Center for Health Care Rights
ADVOCACY FOR HEALTH CARE CONSUMERS

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Comments on Draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

The Center for Health Care Rights (CHCR) submits these comments to DHCS' draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project.

The Center for Health Care Rights (CHCR) is a non-profit health care advocacy organization dedicated to improving consumer access to quality health care. As an integral part of this mission, CHCR provides Medicare advocacy and health insurance counseling services to Medicare beneficiaries and their families in Los Angeles County. Since 1985, CHCR has served as the Health Insurance Counseling and Advocacy Program contractor for the City and County of Los Angeles. As the HICAP contractor, CHCR is also the SHIP contractor for Los Angeles. CHCR also receives funding by the State Bar of California Legal Services Trust Fund Program to provide Medicare legal services to low income dual eligible Medicare/Medicaid beneficiaries.

The Center for Health Care Rights has significant experience with the dual eligible population in Los Angeles County. More than 25% of all dual eligibles in California reside in Los Angeles County. On a daily basis, our agency sees first hand the obstacles that dual eligibles encounter navigating the complex system of Medicare and Medicaid coverage. As the current data on dual eligible documents, dual eligibles are more likely to have multiple chronic conditions, suffer from mental illness and/or cognitive impairment, and reside in institutional settings. In addition, dual eligibles are also more likely to have low literacy and to have limited English proficiency.

These comments present our recommendations for key principles that should be used to develop and select effective Demonstration sites that will be able to provide the effective delivery of care to dual eligibles.

I. Demonstration Model Summary

Key Attributes

1. Demonstration Population:

The demonstration project should include individuals who have HIV/AIDS, End-Stage Renal Disease (ESRD), Amyotrophic Lateral Sclerosis (ALS), and individuals who have been institutionalized for more than 90 days, but only if participation for these individuals is purely voluntary. Because of the complexity of these situations, individuals who have one of these listed conditions or who are institutionalized should be not be locked into a demonstration project for any period of time or passively enrolled into the Demonstration. While we oppose both passive enrollment and a lock-in period for all dual eligibles, we would suggest that if these models are adopted, that duals with any of these listed conditions or who are institutionalized for more than 90 days be exempted from passive enrollment and any lock-in period. Instead we suggest they be offered the opportunity to voluntarily opt in to the Demonstration.

2. Enrollment:

We support a voluntary/"opt-in" enrollment model rather than a passive enrollment/"opt-out" model for the Demonstration sites. This allows beneficiaries to preserve the right to choose their providers and the manner in which they receive care. It also allows dual eligibles who have complex medical conditions to access providers they may not be able to under an integrated care model. In addition, given the mental health, cognitive health, literacy, and language access issues many dual eligibles face, an "opt-out" model may prove to be too difficult for them to navigate. Based on CHCR's experience with Medicare Part D and dual eligibles, which is essentially an "out-out" model, we find that duals undergo a very difficult transition from Medi-Cal drug coverage to Part D coverage. Many duals who are auto-assigned to a Part D plan do not realize there has been change in their drug coverage and that they have been auto-assigned to a Part D plan, and do not understand how to obtain drug coverage through their auto-assigned drug plan. In addition, many dual eligibles remain in auto-assigned plans that do not cover all their medications even though they are experiencing drug access issues because they do not understand how to change plans, and are only able to do so with outside assistance.

We have also seen numerous issues with the transition to mandatory managed care enrollment for Seniors and Persons with Disabilities (SPD) which uses a model that defaults SPDs into Medi-Cal managed care plans if they do not select a plan on their own. We have encountered numerous SPD beneficiaries who experience serious continuity of care issues because they have been defaulted into a plan they know little

about. We anticipate that if a passive enrollment model is adopted for the Demonstration that many dual eligibles will face similar problems.

Overall, passive enrollment models are too significant a change to be imposed on a large scale. If passive enrollment models are adopted, they should only be adopted after a phased-in process which results in quantifiable improvements to integrated and coordinated care for dual eligibles.

We also oppose any type of enrollment lock-in for duals in the Demonstration. Lock-in prevents beneficiaries from exercising the right to choose their providers and the manner in which they receive their health care. Imposing a lock-in period would also treat dual eligibles in the Demonstration differently than other dual eligibles who are entitled to a continuous Medicare Part D Special Enrollment Period (SEP) that provides them with the ability to change their Medicare Part D enrollment on a monthly basis. Dual eligibles enrolled in the Demonstration project should have all the same rights and protections afforded to other dual eligibles.

A passive enrollment model and a lock-in period are flawed methods of ensuring sufficient participation in the Demonstration project precisely because it takes away beneficiary choice. The best way to ensure sufficient participation in the Demonstration project is through an attractive benefits package and a robust provider network that provides a high quality of care, and strong care coordination.

The Draft RFS leaves a number of questions regarding enrollment issues unanswered that should be clarified in the final RFS. These include:

1. Which entity will be responsible for processing enrollments and disenrollments? Will DHCS, CMS, or the Demonstration sites be responsible for enrollments?

2. Will Health Care options be responsible for enrollments and disenrollments?

3. Will a separate entity be created to process enrollments and disenrollments?

4. Will dual eligibles who are already enrolled in Medicare Advantage plans be exempted from the Demonstration project?

3. Geographic Coverage:

We suggest that DHCS avoid selecting Demonstration sites in large counties like Los Angeles, San Diego and Alameda that do not operate under a County Organized Health System (COHS). Implementing a pilot project in large counties with extremely diverse and challenging dual eligible populations poses a number of issues for Demonstration sites. These large counties tend to be very geographically spread out and are more likely to have dual eligible beneficiaries with more complex medical

conditions and who speak multiple languages. The relatively short transition time when DHCS expects that individuals will be enrolled into the Demonstration sites in 2013, provides the selected sites with little time to adequately prepare for such large and complex populations. The level of integration proposed in the RFS does not exist in any current model. We would encourage DHCS to take a more gradual approach to developing the Demonstration by selecting counties with more manageable dual eligible populations. If a large county is selected, we would suggest that the Demonstration site only serve a discrete geographic area in that county based on zip code. We would also suggest that the Demonstration not be expanded to more than four counties at this time.

4. Integrated Financing:

An integrated financing model should not shift financial responsibility from Medi-Cal to Medicare for Medi-Cal covered services. An integrated financing model must include adequate incentives for plan participation and provide for competitive provider reimbursement to ensure that Demonstration sites will have robust provider networks and provide access to specialty services for such a high-need population. An integrated financing model should also provide incentives for providing participants with home and community based services that allow participants to remain safely in the community rather than entering an institutional setting. Savings achieved through an integrated financing model should be reinvested to expand the availability and quality of health care services and long-term care supports and services (LTSS). CMS and DHCS should require plans to collect and make available data measuring health outcomes, quality of care, consumer satisfaction and consumer complaints, and provide financial incentives to high-performing Demonstration sites.

5. Benefits:

The Demonstration model states that the sites will be responsible for providing enrollees with access to the full range of services to all Medicare C and D services and all State Plan benefits and services covered by Medi-Cal which includes the provision of long term care support sand services (LTSS).

The Center for Health Care Rights has direct experience with assisting dual eligibles obtain Medicare and Medi-Cal covered services within Medicare Advantage plans and Medi-Cal health plans. We frequently assist dual eligibles who are experiencing serious access to care problems because the plans or their contracting providers are not using Medicare and/or Medi-Cal guidelines to determine access to medical services. In addition, access to care problems frequently occur because decision making regarding access to medical services is delegated to the contracting IPA/medical group with little evidence of oversight by the plan.

Based on this experience, we ask DHCS to modify the demonstration model to require site plans to provide the following information:

1. How will sites insure the delivery of Medicare and Medi-Cal services if they delegate decision-making regarding access to services delegated to contracting IPA/medical groups? Will IPA/medical group denials be automatically reviewed by the site plan to insure that Medicare and Medi-Cal regulations and guidelines are being used to determine access to care?

2. With regard to providing access to Medi-Cal LTSS benefits, the site plans will work with IHSS, CBAS service providers, long term care facilities and MSSP providers to provide access to these services. Will the site plans primarily play a referral role to providing access to these services? What role, if any will site plan IPA contracting providers play in providing access to or coordinating these services?

3. Similarly, with regard to ensuring access to mental health and substance abuse services, what steps will the site plans take to insure that enrollees will obtain timely access to the most appropriate and mental health or substance abuse services, including those provided by County administered mental health agencies?

4. With regard to enrollee access to mental health, substance abuse and Medi-Cal LTSS, will site plans be required to take into consideration the enrollees past medical utilization in determining the appropriate linkage to needed services and maintaining continuity of care?

5. DHCS proposed to impose mandatory copayments on Medi-Cal beneficiaries. DHCS should clarify whether they intend for these copayments to apply to the Demonstration project. Because of the severe financial burden on dual eligibles, CHCR strongly opposes the imposition of any costsharing on beneficiaries enrolled in the Demonstration project outside of the appropriate Part D copayments.

6. Pharmacy Benefits:

The Demonstration model states that the sites will use Medicare Part D payment rules for pharmacy benefits. However, there is no discussion in the draft request regarding the coordination and provision of Medicare Part B or Medi-Cal pharmacy benefits. We ask DHCS to modify the draft document to provide explain whether Medicare Part B and Medi-Cal formulary, coverage guidelines and payment rules will also be integrated into the demonstration model.

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In addition, CHCR strongly recommends that the Demonstration model continue to use the current Medi-Cal formulary without limitations due to the integration of the Medicare Part B and D benefits into the model.

7. **IHSS:**

The draft Demonstration model summary states that site plans will be required to use state law process to for the first year and contract with local social service agencies, but that in subsequent years demonstration sites may be able to expand their role.

We ask DHCS to provide clarification regarding what is meant by role expansion.

8. **Behavioral Health:**

The draft Demonstration model states that sites must have a plan for full integration of behavioral health services by Jan. 2015 using an integrated capitated model. The integrated model must include incentives that promote shared accountability for coordination and set performance objectives.

We ask DHCS to modify the draft document to include a discussion of the checks and balances that the sites will use to promote shared accountability for coordination and the delivery of services to enrollees.

In addition, we ask DHCS to modify the draft Demonstration model to address how local County administered Department of Mental Health programs will be integrated into the Demonstration project services.

9. **Care Coordination:**

The draft Demonstration model states that sites must demonstrate that they have the capacity to provide care coordination to meet the complex medical and behavioral health and long term care needs of dual eligibles.

Based on our experience with dual eligibles in Medicare Advantage plans, simple evidence that plans have systems in place for care coordination does not provide any information on how the plans will evaluate and monitor the effectiveness of their care coordination systems and identify enrollees who may get lost in the care coordination system.

We ask that this section of the Demonstration model be modified to require sites to provide more detailed descriptions of how their care coordination systems will be monitored and evaluated to assess the effectiveness of the care coordination system.

For example, sites might use enrollee data on use of emergency room services, inpatient hospital stays, Adult Protective Services referral, to identify higher risk enrollees who may need more intensive care coordination services.

10. Supplemental Benefits:

The Demonstration model encourages sites to offer additional benefits to enrollees such as transportation, vision and dental care. We ask DHCS to consider the following questions in better defining the definition, scope and cost sharing for these supplemental benefits:

1. Will sites be permitted to charge copayments for supplemental benefits? If yes, will DHCS place any restrictions on beneficiary cost sharing.

2. Are there any limitations on the types of benefits that a site can propose?

In addition, this section states that sites are encouraged to contract with community based services to provide supplemental benefits. Although CHCR strongly supports the use of community based services, sites should not propose the use of these services as an alternative to delivering needed Medi-Cal LTSS services to enrollees.

11. Technology:

The Demonstration sites that include such technologies in their models such as home telehealth technologies (i.e. daily health vitals monitoring, medication optimization, care consultations), remote monitoring of activities of daily living and safety technologies must have proper training for staff, as well as proper training for the patients.

12. Beneficiary Notification:

With regard to the approval of outreach and marketing materials, we ask DHCS to require consumer/advocate input into the review of these materials.

The Demonstration model states that alternative forms of communication with enrollees are required. We ask DHCS to more clearly define these alternative forms of communication.

Proper notification will require a minimum of three letters mailed out prior to the date of enrollment and three phone calls to the beneficiary to ensure proper notification. Materials must be mailed out in the appropriate language or Braille, and calls must be made to hearing impaired with use of video conferencing. There must be

clarification as to the agency responsible for the notification and who is responsible for fielding calls once notification begins.

In May 2011, the State of California rolled out a mandatory managed care program for Medi-Cal only patients. The notification process included two phone calls and three mailings. Since May, we have received many calls from Medi-cal beneficiaries with questions about their change in coverage. CHCR noticed the communication from the state that prompted the most calls to our agency was a short, one page notification. Given the beneficiaries' response to the mandatory managed care program notification process, we ask that the site plans include a minimum of three written notices, at least one of which is a short one page notice that briefly explains passive enrollment process. The one page notice must include a 1-800 number for beneficiaries to call with questions. The sites plans should also make a minimum of three phone calls to the beneficiaries. Additionally, there must be a properly staffed call center to field the phone calls after the notification is sent out.

Further, if the beneficiary notification is sent out late because of system errors or other issues, the beneficiary's enrollment should be delayed in conjunction with the time notification is mailed out to ensure that enrollment is always six months from the date the notification is mailed out. During the implementation of mandatory Medi-Cal managed care enrollment for the SPD population, CHCR encountered a number of affected beneficiaries who did not receive notices in a timely manner. Consequently, the beneficiaries were not afforded sufficient time to make a selection on their own and were instead defaulted into a plan.

Lastly, the Demonstration model states that the Part D marketing requirements apply. We also ask that the Demonstration model be modified to state that these marketing standards apply to Medicare Part C and D benefits.

13. Appeals:

The Demonstration model states that a uniform appeal process will apply across Medicare and Medi-Cal benefits and will use Medicare model standards. First, we ask that the DHCS modify the model language to explicitly state that the expedited appeals process available within Medicare Part C and D will be available.

Second, the Demonstration model must require strict response/decision time frames that are enforced. (i.e. a decision to a claim request must be made within 48 hours in emergent situations.) Third, the beneficiaries should be informed **prior to** enrollment about the appeal process. Specifically, the appeal process should be described in the materials that are mailed prior to their enrollment in the Demonstration.

Fourth, all denials from the site plan must include specific instructions on how to appeal in the decision, including any prescription drug denials. Specifically, in the event

of a prescription drug denial, instructions should be provided to the beneficiary at the point of sale. Further, we ask for clarification as to the agency that will be conducting the independent review.

Lastly, Medicare provides beneficiaries with a complaint process in which complaints can be filed against Medicare Part C and D providers by contacting the 1-800 Medicare hotline. This complaint process provides an important mechanism for beneficiaries to seek relief when the plan internal complaint and appeal processes are not working. Moreover, the complaints are tracked by CMS through the Complaint Tracking Module (CTM) system, which provides CMS with an independent source of data regarding beneficiary complaints and plan compliance with Medicare requirements. To continue with this type complaint tracking system, CHCR asks DHCS to allow for a beneficiary complaint system that will be part of this demonstration project.

14. Network Adequacy:

CHCR understands that DHCS intends to follow Medicare standards for network adequacy for medical services and prescriptions, Medi-Cal standards for LTSS, and an "exceptions process" for areas where Medicare network standards may not reflect the number of dual eligible beneficiaries. CHCR asks DHCS to provide a more detailed discussion of the exception process that is recommended and a more explicit description of the Medicare network standards. This must be made clear prior to implementation in 2013.

15. Monitoring and Evaluation:

Although this section of the demonstration model states that "all sites will be required to participate in an evaluation process organized by DHCS and CMS", CHCR asks DHCS to explicitly state how frequently the sites will be monitored. Additionally, DHCS must clarify what will be the impact on site services if monitoring and evaluation activities result in sanctions or corrective action plans for site plans.

Further, DHCS and CMS should involve the stakeholders in the monitoring and evaluation process. The beneficiaries should be given written notification about how to file a complaint. Additionally, the repercussions for egregious violations committed by site plans should include plan suspension, fine and or termination of contract.

16. Quality Incentives:

The Demonstration model states that participating sites will not be eligible for Medicare star bonuses but will be subject to an increasing quality withhold.
We ask DHCS to clarify if the quality withhold is based on a Medicare Advantage quality incentive measure or on a state measure. In addition, we ask that quality incentives

that are used in this Demonstration project should incorporate consideration data on member satisfaction, the number of appeals filed by members and the number of complaints filed by members.

Additionally, we ask DHCS to clarify the measure used to determine quality care and also, who is monitoring the quality of the site plans.

17. Medical Loss Ratio:

The Demonstration model states that no minimum medical loss ratio is required. CHCR strongly recommends that DHCS adopt Medicare's Medicare Advantage plan requirement that plans must meet an 85% medical loss ratio.

18. Ongoing Stakeholder Involvement:

CHCR strongly supports DHCS's requirement of meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required. This should include regularly scheduled meetings and also more transparency into the operations of the site program, including site performance and timely access to the information.

CHCR also asks that consumers , advocates and other stakeholders also have access to information on site performance that is gathered by DHCS.

II. <u>Selection of Demonstration Sites</u>:

1. Qualifications:

Successful applicants for Demonstration sites should demonstrate the following experience:

1) Include a Medicare SNP plan with a Medicare star rating of 3.5+ or better. In addition, this SNP plan should have no record of Medicare non-compliance, sanctions, corrective action plans or other evidence of poor plan performance in the last 3 years.

2) All site plans should have strong HEDIS performance results.

3) NCOA or Medi-Cal plan accreditation.

4) Include plans that have strong performance track record as a Medi-Cal contractor.

5) Include the use of provider networks, medical groups, and IPAs that have no evidence of poor performance.

2. Current Medi-Cal Mangaged Care Plan:

CHCR recommends that applicants must have a current contract with DHCS to operate a Medi-cal Managed Care contract in the same county in CA as the proposed dual eligible site.

3. Integrity:

Any applicant that has had sanctions or penalties taken by Medicare or a California agency in the last three years should not qualify as an applicant.

CHCR asks DHCS to state in the request what impact Medicare sanctions or penalties will have on a demonstration site's eligibility to participate in the program.

4. County Support:

Letters of agreement should state clearly the working relationship between the county agency and the applicant. Evidence of contracts or formal agreements will provide stronger evidence of collaboration.

5. Stakeholder Involvement:

Successful site applicants must certify that they meet all of the stakeholder involvement criteria as outlined in the demonstration model.

6. Selection Methodology:

CHCR also asks DHCS to clearly state how the project application for each site will be graded and scored using a point system or other scoring methodology.

We thank you for the opportunity to submit comments the Draft RFS. We look forward to working with you to ensure that the Medicare and Medi-Cal programs provide high quality care and services to older adults and people with disabilities.

Sincerely,

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