Comments on Draft Duals Demonstration Overview

We appreciate the opportunity to comment on the draft overview and the questions it raises. California's proposed pilot raises many complex issues. It is very helpful to have specific papers that explore the challenges for the pilots and to have them shared in a transparent manner. The focus of this paper on key questions is particularly useful.

Background and process overview.

We appreciate the overview section but wish to highlight a number of issues.

- The overview begins by stating that dual eligibles "consists" of the state's most chronically ill individuals. It would be more accurate to state that it "includes" this population. As the overview notes, the dual eligible population is heterogeneous and, although many are chronically ill, others are in relatively good health. A duals pilot should be able to accommodate the range of health needs.

- The overview also refers frequently to the fragmentation in the current system focusing specifically on the fee-for-service system, "where services can be scattered, medical records are not easily shared, and resources are unevenly distributed." It is important to note that these are all elements of many managed care plans and "organized systems" as well. In many cases, services provided through Medi-Cal's fee-for-service system provide the most coordinated experience for many of California's dual eligibles (for example, Adult Day Health Care Centers and Multipurpose Senior Services Program). Alternatively, many dual eligibles enrolled in Medicare or Medi-Cal managed care plans receive very little assistance coordinating their care and can face barriers to access the care they need.

- When designing new systems, it is important to support and build on existing programs that work, whether those systems are currently part of an organized system now or not. Many of the successful programs have developed over decades and have created and carefully nurtured networks that respond to local needs and utilize local resources. It is also important to think critically about whether systems described as organized care are designed to meet the unique needs of dual eligibles.

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- The document indicates that less than 15% of dual eligibles are enrolled in "organized care." It would be helpful to know how that term is defined and how many duals are in each type of "organized care" system.

- The reference in the footnote to "who qualify under Social Security" is confusing. Individuals under age 65 must have been entitled to Social Security for 24 months to be eligible for Medicare. Individuals over age 65 are Medicare eligible if they are a citizen or permanent resident. They will only qualify for premium free Part A if they or a spouse worked and paid Medicare taxes. Even if they do not qualify for premium free Part A, they are still Medicare eligible and many Medi-Cal beneficiaries are eligible for assistance paying their Part A premiums through the Qualified Medicare Beneficiary program.

California's Dual Demonstration

In the second to last bullet, it would be helpful to have more information or a discussion about the definition of 'full-risk-bearing.'

Regarding the last bullet, it is important to recognize that comprehensive consumer protections, particularly consumer direction, and oversight mechanisms are important to ensure quality as well as beneficiary choice, health and safety. In other words, beneficiary protections should be seen as a way to drive success and quality in design and implementation and not just as a way to prevent negative outcomes.

Key Questions: Goals

We appreciate that the paper recognizes that social needs, not just a medical model, are important components to a successful demonstration as well as the willingness to explore options for integrating home and community based services. We agree that the focus should be in creating a seamless experience for the beneficiary and would add that the experience should allow for the beneficiary to make decisions about how they receive their care.

We recommend adding a goal related to increasing the provision of home and community based services.

We understand the goal of creating one point of accountability, but note that, as the single state agency, the State is currently and will remain accountable for ensuring the delivery of all Medi-Cal covered services. Similarly, the Medicare program is and will remain responsible for providing Medicare covered services to dual eligibles. As the State and CMS contract with entities to provide services to dual eligibles, it's important that they play an active monitoring and oversight role and retain ultimate responsibility and accountability for meeting the needs of this population.

Key Question: Financing

We understand that it may be too early to have more detailed discussions about financing. We believe that this is an essential element of the integration demonstrations and one which will require significant, transparent discussion with stakeholders.

Key Question: Site Selection Process

Timing. Table 3 implies that the design proposal will be shared for public comment and then, presumably, submitted to CMS after sites have been selected. We recommend that the proposal be shared for comment and submitted to CMS before any sites are selected. Additional opportunity for public comment may also be useful after sites are selected.

If such an approach is not pursued, we ask that public disclosure of site selection criteria be complete and detailed. Also, that there be adequate time and opportunity for substantive responses by stakeholders and for DHCS to review and incorporate that input into the final criteria. The proposed November/December timeframe seems very compressed and we question whether that timetable will be sufficient for a genuine opportunity for stakeholder input.

Since the capitated approach outlined by CMS contemplates a three way contract between health plans, the State and CMS, we would like to learn more about how CMS will be involved in the development of site selection criteria and the actual site selection process.

RFS Proposal. We strongly object to the proposal to allow all entities "meeting or exceeding the high bar" of criteria to be considered for implementation. Doing so would fundamentally compromise the entire premise of the pilots. The pilots are meant to test entirely new delivery systems for dual eligibles, using new financial and care delivery models. This is a very complex undertaking fraught with both great promise and great risk. As pilots, these demonstration projects need to be carefully structured and rigorously evaluated, with lessons learned that will inform broader implementation.

We question whether the State has the capacity to adequately establish, assist, monitor and rigorously evaluate a large number of sites deploying a wide range of models. It is important to keep in mind that implementing the pilots will involve more than periodic evaluation and data collection. With a system that is new at every level, there will be a need to troubleshoot unexpected issues, including both systemic issues and issues affecting individual beneficiaries. Handling all these issues in a few, carefully selected sites in four counties will be a challenge; doing so with larger populations and more sites puts both the success of the project and the health needs of individuals at risk.

We prefer an approach that would utilize a traditional RFP process with entities competing for a set number of slots. We think the State should set clear goals for the types of models it wants to test and where it would like to test them. These goals should be developed with stakeholder input.

For example, the State may create two separate RFPs, one for entities proposing a capitated approach and another for those utilizing a fee-for-service approach. The RFP could provide options for how each model may work in two-plan versus COHS counties. The state could indicate that it will select a site or sites in a non-managed care county, a two-plan county, a COHS county and one other county.

Under such an approach, the focus should be on finding sites that bring experience and commitment to serving dual eligibles as well as an appreciation for the difficulty of moving towards a more integrated system. It is critical that at this stage only the best of the best programs participate and that the State be able to concentrate its limited human and financial resources on working closely with those programs on the many challenges that a unified funding stream and a highly complex beneficiary group demand.

Whatever the approach the State takes, it will be essential that State demand transparency, collaboration and cooperation between all selected sites. We do not believe the one approach is more or less likely to ensure these things.

We do not support the expansion of this demonstration beyond four counties, per SB 208. As stated above, this project will be testing new models for financing and delivering care to the highest need population in the state. The state must proceed cautiously, ensuring that new models actually improve care and create savings before expanding.

We support the proposal to limit participation to entities that have a Medi-Cal service contract. We do not believe that entities whose sole or primary experience with this population comes from delivering Medicare benefits are well suited to provide integrated home and community based and behavioral health services.

Key Question: Potential Demonstration Participants

Numbers. We encourage the state to not target the most popolated counties for the demonstration. As mentioned repeatedly above, the challenges of integration are significant and the potential benefits unproven. Models that have been successful in other parts of the country have started modestly. California should take a similar approach focusing on counties where local support exists and where new models can develop while serving a manageable number of new members.

Passive Enrollment. We have not seen evidence that, at this pilot stage, passive enrollment is either necessary or desirable.

These programs are pilots and, as such, unproven as to their benefits. Dual eligibles should not be placed into new programs just because they are poor and expensive to serve. They should have an opportunity to choose to participate. When and if these experiments prove successful, there will be time to consider whether an opt-out approach is appropriate. The focus now should be on building models that serve dual eligibles well.

Passive enrollment is antithetical to the concept of a beneficiary-centered program. Genuine affirmative beneficiary choice means using an opt-in process. Further, as has been seen with the mandatory enrollment of the SPD population, transitions for high need individuals who have well established networks serving their needs can be very disruptive. An opt-in approach would make it less likely that those individuals would be negatively affected and would make it more likely that individuals who join a pilot are those without satisfactory networks who would most benefit from an organized system of care.

Nationally, programs that are held out as models of care coordination, including PACE, have relied on voluntary opt-in enrollment and have found that enrollment model to be successful. They do not complain about excessive disenrollment rates.

The paper argues that "for the demonstration to move forward and be successful, adequate enrollment will be essential for ensuring the necessary care delivery investments are made and for establishing sound rates." The argument relates to the further claim that it is necessary to "ensure sufficient enrollment for adequate risk sharing." We note that during the RFI conference held in August, few if any plan representatives made this argument.

We are concerned that the driver for both opt-out enrollment and for expanding the populations in the pilots appears to be primarily actuarial. This stands the pilot on its head. The primary factor in designing every element of the pilot must be improvement in care delivery. That requires deliberate attention to the needs of each member and building the program around the members, which is necessarily an incremental process. This design around the needs of the members will not only bring better care but will also be the source of any savings that accrue from preventing unnecessary hospitalization or institutionalization. Moving too many people into programs too quickly decreases the potential for true person-centered care and thus the potential for savings from that care.

The rationale also seems to include an assumption that the more people enrolled, the greater will be the economies of scale. For the total health care delivery system proposed for the pilots, we question whether such an assumption is justified or supported by experience and data.

In discussing the assumed need for larger pools of beneficiaries in order to establish sound rates and provide adequate risk sharing, it is important to keep in mind that California has the largest population of dual eligibles in the country and that the duals population in large counties like Los Angeles or San Diego exceed the statewide duals populations of several other participants in the 15 state demonstrations. Many of these states are considering capitation and risk sharing with much smaller numbers. California should be able to as well.

To the extent that high enrollment numbers are necessary to support new models, the State should bear in mind the recent experience with the passive enrollment of ADHC members into managed care. That process demonstrated that passive enrollment may not be the best approach to take to ensuring enrollment as the majority of individuals opted-out.

If the state does pursue an passive enrollment approach, strong consumer protections related to the enrollment process must exist. In addition, stronger consumer protections will be necessary in areas such as network adequacy, assessments, transitions and more.

Appendix

The evaluation framework is a helpful piece and we are encouraged to see attention paid to evaluation early in the process.

As a preliminary matter, we ask that data collection methodologies always associate data, no matter the issue, with the age, English proficiency, disability, ethnicity, race, gender, and sexual identity of the individual so that it will be possible to review performance in each area of inquiry with all subgroups. If only aggregate data are used, it will not be possible to determine where there may be particular delivery or satisfaction issues peculiar to a particular group.

With respect to priorities, we believe Item II, Care coordination, is very important, particularly items 4-8. Also items III, IV and V.

Under Item I we recommend collecting data about how people enrolled (did they accept a passive enrollment or did they pick a plan for themselves?), why they enrolled and more. It would also be helpful to track how successful models were at helping dual eligibles retain Medi-Cal and Medicare eligibility.

Under Item II we would recommend adding a measure for tracking how successful models were at transitioning people out of long term care facilities.

Items V and VI both mention appeals and grievance processes, but in the context of efficiencies and timeliness. It also is very important to track appeals for information

on their number, the reasons for appeals, the percent of reversals, and consumer satisfaction with the appeals system.

Finally, it will important that evaluation of the demonstration account for variance between sites in their baselines. Some sites that will be selected are farther along than others in accomplishing the goals of the demonstration. A thorough evaluation that can be used to make recommendations for future expansions will need to indentify the degree to which success or failure was linked to the relative baseline of a given site.

Thank you for providing the opportunity to comment on the Demonstration Overview. Please contact Kevin Prindiville (kprindiville@nsclc.org) or Georgia Burke (gburke@nsclc.org) for more information about our comments.