providers are not aware of benefits to their patients and do not understand rates

- Get early feedback from the stakeholder and advocacy communities
  - Get buy-in on draft materials and scripts
  - Visibility into data – provide dashboard on website monthly – increased transparency for monthly stakeholder groups
  - Formalized contracts with AAAs
  - Get sign-on from Providers before roll-out
Best Practices – Enhancing Outreach Pays Off

• Beneficiary outreach
  – Conduct Town Hall Events
  – Provide webinars
  – Attend community events like health fairs
  – Conduct customer satisfaction surveys and focus message on beneficiary feedback
  – Provide more face-to-face assistance
  – Perform outbound call campaigns

• Provider outreach
  – Team with CMS/states to target providers and teach them about the benefits of the program to their patients and how the rates work
  – Create Fact Sheets for Providers
  – Do the education up-front before beneficiaries get their notices
  – Conduct telephone interviews with providers
  – Potentially provide outcome-based bonuses for providers
Best Practices – Improving Communications

- Enhanced scripting, especially for those opting-out, helps enrollment
  - Scripting needs to emphasize the benefits to the beneficiary of participating in the Integrated Care Pilots
  - Require the beneficiary to go through opt-out script and confirm changes
  - Ensure scripting is short and not too complicated or verbose
- Create notices and fact sheets that are easily to understand and that are culturally and linguistically appropriate
- Ensure that notices are coordinated with the State and received in the right order
- Implement outbound call campaigns to the beneficiaries, providers, and advocates
- Use specially trained CSRs and provide a KMS
Best Practices – Managing Data

• Work more closely with 1-800-MEDICARE and establish protocols for sharing data
• Implement real time interfaces and comprehensive data reconciliation processes to address data inconsistencies, which reduces calls
A Look Ahead….

- Leveraging lessons learned by the later states – smoother implementations and fewer opt outs
- Pilot evaluations and state/federal decision about whether to continue the demonstration projects
- Adoption of the different models by additional states
  - Duals Special Needs Plans Model – Coordinated Care
  - Financial Alignment Demonstration Model – Integrated Care
- Expansion of the model or different models in existing demonstration states?

As the number of elderly and persons with disabilities grows, and the cost of care for duals continues to escalate, states will need a viable strategy for integrating care for their vulnerable and expensive Medicare-Medicaid eligible populations…MAXIMUS can help!
Thank You!

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