Part 2: Questions for Interested Parties

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

Mandatory enrollment should be based on a phase-in approach. The enrollment exemption policy should include the following groups:

- Individuals who currently receive care through a Medicare and/or Medi-Cal managed care so they can maintain their continuity of care.
- Individuals who currently receive a majority of their care from out-of-area providers. Out-of-area providers will likely not contract with the pilot health plan. Also, this enrollment exemption allows these individuals to maintain their continuity of care.
- Individuals who receive a majority of their care from a provider who does not want to contract with the pilot health plan.

2. What type of long-term support and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

The following LTSS are essential to include in an integrated model:

- Home and community-based services
- Personal care services and adult day health care
- Home modification and meals
- Paramedical and nursing services, and physical, speech, and occupational therapies

The institutional long term care (LTC) could be an optional feature of this integrated model. The LTC beneficiaries are receiving primary and specialty care from different groups of healthcare professionals. It is very common that these healthcare professionals are not the beneficiaries' primary care providers. And vice versa, their primary care providers tend not to see their patients in the LTC facilities. Therefore, care coordination could be very challenging if the LTC services are included in the integrated model. Unintentionally, the beneficiaries may not get the care they need.

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

Currently, all Medicare Advantage plans provide behavioral health benefits to Medicare beneficiaries. This benefit category is already integrated in the current managed care system.

4. If you are a provider for long-term support and services, how would you participate in an integration pilot? What aspects of your current contract 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?

Currently, IEHP does not have a LTSS provider network. In order to provide home and community-based services including non-Medicaid long term support and services (LTSS), IEHP may choose to contract directly with LTSS providers, or partner with existing managed care plan(s) and/or an organized care system that already has a strong LTSS provider network. In the Inland Empire, there are few existing organized health systems that IEHP could form a partnership with and deliver necessary services to the Full Duals.

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

All services indicated in the RFI of the pilot program, with LTC as an optional feature.

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

The beneficiaries, participating health plans, all providers, and key stakeholders need to be involved in the development, review, and implementation of the education and outreach program and its associated materials. Communications should start at least 6 months prior to the program implementation, and continue until the program launch date. Communication should occur through different channels and formats; the communication strategy and content should be fluid so that frequent updates reflect the feedback from the beneficiaries and communities.

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

Following are essential areas needed to be addressed in the RFP (but not limited to):

- Network readiness – medical and LTSS – such as size as well as access standards
- Care management and coordination
- Financial stability
- Provider reimbursement
- Provider credentialing and relations
- Community connection
- Network oversight
- IT and support system
- Cultural competency and sensitivity

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?

Current standards set by DHCS for Medi-Cal.

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

If IEHP is not chosen as a plan for this pilot program, we would like to be involved in the discussion. We can contribute our expertise in providing managed care to this population.

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

The department needs to list specific requirements and regulations, with concrete and mutually agreeable measures for evaluating the success of the pilot program.

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

The success is not only measured by quality measures, it should also reflect the care outcome. The evaluation should be conducted after two years from the program implementation date.

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 DHCS on requiring specific approaches to rate-setting and risk?

IEHP believes that in order for the Full Dual pilot program to succeed, DHCS and CMS need to reimburse health plans with sound actuarial payments that fully reflect the risk of the population served.

The department may want to consider an incentive program for the health plans in some key areas.