



RESPONSE TO THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

REQUEST FOR INFORMATION ON PILOTS FOR BENEFICIARIES
DUALLY ELIGIBLE FOR MEDI-CAL AND MEDICARE

Executive Summary

The State has articulated several “achievable principles” for integrated care that would be critical for the success of its planned Medi-Cal pilots for the dually eligible. These include:

- Providing a streamlined continuum of care that is easy for beneficiaries and caregivers to navigate, for example, through access to care management/coordination services;
- Ensuring high standards of quality of care;
- Helping beneficiaries return to their homes after an acute episode of care;
- Preserving beneficiary choice of care providers;
- Preventing unnecessary and/or long-term admissions to nursing facilities and providing robust and coordinated home-and community-based services (HCBS);
- Increasing access to primary care;
- Providing financial support to mental health professionals to participate on care teams and provide caregiver training;
- Blending Parts A and B funding with Medi-Cal dollars to expand flexibility in coverage;
- Blending home and community based funding with Medicaid acute and long-term care institutional funding to align incentives to help people stay out of institutions;
- Using one set of rules for appeals, marketing, quality measures, and reporting; and
- Creating a rapid cycle monitoring and learning process so that integrated care models can be developed, improved, replicated, and scaled as efficiently as possible.

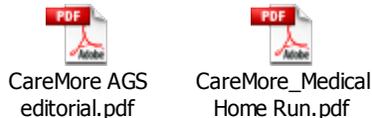
Moreover, in the evaluation of its disease management programs, the California Department of Health Services (DHCS) envisioned a future where it could enable more flexible systems of care with which it could partner to develop medical homes for Medi-Cal beneficiaries. In these medical homes, which would serve as the source of usual care for beneficiaries, disciplines associated with disease management would be woven into the fabric of the way these systems operate rather than imposed by external disease management operators.

CareMore has thrived in meeting similar objectives within a prepaid, risk-based environment. Based in Cerritos, California, CareMore has served the chronically ill for over 15 years, firstly, as a medical group providing services to payors on an at-risk basis and, more recently, as a health care delivery system and Medicare Advantage Health Plan that offers a full array of health care benefits and services to the chronically ill, high risk patient with diabetes, congestive heart failure, coronary artery disease and other heart conditions, COPD, ESRD, as well as to frail seniors who live in nursing homes and assisted living centers. Close to 20% of our members in

California are dually-eligible and approximately 11% of our total membership is under 65 years of age.

Many of these at-risk patients have struggled in managing multiple chronic illnesses and functional impairments and, as such, are at significantly higher risk of hospitalization and nursing home placement. Moreover, they typically have a difficult time advocating for their own needs in a complicated health care system, which exacerbates the risk of their decompensation. Not in the CareMore model.

By providing coordinated medical care and supportive services to seniors, CareMore has shown that it is possible to improve patient outcomes and satisfaction while reducing costs. Indeed, the CareMore model was named an “American Medical Home Run” by Professor Arnold Milstein of Stanford University and a recent editorial in the Journal of the American Geriatric Society called CareMore, “...the bar for performance standards that emerging physician-centered medical homes will need to meet...” These articles are imbedded below.



In the CareMore model, teams of non-physician health care providers such as nurse practitioners, psychologists, podiatrists, social workers and physical therapists, based in a CareMore Care Center (to be described in greater detail), supplement primary care medical practices with hands-on disease and frailty management, providing a detailed array of services that are generally too complex or too capital intensive for the average primary care office to provide. In this way, the benefits of a medical home can be spread throughout any community without creating onerous burden on primary care physician time and capital resources.

As successful as CareMore’s programs have been, we share the State’s perspective that more can and must be done. From our vantage point at CareMore, the “last mile” in the journey toward fully integrated care for high risk, dually eligible patients is to blend Medicaid and Medicare funding streams to address the needs of the whole person across the entire spectrum of medical, psychosocial and supportive services to maintain health an adaptive living.

The advantages of our working together with DHCS to combine the Medicare and Medi-Cal programs are clear:

- There are significant quality improvement opportunities from integration of care for services where Medicaid and Medicare responsibility overlaps (home health, skilled nursing facility care), and also where MA plans may provide supplemental benefits not covered under fee-for-service Medicare that Medicaid also provides (dental, vision, hearing, transportation, care coordination) or where Medicaid pays premiums and cost sharing for dual eligible MA enrollees.
- Consumer choice would be better served by planning ahead with predictable revenue streams to rationalize a more attractive set of health care and psychosocial benefits for dually eligible consumers.
 - For example, for CareMore patients who have suffered a first fall, we have created a Fall Clinic to which they are referred for individual evaluation, typically followed by strength

and balance training. The result is a dramatic reduction in falls and fractures related to falls.

- From the vantage point of a medical home that is committed to coordinating patient care throughout the continuum, and that actively helps its members to access these services, we view the separation of funding streams as creating organizational barriers to consumer access to necessary services. It also limits our ability as a medical home to do the kind of one-stop care coordination that is essential for at-risk seniors, along with one-stop measurement of quality and consumer satisfaction across the full spectrum of relevant results.
 - For ESRD patients, CareMore has assigned dedicated case managers working in concert with dialysis center staff to address the causes of readmission: poor hygiene, poor diabetic control, and vascular clogs. In addition, because we are working in a prepaid environment, we have the resources in hand to incentivize dialysis centers to cooperate in this respect. As a result, CareMore's hospital days are 50% of the national average for FFS dialysis patients.
- Studies have also found that the management of chronic medical conditions in at-risk seniors and people with disabilities has implications not only for patient well-being but for appropriate use of services and costs of care, given the high utilization rates of these patient cohorts. For example, data from a study of elderly dual enrollees in six states, indicated a quarter of hospitalizations over a one year period were ambulatory care sensitive (potentially preventable with appropriate primary care), and eight percent of enrollees experienced such a hospitalization. These hospitalizations, in turn, heightened the risk of preventable downstream utilization of institutional and long term supportive services.
 - For diabetic wound management, CareMore leverages nurse practitioners to provide the highly-repetitive, low-intensity care needed to heal wounds. Through these and other efforts, CareMore amputation rates are 60% lower than the national average.

CareMore will depart slightly from the standard RFI template to describe two models for integrating funding streams for the dually eligible, which we are actively developing in several California markets. These development efforts are part of a strategic initiative at CareMore that we call *One Patient, One Community*. They are:

- Development of community hospital joint ventures to reinforce their capacity to prosper as a source of usual care for the dually eligible within a prepaid, risk-based environment;
- Development of a health plan to health plan carveout to expose at-risk, dually eligible patient cohorts to CareMore's medical home to improve care coordination for at-risk members and, in so doing, to strengthen CareMore's health plan partners by giving them a predictable budget for their complex, hard to manage members.

One Patient, One Community is a strategic call to action at CareMore to develop projects like this that combine our know how as a Medicare Special Needs Plan and health care delivery system serving 55,000 members with new pilot and demo opportunities to improve consumer access to innovative models of care in which communities of providers and stakeholders are empowered to coalesce around underserved, at-risk patients to realize the full potential of care coordination.

The most immediate and relevant of these complementary state and federal pilots would be the CMS Community-based Care Transitions Program (CCTP) that addresses faulty transitions from acute to post-acute services. Management of these transitions is a core competency of the CareMore model.

Finally, medical homes are gaining increased traction with numerous pilot programs either underway or in the planning stage in Medicare, commercial, and Medicaid programs across the nation. However, these pilots have been slow to embrace services for the dually eligible because experienced and willing partners from both the Medicare and Medicaid worlds have been lacking. CareMore's hands on experience with the complexities of Medicare risk, services and regulation and with service delivery within the framework of a medical home, should represent an attractive partnership opportunity for DHCS. By working together, there is a tremendous opportunity to leverage federal payments in behalf of the State.

We are grateful for the opportunity to take part in the RFI process.

Part 1: Questions for Potential Contracted Entities Only

Pilot Project Example One: *One Patient One Community* – Community Hospital Joint Venture

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

Overview:

- CareMore would address the State's achievable principles by empowering community hospitals and the providers in their orbit to offer a fully integrated medical home to high risk, dually eligible patients to strengthen their roles as a source of usual care for the dually eligible.
- Rather than approach community hospitals with a traditional managed care contracting model, CareMore will align its interests with those of the targeted community hospitals through financial joint ventures that will offer to beneficiaries an attractive set of Medicare benefits and a proactive model of care with a caring touch and a focus on wellness.
- CareMore will work with major community hospitals to rationalize a fully integrated system of care in which both CareMore and the hospital work within a prepaid, risk-based system leveraging the knowhow and systems of a successful Medicare health plan (coordinating Medicare Parts A, B, C & D). These resources include guidance in the clinical transformation at the acute level to manage hospital stays more efficiently, as well as reliable financial, case management, quality assurance, predictive modeling, clinical analytics and customer service systems. In addition, CareMore would assist in handling myriad Medicare regulatory matters with CMS including benefit filings.
- CareMore and its community hospital partner will compete for the patronage of dually eligible patients by designing and offering an enhanced package of Medicare/Medi-Cal benefits including elimination of co-pays and deductibles for most items, enhanced transportation, enhanced podiatric benefits, enhanced mental health benefits and coverage of prescription drugs through the doughnut hole, to name a few.

- Working with the community hospital's cadre of community PCPs, the pilot would integrate medical and LTSS through a case management strategy designed to prevent complications of chronic disease, diminishment of patient status, prevention of acute events (hospitalizations, falls, etc). Mental health and social services would play central roles in the case management process. CareMore's experience in teaming with hospital to manage the acute episode and, concurrently to plan and provide post acute case management in this fashion has cut readmission rates by half.
- There are two pilots currently under development. One involves a community hospital in semi-rural market operating within a somewhat chaotic regional delivery system. The second involves a major community hospital in an urban market in which the dually eligible among others are grossly underserved.
- Discussions are under way with the public option health plan in one of these counties to carveout its high risk seniors, which would afford the county a fixed and predictable budget for these services, as well as accountability for clinical outcomes.
- CareMore and its hospital partner will apply for a Community-based Care Transition Pilot as soon as practicable.

a) Geographical location;

Development efforts are focused on community hospitals a semi-rural, two plan county and a large, urban market.

b) Approximate size of target enrollment for first year;

1,000 with the objective of 2,500 members by the end of year 2.

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

CareMore will collaborate with the community hospital to identify the full array of regional providers that are willing to provide the levels of quality, consumer responsiveness and communication with other providers that are the keys to a successful integrated system. Where possible, the pilot will use its resources to create incentive programs such as pay for performance programs to align the interests of key providers with the objectives of the pilot.

Current providers of mental health and LTSS in the region will be included in the network and evaluated on the basis of their performance. We anticipate experimentation with new models of care that might include: integration of our home-based services with existing community programs like HomeMeds; a "Center of Excellence" program that blurs the lines between acute care and skilled nursing to ensure an efficient and reliable transition of the patient back into community settings; as well as expansion of Hospital @ Home services.

To facilitate the hospital's transition from episodic acute care to the hub of a system of continuous and comprehensive oversight, CareMore will invest in a CareMore Care Center (CCC), which is typically a 4,000 square foot clinical facility with 1,500 feet of clinical space that serves about 5,000 patients. The CCC provides a safe, secure and welcoming setting to patients, families and/or caregivers for the full range of medical and psycho-social services. It will be located in the heart of the targeted "neighborhood" and

is generally staffed by CareMore with two MDs and two NPs, along with an array of MA's, podiatrists, physical therapists, nutritionists, psychologists and case managers. The CCC's services typically include:

- Physician and NP support of chronic and frailty care;
- Wound care;
- Coumadin management;
- Physical therapy and strength training;
- Cardiac/pulmonary rehab;
- Nutritional training;
- Disease-specific group sessions;
- Initial and annual "Healthy Start" health risk assessments;
- Counseling and education about long term supportive services.

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

Our case managers currently connect our dually eligible members with resources in the community for which they qualify. Our desire to manage both Medi-Cal and Medicare funding streams is reinforced by experience in trying to overcome organizational barriers, which cause service delays for our members and, frankly, lower standards of service by providers that are not fully integrated into our system.

e) Assessment and care planning approach;

The care management process would be driven by the Healthy Start HRA, which will incorporate an evaluation of LTSS options and needs. Because the CareMore model is unique in the degree to which physician extenders like NP's are used in the home, we will have the ability to assess firsthand the efficacy of home-based LTSS services.

In addition, because we have extensive experience in providing Institutional Medicare Special Needs Plans for seniors living in nursing homes, and we remotely conduct health risk assessments that are maintained in CareMore's companywide electronic medical record.

In addition, we use clinical personnel proactively in planning and managing the acute hospital stay, the SNF stay and the sometimes difficult transition to community-based, post-acute services, often called the "perilous journey".

f) Care management approach, including following a beneficiary across settings;

In contrast to the norm today of episodic care delivered at the time of a crisis, CareMore's medical home model emphasizes early identification of patients at-risk through specialized assessment tools; patient-centric primary care and prevention; continuous treatment planning and evidence-based clinical management; the use of technology and nurse practitioners to take care right to the patient's home (and bedside in the NF); greater attention to techniques that promote patient education and self-monitoring; and proactive follow-up across provider settings and treatment modalities.

The CareMore model also places heavy emphasis on decision support tools including predictive modeling, measurement of consumer satisfaction and, as we have mentioned, delivery system redesign to incentivize providers to embrace a team orientation to care.

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

We would anticipate taking full financial risk and sharing upside and downside with our community hospital partner. We would expect that the blended rates would be risk adjusted based on past utilization of medical services, as well as the frailty or functional capacity of members as reflected by their past utilization of LTSS.

We would also selectively explore downstream risk relationships with providers along with performance incentivization, such as shared upside and/or P4P bonuses that reflect HEDIS scores, STAR ratings, and data on patient and family satisfaction with LTSS.

In addition, we believe that there may be creative ways to help the state achieve immediate savings on the medical component of their costs for non-custodial members. For example, Medicare SNP's will see a total reduction in revenue of 15% over the next four years. We would be willing to limit Medi-Cal's per capita cost sharing for medical services provided to non-institutional, dually eligible members to the gap between the 2011 baseline and reduced Medicare revenue in subsequent years.

2. How would the model above meet the needs of all dual eligible, 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.

In the case of CareMore Health Plan, we would propose focusing our work at first on seniors including people diagnosed with Alzheimer's and other dementias, as well as people who live in nursing homes. These are CareMore's areas of particular expertise.

However, the goal in our joint ventures with community hospitals is to create product lines that would support an "all payor" strategy to make the disciplines of a medical home available to other at-risk populations. For example, we believe that there is an enormous opportunity to focus a medical home on the chronically mentally ill, which as a group demonstrate rapidly increasing rates of chronic illness, in cooperation with the Department of Mental Health.

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?

As those of us who have worked with the chronically ill know, coverage does not always ensure access. Among the consequences of poor care planning are problems in coordinating medical and mental health services for seniors and the disabled. Because of high rates of depression among chronically ill seniors, the health risk assessment and care planning processes will focus specifically on this problem. Mental health is also routinely addressed with every visit to the CCC. Generally, CareMore's benefit design involves no cost share for mental health services to remove the barriers to this type of care when it is needed.

In the same vein, studies have shown that consistent oversight, if not micro-management, by primary care professionals, particularly nurses and nurse practitioners, is the single most important factor associated with high levels of patient self-management. We also support our members with in-home technology that, for example, addresses on a day to day basis blood pressure levels and weight gain in those with CHF. Moreover, facile access to transportation to health care service further reinforces compliance.

This is a perfect example of how the cumulative know how of Medicare risk plans like CareMore gained over years of practical experience in deploying such services could help providers and the State to start on a firm footing in creating new, operationally sound and replicable approaches to blending Medi-Cal and Medicare dollars and service delivery.

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?

As we have indicated, this particular pilot concept and delivery system redesign are inextricably linked. As joint venture partners, CareMore and a community hospital have aligned incentives to improve quality and outcomes through a continuous rather than episodic approaches to care management.

Nowhere would this be more obvious than in the area of nursing home diversion. Hospitals and providers rarely do a good job of assessment and management of the transition from an acute care episode to post-acute services. This leads to extremely high rates of preventable hospitalization, which, in turn, produce higher rates of custodial nursing home utilization.

CareMore hospital and SNF “extensivists” would work with the community hospital and relevant providers to plan and closely monitor the transition to post-acute services. Extensivists are contracted or employed physicians at CareMore who take care to the patient, operating outside of the traditional confines of a medical practice. Close monitoring of progress including home visits by primary care professionals will ensure adaptive reentry to home settings, coordination with family and caregivers and consistent compliance with the plan of care.

And because the responsibility is shared, CareMore and the community hospital are thus able to integrate planning of medical and HCBS services to foster a seamless transition back into the community. In addition, because measurement of quality and consumer satisfaction will be integrated for both categories of service, changes in patient needs will be addressed more rapidly and opportunities for innovation will emerge, e.g., home-based mental health service teams.

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

Blended funding streams would be the catalyst for the development of innovative benefits, new services and new forms of provider icentivization that would facilitate the goals identified in the State’s RFI request. By removing categorical and organizational barriers to integrating Medi-Cal and Medicare services, we are able to unify a community of providers around the medical home model to do early identification of patients at risk through specialized assessment tools; patient-centric primary care and prevention; continuous treatment planning and evidence-based clinical management; the use of technology and

nurse practitioners to take care to the patient's home (and bedside in the NF); greater attention to techniques that promote patient education and self-monitoring; and proactive follow-up across provider settings and treatment modalities.

The CareMore model also places heavy emphasis on decision support tools including predictive modeling, as well as delivery system redesign to incentivize providers to embrace a team orientation to care.

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?

We enjoy good relationships with the advocacy community in California and as projects with partners are solidified, we will pursue efforts to educate them and to secure their formal support by the time of the RFP. We would expect that each project that we develop would have a community advisory board.

In addition, we have developed strong working relationships with "safety net," providers in such underserved areas of Los Angeles as Montebello, East LA, and Pico Rivera.

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

At a minimum, we would like to see three (3) years of Medicare and Medicaid experience data on the targeted population of seniors including a profit and loss statement with major categories of medical expense defined including Rx expenditures, medical cost ratios, admission rates and bed days for acute and SNF levels of care.

In addition, we would request, cost and utilization data for long term supports and services by service type for the comparable population and period including custodial nursing home costs.

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

Apart from the data request above, we would like clarification on how funding streams would be blended, what quality metrics would be applied across all participating pilot contractors and what other regulatory requirements would be imposed by the Medi-Cal contract. In addition, we would also like to understand the role of the Local Initiatives in this process. Will all pilots have to run through the LI's?

To create the most efficient system, we recommend blending funding streams at the health plan/pilot level. Health plans have the systems of financial accountability to manage capitated reimbursement from government sources. We would suggest building on that existing system.

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

We believe that the proposed timeline is reasonable as long as the timeline is adjusted based on delays in providing the data required by bidders and delays caused by the State's negotiation with CMS.

Project Example Two: *One Patient One Community* – Leveraging Existing CA SNP's

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

Overview:

- CareMore is in discussions with health plans throughout California that specialize in Medi-Cal to “carveout” their high risk, dually eligible populations – those seniors who are living in nursing homes and those seniors who are considered eligible for nursing home care by virtue of their functional limitations and health status. The patient cohorts present a problem to these health plans where in some cases, the medical cost ratio is well in excess of revenue. This problem is eminently reversible.
- One detects in the RFI a certain bias toward PACE and Social HMO's and a dismissiveness of SNP's. We admire both PACE and SHMO's. In the case of PACE, there remains the question of replicability. As for Social HMO's, they are essentially SNP's that decided on “day one” to integrate the Medicaid and Medicare sides of the ledger financially and programmatically.
- It would be a worthy public policy experiment then to pursue the hypothesis that a successful SNP is capable of becoming a successful model for the dually eligible by adjusting its systems and workflows at the margin to incorporate Medi-Cal revenue and services. If successful, this pilot could create a replicable model that, by building on the platform of existing Medicare SNP's in California, the State could promote competition to serve the dually eligible and more choice of benefit options or consumers, while minimizing the operating risk associated with new pilots for the dually eligible.
- CareMore's model brings primary care and preventative medicine to the home. On one hand, where the nursing facility is the beneficiary's home, our nurse practitioners and physicians who visit the patient at the nursing home frequently have been highly successful in catching the little things before they become big things and in enhancing palliative services to this group. For example, CareMore has virtually eliminated pressure sores in its nursing home population of 1,500 members.
- On the other hand, the CareMore teams bring this same “high touch” approach to seniors attempting to age in place in their homes, which may include assisted living and board and care facilities. This intensive approach, augmented by technology paid for Medicare and LTSS paid for by Medi-Cal, can demonstrate significant savings, more targeted use of LTSS and considerable traction in reducing unnecessary medical and LTSS costs (healthier beneficiaries need less LTSS).
- CareMore and its hospital partner will apply for a Community-based Care Transition Pilot as soon as practicable with a focus on more efficient management of step downs from acute facilities via SNF's.

a) Geographical location;

Discussions are underway in several counties in California.

b) Approximate size of target enrollment for first year;

1000 with the objective of 2,500 members by the end of year 2.

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

CareMore will identify the full array of regional providers that are willing to provide the levels of quality, consumer responsiveness and communication with other providers that are the keys to a successful integrated system. Where possible, the pilot will use its resources to create incentive programs such as pay for performance programs to align the interests of key providers with the objectives of the pilot.

Current providers of mental health and LTSS in the region will be included in the network and evaluated on the basis of their performance. We anticipate experimentation with new models of care that might include a “Center of Excellence” program that blurs the lines between acute care and skilled nursing to ensure an efficient and reliable transition of the patient back into community settings, as well as expansion of Hospital @ Home services.

To facilitate the hospital’s transition from episodic acute care to serve as the hub for continuous and comprehensive primary care, CareMore will invest in a CareMore Care Center, which is typically a 4,000 square foot clinical facility with 1,500 feet of clinical space that serves about 5,000 patients. It provides a safe, secure and welcoming setting to patients, families and/or caregivers for the full range of medical and psycho-social services. It will be located in the heart of the targeted “neighborhood” and is generally staffed by CareMore with two MDs and two NPs, along with an array of MA’s, podiatrists, physical therapists, nutritionists, psychologists and case managers. The CCC’s services typically include:

- Physician and NP support of chronic and frailty care;
- Wound care;
- Coumadin management;
- Physical therapy and strength training;
- Cardiac/pulmonary rehab;
- Nutritional training;
- Disease-specific group sessions;
- Initial and annual “Healthy Start” health risk assessments;
- Counseling and edition about long term supportive services.

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

Our case managers currently connect our dually eligible members with resources in the community for which they qualify. Our desire to manage both Medi-Cal and Medicare funding streams is reinforced by experience in trying to overcome organizational barriers, which cause service delays for our members and, frankly, lower standards of service by providers that are not fully integrated into our system.

e) Assessment and care planning approach;

The Care management process would be driven by the Healthy Start HRA, which will incorporate an evaluation of LTSS options and needs. Because the CareMore model is unique in the degree to which physician extenders like NP's are used in the home, we will have the ability to assess firsthand the efficacy of home-based LTSS services.

In addition, because we have extensive experience in providing Institutional Medicare Special Needs Plans for seniors living in nursing homes, and we remotely conduct health risk assessments that are maintained in CareMore's companywide electronic medical record.

In addition, we use physicians proactively in planning and managing the acute hospital stay, the SNF stay and the sometimes difficult transition to community-based, post-acute services, often called the "perilous journey".

f) Care management approach, including following a beneficiary across settings;

In contrast to the norm today of episodic care delivered at the time of a crisis, CareMore's medical home model emphasizes early identification of patients at-risk through specialized assessment tools; patient-centric primary care and prevention; continuous treatment planning and evidence-based clinical management; the use of technology and nurse practitioners to take care right to the patient's home (and bedside in the NF); greater attention to techniques that promote patient education and self-monitoring; and proactive follow-up across provider settings and treatment modalities.

The CareMore model also places heavy emphasis on decision support tools including predictive modeling measurement of consumer satisfaction and, as we have mentioned, delivery system redesign to incentivize providers to embrace a team orientation to care.

We should also note here the emphasis that we place on Palliative Care in nursing facilities. Most people define this as simply taking care of symptoms. At CareMore, we define this as matching the medical care that patients and families want with the medical care that they actually receive.

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

We would anticipate taking full financial risk and sharing upside and downside with our community hospital partner. We would expect that the blended rates would be risk adjusted based on past utilization of medical services, as well the frailty or functional capacity of the member as reflected by their past utilization of LTSS.

We would also selectively explore downstream risk relationships with providers along with performance incentivization, such as shared upside and/or P4P bonuses that reflect HEDIS scores, STAR ratings, and evaluation of patient and family satisfaction with LTSS.

- 2. How would the model above meet the needs of all dual eligible, 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.**

In the case of CareMore Health Plan, we would propose focusing our pilot(s) on seniors including people diagnosed with Alzheimer's and other dementias, as well as people who live in nursing homes. These are CareMore's particular areas of expertise.

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?

As those of us who have worked with the chronically ill know, coverage does not always ensure access. Among the consequences of poor care planning are problems in coordinating medical and mental health services for seniors and the disabled. Because of high rates of depression among chronically ill seniors, the health risk assessment and care planning processes will focus specifically on this problem. Mental health is also routinely addressed with every visit to the CCC. Generally, CareMore's benefit design involves no cost share for mental health services to remove the barriers to this type of care when it is needed.

In the same vein, studies have shown that consistent oversight, if not micro-management, by primary care professionals, particularly nurses and nurse practitioners, is the single most important factor associated with high levels of patient self-management. We also support our members with in-home technology that, for example, addresses on a day to day basis blood pressure levels and weight gain in those with CHF. Moreover, facile access to transportation to health care service further reinforces compliance.

This is a perfect example of how the cumulative know how of Medicare risk plans like CareMore gained over years of practical experience in deploying such services could help providers and the State to start on a firm footing in creating new, operationally sound and replicable approaches to blended Medi-Cal and Medicare dollars.

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?

As we have indicated, this particular pilot concept and delivery system redesign are inextricably linked. As joint venture partners, CareMore and its provider partners will have aligned incentives to improve quality and outcomes through a continuous rather than episodic approaches to care management.

Nowhere would this be more obvious than in the area of nursing home diversion. Hospitals and providers rarely do a good job of assessment and management of the transition from an acute care episode to post-acute services. This leads to extremely high rates of preventable hospitalization, which, in turn, produce higher rates of custodial nursing home utilization.

CareMore hospital and SNF intensivists would work with community providers to plan and closely monitor the transition to post-acute services. Close monitoring of progress including home visits by primary care professionals will ensure adaptive reentry to home settings, coordination with family and caregivers and consistent compliance with the plan of care.

And because it is a shared responsibility, CareMore and community providers are thus able to integrate planning of medical and HCBS services to foster a seamless transition back into the community. In addition, because measurement of quality and consumer satisfaction will be integrated for both categories of service, changes in patient needs will be addressed

more rapidly and opportunities for innovation will emerge, e.g., home-based mental health service teams, home-based dentistry, etc.

As previously indicated, in nursing homes, our model breaks the cycle of iterative hospitalizations for easily preventable problems like falls and fractures, urinary tract infections and pressure sores. CareMore sends physicians and nurse practitioners on a frequent basis to see members in nursing homes and works closely with families and the member to shape the course of palliative care to their preferences.

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

Blended funding streams would be the catalyst for the development of innovative benefits, new services and new forms of provider incentivization that would facilitate the goals identified in the State's RFI request. By removing categorical and organizational barriers to integrating Medi-Cal and Medicare services, we are able to unify a community of providers around the medical home model to do early identification of patients at risk through specialized assessment tools; patient-centric primary care and prevention; continuous treatment planning and evidence-based clinical management; the use of technology and nurse practitioners to take care to the patient's home (and bedside in the NF); greater attention to techniques that promote patient education and self-monitoring; and proactive follow-up across provider settings and treatment modalities.

The CareMore model also places heavy emphasis on decision support tools including predictive modeling, as well as delivery system redesign to incentivize providers to embrace a team orientation to care.

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?

We enjoy good relationships with the advocacy community in California and as projects with partners are solidified, we will pursue efforts to educate them and to secure their formal support by the time of the RFP. We would expect that each project that we develop would have a community advisory board.

In addition, we have developed strong working relationships with "safety net," providers in such underserved areas of Los Angeles as Montebello, East LA, and Pico Rivera.

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

At a minimum, we would like to see three (3) years of Medicare and Medicaid experience data on the targeted population of seniors including a profit and loss statement with major categories of medical expense defined including Rx expenditures, medical cost ratios, admission rates and bed days for acute and SNF levels of care.

In addition, we would request, cost and utilization data for long term supports and services by service type for the comparable population and period including custodial nursing home costs.

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

Apart from the data request above, we would like clarification on how funding streams would be blended, what quality metrics would be applied across all participating pilot contractors and what other regulatory requirements would be imposed by the Medi-Cal contract.

In addition, we would also like to understand the role of the Local Initiatives in this process. Will all pilots have to run through the LI's?

To create the most efficient system, we recommend blending funding streams at the health plan/pilot level. Health plans have the systems of financial accountability to manage capitated reimbursement from government sources. We would suggest building on that existing system.

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

We believe that the proposed timeline is reasonable as long as the timeline is adjusted based on delays in providing the data required by bidders and delays caused by the State's negotiation with CMS.

Part 2: Questions for Interested Parties

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

We believe that voluntary enrollment based upon consumer choice from among benefit alternatives would be ideal. This is the typical model for sales in the world of Medicare Advantage plans.

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

We would expect to provide a full schedule of LTSS services. The threshold service would be development of an individualized, comprehensive plan of care to ensure that any services that are provided, either directly or indirectly by CareMore, are made available based on this plan of care. To facilitate this process, we would anticipate a "Concierge" service based at our CCC's that is dedicated to responding to the changing needs of our members for LTSS. We are currently exploring how the Concierge service might be structured to provide 24/7 response to scheduled and unscheduled needs.

We would of course, look to ensure the basic menu of personal services to address ADL limitations either in a member's own home or some form of assisted living venue, such as:

- Housekeeping;
- Bathing;
- Dressing;
- Toileting;
- Transferring;
- Eating;
- Mobility;

- Medication administration;
- Nursing care (e.g., injections, skin care, dressing changes).

Additionally there are supportive services to which we would shift resources:

- Transportation to medical and supportive services;
- Mental health teams that assess and treat patients in the home;
- In the same vein, home-based evaluations of dementia-related problems (e.g., memory loss, depression, sleep disorders) with referrals to related clinics in the CCC.
- Mobile Fall Clinic for those frail elderly, who may not be motivated to come to the CCC as often as we would like.

Moreover, there are also opportunities to blur the lines between medical and long term supportive services and to promote best practices through P4P programs. Two that are currently under consideration would be incentivization of providers of long term supportive services to:

- Assist with programs for less stable medical conditions that require frequent ongoing monitoring (e.g., insulin dependent diabetics);
- Assist with ongoing home based medication management programs. Medication reconciliation and management after an acute episodic have been called the “perilous journey.”

Our goal would be to create a P4P program that is:

- Data driven;
- Beneficiary-centered;
- Transparent;
- Developed through partnerships; and
- Administratively flexible.

While P4P in Medicaid is relatively common, particularly among Medicaid managed care organizations, including MCOs that manage long-term care services, it has been slower to penetrate LTSS. Due to a host of factors, Medicaid agencies have traditionally assumed that FFS provider payments, including payments to case management providers that are outside of the administrative claims process, must be claim- and/or encounter-related. They further assume that payments must be tied to an established fee schedule from which deviations are not allowed, which renders P4P all but impossible.

However, we think that the 2006 CMS “Quality Improvement Roadmap” and subsequently its “Value-Based...Results Driven...Healthcare: The Medicaid/CHIP Quality Initiative,” provides guidance on how we could work with DHCS to develop LTSS/Medical P4P’s. Taken together these CMS documents articulate a vision of Medicaid P4P, which it defines as: “a quality improvement and reimbursement methodology aimed at changing the current payment structure which primarily reimburses based on the number of services provided regardless of outcome.”

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

As those of us who have worked with the chronically ill know, coverage does not always ensure access. Among the consequences of poor care planning are problems in coordinating medical and mental health services for seniors and the disabled. Because of high rates of depression among chronically ill seniors, the health risk assessment and care planning processes will focus specifically on this problem.

Mental health will be routinely addressed with every visit to the CCC. Generally, CareMore's benefit design involves no cost share for mental health services to remove the barriers to this type of care when it is needed.

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?

We have described these opportunities extensively in this document. We would reiterate the need to focus on prevention of the eminently avoidable acute exacerbations of chronic illness. Apart from continuous, high touch clinical and supportive services, we believe that further exploration of home-based technologies holds significant potential for new innovations.

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

There would need to be an extensive education effort in the pilot areas. The approach used for the enrollment of the seniors and Persons with Disabilities into managed care provides a useful road map.

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

We think that the central question for potential contractors is scope of experience and readiness in managing Medicare parts A, B C & D. This is an enormously resource intensive and complex undertaking and involves Medicare regulatory experience, experience in product design and provider relations as well as complex data systems for financial managed, predictive modeling and clinical analytics, case management and utilization management, customer service and appeals and evaluation of consumer satisfaction (STAR ratings).

It would arguably be easier for an experienced Medicare Special Needs Plan to migrate to a model that integrates LTSS as part of its benefit design than it would for an LTSS provider to develop Medicare expertise de novo.

The model is also important, and the RFP should address in some detail, the potential contractors experience with the medical home model and/or care coordination.

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?

N/A

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

N/A. We intend to bid to become a pilot contractor.

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

N/A

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

We believe that there are five aspects of program evaluation that should be considered on an annual basis:

- a. Quality of Medical Services: HEDIS measures are essential to determine the impacts of the pilot on quality of care and patient health status.
- b. Quality of LTSS Services: A data set similar to HEDIS will be developed in this area based on available survey instruments such as that developed by Sanford University for Nevada's LTSS program.
- c. Financial: The ability of the contractor to operate soundly within a prepaid, risk-based funding as judged by medical cost ratio, actual cost of LTSS benefits against plan, hospital admissions/1,000 lives covered and bed days per 1,000 lives covered.
- d. Consumer Satisfaction and Service Levels: Medicare STAR ratings should be included and are currently based on 33 criteria, including members' satisfaction, customer service and how often members get screenings and tests. Plans that also offer drug coverage are graded in 19 additional areas.
- e. Evaluation by the Stakeholder Advisory Board: As previously indicated, this group should play a key role in assisting the contractor in evaluating the overall impact of the pilot on dually eligible beneficiaries, as well as the Contractor's success in coordinating with the community institutions that serve them. The advisory board would also assist the Contractor in evaluating variation in the measures gathered in items a-d.

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?

We would suggest two important considerations:

Firstly, all rating setting should be experience-based and risk adjusted so that payments will be based not only on demographic factors but also on the predicted health status of the beneficiaries in the pilot, determined by diagnoses that appear in Medicare claims in the

prior year. In contrast to the design of the ACO pilots, this implies that the population is identified on an *a priori* basis rather than imputed to the pilot after the fact.

Secondly, the pilot should be fully capitated so that the contractor can use the blended funding streams as an instrument of change, which would entail developing an attractive schedule of benefits that will fully integrate services and if necessary upgrade services across the spectrum of needs for the dually eligible. This opportunity is largely non-existent in fee for service demo's involving high risk populations.