November 4, 2011

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

Re: Molina Healthcare of California Response to California Duals Demonstration Overview Working Paper

Dear Peter:

Thank you for the opportunity to comment on the Duals Demonstration Overview Working Paper. The Working Paper poses several important questions that must be discussed as the state develops the duals pilot programs.

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 over 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.

An overarching consideration that Molina emphasizes is that *these pilot programs are designed to not only coordinate, but integrate, services*. This is consistent with the CMS letter entitled "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." 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 program to effectively coordinate care if the two programs, benefits, and administrative functions are integrated.

With this consideration in mind, Molina provides the following comments in response to the key issues and questions outlined in the Working Paper:

Importance of an Integrated Care Model:

Molina strongly supports the vision of an integrated system for dual eligible care and agrees with the four characteristics as outlined in the Working Paper:

- *At the beneficiary level, a person-centered care plan that addresses medical needs, behavioral health needs, social service needs and long-term supportive service needs.* The importance and inclusion of home and community-based services must be emphasized for this population. Molina sees an opportunity to work with long-term supportive service operators and other home and community-based entities to connect the

various medical and behavioral services by including in-home caregivers, family members, legal guardians, respite providers and other individuals to more closely monitor and communicate with the beneficiary before they require extensive medical intervention.

Molina has developed and implemented a patient-centric care model that is designed to keep members in their homes and in the community and avoid unnecessary institutional care. Our model offers multiple levels of care management, depending on the medical and social issues facing the patient. Molina recommends adoption of this or a similar care management model for the pilot program because the coordination with caregivers provides for a much greater connection to both services and beneficiary needs. A key component of this model is ensuring access to education and training of the family member or caregiver, which will serve to significantly improve the disjointed and fragmented communication that occurs now.

- *At the delivery system level, a coordinating mechanism that links the full continuum of services required by the person-centered care plan.* This coordinating mechanism is an integrated care system managed by one single entity that coordinates the necessary providers and supports for the patient.

- *At the funding level, a blended Medicare and Medi-Cal rate channeled through a single, full-risk-bearing entity that aligns incentives to ensure good health outcomes, patient satisfaction and an emphasis on community-based care*. The funding for a full-risk-bearing entity must be based on transparent, actuarially sound rates and allow for the entity to provide all the services with few, if any, carve-outs.

- *Across all levels, comprehensive consumer protections and oversight mechanisms to help ensure beneficiary choice, health and safety*. Entities providing and delivering care to dual eligibles must be held to standards that include minimum enrollment and experience with the population; a proven track record of licensure in good-standing; no marketing or other monetary penalties; examples of integrating care for low-income or medically fragile populations; and care management practices beyond telephony.

Goals for California's Dual Demonstration

Molina believes that the stated goals are aggressive but achievable, if executed correctly. As noted above, these dual pilots must be viewed as an integration of care, not a coordination of care. Managed care plans coordinate care on a daily basis for millions of Medi-Cal beneficiaries, including seniors and persons with disabilities. The dual eligible population not only needs coordination of their care, but a seamless entity that provides one card, one plan and one set of services. If the dual pilot programs are to be successful, there must be an integration of benefits, administrative functions, and oversight. If managed care plans are going to be held accountable for the delivery, coordination, and management of the full continuum of necessary services, there will also need to be the ability for the plan to provide those services without barriers or unnecessary bureaucratic burdens. Molina is prepared to engage in the significant collaboration that will be required from all levels and types of providers in order to make these pilots work for the dual eligible population.

Financing

Molina is pleased to see that California will be pursuing both financial alignment models as proposed by CMS. Molina suggests that the Department consider applying both models in the same pilot region so that beneficiaries choosing to opt out of one model are still receiving care coordination. Ultimately, a beneficiary will retain choice, but Molina strongly believes that because these beneficiaries have complex and expensive health care needs, a multi-layered care management approach will work best.

Site-Selection Process

Molina supports the "Request for Solutions" (RFS) process as outlined in the overview document. At a minimum, participating entities should have provided full scope Medi-Cal managed care services for a minimum of three years. Other criteria should include:

- Full licensure as a Knox-Keene health plan with a Special Needs Plan contract with CMS for at least five years, which demonstrates the administrative and financial capacity to effectively serve this population and to manage through unexpected high-cost times and fund start-up costs.
- Minimum enrollment of 2500 dual beneficiaries in the state, which demonstrates experience with the population.
- During the past two years, no marketing suspensions or other monetary penalties in excess of $250,000 from state regulators or CMS, which demonstrates adherence to policy/procedures and a commitment to compliance.
- Demonstrated experience with low-income, medically-fragile populations in California.
- Care management beyond telephony, which demonstrates understanding of the population and need for a patient-centric and high-touch outreach program.
- Examples of successfully managing an ACO or similar integrated delivery models.
- Provider network standards and care coordination contracts with home and community-based providers.
- Standards that insure that Primary Care Providers understand the unique aspects of this population and agree to provide a full range medical and social services. Patients who are passively enrolled should only be enrolled with Primary Care Providers who meet an approved definition of a "Health Home."

Molina recommends that the pilot programs should be more focused on the quality of providers rather than the number of counties in which the program operate. California, in its initial application to CMS for a dual planning grant, stated they were seeking to enroll up to 150,000 beneficiaries by the end of 2012. While SB 208 specifies that the pilots will be established in up to four counties, the Department, along with the support of stakeholders, could seek to amend this statute and allow for more regionally-based pilot programs or focus on enrolling beneficiaries in appropriate models and managed care plans rather than county-specific locations. Molina believes the current statute unnecessarily limits the pilot locations and would support statutory amendments that retain the statute's intent while allowing an opportunity for beneficiaries to participate in a larger region of California.

Potential Demonstration Participants

Molina recommends that pilot program beneficiary participants have full-scope Medi-Cal coverage and be eligible for Medicare Parts A, B and D. Dual eligible beneficiaries requiring long-term skilled nursing care should be excluded from the first year of the pilot program. For the first year, when pilot program participants are admitted to a long-term skilled nursing facility for three consecutive months, they would be disenrolled from the pilot. After the first year, carving in long-term skilled nursing care under the pilot program should be considered. The first year would allow providers to hone their integrated delivery systems for the initial pilot program beneficiaries before taking on the additional challenge of managing duals in long-term care skilled nursing facilities. The state and/or contracted entities could offer some medical oversight by arranging providers to make rounds in skilled nursing facilities (hospitalists/SNFists), which would help reduce unnecessary hospital admissions. Bringing duals residing in long-term care skilled nursing facilities into the pilot programs in year two would allow for providers to implement medical oversight and care management programs targeting health status improvements for this vulnerable, fragile population. Molina also understands that the state is considering carving out other populations, including coverage for people with developmental disabilities, which we would support.

Evaluating Success

Since the mandatory enrollment of seniors and persons with disabilities that began on June 1, 2011, managed care plans have been capturing and closely monitoring data on disenrollments, medical exemptions, continuity of care requests and other indicators for the SPD population. Molina suggests this data and transparent dashboard report be replicated as closely as possible for the duals pilot programs, especially because the Medi-Cal managed care plans have made extensive changes to administrative and information technology infrastructure in order to collect and report this data. It would be inefficient to duplicate or re-create another system to capture data on a different, yet similar, population. However, Molina believes that data on medical side should be collected as well, including on the frequency of beneficiary transition from SNF to institutionalization, avoidable ER, and reductions in unnecessary and SNF admission.

Sources of Data

Molina supports using surveys to determine enrollee satisfaction as long as they are standardized, validated and widely used within the health care community. Molina suggests using the Consumer Assessment of Healthcare Providers and Systems or "CAHPS" survey.

Molina Healthcare appreciates the opportunity to comment on the California Duals Demonstration Overview Working Paper. 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
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