June 1, 2011

Mr. Toby Douglas
Office of Medi-Cal Procurement
Department of Health Care Services
State of California – Health and Human Services Agency
Attention: Teri Lesh
c/o: omcprfp9@dhcs.ca.gov

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

Dear Mr. Douglas:

We at HealthCare Partners are very pleased to submit our response to the Request for Information ("RFI") regarding the ideal model for serving beneficiaries who are eligible for both Medi-Cal and Medicare.

We strongly believe that this pilot provides an excellent opportunity to demonstrate the ability to generate substantial savings for the State of California through comprehensive home and community-based services fully integrated into the medical and behavioral delivery system, including vertically-integrated long term care, and structured around the ability for potential contracted entities to risk stratify the patient population and take financial risk.

As a leading Southern California and national medical group organization, HealthCare Partners incorporates these same critical success factors into the daily service of our more than 700,000 patients as reflected in our vision to be the role model for integrated and coordinated care, leading the transformation of the national healthcare delivery system to assure quality, access and affordable care for all.

We look forward to continuing to work with the Department of Health Care Services on this important work. In the interim, please contact us if we can be of assistance.

Very truly yours,

Robert Margolis, MD
CEO
HealthCare Partners

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

HealthCare Partners

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

Passive auto-enrollment with ability to opt-out.

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

Comprehensive home and community-based services capabilities and delivery systems, fully integrated into the medical and behavioral health delivery system as well as long-term care including the ability to take financial risk, relating to medical care, long-term care and home and community-based care.

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

A fundamental precept of the integrated model is that behavioral health be comprehensively integrated into the medical delivery system including full deployment of collaborative care. Anything less (e.g., treated as a separate carve-out or silo) fundamentally prohibits the delivery model from optimizing patient outcomes and cost efficiencies. Medical care integrated with behavioral health intervention through a collaborative care program/bio-behavioral rehabilitation, problem solving therapy, social skills training as well as comprehensive care of all medical diagnosis and social rehabilitation in medical centers co-managed by a internal medicine/family practice primary care physicians, psychiatrists, nurse practitioners, nurse care managers and behavioral health psychologists/social workers improves treatment of medical conditions prevalent in this population as well as the full array of behavioral health disorders such as but not limited to depression, dementia and psychotic disorders.

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?

Providers of long-term support services must be fully integrated into the health care delivery system rather than participating through traditional vendor relationships. Accordingly, the Request for Proposal should encourage active participation and integrated care delivery with the chosen system through vertically-integrated providers of long-term supports and services with the primary delivery system(s) supporting the pilot program.

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

Due to the inherent complexity of diseases in the dual eligible population and wide variability of primary diagnoses, it is necessary to integrate all medical services for the chronically frail and ill to meet their medical needs, activities of daily living, life/social needs and bio-behavioral needs supporting patient and

family empowerment and independence resulting in improved quality of life and demonstrable health care outcomes. The model should therefore include the ability to risk stratify patient populations to best deliver quality medical care by the most cost-effective means while supporting lifestyle independence. Tactically, this would include a comprehensive set of robust specialized integrated programs supporting quality, continuity and patient independence.

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

Education and outreach for participants and their family/ caregivers should emphasize:

Stakeholders: foundational training regarding the components of the coordinated care system and partnerships required to optimize benefits and outcomes; also, explanation of expected outcomes and reporting tools and systems that will be accessible to communicate ongoing results in a manner allowing for stakeholder feedback to make program modifications on a timely basis

Beneficiaries: empowering the partnership with the delivery system in terms of quality and outcomes through defining the components of the delivery system and how best to access and interact with system resources

Providers: ensure providers' missions and visions are closely aligned with the state's own goals for protecting the constituency, improving quality and lowering total cost of care

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

Contractor requirements should include: financial stability; ability to take full risk; experience with successful implementation of large delivery systems; ability to work collaboratively with multiple advocacy and constituency groups as well as the other providers necessary to deliver quality, cost-effective care; experience delivering quality outcomes (as determined by IHA and Medicare Star measures) as well as meeting HEDIS and NCQA Quality measures while reducing total cost of care and not disrupting pre-existing physician-patient relationships while implementing new and continuous-improvement-based coordinated care models; and, robust capabilities in information systems including meaningful use.

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?

Contractors must be able to demonstrate seamless, in-house cultural competency for meeting the cross-cultural needs of the patient population relating to care delivery including cultural, language and communication competency and ability to offer care locally in the patients' communities. These capabilities must be supported by ongoing continuing medical education programs to evolve provider skills consistent with the evolution of their patient populations. In addition, there should be a patient advocacy board supporting and providing input to the provider organizations selected.

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

Participation in patient and family advisory boards and advocacy boards for all delivery systems

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

Critical elements to facilitate successful implementation include: access to Medicare and Medi-Cal funding through full capitation facilitating seamless integration of programs and resources, mechanism for passive auto-enrollment with an opt-out option providing sufficient patient populations to support comprehensive program delivery, and robust data on utilization and finances to support correct design of programs and resource-related financial planning.

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

Programs should be evaluated every six months with a yearly audit to assess results relating to improved quality consistent with IHA standards and Medicare Star guidelines, HEDIS and NCQA quality guidelines, state access standards, minimization of patient disenrollment, patient and provider satisfaction and appropriateness of financial savings to the state.

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?

Potential financial arrangements should be designed as full-risk-only with guaranteed savings. Approaches to rate-setting and risk should incorporate state-of-art risk stratification algorithms and systems to most appropriately align patients with program professionals and resources to ensure cost-effective, quality outcomes.