

**AltaMed Health Services Corporation
Response to Request for Information on
Pilots for Dual Eligibles Part 1 Questions**

Part 1: Questions for Potential Contracted Entities Only (Please limit to 15 pages)

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

- a. Geographical location;
- b. Approximate size of target enrollment for first year;
- c. General description of provider network, including behavioral health and LTSS;
- d. Specific plan for integrating home and community-based services, including non-Medicaid long term supports and services;
- e. Assessment and care planning approach;
- f. Care management approach, including following a beneficiary across settings;
- g. Financial structure, e.g. ability to take risk for this population.

Overview of the Proposed Model (*Assessment and care planning approach*)

AltaMed Health Services Corporation (AltaMed) is a full life-cycle, Federally Qualified Community Health Center (FQHC), which has been providing quality health care to the underserved and uninsured in Southern California for more than 42 years. In 1996, AltaMed opened its PACE program after more than a decade of researching the benefits of this integrated health care delivery system.

Under its Senior Care division, AltaMed provides a comprehensive continuum of senior care services that includes the PACE program as well as seven Adult Day Health Care (ADHC) centers, the Multipurpose Senior Services Program (MSSP) and Integrated Care Management Program (ICMP) services. AltaMed's Senior Care division has thrived as a successful senior care clinical model because we deliver a comprehensive, integrated system of care with competent, multi-cultural bilingual staff and employees who have remained committed to our mission of promoting participant independence. We enable our elderly and disabled patients to remain in their homes and in the community for as long as possible.

To best serve the spectrum of patients who are dually eligible for Medicare and Medicaid, AltaMed proposes a tiered approach that would identify, screen and assign patients, age 18 and older (excluding the CCS population) to the appropriate level of care based on a comprehensive health screening and evaluation. By stratifying patients into appropriate levels of care based on health needs (physical, behavioral and social), AltaMed, its contractors and partners can provide the most cost-effective care for each patient, tailoring services and supports to the patient's individual needs. With extensive experience in managing similar patient populations through our existing programs, we understand the models of care that are most practical for dual-eligible patients.

Across the three tiers of acuity, all patients would receive a standard level of coordinated care and access to services to meet their basic physical and behavioral health needs. As the level of acuity increases, services provided would increase in terms of frequency, intensity and specialization. In all instances, AltaMed will coordinate screening and enrollment with managed care plans to ensure referrals for services occur in a timely manner and limit disruptions to patient care and access to services.

Beginning with the low level acuity patients, individuals will receive coordinated care organized and provided through a patient centered medical home (PCMH). These medical homes are available to all patients and focus on preventive and primary care in an integrated setting that enhances the patient's ability to maintain wellness, receive community support access routine care. For intermediate (medium) level acuity patients, AltaMed proposes to provide these patients with a comprehensive array of services and support. In addition to the PCMH model of care, these patients will benefit from additional hands-on care coordination and coaching from a patient care team. Lastly, in the third level of care for highest acuity patients, individuals would be enrolled into AltaMed's PACE program that comprises a multitude of community-based and in-home services for both chronically ill, frail elderly and populations with special needs (e.g. cognitive impairments).

Criteria for identifying PACE eligible participants would include:

1. Age: 55 and over
2. Requires assistance with two or more limitations to their activities of daily living (ADL) and instrumental activities of daily living (IADL), perhaps using assistive services (e.g., canes, walker, wheel chairs, etc.)
3. Two or more chronic conditions that require supervision or management
4. Eight or more prescriptions in any given month
5. Resides in PACE zip codes
6. Skilled Nursing Facility (SNF) placement/utilization within the last six months
7. Meets criteria for Intermediate Care Facility (ICF) placement

At the core of the care model for all patients is the need to support care transitions and coordination across the continuum of care. Recognizing a major cause of hospital readmissions and poor health outcomes is directly related ineffective care plans, untimely access and poor care transitions, AltaMed, the ACN providers and contracting providers understand the value of enhancing the coordination of care across the continuum. To achieve this level of care, AltaMed will work with providers, particularly area hospitals to strengthen communication and coordination between acute care and primary care settings. This improved communication and coordination will improve the patient's perception of their medical home, creating a stronger bond with primary care. Care coordination efforts will focus on continuously connecting patients back to their medical homes and ensuring primary care providers have timely access to patient information, preferably through web-based portals/exchanges to reduce duplication of services and increase continuity of care. One particular area of focus will include medication reconciliation across providers within the network

AltaMed's Network of Providers for the Pilot

AltaMed is the clinic and IPA partner for the Regional Safety Net Accountable Care Network (ACN), a public-private regional collaborative consisting of AltaMed; Citrus Valley Health Partners, a three hospital system with an inpatient hospice and home health services; Hollywood Presbyterian Medical Center, and acute care hospital with an adjacent sub-acute facility; and White Memorial Medical Center, a full service acute care hospital and regional referral center. AltaMed's Independent Practice Association (IPA) consists of a network of over 700 contracted healthcare providers in Los Angeles and Orange Counties. We are contracted with the local hospitals in our service areas. In addition, we offer Hospitalist Provider Coverage at all of our contracted hospitals.

Our Care Management Program is integrated with our hospital partners to provide additional support to the PCP and patient for care coordination after an admission.

The ACN service area includes Koreatown, Hollywood, Downtown, East Los Angeles and East San Gabriel Valley regions. LAC+USC Healthcare Network (LAC+USC) is also fully engaging as a coordinating entity with the Regional Safety Net ACN. This network of providers has a history of working together to coordinate care and is uniquely capable of providing enhanced management for dual eligible patients. Discussions are under-way with other acute care, long term care and community care providers interested in joining the ACN.

AltaMed's contractual risk sharing arrangements are consistent with the above-referenced PACE program goals and objectives, as the contracting arrangement will enhance provider access, improve enrollee health and functional outcomes, and increase the quality of care provided to program participants. Establishing such an arrangement with a comprehensive community based network of medical professionals enhances service to members by providing added value to the program. Small programs, defined as such by enrollment, are frequently at a disadvantage. The provision and maintenance of a comprehensive professional network offers choice (multiple providers within each discipline), access via expanded geography, and timelier referrals due to abbreviated referral and authorization processes that we believe are ideal.

This arrangement makes available to AltaMed a network of specialist physicians that represent more than 25 different disciplines to provide consultative physician services (including geriatrics) and institutional services in two counties. In some cases, a single contracted effort enhances access, service and quality. It is noted that the key components of the PACE program, the primary care physician services, interdisciplinary team, the ADHC, and the operation of the PACE center (including employment of the interdisciplinary team, the program director, and the medical director) will remain with AltaMed. Subcontracted arrangements would only be applicable to specialist physician referral services, certain ancillary services and institutional care.

Proposed Geographic Service Area and Target Population

Within the ACN, AltaMed currently enrolls patients into its PACE program from the following zip codes, which we would propose as the core zip codes for the pilot:

AltaMed PACE Approved Zip Codes:

90001, 90002, 90003, 90004, 90005, 90006, 90007, 90008, 90010, 90011, 90012, 90013, 90014, 90015, 90016, 90017, 90018, 90019, 90020, 90021, 90022, 90023, 90026, 90027, 90028, 90029, 90031, 90032, 90033, 90036, 90037, 90038, 90039, 90040, 90041, 90042, 90043, 90044, 90057, 90058, 90062, 90063, 90065, 90071, 90201, 90240, 90241, 90242, 90255, 90262, 90270, 90280, 90601, 90602, 90603, 90604, 90605, 90606, 90640, 90650, 90660, 90670, 90706, 90723, 91204, 91205, 91731, 91732, 91733, 91746, 91754, 91755, 91770, 91775, 91776, 91780, 91801, 91803

Based on available data provided by DHCS, AltaMed estimates the following number of eligible beneficiaries by age group in the proposed service area.

Estimated Medi-Cal Dual Eligible Population within AltaMed PACE Approved Zip Codes	
Age Range	Percent of Beneficiaries (n)
0 – 5	2.7% (1,907)
6 – 17	9.3% (6,562)
8 – 20	2.8% (1,985)
21 – 44	20.3% (14,392)
45 – 64	47.3% (33,528)
65+	17.9% (12, 506)

Given the volume of eligible beneficiaries in the service area, AltaMed anticipates that it could enroll 5,000 to 20,000 patients in year one.

Ability to Integrate and Manage Care for Dual Eligibles

AltaMed, with its large number of staff model clinics formatted as patient centered medical homes, a strong IPA, PACE and strong clinical integration with the hospitals of the ACN is well positioned to be part of the care solution for those dual eligibles who will become members of a Managed Care Plan in Los Angeles County. AltaMed and the ACN hospital partners' long-standing expertise in serving the dual eligible population is also an asset to the state and any managed care plan.

The ACN serves as a vehicle for AltaMed to engage in regional level translational and population-based research, establishing evidence-based guidelines in partnership with hospital based physicians, and maximizing regional economies of scale for professional and administrative services.

AltaMed, with its ACN hospital partners, is well positioned to be part of the care solution for many of the dual eligible individuals who will become members of a pilot. Its long-standing expertise in serving this population through FQHC sites, PACE, ADHC, MSSP and ICMP will be an asset to the potential contractor. Access to its network of employed providers, independently contracted community physicians and strong relationships with hospital partners will be of significant value in delivering integrated care.

As an experienced PACE provider and contractor with many managed care organizations, we would like to share best practices and lessons learned with those designing and implementing the pilot.

AltaMed Innovations and Proposed Initiatives to Enhance Services for Dual Eligibles

AltaMed is uniquely qualified to manage the medically complex dual eligible beneficiaries enrolling into managed care and as one of five organizations in California managing a PACE program, AltaMed is the only organization within Los Angeles County offering this specialized service.

Recognized as one of the nation's most innovative providers of all-inclusive medical and social services to the elderly with a specialty in dementia care and caregiver support, AltaMed is committed to making long-term senior care a top priority. Through our dedication to compassionate care, we are helping more seniors live with dignity in the comfort of their own home, and we are giving caregivers the respite and support they need to maintain a loving relationship with their aging parents or family members. AltaMed ensures the availability of over 400 staff caregivers to offer respite and support to the patients and families of this population.

AltaMed is launching a project that expands the use of Remote Patient Monitoring (RPM) technology as a way to assist older adults with ongoing chronic illness to live independently and safely in their homes. The project, named the Remote Patient Monitoring Project—California and Connecticut (RPM-CC), will implement a home-based telehealth monitoring project to help improve self-management behaviors among 75 low-income seniors in East Los Angeles/Boyle Heights with congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, or hypertension. This project was funded in part by the SCAN Foundation and the Public Health Institute. Key objectives of the project include:

- Potential to extend far beyond the initial project pilot sites
- Test the replicability of an evidence-based model of RPM for older adults across different systems of care including a community clinic model of care and PACE settings
- Promote the expansion of a new healthcare para-professional, a “Telehealth Technician”
- Establish a foundation to roll-out this model throughout community clinics and PACE programs in California, and possibly nationwide

In addition to the RPM Project, AltaMed's executives and Senior Care leadership are implementing a number of initiatives to further enhance the quality of care and effectiveness of the PACE program. Initiatives will focus on:

- Ambulatory Care Sensitive Related Condition hospitalizations and readmissions
- Enhanced participant care plans to include patient and family input
- Post-hospitalization follow-up care within three days of discharge
- Medication reconciliation and implementation of additional preventive screenings

Moreover, AltaMed has embraced the Patient-Centered Medical Home's (PCMH's) seven Core Services Delivery Principles for all its patients and has several pilots underway at its primary care clinics. Patient-centered interdisciplinary teams represent staff from the primary care team, ADHC, MSSP and ICMP. AltaMed is planning to apply for NCQA PCMH certification through the HRSA PCMH Initiative in 2011. AltaMed patients who require a more intensive level of care are assessed for the PACE program which provides the optimal model for patient-centered care.

Financial Structure

AltaMed will consider rate-setting and risk sharing methodologies that create incentives that support quality improvement and desired health care outcomes. Given our experience in assuming risk for primary, specialty and institutional care, we plan to phase in financial risk for the management of all elements of the care continuum.

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.

AltaMed is uniquely qualified to serve the aged, blind and disabled dual eligible beneficiaries age 18 and older as a longstanding and experienced provider of adult day health care, MSSP, Area Agency on Aging Care Management Program and PACE Program. This population may include seniors, the younger disabled, persons with mental illness, the developmentally disabled and persons living with dementias. Services will be provided based on individualized care plans that reflect need and will not be constrained by program restrictions.

In Los Angeles County, AltaMed currently has three anchor PACE sites in which Adult Day Health Care services, primary care and some specialty care is provided on site. Specialty services provided on site include: podiatry, optometry, general dentistry, individual and family counseling by a panel of psychologists and therapists, chiropractic care for simple pain management, and audiology screening. Hospitals, ancillary service providers and specialists are contracted to supplement the services provided through the PACE sites and are generally located within 10 miles of each PACE service site.

A few differentiating factors of the delivery system include:

- A team of linguistically and culturally competent hospitalists ensure that PACE members are well managed on an inpatient basis, redirect members to urgent care when appropriate and work within emergency room settings to coordinate with the PACE physicians and staff to address the member's needs in the most appropriate care setting
- Partnerships with community based experts in various disciplines, such as pain management, behavioral health, palliative care, wound care and hospice care, offer a comprehensive approach to providing these services at the PACE sites and/or in the member's home to accommodate patient and family needs
- Onsite pharmacy services are offered to assist with medication adherence, ease of delivery to members, e-prescribing and integration of dispensing data
- Scheduling support and transportation services are offered to patients as part of the program to ensure that appointments with specialty care providers are kept and that care is effectively coordinated
- Laboratory and radiology services are offered on the PACE site and results are integrated with the member's electronic health records

The PACE model of care will be the foundation for developing this pilot. Patients referred to AltaMed's pilot project would have the opportunity to receive a comprehensive benefit

package. In addition, the pilot program would provide the needed management and infrastructure that will allow this group to receive intensive care management services that would ensure that services are delivered at the appropriate level of care in order to minimize unnecessary expenditures of available and valuable health care dollars.

The pilot program will be centered on the belief that it is better for the well-being of adults with chronic care needs and their families to be served in the community than in an institution whenever possible. Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to persons with chronic care needs while maintaining their independence.

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?

The pilot program will incorporate and combine a full range of services with outcomes that result in higher quality of care.^{1,2} The pilot program's services will include primary medical, dental and specialty care delivered by a panel of geriatricians and internists, hospital and nursing home care, in-home health care, day care, meals, and transportation. An interdisciplinary team of physicians, nurses, social workers, therapists and aides will be responsible for developing each treatment plan in coordination with the dual eligible patient, caregivers and family members. This team will be responsible for managing all services. Having a full continuum of care will reduce fragmentation and help the patient to better navigate their services. Moreover, the reduction of barriers to accessing a flexible and comprehensive array of services that will meet their individual needs will improve their quality of life.

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?

Integrated funding would provide the necessary incentives to slow the growth of costs associated with unnecessary institutional placement, hospitalization and emergency room usage. By providing timely access to home and community based services based on their changing needs, patients will be able to experience a higher quality of life and reside in an independent setting.

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

¹ Leavitt, Michael, "Interim Report to Congress: The Quality and Cost of the Program of All-Inclusive Care for the Elderly (PACE)," *Health and Human Services* (2009) [<https://www.cms.gov/PAACE/Downloads/Report%20to%20Congress.pdf>] Accessed February 2011

² Mancuso, David, et al., "PACE: An Evaluation," *Washington State Department of Social Services, Research and Data Analysis Division*, Report Number 8.26 (June 29, 2005)

The use of blended Medicare and Medi-Cal services will reduce fragmented care and improve coordination in a seamless fashion.

6. Do you have support for implementing a dual 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?

As a health care and human services provider since 1969, we are very well regarded in our community and maintain excellent relationships with a multitude of community organizations that are seeking better coordinated and integrated care that will improve health outcomes for their clients. Our governing board of directors maintains 51% consumer representation and includes seniors and persons with disabilities.

Moreover, we have the full support of our local private hospitals, clinic and physician providers of the ACN and a commitment to coordination of care from LAC+USC Medical Center.

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

We would need all of the state and CMS Medi-Cal and Medicare utilization data for dual-eligible patients in LA County.

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

How would new patients be enrolled into managed care? What kind of mechanisms would be in place to allow patients to opt out of a plan and into another and how often could a patient do so?

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

The timelines seem aggressive. The criteria is only now being developed leading to questions as to whether an effective and appropriate model can be proposed. Moreover, can that model be appropriately assessed within this timeline?

**AltaMed Health Services Corporation
Response to Request for Information on Pilots
for Dual Eligibles Part 2 Questions**

**Part 2: Questions for Interested Parties (including potential contracted entities):
(please limit to 10 pages)**

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

Voluntary enrollment would be preferred. However, if mandatory enrollment is required, the patient should be allowed to dis-enroll within 30 days of request.. The enrollment process should be as smooth as possible with minimal bureaucracy and paperwork.

Moreover participants should be allowed the opportunity to opt out of the program, (this could lead to challenges in coordination of care if Medi-Cal insists on retaining their portion in managed care). Enrollment of all benefits should be through the same organization, to assist care coordination as streamlined as possible.

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

In addition to all medical, dental and vision benefits usually available to dual eligible patients, the following services should also be included as part of the integrated model in a manner that is responsive to the changing needs and choices of this population.

- Care Management/Care Coordination
- In-home attendant care for personal and chore services
- Durable medical equipment to facilitate ambulation, mobility, transferring, bathing, toileting
- Assistance with securing ramps for patients with wheelchairs
- Transitional care
- Short term nursing home services with goal to get patient back into a community setting
- Rehabilitative services (PT, OT, and ST)
- Senior Centers
- Medication Management
- Meals on Wheels
- Emergency Telephone Response Subsidies
- Non-Emergent Transportation

- Skilled Nursing Facilities
- Hospice

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

Minimally, screening for mental health/cognitive conditions by appropriate professionals as well as individual and family counseling should be available through appropriate referral and coordination systems. Findings are an integral part of the care plan.

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?

Rates would need to be actuarially sound based on utilization and claim data for this population.

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

Services need to be tailored according to the individual's physical, functional, mental and cognitive impairments and history of hospitalizations, ER and nursing home utilization.

The following principles should be considered:

Interdisciplinary Team with Experience Serving Aged, Blind and Disabled Dual eligible Population

- Geriatrician/Internist
- RN Case Manager
- Social Worker
- Physical and Occupational Therapists
- Speech Therapy (at a minimum screening for those with difficulty swallowing)
- Community Health Worker/Promotora
- Nutritionist/Dietician
- Clinical Pharmacist

Array of Services

- Primary , Dental, Vision, and Specialty Care (Medical and Dental)
- Prescription drugs and Medication Management

- Home Visits by Geriatrician/Internist for special cases should be considered, depending on need
- Disease Management
- Health Education and Prevention Services
- Acute care
- Psychosocial support and Mental Health services with a warm hand off from primary care physician to behavioral health practitioner
- In-home attendant
- Home health with the option of receiving physical, occupational and speech therapy at a center/clinic
- Family respite
- Care giver and family counseling and support
- Nutritional Counseling

Care is Coordinated, Seamless and/or Integrated

- Care Coordination Team management and service coordination
- Aggressive management of care transitions

Quality and Safety

- In-home and environmental assessments
- Fall prevention programs
- In-home safe guards: Hand/tub rails, access ramps
- Emergency Telephone Response System

Enhanced Access

- Transportation to primary care and specialty appointments
- Timely access to specialist for routine appointments: one week
- Timely appointments to specialist for urgent services within 36-48 hours of requests
- Same day primary care appointments
- Specialist panel of over 25 different disciplines

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

The State needs to work with community organizations to educate our beneficiaries in multiple languages on the benefits of the pilot projects. This education needs to be conducted in accessible locations throughout the counties that are selected as pilots in order to ensure that the beneficiaries are informed about the pilots. The content must be appropriate to meet the literacy level of this population. If at all possible, information should be disseminated through ethnic and mainstream media outlets. More webinars and conference calls would be helpful for stakeholders to provide input. Education to providers on the objectives and benefits of the pilots needs to be done. The State can work with groups such as the California Association of Physician Groups, CAL PACE and the California Primary Care Association to educate the providers who may be interested in participating in the pilot.

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

What experience have you had serving frail, aged and disabled (dual eligible) populations and evidence of keeping this population out of nursing homes, reduced hospitalizations and reduced usage of Emergency Room?

What experience do you have in providing integrated care including long-term services and supports?

What is your experience in serving a culturally diverse population needing behavioral health services? How would you propose integrating these services?

Is the potential contractor's network sufficiently robust to handle a medically complex and culturally diverse population? Are their service delivery facilities, furnishings and equipment appropriate for blind, disabled and aged populations?

Provide a description of the network of specialist providers: the type of arrangements in place, the oversight and management for access and quality.

What processes/evidence, such as documentation, can you provide to demonstrate integration of services?

How would you monitor quality?

What outcomes measures would you track for this population?

What experience do you have in providing integrated care to a multicultural population?

What experience do you have in addressing social service issues that affect health care cost and outcomes?

What experience do you have in engaging the families of this population in managing healthcare needs?

What systems do you have in place to facilitate smooth transitions of care between settings of care?

Active engagement of licensed healthcare professionals, support staff and institutions will be critical in aligning the delivery system to manage the population efficiently.

Evidence of commitment to warm hand offs among health care institutions and providers involved with care transitions.

Evidence to the commitment of improving population health through community outreach and engagement strategies will be key in identifying committed organizations.

Evidence of commitment to information technology infrastructure with a focus in the health care community will be key to assure long term success.

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?

Providers shall be held to a standard for facility readiness consistent with State facility review guides.

Staff should reflect the cultural diversity of the population being served demonstrating competency in communication, both verbal and written.

Translation services for this population should not rely on family members but ensure professional competency.

Evidence of culturally and linguistically competent staff including staff trained for sensitivity and responsiveness to individuals with sensory deficits

Environment of facilities responsive to a population with disabilities and sensory deficits (geriatric/disabled friendly)

Geriatric and rehabilitation support services are essential.

Providers should be held to timely access to care as well as telephonic access standards.

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

N/A

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

An assessment of systems and infrastructure for successful management of this population is key. Electronic Medical Records will be essential for care coordination and communication among the provider community. The lack of a sound infrastructure will challenge any opportunity for success.

Contributions/expertise from each of the partners and accountability for processes, facility use allocation, reimbursement.

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

The success of the pilots should be based on patient and provider satisfaction, quality outcome measures, reduced hospitalizations and ER usage as well as the prevention of nursing home placement.

The evaluation needs to have short term and long term goals related to the achievement of measurable improvements in health care outcomes.

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?

- Redirecting funding currently allocated towards all elements of the program through the contractor will be critical to long term success and sustainability.
- A plan to phase in savings for the combined scope of services should be developed.
- A plan to test and phase in outcome measures to be tied to future funding should be developed.
- A plan to phase in provider and patient satisfaction to be tied to future funding should be developed.
- Sharing of prior cost experience for the combined scope of services should be provided to potential contractors in the rate development phase of the pilot.
 - Encounter data elements to be determined: Ambulatory visits, ER utilization, Institutional cost and management, SNF utilization, Specialist use and costs, Care Coordination (SW's), Rehabilitation visits may be a separate tracking from primary/ambulatory visits, laboratory and radiology utilization, etc.

- Willingness on the contractors' part to assume full financial risk or phase in financial risk for management of all elements of the care continuum should be incorporated.