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HEALTH PLAN
A Division of Contra Costa Health Services

A Culture of Caring

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Se Habla Español

June 1, 2011

Kevin Morrill, Chief
Office of Medi-Cal Procurement
California Department of Health Care Services
MS 4200
P.O. Box 997413
Sacramento, CA

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

Dear Mr. Morrill,

Contra Costa Health Plan welcomes the opportunity to respond to the RFI on pilots for the dually eligible. As the public entity Health Plan in our Two-Plan County Model for 38 years, we feel that our Health Plan is well prepared to contract with the state to operate a pilot project integrating Medicare and Medi-Cal for the dually eligible.

Attached you will find our answers to the nine questions that you have posed for potential contracted entities. Where appropriate, we have included in our responses additional information applicable to our situation that addresses questions that you have directed to interested parties.

Over fifteen years ago, in partnership with Contra Costa County Aging and Adult Services, our health plan began a comprehensive community stakeholder planning effort to develop a capitated, consumer-driven system of integrated long term care for medical, social, and supportive services for seniors and persons with disabilities eligible for Medi-Cal only or dually eligible for Medi-Cal and Medicare. Planning and implementation grants from the formerly named California Department of Health Services helped support our efforts. By 2005, we were prepared to begin implementation of such a program. However, we were not successful in gaining state level support for our proposed model.

In subsequent years, CCHP has gained experience providing comprehensive care to seniors as a Medicare Advantage-Special Needs Program (MA-SNP) and has recently enhanced our health care delivery system to enroll Medi-Cal only seniors and persons with disabilities (SPD's) under the 1115 waiver. We now look forward later this year to responding to the RFP for the Dual Eligible Pilot Project as the vehicle for fully implementing our vision of integrated care for Contra Costa County.

I want to thank you for the opportunity to participate in the development of the RFP for the Dual Eligible Pilot Projects by being able to respond to this RFI.

Sincerely,

Patricia Tanquary, MSSW, MPH, PhD
Chief Executive Officer

Attachment

RESPONSES TO QUESTIONS FOR POTENTIAL CONTRACTED ENTITIES

1. Pilot Program Model

   a. Geographical Location

   Contra Costa Health Plan (CCHP) is the public health plan option serving all of Contra Costa County under California's Two Plan County Model. CCHP proposes to serve dually eligible residents from throughout the county under the proposed pilot project.

   CCHP is a Knox-Keene licensed agency and has been serving residents of Contra Costa County since 1973. It was the first Federally qualified, State licensed, county sponsored health maintenance organization in the United States. We have offered Medi-Cal managed care since 1973 and have delivered managed care to Medicare members since 1976 as well as commercial members since 1980. Additionally, beginning in 2008, we have offered a Medicare Advantage-Special Needs Plan (MA-SNP) to duals.

   We currently have 5500 voluntary SPDs (Medi-Cal eligible seniors and persons with disabilities). Beginning June 1, 2011, we will start enrolling additional mandatory Medi-Cal SPD's residing in all of Contra Costa County under California's 1115 waiver.

   b. Target Enrollment

   According to the January 2011 report of the Research and Analytic Studies Section, California Department of Health Care Services, there were approximately 21,000 dual eligibles residing in Contra Costa County as of that date. We propose to enroll approximately 10,000 of those duals during the first year of the pilot project and would enroll the remaining 11,000 by the end of the second year.

   We recommend that the 21,000 duals be enrolled on a rolling monthly basis approximating 4% of the total pool of eligibles each month over a twenty-four month period. Under this methodology approximately 900-1,000 duals would be enrolled monthly allowing for growth in the dually eligible population over that two year period.

   We would prefer that all duals be mandated to enroll in the pilot project in order to minimize the fiscal risks of adverse selection. However, recognizing that

mandatory enrollment may not be possible, then automatic enrollment into the pilot program with an opt out provision would be acceptable provided that reimbursement rates are based upon an actuarially determined risk adjustment reflecting the risk status of the pool of actual enrollees as determined by Health Risk Assessment reviews. We anticipate that duals appropriate for the Program of All Inclusive Care for the Elderly (PACE) which serves a portion of western Contra Costa County and duals already enrolled in Kaiser or other SNPs in Contra Costa County will be a carve out for this pilot program.

c. Provider Network

The pilot program will deliver medical care through an expansion of the two existing provider networks available to the 100,000 Contra Costa residents currently enrolled in CCHP. The Contra Costa County Regional Medical Center in Martinez and its eight neighborhood clinics throughout the county offer a broad network of primary care physicians (PCPs) and medical specialists in a publicly operated setting. The Community Physician Network includes a comprehensive array of private primary care physicians, medical specialists, community clinics, and hospitals.

By the time of the inception of the pilot project, in collaboration with Contra Costa County Mental Health, a model of coordinated and collocated care management will be in place for CCHP members who receive behavioral health services as well as medical services.

CCHP will build upon its existing relationships with a broad network of county government agencies, nursing facilities, community based organizations, and health care and social service providers to assure that dual members have access to a comprehensive range of Long Term Services and Supports (LTSS). Integrating LTSS into the pilot program make it possible to promote the most independent level of functioning possible for duals and avoid unnecessary or inappropriate emergency room visits, acute care hospitalization, or skilled nursing care. The care management model of the pilot program will assure that the dually eligible have access to the appropriate mix of LTSS through memoranda of understanding (MOU's), vendor agreements, and contracts with LTSS providers including skilled nursing and intermediate care; In Home Supportive Services (IHSS); Multipurpose Senior Services Program (MSSP) services; Adult Day Health Care (ADHC); personal care; home modifications; meals; durable medical

equipment; Older Americans Act (OAA) services; independent living services; paramedical/nursing services; and medical rehabilitation services including physical, occupational, and speech therapy. The care management model will coordinate access to LTSS to which dual members are otherwise eligible and/or purchase necessary LTSS from providers when appropriate.

d. Plan for Integrating Home and Community Based Services (HCBS)

CCHP intends to integrate institutional long term care into the pilot program. This integration will be an essential program component for minimizing inappropriate or unnecessary institutional care and assisting the dually eligible to obtain HCBS in order to remain living at home. CCHP care management staff will have the ability to coordinate access to and/or purchase HCBS as an alternative to institutional nursing care when that is appropriate to the individual member's situation. CCHP will amend its existing contracts with a range of private skilled nursing facilities and add intermediate care facility contracts from among the forty plus facilities in the county to assure access to institutional long term care when that is the most appropriate alternative.

Over the past fifteen years, Contra Costa County Aging and Adult Services, a bureau of the County Employment and Human Services Department, has collaborated with CCHP in jointly leading a comprehensive community wide planning effort to design a model of long term care service delivery that would integrate HCBS into the health care delivery system administered by CCHP. We have previously been unsuccessful in gaining State level support for implementing this vision. The dual pilot program now offers the opportunity to implement that model of care.

Aging and Adult Services administers IHSS, Adult Protective Services (APS), and OAA Services under the Area Agency on Aging (AAA). All of those programs would become part of a coordinated and integrated model of care for the duals. CCHP will sign a Memorandum of Understanding (MOU) with Aging and Adult Services to coordinate IHSS assessment with CCHP case management and to coordinate case management with APS for those dual members who are in need of protection from abuse, neglect or exploitation. CCHP will sign a MOU with the AAA to facilitate dual member access to OAA services for individuals age 60+ including information and assistance, legal services, home visiting,

home chore registry services, social day care, caregiver support, and congregate and home delivered meals.

CCHP already has contractual relationships for case management services with the two private non-profit agencies that operate the three ADHC sites in the county. These contracts will be expanded to provide ADHC for the dually eligible when appropriate, assuming that ADHC remains a Medi-Cal benefit in California.

Approximately 175 duals residing in Contra Costa County receive MSSP case management and waived HCBS from the non-profit agency operating that program. CCHP will contract with that organization to integrate MSSP into CCHP care management.

CCHP will sign an MOU with the non-profit independent living center serving Contra Costa County to arrange for delivery of services to dual members with disabilities who are in need of independent living assistance including help obtaining assistive devices and arranging transition out of nursing facilities to live in the community.

e. Assessment and Care Planning

The assessment and care planning model to be implemented in the duals pilot program will draw upon the research and development efforts of the Contra Costa Long Term Care Integration Project completed in 2005 under planning and implementation grants funded by the State under the auspices of AB 1040.

Under that project, we determined that the best assessment is one that provides the maximum amount of relevant information in the least invasive and duplicative manner. Assessment information needs to be readily available to the Primary Care Physician (PCP) and other practice team members, to members, and to their families, as appropriate and permitted under Health Insurance Portability and Accountability Act (HIPAA) guidelines.

Assessment should identify member strengths and limitations so that effective and appropriate interventions can be delivered to prevent or delay functional decline and institutionalization for as long as possible. Both initial assessments and ongoing reassessments must be comprehensive and facilitate clinical, behavioral, social service, and member self-care interventions. The assessment process must

consider the interrelationship between physical, psychosocial, social, and supportive conditions in the member's environment.

The assessment tool must facilitate the development of a care plan. The care plan process would include not only the case manager and member but, guided by the member's preferences, encompass the broader care community including community based service providers, the PCP, medical practice teams, caregivers, and family members. The goal will be to develop a care plan that wraps HCBS around medical services in a seamless system of care. These individualized care plans should include specific timelines for measurement of health care outcomes and quality. Members and their family members and caregivers should be included in the care planning process through telephone contact, home visit, or electronic communication, as appropriate.

f. Case Management

The existing Case Management Unit of CCHP authorizes and coordinates health care within established guidelines. These guidelines will be expanded to include facilitating access to and/or authorizing purchase of LTSS and HCBS as well as traditional Medicare and Medi-Cal health care services. In fulfilling the recommended care plan, case management staff will refer members to non-Medi-Cal HCBS for which they are otherwise eligible in order to minimize the need to authorize purchase of LTSS or HCBS.

Also, case management staff will be responsible for facilitating communication with other medical team members and other agencies and community based organizations serving the dual members. The care management model for integrated care requires active coordination and communication among the case management staff, the member, caregiver(s), family members, community based service providers, PCP, and other health care practitioners. Shared decision making is an important element of integrated case management.

Monitoring the outcomes of the authorized care plan across a variety of care settings will require coordination among many professionals and agencies. Case managers must have access to direct care provider information across the continuum of medical, LTSS, and HCBS providers. CCHP will provide physician and/or nurse practitioner staff to provide routine medical care and follow-up care for dual members residing in nursing facilities. MOU's and/or contracts with the

IHSS program, APS, OAA community based service providers, ADHC's, MSSP, independent living center, the Regional Center of the East Bay, and other HCBS providers will be necessary to create a system for collecting data and monitoring the effectiveness and quality of HCBS being delivered under individual care plans. In addition, guidelines will need to be established for triggering reassessments and care plan revisions when there are substantive changes in the dual member's physical condition, functional abilities, or social environment. Such a monitoring system is an important element in being able to intervene promptly to avoid and/or minimize episodes of inappropriate or unnecessary emergency room care, acute care hospitalization, or skilled nursing care.

g. Financial Structure

CCHP has been in operation for thirty-seven years as a county operated health maintenance organization. It is a division of the Contra Costa County Health Services Department which includes the Contra Costa Regional Medical Center and eight neighborhood clinics. CCHP is ultimately governed by the Contra Costa County Board of Supervisors and has the fiscal support of the county government.

We are a Knox-Keene licensed agency and have offered prepaid Medi-Cal health services since 1976 and provided Medicare coverage since 1978. Over these decades we have developed a fiscal infrastructure currently enabling us to serve over 100,000 members through individual, family and employer group coverage; a Medicare Advantage-Special Needs Plan; Contra Costa County employee coverage; IHSS homecare worker coverage; the Major Risk Medical Insurance Board program; the Access for Infants and Mothers program; Health Care Coverage Initiative for uninsured county residents; Healthy Families Program; and Medi-Cal Managed Care.

With well over three decades of experience operating capitated managed care programs, we have the financial systems in place to operate a pilot program for duals integrating Medi-Cal and Medicare coverage, LTSS, and HCBS. However, for CCHP to assume financial risk for the pilot program, it is essential that the reimbursement rates for the pilot be actuarially adjusted to reflect the risk status of the dual eligibles actually enrolled.

2. Meeting the Needs of all Dual Eligibles

By offering a member centered care management model which develops a uniquely determined care plan for those members in need of case management, CCHP will be able to serve the heterogeneous dually eligible population. The care plan will be developed through an interdisciplinary medical/social assessment identifying the appropriate mix of LTSS and HCBS to be combined with appropriate medical care for the chronic conditions and health problems of the individual. Taking into account the needs and preferences of the member, caregiver(s), and family members, a care plan can be developed that provides access to LTSS and HCBS to maximize personal independence and reduce reliance on emergency care, acute hospitalization, or skilled nursing care.

CCHP has many years of experience providing culturally competent health care services to a socially and ethnically diverse low-income population. Bilingual staff and translation services are readily available. Moreover, over the past year in preparation for the imminent enrollment of the Medi-Cal SPD's, CCHP has made major efforts to assure adequate accessibility within the provider networks for persons with disabilities. Also, we have made major efforts to recruit additional PCP's specializing in geriatrics and physician specialists in neurology and other fields essential for serving persons with disabilities.

The dual senior population will be served by building upon longstanding CCHP collaboration with Contra Costa County Aging and Adult Services and by including IHSS, APS, and OAA services as core HCBS in assessment, care planning and service delivery. In addition, partnering with the MSSP and ADHC providers in assessment and care plan development will ensure the availability of these LTSS to the dual seniors. Contracts with skilled nursing facilities will assure access to institutional long term care.

With the exception of access to Older Americans Act Services and MSSP, younger adults with disabilities will be served by same collaboration, partnerships, and contracts for LTSS and HCBS as seniors noted above. In addition, collaboration with the independent living center program will provide this population with access to advocacy services, help obtaining assistive devices, and transition services to leave skilled nursing facilities as part of their care plan development.

For those dual eligibles experiencing serious behavioral health issues, their behavioral health providers will be included as part of the assessment and care planning team to assure that they receive integrated care. As previously noted, persons with serious mental illness will be able to receive behavioral health services from the County Mental Health Division of our department in an integrated collaborative service delivery model in partnership with the Ambulatory Primary Care at our regional clinics by the time the dual pilot program is underway.

CCHP will contract with intermediate care facilities to provide care for persons with intellectual and developmental disabilities when necessary.

At this time, we do not anticipate including regional center services among the HCBS to be included in care planning and service delivery. We propose providing health care and LTSS care management only to the dual population served by the Regional Center of the East Bay.

Persons with Alzheimer's disease and other dementias are a segment of the dual population for whom the pilot program clearly offers the opportunity for providing more effective and less costly care than may currently be available to them. Coordinating and providing access to OAA home visiting, chore, meal, and caregiver services; ADHC; APS; and IHSS may prolong the length of time that the member is able to continue living at home and reduce the amount of time spent in more costly institutional skilled nursing care. HCBS that provide respite and time off for family caregivers can delay the need to institutionalize such individuals. Given the exponential growth expected in this population, an integrated service delivery model may be an important vehicle for achieving significant cost savings.

As noted earlier, CCHP proposes to contract with skilled nursing facilities and intermediate care facilities to provide LTSS for duals requiring that level of care. Physicians or nurse practitioners will be assigned to provide routine medical and follow-up care to these institutionalized members. Inclusion of the skilled nursing benefit in the pilot program offers the opportunity to build into the assessment and care planning model the ability to divert dual eligibles from inappropriate skilled nursing placement or to transition duals out of nursing homes back to independent living in the community in a timely manner before they lose access to independent housing or other community based supports. Under the current non-integrated model of care, when a medical crisis occurs, in the absence of a comprehensive assessment

of what HCBS and LTSS may be available, nursing home placement is often the automatic default choice for far too many dual members.

3. Change Promoted by Integrated Model

   a. Member Behavior

      The care management model proposed in this integrated model will promote the ability of members to manage their own self-care to the greatest extent possible. Dual enrollees at risk of medical problems and/or inappropriate emergency care, acute hospital care, or nursing home placement will be identified both by a self screening tool and Health Risk Assessment similar to that being used by SPD's currently being enrolled by CCHP as well as by a review of individual diagnoses and prior utilization patterns indicating high risk characteristics. Those individuals will then undergo a comprehensive assessment to determine their personal strengths and limitations and to develop a care plan to provide appropriate medical care for any chronic conditions and offering them access to LTSS and HCBS to assist them to live as independently as possible. This care plan will promote member self-empowerment to the greatest extent possible in order to maintain or increase his/her ability to maintain independence and avoid episodes of unnecessary health care intervention.

   b. Use of Services

      Objectives for care management will include increasing member knowledge, understanding, and effective utilization of available and appropriate LTSS, and HCBS; encouraging the member to proactively access appropriate medical care to reduce the occurrence of health crises, emergency care, acute care hospitalization, and the need for case management intervention; and enhancing the member's and caregiver's ability to anticipate and/or self plan for future health care and social service needs.

      Pilot program case management will make it possible to reduce reliance on nursing home placement after medical crises by offering access to LTSS and HCBS as an alternative whenever they are more appropriate than institutional care. Or, in those situations where nursing home placement is appropriate, case management will be available to assess the member's ability to transition back to

independent living at the earliest possible time before independent housing and personal support systems become unavailable.

CCHP has initiated a Hospital Transition Nurse to assist patients discharged from hospitals with a home visit to coordinate access to ambulatory care and prevent unnecessary readmissions to hospitals or unnecessary SNF admissions.

4. Change of Provider Behavior and Service Use

This integrated model of care provides financial incentives to divert care from more expensive institutional skilled nursing care to less costly HCBS such as IHSS, ADHC, MSSP, social day care, home visiting, chore services, home health care, etc. Inclusion of institutional nursing care in the capitated rate for the dual eligibles will create a fiscal incentive to shift care to these community based services whenever they are the appropriate alternative. Moreover, involving individual members in the development of their care plan and informing them of the availability of these HCBS will create increased member demand for avoidance of nursing home placement. It is highly unlikely that a dual member would choose nursing home placement if he/she is made aware of the actual availability of HCBS alternatives. In addition, enhancement of HCBS will make it possible to encourage family caregivers to continue providing care in the home environment with the assistance of additional services and supports.

5. Blending of Medicare and Medi-Cal Funds

The blending of Medicare and Medi-Cal funds in the dual pilot will further support the ability of CCHP to direct service delivery toward HCBS and away from emergency care and acute care hospitalization. To the extent that the dual pilot program is successful in promoting effective self-care among members and appropriate use of PCP's while reducing episodes of emergency care, hospitalization, and unnecessary SNF placement, the resulting Medicare and MediCal funded savings in emergency care and hospital care will make additional resources available to expand alternative HCBS or enhance care management, health care education, and outreach activities for the dual eligibles.

6. Community Support

a. Local Provider and Stakeholder Support

A comprehensive community planning effort which began fifteen years ago jointly led by CCHP and Contra Costa Aging and Adult Services resulted in a broad base of community support for the development of an integrated long term care service delivery model in Contra Costa County. CCHP was prepared in 2005 to begin implementation of such a program in collaboration with Aging and Adult Services but set the plan aside after failing to gain State support for the concept.

The community planning effort included participation from such stakeholders and providers as the County Advisory Council on Aging, Independent Living Resource, the network of Area Agency on Aging service providers, the ADHC's, city commissions on aging, IHSS staff, IHSS Public Authority, home health care agencies, public health nursing, senior centers, advocates for both seniors and persons with disabilities, and community hospitals. We expect these stakeholders and service providers to see the Dual Eligible Pilot Program as the opportunity to finally implement the vision developed years ago in our planning effort to implement "a capitated member-driven system of comprehensive integrated long term care for medical, social, and supportive services for seniors and persons with disabilities" including those "dually eligible for Medicare and Medi-Cal."

We have recently met with the Director of the County Employment and Human Services Department and the Aging and Adult Services Director and they both endorse participation in the Dual Pilot Program as a vehicle for moving forward with long term care integration in the county. In addition, the Program Officer responsible for administration of MSSP and ADHC at Rehabilitation Services of Northern California has expressed support for our intention to pursue the pilot program. We intend to work closely with these two agencies and other major stakeholders in preparing our response to the future RFP.

b. Member Participation in Governance

The Managed Care Commission provides advisory oversight to CCHP, the County Health Services Director and the County Board of Supervisors regarding the operations of CCHP. The County Board of Supervisors appoints its fifteen members. To assure member participation in the governance of the pilot program,

we propose to expand the membership of the commission to include additional member representation from the dual eligible subscriber membership.

7. Data Needed

In order to adequately prepare a proposal in response to the future RFP, we would like access to recent cost, utilization, and demographic data from Medi-Cal, Medicare and IHSS for the dual eligibles residing in Contra Costa County including risk profiles, diagnoses, chronic conditions, medical providers, LTSS usage including skilled nursing and waiver programs, age distribution, and residential zip codes.

In addition, we would like to have recent data regarding the numbers of duals currently residing in the county who are already enrolled in various managed care plans.

8. Questions Needing Answering

a. Will the rate development process be based upon the risk adjustment of the population?

b. Will the State give sufficient assurance to CCHP and Contra Costa County government that the reimbursement rate(s) ultimately developed will be adequate for the county to accept financial risk for implementation of the pilot.?

c. Will there be funding available to cover start-up costs and pre-implementation activities such as education and outreach to providers, members, caregivers, and community stakeholders?

9. Timeline

As noted earlier, we have proposed phasing in the enrollment of the dual eligibles over a two year period to provide enough time to gradually build a larger care management staffing capability, expand the medical provider networks, and broaden the capacity of HCBS providers. If the pilot sites are not selected until March, 2012 and start-up activities cannot begin until some time after that date, there will be only seven or eight months available to undertake implementation activities before enrollment of the first duals.

Realistically it will take several years to fully build a system of care for approximately 21,000 duals. Enhancement of HCBS is a particular challenge in the current political environment where many of those providers have experienced major program reductions in recent years due to State budget problems. Rebuilding and expanding their capabilities will take time as CCHP gradually becomes able to shift expenditures from skilled nursing and acute care to community based care.