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May 31, 2011

Kevin Morrill
Chief
Office of Medi-Cal Procurement
MS 4200
P.O. Box 997413
Sacramento, CA 95899-7413

**Re: Request for Information on Pilots for Dual Eligibles**

Dear Mr. Morrill,

On behalf of On Lok, I am submitting the enclosed response to the Department of Health Care Services' Request for Information on Pilots for Beneficiaries Dually Eligible for Medicare and Medi-Cal.

Please contact me if you have questions or need additional information. Thank you for your consideration.

Sincerely,

Robert Edmondson
Chief Executive Officer

May 31, 2011

**Re: Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare**

On Lok Senior Health Services respectfully submits this response to the Department of Health Services' (DHCS) Request for Information (RFI) on Pilots for Beneficiaries Dually Eligible for Medicare and Medi-Cal. As the national prototype for the Program of All-inclusive Care for the Elderly (PACE) model, we believe strongly in the benefits of integrated financing and care for beneficiaries who are dually eligible for Medi-Cal and Medicare. We believe DHCS' proposed pilot program for dual eligible presents an important opportunity to better serve beneficiaries and more effectively use Medicare and Medi-Cal funds.

We appreciate and want to underscore DHCS' recognition of the heterogeneity of the dual eligible population. For this reason, we believe it is critical that the demonstration test a variety of models that respond to diverse characteristics of sub-groups of beneficiaries that make up the dual eligible population.

PACE meets all the requirements of the request for information except that PACE does not serve beneficiaries who are younger than 55 years of age or those who are not eligible for a nursing home level of care. PACE is a proven model for older adults with multiple chronic medical conditions and functional impairments that benefits consumers, providers and payers. While PACE has expanded nationally, including development in rural areas and through partnerships with the Veterans Administration to serve veterans, it only serves a small proportion of those eligible in a limited number of areas of California. We believe the Dual Eligibles Pilot Projects is an opportunity to address barriers to PACE expansion and incorporate PACE as a critical part of the continuum for services for vulnerable populations.

## Response to Part 2 Questions

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

Dual eligible beneficiaries and their families need to receive full disclosure about the options available and the benefits of the different options, including integrated dual pilots when available. For those needing long-term supports and services, beneficiaries should have the ability to select specialized programs designed to meet their needs. While we understand it is desirable to have mandatory enrollment for Medi-Cal and passive enrollment with an opt-out for Medicare, we do not believe such a model should be put in place at this time. Passive enrollment during the implementation of Medicare Special Needs Plans for dual eligibles resulted in disruption of care and confusion for beneficiaries. Additional systems need to be put in place designed to facilitate education and appropriate enrollment for the

different sub-groups of the dual eligible population (e.g., uniform assessment instrument, single entry point for long term supports and services). Until systems are in place to fully inform beneficiaries of their choices including access to long-term supports and services, the best enrollment model for the pilot program is a voluntary enrollment model with no lock-in requirement similar to Medicare Advantage Special Needs Plans for dual eligibles and PACE. We also believe the experience with mandatory enrollment of Medi-Cal only seniors and people with disabilities must be evaluated.

2. **Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential in this program?**

   In addition to all medical services, a full continuum of long-term supports and services are needed to make this program successful, including:

   - care management and coordination
   - nursing services (in clinics, centers and beneficiaries' homes)
   - personal care services (in centers and beneficiaries' homes)
   - restorative and maintenance therapy services (physical, occupational and speech therapy services)
   - social work services
   - dietary services
   - homemaker and chore services
   - mental/behavioral health services (including substance abuse services)
   - podiatry, audiology and optometry services
   - dental services
   - transitional care
   - congregate and home delivered meals
   - non-emergency transportation and para-transit services
   - home modification
   - residential care
   - long-term custodial nursing home services
   - 24-hour non-emergency call services
   - respite services
   - durable medical equipment
   - palliative and end of life care

   We did not list specific programs since we wanted to focus on the services needed. In addition, the pilot program may result in the reconfiguration of some programs.

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

   In PACE, behavioral health services are fully integrated into the model of care. Based on our PACE experience, it is essential that behavioral health services be included in the integrated model to meet the needs of beneficiaries. Behavioral health issues often are co-morbid conditions that interact with medical and functional conditions.

   There should be flexibility in delivering behavioral health services in order to be responsive to beneficiary needs and the diversity of the population. Services could be delivered through a staff model where practitioners are hired by a health plan, sub-contracts with agencies specializing in these services and contracts with individual providers.

   It will be important to have a triage system which enables the identification and referral to these services. Recognizing that these services are currently carved-out from Medi-Cal health plans, a sub-contract with an existing mental health specialty plan may be appropriate.

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 contracts 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?**

   On Lok expects to continue to contract directly with the Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) as a fully-integrated PACE program. We believe it is very important to keep intact the current financing model for PACE programs and the direct enrollment process into PACE by beneficiaries. We believe there are opportunities for working with Dual Integration Pilot Projects to educate potentially eligible beneficiaries about the benefits of integrated care models and the option of selecting PACE. For areas where PACE currently does not exist, there should be no restriction on PACE expansion in the pilot counties for new or expanding PACE programs.

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

   It is essential that the model include all primary medical care, acute care, medical specialty services, drugs, and long-term services and supports (listed above). Of particular importance is a strong primary care component combined with care coordination and an integrated electronic health record. All traditional

Medicare and Medi-Cal services need to be included in the model as well as services currently provided under Medi-Cal waivers.

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

   A comprehensive education and outreach plan is needed that includes group community meetings, webinars for provider agencies and consumers, individual counseling through HICAP, area agencies on aging and Aging and Disability Resource Centers (ADRCs) and community organizations. If Health Care Options or another centralized entity is used for enrollment, it is critical that individuals receive training on issues specific to the sub-groups of the population and the available options. DHCS needs to develop and implement a plan for evaluating and tracking rates of beneficiary enrollment and disenrollment trends.

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

   We suggest that the following questions be included in the RFP:
   1. What experience have you had serving the dual eligible population?
   2. What experience do you have in providing integrated care including long-term supports and services?
   3. What is your experience in providing behavioral health services? How would you propose integrating behavioral health services?
   4. What is your process for assessing individual beneficiary needs and developing a comprehensive care plan?
   5. Do you have an Electronic Health Records (EHR) and data systems able to meet comprehensive reporting requirements?
   6. What's been your experience in the following areas: satisfaction surveys, complaints, quality improvement initiatives, results of state audits and reviews, and disenrollment trends?

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?**

   DHCS needs to require contractors to develop and implement a structured assessment process and mechanisms for identifying beneficiaries with different levels for services including those needing long-term supports and services.

   The pilot projects need to hire, and require sub-contractors to have, culturally and linguistically competent staff reflecting the different sub-groups served.

Translators and interpreters for languages not represented by staff must be available.

Because of the assumption of full risk, the pilot projects should be licensed as risk-bearing entities in California (e.g., Knox Keene, Department of Insurance or PACE providers).

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

   At a minimum, On Lok will continue to be a contractor with DHCS (and CMS) to operate a PACE program.

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

    We are concerned about the proposal to integrate Medicare and Medi-Cal funding streams at the state level. We strongly recommend that Medicare and Medi-Cal funding streams be integrated at the plan level. The Medicare HCC risk adjustment model has evolved over many years of development and should not be replaced. We are also concerned about DHCS ability to ensure adequate Medi-Cal rates given the state budget situation. Expecting significant savings with the pilot projects, particularly in the short run, is not realistic in our opinion since it will take time to develop new financing and care delivery models to serve this population.

    We are concerned that there will not be adequate resources available to educate beneficiaries about the choices available to them. Enrollment documents developed to implement mandatory enrollment for seniors and people with disabilities still do not include the option of selecting a PACE program even though beneficiaries may select PACE per state statute. It is critical that DHCS have the resources available to establish an educational system that provides complete and accurate information about options available to beneficiaries. We also believe a uniform assessment instrument and data reporting system is needed to collect comparable beneficiary information. Without this, it will be difficult to make comparisons among plans within a pilot county.

    We are concerned about the potential impact of large insurers with limited experience serving the diverse dual eligible population expanding too quickly to implement a pilot project. This could result in negative consequences for beneficiaries and network of safety net providers with a history of serving this population including PACE programs.

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

The success of the pilots should be measured based on agreed upon quality indicators specific to the different sub-groups in the dual eligible population served including clinical measures, consumer satisfaction, quality of life, comprehensive care plan, and incident reporting (e.g., pressure ulcers, falls, presence of advance directives, etc.). Desired outcomes of the pilots would be high consumer satisfaction rates, lower inpatient utilization, lower readmission rates, and improved access to community-based services. While lower overall cost is a desirable outcome, a more appropriate outcome may be lowering the rate of growth or "bending the cost curve." The evaluation timeframe should be long enough to determine the pilot project's success in preventing nursing home placement and in providing care at the end of life. Other factors that should be evaluated are the financial viability of the pilot projects and the satisfaction of providers participating in the pilots.

Since a goal of the four pilots is to develop models that can be expanded throughout the state, it is important to evaluate the feasibility of replication to other counties. What can be learned from the pilots that can be applied to other counties? In particular, what experience is applicable to rural areas of California? DHCS should consider selecting one pilot project that includes both urban and rural areas to test the feasibility in rural areas.

**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 DCHS on requiring specific approaches to rate-setting and risk?**

DHCS will need to set rates that encourage participation by contractors. Contractors should bear full financial risk for all services in order to align incentives, encourage prevention and reduce the institutional bias of the traditional fee-for-service system. In selecting possible pilots, DHCS should consider an entity's capacity to assume and manage full financial risk.