



"Your 1st Choice in Health Care"

Care 1st Health Plan

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323.889.6638

June 1, 2011

Via E-mail omcprfp9@dhcs.ca.gov

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

Attention: Teri Lesh

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

Dear Teri:

Attached is our Response to the Request for Information (RFI) on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare. We appreciate the opportunity to participate in this RFI, and look forward to working with you to design the best model of care delivery for this population.

Sincerely,

A handwritten signature in black ink, appearing to read "Anna Tran", is written over the typed name and title.

Anna Tran
Chief Executive Officer

**Care1st Health Plan
Response to CHCS RFI Duals Pilot Projects
June 1, 2011**

RFI - Fully Integrated Duals Pilot

Part I

Care1st Health Plan ("Care1st") will focus on enrolling dual eligibles (duals) in the pilot in the following counties: Los Angeles, Santa Clara, Stanislaus and San Joaquin. Care1st is a fully licensed Knox-Keene plan meeting all the financial solvency requirements of the Department of Health Care Services ("DHCS") and the Department of Managed Care ("DMHC"). Care1st currently provides health care services to Medi-Cal beneficiaries in Los Angeles and San Diego Counties. We are also approved by CMS ("Center for Medicaid and Medicare Services") as a Medicare Advantage Part D Plan ("MAPD") as well as Dual Eligibles Special Needs Plan ("SNP") in the following counties: Los Angeles, Orange, San Bernardino, Riverside, San Diego and Santa Clara. We have order of approval to expand to Stanislaus and San Joaquin counties for 2012 for MAPD and SNP from the DMHC. Conditional approval was also granted by CMS pending final submission in June 2011.

1 a. Currently, the approach best suited to a particular county depends on several factors, such as the county's Medi-Cal delivery system model, the degree of existing coordination among and between health and supportive services, local economic and budget realities, and local resources available to plan for and implement change (e.g., staff, outside expertise/technical assistance, information technology, etc.). Since this RFI is seeking feedback regarding the "ideal" system to provide care for beneficiaries dually eligible for Medicare and Medi-Cal, we are setting aside local economic and budget realities and providing suggestions for a model that could potentially be implemented in any and all California counties.

b. Target enrollment for the four counties: Los Angeles - 20,000 to 35,000 enrollees; Santa Clara - 12,000 enrollees; Stanislaus – 5,000 enrollees ; and San Joaquin – 8,000 enrollees.

c. The transition of duals to the fully integrated pilot will be done in a way that preserves the ability of the various providers to continue to perform the important role of delivery care to this population. We anticipate expanding the customary Medicare and Medi-Cal providers to include behavioral health providers, long-term care providers, home and community based providers in the Aging Network and Independent Living community, etc.

d. Care1st 's ideal Duals Pilot will create an integrated, seamless system of acute, behavioral health, long-term supports and services, home-and community based and independent living services (hereinafter collectively referred to as "expanded home-based services and supports"), that offer individually tailored and culturally competent care that promotes access and consumer direction, dignity, and maximum independence. Our model will have a "No Wrong Door" point of entry,

integrated care coordination throughout the continuum, integrated health information technology (HIT) system accessible to all providers, and a support system that ensures the highest possible quality of care and independence for California's dual eligible population.

The ACA provides the authority to enable California to develop a state-based integrated care program, in which the state serves as the integrated care entity and provides the full range of Medicare and Medicaid services by combining the funding streams for both programs. In response to the request for information regarding an "ideal" model for dual eligibles, hereinafter referred to as "duals," the following responses go a step further and suggest that funding for expanded home-based services and supports be included to develop a fully integrated model.

There is a national momentum toward a more integrated community based long term care system fueled by personal preference for and cost-effectiveness of home and community-based care, as well as the *Olmstead*¹ decision that supports providing services in the most integrated setting. We believe these recent improvements to modernize the system are steps in the right direction. The industry has grown to include a wide range of home and community-based services outside SNFs; however, without major systemic changes to integrate data, care management and funding streams, we are missing an opportunity to integrate and connect unsustainable duplicative functions, services and systems.

There are currently six departments within the California Department of Health and Human Services Agency that provide funding for health care and supportive services that may have a direct association with medical, behavioral health, and social services to dually eligible beneficiaries, to-wit: the (1) Department of Aging, (2) Department of Mental Health, (3) Department of Rehabilitation, (4) Department of Developmental Services, (5) Department of Social Services and the (6) Department of Health Care Services. The "ideal" model would integrate funding from these various sources and provide a fully capitated rate to health plans to measure the improved clinical outcomes and real costs savings for this population. We welcome the opportunity to demonstrate costs savings, not only from the integration of Medicare and Medi-Cal, but also from the inclusion of these additional funding sources, which are also providing much-needed services to help duals remain in their homes and avoid costly and avoidable hospital, Emergency Department (ED) and skilled nursing facility (SNF) utilization.

For example, in addition to long-term services and supports funded by Medi-Cal and administered by the Departments of Social Services and Health Care Services, there are numerous programs administered by the Departments of Aging, Developmental Services, and Rehabilitation that provide a wide range of services and supports that are needed by older adults and persons with disabilities to live independently in the community, i.e., home care, personal care, independent living services, adult day care, case management, home modifications, transportation, respite for caregivers, congregate and

¹ *Olmstead v. L.C.*, 1999 Supreme Court ruling, upheld Title II of the Americans with Disabilities Act (ADA) – the 'integration mandate' that prohibits states from keeping people in institutions when they could be "reasonably accommodated" in less restrictive settings. Outcomes of the decision include: creating alliances among aging and disabled communities, creating a "lifespan" approach to LTC rather than a disability or aging view, funding and implementation of Real System Change Grants to facilitate demonstrations and compliance with *Olmstead*, greater interest in HCBS that include consumer direction and support for quality of life as an outcome measure.

home-delivered meals, friendly visitors, to name a few. However, these programs are administered separately, and do not currently communicate or share critical demographic or service utilization information with each other. Consumers face a bewildering maze of agencies, programs and providers that ultimately results in the erosion of quality of health and life for many individuals.

The patient-centered medical home (PCMH) model and our proposed fully integrated pilot model for duals are potential solutions to the escalating health care costs resulting from our current fragmented and oftentimes duplicative care delivery systems. The critical first step in our fully integrated care model for duals is to design a health care delivery system that helps duals and their families access and navigate the full range of services, including acute care, behavioral health care, and expanded home-based services and supports, that can meet individual medical, behavioral health and social service needs and preferences.

The integration of Medicare and Medi-Cal and the funding streams that fund behavioral health care and expanded home-based services and supports to the various dual eligible populations has the potential to redirect resources from preventable hospital, ED and SNF utilization to better preventative and primary care, as well as behavioral health, and expanded home-based services and supports provided in the home. Achieving this goal will require us to integrate all funding streams for programs and services for duals.

The ideal model will focus on reducing duplicative and fragmented services in a PCMH environment by integrating: (1) funding, (2) HIT systems that allow providers at all levels of care to share information about service utilization, and (3) medical, behavioral health and social care management functions. The combined funding will allow us to organize, arrange, and coordinate the delivery of all necessary resources and services across the full continuum of care for duals, and provide us with the flexibility that is needed to create individual care plans that address each beneficiary holistically and take personal preferences into consideration. . Our expanded provider network, which will include direct contracts and collaborative partnerships with behavioral health, senior service and independent living providers, will allow us to use Medicare savings from reduced hospitalization, ED and SNF utilization to offset investments in improved Medi-Cal services through focused care management and community-based care.

The Core Building Blocks of Ideal FIDP are:

- Patient-centered medical home model as the care foundation, with integrated care managed by interdisciplinary care teams (ICT)
- ICT and Care Transitions Specialists are responsible for coordinating and navigating duals across all care settings
- Expanded network that includes contracts and collaborative partnerships with behavioral health providers, senior service providers, independent living providers and in-home supportive services (expanded home-based services and supports) and other providers, as appropriate
- Holistic whole patient approach to care

- Fully integrated funding includes Medicare, Medi-Cal, and funding for expanded home-based services and supports
- Comprehensive benefit package providing services and supports for the entire continuum of care – acute, behavior health, long-term services and supports and an expansion of current Medicaid-covered support services to include expanded home-based services and supports
- HIT and shared electronic health records (EHRs) are core elements of integrating communication between all providers. Types of HIT to be included in the model include EHRs, health information exchanges (HIE), electronic prescribing of medications, web-based provider and patient information and education, and telemedicine technologies.
- Emphasis on prevention and wellness
- Single set of rules for outcomes measurements, grievances and appeals, marketing, enrollment and member materials

Comparison of Current System and Fully Integrated Care System for Duals

CURRENT CARE SYSTEM	FULLY INTEGRATED CARE SYSTEM
<p>Acute, behavioral health and long term care (LTC) services for people with chronic care needs are fragmented by: source of payment, type of client, type of provider, source of regulatory oversight, and geography. Each government agency or institution tries to provide good quality care independently.</p>	<p>Fully connected system of acute, behavioral health, long term supports and services, home and community based and independent living services (expanded home-based services and supports) provides duals with the right services at the right place at the right time. ICT and Care Transition Specialists coordinate all services across the full care continuum. All providers communicate and share information and work together to provide the best possible quality care.</p>
<p>Current system is built around existing institutions and funding sources. Providers and funding sources are the decision makers.</p>	<p>The system is built around duals' needs and preferences while maintaining cost neutrality. To the greatest extent possible, the dual is the primary decision-maker.</p>
<p>Medical, social and supportive services, residential care facilities and SNFs are separate entities with little or no communication. Categories of aged, physically disabled, developmentally disabled, mentally ill, and HIV/AIDS have separate systems, with little or no communication between them.</p>	<p>The system brings together medical care (e.g. hospital, physician therapy, pharmacy, skilled nursing), supportive services (e.g. personal care, meals, housekeeping, transportation) for those with chronic (ongoing or of long duration) care. Medical, behavioral health, and expanded home-based services and supports are integrated.</p>
<p>Duals that are frail with multiple chronic conditions and service needs, face a confusing maze of providers, eligibility requirements, application forms, assessments, transportation issues, etc.</p>	<p>Duals perceive a single point of access regardless of funding sources for the services they need. A uniform assessment tool is used. Web-based electronic health records allow ongoing communication between all providers.</p>
<p>Because case management is most often tied to particular problems or specific programs, when consumers are hospitalized or have to stay in a SNF, their community services case managers may lose touch.</p>	<p>Case management is consumer-centered and integrated. ICT and Care Transition specialists at the health plan and the PCMH navigate consumers through all levels of care and all types of services, including acute, behavioral health, long term support services, including IHSS and expanded home-based services and supports. In-home assessments are</p>

	<p>conducted for “at risk” duals by providers of expanded home-based services and supports, who provide linkages to appropriate home-based services.</p> <p>Care Transitions Specialists provide assistance at hospitals and SNFs and following discharge at home to ensure appropriate services are provided to avoid costly rehospitalization.</p>
<p>Services are provided by multiple government agencies, with separate eligibility requirements, with most requiring an assessment, preparation of a care plan, and separate record-keeping.</p>	<p>The network of providers is accessed from a central point. Resources are not wasted in doing the same activity at multiple agencies or by multiple providers. An integrated health technology system minimizes duplication and maximizes communication between all providers, resulting in a single intake and continuous access to record keeping by all providers, as appropriate.</p>
<p>Care is fragmented, with multiple fee-for-service providers, who do not share information. Duals may be given medicines or treatments that interact in negative ways because providers are not aware of each other’s existence or services.</p>	<p>Providers have access to information about all care services provided to duals through a shared web-based case management program. All providers, as appropriate, have access to all relevant information in duals’ medical records, with online outcome indicators.</p>
<p>The fee-for-service approach may encourage providing more care (and incurring more costs) than is needed. Individual programs and funding sources can result in shifting costs to other programs and funding sources.</p>	<p>Economic incentives to over-treat or withhold care are removed. Programs and services are coordinated so that there are no incentives to shift costs. Care is given according to each dual’s individual needs.</p>
<p>There are numerous service gaps and duals and their families often do not know where to go or who to contact to get information about much-needed home-based services. Many areas completely lack adult day care, hospice, and assisted living programs. In many cases services are not available to low-income people. There is often no choice of providers.</p>	<p>The system is complete – all services needed by duals with chronic health conditions are available and provided regardless of location, qualification and income.</p>
<p>Clients may be institutionalized because home-based interventions are not reimbursed under Medi-Cal or Medicare.</p>	<p>Flexibility allows the PCMH and health plan to offer consumers access to appropriate alternative services in the home that may not be available through mainstream Medicare or Medi-Cal.</p>
<p>Health and social services providers, and care managers must put substantial effort into finding and securing funding from many different funding sources, both public and private.</p>	<p>Funding sources are pooled into a single payment to health plans for all services in the care continuum.</p>
<p>The desire to avoid increasing the total public cost of LTC has resulted in a situation in which the status quo is maintained.</p>	<p>The system promotes innovation and prevention in order to improve dual’s quality of life while controlling the total public cost of care.</p>

Source: Originally created by the CA Center for Long Term Care Integration (no longer in operation) with funding from the State of CA. Substantial revisions have been made to address current conditions and the recommended Duals Pilot.

e. Care management is recognized as having the potential to help individuals to better access and negotiate complex health delivery systems, arrange and schedule services, facilitate communication among multiple providers, promote medication compliance and healthy living, including exercise and nutrition, and to monitor changes. When successfully implemented, integrated medical, behavioral health and social case management functions hold the promise of significantly increasing the quality of care for duals with chronic conditions and reducing costs. The management and coordination of care of duals with chronic conditions is critical to managing costs, and can result in a significant reduction in hospital, ED and SNF utilization. This is especially problematic with duals that are at higher risk than other populations to have multiple chronic conditions and high risk/complex medical and behavioral health needs.

The linchpin of ideal duals model is the integration of medical, behavioral health and social case management functions, which includes conducting a comprehensive in-home assessment for “at risk” dual members, especially for individuals with multiple chronic conditions. The model addresses the needs of beneficiaries who are frail, elderly, coping with disabilities, compromised activities of daily living, chronic co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues. The in-home assessment provides a significantly expanded perspective of the individual’s living environment and identification of needed expanded home-based services and supports that will help promote the ability of duals to live more independently in his or her home, as well as opportunities for behavior change.

Duals will benefit from the full integration of services and programs primarily because all care is coordinated with a focus is on helping duals continue to live independent in the community, or in the care setting of his or her choice. An important benefit is the reduction in the confusion inherent in being case managed by multiple nurses and social workers, and enrolled in multiple disease management and community-based programs and services, which results in receiving uncoordinated care from multiple providers. Many duals are being “case managed” by multiple case managers from different entities, none of whom communicate with each other. In our ideal fully integrated model, all case managers and providers will be linked technologically, with a single enrollment mechanism and a uniform assessment tool that is common to all providers, including providers of expanded home-based services and supports.

There are several uses of HIT that can improve the assessment and care management approach, including (1) systematic screening and case identification, (2) shared communication between all providers, (3) decision support, (4) monitoring of clinical status and medication adherence, and (5) treatment delivery (e.g., telemedicine).

The assessment and care planning approach in our ideal fully integrated model will focus on creating a “Care Management” Interdisciplinary Care Team (ICT) that shares information between the member and multiple providers and case managers in an integrated HIT system that is accessible to all providers, to minimize duplicative and at times, conflicting or incomplete information . The ICT, which includes Care

Transitions Specialists are responsible to navigate duals throughout the entire care continuum to ensure access to appropriate services to provide the best possible outcomes.

Specifically, the following medical, behavioral health and social assessment, care planning and ongoing case management monitoring functions will be available in a secure and HIPAA compliant care management system, which will be part of an overall HIT system.

- Initial health risk assessment (HRA) conducted on all members within ninety (90) days of enrollment and yearly thereafter. The HRA will serve as a tool to help evaluate all medical, behavioral, social, cognitive and financial needs.
- Development of an Individualized Care Plan by a nurse case manager based on responses of the HRA and telephonic or face to face nursing assessment

Identifying all necessary members of the ICT based on the HRA and sharing the care plan with all of them through a secure electronic portal. The ICT will be comprised of Case Managers, Social Workers, Pharmacists, Physicians, behavioral health providers, and Care Transition Specialists. Care Transitions Specialists will be assigned to each dual member identified as “at risk” to navigate duals and their family caregivers through the entire continuum of care, and to guide each and every care transition

- Updating and sharing the care plan on a regular basis through follow up assessments and concurrent analysis of pharmacy, claims, laboratory and encounter data.
- Comprehensive in-home social assessments and ongoing monitoring will be conducted by Care Transitions Specialists and through partnerships with senior service and independent living providers for duals identified as “at risk” or following a care transition from the hospital or SNF to home

This integrated care management approach will allow the identification of members who are “at risk” of emergency room, hospitalization, rehospitalization, and skilled nursing utilization through multiple sources, i.e., the health risk assessment (HRA), concurrent review of hospitalized members, hospital discharge planners, ICT referrals, and provider and member referrals. When a dual is identified as “at risk,” a comprehensive in-home assessment will be made in order to assess all medical, behavioral, social and financial needs. The comprehensive in-home assessment will also identify members that may benefit from expanded home-based services and supports, including but not limited to: transportation, home care, counseling, legal assistance, home making /chore assistance, adult day health care, home delivered meals, and family caregiver support programs, etc. The information from the assessment will update the care plan and identify a series of problems with subsequent interventions and goals. It is the responsibility of the care manager to inform the members of the ICT of all findings and implement necessary actions to restore the member to the highest possible level of physical and emotional well being and independence.

This integrated approach allows a holistic whole person approach to address the needs of beneficiaries who are often frail, elderly, and coping with disabilities, compromised activities of daily living, chronic

co-morbid medical/behavioral illnesses, challenging social or economic conditions, and/or end-of-life care issues and connects them with the right services at the right place at the right time.

In addition to high levels of co-morbidity and co-occurrence of physical and behavioral health conditions, many duals face challenging social and economic situations such as lack of emotional and social support and residential instability, which frequently impairs their ability to adhere to treatment plans and to maximally benefit from them. The biopsychosocial complexity of the population mandates a multifaceted member centric approach to care based on physical and mental health integration and intensive coordination and case management interventions. This approach provides the most appropriate and timely support to improve duals' quality of life and allows members to achieve optimal health and independence.

2. The FIDP model will require expanding the current Medicare and Medi-Cal provider network to include contractual relationships and partnerships with behavioral health and expanded home-based services and supports to ensure timely access and appropriate utilization of services.

Seniors: partnerships with Area Agencies and Aging and senior service providers that provide home and community-based services to help individuals to age-in-place and avoid preventable and unnecessary institutionalization.

Younger beneficiaries with disabilities: partnership with Centers Independent Living and independent living providers to provide independent living skills training, counseling services, rehabilitation technology, mobility training, life skills training, interpreter and reader services, personal assistant and supported living services, accessible transportation, therapeutic treatment, provision of prostheses and other devices, etc., to help duals with disabilities to maintain the highest possible functionality and independence to live in the least restrictive environment of choice.

Persons with serious mental illness: partnerships with behavioral health providers who focus on combining psychopharmacology treatment with functional assessment of each dual's skills and abilities with appropriate behavior modification strategies and resources.

People with intellectual and developmental disabilities: partnerships with behavioral health and health care specialists and independent living providers to provide a whole-person approach to care focused on early intervention, behavior modification and assistance to encourage behaviors that build wellness and emotional resilience. Ideally, assessments must also assume that limitations often coexist with strengths, and that a dual's level of life functioning will improve if appropriate personalized supports are provided over a sustained period to promote mobility, ongoing learning, self-help and independent living.

People diagnosed with Alzheimer's disease and other dementias: providers include neurologists, neuropsychologists, neuroradiologists and psychiatrists, as well as partnerships with organizations like the Alzheimer's Association to ensure early and appropriate diagnosis, individualized care plans focused on slowing the progression of the disease(s), management of behavior problems, confusion, sleep problems and agitation, home environment modifications and support to family caregivers.

Additionally, partnerships will include Alzheimer's Day Care Facilities, which provide access to medical care and therapy to assist individuals to remain at home and in their communities as long as possible to reduce costly institutionalization. When appropriate, members will be transitioned to long-term care facilities specializing in treatment of individuals with Alzheimer's disease and other dementias, to ensure appropriate care.

People Living in Nursing Facilities: our PCMH ICT approach for duals requiring short-term skilled nursing services and/or a focused rehabilitation program may include, but is not limited to, the following providers: physical therapists, occupational therapists, social worker case managers, speech pathologists, dietitians and restorative nursing aides to ensure appropriate SNF utilization and to assist with care transitions to the home at the earliest possible opportunity.

Nursing home residents are too often hospitalized during the last weeks and months of life, resulting in unnecessary suffering and the potential for increased health care costs. The ideal Duals Pilot should include initiatives to reduce such transfers by improving advance care planning, including use of Physician Orders for Life-Sustaining Treatment (POLST). Interventions could include clinician educators assigned to SNFs to offer education, role modeling, and coaching of key staff to ensure appropriate utilization of hospitalization and hospice.

Additionally, we support participation in the federal "Money Follows the Person" project, called California Community Transitions, which includes \$130 million in federal funds over the next four years to move Medi-Cal-eligible residents from long-term care institutions back to living in the community, and other CMS-funded Care Transitions programs through partnerships with non-profit community providers and hospitals to facilitate transitions from hospitals and SNFs to the home with appropriate expanded home-based services and supports.

3 (a). In all models of behavior change, assessment is critical. It is important for providers to understand dual's existing behavior to establish the baseline behavior. It's not enough for duals to know what to do and intend to do it; what matters is what he or she does, how often, and under what conditions. It is crucial to understand the circumstances (environmental, social, financial, and attitudinal) that help or hinder each dual in making changes. For example, many duals may not have the financial resources to join a health club and may live in a neighborhood that is unsafe for outside exercise or even walking. On the other hand, he or she may live a 10-minute bus ride from a community center with a gym where she or he can begin using an exercise bike. Understanding these circumstances can help the ICT and duals plan for behavior change.

The linchpin of ideal Duals Pilot is the integration of medical, behavioral health and social case management functions, which includes conducting a comprehensive in-home assessment for "at risk" dual members, especially for individuals with multiple chronic conditions. The in-home assessment provides a significantly expanded perspective of the individual's living environment, identification of needed services and supports that will help promote the ability to live more independently in his or her home, as well as opportunities for behavior change.

The model will include shared decision-making tools and evidence-based programs, which empower and help dual beneficiaries to change behavior and manage their own health. A self-managing patient is one who is informed, compliant to medications; adherent to necessary lifestyle changes and, most importantly, is an active partner in his or her care. Successful programs rely on a collaborative process to define problems, set priorities, establish goals, identify barriers, create treatment plans, and solve problems. Utilization of automated medication dispensing machines and other medication management tools to monitor and assist duals with taking prescribed medications will be explored.

An example of an established program adhering to the definition of making “self-management” key is Stanford’s Chronic Disease Management Program (CDSMP). The CDSMP is a 6-week small group community-based self-efficacy intervention taught by lay individuals from a highly structured manual. The CDSMP emphasizes skills building, modeling, problem solving strategies, and social persuasion to achieve behavior change in patients with a physician confirmed diagnosis of a chronic condition such as hypertension, heart disease, lung disease, stroke, arthritis or diabetes. Patients are taught how to control their symptoms through relaxation techniques, diet, managing sleep and fatigue, exercise and how to communicate with health providers. Research has found that after one year participants experienced statistically significant improvements in various health-related measures including cognitive symptom management, communication with the physician, self-efficacy, depression, and health distress.

3 (b). As stated in 3(a) above, conducting a comprehensive in-home assessment for “at risk” dual members, especially for individuals with multiple chronic conditions, is the most effective way to assess the living environment and identify appropriate expanded home-based services and supports that are needed to help promote the ability of duals to continue to live independently in their homes, as well as identify duals’ informal support structure, i.e., family and friends, who can provide critical support for behavior change interventions. Social case managers have extensive knowledge of the wide array of expanded home-based services and supports that are available in the local community and can provide linkages to important community resources that can make the difference between living independently in the community versus less desirable and more costly institutionalization.

4. The customary patient – physician relationship will change considerably because the PCMH will have expanded resources at its disposal to provide expanded home-based services and supports. The linchpin of the ideal Duals Pilot, “integrated care coordination,” will allow providers to take a more holistic patient-centered approach to care, versus the current silo approach which separates medical, behavioral health and social services, and results in treating diseases and conditions independently. The fully integrated approach will allow providers to ensure that duals receive the right care at the right place at the right time; This intervention facilitates keeping people in their homes and communities and out of costly institutionalizations. Integrated care coordination creates a true continuum of medical, behavioral health and expanded home-based services and supports that are accessible and easily navigated as part of a comprehensive care system that facilitates quality and cost-effectiveness overall. This is a significant change for providers.

Some of the benefits of a fully integrated medical, behavioral health and social model in a PCMH setting include:

- The integration and consolidation of the full array of services and programs, for providers and duals, breaks down limitations and barriers to care. Instead of duals having to go to different providers, agencies and organizations to access care, the system will be truly seamless for duals and their family caregivers.
- Ability to access and pay for services across the full continuum will result in: increased utilization of lower cost services in the most appropriate and least costly setting, and decreased utilization of hospital, ED and SNF utilization.
- Ability to help more people receive care in their homes versus costly institutionalization
- Improved communication and coordination between all providers will increase efficiencies from a reduction and potential elimination of duplicate tests and services
- Improved care transitions between all care settings has been proven to reduce rehospitalizations

5. While we wholeheartedly support the integration of Medicare and Medi-Cal funding for the duals, the integration of Medicare and Medi-Cal alone does not provide the full continuum of services utilized by the dual eligible population and potentially limits the true cost savings that can be realized by fully integrating all funding streams. Combining funding for behavioral health care and expanded home-based services and supports with blended Medicare and Medi-Cal has the potential to significantly decrease hospitalization, ED and SNF utilization. These cost savings can be redirected to provide better preventative and primary care, and help us serve more individuals. Achieving this goal will require us to integrate all funding streams for programs and services for duals.

The ideal model will focus on reducing duplicative and fragmented services in a PCMH environment by integrating: (1) funding, (2) HIT systems that allow providers at all levels of care to share information about service utilization, and (3) medical, behavioral health and social care management functions. The combined funding will allow us to organize, arrange, and coordinate the delivery of all necessary resources and services across the full continuum of care for this population, and provide us with the flexibility that is needed to create individual care plans that address each beneficiary holistically and take personal preferences into consideration. For example, we could substitute additional home health or personal care attendant hours for confinement in a skilled nursing facility, or install grab bars and other home modifications that allows beneficiaries to remain safely at home and avoid preventable falls, etc. Our expanded provider network, which will include direct contracts and partnerships with behavioral health, senior service providers and independent living providers, will allow us to use Medicare savings from reduced hospitalization, ED and SNF utilization to offset investments in improved Medi-Cal services through focused care management and community-based care.

6. Our company is currently participating in an Integrated Care Management Pilot program with the Area Agency on Aging, Region One in Maricopa County, Arizona, which was launched in 2010. The pilot extends the care management capabilities of our Medical Management Department by integrating the

medical and social case management functions for our Medicaid (AHCCCS) and Medicare Special Needs Plan members in that county.

In addition to our extensive relationships with health care providers, we have expanded our relationships with local providers and stakeholders in the Aging and Disability Networks through our various partnerships and consulting relationships. We are currently significantly expanding our networks to respond to the needs of the SPD populations and anticipate there will be a service overlap with duals.

We will conduct public forums with providers of expanded home-based services and supports in each geographic area to obtain support and ideas for partnerships and collaborations.

Additionally, we propose to include consumer participation in the governance of our Duals Pilot in California through the creation of a Consumer Advisory Board with stakeholder representation from all populations to be served.

7. Demographic and claims utilization data for all dual populations, including types of services, ED and hospital utilization frequency, including pharmacy utilization, behavioral health, SNFs and expanded home-based services and supports provided by the Aging and Disability networks.

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

None at this time

9. Yes, we consider the proposed timeline to be adequate to create a Duals Pilot that responds to the goals described in this RFI.

Care1st Health Plan
Response to CHCS RFI Duals Pilot Projects
June 1, 2011

Part II

1. The best enrollment model for this program is automatic enrollment with an opt-out feature. Additionally, we recommend that DHCS consider restricting disenrollment from the Pilot to 12 months, similar to current MA-PD disenrollment restrictions, to enable all parties, most importantly duals, to experience the true benefits of a fully integrated care management approach and the ability to access to the full array of services in the fully integrated medical, behavioral health and social support services model.
2. We recommend integrating all expanded home-based services and supports that are currently administered by six departments within the California Health & Human Services Agency, identified in the following chart, into the Duals Pilot, as appropriate.

List of Services by Department within the CA DHHS

Program	Population	Service Components	CA DHHS Department
Institutional Care			
Nursing/ICFs	Seniors; Younger Beneficiaries with Disabilities; People Diagnosed with Alzheimer's Disease and other Dementias	Skilled nursing & supportive care in private, licensed facilities	DHCS
State Hospitals	Persons with Serious Mental Illness	In-patient treatment services in a state institution	DMH
Developmental Centers	Developmentally Disabled (determined to meet admission criteria by a court)	24 hr. services & supports to people in need of a secure environment through licensed and certified nursing facilities, ICFs for mentally disabled and acute care hospitals.	DDS
Intermediate Care Facilities	Developmentally Disabled	24 hr. personal care, habilitation, developmental and supportive health services.	CDPH
Nursing Facilities	Seniors; Younger Beneficiaries with Disabilities; People Diagnosed with	LTC in an institutional setting	DHCS

**Alzheimer's Disease
and other
Dementias**

Community-Based Care

Adult Day Health Care	Seniors; Younger Beneficiaries with Disabilities	Health, therapeutic, social services on a less-than-24-hour basis to prevent institutionalization	CDPH (licensing), CDA (certification)
AIDS Waiver Program*	People with HIV Infections, AIDS	Case management, skilled nursing, attendant care, psychotherapy, meals, medical supplies, non-emergency transportation and other services as an alternative to nursing facility or hospital care	DHCS
Alzheimer's Day Care Resource Center Program	People Diagnosed with Alzheimer's Disease and other Dementias	Support services and individual care plans to prevent premature or inappropriate institutional placement	CDA
Assisted Living Waiver*	Seniors; Younger Beneficiaries with Disabilities	Home and Community-Based services – daily living, health related, skilled nursing, transportation, recreation, housekeeping	DHCS
Brown Bag Program**	Seniors age 60+	Surplus and donated fruits, vegetables and other food	CDA
CA Aging & Disability Resource Centers**	Seniors; Younger Beneficiaries with Disabilities	Assists individuals in accessing health care, medical care, social supports & other long-term services and supports, counseling and service coordination. One-stop approach for the disabled and those with chronic conditions.	CDA
CA Community Transitions Project (Money Follows the Person)	Seniors; Younger Beneficiaries with Disabilities	Transitional support from institution to community setting for Medi-Cal beneficiaries who have received services in an institution for 90 days or more.	DHCS
Caregiver Resource Centers**	Families & caregivers of people with Alzheimer's stroke, Parkinson's disease & other disorders	Information, short-term counseling, respite, education and training support.	DMH
Family Caregiver Support Program	Caregivers of elderly & grandparents raising children	Coordinates information, counseling and training support, temporary respite and limited supplemental services.	CDA
Home and Community-Based Services Waiver *	Developmentally Disabled (who meet level of care for ICF)	Home and community-based services, including home health aide services, respite care, habilitation, environmental accessibility adaptations, skilled nursing, transportation	DHCS (oversight), DDS (operations)

Independent Living Centers	Younger Beneficiaries with Disabilities; People with Intellectual & Developmental Disabilities	Provide independent living services, including housing referrals, information & referral, peer counseling, personal assistant services, independent living skills training.	DOR
In-Home Medical Care Waiver (now part of Nursing Facility/Acute Hospital Waiver)*	Severely disabled	Alternative to care in an acute hospital for people who are Medi-Cal eligible, severely disabled requiring care in an acute hospital for 90 days.	DHCS
In-Home Operations Waiver*	Physically disabled (who qualify for care in an inpatient nursing facility)	Environmental accessibility adaptations, care management, respite care, personal emergency response system, community transition services, home health aide and habilitation services, family training, etc.	DHCS
In-Home Supportive Services (IHSS)	Seniors age 65+, low income, blind or disabled	Provides in-home personal care with daily tasks and case management services (currently coordinated by county welfare departments) to allow individuals to remain in their homes.	CDSS
Linkages	Seniors; Younger Beneficiaries with Disabilities (not eligible for other care management programs)	Provides comprehensive care management to prevent/delay institutional placement.	CDA
Multipurpose Senior Services Program (MSSP)*	Seniors age 65+ (who are certifiable for nursing care facility)	Provides social and health care management, adult day care, housing assistance, protective supervision, respite, transportation, chore and personal care, meals, social and communication services to prevent or delay premature institutional placement.	CDA
Nursing Facility A/A Waiver (now part of Nursing Facility/Acute Hospital Waiver)*	Physically disabled who meet nursing facility criteria for 365 days.	Alternative to nursing facility level A or B	DHCS
Nursing Facility/Acute Hospital Waiver*	Individuals of any age who are Medi-Cal eligible and have long-term medical conditions	Provides community-based alternatives to institutional care.	DHCS
Nutrition	Seniors and	Provides meals in congregate or home settings.	CDA

Services	disabled		
Regional Centers**	Developmentally disabled who reside in their own homes, relatives' homes, or community care facilities	Day programs, community care facilities and supportive service provides access to comprehensive services by coordinating outreach, intake and assessment, preventive services, case management/service coordination.	DDS
Respite Care	Seniors and disabled and their caregivers	Temporary or periodic services to relieve primary and unpaid caregivers.	CDA
Senior Companion Program	Seniors and disabled	Provides respite for caregivers, companionship, assistance with chores, grocery shopping, meal preparation, transportation and other services. Volunteers.	CDA
Supportive Services	Seniors	Programs authorized by the Older Americans Act, including case management and transportation	CDA
Traumatic Brain Injury Program	Disabled due to a traumatic brain injury	Provides community reintegration, service coordination, family and community education, vocational supportive services and service coordination.	DOR, DMH
Vocational Rehabilitation Services	Disabled individuals	Assists disabled individuals to obtain and retain employment to live independently in the community; services include counseling & guidance, referrals, job search & placement assistance, vocational and other training, transportation, on-the-job personal assistance services.	DOR

* Waiver Programs; ** Collaborative Partnerships

3. The literature suggests that integrated models of care offer the potential to improve access to treatment, improve quality and reduce costs.

In the ideal Duals Pilot, integrated care occurs when behavioral health and medical providers work together to address both the physical and behavioral health needs of duals. The PCMH model's defining features of continuity, comprehensiveness, and coordination match the needs of persons with chronic illnesses; and people with chronic mental illnesses, such as depression and anxiety disorders, often engage with health care by first presenting to the primary care provider. Integrating medical and behavioral health allows duals to access the right care at the right time and at the right setting. Further, behavioral health problems, exacerbate the disability associated with physical disorders and may complicate their management. Thus, integrating medical and behavioral health providers will allow a holistic whole patient approach to care with concomitant improvements in outcomes and reduced costly service utilization.

At the simplest level, our model will allow behavioral health and medical providers to work together collaboratively to address both the physical and mental health care needs of duals.

The ideal Duals Pilot focuses on managing chronic conditions by integrating medical, behavioral health and social case management functions in the PCMH setting. Appropriate and focused care management and ongoing communication between all providers are essential to improving outcomes for persons with mental illnesses who have multiple medical conditions and complex social needs.

Our model will allow our providers to shift from reacting to acute illnesses to proactively coordinating the provision of care. This requires two types of collaboration: (1) between duals and health providers in developing care plans to achieve agreed-on treatment goals and ongoing education and support of duals' self-management of conditions and diseases, and (2) collaboration between providers, ensuring that the treatment plan and provision of services is appropriate and coordinated across providers with different expertise and treatment domains. This second use is of particular importance in integrated care because the collaboration is taking place between providers from what has been two parallel health systems representing historically different perspectives and approaches to health and health care.

If duals do not comply with medication schedules, do not return for follow-up visits or are jettisoned back into toxic family and community environments, chances for recovery and successful outcomes can be compromised. To address these types of issues, our integration model will give us a complete picture of duals, which will allow us to be more responsive and minimize preventable costly interventions and to help us better monitor outcomes.

4. N/A.
5. We consider the services identified in our response to Part II, Q 2 above, to be essential to an integrated model of care for duals. The chart below also identifies the various programs in six departments within the CA DHHS that we believe are important to provide the best possible quality of health and to produce cost-savings for dual populations identified in Part I, Q 2.

California's Department of Health and Human Services

Dept. of Social Services	Dept. of Aging	Dept. of Health Care Services	Dept. of Mental Health	Dept. of Developmental Services	Dept. of Rehabilitation
In-Home Supportive Services Program	Adult Day Health Care	Medi-Cal Waiver(s), as appropriate	Mental Health Services	Day Program Resources	Independent Living Services
	Alzheimer's Day Care Resource Centers			Supportive Living Services	Traumatic Brain Injury Services
	Nutrition Services – Home-Delivered			Independent Living Services	

Meals	
Transportation	Transportation

6. We plan to spend a significant amount of time educating all providers, potential beneficiaries and stakeholders for all dual eligible populations about the Duals Pilot model. We plan to conduct focus groups with dual eligible beneficiaries and public forums with stakeholders from the various provider communities, to obtain their feedback and recommendations about the model design and service delivery approaches to ensure that all concerns are considered and appropriately addressed.

7. N/A

8. The requirements that DHCS should hold contractors to for the dual population are:

Entities awarded funding for the Duals Pilot should be currently contracted Medi-Cal providers in the state of California. Special consideration should be given to NCQA Accredited Plans

Standards for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., should be required. The model presently used for the SPD population can be considered as a starting point.

9. N/A

10. [NA

We recommend that DHCS seriously consider opening the RFP to GMCs, specifically San Diego County, which has demonstrated its readiness to develop a fully integrated service delivery system for duals.

11. List how the pilot should be evaluated, and over the timeframe.

The evaluation should be designed to test the success of the pilot in improving outcomes and slowing and reducing the rate of growth of the cost of care. The timeframe allowed should be no less than 18 to 24 months. Key elements of the evaluation should include:

- Documentation of structural elements of the organized systems of care, including network capacity, integrated care management approaches and communication between the various providers and case managers, implementation of PCMH concepts, and beneficiary supports and linkages to behavioral health services and expanded home-based services and supports;
- Analysis of beneficiary complaints regarding care systems, including frequency, subject, and resolution;
- Beneficiary satisfaction related to the pilot and access to the full array of services and supports based on newly developed surveys;
- Measurement of the successful integration of behavioral health care and expanded home-based services and supports into a fully integrated system of care;

- Comparison of utilization data such as ER visits, admissions/1000, readmission rates, SNF days and custodial bed day utilization for pre pilot and post pilot time frames
- Comparison of HEDIS outcomes for pre pilot and post pilot time frames

12. What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

Rates should be actuarially sound. However, setting rates for a fully integrated duals pilot model is a new territory for everyone -- including actuaries. Factors to take into consideration are the (1) new populations that will be served, (2) new services that will be included in the model (3) rates for the different levels of services, i.e., utilization of expanded home-based services and supports may require a higher reimbursement rate than for duals that do not require these services and (4) consideration should be given to areas where providers will not accept Medi-Cal fee for service rates.