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

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:

Overview of CalOptima's Proposed Model

CalOptima's success as a County Organized Health System (COHS) is derived from our relationship with and commitment to the community. As a COHS, CalOptima operates in an open and transparent manner with its community. We have a demonstrable record of serving as an efficient steward of public funds and consistently operating with administrative costs of around approximately 5%. Our Board of Directors is publicly appointed and holds its meetings in accordance with California's Brown Act. Our commitment to quality is reflected in consistently high HEDIS scores, as well as a recent national quality award for our Medicare Pharmacy program. Our commitment to an enhanced delivery of care for SPD and Duals is reflected in the array of programs we operate that serve the most vulnerable in Orange County. In addition to our Medi-Cal and Medicare Special Needs Programs, CalOptima has:

- Served as a Multipurpose Senior Services Program (MSSP) provider since 2001;
- Operated a Community Liaison Program to help members navigate community supports since 1997;
- Lead grant activities for the local Aging and Disabilities Resource Center (ADRC) since 2008;
- Operated a Community Relations Department since 2007 to ensure optimal collaboration among the community-based organizations that serve our members; and
- Secured Board authority to establish Orange County's first Program of All-Inclusive Care for the Elderly site, which is planned to be operational in early 2012.

CalOptima proposes to use its Medi-Cal managed care health plan as its platform to unify the delivery and financing of Medi-Cal and Medicare covered services for the dually eligible population. The goal is to integrate the provision of primary, acute, and long term care services through a single and accountable organized health care system. This model would provide dual eligible health plan enrollees a fully integrated benefit package through one managed care entity. This integrated delivery system model shall facilitate access and coordination of care for both enrollees and their providers, reducing the burden and challenges involved when having to navigate two separately operated health care programs. CalOptima is specifically interested in a model that integrates behavioral health, IHSS, ADHC, and other long term care services and supports that can help prevent or delay long term care institutionalization.

As a County Organized Health System (COHS), CalOptima is well positioned to implement and operate a Medi-Cal / Medicare integrated health plan model. As a State of California Department of Health Care Services contracted COHS, CalOptima already serves as the sole Medi-Cal managed care health plan to arrange for and administer Medi-Cal benefits for all Orange County dually eligible beneficiaries. In addition, CalOptima is already contracted with the state as a Multipurpose Senior Services Program (MSSP) site to provide social and health care management services to frail, elderly members. These services help them to live in the community as long as possible and prevent or delay admission to a skilled nursing facility. In its quest to offer further integration models of care to its members and their caregivers, CalOptima has submitted an application and leased space for a Program of All-Inclusive Care for the Elderly (PACE). PACE will provide interested elderly dual eligible members with an alternative fully integrated system of care.

To establish a Medi-Cal / Medicare integrated system of care pilot for the dual eligible population, CalOptima shall also leverage its model of care utilized for its Medicare Advantage Special Needs Plan (MA-SNP). CalOptima has operated a Medicare Advantage Special Needs Plan (MA-SNP), known as *OneCare* and a Medicare Part D plan, through competitive risk-based contracts with the Centers for Medicare and Medicaid Services (CMS) since 2005. CalOptima strategically pursued MA-SNP and Medicare Part D contracts in order to afford its CalOptima dual eligible membership more choice at enrollment to receive integrated Medi-Cal and Medicare covered benefits. While OneCare has proven to serve as a very helpful vehicle to facilitate coordination of health care services covered across both Medi-Cal and Medicare programs, the MA-SNP structure does not integrate home and community-based long term care services and supports as would be possible through a dual eligible pilot.

As a COHS, CalOptima's Medi-Cal managed care platform coupled with its current MA-SNP infrastructure and experience will serve as a strong foundation upon which to build a Dually Eligible Pilot Program that fully integrates a wider range of services for this frail and vulnerable population including long term care services and supports. Adding such services into the benefit package will provide beneficiaries and providers more choices and flexibility to develop treatment care plans that are patient-centric and address the true needs of a beneficiary; rather than a care plan that is driven by reimbursement and payor rules.

The following provides further information about CalOptima's proposed model.

a. Geographical location:

CalOptima is interested in operating a dual eligible pilot in Orange County, California to serve Orange County's dual eligible population. As stated above, CalOptima is already the sole responsible Medi-Cal managed care health plan for covered services provided to the Orange County dually eligible population.

b. Approximate size of target enrollment for first year

CalOptima currently serves more than 370,000 Medi-Cal recipients in Orange County. Approximately 70,000 of those members are dually eligible for Medi-Cal and Medicare. This includes 12,000 members in OneCare and 568 client slots in the MSSP. CalOptima proposes to make the dual eligible pilot available to all of these eligible beneficiaries.

Target enrollment in the first year shall depend on the enrollment approach utilized by the State. CalOptima will support the approach that works best for the community. As a COHS, CalOptima is able to communicate to the community the impact of the dually eligible pilots through the public meetings of our Board of Directors. Additionally, our vetting process includes Member and Provider Advisory Committees. CalOptima is the model of a transparent public agency that fairly and openly represents the diverse community it serves.

CalOptima is committed to the following principles related to enrollment and member choice:

- As a COHS, CalOptima works collaboratively with its communities of interest and will continue to actively work with them on this initiative; and
- As a COHS, CalOptima is committed to ensuring member choice through the delivery system it creates. Just as in the Medi-Cal delivery system it has created, members have

the choice of a number of health networks from which to obtain their health care services, so too CalOptima anticipates creating an array of service options for its members in the duals pilot.

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

CalOptima intends to leverage its existing Medi-Cal, MSSP, residential long term care, and MA-SNP provider network platforms and its extensive relationships among the community-based organizations that serve the dually eligible pilot membership. This will maximize continuity of care for members transitioning between CalOptima's current programs and the Dually Eligible Pilot Program with minimal disruption.

Description of Provider Network

CalOptima has a strong patient-choice primary care provider network base. CalOptima has a unique delivery model in that approximately 75% of the providers are private / community providers who participate in large IPAs or medical groups. This allows CalOptima to provide dual eligible members access to clinical services that are often not available in the traditional Medicaid environment. By leveraging its strong medical group and IPA provider relationships, CalOptima will be able to increase access to specialists and other clinical services. For example, access to pain management services in an area of the county that has only four pain management specialists was improved through CalOptima's medical group contracting. These pain specialists did not accept fee-for-service Medicaid. However, through one of our contracted primary care medical groups, CalOptima was able to negotiate for these specialists to provide services to CalOptima members.

CalOptima has deep provider penetration in the county. Its provider base has 1,123 primary care physicians and 2,139 specialists that are geographically distributed across the entire county. This represents 60% of the Orange County primary care providers and 35% of the Orange County specialist providers. This allows access to services geographically close to where members live and work. CalOptima's provider contracting strategy of establishing and executing agreements with high quality providers who are member preferred has been especially successful in addressing our members' cultural preferences.

Behavioral Health Services

CalOptima contracts with a behavioral health services IPA to provide behavioral health services to dually eligible members enrolled in OneCare. The behavioral health IPA offers members multiple clinical locations to access services throughout Orange County. This arrangement increases access to behavioral health care services. CalOptima's behavioral health providers offer telephonic and in-home assessments and therapy. They work closely and coordinate care with the contracted primary care physicians. They also have a robust outreach service that has various levels of engagement and is based on the members' readiness for engagement. For example, recently a member refused both telephone and in-home therapy but was willing to talk with a behavior health specialist one day a week at the local McDonalds. These types of flexible arrangements are critical to the success of implementing a comprehensive care treatment plan that addresses co-morbidities often seen in the dually eligible population.

Long Term Care Services and Supports

As a COHS, CalOptima is responsible for the administration of nursing facility benefit which includes provision of services in subacute, skilled nursing care and intermediate care facilities. As such, CalOptima has a contracted network of these various long term care facilities.

Additionally, CalOptima has contracted relationships with vendors that provide personal assistance and home-based services and supports through its MSSP.

CalOptima provides access and linkage to social services through traditional case management models staffed by social workers and behavioral health specialists. Moreover, through strong links with numerous community-based organizations (including but not limited to Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, Orange County Goodwill and Orange County Community Centers), CalOptima has the ability to provide Dually Eligible beneficiaries linkages to a wealth of long term care services and supports that will help maintain independence in a community-based setting. Furthermore, CalOptima's participation on the "Orange County Committee for Choice" provides CalOptima access to important agency resources that help facilitate increased access to locally available long term care supports and services. This committee is a quarterly forum of community organizations aimed at providing services for the aged and disabled. Recently, CalOptima sponsored a well attended meeting of over 150 community service coordinators participants and discussed referrals for community programs with presentations by the Orange County Department of Behavioral Health, Orange County Department of Education, and the Orange County Regional Center. This committee continues to serve as the primary agency responsible for convening community-based organizations to discuss best practices for long term care service models. It has served as a springboard for CalOptima incremental long term care service integration initiatives including CalOptima's decision to pursue contracting with the state to be a MSSP site. CalOptima also was the lead applicant for the Orange County Aging and Disability Resource Center (ADRC), and is pursuing the establishment of a PACE site.

Summary

As the second largest health insurer in Orange County, CalOptima is proud to offer its members access to a comprehensive network of providers and long term care services and supports. CalOptima offers its membership including the dually eligible population a very broad provider network composed of a wide range of clinical and social support service specialties including:

- Primary care physicians;
- Physician specialists including gerontologist;
- Hospitalists;
- SNFists;
- Acute care hospitals;
- Acute rehabilitation facilities;
- LTC facilities (includes SNF, sub acute, ICF, and ICF DD/N/H);
- Durable medical equipment (DME) agencies;
- Outpatient surgery centers;
- Home health agencies;
- Palliative care providers;
- At home meal providers;
- Transportation (e.g., all types for emergency and non-emergency services);
- Behavioral health providers (e.g., inpatient, outpatient facilities, psychologists, psychiatrists, and behavioral health specialists);
- Optometrists, dentists;
- Urgent care centers;

- Social workers thru strong links with community organizations (e.g., Dayle MacIntosh Developmental Center, Orange County Goodwill, and Orange County Community Centers);
- Internal support from CalOptima staff (e.g., MSSP and OC ADRC); and
- Health educators (e.g., dieticians, diabetic specialists, smoking cessation specialists, obesity specialists, and asthma specialists).

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

Since its inception in 1995, CalOptima has maintained a commitment to explore opportunities for integrating primary and acute care, long term care services and supports into an organized system. To this end, CalOptima has pursued available approaches, while incremental, to integrate health care services. For example, CalOptima has already integrated:

- Institutional long term care services; and
- Multipurpose Senior Services Program services.

CalOptima would like to integrate further Medi-Cal home and community based services such as:

- In Home Supportive Services;
- Adult Day Health Care Services and;
- Any other range of "in lieu of" services.

By fully integrating primary, acute and long term care services and supports into a single benefit under one accountable health care delivery system, beneficiaries and providers will have flexibility to design treatment plans that promote beneficiary independence, and prevent or delay institutional long term care. CalOptima's program will foster an improved environment for coordination of health care services across a broad of range providers. Additionally, as the health plan, CalOptima will improve its ability to proactively manage a member's care along the continuum of care.

Additional benefits include:

- Increased flexibility for members: Services such as those provided by the MSSP can be offered to people who may not qualify under today's rules because of where they reside
- Appropriate incentives: CalOptima will have the proper financial incentives to spend more on services to keep people out of nursing homes or prevent or delay entrance into a nursing home by providing services where they live
- Greater efficiency while achieving higher quality of life: Services can be provided in less restrictive settings in lieu of nursing home care (i.e. Board & Care and Assisted Living facilities)
- Accountability: CalOptima will ultimately be responsible for all aspects of care for its members (medical and social)
- Cost-effectiveness: The State will realize financial benefits from providing services in less restrictive, and less costly settings when appropriate for members

e. Assessment and care planning approach

CalOptima proposes to leverage its current "Model of Care" designed for its dual eligible population enrolled in its MA-SNP, to plan and coordinate care for enrollees in its dual eligible pilot. CMS approved CalOptima's OneCare "Model of Care" that reflects the Center's high

standards. The following describes in further detail components of CalOptima's "Model of Care."

Assessment:
The health risk assessment (HRA) is a tool used to assess the medical, psychosocial, cognitive, and functional needs of members. The HRA is given to new members soon after their enrollment and at least annually thereafter. The information from the HRA is used to assign each member to a specific risk level, identifying the severity of risk of an adverse situation (e.g. institutionalization, acute hospital care, or an emergency room visit). A member's HRA is then used in the development of a care plan, to further aid in service coordination, and to identify appropriate referrals to case management.

CalOptima currently uses this tool in the OneCare SNP and provides an initial and annual health risk assessment for each beneficiary in the program. OneCare's HRA includes a medical and mental health history and may be provided face-to-face, telephonically, electronically, or paper-based to ensure that all members are reached.

Care Planning:
After conducting the initial health risk assessment for each member, CalOptima and the PCP will develop an individualized care plan (ICP) to meet each member's needs. Care plans are a set of information that facilitates communication, collaboration and continuity of care across settings. A care plan will be tailored to each individual and take patient health status and preferences into consideration. The ICP will be reviewed and updated at least annually, with more frequent updates occurring to reflect any changes in a member's health status. Additionally, the ICP will be communicated to pertinent providers at all points of transitions of care. Each ICP will include the following:

- Goals and objectives;
- Standard and specialized services and benefits that meet needs identified in the assessment;
- A stratification of needs matched to services and benefits; and
- Measureable outcomes to determine the effectiveness of the care management plan.

CalOptima has experience using this approach with the dually eligible population through its OneCare program. CalOptima will extend the lessons learned through the process of implementing ICPs in OneCare for full dual eligible members to the participants of the proposed pilot.

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

As mentioned above, CalOptima proposes to use its MA-SNP "Model of Care" to care manage members enrolled in the dual eligible pilot. The following is the Care Management approach component of CalOptima's "Model of Care":

The goal of integrated care is to develop a streamlined, coordinated system of care the meets the needs of beneficiaries at each point in the care continuum. This requires a member-centric care model, ensuring the members and/or their families are the responsible parties in the care planning. A member focused approach allows members along with their PCP to direct the development of their care plan and amend the plan as their needs evolve. This is particularly important for dually eligible and other frail members who have unique and complex health care needs. The success of medical care is often dependent on other, particularly social, needs also being met. These needs

include the daily support services provided through IHSS, assistance preparing or eating meals, ADRC, transportation, and social interaction among many others. CalOptima recognizes that the traditional medical model does not adequately meet this range of needs and that care management must evolve to be inter-disciplinary and follow the member along the continuum.

As mentioned previously, CalOptima's Medicare Advantage SNP, OneCare, focuses on serving our dual eligible members. OneCare integrates the management and service delivery of the majority of Medicare and Medi-Cal benefits under one system of care for those seniors and persons with disabilities who choose to enroll in the plan. Ensuring coordinated care for our SNP members has required CalOptima to expand care management practices and capacity, including the thorough management of transitions in levels of care. CalOptima can apply the experience and expertise developed in administering this program to improve care coordination for the Medi-Cal population. Key care management functions include:

- Health Risk Assessment;
- Individualized Care Plan;
- Interdisciplinary Care Team; and
- Coordination of care along the continuum.

An interdisciplinary care team (IDT) manages the medical, cognitive, psychosocial, and functional needs of members, providing service coordination and access to the needed range of services. The IDT plays multiple roles in ensuring care coordination. First, the IDT must analyze and incorporate the results of the initial/annual HRA into the ICP. Second, the IDT must work collaboratively to develop and update an individualized care plan (ICP) for each member. The IDT is also responsible for communicating the care plan to relevant stakeholders. Each incoming member will be assigned to an IDT. An IDT minimally includes the following providers:

- Medical expert (typically a primary care physician but may vary depending on member needs i.e. for ESRD members their nephrologist may be their PCP);
- Mental and/or behavioral health expert;
- Social services expert; and
- Care manager.

An IDT may include additional staff based on the needs and preferences of the member, such as a pharmacist, health educator, disease management specialist, or pastoral specialist. Ensuring that member preferences are reflected in the IDT will increase the likelihood of participation from the member and, ultimately, compliance with the ICP. The IDT should evolve as the member moves along the continuum of care, ensuring that new health care needs are identified and addressed. It is paramount that the member and/or caregiver be involved to the maximum extent possible.

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

California has experience with various degrees of integrated delivery systems for the dually eligible. COHS plans, like CalOptima, are currently financially at risk for certain Medi-Cal benefits for duals – most significantly the institutional long term care benefit. COHS plans that also have a SNP, like CalOptima, have the added experience of being at financial risk for Medicare Parts A, B, and D. As noted in the RFI, SNPs are able to integrate services for members, but are not able to integrate the funding or the home and community-based services (HCBS). This pilot offers the opportunity to integrate funding into a new, blended capitation rate that aligns the financial structure to the services. Such a rate would be a global rate for Medicare and Medi-Cal medical services, and HCBS.

PACE provides an example of such a global blended rate. As a future PACE site for Orange County, CalOptima anticipates that the financial structure for the pilot may be modeled to some degree on the payments for PACE, which reflects the needs and frailty level of the participating population.

As the COHS for Orange County for the past 16 years, CalOptima has the experience of managing financial risk for the Medi-Cal medical services, including institutional long term care, for the SPD population for the past 15 years. In addition, as a SNP, CalOptima currently manages Medi-Cal and Medicare risk for nearly 12,000 dual eligibles. CalOptima has been able to manage within this fragmented system and maintain a healthy financial position during its entire history. With our experience, we are confident that a pilot that integrates funding and allows flexibility in program services can only help us achieve efficiencies and better use scarce public resources.

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.**

The "Model of Care" that CalOptima proposes to use for the dual eligible pilots provides the needed flexibility to be applied to address the needs of all dual eligible sub-populations listed above. More specifically, the interdisciplinary care team (IDT) component ensures that there is a unique team comprised of all needed disciplines for each member. Therefore the IDT of a younger beneficiary with developmental disabilities will have a different composition than the team of a dual eligible senior with serious mental illness. The team composition will be dictated by the unique needs of each member in order to adequately develop a care and treatment plan.

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?**

An integrated model of care provides the beneficiary a single health system to navigate for all their health care needs. Easier navigation removes barriers that beneficiaries face today when trying to access multiple complex health care systems to address their medical and psychosocial needs. Simplification of a beneficiary's health system can help foster increased patient involvement and compliance.

Furthermore, the use of "Model of Care" interdisciplinary care team (IDT) component ensures that the beneficiary is an active participant of the IDT and therefore involved in the development of the care treatment plan. This provides the beneficiary access to information about various options for addressing all of their medical as well as psychosocial needs. This process empowers beneficiary to evaluate and make choices that maximize their independence and ability to remain in their home or community. With an integrated model that incorporates ease in access, flexibility, and a wider range of home and community-based services, a beneficiary is assured that they will have the medical and psychosocial services and supports necessary to support their overall wellbeing. Choice and flexibility for non-traditional services alone would be expected to lead to greater beneficiary satisfaction and drive a beneficiary's motivation to direct their care and use services that will support their need for independence.

In summary, key attributes of the integrated model that will help change a member's behavior and use of services include the following:

- The integrated model is member-centric giving beneficiaries more opportunities to be active participants in their care;
- The care management process will provide beneficiaries with additional tools/support to make better health decisions; and
- The integrated model creates a support structure to help beneficiaries as they transition between points of care, by eliminating the fragmentation in the health system they encounter today.

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?

An integrated model of care offers the provider community a unified and streamlined health care system to navigate when attempting to coordinate care for their patients. Moreover, when a wide range of services and their associated financing becomes integrated, providers are able to work in a health care system environment that is patient-centric and not plagued by system barriers driven by reimbursement structures and cost-shifting incentives. Thus, a provider's ability and their personal experience in coordinating the right care at the right time are improved.

The "Model of Care" utilized by the pilot is another essential component to alter a provider's behavior and use of services. Through the use of an interdisciplinary care team, a provider is able to access a greater amount of information to inform the care planning process. This is a key element to inform all providers on the team to discuss a beneficiary's service utilization patterns, medical and psychosocial needs, and options for addressing these needs. The whole team is able to become informed about a wider range of options for treating the member. Through this vehicle, the care manager can introduce the availability of home and community based services and identifies other alternative long term care placement options. The successful execution of such model of care is a key ingredient to foster use of more economical services to achieve such goals as preventing 30-day readmissions, decreasing unnecessary hospitalizations and ED visits, and reducing reliance on institutional long term care.

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

Full Medicare integration is similar in many ways to the components of PACE. PACE programs provide comprehensive medical and social services, and are reimbursed with a blended capitation rate that includes both Medicare and Medi-Cal reimbursement. However, full Medicare integration in this context would not operate with the same eligibility or provider restrictions, but rather as a PACE 'without walls.'

PACE	Full Medicare Integration
Provider and insurer of care	CalOptima will continue to operate as a delegated model, contracting to provide services
Covers many non-covered Medicare and/or	LTCI would provide CalOptima with additional

PACE	Full Medicare Integration
Medi-Cal services	flexibility to provide a range of services
Integrates acute, chronic, and long term care	LTCI's goal is to integrate acute, chronic, and long term care
Provides care through interdisciplinary teams	CalOptima will develop/strengthen IDT to provide comprehensive and coordinated care
Receives blended Medi-Cal and Medicare payments	Ideally, LTCI would include a fully blended capitation payment for duals

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?**

   As a public agency, CalOptima has actively sought collaboration with key community stakeholders in the development of its integration strategies to ensure that the needs of the members they serve are being considered and met. These partners include the county agencies and local stakeholder groups. Key partnerships include:

   - **Partnership for CHOICE:** A group of local stakeholders that provide critical HCBS to Orange County. This group of providers and county and regional government representatives meet with CalOptima quarterly to provide input and guidance on current initiatives. There are also several subcommittees and advisory committees that have been tasked with strategic planning and other responsibilities.

   - **ADRC OC Advisory Committee:** A 12 member committee that convenes quarterly to advise the Orange County ADRC Steering Committee on the design and operations of the ADRC, products and program strategies, progress towards achieving the goal and vision of the initiative, and other program and policy development issues related to the ADRC OC. Each member provides expert knowledge in the process of evaluating plan, proposals, and progress reports that are generated by the Steering Committee. Members include representatives from all populations served by the ADRC OC, organizations that provide services to individuals served by the program, and government and non-government agencies impacted by the program.

   CalOptima's relationship with these partners and other community-based organizations and agencies continues to guide long term care integration efforts. CalOptima will continue to work with these stakeholders to develop program models that meet the unique needs of all dual eligibles in Orange County. All such groups have been updated and educated about the potential for dually eligible integration.

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

   Cost and utilization data for HBCS in Orange County that are carved-out of CalOptima's contract with DHCS, will help CalOptima prepare a more complete response to future RFPs. Other data that

would be necessary is Medicare FFS data for Orange County, including data that can demonstrate the acuity of the dual eligibles who currently receive services in the Medicare FFS system.

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

Responses to the following questions would be helpful:

- What will be the contracting relationship? Will the contract to operate the pilot be between the state and the plan? Or the State, CMS, and the plan?
- What enrollment approach will be applied to the dual eligible pilots?
- What will be the disenrollment terms and conditions?
- How will the enrollment broker interact with the dual eligible pilots?
- What outreach / marketing activities will be allowed and/or restricted?
- Will beneficiaries who have Medi-Cal, but only qualify for Medicare Part A or Part B, but not both be eligible to participate in the pilot? If yes, will plans chosen to implement the pilot receive full funding for these beneficiaries?
- What type of risk arrangements will be considered? Will rates be set on an annual basis?
- Will community behavioral health care services and substance abuse be integrated?
- What will be the reporting requirements for quality and other performance metrics?
- Is DHCS considering the integration of dental services and services covered by the Department of Developmental Services to the dual eligible pilots?

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

Yes, CalOptima considers the timeline reasonable. Nonetheless, it is important to note that in order to meet all milestones, it will be critical that the State provide health care cost and utilization data in advance and settle final rate and reimbursement structures in a timely manner. Delays in these areas can affect the ability to provide an optimal bid and finalize provider contracts.

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?

There are various possible enrollment options. We would like to comment on enrollment approaches: passive enrollment, voluntary enrollment, and a hybrid mandatory enrollment with an opt-out provision:

Passive Enrollment with an "Opt Out" Option
Passive enrollment is enrolling persons in plans, or switching enrollees from one plan to another, without first obtaining the enrollee's consent. In the context of Medicare Advantage plans, individuals who are passively enrolled have the opportunity to opt out, but they must affirmatively exercise that option.

This approach allows the state to reach a high enrollment in its dual eligible pilots rapidly. This has many benefits such as maximizing the amount of people whose care can be managed more effectively and increases the number of beneficiaries who can access a wider range of services. Alternatively there could be negative impacts associated with the need to automatically enroll beneficiaries who are in the middle of care. Procedures must be in place to ensure continuity of care is preserved if provider changes are required. Also, members may perceive passive enrollment with an "opt out" option as losing "freedom of choice." While various strategies can be utilized to ensure provider choices within a managed care plan, a beneficiary's perception may pose a barrier to understanding the choices and benefits of this model. Simple and thorough beneficiary communication in advance of implementation is necessary to mitigate any unfounded beneficiary concerns.

Voluntary Enrollment

In the voluntary enrollment model, consumers have the choice to either participate in the managed care program or receive care in the fee-for-service system**.** This is an optimal approach from a member perspective in that it is perceived as maximum choice. However, without a strong education, outreach and marketing component, voluntary enrollment can result in low participation rates in the pilots. With low participation rates, the true benefits of an integrated model may not emerge in an evaluation design. But from beneficiary perspective, those not enrolled due to poor understanding of the program will lose the opportunity to avail themselves to a wider range of services and an improved system of care management. It also will result in fewer saving for payors. In a voluntary enrollment environment, it is critical that a large investment be made in outreach. This is the model for SPDs and dually eligible beneficiaries that CalOptima currently utilizes.

Hybrid Mandatory Enrollment with an Opt-Out Option

All eligible members are enrolled in the managed care program, but can choose to opt-out after a specified time period (e.g., 60-day). Wisconsin uses this enrollment option. This option provides all dual eligible beneficiaries an equal opportunity to avail themselves to an improved system of care management and a wider range of services for a limited time. Thus, it provides beneficiaries a "trial period" for a designated period of time to experience services with the guarantee to opt out. The dual eligible pilots' contractors are charged with the task to demonstrate their "value added" during this designated period, with the goal of achieving a high retention rate. Again, in this model states must invest heavily in a comprehensive education/outreach program to ensure beneficiary understanding.

In deciding on an enrollment approach the state should give consideration to the following factors:

- Beneficiary choice;
- Member education and outreach;
- Stability of the dual eligible risk pool;
- Plans financial viability and infrastructure needed to serve this complex population;
- Achievement of managed care goals (e.g., linking consumers to medical homes, accountability to deliver improve health outcomes, and achieving a level of budget predictability); and
- Minimize continuity of care disruptions.

In all approaches, the state should make sure it maximize beneficiary provider choice within the dual eligible pilots' model.

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

CalOptima proposes that the following long term supports and services be included in an integrated model to provide a wider range of covered services to beneficiaries:

- In Home Supportive Services (IHHS);
- 1915(c) Home and Community Based Waiver services including Multipurpose Senior Services Program, Assisted Living Waiver, and Nursing Facility / Acute Hospital Waiver;
- Adult Day Health Care Services (ADHC) and other personal health care services;
- Institutional Long Term Care Services; and
- Non-Medicaid services such as those funded under the Older Americans Act.

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

It would be optimal to fully integrate all covered Specialty Mental Health Waiver and community behavioral health services into the integrated model. It has been well documented that a large percentage of the dual eligible population has co-occurring physical and behavioral health medical conditions. In fact, it has been cited that about 52% of dual eligible individuals have psychiatric illnesses and health care spending is several times higher for this group than for a dual eligible without psychiatric illness. Of serious concern is the premature death of many individuals that suffer from serious mental illness and other medical co-morbidities.

In order to adequately treat individuals with such co-morbidities, it is essential that there is strong coordination and communication amongst the individual's physical health and behavioral health providers. Integrating physical and behavioral health benefits under a single, accountable managed care entity creates an opportunity for improved coordination to occur amongst the multiple providers involved in the individual's care. It also leverages the care management models to help promote proactive planning and execution of interventions that curb unnecessary ER visits, hospital admissions, and drug-seeking behaviors.

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?

N/A

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

CalOptima considers the following services essential to a model of integrated care for the dual eligible population:

- Acute Care;
- Institutional LTC;
- Multipurpose Senior Services Program (MSSP);
- In Home Supportive Services (IHSS);
- Adult Day Health Care (ADHC); and
- Behavioral Health.

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

Prior to implementation it is important that the state and selected dual eligible pilots' contractors jointly develop and implement a robust provider and beneficiary outreach campaign.

Provider education outreach should address any new procedures for verifying if a patient is enrolled in a dual eligible pilot, requesting and obtaining authorization for covered services for a dual eligible pilot enrollee, and be provided an informational briefing about the wider range of services available through the pilot. Moreover, providers should be given adequate notice to ensure that current patients in the midst of care and treatment plans do not experience disruptions in care. The dual eligible pilots' contractors should be expected to reach out to all local provider groups and associations in order to disseminate more detailed information about upcoming programmatic changes and goals of the demonstration pilots.

Beneficiaries must also receive similar information and education about how access and the delivery of services will or will not change. Beneficiary mailings should be utilized to reach all impacted individuals. The State should invest in a comprehensive education and outreach program to ensure that beneficiaries, their family member/care taker, and advocates understand the pilot's enrollment process. In addition, beneficiaries should be afforded a resource telephone line as a source of help to answer any questions or concerns. An on-line resource line can also be helpful for those that that use technology for communication due to hearing and other disabilities. Cultural and linguistic needs must be considered when developing beneficiary communications and outreach strategies.

Consumer advocates and community-based organizations serving seniors and persons with disabilities can serve as important resource outlets to make information available to dual eligible beneficiaries enrolled in a dual eligible pilot. They can also serve as a key resource to help educate the community about options to enroll in the dual eligible pilots.

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

Key areas that should be addressed by contractors include:

- How the contractor can demonstrate accountability and transparency for such an important program;
- How the contractor will report on outcomes to the public, its community, and the state;
- How the contractor will establish an open advisory committee to ensure input from all levels of stakeholders;
- How the contractor will ensure that it continues to support the safety net ;

- The contractor's experience in dealing with, and meeting, the cultural and linguistic needs of a Medi-Cal population and the programs it has embedded in its organization to meet those needs;
- The proposed Model of Care that will be used to manage the dual eligible population;
- Demonstrate a broad provider network;
- Demonstrate the ability to respond to the cultural and linguistic needs of members;
- Experience with serving Medi-Cal populations and in particular seniors and persons with disabilities;
- Describe any administrative and/or clinical functions that will be delegated and who is the proposed subcontractor for those services;
- Describe its proposed member outreach and marketing plan, quality assurance plan and compliance plan; and
- Demonstrate the ability to assume financial risk.

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?

DHCS should consider its current Medi-Cal managed care plan contract standards for inclusion in the dual eligible pilot contracts as they address access, quality, cultural competency, provider network adequacy, and financial aspects of operations. The contract standards and requirements are strong and in some cases stricter than federal programs. Nonetheless, in cases where Medicare standards are stricter, such as in marketing and complaints and grievances, the stricter standard should prevail. DHCS should also consider CMS' requirements for MA-SNPs as it relates to the Model of Care that is to be used.

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?

Prior to allowing a demonstration pilot to commence, it is recommended the State ensure the following:

- Develop a strong communication plan for impacted beneficiaries and providers to allow them to identify in advance potential issues that may emerge and prepare a contingency planning;
- Create a strong outreach and education plan to educate beneficiaries, family/caregivers and other interested stakeholders about goals of dual eligible pilots and expected benefits;
- Strong stakeholder input and research process to determine best practices for enrollment and disenrollment approaches;
- Adequate understanding from CMS about process to integrate Medicare funding;
- Strong rate setting methodology determined to ensure success of program;
- Operational readiness assessment framework to evaluate contractors at multiple points prior to implementation; and
- Financial viability framework to evaluate a contractor's readiness to assume risk.

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

DHCS should evaluate the dual eligible pilots after three (3) years of its implementation date. A three (3) year timeframe would allow the DHCS to effectively evaluate the dual eligible pilots. This period would yield more meaningful results because the pilots would be given a sufficient amount of time to implement interventions and achieve outcomes. After this period, providers including health plans, can gather data for various metrics as a baseline. DHCS could evaluate the pilots annually over a three year period to look at year to year trends. As an alternative, a retrospective analysis can be done at one time for looking back at data for a three (3) year period. In addition data collected from the dual eligible pilots can be compared to data of a peer cohort (e.g. COHS county without a dual eligible pilot to COHS county with a dual pilot).

Some suggested performance metrics for evaluating the success of the pilots include:

- Beneficiary and family/caregiver satisfaction;
- Provider satisfaction;
- Preventive care access quality measures (e.g. HEDIS);
- Preventable admissions;
- Preventable emergency room visits;
- Average hospital length of stays;
- Hospital admissions PMPM;
- Reduction in institutional long term care admissions;
- Increased rate in home and community based services;
- Total health care costs by PMPM;
- Number of beneficiaries connected to a primary medical home;
- Pharmacy costs trends; and
- Changes in use of mhealth technology.

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?

A blended global capitation rate can align the financial incentives with the policy goal of maintaining beneficiary independence and community-based care. However, given the complex needs of this population, an initial investment of resources may be needed before efficiencies and savings can be realized. Also, some savings realized will need to be reinvested into the care system to maintain appropriate incentives and ensure financial sustainability. Risk corridors in the first few years of the pilot may provide the level of risk protection needed to realize savings and provide time to refine the rate development process. Finally, given the diversity in needs even within the dual eligible population, a frailty adjustment may be appropriate.