



June 1, 2011

Kevin Morrill
Chief, Office of Medi-Cal Procurement
MS 4200, P.O. Box 997413
Sacramento, CA 95899-7413

Re: Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

Dear Mr. Morrill:

AIDS Healthcare Foundation responds both as an interested contractor and stakeholder to the Office of Medi-Cal Procurement's RFI. We want to emphasize what we believe is the importance of maintaining and expanding Chronic Special Needs Plans that also include dually eligible MediCal and Medicare beneficiaries, (Duals). As your letter points out, "The so-called 'dual eligibles' are not a homogenous group of people, and DHCS is very interested in your ideas about how possible models might meet the needs of people who are younger and physically disabled and those who are older and chronically ill" AIDS Healthcare Foundation's Medi-Cal managed care plan, Positive Healthcare (PHC), has been providing care to Medi-Cal and Dual eligibles with AIDS in Los Angeles County since 1995, and over these sixteen years around 40% have been dually eligible. With the advent of Medicare Advantage in 2006, AHF applied for a Knox-Keene License and opened a Medicare Advantage (MA) Chronic Care Special Needs Plan (SNP) for people with HIV and AIDS. The MediCal Managed Care Division (MMCD) of the Department of Health Care Services (DHCS) was supportive of AHF's integration efforts, and CMS passive enrollment process, AHF was able to enroll its Duals from PHC into AHF's new MA-PD HIV/AIDS Chronic Care Special Needs Plan, Positive Healthcare Partners.

AIDS Healthcare Foundation therefore submits its response to your RFI as an experienced Chronic SNP provider for Duals and our response to the second question in the Contractor's section will describe an approach to serve a specific segment of duals.

The RFI notes that "Managed care plans provide a coordinated system of care for [only] a number of Medi-Cal beneficiaries" and that "Other systems still only offer partially managed services for Medi-Cal benefits, while Medicare Advantage – Special Needs Plans (MA-SNPs) offer management of Medicare services alone." While we agree that Duals often receive fragmented care, AHF has been able to integrate the care it provides its Duals to the extent that members see only "one" plan on the "front end," while AHF deftly manages the multiple payors and divergent regulations, reporting and system requirements on the "back end."

AIDS Healthcare Foundation would argue that your Dual integration pilot RFP proposes to build upon models already in place in State Medicaid managed care plans and Medicare Chronic Care SNPs in order to provide an innovative chronic special needs plan that would:

- Adhere to the fifteen chronic conditions identified by CMS for their MA chronic SNPs
- Demonstrate that specialization fits into the overall vision of health reform and can raise the quality of care while lowering costs
- Incorporate passive enrollment of dual eligibles who are identified both by DHCS and Medicare with a specific chronic condition

The rationale is that a Chronic Special Needs Plan would:

- Provide a high quality of care to Medicaid and Medicare recipients with a chronic condition. Mainstream plans do not have the expertise in medication therapy and clinical management of these chronically ill special needs individuals to ensure quality.

- Have the best chance of saving dollars on these high-cost individuals
- Function side by side with mainstream plans, with both concentrating on their respective quality improvement initiatives and cost-effective strategies

In the case of HIV and AIDS, we have found that an opt-out model makes sense because these populations are difficult to identify and reach by conventional marketing methods—for example, stigma, especially in communities of color, and co-morbidities like substance abuse prevent many HIV-infected individuals from seeking and remaining in care. The cost of anti-retroviral therapy and maintaining optimum adherence to medical treatment and medication therapy requires a high level of care coordination for optimal health outcomes and the efficient use of scarce healthcare dollars. With the appropriate level of care coordination, people with HIV and AIDS can live long and healthy lives and the cost of care can be contained. Recent definitive published research regarding the decrease of HIV transmission based upon the initiation of early antiretroviral treatment in persons with HIV¹ definitively makes the case for specialized management of people with HIV more urgent: the public health implications of decreasing HIV infection in an environment where 25 years of vaccine research has found no viable avenue of immunization against HIV makes the case for implementing a pilot program for Duals that focuses on a chronic, but manageable, condition.²

The success of such a demonstration project would depend on both DHCS and CMS developing and approving an enrollment mechanism by which dual eligible Medicaid and Medicare enrollees with HIV were identified, notified, and enrolled in an integrated HIV/AIDS SNP while still providing eligibles with the ability to opt out of such an enrollment within 90 days.

I hope that our responses and suggestions help you and the Technical Advisory Panel design a robust and responsive RFP for the four Dual Pilot Projects; if you have any questions or want to contact me, I can be reached at 323.860.5325 or donna.stidham@aidshhealth.org, or you can contact Neil Hathaway, our Director of Business Development for US Government Contracts at 323.860.5274 or neil.hathaway@aidshhealth.org.

Sincerely,



Donna Stidham, RN
Chief of Managed Care

¹ National Institute of Allergies and Infectious Disease, “Treating HIV-infected People with Antiretrovirals Protects Partners from Infection,” Press Release May 12, 2011, <http://www.niaid.nih.gov/news/newsreleases/2011/Pages/HPTN052.aspx>.

² Glenda E Gray, et al., “Safety and efficacy of the HVTN 503/Phambili Study of a clade-B-based HIV-1 vaccine in South Africa: a double-blind, randomised, placebo-controlled test-of-concept phase 2b study,” <http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2811%2970098-6/abstract#aff1#aff1>.

Contractor Section

1. Describe the model you would develop to deliver the components described above, including at least:

Over the past sixteen years AHF has developed and refined an integrated managed care model for MediCal and Medicare disabled, aged, and dually eligible persons with HIV and AIDS. Our experience, unlike most general managed care entities, is profoundly rich with the essential element of care coordination of dual eligible beneficiaries, who are not primarily elderly or developmentally disabled, that incorporates and integrates care across Medicare, MediCal, long term care supports such as the home and community based waiver services of the AIDS Waiver program, adult day care, behavioral health coordination/coverage and non-benefit community resources to support the plan of care focused on improvement of health outcomes and decrease of emergency and acute or long term institutional services.

a. Geographical location

In proposing that October's RFP include a focus on at least one chronic care model, this would not alter DHCS's plans to include four counties. We believe that the Chronic Dual SNP should be located in a populous county that would provide a critical mass of enrollees.

For example, AHF operates Medi-Cal and Medicare Advantage Part D (MA-PD) Chronic Care SNPs in Los Angeles County. Both plans are predominantly HIV/AIDS expert staff models with a few specifically selected and contracted HIV expert Primary Care Providers. AHF's Medicare and Medicare special needs plans have enrollees at each of the AHF nine Healthcare Centers (HCCs) and two HIV/AIDS Primary Care Practices located in the County. There are Plan HCCs located in each of the Los Angeles County Department of Public Health's eight Service Planning Areas (SPAs). Our four full-time (40 hours per week) HCCs and two network PCPs are located in four of the five the SPAs where the HIV epidemic is widespread, i.e., the Metro, San Fernando, South Bay and West SPAs. The remaining five satellite HCCs (open one to three days per week) are located in the remaining five SPAs. These strategic locations of HIV expert PCPs allow AHF's Medicare and MediCal Plans to serve the entire County.



LA County Service Planning Areas

b. Approximate size of target enrollment for first year

As noted in the RFI (p. 4), Los Angeles County has the largest number of Dual eligibles in the state, in fact 33.2% of them.³ Los Angeles County also has the highest HIV incidence in the State of California, with an estimated 42,000 people living with HIV and AIDS as of May 2009.⁴ AHF cares for

³ State of California, Department of Health Care Services, "Medi-Cal/Medicare Dual Eligibility By Age, By County, January 2011,"

http://www.dhcs.ca.gov/dataandstats/statistics/Documents/18_Dual_eligible_by_age_by_County_2011.pdf.

⁴ HIV Epidemiology Program, Los Angeles County Department of Public Health, "An Epidemiologic Profile of HIV and AIDS in Los Angeles County, 2009," p. 16, <http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2009-epi.pdf>.

approximately 6,500 of those 42,000 persons in their HCCs and network PCP sites. Based AHF's experience, i.e., the percentage of Duals in our HCCs, both in our MA-PD Chronic Care SNP and Medicare FFS, the non-AHF potential beneficiary pool of dual eligible would be 3,000 to 4,000 of those 42,000 persons in the first year of the pilot project⁵, which would be passively enrolled under the Pilot enrollment structure. The LA County Office of AIDS Program and Policy, which is responsible for oversight of the Ryan White funded programs, estimates that 8,000 of the 18,000 Ryan White eligible individuals currently receiving medical care will become eligible for MediCal in 2014, and of that 8,000, AHF estimates another 40% (3,200) will be Duals and eligible for this Dual Specialty Pilot. ⁶ While estimating the number of new Medi-Cal recipients with HIV/AIDS who would also be eligible for Medicare is hard to calculate currently, we believe there would be a critical mass for demonstrating that a SNP that also serves Duals can reduce costs and improve outcomes for the chronically ill vulnerable population that currently experiences barriers to the appropriate level of care and therefore accesses costly emergency and acute hospital services to meet their chronic care needs.

c. General description of provider network, including behavioral health and LTSS

Provider Network

Provider networks need to be developed that are focused on meeting the needs of the Dual special needs population. AHF has provider networks that are specifically recruited to meet the needs of its special needs population in addition to meeting the time and distance standards for the DHCS for its Medi-Cal managed care SNP Plan; for CMS for its Medicare Chronic SNP plan; and for a community-based services referral network. The AHF Medicare and MediCal networks are integrated and managed through our Provider Relations Department. Our members enjoy access to medical and ancillary providers in a seamless manner due to our integrated contracting for Medicare and MediCal care and services. The providers in the AHF specialized network have many years experience treating people living with HIV and AIDS on a primary and specialty medical care basis.

The essential element to integrated Dual care is a network that requires providers with experience in the care of dual eligible individuals, especially those with chronic conditions and multiple co-morbidities. For example, persons with HIV and AIDS regularly need to see Cardiologists, Ophthalmologists., Neurologists, Gastroenterologists, Urologists, and Colo-Rectal or General Surgeons for the most common co-morbid conditions that they face because of weakened immune systems and opportunistic infections, and the side effects associated with antiretroviral therapy.

Behavioral Health:

After sixteen years of experience with a disabled and dually eligible population, AHF has clearly experienced the effects of the fracture of care because of separate medical and behavioral health systems. It is essential that Dual members have behavioral health services as part of their whole plan of health care, in a real time basis, without delay experienced in obtaining referrals, approvals and access to another health system, i.e., LA County Mental Health MediCal system, AHF has developed a behavioral health system to meet the integrated needs of Plan members and accesses these services through its Chronic Care Management Model in a seamless manner for the Duals in their Plans. AHF Medicare SNP and MediCal Managed Care Plans access a staff model behavioral health system as well as a county wide behavioral health network to meet the needs of Plan members. AHF has found this system facilitates the care of the whole patient and is essential for care integration for the fragile dual eligible population. Behavioral health benefits must be incorporated in a dual plan as well as adequate financing structures to support this essential service for Duals.

⁵ AHFs HCCs serve primarily as safety net clinics, and approximately __10% of our 6,500 patients are Duals.

⁶ Julie Cross, "Overview: 1115 Waiver. Impact on Los Angeles County's HIV Population," April 13, 2011.

Long Term Supports and Services (LTSS):

AHF has ten years experience of integrating LTSS into its managed care programs due to our home and community based AIDS Waiver contract. Because of our experience, integration of these home and community based services (HCBS) as well as adult day care services into a comprehensive Dual plan, we believe it is essential to provide seamless comprehensive care and services designed to divert institutional care, promote improved individual health and functional outcomes, as well as decrease health care expenses.

d. Specific plan for integrating home and community-based services, including non-Medicaid long term supports and services

Ten years of experience has informed AHF in the essential nature of integrating Home and Community Based Services (HCBS) into the constellation of services for Dual integration. HCBS and adult day care services are chronic care management tools and should be incorporated into the overall care delivery model for Dual integration. Separation of these benefits has produced fractures in care coordination due to contracting, lack of plan knowledge of these types of systems due to lack of fiscal and care benefit responsibility. These fractures in care consistently lead to higher medical expenses, decreased health outcomes and decreased patient satisfaction.

e. Assessment and care planning approach

A Chronic Care Model requires a Chronic Care plan that is specific to the patient's chronic condition. However, in developing a chronic care program, there are components that should be in place for any chronic condition. AHF has developed a wrap-around chronic care management program that is patient centered: a patient centered chronic care model managed by nurse care managers is a new concept for dual eligible and individuals with chronic conditions. This concept expands the traditional acute case management model to recognize the need for long term chronic disease management, evidence based medicine management and cost containment. The following outlines AHF's Chronic Care Program for people with HIV and AIDS.

The Chronic Care Program is a patient centered philosophy that involves building a relationship with providers, patients, and the community to facilitate improved patient self management of their healthcare and improved health outcomes. Additionally, the program strengthens centralized care coordination role of the professional nurse in care coordination by designating registered nurse case managers as care team coordinators who work directly with patients and medical providers to achieve the individual patient treatment plan goals. The program fosters the principles of care coordination to address the continuing care needs of patients with multiple payer sources and diverse programs available to support the individual patient plans of care.

AHF's experience has demonstrated that a member's primary care provider (PCP) should also be a specialist in the chronic condition or needs of vulnerable dual eligible individuals, e.g., an endocrinologist for people with diabetes. At AHF, a patient's PCP is also an HIV specialist and an experienced provider of services to dual eligible individuals. AHF incorporates the HIV PCP definition into its formal credentialing requirement as a Plan PCP and defines the HIV PCP as someone with:

- Meeting the certification experience/criteria as described by the American Academy of HIV Medicine or the HIV Medical Association of the Infectious Disease Society of America
- Has at least twenty patients diagnosed with HIV or AIDS currently on her or his roster

The Chronic Care Management Program RN Care Manager (RNCM) assesses the patients and determines the patient severity of illness level. Based upon this extensive clinical assessment the RNCM works with the patient and the HIV PCP, behavioral health issues, other applicable ancillary health care providers and community support service providers to design a coordinated plan of care that addresses the medical plan, adherence, integration of LTSS and the patients' goals. This type of

integrated assessment and plan of care is the cornerstone to dual integration and must be included in any pilot with the goal of integrating care.

Overall Goals

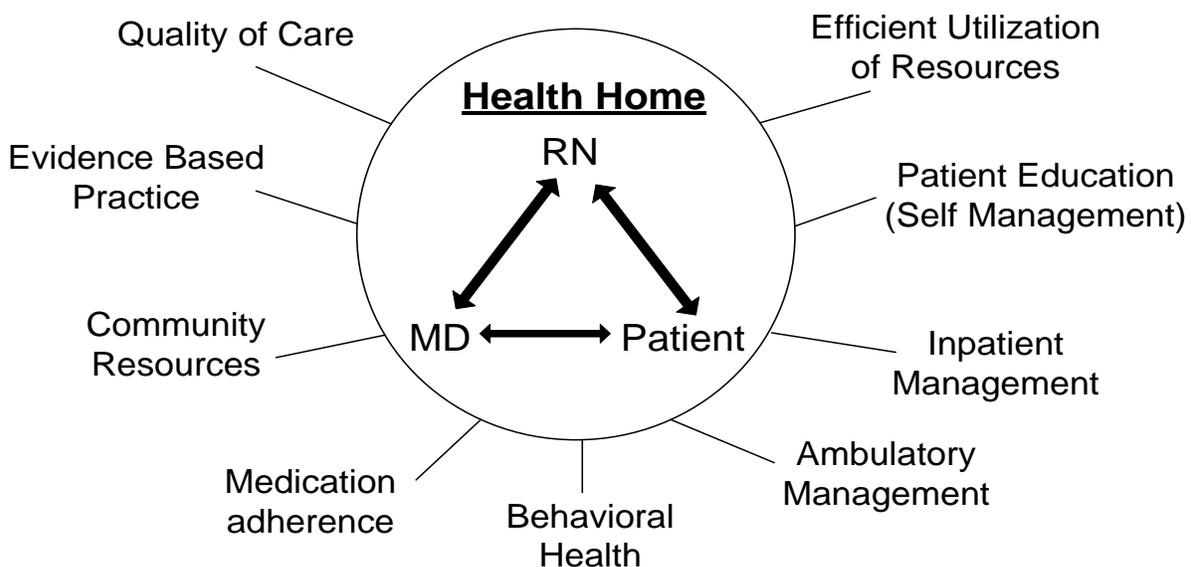
The Chronic Care Management program is focused on meeting the ever evolving needs of people living with HIV/AIDS in an effort to improve their health outcomes and quality of life. It is also aimed at more efficient utilization of existing resources as it relates to patients, providers and staff. One of the other goals of the program is to help patients successfully navigate a complex system of healthcare in order to provide seamless coordination and transition from one level of care to another.

The Chronic Care Model

AHF takes the “Medical Home” in which the Primary Care Provider, nurse and patient participate in a partnership of care. The team incorporates evidence-based practices primarily through evidence based care coordination nursing interventions which bring integration of plan medical and behavioral health benefits as well as LTSS and other community resources that will benefit the patient in reaching the goals of the overall treatment plan.

Patients are assessed and reviewed by all team members and assessments are documented in care plans via standardized assessment fields within the patients’ electronic health records. Ambulatory Management is provided by the team when they follow up on services in the outpatient setting. Inpatient Management is provided when the team contacts the patient, coordinates discharge plans with the Utilization Management Nurse and assesses patient self management skills in the implementation of services. Patient Education is provided by all members of the team. This fosters efficient utilization of resources by involving the team in care review, encouraging medication adherence, supporting self management, and assessing compliance with the plan of care.

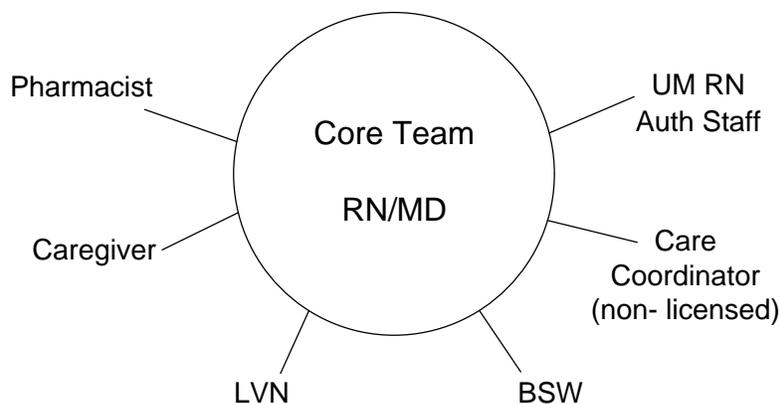
The Medical Social Worker and, if appropriate, other behavioral specialists, e.g., a psychiatrist, are members of the care team. These psychosocial specialists receive referrals from the team and supports patients by further assessment and the inclusion of their findings in the care plan and consultation with PCP and nurse for further referrals. The following schema illustrates AHF’s Chronic Care Model:



f. Care management approach, including following a beneficiary across settings

Nine core measures are assessed and reported quarterly to Utilization Management Committee and monthly to Managed Care Executive Committee. Each measure has standards or targets that can be determined and the success of the Chronic Care Model is evaluating how well these targets are met. Some are tailored for people with HIV and AIDS, for example, T-Cell (or CD-4) count, and are standard outcomes measures established by the likes of HHS and HRSA's HIV/AIDS Bureau while others are standards applied to any chronic special needs population, e.g., number of ER visits or hospitalizations.

The RN Team Manager is responsible for managing the core team. Each core team is assigned to a specific Health Home. RN Care Team Managers are assisted by the LVN/LPN Care Partners and non-licensed Care Coordinators. The Medical Social Worker is an additional resource for the patients as well as the teams. There is psychosocial assessment and referrals for community resources. Pharmacists support the team and patients with additional assessment and medication information. The diagram below depicts the team structure.



Impact of Program

The case management program also builds a partnership with the physicians through team conferences and patient conferences. The team's activities under the direction of the registered nurse assists in the development of comprehensive treatment plans and provide information on the patient's home environment and the psychosocial aspects of care. The Chronic Care Management Program improves the SF-12 quality of life scores, improves patient satisfaction with the care system, and decreases the utilization of emergency services, hospitalizations and readmissions. Effective evidence based management of the utilization of services and utilization of care transition interventions by the care management staff has a positive impact on patient health outcomes, readmissions to the hospital and the financial resources that can then be utilized to support other care benefits that are not covered by Medicare or Medi-Cal.

g. Financial structure, e.g., ability to take risk for this population.

Pilot project should possess the ability to accept risk on a shared basis with the DHCS, e.g., a Primary Care Case Management (PCCM) program or be a Knox-Keene licensed health maintenance organization..

2. How would the model above meet the needs of all dual eligibles, i.e., seniors, younger beneficiaries with disabilities, persons with serious mental illness, people with intellectual and developmental disabilities, people diagnosed with Alzheimer's disease and other dementias; people who live in nursing facilities, etc. If you would propose to serve a smaller segment than the full range of dual eligibles, please describe that approach.

Not all dual eligible individuals have the same needs. As outlined in our introductory letter, we strongly believe the pilots should explore providing a specific pilot for dual eligibles with one of the CMS-defined Chronic Care SNP conditions for Medicare Advantage Part D plans.

3. How would an integrated model change beneficiaries' a) behavior, e.g. self-management of chronic illness and ability to live more independently, and b) use of services?

Integrating Medicare, MediCal, behavioral health, LTSS and community services provide seamless access for care coordination and flexibility. This coordination and flexibility allow for creative care approaches that promote patient self care empowerment and integration of support services which leads to indicated and appropriate use of services at the appropriate level of care. The program facilitates access to care for patients through case management. AHF adopts the definition of the practice as set by the Case Management Society of America: "case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes" (CMSA, 2009).

The following are the standards with which AHF implements its Chronic Care Management Program:

- Focus on the total individual and her or his caregivers
- Support self-care when possible
- Increase the patient's involvement in decision making
- Minimize fragmented care
- Use evidence based guidelines
- Facilitate a complete transfer to the next care setting
- Improve outcomes by use of guidelines, tools and processes that measure a patient's understanding of the care plan and willingness to maintain a behavior change
- Expand the care team to include community and facility based providers such as pharmacists and holistic practitioners
- Support regulatory adherence
- Move patients to optimal levels of health by improving adherence

Patients with higher acuity receive more personalized care by increased face-to-face interactions with the care team. The RN Care Team Manager integrates the care patients receive by acting as the crucial point in the coordination of care and services.

4. How would an integrated model change provider behavior or service use in order to produce cost-savings that could be used to enhance care and services? For example, how would your model improve access to HCBS and decrease reliance on institutional care?

The philosophical framework upon which the case management program is built places Medical providers in a team relationship with the patient, the case manager, other specialty providers and community resources. This team approach ensures that the patient is supported in a coordinated plan of care that meets the patient's needs.

Medical providers are involved in team conferences and receive additional assessment information from all care providers. This model fosters efficient utilization of resources by involving the team in care review, encouraging medication adherence, supporting self management and compliance with the plan of care.

5. How would your specific use of blended Medicare and Medi-Cal funds support the objectives outlined in the proposal above?

The blended use of Medicare and MediCal funds would allow services to be comprehensively negotiated and integrated into one plan of care with each unique provider of care. Integration of

funds allows flexibility in providing seamless care and services in an effective and efficient manner. Separate and distinct Medicare and MediCal funds require separate contracting, accounting reporting, benefit and authorization processes. Integrating funds integrates these processes and improves administrative efficiency which allows care management to flow appropriately for each individual member.

6. Do you have support for implementing a duals pilot among local providers and stakeholders? If so, please describe. If not, how would you go about developing such support? How would you propose to include consumer participation in the governance of your model?

AHF has an integrated network in place due to its Medicare Advantage Part D Special Needs Plan and its MediCal Managed Care AIDS Plan that are currently operating in Los Angeles County,

7. What data would you need in advance of preparing a response to a future Request for Proposals?

The data needed would be de-identified unique member claims data for special needs population in LA County.

8. What questions would need to be answered prior to responding to a future RFP?

What is the state's plan for integration of funds?

Will the state contract with Chronic Care Medicare SNPs with dual and non-dual populations?

9. Do you consider the proposed timeline to be adequate to create a model that responds to the goals described in this RFI?

Since AHF is operating as a Medicare and MediCal plan, we feel the time line to create the operational model is adequate. The time line for state determination of appropriate rates is subject to state confirmation of the ability to meet the time line outlined.