October 28, 2011

Peter Harbage
Harbage Consulting
Sent Via email: info@calduals.org

Re: Molina Healthcare of California Responses to Framework Documents

Dear Mr. Harbage: Peter

Thank you for the opportunity to comment on the Dual Eligible Integration Framework Documents. The Framework Documents provide important insight into the state's thinking around the dual eligible population.

As the eighth largest Medicare Special Needs Plan in the nation, Molina Healthcare knows first-hand the broad spectrum of care required for individuals dually eligible for both Medicare and Medicaid services. In California, Molina Healthcare currently provides these services to 6,000 individuals. The dual integration pilots represent a clinical and financial opportunity to provide a comprehensive set of benefits in a more cost-effective manner.

Comments on General Framework

Consistent with the CMS letter entitled "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," Molina emphasizes that these pilots are seeking to not only coordinate, but integrate, services. In fact, CMS stated in its letter that it seeks to expand access to "seamless, integrated programs," meaning that the goal is to incorporate multiple programs into one—not just coordinate access to—all clinical and behavioral services, long-term care supports and services (including home and community-based services), administrative and appeal functions, oversight, monitoring and funding. It will only be possible for health plans and providers in the pilot to coordinate care if the two programs, benefits, and administrative functions are integrated.

Molina suggests that a specific framework and process be developed for interested providers/health plans to talk about the administrative and network issues that will need to be addressed before the pilot programs begin enrollment. For example, health plans and providers will need to understand and work through issues with monitoring and quality measures; utilization and cost data; rates; appeals and grievances; and other provider-specific issues. Just as plans will be participating in the other areas of policy development, consumer advocates should be invited to this provider-specific discussion.

Long-Term Care Coordination

Consumer Choice:

Molina supports a patient-centric care model. The dual pilots will provide an opportunity for the most medically-complicated population to benefit from an integrated system that provides a range of medical, behavioral, and social services. Choice of plan, provider, and service delivery will be important for these beneficiaries. Keeping choice in mind:

- More information is needed about the Department's plans for dual eligibles already residing in skilled nursing facilities. Specifically, whether it intends to transition this population back to the community, and whether it views individuals living in group homes, residential care facilities for the elderly (RCFE), intermediate care facilities (IFC-DD, ICF-BH), congregate living facilities (CLF) or other type of similar setting as "institutionalized." Stakeholders need further clarification on the Department's goals for this difficult & fragile population. We believe that there are some populations in long term care facilities for whom a successful transition will be extremely challenging, but would benefit significantly from better management in the long term. We should fully understand the clinical issues before effectuating a phased-in transition.

- Consumers should be allowed to choose their health care providers (consistent with the plans' networks and processes for seeking out-of-network care).

- Consumers have the right to opt out of the assigned plans; individuals choosing to opt out should be required to either choose another plan or be enrolled in the managed FFS option in order to provide some care coordination.

Access to services:

Molina has been providing services to low-income Californians for over 30 years. While the dual pilot programs are designed to provide the most appropriate care in the most cost-effective setting, Medi-Cal does not currently cover some of the most cost-effective services, such as adult day health care, respite, home modification, and meal delivery. How will the Department authorize services that are not on the list of approved Medi-Cal benefits? We assume that in line with previous Medi-Cal policy decisions, plans will be allowed to provide these services regardless of available funding, but ideally, a blended rate should reflect all or a portion of these costs.

Oversight and monitoring:

Providing adequate and appropriate benefits will ensure that individuals are kept in the community for as long as possible. However, if plans are not provided an actuarially appropriate rate, they will be unable to provide the full range of services required, and there will be new uncompensated care costs, further exacerbating the county-state-federal cost-shift. The cost shift will continue to occur if the programs are not fully integrated and the state is unable to capture Medicare savings. The best way to integrate the programs is to require health plans to manage full-risk contracts, provide appropriate rates, and establish strict but achievable quality and consumer satisfaction standards that ensure plan accountability to members, the state, and CMS.

For purposes of oversight and monitoring for in-home care, Molina supports the inclusion of IHSS-services in the dual pilots, especially because a relatively high proportion of the current beneficiaries are duals and it makes no sense to disrupt their current care. However, the quality and utilization of these services needs to be better defined so Molina can incorporate the providers, payments and authorization of service hours into its clinical care model. Molina needs to have some ability to understand and account for hours provided, as well as include these costs in an appropriate rate structure.

Workforce training:

Molina recognizes that retaining and using all levels of providers will best address the needs of this medically-fragile population. There are very few training programs available to IHSS workers now, but there should be opportunities for training if IHSS workers so desire or if needed. Training should be available to help workers know basics of clinical issues—such as signs of dehydration, hygiene, importance of medication management, and what to ask doctors at appointments, as well as administrative issues—such as what numbers to call for different problems, which doctor to call for various issues, the importance of making appointments, and the importance of working collaboratively with health plans. Demonstration project participants should develop policies to work closely with IHSS workers, and establish communication as early as possible upon member enrollment in the program, and during important stages of health care delivery, such as discharge from a hospital. Also, demonstration project participants should get consent from beneficiaries to work with IHSS worker to deal with appointments, as early as possible upon enrollment.

The opportunity for training is an important aspect of ensuring a high quality of care delivery for our most vulnerable. Molina is interested in helping to pursue curriculum and training programs for dual enrollees for IHSS workers who would like to receive training.

Consumer Protections

Molina supports, and successfully implemented, the consumer protections for the mandatory enrollment of seniors and persons with disabilities (SPD) into Medi-Cal beginning June 1, 2011. The framework that was developed included important readiness standards such as:

- Clear and appropriate notification for beneficiaries
- Cultural awareness and sensitivity training for state employees and plans/providers
- Identification of members that are "higher risk" and have complex health needs
- Provider training
- Facility site review tools
- Sanction policies for failure to meet performance standards
- Continuity of care provisions and specialty providers serving as PCPs
- Communication in alternative formats
- Out-of-network provider access under specified fee and quality standards
- Performance measures and appropriate data collection
- Medical and financial audit reviews
- Assessment of provider network adequacy
- Clear, timely, and fair processes for complaints, grievances, and disenrollment requests
- Stakeholder and member participation on advisory bodies
- Contracting with safety-net and traditional providers
- Maintaining a dedicated liaison for developmental and regional centers in California
- Assessments of all enrollees within specified timeframes, depending on their current health risk

Molina believes that the fundamental consumer protections have been created and are actively in use in California for the SPD population. This framework should be extended to the dual eligible population with slight modifications to accommodate the comprehensive Medicare and Medicaid benefits that have not previously been integrated (e.g., home health, respite, meal delivery, behavioral health, etc.).

Beneficiary control and choice:

Molina supports a passive enrollment of dual eligibles into the pilot programs with an opt-out. The opt-out provision should require the person to choose another plan or to enroll in a managed FFS model. This would ensure that individuals receive the benefit of some care coordination.

Comprehensive benefit design:

Molina supports a comprehensive benefit design in an integrated setting. Consistent with the CMS letter, Molina will participate in a pilot program "to develop, test and validate fully integrated delivery system and care coordination models that can be replicated." The system must be fully integrated before the care can be coordinated. The dual pilot programs in California must give the responsibility for beneficiary care to an entity with appropriate oversight and monitoring. Members should also have an integrated ID card that helps them easily access their health care benefits.

Responsive appeals process:

Molina strongly supports and urges the Department and CMS to provide greater detail on the administrative simplification for these pilots so system changes can be made. A single process for beneficiary notifications, complaints, appeals, and grievances will be critical to an integrated care model.

Transition rights to avoid care disruptions:

Molina supports the process currently required for the SPD population in California. This includes: (1) allowing the beneficiary to request a specialist or clinic as a primary care provider as long as the provider agrees to serve in the PCP role and is qualified to treat the range of conditions of the beneficiary; (2) providing access to out-of-network providers for 12 months for new members who have ongoing relationships with providers, so long as the providers accept the plans' rates or fee-for-service rates (Medi-Cal rate for Medi-Cal benefits; Medicare rate for Medicare benefits) and meet applicable professional standards; and (3) allowing for appropriate medical exemptions when necessary for a member's health.

Meaningful notice:

Molina supports providing beneficiaries with timely information that clearly describes the transition and encourages members to select a health plan. These notices should be available in alternative formats to ensure that individuals with disabilities are able to access information in the format best suited for their individual needs. Molina encourages the Department to share a list of these administrative notices as soon as possible so stakeholders can review the items that will require coordination between Medicare and Medicaid rules and provide feedback. Additionally, community meetings, co-hosted by demonstration project participants and providers, could be helpful in getting information out to the community that will be affected by the transition. Similar meetings were held for the SPD transition; however, with long-term planning and thoughtful discussion before the meetings, the effectiveness of the meetings will be enhanced.

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Oversight and monitoring:

The Department's monthly monitoring and oversight for SPD enrollment should be a model for the dual pilots.

Appropriate and accessible:

Molina fully embraced the facility site review tools and ensured that its clinics were accessible to individuals with disabilities. We renovated at least one clinic in each of our service areas, installing height adjustable exam tables, wheelchair accessible weight scales, Hoyer lifts and lowered reception counters. The dual pilot programs should use readiness review standards and metrics for ensuring access that are similar to the SPD facility site review tool.

Phased-in approach:

Molina supports a phased approach as long as enough beneficiaries are enrolled in the pilot programs to justify the necessary and appropriate infrastructure investments and network development.

Mental Health and Substance Use

Molina supports the inclusion of behavioral health services in the dual pilot programs in order to provide comprehensive services in a seamless and integrated manner for individuals with mental illness or substance use treatment needs. With over 40% of dual eligibles having at least one mental or cognitive impairment and 60% of dual eligibles having multiple chronic conditions, behavioral health treatment will be critical to the overall success of the program.

Molina has experience in behavioral health integration; in our clinics in California we have hired full time social workers to better coordinate medical and behavioral support services, and through a demonstration site in Everett, Washington. Molina opened Molina Medical at Compass Health in February 2010 and is delivering primary care on the premises of Compass Health to individuals with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). This successful integrated approach is based on a multidisciplinary strategy to provide coordinated care to individuals with SMI by locating primary care and behavioral health teams on a single campus. Co-location maximizes communication and collaboration between the primary care and behavioral health teams, and provides easy and convenient access for the beneficiary.

General Approach:

Both Medicare and Medi-Cal provide coverage and funding for specified modalities of behavioral health treatment. The dual pilot program will allow regions in California to build systems of care that integrate services performed by community providers. Given the increasing difficulty in providing timely access to mental health providers, this will be an important network to develop and maintain.

Care Management:

Molina would like to better understand how a reimbursement structure would support services on a "recovery trajectory" rather than a narrow medical model. This seems to imply that providers would be paid a bundled rate or some type of payment based on reaching specific treatment goals. While this concept has merit in certain instances, there are other patients with serious and persistent mental illness that will not have a "recovery trajectory," but will benefit from care coordination and medication management. This may be measured through a reduction in emergency room utilization or inpatient admission for psychiatric episodes. The concept of "recovery trajectory" should include these types of metrics—they correlate with better health and cost-effectiveness, but may not result in complete or even partial "recovery" from illness.

Molina supports a team-based approach as noted above, but would willingly use contracting providers through telemedicine and e-referrals for patients in areas without immediate access to local providers.

Adequate screening and links to services:

As noted, both Medicare and Medi-Cal provide coverage for mental health and substance abuse treatment. DHCS should provide a list of Medicare and Medi-Cal covered services and associated funding sources, as well as a list of fee-for-service providers, as a starting point to understand the care delivery system currently used by dual eligible beneficiaries.

The mental health and substance use provider community in California has historically been overseen by different state agencies and governed by different sets of programmatic standards. This provider network must be included in the dual pilot programs because of the wealth of the provider experience serving the population. Molina would like to better understand the current delivery system, its ability to provide access according to Knox-Keene and Medi-Cal contracting requirements, and its ability to accommodate co-location of primary care services. As long as the traditional mental health and substance abuse providers can provide access as required by the dual pilots, Molina will gladly contract with these providers in order to assure greater continuity of care for beneficiaries.

Person-centered health homes:

Molina has designed a patient-centric care model that allows members to manage their medical and behavioral health care needs through an integrated team approach, care transition interventions, face-to-face interactions and a multi-level care management process designed to address various levels of medical and behavioral health complexity. The dual pilot programs must require a process that engages the beneficiary (and family/caregiver as necessary) in their care. This process must be customized to their specific needs and coordinated with all relevant providers, including caregivers and in-home providers. For some with significant behavioral health conditions, the in-home provider may be the first contact and serve as the team's early detection alert when a patient is destabilized.

Financing arrangements:

The federal-state-local funding for behavioral health services in California poses one of the most significant challenges in the dual integration pilot programs. While Medicare covers specified mental health services, Medi-Cal relies on county realignment funding to draw down the federal matching funds for Medicaid mental health services. Given the ongoing realignment discussions and negotiations on mental health and substance abuse services, this will require a separate and distinct set of expertise in order to include and integrate this benefit for enrollees.

Community based services are more cost-effective than emergency room and inpatient admission. However, access to these services is challenging at best and persistently unavailable at worst. Molina, as well as other potential participants in the pilot program, cannot be expected to provide a comprehensive set of benefits if there are no available mental health professionals to meaningfully contract with. This is not simply a matter of redirecting services from hospital-based episodic care, but ensuring that contracts with mental health professionals, either county mental health providers or other providers, are sufficient to ensure timely and appropriate access.

County mental health funding:

For the dual eligible population that will enroll in the pilot programs, Molina would like to know if these county funds can be included in a rate calculation for a comprehensive set of benefits. If counties were willing to continue to provide a local realignment match in order to draw down a federal payment, Molina would contract with county mental health providers to ensure their voluntary contribution is not removed entirely from the mental health delivery system.

Coordination between counties and demonstration program participants:

Demonstration project participants should become familiar with each county's access and availability standards and capabilities. Knox-Keene licensed plans have strict access guidelines, and there are questions as to whether the counties' networks meet the KKA standards, or whether demonstration project participants will need to build a private network. Additionally, there should be discussion regarding counties' ability to contract and negotiate rates with private payors.

Again, Molina Healthcare appreciates the opportunity to comment on the Framework documents. Please contact me at 562-491-7044, or April Alexander, Regional Director of State Affairs, at 916-648-2476, if you have any questions about our comments.

Sincerely,

Lisa Rubino
President

cc: Jane Ogle, Deputy Director, Health Care Delivery Systems, DHCS
John Shen, Chief, Long Term Care Division, DHCS
Carol Gallegos, Long Term Care Division, DHCS