HealthCare Partners™

Medical Group and Affiliated Physicians

Dual RFI Response Summary

Improving Care through Integrated Medicare and Medi-Cal Delivery Models

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Organization Background

HCP Mission

HCP partners with our patients to live life to the fullest by providing outstanding healthcare and supporting our physicians to excel in the healing arts.

HCP Vision

HCP will 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.

- Managed care membership Medicare Advantage: 102,000; Commercial & POS: 437,000; Medi-Cal and Healthy Families managed care: 46,000;
- FFS Medicare, Medi-Cal, and dual eligible patients
- Staff model facilities (66 primary, urgent care, walk-in, ambulatory surgery, pharmacy); primary care physicians (236 MD's), specialist (287 MD's), IPA PCP medical offices 753, IPA PCP's (975 MD's), IPA Specialists (3,124 MD's); CA members 55% IPA, 45% staff model
- Broad health plans accepted/ 57 Affiliated Hospitals/ 50+ languages
- Coordinated integrated medical delivery system

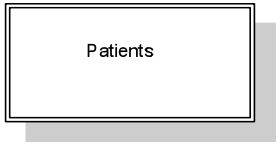
Existing Problems This Proposal Addresses

- Quality of care, absolute cost, and cost trends for the 360,000 dual eligible patient in FFS delivery system in LA County
  - Long term care rate of 6.8%; high hospitalization and readmit rates
  - Measurement and physician accountability to ensure quality
- Infrastructure and tools for clinicians, agencies, and delivery system
  - Data analytics, IT, actuarial, finance; EMR
  - Support for all willing qualified physicians
- Fully integrated physician delivery system meeting patient needs
  - Meet the challenge of patients opting out
  - Patients will have direct access to physician/med home
  - Access to care management and home monitoring
- Achievable cost savings of billion plus dollars
  - Population-based payment; global financial risk management; compensation tied to achieving budget & hitting quality targets
  - Scale to drive operating efficiency and effectiveness

Relationships With Key LA Partners

Partnership with SCAN for NHC patients duals and LA Care for safety net duals.

Integration with home & community-based services to reduce LTC Nursing Home institutionalization.



The "Integrator Program" with SCAN Health Plan

Overview: Proposed Integrated Care Plan

- Service Area/Location: LA County
- HCP coordinates all care – Acute, LTC , Home and Community
- Provider Network Basics: HCP will employ an all-willing, qualified provider methodology; large physician population in underserved areas; long term care medical home and home based care; collaborative behavioral health care
- Financial structure: Population-based payment; global financial risk

Key Points: HCP-SCAN-LA Care Coalition for Dual Eligibles

- Enroll 50,000 dual eligibles in 2012, up to 200,000 by 2013 and up to 360,000 by 2014. Directly enroll through passive auto-enrollment with opt-out dual eligible, non-NHC, non-safety net provider patients directly with HCP. Significant guaranteed financial savings.
- Enroll NHC patients into the "Integrator" model with SCAN and enroll additional patients from traditional safety net providers with LA Care
- Deliver core health care, supplemental services, care coordination, social /behavioral services and LTC; population management
- SCAN leadership in prevention of LTC institutionalization of NHC patients and integration of home/community-based services
- LA Care leadership with community clinics/FQHCs/safety net providers and SPD population

HCP Clinical Integration for Chronically Frail Complicated Patients
Risk Stratification Individualizes Care of Dual Eligibles

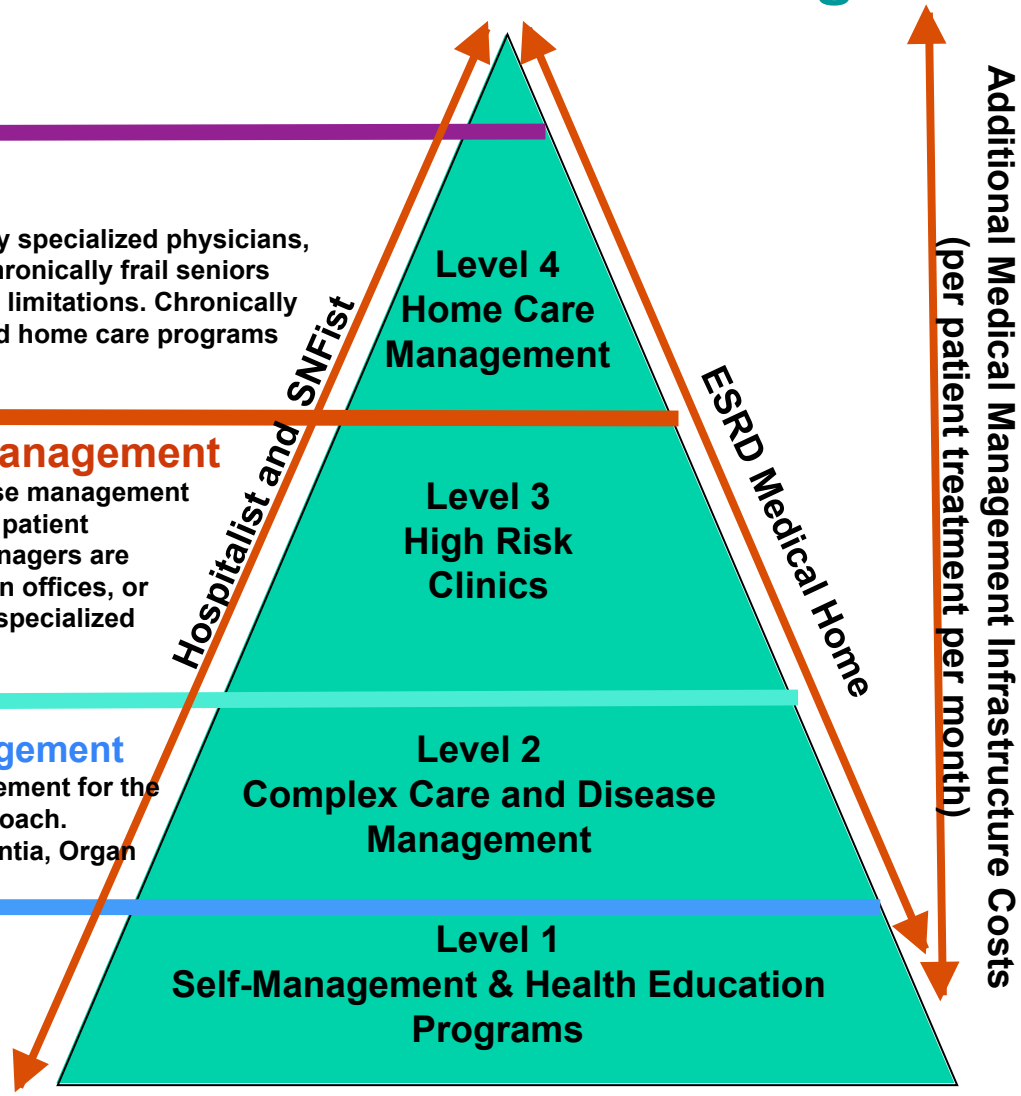
Hospice/Palliative Care

Home Care Management
Provides in-home medical care management by specialized physicians, nurse care managers and social workers for chronically frail seniors that have physical, mental, social and financial limitations. Chronically disabled patients receive specialized integrated home care programs

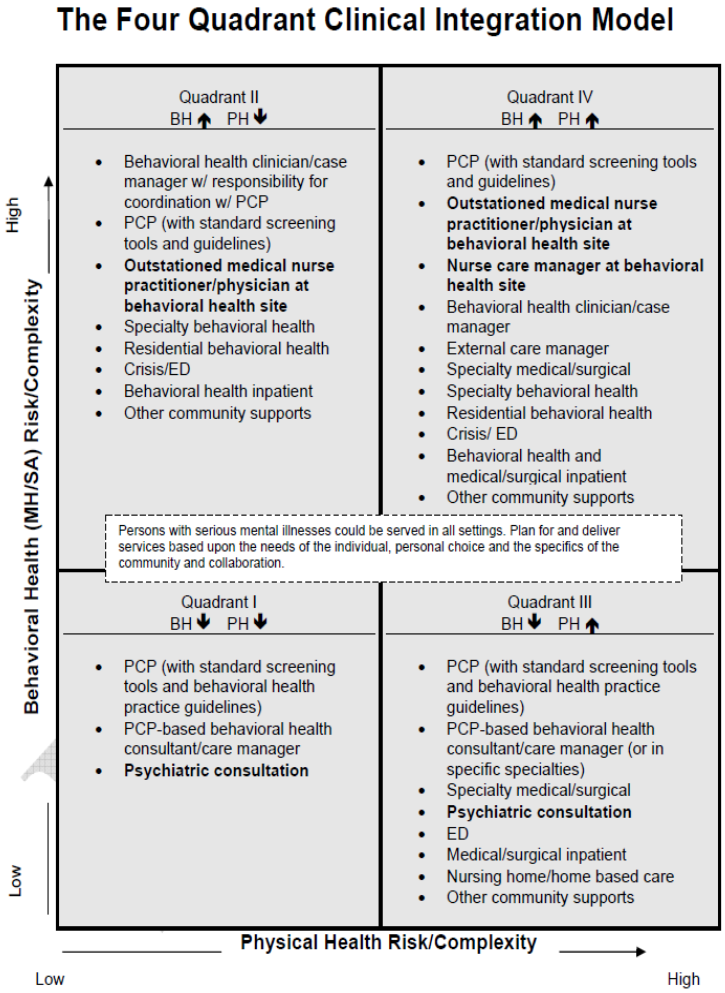
High Risk Clinics and Care Management
Provides one-on-one physician /nurse, and case management for highest risk population. As risk is reduced, patient transferred to Level 2. Physicians and care managers are integrated into community resources, physician offices, or clinics. Chronically mentally ill are directed to specialized medical clinics

Complex Care and Disease Management
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia, Organ transplant and Cancer.

Self Management, PCP
Provides self-management for people with chronic disease and prevention services.



Collaborative Care Model for the Chronically Mentally Ill



- Based upon the IMPACT model (Dr. Levine Original Team Lead in Design/ Implementation)
- All Patients and family have PCP and Psychiatrist Foundation for Care
- Collaborative Care – Integrated Bio-psychosocial Model

Long Term Care

Integration of Best in Class- Medical with Home and Community Services to reduce Long Term Care rates

Measures for Success

- Patient and Caregiver Satisfaction
- Opt Out Rate
- Hospital and ER Admits per 1,000 member per year
- Readmission rate per 1,000 member per year
- % of membership in SNF/NH for >90 days
- % of SNF/NH admits discharged to home in < 90 days
- % of all willing PCPs Participating in HCP-SCAN-LA Care Coalition
- % of all willing PCPs Credentialed by HCP-SCAN-LA Care Coalition
- Savings To State of CA: Pilot
- Savings to State of CA: Rollout

Information Needed from CMS and the State

- What is the patient population?
- What is the auto enrollment methodology?
- What is the full risk financial model?
- All willing provider participation?

Executive Summary

- HCP partnership with SCAN / LA Care and CMS / DHCS to deliver high quality and cost effective services to all of the Los Angeles County dually-eligible population
- HCP proven experience as top performer P4P/IHA for past 7 years and high Medicare STAR scores
- DHCS implements passive auto-enrollment with ability to opt-out
- HCP contracts with existing PCP and Specialists, subject to HCP credentialing, and training clinicians on HCP evidence-based medical guidelines, best practices and IT systems
- HCP to fully-enroll all of LA County's 360,000 dual eligibles by 1/1/14
- Substantial annual projected savings in LA County alone on full-risk design with guaranteed savings including LTC

HCP qualifications highlights

- Track record collaborating with caregivers and families of chronically-ill and frail driving quality care, dignity and independence
- History of care coordination and management; replicable and scalable systems; protocols for continuous improvement
- Financial and care management replicated in new markets/acquisitions
- Consistent improved quality while significantly reducing total cost

HCP coordinated care approach will help solve the CA FFS dual eligible financial and quality challenge

- Improve health care quality, reduce total cost of care, and improve patient access through innovation and re-engineering
- Movement away from fee-for-service physician reimbursement toward prospective capitated full risk payment methodology
- Multispecialty integration of physicians combined with hospitals and outpatient programs in group and IPA delivery systems
- Top rating IHA seven years in a row
- Accountable Care Organization; One of five national D/B ACO pilots

Deliverable: Savings With High-Quality Outcomes

- With an emphasis on coordinated outpatient care, HCP can reduce hospital costs while achieving outstanding clinical results
- HCP Medicare senior acute hospital bed day utilization and dual eligibles senior acute hospital bed utilization performance significantly better than National and California standards
- HCP dual eligible patients in LTC SNF facilities performance significantly better than National and California Standards
- HCP's ESRD Medical home, Behavioral Health Collaborative Care, Home Care & Comprehensive Care Clinics versus State of CA performance
- Expert in integration of new IPA physicians and medical groups to achieve quality and cost savings
- Accurate, timely program tracking; accelerated transition to a county-wide pilot program and then to full county implementation

Technology Backbone Facilitates Outcomes & Savings

- Allscripts/Touchworks EHR
  - Fully deployed Group Model
- EPIC Practice Management and EHR
- NextGen/PACIS for Affiliated Model
  - Physician practices at 200+ / year
- IDX Practice Management
- All feeds to Integrated Data Warehouse
  - Clinical EHR, Lab, Rx, Images
  - Encounters, Claims, Hospital A/D/C
- Patient Keeper Hospitalist System
- Predictive Modeling
- PIP – Physician Information Portal
- POP – Patient On Line / PHR
- HealthCarePartners.com