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;**
    b. **Approximate size of target enrollment for first year;**
    c. **General description of provider network, including behavioral health and LTSS;**
    d. **Specific plan for integrating home and community-based services, including non-Medicaid long term supports and services;**
    e. **Assessment and care planning approach;**
    f. **Care management approach, including following a beneficiary across settings;**
    g. **Financial structure, e.g. ability to take risk for this population.**

The Department of Health Care Services should consider a larger geographical area for the pilot programs that include more beneficiaries than 150,000. Enrollment in the pilots should be mandatory to minimize adverse risk selection or providers cherry picking healthier beneficiaries. Pilot organizations should be phased in, allowing organizations that can demonstrate the ability to improve overall health with quality care and decrease costs by providing more efficient and effective coordinated care, begin the pilot program much sooner than January 1, 2013.

Organizations qualifying for the first phase of pilots should be required to demonstrate:

- Adequate financial solvency - revenue to debt ratio of less than 10
- Approved limited Knox Keene license
- 10 years of full risk experience for the provision of both professional and institutional services
- NCQA certified in credentialing and recredentialing
- Stability in provider networks with contracts in place for over 10 years
- Combination of staff model and IPA model to ensure beneficiary choice
- Proven track record to effectively manage hospital utilization

- Use of effective predictive modeling to reduce hospital readmissions for high risk patients
- Ability to implement within 60 days

The model should be a fully integrated health care network organization. The delivery network should consist of affiliated medical groups and physicians, which include both large staff model campus facilities, satellite facilities at geographically distant locations and wrap around Independent Physician Associations (IPA). The model should employ physicians at their own primary care and multi-specialty group clinics as well as contract with independent primary care and specialty physicians and hospitals. The organization should use nationally recognized tools and standards of practice to guide providers in the provision of medical care. The network should be continuously assessed to determine where appropriate network development and growth needs to occur to ensure there are sufficient providers and facilities.

The organization works closely with its Behavioral Health partners in ensuring the members are provided services to meet their behavioral health needs. A network of physicians, licensed psychiatric assistants, licensed therapists, and licensed clinical social workers will triage the member and provide the necessary services. Members with diagnoses such as Depression, Anxiety, Dementia and Substance Abuse, are provided care with a special emphasis on: coordination of their medical and behavioral care through a central point of contact; and, seamless service delivery that meets the expressed needs and preferences of the member' behavioral health needs.

The model supports the provision of institutional long term care through a team of Skilled Nursing Facility physicians (SNFists), nurse case managers and other team members (i.e. Social Workers, Pharm Ds, Dieticians, Physical or Speech Therapists, etc) who have been identified through the health risk assessment of the member. The identified team manages and coordinates the member's care in the institutional setting.

Since community based services are integral in the provision of care to dual eligible members, the Case Management Team includes Licensed Social Workers (LSWs) which collaborate with the clinical team to determine the necessary home and community based services, personal care

services, adult day health care, meals and necessary physical, speech and occupational therapies that the member may require. The LSWs review the member's benefits and identify the community resources available to meet these needs. They work closely with the nurse case managers to ensure these services are delivered according to the care plan established for that member.

Home Health services are provided across the continuum of care from newborn to the elderly, and delivered in the privacy and comfort of the patients own home with staff available by phone 24 hours a day. The goal is to help prevent exacerbation of illness and unnecessary hospitalizations and/or emergency room visits, and to assist and encourage patients in becoming knowledgeable about their illness and as independent as possible with their care.

The organization facilitates collaborative coordinated primary care to our high-risk populations through a clinical team working in partnership with the member, the member's family/caregiver, member's primary care practitioner ("PCP"), the identified support structure, and other key parties.

The model includes expert, timely recognition and management of medical and behavioral health care needs with special emphasis on: coordination of care through a central point of contact; preventative health services; seamless service delivery that meets the expressed needs and preferences of the member; collaborative practice by interdependent professionals; paraprofessionals and ancillary personnel; implementation of clinical guidelines promoting best practices in the care of the member; and continuous quality improvement processes.

The medical care goals of the model include:

- Reducing unwarranted hospitalizations, emergency room visits and skilled nursing facility utilization
- Improving and/or stabilizing the member's self management and independence
- Improving and/or maximizing function and patient satisfaction by focusing on achievable outcomes which present more benefits than burdens for the member
- Stabilizing and delaying, if possible, progression of chronic illness to maximize the quality of life.

Once the member has been identified through eligibility or data mining efforts by the organization, the patient is assessed as to their acuity. The acuity score is used to stratify the patient into the appropriate programs. The programs available are disease management programs, anticoagulation program, ambulatory care program, palliative care program or a high risk case management program. The member is provided information in writing and, where applicable, in person on how to use the services, how they become eligible to participate in a program and how they can opt in or out of the programs.

The cornerstone of the model is the interdisciplinary team or IDT ("team"). Since high risk populations have at least one acute or chronic health condition and potentially other co morbid conditions, the team assigned to the member may consist of clinicians and allied professionals with specialized expertise-providing care through the life continuum.

The IDT plays an essential role in meeting the changing health care needs of its members by promoting partnership, teamwork, and collaboration while providing comprehensive medical services and benefit coordination.

Members of the IDT may include primary care practitioners, nursing professionals, pharmacists, social service workers, ancillary health care providers, (e.g. nutritionists, restorative therapists, etc.), UM staff, and other medical specialty and/or behavioral health providers who focus on collaboration, development, management, coordination and communication.
The IDT provides an array of individualized comprehensive services to each member that facilitates the PCP-patient centric relationship while focusing on preventative care, coordinating care delivery and facilitating communication with families, caregivers and providers.

A priority of the model is the coordination of care when members move from one level of care to another whether it is planned or unplanned. In most instances our concurrent review process monitors and assists in this coordination through communication with the member, the member's family and the PCP. The concurrent review nurse communicates with the discharge planner and case manager when appropriate to coordinate the member's care. Data is collected on all transitions of care and analyzed on an annual basis to determine if there are areas, which need improvement. If so, an action plan is developed and plans for evaluation is developed.

The model actively embraces the continuous quality improvement ("CQI") method in goal attainment. The model utilizes health outcome, program, quality and process measures to assess our performance in positively impacting our membership. Both quantitative and qualitative data analysis is completed to determine if the model has met or exceeded its benchmarks and if not why not. Opportunities for improvement are identified and a decision is made as to which improvements will be pursued and why.

Monitoring metrics include measuring patient satisfaction, tracking changes in health care utilization, cost of care, assurance of network adequacy, monitoring coordination and transition opportunities, development of individual care plans, and application of evidence based practice guidelines. All grievances and appeals are reviewed for quality of care, access, timeliness of care and staff attitude issues to identify opportunities for improvement.

The model of care emphasizes the value of providing preventative care through collaboration, coordination and communication. To reinforce this model's philosophy, robust training is provided both initially at hire or contract and at least annually thereafter throughout all levels of the care delivery system. A Quality Improvement Council provides oversight of the training and measurements of the program through regular established reports.

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.**

The model's case management care planning process is very robust and addresses all facets of the member's health, functional, mental and spiritual needs identified from a comprehensive initial health risk assessment tool. The tool has a built in scoring system which calculates an acuity score with which the case manager can risk stratify the interventions that need to be put in place to better manage the member's conditions/diseases. The care plan is a living document, which

includes results of IDT case rounds discussion and actions to be taken. It is important that a collaborative environment is established in working with the member to develop a care plan that is appropriate to the member's needs.

Care management for each member includes:

- Comprehensive health risk assessment of each member's medical, psychosocial, cognitive, and functional needs to develop the initial and ongoing plan of care
- Coordinating health care visits with a focus on early identification and treatment of illness
- Seamless care coordination of hospitalizations, emergency room visits and outpatient procedures
- Regular communication with the member and/or the member's family or responsible parties to foster open communication and verify agreement of care plan and advanced directives
- Ongoing communication with specialty, ancillary, and other providers
- Participation in team cares planning and case reviews on an ongoing basis.

3. How would an integrated model change beneficiaries' a) behavior, e.g. self-management of chronic illness and ability to live more independently, and b) use of services?

This model decreases the fragmentation of care by providing the IDT members the access to the member's health information electronically to facilitate care and documentation in the provision of seamless care. The team works together to determine what interventions and resources are necessary to manage the member's care and then ensure these services are delivered timely. The approach to delivering care is member-centered and encourages the member and the member's family/caregiver to participate in the decision process. By putting individuals first, this model assures every member has access to the highest quality of life as defined by individual preferences.

The model supports each member's right to self-determination, which includes an individualized care plan with an advanced directive program resulting in the clear communication of goals for ongoing care and the end-of-life experience. The goal of the model is to increase the member's self-

management skills to better manage their disease and condition and to use services more effectively and efficiently.

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?

Since dual eligibles have substantial health needs, they often see multiple providers, rely on both acute and long-term care services, use multiple prescription drugs, and do not have a single entity coordinating their care. These members might not be well served by incentives providers face to provide services based on Medicare and Medicaid reimbursement. The split of services between Medicare and Medicaid, and the overlap in coverage of some services, such as home health, DME, and skilled nursing, creates incentives for cost shifting between the programs rather than to provide care in the most efficient way.

Lack of coordination between Medicare and Medicaid may also affect the type of post-acute care patients receive when they are discharged from a hospital and the overall spending for that care. In some cases, dually eligible patients needing long-term care are discharged to a SNF because Medicare covers the first 100 days of SNF care. When the 100 days of Medicare coverage expires or the patients' needs shift from skilled care to a lower level of care, then Medicaid becomes the primary payor. However, if Medicaid had been the primary payer from the beginning, the patients might have been advised about non- institutional options at the outset of the stay, potentially leading to a better outcome for the patient and lower costs to Medicaid.

Of particular importance to this model is mitigation or management of planned or unplanned hospital admissions and admissions to long-term care facilities. The model requires that all its contracted hospitals and long-term facilities report admissions with one business day. Information on these admissions are collected and analyzed as to time when the report was received and where the member was admitted. A goal of the model is to minimize the number of unplanned admissions by working with our contracted hospitals and long-term facilities in the notification process. The model constantly examines the network to determine which facilities are not contracted so that

communication regarding contracting negotiations can take place. In addition, the model, through the IDT also communicates with the members to educate them on the importance of working with their PCP in preventing unplanned transitions of care. Data is analyzed on a scheduled basis regarding ED visits and unplanned admissions to determine the drivers of these admissions and what can be done to decrease them.

5. **How would your specific use of blended Medicare and Medi-Cal funds support the objectives outlined in the proposal above?**

Having beneficiaries enrolled in one managed care plan for Medicare benefits and another for Medicaid benefits raises a variety of problems for coordination of care. For example, a Medicaid managed care plan often has no opportunity to provide case management or direct its members to in-network providers. Similarly, the Medicare managed care plan does not have an incentive to manage beneficiaries' care to avoid long term care spending since the majority of the long term care spending in Medicaid's responsibility.

Many of these coverage and payment issues are generally alleviated if the dual eligible is enrolled in the same model for both Medicare- and Medicaid-covered services, and if that model is committed to integrating benefits.

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?**

This model currently manages the health care of hundreds of thousands of individuals in seven counties throughout Southern California. Contracts are held with approximately 2,300 primary care physicians, 30,000 specialist physicians and over 100 hospitals to provide the needed health care. In addition, the model employs hundreds of physicians at their own primary care and multi-specialty group clinics. The extensive provider network of physicians comprises both large staff

model campus facilities, satellite facilities at geographically distant locations and wrap around IPAs. The model has been developed to be scalable and has the capability of being exported to any geography.

There are 1.1 million dual eligibles in the State of California, of which about 700,000 live in the counties in which this model already provides an integrated care delivery system. For the counties that lack a strong network, we will work with the providers currently serving those beneficiaries and encourage them to join or contract with our network to eliminate the need for beneficiaries to change primary care physicians. The outreach process would include working with the Federally Qualified Health Centers (FQHCs) to encourage integration with our network. We also plan to engage in discussions with the beneficiary community to describe our model and provide them the assurances they need that we can provide better health care.

7. **What data would you need in advance of preparing a response to a future Request for Proposals?**

Claims and encounter data, pharmacy data, lab data and utilization management ("UM") data.

8. **What questions would need to be answered prior to responding to a future RFP? Are there specific geographies that need to be addressed in the RFP? If so what is the number of dual eligible members for each geography?**

We suggest that the geography be broader than 4 counties. There are over 1.1 million dual eliglble beneficiaries in California that would benefit from an improved delivery system and we suggest allowing as many dual eligibles to participate as possible. Also given the diversity of the patient mix in counties across California, we believe that a broader geographic area will give the State more information and experience in addresses the needs of the diverse population it serves. We suggest at a minimum that Los Angeles, Orange, Riverside and San Bernardino counties be included.

9. Do you consider the proposed timeline to be adequate to create a model that responds to the goals described in this RFI?

No, the timeline is too long and should be moved up at least 6 to 12 months. Our suggestion is to have a phased in project plan. This allows networks that already have infrastructure, a robust network, and a proven track record of improving health, improving quality of care and reducing costs to begin sooner. California's health care delivery system is built on the coordinated model and there are organizations that have the ability to provide better services at a lower cost to these beneficiaries immediately. The current delivery system encourages uncoordinated episodic care among providers causing not only duplication and inefficient costs to be incurred, but more importantly does not provide quality health care.