Care1st HEALTH PLAN

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November 4, 2011

Mr. Toby Douglas, Director
Department of Health Care Services
Office of Medi-Cal Procurement MS 4200
PO Box 997413
Sacramento, CA 95899-7413

Mr. Peter Harbage, President
Harbage Consulting

Dear Mr. Douglas and Mr. Harbage:

We are pleased to submit our comments and recommendations below to the request for feedback to the draft paper regarding the Duals Pilot submitted by Peter Harbage on October 20, 2011.

Care1st Health Plan Response to Draft Duals Project Paper

I. Consumer Protections

1. Beneficiary Control and Choice.

The integration of the In-Home Supportive Services (IHSS) program into the Duals Pilot needs to be addressed to determine how health plans will be able to monitor and ensure the quality of personal care services provided to Pilot participants. If the IHSS program is carved out, plans must have the authority and resources to pay for similar personal home care services to ensure that Pilot participants who are able to stay in their homes, have access to appropriate and cost-effective services they need to do so safely. If the IHSS program is integrated into the Duals Pilot, plans' Utilization Management Care Managers should play a significant role in the decision-making process to determine eligibility, type of personal care services and number of hours needed to ensure appropriate care in the home.

2. Comprehensive Benefit Design

We embrace the Duals model to integrate medical, behavioral health, social supports, and long-term care benefits. In addition to the integration of IHSS into the Pilot, we recommend that DHCS also consider the inclusion of services and programs currently administered by the Department of Aging (Older American's Act and Older Californian's Act) and the Departments of Rehabilitation and Developmental Services into the model. Access to critically needed home and community-based services (HCBS) administered by these departments are needed to help older adults and persons with disabilities to maintain independence and to change utilization patterns, i.e., shifting from inpatient-based and SNF-based care to HCBS. The inclusion of these services to create a *fully*

integrated system of care for dual-eligible beneficiaries will allow a holistic person-centered approach to meet the needs of duals who are often frail, elderly, coping with disabilities and compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social and economic conditions, and end-of-life care issues, will provide plans and its contracted providers with the tools and resources to connect Pilot participants and their family caregivers with the right services at the right time and place.

3. **Integrated grievance and appeals processes**
   We recommend building one integrated grievance and appeals process that retains the elements from the Medicare and Medicaid [Medi-Cal] processes that provides the greatest protections for Duals. Pursuing both paths is duplicative, arduous and complicated for members and plans.

   We welcome an administrative simplicity approach, to the extent possible. In addition to an integrated process for the submission of grievances and appeals, marketing (if passive enrollment is not used) and enrollment materials should be integrated so there is one set of regulations and approval process.

4. **Integrated Quality Outcomes Measurements**
   We recommend integrating specific HEDIS measures from the Medicare Dual-SNP such as Care for Older Adults and Medication Reconciliation measures. We recommend integrating CAHPS with the Medicare Dual-SNP, including Health Outcomes Surveys.

II. Site-Selection Process

Recommendations for the Duals Pilot Request for Solutions (RFS) or Request for Proposals (RFP):

1. The selected health plans should have sufficient experience serving dual-eligible beneficiaries, both under Medi-Cal and through Medicare Advantage-Special Needs Plan contracts, preferably in multiple CA counties.

2. The Duals draft paper indicates the sites will be selected in COHS and Two-Plan counties. If Los Angeles County is selected as a Two-Plan county site, since Care1st is currently a LA Care subcontractor, we are very interested in participating as a subcontractor to LA Care in the Pilot.

3. We are open to participating as a GMC county site, specifically San Diego County, which has made significant progress in developing an Integrated Long-Term Care system through the San Diego Aging and Independence Services, if DHCS decides to include a GMC county in the Pilot.

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III. **Potential Demonstration Enrollees**

1. **Passive, opt-out enrollment process**

The draft states, "To *minimize adverse risk selection and ensure sufficient enrollment for adequate risk sharing, the actuarial analysis will likely prohibit the ability to cap county enrollment or to have sub-county subdivisions.*" If the decision is made to utilize passive enrollment, with an opt-out, for both Medicare and Medicaid, and a plan(s) in a Two-Plan county is selected for the Pilot, would all duals in that county be passively enrolled, including those duals that are currently members of another health plan or would only fee-for-service duals be targeted for the Pilot? Would plans with existing MA-SNPs for duals be able to continue to operate and market their product within existing CMS and DHCS guidelines? We realize the importance of ensuring sufficient enrollment in the Pilots, but also recommend that DHCS take into consideration the current contractual relationships between health plans in Two-Plan model counties and the potential disruption to care if all duals in a county like Los Angeles were to be auto-enrolled.

A recommendation to address this, for example, in Los Angeles County, if selected as a two-Plan site, is to include the current subcontractors with duals membership in the Pilot as a subcontractor.

2. **Enrollment Process and Identification Cards**

The Pilot should include one enrollment process and one ID card for integrated Medicare and Medi-Cal benefits.

3. **Carve-Outs**

In keeping with the goal of creating a fully integrated system of care for duals, we recommended that no populations be carved out.

IV. **Financing**

Under the capitated approach, the State, health plans and providers should share in savings resulting from Duals Pilot initiatives that improve quality and reduce costs for both Medicare and Medi-Cal.

With regard to individuals who are passively enrolled into the Pilot and are currently residing in skilled nursing facilities, we recommend the exploration of a phased-in approach to risk

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sharing to allow plans the opportunity to recommend and facilitate potential transitions to the home with HCBS versus institutionalization for those individuals who may be able to return to their homes.

We agree that an integrated model should reduce the administrative overhead required for claims processing, but recommend that the new and additional claims from behavioral health, long-term care and HCSB providers be taken into consideration when forecasting potential administrative savings.

We applaud the Department of Health Care Services for its work on this exciting initiative, and appreciate the opportunity to participate in the demonstration development process. We are committed to working with DHCS and other stakeholders on this Pilot. If you have any questions or would like additional information, please feel free to contact us.

Sincerely,

Anna Tran
Chief Executive Officer