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June 1, 2011

SENT VIA ELECTRONIC EMAIL TO: omcprfp9@dhcs.ca.gov

Re: Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare – Response from Health Plan of San Mateo

The Health Plan of San Mateo (HPSM) intends to submit a proposal to DHCS to be one of the contracting entities for the duals pilots. HPSM, in partnership with the San Mateo County Health System (SMCHS), have long sought to adopt more integrated systems of care for duals. We are excited about the potential opportunity to contribute to this important initiative. We also would like to take this opportunity to comment on the questions listed in the RFI released April 29, 2011. Our comments are outlined below and follow the structure of the RFI.

HPSM is a County Organized Health System (COHS) serving vulnerable residents of San Mateo County since 1987. HPSM currently provides services to nearly 100,000 members through multiple coverage programs including Medi-Cal, Healthy Families, a Medicare Special Needs Plan, and other local insurance and coverage initiatives. Nearly all San Mateo County residents covered by Medi-Cal are members of HPSM. Approximately 13,300 full benefit duals receive their Medi-Cal benefit through HPSM, of which 8,100 (or 61 percent) are enrolled in HPSM's Special Needs Plan (SNP).

Part 1: Questions for Potential Contracted Entities Only (Please limit to 15 pages)

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

a) *Geographical location:*
- San Mateo County

b) *Approximate size of target enrollment for first year:*
- 13,300, i.e., all full benefit duals who are San Mateo County residents.
- 8,100 are already members of HPSM's Special Needs Plan (SNP) for dual eligibles. Remaining dual eligibles are in Fee for Service (FFS) Medicare, enrolled in the other SNP in the county, or enrolled in other Medicare Advantage plans.

c) *General description of provider network, including behavioral health and LTSS*
- Robust preventive, primary, acute, and long term care institutional provider network currently contracted with HPSM:
  - 850 primary care providers
  - 1,500 specialists
  - Hundreds of pharmacies
  - 150 skilled and long term care nursing facilities, including a county owned 280 bed Distinct Part Skilled Nursing Facility (Burlingame Long Term Care)
  - Over two dozen contracted acute care facilities

    - Tertiary care facilities
    - Multitude of specialty allied health providers (home health agencies, outpatient rehabilitation facilities, multi-specialty clinics, radiology, surgery centers, audiology, medical transportation, hospice, durable medical equipment, orthotics and prosthetics providers)
    - San Mateo County safety net providers, including a public hospital and its 10 outpatient federally qualified health centers (FQHCs) and a freestanding non-profit FQHC.
    - A multi-disciplinary senior care center that specializes in care for older dual eligibles
- Behavioral health and substance use network through a subcontract with San Mateo County Behavioral Health and Recovery Services (BHRS):
    - BHRS currently provides such services for all HPSM Medi-Cal members and already serves as HPSM's subcontractor for our SNP members, including specialty mental health and substance use services for duals with complex issues.
    - Services for those duals with less serious and complex mental health and substance use problems are embedded in primary care settings.
    - Services are directly operated or contracted by BHRS, including
        1. Five specialty mental health clinics operated by BHRS
        2. Entry/call center operated by BHRS and staffed by licensed and unlicensed clinical social workers, marriage family therapists, community mental health nurses, psychiatrists, community workers, and administrative staff
        3. Nurse practitioners from primary care, nurse care managers, and wellness coordinators located in the specialty mental health clinics and who provide primary care services to mental health clients who would not be successful accessing primary care clinics. This model needs to be expanded to improve access to primary care for clients who have addictions.
        4. Primary care based mental health services through a clinical team that is co-located with primary care federally qualified health centers.
        5. More than 120 private providers, six community non-profit providers, and three hospitals in the mental health network that offer the full range of screening/assessment, outpatient, case management, residential, inpatient and medication services reimbursable through Medicare and Medi-Cal.
        6. Substance use treatment system includes 13 nonprofit provider organizations who deliver screening/assessment, outpatient, case management, residential, non-medical detoxification, and medication assisted treatment.
- Long term services and supports (LTSS) through partnerships and subcontracts with San Mateo County Aging and Adult Services (AAS), the San Mateo County Public Authority, and Adult Day Health Centers:
    - Many LTSS for seniors and adults with disabilities are currently centralized in AAS and within the Health System, which has enabled AAS to develop expertise in case management and service coordination. AAS provides

direct services through programs such as: In-Home Supportive Services (IHSS); Multipurpose Senior Services Program; Information and Assistance TIES Line; Adult Protective Services; 24-Hour Response Team; Linkages; Public Guardian Program and the Representative Payee Program.
    - San Mateo County's Public Authority currently contracts with more than 3,000 Independent Providers and a contract personal care agency to provide personal care services for IHSS consumers
    - AAS also serves as the Area Agency on Aging (AAA) for planning, coordination, funding, and advocacy for seniors and adults with disabilities in San Mateo County, and contracts with community organizations for AAA funded and other funded services, including: Hospice; adult day care; Alzheimer's Day Care Resource Center services; transportation; meals on wheels, congregate nutrition, family caregiver support services, recreation, legal and ombudsman services, and other types of medical or non-medical care to help consumers maintain their health and well being.
    - Two Adult Day Health Care Centers operate in San Mateo County and both have indicated interest in contracting with HPSM as part of the LTSS network.
    - Housing developers and operators will be important partners, particularly those specializing in low income and senior housing, such as the Lesley Foundation, a non-profit operator of assisted living facilities for low-income consumers.
    - Community board and care facilities that specialize in housing behavioral health and other dual beneficiaries will also be critical to the success of the pilot .
    - A goal of the duals pilot will be to incorporate the PACE option for eligible and interested beneficiaries, most likely through neighboring PACE programs in adjoining counties.
- HPSM is committed to contracting with all necessary providers to ensure a sufficient provider network is available to deliver timely, high quality care for all covered services. HPSM currently meets and exceeds network adequacy requirements in our existing Medi-Cal and SNP contracts.

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

- HPSM will be the single accountable entity that will receive funding for HCBS services funded by Medicaid and will have overall responsibility for providing high quality and appropriate integrated services.
- HPSM will subcontract with AAS, the San Mateo County Public Authority, and Adult Day Health Centers to arrange for and provide HCBS services. AAS will also coordinate all non-Medicaid funded home and community based services in conjunction with this pilot.
- AAS will be responsible for managing the single point of entry (SPOE) for long term care integrated services, and will ensure that consumers are appropriately registered and that their health, functional status, and social service needs are assessed in a comprehensive and uniform manner.

- Program participants will be assessed using San Mateo County's Uniform Assessment Tool (UAT) to determine their medical, social and behavioral health needs.
- The client or consumer will be at the center of an interdisciplinary care team (IDT), joined by HPSM and AAS staff, the PCP, and – with the agreement of the consumer – the in home care worker(s). These teams will develop care plans, coordinate care and ensure consumers receive the assistance they need to maintain their health and remain in their homes and communities. Other staff, such as BHRS staff or HCB service providers, will participate in the IDTs as needed.
- The Public Authority will maintain responsibility for employing, training, and arranging for payment of IHSS workers through a contract with HPSM. With agreement from the client, qualified IHSS home care providers will be integrated into the primary care IDT to play a key role in monitoring and coaching their clients on their care plans. Functionally, all personal care services would continue to be consumer-directed.

e) Assessment and care planning approach

- The core principle of the care planning approach is it will be person centered. Rather than working to make a consumer eligible for the confusing patchwork of current categorical programs, the integrated services program will assess the client for all needed services. The program will then bring those needed services to the client in a seamless way.
- As stated above, AAS will be responsible for managing the Single Point of Entry (SPOE) and the intake process. The goal is for HPSM, any hospital, home and community based organization, nursing facility, and other county divisions to serve as a "virtual" SPOE, meaning that every relevant organization in San Mateo County (SMC) through which a client may seek service (e.g., medical, social, emergency) will be trained to complete formal referral to the actual SPOE. This model will ensure that there is "no wrong door" to access integrated long term care services.
- Following referral to the SPOE, the SMC Uniform Assessment Tool (UAT), a validated tool for assessment across a number of demographic, social, cognitive, behavioral, functional and clinical domains that reflects the various needs of older adults and people with disabilities, will be administered by a care coordinator.
- HPSM will also target pilot participants through review of information on its own SNP members. All dual members of the SNP already have detailed care plans, as required by CMS. These will be reassessed and updated with the assistance of the IDTs to ensure members receive all benefits available in the pilot program.
- For pilot participants not currently enrolled in HPSM's SNP, care coordinators will conduct a comprehensive assessment and develop an individualized care plan that addresses the full continuum of care – preventive, primary, acute, behavioral and long-term care.

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

- Care management via interdisciplinary teams (IDTs) build on the medical home framework that encourages all providers to work together to meet the full range of service needs of patients across the continuum of care. The client will be at the

center of the IDT and, with his or her agreement, the in home provider will be part of that team as well. Clinical, social services and care management staff from HPSM, AAS, and BHRS, also part of these teams, will ensure participants receive the assistance and care they need to maintain their health and remain in their community.

- IDTs will be responsible for identifying pilot participants transitioning between levels of care and conducting necessary care coordination and follow up activities. HPSM's dedicated Care Transitions Team performs similar functions for our SNP members. Other responsibilities of the IDT include:
    - Ensuring the pilot participants are actively involved in defining their desired outcomes and their care management;
    - Reviewing the health and social service needs of newly enrolled pilot participants;
    - Stratifying pilot participants into risk categories for high-level management;
    - Developing evidence-based individualized health and social service care plans;
    - Referring pilot participants to social services and to health and HCB providers for services as needed;
    - Monitoring care delivery across the continuum of services; and
    - Regularly reassessing pilot participant needs as they move through their care plans.

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

- HPSM is a County Organized Health System which has been taking risk for this population for nearly 25 years, albeit for a more limited array of services. HPSM is already at risk for all Medicaid acute, primary and specialty care, allied health services, and long term care custodial services for the duals population in San Mateo County. With a few exceptions, all Medicaid beneficiaries in the County, including duals, are required to enroll in HPSM for their Medicaid services.
- Since 2006, HPSM has also held full financial risk for all Medicare covered services for the 8,100 duals enrolled in HPSM's SNP.
- HPSM holds a Knox-Keene license from the Department of Managed Health Care for all of its insurance service lines.
- HPSM would be the single entity accountable for financial, operational, and clinical outcomes. The Plan will develop contracts with all the organizations participating in the integration pilot.

2. How would the model above meet the needs of all dual eligibles, i.e., seniors, younger beneficiaries with disabilities, persons with serious mental illness, people with intellectual and developmental disabilities, people diagnosed with Alzheimer's disease and other dementias; people who live in nursing facilities, etc. If you would propose to serve a smaller segment than the full range of dual eligibles, please describe that approach.

- Our proposed model would apply to all dual eligibles. We strongly believe that carve outs of specific populations should be avoided as much as possible, especially since many beneficiaries do not fit neatly into certain categories and experience multiple conditions. While the model is still being developed, the

following are current thoughts and experiences concerning how the integration model meets the needs of all dual eligibles:

- The model would meet the needs of duals with **serious mental illness and substance use problems** by leveraging the capacity and continuum of rehabilitative services already provided through the existing San Mateo County behavioral health system of care and providers. This system has the advantage of offering and linking beneficiaries to other publicly available supports for people who qualify, such as housing. The providers in this system already collaborate with the providers of long term care and other older adult support services. Possible enhancements to this existing system of care through this integrated plan for duals include: Further integration of primary care, mental health, and substance use services to improve both health and behavioral health outcomes (Total Wellness) for people with serious mental health and substance use problems; integration of all types of treatment with the other supports that are provided through integration of long term care and other older adult support services; and integrated care management strategies for those duals with the highest utilization patterns, poorest health outcomes, and highest costs across systems.
- HPSM and San Mateo County already have substantial experience working with **duals with developmental disabilities:** HPSM was one of three managed care plans deeply involved with the transition of former Agnews residents to homes in their communities; and HPSM and SMC in recent years have developed two specialized clinics – the Puente Clinic at BHRS and the Esperanza Clinic at San Mateo Medical Center – that provide tailored behavioral health and medical services to adult DD consumers. Because HPSM already enrolls more than 700 DD members in its SNP, it has tested specialized interventions for this population. Finally, HPSM works very closely with the Golden Gate Regional Center (GGRC), assigning a full-time nurse to ensure integration of medical services offered by HSPM with the social services delivered by GGRC.
- HPSM also has experience in clinical management for **duals residing in long term care facilities.** The Plan currently employs a geriatrician, nurse practitioners, and a nurse to support quality of care for HPSM's nursing home SNP members and reduce unnecessary hospital admissions and visits to the ED. In addition, HPSM clinical staff ensures each member and their caregiver has had the opportunity to consider end of life choices they prefer and specify them through the California's Physician Orders for Life Sustaining Treatment (POLST) form. With a duals pilot, the model could expand to include stronger community supports for individuals who wish to transition from long term care facilities.
- More than two-thirds of HPSM's current SNP members are **over the age of 65;** the average age of the SNP membership is 70. As such, HPSM's SNP has built several programs focusing on the needs of seniors. One example is a grant funded project conducted jointly with San Mateo County's Ron Robinson Senior Care Center. Called the High Utilizers Grant, this program focuses on older duals at highest risk, with the most

complex problems, and who also receive IHSS services. The goal of this project is to bring interdisciplinary care coordination support to the members and their primary care providers to ensure the best possible health outcomes. An expanded duals pilot would permit the integration of more community supports for this especially vulnerable population.

- For duals with Alzheimers and other dementia, the first task will be to ensure there is proper identification of these conditions, which often go underreported. Inclusion of the UAT in the initial assessment will ensure a comprehensive planning approach that responds to these conditions. Having Adult Day Health Care Centers as part of the directly contracted network will also help ensure appropriate services for these individuals and their families. We will work closely with the Alzheimers Association and other stakeholders to improve service integration in this area.

3. *How would an integrated model change beneficiaries' behavior, e.g. self-management of chronic illness and ability to live more independently, and use of services?*
    - An integrated approach would allow HPSM the flexibility to provide services based on individuals' needs, rather than on categorical program restrictions like those currently in place for Medi-Cal and Medicare.
    - Integration of long-term care financing, services, and covered benefits would provide appropriate financial incentives for helping people live in least restrictive environments. Currently, HPSM receives community level reimbursement unless an individual is in a long term care aid code, i.e., lives in an institution. Therefore, no financial savings can be accrued to the plan or program if an individual is moved out of an institution or admission is prevented or delayed. With this pilot, HPSM will be able to identify pilot participants who are currently reliant on institutional care but may be able to live in the community with the appropriate investment in HCB services. An integrated approach also would promote more use of HCB services for those at-risk for institutionalization in order to prevent or delay nursing home placement. HPSM would reinvestment any institutional savings to fund and provide gap services that are medically necessary but current categorical programs do not cover or allow.
    - The model will be based on the principle of consumer directed care to the great possible extent, including for behavioral health and substance use services.
    - Program models currently in use at HPSM emphasize this approach to the greatest extent possible. For example, HPSM's Care Transitions Program focuses on self management by providing coaching for individuals who are discharged from hospitals. Patients are empowered to manage their own care over the long term and given practical tools to do so.

4. *How would an integrated model change provider behavior or service use in order to produce cost-savings that could be used to enhance care and services? For example, how would your model improve access to HCBS and decrease reliance on institutional care?*
    - As described in the response to #3, above, an integrated model can substantially improve the financial incentives for a risk bearing entity to improve access to HCBS and decrease reliance on institutional care. The current financial

arrangements create an institutional bias for long term care by penalizing plans financially for developing alternative non-institutional housing arrangements.
- By consolidating the accountability for finances, services, and outcomes within one risk bearing entity, the opportunities for seamless access to HCBS would increase. The current patchwork of categorical programs makes the timely provision of appropriate services difficult for providers and consumers.
- Under the proposed model, IDTs would have the flexibility to ensure clients receive the services they need timely, without having to wade through the categorical restrictions associated with individual HCBS programs.
- The proposed model will produce cost savings in areas beyond long term institutional care. For example, we anticipate reductions in hospital admissions and ER visits through appropriate care coordination, social services supports, care transitions planning, targeting of the highest risk consumers, and through enhanced clinical care in long term care facilities. Provision of appropriate coordinated care support to primary care physicians for their most complex patients will also help reduce costly inpatient admissions and ED visits.

5. *How would your specific use of blended Medicare and Medi-Cal funds support the objectives outlined in the proposal above?*
   - Blended funds will: a) allow IDTs to develop treatment plans based on the person and their individual needs, and not be limited by whether a medically necessary services are covered or not covered; b) simplify the patient experience and reduce administrative barriers to care by eliminating administrative duplication and complexity; and c) encourage greater utilization of preventive services knowing that short-term savings that would normally accrue to Medicare (or the federal government) will accrue to and be reinvested in the local community.
   - Blended funds will also reduce administrative complexities involved in operating two programs under two different oversight organizations, yet both serving the same individual. We concur with the principle that any new blended program should comply with the strictest consumer protections, whether they fall under Medicare or Medi-Cal rules. However, the current administrative burdens associated with complying with two sets of regulations and laws often do not benefit the consumer but do add to the expense of operating a program for dual eligibles.
   - Blended funding will ensure program alignment for the best interest of the consumer or beneficiary. This does not always occur under the current SNP structure, where SNP's and their focus on dual eligibles get lost in broader Medicare policies and regulations. These policies and regulations can run counter to the best interests of duals.
   - Finally, blended funding will ensure that community and county based social and behavioral health programs can bring their expertise and experience in service of dual eligibles. These programs are not designed to comply with the strict insurance based standards of the SNP program, which is a subset of Medicare Advantage, making it very difficult operationally to subcontract with county or community based organizations under the SNP Program.

6. *Do you have support for implementing a duals pilot among local providers and stakeholders? If so, please describe. If not, how would you go about developing such support? How would you propose to include consumer participation in the governance of your model?*

   - HPSM has the full support of the San Mateo County Health System (SMCHS), including AAS and BHRS, both of which will be primarily responsible for behavioral health and long term services and supports under the duals pilot. HPSM has worked closely with SMCHS for many years to establish a more integrated and locally-controlled health and social service delivery system in San Mateo County. In addition to the duals pilot, we also are collaborating in several areas, including a CCS integration pilot proposal. As mentioned above, BHRS already serves as HPSM's subcontractor for Medicare services provided for duals in the SNP.
   - HPSM has already begun and will continue to build support from other key providers and stakeholders through a series of in-person meetings to discuss our interest in this opportunity and program design ideas. So far in this process, we have discussed integrating long term supports with: hospitals in the community through the local Hospital Consortium; physicians through HPSM's physician advisory committees; nursing facilities; Adults Day Health Care centers; the IHSS Advisory Committee; Commission on Aging; Commission on Disabilities; SEIU, the union representing IHSS providers; community forums such as for the reauthorization of the Older Americans Act; the New Beginnings Coalition (a broad locally based coalition of community advocates); and non profit housing providers.
   - Depending on the model designed to integrate behavioral health and substance use services, we will plan additional outreach activities with mental health and substance use stakeholders in the community.
   - We will form a dedicated advisory committee that will ensure adequate consumer protections are in place during the transition to and implementation of the pilot. This advisory committee will be involved in the program design development process, review potential implementation issues affecting pilot participants, and make recommendations for consideration by HPSM's Commission. We would actively seek representation from pilot participants and providers throughout the continuum of care. We will also consider creating formal representation for pilot consumers and providers on the HPSM's governing board.

7. *What data would you need in advance of preparing a response to a future Request for Proposals?*
   - Fee for Service Medicare utilization data
   - Fee for Service Medicare cost data (if available)
   - Data on enrollment in other SNPs and/or Medicare Advantage plans for San Mateo County duals

8. *What questions would need to be answered prior to responding to a future RFP?*
   - How will the State ensure sufficient number of duals participate in the pilot? Will the state and CMS allow passive enrollment with ability to opt-out for all eligible duals in the target geographic area?

- Will there be any flexibility in the use of pilot funding for housing alternatives, considering the lack of appropriate housing is a key factor leading to unnecessary institutionalization in many parts of the state?
- Will the State lift categorical program rules and reporting requirements with the blending of Medicare and Medicaid funding, especially for categorical HCBS programs? If not, how will the State guarantee the reduction of the administrative complexities and expenses associated with these programs?
- Will there be additional funding available through the duals pilots, especially for historically underfunded Medi-Cal services such as for substance use prevention and treatment?
- Does the State plan to incorporate the ACA Health Home program for patients with chronic conditions into the duals pilots, particularly for dual eligibles with behavioral health conditions?
- How does the State plan to approach care for Medicaid only beneficiaries who may suffer from conditions as complex as the dual pilot participants? If programs that participate in the duals pilots also serve Medi-Cal senior and persons with disabilities how will the State prevent further carving up of populations on the local level? Will the State consider pilots that also include Medi-Cal only participants, especially clients in need of long term care supports and behavioral health services?
- Does the State plan to replicate Medicare risk adjustment methodology for the duals pilot? If not, how can plans be assured that reimbursement will be at least be as robust as under Medicare's system, if not improved (there are serious shortcoming in Medicare's risk adjustment process for certain categories of dual eligibles, about which we can provide additional information)?
- How will the State assure that cost savings from the pilots are used to enhance care and services, and do not accrue entirely to the State and/or the federal government for non-pilot services?
- HPSM's SNP experience has shown that Medi-Cal retention is a serious challenge for many in the duals population. Members who temporarily lose their Medi-Cal status risk losing all their duals related benefits and are forced involuntarily back into FFS, often causing disruptions in care. We have found a surprisingly high amount of churning among the dual Seniors and Persons with Disabilities (SPD) population. Will the State be addressing enrollment and disenrollment challenges related to Medi-Cal in preparation for the duals pilots, or at least consider how these can be mitigated in the pilots?

9. *Do you consider the proposed timeline to be adequate to create a model that responds to the goals described in this RFI?*
    - Proposed timeline is aggressive but achievable, as long as we have at least four months after finalizing rates in order to negotiate contracts with providers, obtain board approval, and conduct necessary outreach to and training for members and providers in the community.

Part 2: Questions for Interested Parties (including potential contracted entities): (please limit to 10 pages)

1. *What is the best enrollment model for this program?*
    - We propose passive enrollment with the ability to opt-out for all full benefit duals in San Mateo County. Passive enrollment was successful in San Mateo County during launch of our SNP in 2005-2006 – we experienced low number of beneficiary complaints and relatively low opt-outs. The program must obtain sufficient duals participation in order to generate meaningful results for other counties or regions of the State, and to be financially sustainable.
    - The State may want to consider different enrollment models in different pilot areas. Medical markets and the pilot models will vary widely throughout the State. In some regions, nearly all providers may be part of a duals project while in others relatively few may participate. In places where there is wide provider participation, there will be fewer disruptions in care for consumers and general acceptance from providers and consumers for a passive enrollment/opt-out approach. We recommend that pilot programs propose an enrollment approach that makes sense for their region and be responsible for obtaining and demonstrating local stakeholder support for that approach.
    - It is essential that consumer protections be built into the enrollment model and proposers need to demonstrate that there will be minimal disruption for consumers. However, our concern is that some of the people who would most benefit from coordinated care are the most difficult to reach through voluntary enrollment.

2. *Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?*
    - All current Medi-Cal covered LTSS and HCB services, as follows:
        i. In Home Supportive Services (IHSS)
        ii. 1915(c) Home and Community Based Waiver services including Multipurpose Senior Services Program (MSSP), Assisted Living Waier, and Nursing Facility / Acute Hospital Waiver
    - Institutional Long Term Care Services
    - Non-Medicaid services such as those funded under the Older Americans Act
    - Contract entities should have the flexibility to provide non-Medi-Cal funded services, or gap services, as needed – such as services provided in residential housing (e.g., assisted living or board and care)
    - Consideration should be given to providing housing services

3. *How should behavioral health services be included in the integrated model?*
    - The duals pilot should be a fully integrated model that includes both a full continuum of rehabilitative substance use treatment services and mental health services. Successful approaches to integration were explored thoroughly through the State's stakeholder process for the 1115 Waiver and the Behavioral Health Integration Technical Work Group devoted to this topic. The work group's recommendations should be revisited for this pilot. The benefits of an integrated approach have been thoroughly described in a number of papers that are posted

on the Behavioral Health Integration Work Group portion of the DHCS Waiver website: http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupBHI.aspx.

- In San Mateo County, we have been designing an integrated model that builds on the National Council on Community Behavioral Health Care's 4 Quadrant Model, which is described in several papers on the DHCS website: *Behavioral Health and Primary Care and the Person Centered Health Care Home* and *Substance Use Disorders and the Person Centered Health Care Home.* This model locates mental health and substance use services in primary care based person centered health care homes for most of the population. However it also provides for flexibility in tailoring health care homes for people with the most complex behavioral health problems. The health care home for the person with serious mental illness or addictions should tie directly to the specialty behavioral services, which may be field based or located in a specialty setting. The Behavioral Health Integration Work Group recommendations for pilots under the 1115 Waiver and the California Mental Health Directors Association Recommendations for Pilots through the 1115 Waiver identify many of the key elements of this approach.

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?*

   No Response

5. *Which services do you consider to be essential to a model of integrated care for duals?*
   - LTSS and HCB services (IHSS, MSSP, ADHC and other "gap" services such as services for people living in assisted living)
   - Acute care
   - Institutional LTC
   - Behavioral health and substance use services
   - Housing alternatives

6. *What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?*
   - Beneficiaries need to receive information about:
     i. Enrollment and opt out processes, as applicable
     ii. Access to and delivery of services
     iii. Consumer protections
   - Consumer advocates and local community organizations should be involved in beneficiary education and outreach, particularly to help tailor messages for specific types of consumers.
   - Providers need to receive information about:
     i. Enrollment and opt out processes, as applicable
     ii. Authorization procedures for covered services
     iii. Types of services offered and how to access those services

7. *What questions would you want a potential contractor to address in response to a Request for Proposals?*
    - Demonstrated support from and collaboration with local stakeholders, including beneficiaries, medical providers (physicians, hospitals, LTC facilities), HCBS providers and organizations (including local Public Authority, IHSS beneficiaries, and IHSS providers), counties where the program plans to operate, consumer advocates and unions, if appropriate.
    - Past success with managing care for duals
    - Experience serving Medi-Cal populations and in particular seniors and persons with disabilities
    - Demonstration of capacity and plans to meet the particular needs of dual subpopulations (i.e., developmentally disabled, severely mentally ill, physically disabled, etc.)
    - Demonstrated ability to respond to cultural and linguistic needs of program participants
    - Demonstrated ability to assume financial risk

8. *Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?*
    - DHCS should expect contractors to meet requirements put in place in the recent 1115 Waiver for SPD expansion as well as requirements and standards set by CMS for SNPs. Theses consumer protections are extensive and comprehensive.
    - In cases where Medicare standards are stricter than state standards, such as in marketing and complaints and grievances, the stricter standard should prevail. The same is true in cases where state standards are stricter.

9. *If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?*
    - No response.

10. *What concerns would need to be addressed prior to implementation?*
    - Communication plan for state/local program to inform all consumer, providers, and other organizations affected to identify and resolve issues
    - Outreach and education for beneficiaries, family and caregivers
    - Clear understanding of risk-sharing arrangement among entities involved – CMS, state and contract entity.
    - Transparent rate setting methodology

11. *How should the success of these pilots be evaluated, and over what timeframe?*
    - Ideally, there will be resources available to conduct an evaluation that:
        i. is comprehensive for all pilot sites, utilizing both quantitative and qualitative research methods;
        ii. represents at least three years of data to factor long-term impacts of interventions; and
        iii. is led by an independent and reputable research organization.

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?*
    - All Medi-Cal and Medicare utilization data used to develop rates should be shared with potential contract entities to allow such entities the ability to validate results
    - Rates should be appropriately risk-adjusted and be based on the acuity of actual duals enrolled in the pilot program, and not based on state or county-wide averages.
    - The State needs to develop a process to assure that pilot cost savings are used to enhance pilot care and services, and do not accrue entirely to the State and/or federal government
    - The State and CMS should consider a three-way contract and financial arrangement for the pilots to ensure CMS is a strongly engaged partner as these prototypes for risk sharing are being developed.