



June 1, 2011

California Health Advocates' Comments to DHCS' Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

The State Demonstration to Integrate Care for Dual Eligibles should aim to achieve the 3 overarching goals that the Centers for Medicare & Medicaid Services (CMS) has set:

- Improve care;
- Improve health; and
- Reduce health care costs.

We would also like to refer to a Technical Assistance Brief from the Center for Health Care Strategies titled "From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles."

1. What is the best enrollment model for this program?

California Health Advocates (CHA) recommends an opt-in model over a mandatory model. An opt-in model honors individual choice. Presumably, a beneficiary who voluntarily enrolls in a pilot makes an informed decision, choosing the pilot over other options like fee-for-service. When someone voluntarily enrolls, he/she is more likely to be an active participant in his/her own health care. For example, if enrolling in a pilot means changing providers, a beneficiary who has voluntarily enrolled would be more willing to accept the change. In contrast, a beneficiary who was passively enrolled in a mandatory model, may resist the change and opt-out without finding out what are the available options, and which best fits his/her needs.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

Duals in an integrated model should have access to the same LTSS that are available to duals not in an integrated model. LTSS include both Medi-Cal and Medicare funded home health services (including skilled nursing, physical, occupational and speech therapy); In-Home Supportive Services; MSSP; ADHC; and so forth. Given the tight time schedule, it may not be realistic to completely integrate that all LTSS into the integrated care model. Whether a pilot manages to integrate all LTSS into the model when the pilot starts, duals enrolled in the pilot should have access to all LTSS.

3. How should behavioral health services be included in the integrated model?

We are glad that the pilot includes both behavioral health services and substance abuse. As we have limited experience working in behavioral health services, we defer to experts in that area. If behavioral health services and substance abuse are not integrated into the model at the outset, enrollees should still have access to these services.

4. If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

CHA is not a provider of LTSS.

5. Which services do you consider to be essential to a model of integrated care for duals?

The integrated model should be as good as or better than other options a beneficiary has, such as fee-for-service. Thus, the integrated model must include all services covered by Medicare and Medi-Cal. To encourage enrollment, the model would include additional benefits.

For services covered by Medi-Cal and Medicare, the standards should be the same or more generous than standards under Medi-Cal or Medicare. For additional benefits, the standards should be clearly defined and in the contract as well as in informational materials provided to enrollees.

Enrollees in the integrated model should be given the same protections as beneficiaries in fee-for-service Medi-Cal and Medicare. For example, they should have appeal and grievance rights, meaningful notice, and should not be charged a higher cost-sharing than what is charged to a beneficiary in fee-for-service Medi-Cal and Medicare.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

A successful opt-in model depends on duals making an informed decision to voluntarily enroll in the pilot. Thus outreach, education and counseling to beneficiaries play a critical role in helping duals gather information to make a decision appropriate for their health care needs. As the pilot develops, outreach should ask duals for input. Opportunities to provide input should include in-person meetings, teleconference, webinars/online, and other communication means. In-person meetings should be publicized at least one month in advance in the local media, such as newspapers, TV and radio, as well as social media.

When the pilot is finalized and prior to implementation, outreach, education and counseling would be necessary to inform people about the pilot and how the pilot compares to other options for duals, such as fee-for-service. Information from a neutral third party, such as a government agency or not-for-profit organization, would probably be better received than information from the plan, although the plan should not be excused from doing outreach and education. In its outreach and education, the plan should refer duals to a neutral third party responsible for counseling.

Outreach and education to providers are also necessary. In addition to reaching out to encourage providers to participate in the plan's network, a plan should provide them with information since beneficiaries trust their providers and look to them for information.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

We would want a potential contractor to describe its experience with the Medicare and Medi-Cal programs; with Medicare Advantage Special Needs Plans (if any); and working with populations similar to dual eligibles (who have diverse needs such as multiple chronic conditions and

disabilities). In addition, how long the contractor has been in the county it proposes to serve and what relationships it has in the community.

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

Cultural competency includes language access (in a language that the beneficiary can understand) as well as information written at a literacy level accessible to most duals. There should be physical accessibility to all plan providers and services. Comprehensive assessment should be built in so that they can learn and meet the needs of the enrollees. Plans should be able to show that their networks have adequate providers to serve the dually eligible population, both sufficient primary care providers as well as different specialists to meet the diverse needs of enrollees.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

CHA can contribute our experience from providing information to dual eligibles since 1997. One crucial period was when the Medicare prescription drug program became effective in January 2006. CHA played a major role in providing accurate and objective information to educate people about this new program and empower them to make informed decisions. The Medicare Part D program has different rules for dual eligibles: they are deemed eligible for and automatically enrolled in the Low Income Subsidy (or Extra Help) program; they are automatically enrolled in a Medicare Part D plan; and they have an ongoing Special Election Period to change plans throughout the year. CHA continues to communicate these different rules to the dually eligible population and also explaining the change from Medi-Cal prescription drug coverage to coverage under Medicare Part D. CHA also has experience and knowledge about Special Needs Plans for dual eligibles.

10. What concerns would need to be addressed prior to implementation?

Prior to implementation, pilot entities would need to undergo readiness reviews to ensure that they are ready to perform their contracted duties. Network adequacy, disability access, assessment tools and care coordination models, care transition policies are just a few of the elements that would need to be affirmed as in place and functioning properly before implementation.

11. How should the success of these pilots be evaluated, and over what timeframe?

There are many ways to evaluate and we recommend a combination of methods to collect quantitative and qualitative data to measure enrollee satisfaction, health outcomes, and cost savings.

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

CHA does not have expertise in this area and defer to experts in this area.