Molina Healthcare of California

**Response to the California Department of Health Care Services (DHCS)
Request for Information (RFI) on
Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare**

June 1, 2011

MOLINA®
HEALTHCARE

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State of California—Health and Human Services Agency
Department of Health Care Services
Office of Medi-Cal Procurement MS 4200
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Response to the Department of Health Care Services Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

Dear Kevin Morrill:

Molina Healthcare of California welcomes the opportunity to provide a response to the California Department of Health Care Services (DHCS) in its request for input concerning ideal models of care for its integrated care pilot programs that will serve dual eligible beneficiaries.

Molina Healthcare of California is a Knox-Keene licensed managed care organization that provides healthcare services for individuals eligible for Medi-Cal, Medicare, and the Healthy Families programs throughout Riverside, San Bernardino, Sacramento, San Diego, and Los Angeles counties. Molina Healthcare of California has 347,000 members, 15,000 of whom are Aged, Blind and Disabled and 5,400 of whom are Medicare dual eligible enrollees. Molina Healthcare of California also operates 15 community-based clinics.

Molina Healthcare of California is one of ten licensed state health plans managed by its parent corporation, Molina Healthcare, Inc. The nine other Molina health plans are located in Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. In total, the ten health plans serve approximately 1.6 million members including approximately 170,000 Aged, Blind and Disabled and 20,000 dual eligible members, making Molina one of the ten largest Special Needs Plans in the nation. Eight of the ten health plans are accredited by the National Committee for Quality Assurance (NCQA). Molina Medicaid Solutions, another subsidiary of Molina Healthcare, Inc., provides business processing and information technology administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey and West Virginia and drug rebate administration services in Florida. The combined services of Molina Healthcare's state health plans and Molina Medicaid Solutions touch approximately 4.3 million Medicaid beneficiaries and 189,000 providers in 15 states nationally, making Molina Healthcare one of the country's largest Medicaid healthcare services vendors. Dr. J. Mario Molina, the son of the founder of the company, serves as the chief executive officer of Molina Healthcare, Inc. Dr. Molina's first-hand understanding of patient needs and medical service delivery distinguishes Molina as a member-centric healthcare company.

Using a member-centered, cost-effective model of managed healthcare services, Molina Healthcare of California arranges for a broad spectrum of care that often requires integration of overlapping services, including coordinating acute, behavioral health, substance abuse and long-term care services. Molina Healthcare of California has extensive experience in managing quality healthcare services for vulnerable populations, including an established track record of effectively providing integrated care coordination for members who have multiple or complex conditions. Since 2006, Molina Healthcare of California has been managing Medi-Cal wrap-around services for dual eligibles.

The key strengths of Molina Healthcare of California's model of healthcare services include the following:

- Administering an efficient managed care model that provides quality services in a cost efficient and sustainable manner while meeting all state, regulatory and other requirements;

- Maintaining a robust service delivery network focused on contracting with primary care physicians (PCPs), many of whom are contracted to support a Medical Home environment, as well as specialists, hospitals and ancillary providers to ensure access to experienced community and safety net practitioners;

- Providing flexible and innovative care management delivery approaches to integrate service coordination for persons with disabilities, chronic medical conditions, and behavioral health and substance abuse issues to ensure delivery of the right care, at the right time, in the right setting.

- Ensuring plan members receive comprehensive, integrated care management through programs and services that include:

  ▸ Care Coordination that integrates an array of health care services designed to improve health outcomes for chronically ill, disabled and aged populations, including individuals with acute, behavioral health and/or substance abuse issues, and persons with long-term care needs;

  ▸ Care Transition services that ensure members are educated prior to hospital admission (or any change in level of care). Members also receive post-discharge support services to prevent readmission and ensure members adhere to discharge instructions.

  ▸ Disease Management designed to actively engage members in addressing their own health care needs, and which have been proven effective in reducing inpatient admissions, readmissions and Emergency Room services;

  ▸ Case Management based on risk-stratification of members with complex medical conditions for assessment of needs, interventions and evaluation of outcomes;

  ▸ Utilization Management designed to ensure quality, cost-effective and medically necessary services are delivered across the continuum of care; and

  ▸ A dedicated multi-lingual Nurse Advice Line available 24 hours per day, seven days per week that is staffed by registered nurses who provide comprehensive and personalized telephone services with a goal of decreasing inappropriate use of Emergency Room services.

- Utilizing a scalable information technology system capable of handling and processing complex data requirements.

Enclosed you will find Molina's responses to Part 2: Questions for Interested Parties.

Based on Molina's experience and expertise accumulated in over 30 years of providing managed healthcare services to California residents, we are pleased to be afforded the opportunity to provide input to DHCS for the Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare program, and are excited to work with DHCS in developing a model of care that promotes the department's objectives.

Feel free to contact me at your convenience should you wish to discuss this further.

Sincerely,

Lisa Rubino
President, Molina Healthcare of California

Part 2: Questions for Interested Parties (including potential contracted entities):

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

The experience of Molina[1] and the experience of other established long-term care programs show that a fully-integrated, full-risk enrollment model utilizing capitated Managed Care Organizations (MCOs) that blends Medicare and Medicaid funding streams and combines benefits can result in the provision of high-quality coordinated care services for dual eligible beneficiaries at stabilized or reduced costs.

Approximately 8.8 million individuals in the United States are dually eligible for Medicaid and Medicare benefits. This dual eligible population is the most complex segment of Medicare and Medicaid programs, as individuals often have multiple chronic conditions, physical and developmental disabilities, suffer from cognitive impairment or mental disorders, need assistance in daily living activities and often have less than a high-school education. Thus, it is no surprise that dual eligible beneficiaries comprise a disproportionate share of Medicare and Medicaid expenditures: dual eligibles account for 16% of Medicare enrollment but 27% of spending,[2] and 15% of Medicaid enrollment but 39% of spending. Total annual spending on dual eligibles is projected to be more than $775 billion by 2024, with projected annual per-capita costs in excess of $80,000.[3] Clearly, given the characteristics of the dual eligible population and of both current and projected economic and budgetary factors, federal and state agencies must consider innovative solutions that achieve simultaneous objectives of maintaining high-quality care for dual eligibles while stabilizing expenditures. Molina believes that the proposed enrollment model provides one such solution.

The benefits of a fully-integrated, full-risk capitated MCO-based enrollment model are multifold:

- Allows for the creation of a team-oriented, multidisciplinary comprehensive care coordination model for the member, which has been demonstrated to produce better outcomes when compared to the fragmented care coordination services delivered under fee-for-service or less comprehensive models;

- Promotes the development, implementation, and maintenance of individualized care plans and the establishment of a point-of-contact that facilitates the coordination of care between providers and other stakeholders, resulting in prioritized delivery of necessary services and therefore improved member satisfaction;

- Improves programmatic evaluation capabilities from all stakeholders' perspectives, minimizing the number of participants and/or programs to be reviewed;

- Improves access to care by leveraging an MCO's contracted network of providers that can be readily made available to the member;

- Results in improved outreach programs which promotes successful program implementation, as MCOs are well positioned to undertake and finance the substantial education efforts;

- Aligns MCO's and regulatory incentives by preventing unnecessary and/or long-term admissions to nursing facilities and promoting increased utilization of Home and Community-Based Services (HCBS), thus accomplishing the objectives of reducing costs, slowing cost-shifting between Medicaid and Medicare, and providing care in the least restrictive setting.

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[1] Unless otherwise indicated herein, references to "Molina" in this RFI response shall mean both Molina Healthcare of California and its parent company, Molina Healthcare, Inc. "Molina Healthcare" shall mean solely the parent company, Molina Healthcare, Inc.

[2] The Medicare Payment Advisory Committee (MedPAC) (June 2010). *A Data Book: Healthcare Spending and the Medicare Program.* http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf

[3] "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities," Lewin Group, November 2008, pg. 1.

As described above, while the dual eligible population is uniquely positioned to benefit from comprehensive care management services due to their complex conditions that require multidisciplinary coordination of care across a wide spectrum of services, to date only a small fraction of eligibles (approximately 120,000) are enrolled in some form of a fully-integrated program. However, fully-integrated capitated programs have demonstrated that this model can meet the competing objectives of high-quality care and reduced cost. For example, Massachusetts' Senior Care Options program reduced Skilled Nursing Facility admissions by 42% while achieving high satisfaction rates, and in a 2009 survey of Wisconsin Family Care enrollees, more than 80% expressed satisfaction with the program.[4]

In terms of populations that should be covered by the Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare program, Molina recommends that DHCS adopt a model that requires mandatory enrollment of all generalized dual eligible beneficiary groups: Frail Elders, Intellectual and Developmentally Disabled, Physically Disabled, individuals with Serious Mental Illness, and all other applicable groups under Medicaid demonstration waivers and state plan amendments, including individuals residing in institutions. Including all groups into the Pilots Program promotes directed care management of the highest cost groups, which promotes increased potential savings. As described above, these individuals can be cared for in fully-integrated, capitated health plan settings without loss of quality of care.

Molina concurs with DHCS' objective of preserving beneficiary choice of care providers, which Molina believes should also extend to choices of MCO's. However, true high-quality, cost-effective care coordination, including the development of an individualized care plan that encompasses all providers and stakeholders in the care management process, requires some level of member retention consistency. To promote these objectives, Molina recommends that DHCS adopt an enrollment model that provides the member (and their legal guardian, representative(s), etc.) appropriate timeframes in making a choice of MCO's while then affording the MCO the opportunity to implement effective care coordination:

- During initial program enrollment, members (or their designee for healthcare) should be provided a choice of health plans to enroll in, and provided sufficient information and time to make an enrollment decision.

- Comprehensive, but not voluminous, information regarding each health plan and its respective provider network should be provided to the beneficiary and/or their representatives 90 days in advance of initial enrollment.

- Beneficiaries should be provided 60 days to make a health plan enrollment selection. If at the end of this decision period the beneficiary has not made an enrollment selection, they then should be auto-enrolled into a health plan as determined by an algorithm that prioritizes the distribution of membership into health plans that have demonstrated sufficient scalability to provide high-quality, complex coordinated care services in a cost efficient manner.

- Further, enrollees should be allowed to opt-out of either their chosen or auto-enrolled health plan for a period of up to 90 days subsequent to initial enrollment to allow time for the individuals to change their options.

- After the opt-out period expires, members should remain enrolled in the health plan of choice for a minimum of one year, to achieve the clinical benefits provided through continuity of care. Periods shorter than one year or excessive member plan switching will inhibit the health plan's ability to effectively maintain coordinated and continuous high quality care.

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[4] "An Evaluation: Family Care, Department of Health Services," Wisconsin Legislative Audit Bureau Report 11-5, April 2011, pg. 6.

- Subsequent enrollments of new members should be administered in the same fashion.

A phased-in auto-enrollment approach based on volume and geographic region may be necessary to enable contracted MCOs to collaborate with DHCS and other state agencies, make initial contact with dual eligible members to determine transition of care needs, arrange for continuation of services, and communicate with providers and community-based groups to develop a solid collaborative foundation to ensure successful transition into the dual eligibles pilot program.

Molina understands that part of DHCS' objective is to establish this pilot program in a County Operated Health System (COHS) service area. Molina recommends that at least one alternative SNP-contracted plan be established in COHS service areas prior to statewide expansion of the pilot program (and potentially more than one in urban areas) to maintain the important beneficiary choice options described above.

To ensure that the provider network expands as enrollment increases, Molina recommends that DHCS require its contracted MCOs conduct regular assessments of the provider network to confirm that it meets DHCS' access requirements. Home and Community-Based Services should be a critical component of the network to ensure members have the resources to remain safely in the community. Provider Services field personnel should focus on obtaining contracts with providers that are geographically accessible to members and familiar with the population needs. It is important to focus on meeting members' needs through the provision of adequate access; therefore, collecting, reviewing and analyzing out-of-network reports, PCP termination reports, member access complaints, and after-hours availability on a regular basis will also be essential.

Molina recommends that DHCS require its contracted MCOs to auto-assign members under the pilot to PCPs (or specialists assuming the PCP role) when they do not make an active PCP choice to ensure each member is assigned to an appropriate Medical Home. This process should assign PCPs to members in accordance with programmed auto-assignment criteria, such as provider specialty, members' age/sex, provider distance from members' residence, members' PCP history, and members' primary language. The MCOs should be responsible for clearly communicating to the member the PCP assignment and for addressing any issues and questions.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

Many dual eligible beneficiaries requiring long-term supports and services also have complex care needs, including a wide spectrum of physical and behavioral health services, making integration of services essential. Molina believes long-term supports and HCBS are necessary as preventive services to avoid more expensive hospitalizations, Emergency Room visits or institutionalization for many who have complex care needs, and to assure maintenance of the highest level of functioning possible in the least restrictive setting. Therefore, Molina recommends that DHCS require, as part of an integrated model, the implementation, coordination, monitoring and assessment of a comprehensive array of functionally necessary In-Home Supportive Services, as well as HCBS Waiver services, such as:

- Care coordination
- Service plan implementation and monitoring
- Post-hospital discharge planning
- Transitional Assistance Services
- Personal care services
- Private duty nursing;
- Adult residential care
- Crisis intervention

- Case management
- Medication management and administration
- Nursing facility and/or institutional care
- Adult Day Health Care
- Consumer directed personal care services
- Minor Home Modifications;
- Habilitation services (residential and day)
- Behavior intervention services

- Nutritional consultation
- Environmental Accessibility Adaptations
- Vehicle adaptation

- Home Delivered Meals
- Personal emergency response system
- Communication aids

In addition, Molina further recommends that DHCS require ancillary services such as dental and vision be included in covered benefits, since when they are included they improve outcomes by allowing for the identification of diseases in early-stages. Additionally, non-emergency transportation benefits should be included, particularly for beneficiaries with developmental disabilities who are more likely to utilize transportation services; and multilingual services should be included to eliminate barriers to care caused by language issues.[5] The MCOs should also be empowered to give the member (or designated representative) choices in managing the activities of their daily living needs, including an option for self-directed services.

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

According to CMS, "forty-three percent of dual eligibles have at least one mental or cognitive impairment, while 60 percent of dual eligibles have multiple chronic conditions."[6] Because of the high prevalence of mental and cognitive impairment and due to the importance of such services being provided in a coordinated care setting, Molina recommends that behavioral health services should be included as an MCO-covered benefit.

Molina recommends that care management teams be comprised of both physical and behavioral health professionals. These combined care management teams enhance the direct communication of member needs and cross-communication of treatment plan issues with all providers, and foster an ongoing consultative exchange between behavioral health and physical health care professionals. Effective integrated care coordination and case management of behavioral health and physical care needs can also be enhanced through the use of a single MCO's shared documentation software application that supports recording, tracking and modification of all member care information. Shared information can then be used for consideration and coordination of other care needs by all care management teams.

Another key consideration is for DHCS to require MCOs under the pilot to receive appropriate community-based advisory feedback on the provision of physical and behavioral health services. An example is Molina Healthcare's National Behavioral Health Advisory Committee, which is comprised of consumers and consumer advocates, including national experts, who meet semiannually to review Molina Healthcare's behavioral health programs to ensure appropriate focus on person-centered care and integration. The Committee provides guidance and information from a breadth of participants, including community mental health providers, public policy advisors, and representatives from academic centers. Molina Healthcare's community-based consumer advisory panels provide direction and feedback specific to Molina Healthcare's subsidiary health plans on local program development and management of behavioral health services, and integration with other medical care management services.

Molina recommends that DHCS consider building behavioral health care upon similar expert community-based advice and support to facilitate advisory committee feedback specific to local issues related to behavioral health and medical services. An advisory panel should also be established to involve the participation of a variety of local stakeholders, such as consumers, consumer advocates, and local community-based mental health centers. The panel's purpose should be to encourage the sharing of experiences, insights and identification of opportunities for improvement that lead to greater knowledge about member expectations and improve member health outcomes.

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[5] UMASS Medical School Center for Health Policy and Research (December 2007). *Senior Care Options Evaluation Phase 2: Member Experience Report of Individual Interviews.* http://www.mass.gov/Eeohhs2/docs/masshealth/sco/umms_sco-interview-report.pdf
[6] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) (May 16, 2011). *Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare.* http://federalregister.gov/a/2011-11848

As an example of successful physical and behavioral health integration, Molina Healthcare opened Molina Medical at Compass Health (Molina Medical) in Everett, Washington in February 2010. Molina Medical is an innovative primary care person-centered clinic on the premises of Compass Health, one of the largest community mental health providers in Washington. Molina Medical at Compass Health is dedicated to integrating primary care and behavioral health for members with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). Molina Healthcare of Washington and Compass Health's successful partnership is based on its distinctive multidisciplinary strategy to provide coordinated care for individuals with severe mental illness by co-locating primary care and behavioral health teams within a single campus. Establishing a single location for the delivery of person-centered services provides a safety net to members whose needs may not be met by separate physical and behavioral health care services, and maximizes efficient communications and collaboration among primary care and behavioral health teams.

Molina recommends that DHCS require its contracted MCOs consider this type of full integration and encourages DHCS to explore similar innovative approaches to incorporate physical and behavioral health care.

4. If you are a provider of long-term supports and services, how would you propose participating 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?

While not a direct provider of long-term supports and services, Molina Healthcare does have experience in the administration of long-term care benefits and participates in state Medicaid managed long-term care programs, such as the Texas STAR+PLUS program and the Washington Medicaid Integration Partnership. Molina recommends that DHCS to establish a model of integrated care for DHCS' pilot programs that provides comprehensive coordination of Medicaid/Medicare services that are seamless to its dual eligible beneficiaries. Molina also recommends that DHCS consider requiring contracted MCOs to develop partnerships with long-term care providers to orient them to the philosophy and practice of integrating their services with those of other care providers via communication and education to streamline the delivery of comprehensive services and to decrease administrative burdens on HCBS providers.

Molina proposes that MCOs actively participate in all aspects of the integration pilot program. Comprehensive care management led by a single entity ensures that all aspects of members' whole-health needs are the focus of care delivery and increases the possibility of achieving improved health outcomes. Molina recommends that care managers act as a single point of contact to facilitate interdisciplinary team communications and share information with all providers. Care managers will also have the advantage of access to the MCO's shared documentation software application that allows for comprehensive review of members' entire spectrum of care. Using this approach for the dual eligible pilot program will result in an efficient, cohesive, well-managed program that will fully integrate all services, including long-term supports and services, while simultaneously controlling costs.

An important component of an MCO's managed care delivery system should be a contracted Medical Home model, central to the efficient administration of integrated care coordination. To effectively manage its members in a Medical Home setting, MCOs can utilize the seven essential components of a Medical Home described by Rittenhouse[7]:

1. A personal physician;
2. Physician-directed medical practice by a multidisciplinary team;
3. Whole person orientation;

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[7] "The Patient Centered Medical Home: A Work in Progress," Alliance for Health Reform Briefing, Diane R. Rittenhouse, MD, MPH, 2008.

4. Coordinated/integrated care;
5. Quality and safety;
6. Improved access to care; and
7. Payment reform that values primary care.

Molina's partnerships with Medical Home PCPs form the foundation upon which all clinical care is based. This model results in a coordinated approach and better management of member needs, controlled Emergency Room use, and reduced inpatient bed days for physical, behavioral health and substance abuse treatments. Molina ensures its contracted Medical Home PCPs are aware of the expectation to establish caring, ongoing relationships with members and their families and encourages them to provide Medical Home services from first contact through continuous comprehensive care.

Molina is prepared to help DHCS offer similar Medical Home services based on quality programs for its pilots that meet the needs of its dual eligible populations and provide coordination of services for members, regardless of payer, through well-run programs that produce:

- Reductions in inappropriate Emergency Room and other utilization;

- Outstanding Care Management programs, such as Case Management and Care Coordination, Disease Management, Utilization Management and 24-hour access to medical personnel;

- Frequent communications between different provider groups and types of providers;

- Efficient reporting for claims, healthcare cost and financial information.

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

Molina recognizes that many DHCS dual eligible beneficiaries will have significant and complex issues that necessitate comprehensive care management. In California, research indicates that comorbidity is significantly higher among dual eligibles. Approximately 87 percent of dual eligibles have 2 or more conditions and the most expensive conditions include hypertension, diabetes and COPD.[8] Necessary to the effective integration of care for dual eligible beneficiaries are services designed to provide specialized care for these high-risk members. Through Molina's Care Management program, which includes Care Coordination, Care Transitions, Disease Management, Case Management, and Utilization Management, the Care Management staff provides the critical link to ensure members receive access to essential providers and comprehensive integration of health care services. Molina's experience also indicates that members significantly benefit from having access to a toll-free Nurse Advice Line, staffed by live trained personnel 24 hours per day, seven days per week ready to address members' health questions, provide a forum to discuss available services and offer referral assistance to make certain members receive care in the appropriate settings.

Molina recommends that all dual eligible members be thoroughly screened for risk stratification to determine the urgency for health care services. They should also be contacted for an in-depth health risk assessment to assign them to basic or complex care management. Members who are assessed as appropriate for high-level interventions should be enrolled in both Disease Management and Care Coordination programs. Molina's Disease Management programs are designed to educate members to help them gain a better understanding of their health care needs and successfully engage them in taking responsibility for and actively participating in managing their health. In an integrated model, care coordinators manage high-risk members, including working with their PCP and other stakeholders, to develop care plans that establish coordination of Medicare services (such as physician visits, pharmacy, hospital care, skilled nursing facility, and skilled home health) with Medi-Cal services (such as custodial

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[8] "Medi-Cal's Dual Eligible Population Demographics, Health Characteristics and Costs of Health Care Services," California Department of Health Care Services Research and Analytical Studies Section, April 2010.

long-term care, attendant care, and home- and community-based services authorized under Medicaid waivers). Care coordination teams will need to be knowledgeable about available services and covered benefits, and look for opportunities where these services can add value to members' individual health circumstances.

To optimally deliver Medicare, Medi-Cal and other program benefits, Molina recommends that DHCS partner with MCOs that have existing infrastructure, operational capabilities and a thorough understanding of the key factors related to providing full integration of services to dual eligible members. The MCOs should have infrastructure in place to effectively manage the Medi-Cal-covered financial responsibility for Medicare's out-of-pocket costs, such as Part A and Part B deductibles, copayments and coinsurance; Medi-Cal coverage and coordination for community based long-term care including waiver services where applicable; prescription drugs including gap coverage; and medical-related services, such as doctor's visits, inpatient hospital care, outpatient hospital care and preventive services that Medicare may cover.

Molina believes that successful coordination of care for dual eligible members includes helping members manage the complex system of Medicare and Medi-Cal services. Therefore, Molina recommends that DHCS require that its MCOs work with all providers to identify issues and achieve maximum care for dual eligible members receiving Medicare services through either fee-for-service Medicare or another Medicare HMO where the responsibility and financial risk of Medicare services may fall on a different organization or agency.

Molina also recommends that DHCS consider requiring contracted MCOs to provide supplemental benefits for dual eligibles, such as non-emergency transportation to and from medical appointments; over-the-counter medications and supplies; Medication Therapy Management; additional preventive care services; routine vision exams and hardware; routine hearing exams and hearing aids; and preventive and comprehensive dental coverage.

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

Molina's experience has shown that education and engagement of all relevant parties during and after program implementation is essential for program effectiveness. Therefore, Molina recommends that DHCS require its contracted MCOs to develop effective outreach programs that educate individuals and their legal guardians about available health care programs to help them determine their best health care options. These outreach efforts can be accomplished through a variety of strategies including working with community-based organizations and faith-based groups, supporting DHCS and CMS outreach activities, interacting with prospective members at public events, and participating in enrollment fairs.

Molina recommends that DHCS consider requiring its contracted MCOs develop collaborative relationships with community organizations and stakeholders, such as Molina's Bridge2Access Statewide Advisory Committee. The Committee illustrates a consumer engagement approach to developing strong collaborative relationships with key community organizations and stakeholders to be responsive to the communities it serves. For this purpose, sponsored community advisory boards are comprised of members, providers and organizations interested in discussing the community perspective on issues, such as linguistic and cultural challenges faced by Molina's members. The community advisory boards meet quarterly in each service area where a board has been established to help direct the development of programs and health education materials in ways that meet the needs and sensitivities of Molina's diverse communities.

Molina supports PCPs in their efforts to deliver culturally competent, quality services in ways that promote positive outcomes for members. Therefore, a coordinated and comprehensive system of provider education and outreach should be developed to support providers to develop meaningful relationships

with their patients that improve health outcomes and quality of life, reduce morbidity and mortality, and decrease medical costs.

Molina recommends that DHCS require its contracted MCOs to employ a proactive and multifaceted provider network development and management strategy to effectively recruit, pay and retain PCPs and high volume specialists using best practices and state program goals. Methods of proficient network management include:

- Reaching out to physicians, hospitals and clinics, including affiliated groups, systems and associations during the RFP stage and after contract award;

- Collaborating with providers to efficiently manage Medi-Cal and Medicare programs;

- Establishing relationships with PCP/Medical Home providers, targeted hospitals, geriatrics, behavioral health, obstetricians, FQHCs/RHCs and other providers by conducting face-to-face meetings or by using direct mail, phone and fax outreach;

- Generating GeoAccess maps to continually monitor and refine provider network development outreach, focal points and targeting strategies;

- Working collaboratively with the state to help identify and bolster areas where beneficiaries may have historically had issues accessing health care services; and

- Seeking to understand the barriers providers might face in serving dual eligible beneficiaries and collaboratively developing strategies to address those barriers.

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

The following questions should be addressed by a potential contractor in a Request for Proposal response in order to ensure that DHCS awards qualified, committed MCO's to successfully administrate care management services for dual eligibles:

- Describe your at-risk model and demonstrate your financial viability/stability to ensure significant capital reserves and sufficient scalability are in place to support changes in utilization patterns, widespread environmental events, etc.

- Describe your experience with dual eligible populations.

- What is your experience with the management and integration of physical health services with behavioral health services and long-term care services?

- Describe in detail, your care coordination model and how you will ensure stakeholders and providers are involved in the process.

- Demonstrate how your care coordination model works by describing how you will handle the top 10 most common conditions for this population.

- What innovative solutions have you created and implemented to promote coordination and integration of care for dual eligibles?

- Is your health plan currently National Committee for Quality Assurance (NCQA) accredited, or have you applied for accreditation?

- How will quality be monitored, measured and reported and if found deficient, how will quality improvement initiatives be identified and implemented?

- Identify the MCO-level HEDIS and any other statistical clinical indicator measures that will be generated to identify opportunities for clinical quality improvement.

- Submit a table listing of the network providers for which you have secured Letters of Intent (LOI) or Letters of Agreement (LOA) to demonstrate adequate access for pilot program members by specialty and service area.

- Describe the data collection and metrics that will be used to ensure that the state program goals and objectives are met.

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?

Molina recommends that DHCS require its contracted MCOs to utilize evidence-based practices, practical experience, industry standards, and national standards and benchmarks to establish key performance indicators used to meet federal, state and program requirements, and to demonstrate accountability.

Measurable baselines should include measures specific to:

- Healthcare Effectiveness Data and Information Set (HEDIS) data;

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member and provider surveys;

- Accessing Care of Vulnerable Elders (ACOVE) quality measures;

- NCQA Quality Compass and national benchmarks;

- U.S. Preventive Services Task Force (USPSTF) recommendations.

Participating MCOs should apply a general outcomes evaluation process to specific conditions, diagnoses, operational processes, services or populations for which measurable outcomes are desired and includes the following steps: establishing standards and benchmarks; collecting data; analyzing data and determining performance levels; identifying opportunities for improvement; prioritizing opportunities; designing and implementing interventions, including corrective actions; and measuring effectiveness and adjusting program design as necessary to achieve desired behavioral change. Cycles of ongoing monitoring will need to be performed as outcomes are remeasured and specific programs are enhanced with each cycle.

Molina also suggests that DHCS require contracted MCOs to have NCQA accreditation as a significant indicator of meaningful performance. Accreditation evaluates not only the core health plan systems and processes, but also the demonstrated outcomes that the plan achieves on key dimensions of care, service and efficiency.

To ensure consistency in evaluating access to care, Molina recommends that DHCS require the contracted MCOs to perform annual network reviews for all PCPs, high-volume specialists and high-volume behavioral health providers. Reports should be reviewed by language, ethnicity and gender to ensure that NCQA standards are met. Report reviews should ensure that members have adequate representation of network providers that reflect the cultural diversity of the service areas, access to physicians within the appropriate geographic radius, access to care within required time frames and access to emergency services at a service delivery site. Report results should also identify opportunities to reduce and/or eliminate gaps in the network.

Managing the cultural diversity of the dual eligible population is important to ensure these members receive oral and written communications that provide an understanding of various cultural beliefs and practices. Molina has the experience and resources needed to address diverse populations through unique

as well as time-tested approaches to accommodate the cultural and linguistic diversity of its members. Molina provides and maintains 24-hour access to oral and written interpreter services for members whose primary language is not English. This includes all medical and non-medical points of contact. Additionally, as a Hispanic minority-owned firm, Molina Healthcare has formed the Molina Institute for Cultural Competency, which provides research, evaluation, consultation, training and support materials, policy and procedure review, and recommendations to improve cultural competency.

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

Not applicable.

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

Utilizing its experience working with populations requiring a complex range of services in the State of California, Molina has identified the following key areas of challenges and opportunities associated with implementing this integrated care for dual eligibles pilot program:

Establishing a Practical Timeline
The time needed to transition members to a new pilot program is greatly dependent on whether the state has implemented HIPAA transaction standards and code sets, and on the number of proprietary formats required. Implementation time frames are also dependent on reporting requirements and the complexity of file exchange edits and validations. Best-case integration of technical feeds and business operations to deliver health care services in a managed care environment can be achieved in as little as six to ten months, of which three to five months would be dedicated to systems testing with the state and/or its fiscal agent. It has been Molina's experience that states that secure contracts with several MCOs require longer transition periods due to the need to manage multiple companies with varying systems capabilities. Optimally, Molina prefers to schedule 12 to 16 months from the initiation of a project to enrollment of the first effective member to transition a state from fee-for-service to managed care.

Developing and Executing a Comprehensive Implementation Plan
Molina's implementation approach is comprised of five interdependent and often overlapping phases that begin upon contract award. The phases include Planning, Development, Testing and Readiness Review, Implementation, and Post Implementation Support. Key program milestones will be achieved during each phase. If Molina is a participant it will work with DHCS to conduct planning sessions that facilitate coordination of implementation expectations, timelines and deliverables. Molina will develop and update communication and implementation plans based on planning session outcomes and schedule recurring meetings with the state to facilitate communication throughout the transition period.

Throughout the implementation phase and on an ongoing basis, Molina solicits input from community stakeholders through the operation of a Molina Integrated Care Program Advisory Board consisting of enrolled members and key representatives from hospitals, regional centers, disability advocates and safety net providers. This ensures local stakeholders play an active role in supporting innovative and effective programs that remove barriers to member access and continuity of care.

Building Relationships with Providers and Community Stakeholders
Participants should also establish successful provider relations programs to ensure providers are kept up-to-date regarding planned changes to DHCS' dual eligible pilot programs. Participating MCOs should work closely with DHCS prior to implementation to develop outreach strategies that prepare providers for a transition to a new model of care. They should also develop sound working relationships with providers to ensure adequate member access, appropriate member service utilization, and the capacity to communicate with members who speak languages other than English, as well as with those who are deaf or hearing impaired. Throughout the term of its contracts, Molina audits its provider network to ensure alignment with state and federal eligibility criteria, reporting requirements and other applicable rules

and/or regulations. Molina will perform outreach activities with community stakeholders in order to proactively identify and address issues and concerns.

<u>Ensuring Transition and Continuity of Care for Members</u>
Molina has many years' experience transitioning members whose health could be jeopardized by an interruption in care and ensures timely authorizations and coordination of needed services during this critical period of adjustment for newly enrolled members. Members requiring transition of services will need to be evaluated on a case-by-case basis to determine the length of time transitional care is needed. In order to ensure continuity of care for outpatient services, MCOs will need to work with treating physicians to develop care transition plans for a specified period of time as deemed appropriate, typically up to 90 days from the date of enrollment. Requests for continued outpatient care should be reviewed by the MCO's Chief Medical Officer and the treating provider(s). A continuity of care plan should be established within 48 hours, and both member and providers should be notified to ensure seamless continuity of care. For Molina members currently under treatment for acute and chronic health conditions, Molina assigns appropriate clinical staff to follow up with members and their treating physicians to minimize disruption of services and to ensure that current service levels are maintained for an agreed-upon period. Molina supports the use of out-of-network providers if necessary to provide uninterrupted medical services.

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

The success of these pilots should be evaluated over a three- to five-year period to gauge effectiveness in meeting DHCS's goals. The evaluation should be based and on outcomes-based measurements at six month intervals for the entire contract period of program operations. Measurements should include:

- Increased utilization of preventive care, including PCP visits, behavioral health services, substance abuse services and HCBS care where appropriate and documentation of services rendered to ensure optimal outcomes;

- Emergent and inpatient care to reduce Emergency Room utilization and decrease hospitalizations and/or readmissions;

- Reduction or prevention of long-term care admissions to nursing facilities.

- Member and provider satisfaction surveys performed at least annually to ensure issues are addressed proactively; and

- Data for new members successfully placed in Medical Homes as documented by the percentage of members each year with visits to their assigned PCP.

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?

Molina recommends DHCS utilize a system of rate setting based on actuarially sound, risk-adjusted capitation rates derived from analysis of population-specific utilization, calculation of the impact of programmatic changes, trend assumptions and estimates of non-medical costs, such as administration, profit, risk and contingencies to ensure sustainability of an efficient managed care model. While many California MCOs traditionally provide managed care services through capitation arrangements, this pilot provides the opportunity for DHCS to develop risk-sharing methodologies that meet both DHCS and MCO needs. One area that deserves consideration concerns the management of members who, regardless of intervention and/or care coordination efforts, remain extremely high cost members. High cost members over a certain dollar threshold could be supported with state managed reinsurance, a high-risk pool, or

diversion to alternative funding beyond the supports provided in the program. As an alternative, DHCS should require MCOs assuming risk to acquire reinsurance to ensure the financial solvency of the pilot.

Molina has had success with a variety of shared savings arrangements with provider entities in its existing markets that incentivize providers to deliver high quality care. Examples range from delegating management and attributing commensurate financial risk for certain services in which the provider has an opportunity to have a direct impact, to pay-for-performance financial incentives to reward individual providers who demonstrate continued excellence and performance improvement by scoring well on provider profile metrics. Participation in such shared savings contract arrangements is often contingent upon providers meeting certain delegated services assessments and financial solvency criteria. DHCS should consider similar arrangements in creating the dual eligible pilots.

Molina also recommends that DHCS require its contracted MCOs to evaluate pay-for-performance programs on an annual basis. The overall success and outcomes relating to the pay-for-performance program should be documented in an annual Quality Improvement evaluation and work plan. MCOs should also assess HEDIS and CAHPS measurements annually for the overall outcome of each clinical measure relating to a pay-for-performance initiative to evaluate if the initiative is impacting quality of care, member and provider satisfaction, and cost of health care.