Testimony of Mary K. Dewane
former Chief Executive Officer, CalOptima
before the CO-OP Advisory Committee

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Good Morning. Thank you for the opportunity to testify today. I appreciate the opportunity to share my experience, knowledge and insight from the start-up of a large public Medicaid managed care program, CalOptima, a program that shares certain characteristics with the Cooperatives (Co-Ops) and State Health Exchanges being developed under the Patient Protection and Affordable Care Act.

A. Background

CalOptima is the Medicaid managed care program that is administratively and financially responsible for providing Medicaid covered services to virtually all Medicaid eligible individuals residing in Orange County, California, a large urban county directly south of Los Angeles. CalOptima is a governmental entity that operates under a special designation known as a Health Insuring Organization (HIO), or more commonly known in California, as a County Organized Health System (COHS). Among other things, this designation denotes CalOptima as the single entity responsible for administering the Medicaid program in Orange County. More formally, CalOptima operates under a Medi-Cal (as Medicaid is known in California) managed care contract with the California Department of Health Care Services (DHCS). CalOptima's Board of Directors is appointed by the Orange County Board of Supervisors, but other than this, the program is independent of the County, and operates as a stand-alone independent managed health care entity.

Today, CalOptima serves approximately 350,000 Medicaid-eligible individuals, including the TANF population (largely pregnant women and families with children), seniors, persons living with disabilities and individuals residing in long term care settings including nursing facilities. In addition, CalOptima competes with other health plans in serving the Children's Health Insurance Program (CHIP – known as the Healthy Families Program in California) and dual eligible (persons eligible for both Medicare and Medi-Cal) populations in Orange County.

B. Features of the CalOptima Program and Application to the CO-OPs

There are some important features of the CalOptima program model that are relevant to the Co-Op model under development today that I would like to elaborate on a bit for you.

1. Service Delivery Model

For example, as originally designed and implemented, CalOptima operated under a rather unique health care delivery model. CalOptima contracted with at-risk Independent Physician Associations (IPAs) to provide the physician component of care, and at-risk hospitals to provide the hospital component of care (including DME and nursing home care). The IPAs and hospitals were required to have a risk-sharing agreement which would incentivize high quality low-cost care. While their contracts were with CalOptima, the IPAs were required to sign Memoranda of Understanding (MOUs) with each other ensuring that each entity (the physician and the hospital side) would work together to provide and coordinate covered services for the members. We called these entities "Physician/Hospital Consortia" (PHCs) or "health networks." CalOptima did contract directly with individual physicians and hospitals on a fee-for-service basis using the Medi-Cal fee schedule, but only for services provided to members prior to their selecting or being assigned to a PHC. This was usually for a period from 15 days to two months. But on an on-going basis, CalOptima required contracts with the IPAs and hospitals, which, in turn, through the PHCs, were responsible for ensuring an adequate provider network to provide covered services to their enrolled members. CalOptima did, however, conduct oversight and ensure that the PHCs met all the requirements of their contracts with CalOptima. These contracts, in turn, reflected all state and federal Medicaid managed care requirements.

2. Same Benefit Package Across Participating Plans

Also, the PHCs that contracted with CalOptima were required to provide all of their members with the same set of benefits. There was a pre-determined package of benefits for which all members were eligible, all contracted PHCs were required to provide and for which CalOptima paid the PHCs a capitated payment per member per month.

3. Enrollment into Health Networks Process

It is important to note that CalOptima was not responsible for the Medi-Cal eligibility determination process in Orange County. This responsibility remained with the State of California, in conjunction with local welfare offices. However, while not responsible for eligibility determination, once an individual was deemed eligible for Medi-Cal, CalOptima was responsible for informing new members about their PHC options and ensuring that they were enrolled in a PHC within a pre-determined timeframe. CalOptima developed and implemented a policy and procedure by which members who did not select a PHC were automatically assigned to a PHC because of the mandatory enrollment aspect of the program.

C. Key Implementation Issues and Challenges

There are a range of important and critical issues in the development and implementation of a public Medicaid managed care program. As your actions are directly related to an individual's receipt of often critical health care services, it is important that the program is well-developed and implemented prior to assuming responsibility for the provision of services.

Beyond this, there are a number of critical operational, financial and medical issues and challenges that need to be considered:

1. Information Systems

Information Systems (or Information Technology "IT") are critical to the operation of a complex health care program and must be given a very high priority. Information systems are central to running all aspects of the program, including enrollment, care coordination, financial systems, billing and payment, encounter data, member services and provider contract management.

Eligibility and Enrollment - CalOptima and its PHCs needed to know who was eligible for services and during what timeframe. This was important for providing services and of course, billing for services provided. Co-Ops will likely need the capacity to track and monitor the eligibility of individuals and their enrollment and enrollment choices over time (at CalOptima we also tracked members' primary care physician choices, etc.). Additionally, there are other entities with which a Co-Op may need to communicate with regularly and share data and information. For example, in addition to receiving eligibility information from tax or other entities, I imagine that Co-Ops will need to communicate eligibility and enrollment information to contracted medical groups, health plans, networks and/or physicians. Additionally, there are other entities that may require information, such as Pharmacy Benefits Managers (PBMs), who may be involved with managing pharmacy services for Co-Op participants and other types of providers or vendors who will need to be aware who is eligible and for what services.

Medical Management - In order to appropriately coordinate the care of its members, the Co-Ops may need to receive information from physicians and hospitals and other care providers about the health status of its members, so appropriate interventions and follow-up care may occur. Utilization and quality management systems rely on eligibility and member specific data essential to care coordination. Information systems are also used to help with the management of members' care and services, through case management, disease management and similar information systems that are capable of identifying high-risk patients, stratifying patients according to risk, helping to monitor their progress or other aspects of their care and/or condition.

Financial Management - The Co-Ops will also likely need to support all financial and payment systems, including tracking all premiums, copayment, deductibles etc. Finally, a Co-Op will need to interface with the Department of Treasury in

order to receive payments for members eligible for tax credits, which is a new information sharing function for the Co-Ops and the Treasury.

While there are excellent IT systems on the market that are capable of performing these functions, the business decisions determining how these systems will function are made by people in the health plan that will use them. Whether these types of systems are available "off the shelf" or not is one thing, but in addition and regardless of whether they are "bought" or "built," it all takes time to develop and implement – an issue for a Co-Op, especially one just starting up.

2. Human Resources

Staffing is another important area that I would like to bring to your attention as you think about the development of the Co-Ops. At CalOptima, we had policy and operations staff, all of whom were critical to the design, development and operations of the program. I would like to make a few points regarding HR issues.

Board of Directors – Assuming the Co-Ops will operate under a Board of Directors, the skill set of the program's Board of Directors is also very important. CalOptima's Board consisted of designated seats – including a member of the county board of supervisors, two physicians, a hospital administrator and consumers – all of whom were active and well-respected members of the community in general and their profession. Most had strong financial and managed care backgrounds and additionally could help the health plan politically locally. They understood their role as a board member and understood the role of staff. They were essential in ensuring the viability of CalOptima, providing helpful and constructive input in the program design and operations and facilitating the success of the program within the community and state.

Staffing -- Hiring the right people is important for any business. Start-up situations are complex, in part, because of the intersection between bringing up an organization, bringing on staff and starting or anticipating business operations. Timing of hiring staff is critical and important.

Hiring staff brings up the additional critical issue of adequate funding and access to initial and ongoing revenues to support program operations – especially in the time period before there is an established revenue stream from premiums, capitation payments or the like. It can be difficult to attract and keep good staff if the organization does not appear to be on solid financial footing.

The skill set needed for staff in a start-up mode may be a bit different than the kinds of skills needed for on-going operations. Many decisions need to be made very quickly. Timelines are critical. The individual cannot be afraid to make decisions or mistakes. Mistakes must be recognized quickly and fixed. There is no time to dwell on the perfect.

3. Financing and Early Administrative Issues

Financing is another critical issue for a start-up organization. CalOptima's start-up funds were provided by the local hospitals and physicians, and Kaiser Permanente, whose goal was to set up a health plan that would organize the care locally and establish medical homes for the Medi-Cal members in Orange County.

While I understand that there will be loans available to support the start-up and insurance requirements of the Co-Ops, it is not as clear that they will have a reliable source of funding after the start-up period. CalOptima was designed to serve almost all the Medi-Cal beneficiaries in Orange County on a mandatory basis. Therefore, when we started operations in October, 1995, we immediately received capitation payments for almost 200,000 members, and three months later, another 60,000 members. While the sheer numbers of enrollees created other operational issues, we did have a significant revenue stream to support on-going operations.

The Co-Ops need to be financed appropriately for both the start-up period and for the operations period. If there are delays in start-up, or if the Co-Ops do not attract sufficient numbers of enrollees based on their budgeted estimates,

there will be serious financial issues and Co-Op failures. It is very important that a great deal of thought be given to these issues and that everyone is realistic about the abilities of the exchanges and the Co-Ops to perform.

Consumer and Marketing Issues – Without mandatory enrollment, marketing and sales will be a critical issue which will enable Co-Ops to achieve critical mass of enrollment. Co-Ops need to identify revenue sources for funding of this effort before enrollment begins. Outreach and education of affected consumers are very important. For the Medi-Cal population, we recognized the cultural and linguistic diversity of the population served and the different ways different people receive and take in information. It is also important to recognize those who influence or educate (secondarily) affected populations. For example, social service workers, cultural centers, physicians and office staff are often sources of information to populations who are new to a program.

If individuals have a relationship with a physician they are inclined to want to stay with that physician. At time same time, with changes in the way health care is organized, physicians are very concerned that they will lose their patients. When we began enrolling Medi-Cal beneficiaries in our PHC networks, we found this relationship to be very helpful in maintaining continuity or care. It was also very helpful to our PHC health networks in getting market share and maintaining viability in a changing market. This can be a tool for the Co-Ops. Recruiting physicians can be a powerful source for gaining enrollment later on.

Coordination with Governmental Agencies - During the start-up phase CalOptima worked closely with the State of California's Department of Health Care Services (DHCS). DHCS was CalOptima's regulator, but also our partner – particularly during the start-up phase. DHCS was extremely helpful to us in ensuring that all aspects of the health plan and our systems interfaced appropriately with the State and would be operational on Day One. It was imperative that the health care of our members not be interrupted as some percentage are in the active course of care and/or treatment at any given time. As such, all parties must have a thorough understanding of the requirements and the needs of the members and the program more broadly. Constant and constructive dialogue is important. I understand that the Co-Ops may have to coordinate with more that one governmental entity, which will make communication more complex between and among the entities. Constant and constructive dialogue is important for successful program implementation.

Provider Network Development and Contracting Issues – Ensuring that there are sufficient providers to meet the needs of the population served are critical. CalOptima had sufficient numbers of primary care providers and most specialists, but had difficulty meeting the State's timeliness requirements (an appointment within 45 days of request) for certain pediatric subspecialists. To address this problem, we developed special contracts which included enhanced reimbursement for the physician groups working with the local children's hospital and the university hospital on behalf of our PHCs, and also paid for their recruitment efforts for additional subspecialists. Medicaid has specific guidelines and requirements which we were required to follow and our RFPs and contracts were focused on meeting these requirements.

Provider contracting efforts take time. The contracting process requires that a range of issues be worked out in advance and across providers. In addition to payment issues, it is important that providers are informed and educated about how the program will operate and what that means for the services they provide to their patients. Moreover, providers need to be familiar with any reporting requirements, such as encounter data, care coordination issues, prior authorization, encounter data, and etc. Depending on the model, there may be a need to spend time on the street, meeting with and developing contracts with individual providers or groups of providers. Executing contracts takes time as well, especially with significant volumes of providers. The contracts you develop tie back to your information system. They must be accurate and managed well initially and overtime. They must be kept current and accurate. It is a very dynamic process – one that is critically important at start-up, but that does not stop with start-up.

CalOptima chose a very unique approach to contracting for services for most of our members. As stated previously, we created this model called "PHCs." We developed an RFP that included requirements for interested parties to come together and form the PHCs. Initially we allowed any PHC which met our requirements to participate because we wanted to give all the groups of physicians and hospitals an opportunity and because we wanted to attract a broad base of providers. However, many of the PHCs we contracted with did not reach a critical mass of enrollment sufficient to remain financially viable and consolidated with other health care networks.

Medical Management - Co-Ops will need to have a clinical management focus to ensure that members are receiving timely care in appropriate settings. Co-Ops will need to hire a disciplined Medical Director to oversee management of members across the continuum of care. He/she should be experienced in cross provider management problems, and clinical management systems to coordinate care and detect high need, high cost patients. High cost members are a relatively small subset of a population. For example, the last health care company I worked for found that 2 percent of the population of a commercial customer drove 50 percent of the costs. However, it can be difficult during start-up to identify who these high cost members are. At CalOptima we used a health survey questionnaire that was mailed to members to fill out and return. The response rate was about 30 percent for the TANF population and 60 percent for seniors and persons with disabilities. These surveys were sent to our contracted PHCs once members enrolled. Additionally we were able to use pharmacy data uploaded form the State to identify patients with certain at-risk conditions, such as diabetes, chronic and obstructive pulmonary disease (COPD), hypertension, congestive health failure (CHF), etc. and pass this information on to PHCs as well.

Financial Management Issues – To ensure the viability of the Co-Ops, the Exchanges will need to hire qualified actuaries to set rates paid to health plans. Most importantly, the rates need to be risk-adjusted so that the dollars follow the members. Many times high cost patients gravitate to a certain health plan because of provider networks and/or programs available at the health plans, such as centers of excellence, university or children's hospitals. The Exchanges need to take these factors into account or certain health plans and Co-Ops will not be able to survive. For example, at CalOptima we found that two health plans had many of the high cost patients.

Anticipate higher front-end costs for persons who were uninsured prior to coverage. Experience has shown that people with delay care that is medically necessary but not emergent. For example, these would include surgeries such as hernia repair, back surgery, hysterectomies, joint replacements, etc.

Other financial management issues that require close attention during start-up is creating the business requirements to track services incurred but not reported (IBNR), collect and track enrollment premiums and payments, and tax credits. The claims processing system needs to accurately reflect the benefit package and have the ability to take into consideration the co-pays and deductibles. Once again, a robust information system is needed to support all these essential elements to manage the financial aspects of the Co-Op, as well as qualified staff who know what they are doing.

D. Summary and Key Recommendations for Co-Ops

In summary, I would like to walk through some recommendations I would have for Co-Ops based on my experience with CalOptima. These are the following:

1) Plan for start-up and implementation - Start-up and implementation period requires specific attention. Key components of the plan should include a start-up budget with expenses and the revenues necessary for the start-up period and to get the program to implementation.

2) Timeline – Develop a realistic timeframe for implementation. Start with the date of implementation of the program and, working backward, calculate the time necessary to develop critical aspects of the program, such as identifying, procuring and programming necessary Information Systems, contracting with providers, developing care coordination systems, outreach to local stakeholders, etc. If there are slippages, there needs to be the ability to implement back-up/alternative plans right away.

3) Information Technology - IT will be the backbone of the Co-Op. Select your contractor carefully. Make sure they are experienced. Talk to HMOs that use the vendor and get their honest assessment of its ability to deliver what they promise. Find out what the company's capacity is to add additional Co-Ops and what other new business they are contemplating. IT support is critical during the development and start-up phase of operations. The Co-Op will need the undivided attention of the IT vendor during this critical period. (On the "buy or build" argument, I would lean toward the do not try to build your own system).

4) Staffing – It is very important to hire a qualified human resources director. In general, hire experienced staff with initiative. Key staff must work independently, know what needs to be done and do it. In certain cases, consider using qualified consultants in lieu of staff to keep costs down during start-up.

5) Financial Systems – During start-up the most important aspect of finance is strong actuarial support, the development of business requirements to set up the necessary information systems to support the financial elements of the Co-Op, and budget development.

6) Medical Management – During start-up, medical management's most important functions are to establish business requirements for IT that will support care management, including utilization and quality management, contract with a qualified pharmacy benefits manager, and establish behavioral health programs.

7) Provider Services – decide on an approach to contracting as soon as possible, develop provider contracts that comply with State standards, work with finance to establish reimbursement levels to contractors for services and execute contracts.

8) Member Services – Keep staffing to a minimum until the "go-live" date. Focus on the development of members' services manual and other member services materials, policy and procedures and training materials for member services staff, and member services business requirements for IT.

9) All Departments – Document and develop uniform standards for writing policies and procedures for the Co-Op.

10) Inherent Limits on Resources – Under the proposed legislation, Exchanges and Co-Ops are scheduled to start up at approximately the same time. This will put a strain on the Co-Ops' ability to find qualified staff, as well as their ability to contract with qualified IT venders and consultants. While there are provisions in statute for collective purchasing agreements which can resolve some of the scalability issues facing Co-Ops, Federal Government and State Exchanges can help Co-Ops by funding and organizing work groups where staff from the Co-Ops can come together on a periodic basis to share experiences and hear from experts. In addition, the Federal Government could contract with consultants to address issues common to all Co-Ops and assist individual Co-Ops on an ad hoc basis.

As a footnote, it is worth noting that there is an alternative to building all this infrastructure with its significant cost (millions of dollars) and time. There is a mature administrative services infrastructure that contracts with employers and provider- sponsored health plans to provide most of the services needed to run a Co-Op. Major insurers such as Aetna, United, and other Administrative Services Organizations (ASOs) companies, provide the services needed to run a Co-Op. The Co-Op could then hire a small staff and contract with an ASO for operations functions. See Attachment 1 for a listing of administrative services that can be considered for inclusion in an ASO contract.

Thank you this opportunity and I would be happy to answer any questions.

Administrative Service Responsibility

Function*	ASO Vendor Responsibilities	CO-OP Responsibilities
Medical Management		
• Utilization Management		
• Case Management (prior authorization, concurrent review, retrospective review)		
• Disease Management		
• Pharmacy Benefits Management (PBM)		
• Health Education & Training		
• Behavioral Health Management		
• Quality Management/Outcome Monitoring		
Operations/MMIS		
• Provider Network Services		
• Member Services		
• Compliance Management		
• Information Technology		
• Predictive Modeling/Data Analysis		
• Key Indicator Reporting		
Financial Management		
• Financial Reporting		
• Actuarial Analysis		
• Claims Payment		
• Trend Analysis		
• Decision Support Systems		
Claims Payment		
Pharmacy Benefits Management		
Coordination with ASO, FI, and PBM		
Overall Program Management		

*Individual functions listed may include multiple activities within each function.