

Stakeholder Discussion from Dual Eligible Medicaid Forum Held October 26, 2011

(Derived from a summary of stakeholder input from the public forum that will be used to help Idaho Medicaid transition to managed care for dual eligibles.)

1.) The majority of dual eligibles are older than 65 years of age, but also includes individuals who are younger than 65 years of age and disabled. Should the managed care contracts include all duals or would you recommend a phased-in approach for certain subgroups of duals?

- More dual eligible nursing home residents are younger these days, under 65, and there needs to be an improved option for them.
- There was a suggestion of carving out older folk from this plan. Younger people are an ideal population for managed care, due to having fewer chronic conditions and greater potential for improvement and savings.
- Start with those participants with chronic care needs. Look at managed care from a utilization standpoint, and not age. Ensure that you review utilization sub-groups; utilization distinctions are more important than age distinctions.
- Don't use age; use needs.
- Why have any exclusions? If it is a desirable option, leave it open for all right away.

2.) What performance requirements should Idaho Medicaid require of the managed care contracts to ensure that dual eligibles receive the best quality of care?

- It should not be based just on cost savings, but rather on ease of access and quality of life.
- A holistic model should be used. It needs to be consumer-directed. Have providers, MCOs, and individuals at the table together so that the MCOs will be more accountable and responsive.
- Prompt payment to providers is important.
- Strong state oversight is critical; be sure that Medicaid partners with the MCO to create benchmarks they are expected to attain. Ensure that those benchmarks include both provider and consumer satisfaction, and require timely access and payments. Meaningful benchmarks are critical; assuring access to services must be a benchmark as well as good pay for providers.

- The consumer/care coordinator relationship needs to be measured; it must be strong for this to work.

3.) The managed care contractors are responsible for establishing provider contracts across the range of medical, behavioral health and Long Term Care benefits. Other than requirements that ensure access to services, what other standards should be used by the managed care contractors to establish provider contracts?

- We need legislation that says long-standing (10 yrs. or more), established providers cannot be excluded.
- Specialists are often out of network and that is a problem; they sometimes do not participate in managed care.
- We need to let all providers participate in the network. One managed care plan being used today is a nightmare; rates are too low, and we can't get a contract with them. We have to jump through hoops to receive reimbursement.
- Lewin Group has some good research that says MCOs fail if they drive utilization to too few providers. Don't allow managed care to add more bureaucracy. More rules would be a barrier to access since we already have too many rules with Medicaid and Medicare. Managed care fails if it's just based on price.
- MCOs should establish baseline standards for providers to ensure access to services. There needs to be real clarity to consumers about options, benefits, etc.
- Reward good providers and don't reward bad providers. Quality standards need to line up with what will be paid for. All must agree on what good quality is. Quality should be defined without making it unnecessarily complicated.

4.) Should Idaho require the managed care contractors to include primary care medical homes for people with chronic conditions?

- Yes. The Healthy Connections concept, which already includes medical homes, is good.
- Idaho has a shortage of primary care physicians. It would be good to implement them, but it would be challenging due to the shortage of primary care physicians.
- A Medical home model is a good one, but it is complicated to achieve in rural areas.

5.) What managed care contract requirements should be established to prevent and reduce inpatient hospitalization and nursing home admissions?

- Currently, a RALF or facility may take a participant who has more intensive needs than they're capable of dealing with, and then 9-1-1 becomes the facility's nurse if no other resources are available.
- Home care does not work for everyone; there is no guarantee of services in home care. MCO need to help move folks from higher cost settings to lower cost care settings where appropriate. It is a myth that people can be guaranteed the services that they're supposed to get in the in home care setting.
- A MCO contract needs to spell out the services and should exclude the "middle man." Remove the regulation "handcuffs." Adopt uniform standards or supplement state standards. Choose the appropriate setting, even if it's outside the box.
- Medicare and Medicaid need to be coordinated. Savings should not go to MCO, but should be used to improve care. Some states actually expand services under managed care. The number of people using nursing facility level of care often decreases with managed care.
- Coordinate the plan with Medicaid and Medicare; coordination is key. Eliminate cost-shifting.

6.) How should advanced illness care planning and palliative care services be made available early in the onset of a life-limiting condition to assist the patient to make informed decisions in keeping with their personal values and avoiding expensive services that increase risk of harm and do not lengthen life or improve quality of life?

- It is important to catch conditions early enough to help people, an example being people with Huntington's disease (a neurological disorder).
- Everyone should have a right to live with dignity, but provisions for services that do not help should not be paid for. It's not always the best thing to do everything possible in all situations. However, personal rights issues come into play. Managed care must meet humanity. The dual eligible population is likely to increase significantly by 2014.
- Create incentives for people to have a "Living Will."

7.) How should patient choice be protected while offering the safest, most effective level of care and services in a streamlined, seamless manner during transitions between care settings, e.g. when discharged from the hospital?

- Person-centered discharge planning is critical and it takes skill and training. Look at all options at discharge to deflect re-admittance; consider goals, needs, dreams, and facts. Use available supports/services to come up with the best plan; consider prevention.
- MCO needs to be the one stop shop for learning about all options, not just select options. Options are often not available in rural areas. Look at the Oregon model Medicaid model for a state doing a lot of things right, and the Texas model for lessons learned. Meaningful interaction with the case manager is key. Managed care will force decisions upon consumers that they don't like, and so the quality of case management to work through that is imperative.
- Not all providers like the Oregon model. You need to assure true consumer choice; not just MCO-only selected options/providers. We don't want the consumer getting a MCO's "preferred provider list."
- You want government oversight to prevent provider favoritism by MCOs.

8.) What managed care contract requirements should be established for working with certified family home providers?

- We need safeguards protecting people from limited choices since they are living in someone else's house. CFHs need to be part of the puzzle; there are more than 2,000 in Idaho.
- Find a balance between personal and state responsibility. Gov. Otter talks about family responsibility and caring for your family.
- Most people in nursing homes do not have home supports; CFHs should not be for profit. There's a place for CFHs, but the idea of a family being paid to care for other family members is a struggle.

9.) What are the opportunities to reduce duplication and conflicting requirements between Medicare and Medicaid?

- There should be a laundry list of options; look at streamlining and offer lots of options. Use common sense; Medicare will pay for brain surgery, but not a bath aide.
- MCO should use technology to track and coordinate care, avoid duplication, and catch medication errors.

- Rules should not define what medical equipment is available to patients. Patients should decide what fits best.

11.) How should the Money Follows the Person (MFP) demonstration project work with the managed care contractors to support the Home and Community Based Services (HCBS) infrastructure and systems for people who are dual eligibles?

- MFP excludes certain care settings, so it's already flawed since it determines what the settings can be. Don't exclude certain care settings.
- MFP was designed by federal CMS rules, not the states. It was designed to help people out of institutions. Sometimes there aren't enough community options, and that limits people's choices.
- MFP and MCO dovetail well together.
- MFP helps provide good support services for people, and helps people to be connected with family in community.

13.) What managed care contract requirements should be established to support dual eligibles that choose to work?

- Not all duals are sick; they are people with unique needs. One person had four insurance plans at one time. Don't put them in a category. A dually eligible individual should be able to get an idea of how long they'll be in the hospital when they have to go. You need to have good coordination with all providers whose services are being accessed.

14.) How should Idaho Medicaid receive ongoing input from duals, providers, and other stakeholders?

- The key is to have an ongoing work group with a variety of people involved to work with DHW Deputy Director Leslie Clement over time. Provider and public feedback are important. Legislation needs to be crafted together with stakeholders, or there will be a fight. The discussions like we are having today need to continue. A 2012 implementation is too quick. It should slow down. We need to learn the lessons from last year's education reform because they went too fast without including important groups in the process. The public needs to be informed as this goes along.
- The Community Care Council is a good forum to report to the legislature about this effort and how it is going. Give a report with a grade for each benchmark.
- There needs to be an oversight committee with a real voice, not just a token to hear what DHW has already decided. We need active participation from the committee.

- There should be more publicity so that the public can be involved in the process.
- Use the State Independent Living Services (SILS) and Area Agencies on Aging (AAA) to continue the public forums across the state. If we're not involved in this, we'll fight it to the bone.
- Posting the questions and responses to website is a good idea.