

SCAN Health Plan
Comments on
“California Duals Demonstration Overview”
Working Paper
November 4, 2011

SCAN Health Plan (“SCAN”) is pleased to provide our comments on the California Duals Demonstration working paper. SCAN Health Plan is the nation’s fourth largest not-for-profit Medicare Advantage plan. SCAN currently provides comprehensive, coordinated care to nearly 130,000 individuals, including nearly 8,000 individuals eligible for both Medicare and Medi-Cal in California. This experience has allowed SCAN to develop unique expertise in coordinating and managing the full range of services required by a dual eligible population, including long-term care and home and community-based services. As a result, over the years, SCAN has used its experience to further refine and develop its Model of Care, which has delayed or prevented approximately 100,000 nursing home admissions in California alone.

SCAN was founded in 1977 by a group of Long Beach senior citizen activists who were frustrated with a lack of access to appropriate services and who wanted to remain independent and living in the community. From its inception, SCAN has sought the most innovative and effective ways to care for, and to promote the independence of, older adults. An original participant in the Multi-Purpose Senior Services Provider (MSSP) program, SCAN now operates the largest site in California. SCAN also participated for more than two decades in Medicare’s Social HMO demonstration. SCAN is uniquely positioned to better coordinate comprehensive home and community based-services under the auspices of a public-private partnership.

General Comments

California’s dual eligible demonstration program provides an extraordinary opportunity to integrate care and services for dual eligibles. SCAN believes that the following principles will play a critical role in determining the demonstration’s success in improving the health and well-being of California’s dual eligibles:

- Qualifying plans should be allowed to contract directly with the State and with the federal government to serve as the Integrator of care for a duals population.
- Dual eligibles who are eligible for participation in the demonstration program should not be precluded from enrolling in (or continuing their enrollment in) plans that

currently operate under state contracts (such as PACE and SCAN). Furthermore, it is important that all dual eligibles are informed and educated about the availability of these plan options, and of the requirements for enrollment in these plans. Beneficiaries should be allowed to directly enroll without first opting out of their assigned health plan.

- A phased-in enrollment of beneficiaries is critical to ensuring a smooth transition of care for dual eligibles under the demonstration program. This will permit plans to develop the capacity to serve this population appropriately and to ensure sufficient time for credentialing and training of providers who have traditionally served dual eligibles but may be new to this system, including safety-net providers.
- Stakeholder, beneficiary, and caregiver outreach and education will be vital to affording a seamless and collaborative transition to this new care model.
- There should be a strong emphasis on establishing a fully seamless and unified system across the Medicare and Medi-Cal programs. This should include a minimum benefit package that reflects coordination between Medicare and Medi-Cal benefits; a single coordinated grievance and appeals system; and a single set of marketing guidelines to reduce confusion for demonstration participants and to lower administrative burdens and associated costs.
- The demonstration should include a set of published metrics. Participating plans would report publicly on this set of metrics annually, as well as on member satisfaction. Financing and incentives should support quality improvement and other performance goals and objectives.
- The integration of Medicare and Medi-Cal funding is critical to ensuring that participating plans have the flexibility to provide services to dual eligibles as needed, and to ensure the alignment of financial incentives within the demonstration program.

Goals

SCAN strongly supports the goals outlined in the working paper. SCAN believes that more effective integration of Medicare and Medi-Cal services for dual eligibles is critical to ensuring a seamless and unified system of care, to improving the quality of care for these beneficiaries, and to ensuring savings to both the State and federal governments under both programs.

SCAN supports the concept that one entity should coordinate care for the total needs of an individual, including medical care, behavioral health, social supports, and long term care services. It will be critically important that the Integrator of care combine actual experience

working with vulnerable populations with a receptivity to input from the State, counties, beneficiaries, providers, health plans, and advocates. Given the multiple and complex medical, behavioral, social, and other needs of the dual eligible population, as well as the immediate need to design the support system, SCAN envisions many examples of collaboration in which partners take responsibility for areas of their greatest acumen.

Program criteria for participating plans should include the following:

- Applicants must currently be operating a Medicare or Medi-Cal health plan in the State of California.
- Plans must have a proven track record of successfully caring for vulnerable populations, and must demonstrate their ability to provide participating dual eligibles with a system of care based on a patient-centered medical home.
- Plans must demonstrate their ability to operate multi-disciplinary care teams capable of meeting the full range of a beneficiary's needs (including medical, behavioral, social service, and long term services and supports services). Plans must offer an integrated medical and social service approach through this team and through care planning that involves the individual member; his or her caregiver or family (as appropriate); and other necessary and involved providers, such as physicians, nurses, social workers, and other health care and social service professionals.
- Plans must be prepared to provide home and community-based services for demonstration participants who are found to require such benefits. Plans should be able to bring home and community-based service organizations, such as adult day care, attendant care, home-delivered meals, home health, home maker, personal care, respite care, and home modifications, to the demonstration program.
- Plans must be able to provide behavioral health services to manage individuals living with cognitive disorders, mental illness, and other conditions in a medical home environment. This includes providing programs that support these individuals' efforts to remain in or return to the community from an institutional setting.
- Plans must be able to offer comprehensive management of high risk individuals, including providing programs and interventions that address improving care transitions, reducing preventable hospital readmissions, and medication management.
- Plans must have evidence-based care management programs that work with individuals to ensure care plan adherence, timely access to primary care physicians, and preventive health referrals; to improve self-management of chronic conditions; and to ensure medication reconciliation and referrals for community resources.
- Plans must have strong provider group relationships to enable a high degree of integration between medical and social supports. This includes supporting and encouraging providers to improve the quality of care provided through health

information technologies (HIT) investments, quality measurement and reporting, provider education, and payment incentives.

- Plans must demonstrate that they have the resources necessary to accept the financial risk associated with participation in the program.
- Plans must align financial incentives for providers to meet quality benchmarks and to have the ability to measure performance through sophisticated HIT systems.
- Plans must be willing to participate in evaluations of the program as required by the State and/or federal governments.

In establishing its criteria for participation, the State should distinguish which of the requirements a plan must have in place to participate versus what it will ultimately need to develop. This distinction will be important to plans as they work to develop the necessary infrastructure to accommodate care for this specialized population.

Financing

SCAN believes that dual eligible beneficiaries are best served through a system that integrates the financing of Medicare and Medi-Cal covered services through a capitated model. Under this model, participating plans would accept financial risk for providing all services under the demonstration program, and would fully integrate all Medi-Cal and Medicare Parts A, B, and D benefits. Importantly, this would signify that plans are not only at financial risk, but also that they have the flexibility to use covered and non-covered services, as appropriate, to divert or prevent the need for more costly services and to support individuals in the most appropriate setting. Being at financial risk encourages participating health plans to deliver the right care at the right time, thus preventing unnecessary emergency room utilization, re-hospitalizations, and other costly episodes of care.

SCAN envisions that the State will establish a capitated rate that would afford both the State and the federal government guaranteed levels of savings compared to historical fee-for-service expenditures associated with Medi-Cal and Medicare costs for the dual eligible population. Care management expenditures by the plans should be included in the medical cost calculation. In addition, the Department may want to consider other innovative approaches to rate development and setting that would provide financial incentives to health plans to promote quality outcomes and cost efficiency. These could include, but would not necessarily have to be limited to, bonuses for reaching specific quality or performance benchmarks or levels of savings.

SCAN believes that adequate and actuarially sound payment methodologies for participating health plans and health care providers will be critical to meeting beneficiaries' expectations for the demonstration. A well-designed, transparent, and actuarially sound payment methodology

that reflects the cost of caring for this complex population will help increase the likelihood of additional shared savings accruing to the State and to the federal government.

Should the State decide to require selected demonstration sites to engage in direct rate negotiation and to undergo readiness assessments, additional clarification should be provided to applicants on whether rate variation would exist among demonstration programs. Payment methodologies should not disadvantage one plan or population subset.

Site Selection Process

SCAN supports the concept that candidates for participation must first meet a “pass-fail” test as to whether they are capable of proceeding to the next round. As part of that contracting process, SCAN strongly urges the state to consider those plans that have demonstrated experience in providing integrated, comprehensive care for dual eligibles. One effective metric for demonstrating experience could be prioritizing those plans that have had state contracts as of 2009.

Criteria for participation in the demonstration program should provide dual eligibles, their caregivers and families, advocates, participating health plans, and others with assurance that the program will ensure uniformly high standards of quality and consumer protection.

All candidates that meet the initial benchmark should then be permitted to participate in the operations planning phase, where rate discussion and detailed readiness assessments will take place. Given their expertise, plans should be well qualified to help develop benchmarks for the program.

Finally, and perhaps most importantly, SCAN believes that any qualifying health plan should be able to contract directly with the State to serve as an Integrator.

Potential Demonstration Participants

SCAN believes that an optimal model of care for dual eligibles is based on improved care coordination and effective partnerships. Because a majority of California’s duals reside in just five counties – Los Angeles, Orange, San Bernardino, Santa Clara, and San Diego – the demonstration program might first target those counties in order to reach a significant number of the State’s dual eligible population.

To qualify as a participating health plan in the demonstration program, a plan should have the capacity to manage the health of all duals populations, including those patients with behavioral

health conditions. This not only guarantees that an enrollee’s health care needs will be fully-coordinated, but it also gives plans an incentive to identify any limitations that they might have, and to streamline efforts and create partnerships. Specifically, plans should endeavor to include existing safety net providers in their networks to the greatest degree possible. This will help to ensure continuity of care for dual eligibles who will participate in the demonstration.

The State should engage stakeholders in making these geographic and population determinations, and in building support for this initiative.

SCAN recommends that enrollment of dual eligibles into the demonstration programs be conducted in a phased-in manner. This approach will alleviate any potential capacity issues and ensure that plans are not overloaded with massive enrollment at one time.

The State should allow duals in the demonstration to opt out of their initial plan assignment. In addition, “intelligent assignment” of beneficiaries would ensure that each beneficiary is assigned to the plan that best meets his or her unique needs.

Evaluating Program Success

SCAN supports using enrollee satisfaction surveys, claims and encounter data, and enrollment data as sources of evaluation. In addition, we recommend using carefully designed audits and evaluations of plans with site visits utilizing published audit tools. Early audits should address how effectively the plan was able to implement the program requirements. Demonstration “learnings” reported by CMS consistently indicate that the early years of a demonstration are best evaluated by assessing implementation rather than outcomes, which may take 3-5 years to show positive results.

We believe that measurements and evaluations should be grouped into the following categories:

- *Consumer Satisfaction:* Most of these metrics can be obtained from CAHPS-type surveys of members. An additional measure might examine whether a beneficiary’s plan helped him or her to better manage his or her health.
- *Quality Metrics:* Many of these can be selected from existing HEDIS measures. However, careful attention should be paid to ensuring that the metrics selected reflect the unique characteristics of a dual eligible population. These include: the 30-day hospital readmission rate; selective preventive services; using appropriate hypertension medication for diabetics; medication adherence for patients with diabetes,

hypertension, and elevated cholesterol; and behavioral health care management services. Quality metrics should also be established for the long term services and supports benefits (e.g., the home care worker making regular visits and providing the agreed-upon care). Specifically, a measure should be added which addresses how frequently care plans are updated and approved by the member.

- *Utilization Metrics:* The measurement of services that reflect Medicare, Medi-Cal, and waiver services is critical to evaluating sufficient access and availability of these benefits, and to ensuring the financial success of the program for all stakeholders. These metrics should be linked to benchmarks recommended by a respected and objective third-party, such as Milliman. They should include: emergency room visits per member per month, primary care provider visits per member per year, hospital admissions for ambulatory sensitive conditions, the percentage of nursing home level of care (NFLOC) members discharged to their homes after nursing home stays, and long-term care facility admission rates. To facilitate useful comparisons across the Medicare and Medi-Cal programs, established metrics should compare demonstration enrollees with dual eligibles in fee-for-service. The State and CMS could consider providing plans with incentives to meet established benchmarks and to ensure the availability of high-quality care, much in the way that the Five-Star program does. This will require the underwriting philosophies of the federal and State agencies to be harmonized.

Conclusion

SCAN is pleased to have this opportunity to provide input on the structure of this important demonstration program. Our long history of serving frail and vulnerable seniors provides us with a unique perspective and experience on dual eligibles and how to best meet their medical, social, and long term care needs.

We firmly believe that a fully integrated system of care provides the greatest opportunity to achieve the varied goals and objectives of individual members, their caregivers and families, the State, and the federal government. California has unprecedented opportunity to reduce barriers to care for dual eligibles and to offer this population improved quality of care, greater flexibility in the use of the services for which they are eligible, and to streamline a very complex and fragmented health care system for our most vulnerable state residents.

SCAN looks forward to continuing to providing input on this process, and to participating in the demonstration program.